



RIGHT CARE

RIGHT TIME

RIGHT PLACE

## **‘Right Care, Right Time, Right Place’**

### **Report of Findings – Stakeholder Event Tuesday 12<sup>th</sup> August 2014**

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## 1. Purpose of the Report

The purpose of this report is to present the findings from the recent Stakeholder Event for 'Right Care, Right Time, Right Place'. This report describes the running order of the event, the content of each presentation and the feedback we received from key stakeholders. The report also sets out the legal obligations for engagement and the principles by which the Commissioners' want to engage, which forms part of their organisational strategy.

The Stakeholder Event is only one part of a whole process of engagement which has taken place over the past 3 months. The Stakeholder Event is referenced in the 'Communication, Engagement and Equality Strategy' for both the Providers and Commissioners response to the case for change.

The background to the engagement activity and the 'Case for Change' is described to set the context. This includes a brief introduction to the Providers' response to 'Right Care, Right Time, Right Place' and Calderdale and Greater Huddersfield commissioning intentions, and can be found in Appendix 1.

## 2. The Stakeholder Event

The purpose of the stakeholder event was to ensure that the process we had followed as part of both the Providers' and Commissioners' engagement process had adequately captured the views of all those who wanted to share a view or make a comment. In addition we wanted to provide feedback on the findings so far so we could gather any final views which could then be considered as part of the engagement process.

Following the Providers' and Commissioners' engagement process a joint report of findings was written on the feedback we had received. This report provided analysis on the data gathered and presented the key findings from:

- The commissioning intentions, and
- The Providers Strategic Outline Case

This report of findings formed the basis of the stakeholder event ensuring that we were able to;

- Present the findings from the engagement activity to key stakeholders.
- Provide a further opportunity to provide comment.
- Describe how the information will be used.
- Describe the community model, in hospital model; and
- Present the evaluation criteria

The purpose of the event was to ensure key stakeholders participated in helping to align the findings from the engagement activity with any future models and plans. The event plan can be found on the website.

## 2.1 The Event

A stakeholder event took place on Tuesday 12<sup>th</sup> August at the Shay Stadium in Halifax and the event ran from 10:00 -3:00pm. Stakeholders were invited and through this invitation (see Appendix 2) were asked to nominate representatives to attend the event. This was to ensure there was representation from a number of organisations from both Calderdale and Greater Huddersfield.

Representatives were made up from the following stakeholder groups:

- Local Councillors and MPs
- Heathwatch
- GP Practice Patient Reference Groups
- The Third Sector
- Right Care, Right Time, Right Place, Reference group
- Clinicians and staff from a number of local health and social organisations.

A full list of invitees will be added to the appendices in early September.

## 2.2 Presentations and Content

The stakeholder event was managed in four sections, with each section containing a presentation (please see website) followed by a table discussion. The four sections were:

- What has happened so far?
- The community model
- The in hospital model
- The evaluation criteria

In addition there were a number of additional opportunities to provide feedback which included;

A **comments clothes line** for people to peg up comments on pieces of card of anything they wanted to say that could not be captured adequately in the discussions.

The **opportunity to read each tables comments and vote on them**. Each table displayed the views they had gathered at lunchtime. Participants were given a strip of green (agree with) and red (disagree with) dots that they could place next to any comment to show their vote (see appendix 3).

A **question and answer session with commissioners** at the end of the event to enable participants to ask any question and share a view or request a comment.

An **evaluation form** which gathered people's views at the end of the event, and provide a final opportunity for participants to tell us anything they thought we should know.

### 3. Findings from the Stakeholder Event

#### 3.1 Presentation 1: What has happened so far?

The first presentation explained the 'Case for Change', the Provider and Commissioner response to the case for change and the engagement process which followed. The findings from the previous and most recent engagement activity were shared with key stakeholders. Following the presentation an activity took place.

The activity involved a table discussion and each table was asked to consider the following questions:

- What are your general views on what people have already told us?
- What do you agree with, or disagree with?
- Is there anything you do not understand in this section?

The information provided was captured on an opinion board. This board gathered post it responses to the questions using the categories agree, disagree, questions and comments. The findings from this activity are as follows:

##### 3.1.1 Opinion board key themes and comments

**Agree:** There was general agreement in the room around a number of key themes relating to what people had told us as part of the engagement process, for some there were no surprises. The things people agreed with were related to the following themes:

- In general people agreed with the broad themes from the engagement activity.
- There was agreement that there were concerns about finances and monetary constraints.
- Prevention and supported self-care was a general theme that featured highly including education and information and information sharing between agencies.
- People agreed in principle that services need to be closer to home.
- There was agreement that travel needs to be considered as part of these plans.
- The community and third sector needs to be part of the solution and some services such as mental health require more resource.
- In addition some people did not want to go to hospital unless they needed to and there needs to be 24/7 access to emergency care.

**Disagree:** In general a few people disagreed with the engagement process and the equality considerations. The things people disagreed with were related to the following themes:

- Need to engage more people to get agreement on future services – the response is low

- The engagement needs to be more specific.
- The plans need to be described in a way that is clear and easy to understand.
- Equality needs to be considered more.

**Questions and comments:** The questions and comments we received are summarised below into key themes.

- The presentation was very health focussed and needs more social care.
- There were comments about the complexity of the engagement documents, the engagement process feeling rushed and not engaging enough older/younger people. Not enough explanation in the documents and questions being very broad and low numbers from Greater Huddersfield.
- Chronic care, long term care, mental health needs to be right
- Concerns about travel and transport, particularly for those who are elderly and vulnerable.
- Quality and care from one provider with equal access for all.
- Need to be clear about the evidence to ensure good outcomes i.e. transport times and share the evidence gathered.
- The cost of care closer to home and needing to be clear when it cannot be applied.
- Utilise third sector organisations
- A number of comments about A and E in Calderdale including transport, safety and the number of objections we received about its closure.
- People don't understand the context to change, what happens now, what does and does not work.
- How will we tackle the shortage of GPs and other trained staff – more trained nurses and financial incentives to encourage new GPs.
- Consider the views of the silent majority and work with the media and other channels to encourage positive, simple and clear communication and publicity to keep people updated
- 

### **3.2 Presentation 2: The Community Model**

The second presentation described the community models for both Calderdale and Greater Huddersfield CCG. The models were presented by the commissioners and included diagrams of how the model would work with a brief explanation of the delivery; this included how previous engagement activity had informed the model. (appendix 5: presentation 2). Following the presentation an activity took place.

The activity involved a table discussion and each table was asked to consider the following questions:

- How well do our community models reflect what people are telling us?

The information provided was captured on a target board. This board gathered post it responses to the questions, and stakeholders had to tell us how close to the target we were with our models. The findings from this activity are as follows:

### 3.2.1 Target board comments

The key themes from the target board comments for the community model are described below. They are presented on a scale of 0-10, with zero being outside the target board to 10 representing the bulls eye (yellow). The themes are reported in sections using this scoring system to reflect how close to the target we are on our ideas for a community model.

#### **Outside the target board and way off target – 0**

The key themes were:

- Not enough information to provide a view.
- Not enough focus on choice and self-help, drop in opportunities and shaping public attitudes to health.
- Require better scoring system for procurement of third sector services.
- Social care and social prescribing is missing from this model, a very medical model.
- Where will the money and workforce come from to achieve this?
- The model is not innovative enough.
- Are there enough premises to accommodate this model.

#### **Just on the target board 1-3**

The key themes were:

- Need more blue sky thinking with third sector.
- Need real life examples to understand the model further.
- Define locality and community, the Huddersfield model is clearer.
- The model needs to be seamless and requires more explanation especially on how services currently link together.
- Supported self-care requires staff skills and technology.
- What about services already provided in the community, are they considered.
- More explanation on 24/7 access.
- Consistency of access to GP services in all locations.
- Travel, transfer and transport times to A and E and hospital need more thought.

#### **On target 4-7**

The key themes were:

- Transport requires consideration.
- Test the models through focus groups and continue engaging.
- Ensure that staff have the appropriate skills.
- Need to make best use of the estates we already have.
- Services and staff need to work together to make this work across all systems including multi agency working.
- The model is not about putting hospital services in the community, people will still have access to specialists.

#### **Red and yellow (bulls eye) 8-10**

The key themes were:

- People agreed that good discharge from hospital requires support
- The single assessment process and single point of access were on target.

- That the model addresses the themes from the engagement.
- Supported self-care and preventative services are key.
- That GP and primary care services should cover 24/7 working.
- Focus and investment in the community and identifying the individual needs of each community.
- That information should only be shared once.

### 3.3 The in Hospital Model

The third presentation explained the in hospital model and the standards that would develop this model. The commissioner presented the standards and following an activity took place.

The activity involved a table discussion and each table was asked to consider the following questions:

- How well do our hospital standards reflect what people are telling us?

The information provided was captured on a target board. This board gathered post it responses to the questions, and stakeholders had to tell us how close to the target we were with our models. The findings from this activity are as follows:

#### 3.3.1 Target board comments

The key themes from the target board comments for the in Hospital model are described below. They are presented on a scale of 0-10, with zero being outside the target board to 10 representing the bulls eye (yellow). The themes are reported in sections using this scoring system to reflect how close to the target we are on our ideas for an in hospital model.

#### **Outside the target board and way off target – 0**

The key themes were:

- Keeping standards means change, is there a compromise?
- Have service users been engaged in developing these standards, how have they been developed, people have not seen them, are they published. The public want to understand these standards.
- How do the hospital standards apply when there is a change from hospital to community including transition from one to the other including discharge.
- Need to focus on how you enforce standards.
- Is the ambulance service part of those standards, what happens before you get to hospital matters.
- The workforce needs to be considered if you are to enforce standards.

#### **Just on the target board 1-3**

The key themes were:

- Need to determine what else should the hospital need to do to make the service a positive experience.
- Patients need to be informed of quality standards so they can help monitor, what do they have now so they can compare.

- Standards should cover the basics like communication, appropriate public transport, discharge, what people can expect a patient's charter.
- Workforce issues need to be addressed through standards – reduce agency staff.
- Need to have standards for specific conditions and abilities i.e. Learning Disability.
- Public assume quality is already covered.
- Consistent standards are required on both hospital sites.

### **On target 4-7**

The key themes were:

- Information is needed to ensure people use the right services at the right time.
- We should consider guidelines but they are not law.
- Monitoring standards and enforcing them.
- Current system prioritises staff time not patient time.
- More understanding of the standards and what they mean.

### **Red and yellow (bulls eye) 8-10**

The key themes were:

- Good hospital discharge needs to be supported and requires clear quality standards.
- Deliver the best standard of care for patients.
- Change should be an incremental process and not overnight.
- Retain 24/7 access and rapid response.
- Single assessment process.

## **3.4 The Evaluation Criteria**

The final presentation explained the evaluation criteria. This presentation was delivered by the commissioner and explained the criteria that would be applied when procuring a provider. Following the presentation an activity took place.

The participants were given a list of the criteria. Each table was asked to consider the following questions:

- What would you like to see within the evaluation criteria?
- What advice, guidance or support can you offer?

The information provided was captured on an opinion board. This board gathered post it responses to the questions, the findings from this activity are as follows:

### **3.4.1 Opinion board comments**

The key themes from the opinion board comments on the evaluation criteria are listed below. The participants made suggestions about changes to the wording of the criteria and the detailed questions they would expect to see, these are not documented below. The key themes and questions were:

- The need for providers to use case studies and examples to illustrate previous success.
- Evidence and examples of collaboration with all sectors as part of delivery.
- How will the voluntary and community sector engage in the process?
- In general participants agreed most of the headings were correct but felt it was critical to ask the right questions.
- How will joined up working operate including sharing information, connectivity between services including the hospital.
- How will supported self-care, work with the voluntary sector and quality be measured and tested.
- Participants want to know who will make decisions and who the panel will consist of.
- The provider needs to demonstrate value for money and sustainability including social value and social and corporate responsibility.
- Organisations that are transparent and honest and provide simple and easy to understand information for patients.
- What is the weighting for each criteria and does the organisation have to meet all or some of them?
- How are contractors audited and monitored and what is the length of the contract?
- Is the patient engagement reflected in the criteria and is the patient at the centre, will the contract meet the patient's needs?
- Some participants also wanted more information on how the criteria would be applied

### 3.5 Comments Clothes Line

The comments clothes line provided participants with an opportunity to post up anything. The comments were harder to theme on this basis but the key messages and comments were:

- The model needs to be explained further to help people understand what it will mean for them including who is the multidisciplinary team, what do we mean by 24/7 care i.e. Is it a person/telephone.
- We need to describe the single point of access further.
- Social care needs to be a greater part of the community model.
- We need to explain how the in hospital standards apply to out of area referrals with choice and choose book being central to supporting service users.
- Access to GP appointments requires improvement.
- Transport needs to be considered as central to any plans.
- Can we afford the change and the transition?
- The model needs to be based on the views of a representative sample of the population.
- Supported self-care needs to be part of the model and the technology to support it.
- Public need to know what to expect from services – standards.
- What do we mean by only telling information once, what if your circumstances change?

A more detailed analysis on this section can be found in Appendix 3

#### 4. Equality and Diversity

46 people completed or partially completed equality monitoring form (from 92 attendees) at the event (see Appendix 4). This is a small number and unlikely to produce significant results, however the detail is outlined below.

The demographics of the respondents will be compared to the local community profile with the caveat that the people at the event were invited key stakeholders, representing the voluntary and statutory sectors so they may not be representative of the community as a whole.

The data is drawn from the Census 2011; however this provides data for the local authority areas, so the data for Greater Huddersfield will include all of Kirklees.

Of the postcodes 17% were from Huddersfield, 63% from Halifax postcodes. 19% either did not state or were from out of area. People may have recorded their home address and while they may work in Calderdale and Greater Huddersfield do not live there.

##### Sex

	%	Men	Women
<b>Calderdale</b>		48.9	51.1
<b>Kirklees</b>		49.4	50.6
<b>Respondents</b>		41.3	58.7

##### Age

The data for age was sourced from the mid 2011 population estimates for CCGs based on the 2011 census, so reflects the most accurate available picture for Greater Huddersfield.

Age	Place	%	Respondents %
<b>0-17</b>	Calderdale	22	0
	Greater Huddersfield	22	
<b>18-25</b>	Calderdale	9	0
	Greater Huddersfield	11	
<b>26-40</b>	Calderdale	19	15
	Greater Huddersfield	19	

<b>41-55</b>	Calderdale	22	43
	Greater Huddersfield	21	
<b>56-65</b>	Calderdale	12	15
	Greater Huddersfield	12	
<b>66-75</b>	Calderdale	8	15
	Greater Huddersfield	8	
<b>75+</b>	Calderdale	7	9
	Greater Huddersfield	7	

Given the stakeholders were representing organisations the age spread is not surprising, however it is noticeable that the younger groups are not represented.

### Ethnicity

	<b>White:</b> English/ Welsh/ Scottish/ Northern Irish/British	<b>White:</b> Irish	<b>Asian/ Asian British:</b> Pakistani	<b>Black/African/ Caribbean/Black British: Caribbean</b>
<b>Calderdale %</b>	86.7	0.9	6.8	0.2
<b>Kirklees %</b>	76.7	0.6	9.9	1.1
<b>Respondents%</b>	86.9	2.1	4.3	2.1

There is a limited depth of representation across the local communities, some due to the small sample size but also the size of the event and response rate.

### Religion

54.3% of the respondents stated they had a religion of which all but one (Muslim) were Christian. This is relative to a local population for Christianity at 56.3% (Calderdale) and 53.4% (Greater Huddersfield).

### Disability

There is limited data available about the local population of disabled people the census has two measures; 'day to day activity limited a lot' and 'day to day activity limited a little'. The survey respondents were asked 'do you consider yourself to be disabled' and 28.2% responded yes. The data from the census recorded 17.9% (Calderdale) and 17.7% (Kirklees). This was made up of people limited a lot, 8.2% (Calderdale) and 8.4 (Kirklees) and limited a little 9.7 (Calderdale) and 9.3% (Kirklees).

	<b>Day-to-day activities limited a lot</b>	<b>Day-to-day activities limited a little</b>	<b>Respondents 'do you consider yourself to be disabled'</b>

<b>Calderdale</b>	8.2	9.7	28.2
<b>Kirklees</b>	8.4	9.3	

## Carers

Of the respondents 8.7% identified themselves as carers, the 2011 census found 10.5% (Calderdale) and 10.4% (Kirklees).

## Themes

Considering the qualitative data captured at the event there were some equality themes that can be drawn out;

- Information should be accessible; this is for both the future and for the materials used through the engagement
- Specific groups should be considered such as; carers, older people and women
- Specific areas should be considered, such as; elderly discharge, transitions for young people to adults services.

## 5. Overall findings and common themes

The key emerging themes from the Stakeholder Event were similar to those gathered in the report of findings for the Provider and Commissioner engagement process.

The stakeholders who attended the event provided a more detailed commentary and this has ensured that we have gathered rich data and very detailed stories, information and feedback. The detail of this feedback cannot be captured as adequately in this report and so it is recommended that the raw data is used to provide context to the key findings (see appendix 5). However the key emerging themes from the event are:

- Participants were generally in agreement that they want services closer to home, delivered by the right staff in the right setting with transport and estates considered.
- Stakeholders want to see more detail to these plans which they felt were too vague. Stakeholders want to know what it means for them and they want to continue to be engaged in this process.
- Supported self-care and prevention was a key focus to enable these plans to work and this included the right approach, information and communication.
- Stakeholders wanted the model to reflect the diverse population and meet the needs of those who are more vulnerable and require different approaches and support.
- The third sector wanted to play a key role in developing and delivering these services at a local level in a variety of community settings.

- Participants were considered about the financial and work force considerations required by this model and whilst it looked good in principle were unsure if it could be delivered.
- Stakeholders welcomed multi agency working, single care plans and a single point of access which included information sharing, but wanted to see social care as a more central part of the community model.
- The in hospital standards confused people, they wanted to know what this would mean for hospital services and needed more information.
- People agreed with 24/7 access in primary care and saw the GP as central to this model, however access and availability of GPs were a concern.
- Stakeholders want Commissioners to address some of the issues relating to hospital discharge, transport and A and E as part of this model.

In addition we evaluated the stakeholder event to ensure that future events provide the right level of information and support future participation. The evaluation form can be found in Appendix 6 and the evaluation report will be added to the appendices in early September..

## **6. How the findings will be used and next steps**

With the information we already have, the findings from the recent engagement activity and the information gathered at the stakeholder event we will:

- Further develop a 'Community Model' for Calderdale.
- Further develop a 'Community Model' for Greater Huddersfield.
- Inform the specification we have developed for the 'In Hospital Model'

In addition:

- The CCG governing bodies will make a decision about the next steps.
- NHS England will look at our plans along with the 'Yorkshire and Humber Clinical Senate' as part of the NHS England 'Strategic Change Assurance Process'.

We will provide a full document containing all our findings and the feedback from the engagement activity on the Right Care, Right Time, Right Place website. In addition we will inform people of any further decisions or updates on the website. The website address is <http://www.rightcaredtimeplace.co.uk/>



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# **‘Right Care, Right Time, Right Place’**

## **Appendices 1 – 6**

## **Appendix 1 – The Background to Right Care, Right Time, Right Place The Case for Change (Right Care, Right Time, Right Place)**

The case for change sets out the way we deliver health and social care services and the need to change if we are to make sure we can meet current and future needs. Huge advances in medicine have changed the way we treat illness and injury; we have a growing and an ageing population; our illnesses are different and people's expectations of health care are growing. We know people want care closer to, or at, home and a choice about how, when and where they're treated.

The cost of health and social care across Calderdale and Huddersfield is now more than £600 million a year. Growing demand, price inflation and the costs of new drugs and treatments mean we need to look at how we spend budgets to get maximum benefit for everyone. We need to ask some serious questions;

- Can we do things differently but maintain high quality services?
- Can we keep people out of hospital for everything but the most serious illness by improving the way we care for them at home?

All seven organisations involved in health and social care in Calderdale and Huddersfield are working together on the 'Right Care, Right Time, Right Place':

- Calderdale and Huddersfield NHS Foundation Trust (CHFT)
- NHS Calderdale Clinical Commissioning Group (CCCG)
- Calderdale Council
- NHS Greater Huddersfield Clinical Commissioning Group (GHCCG)
- Kirklees Council
- Locala Community Partnerships
- South West Yorkshire Partnership Foundation Trust (SWYPT)

### **The Providers' response to 'Right Care, Right Time, Right Place'**

A Strategic Outline Case (SOC), prepared by three providers: Calderdale and Huddersfield Foundation Trust, Locala Community Partnerships and South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) set out a response to 'Right Care, Right Time, Right Place' which included a review by the National Clinical Advisory Team (NCAT) in spring 2013.

The Providers' response describes a new model for the provision of hospital and community services across Calderdale and Greater Huddersfield. Under this model, the three providers would work together and closely with general practice, social care and voluntary organisations to deliver integrated care and support services in the community. This would include including moving current hospital-based services closer to where people live.

The response states that: integrated community services would work seamlessly with acute and emergency services based on one specialist hospital site and with planned and elective care on a second specialist planned care hospital site. It also identified significant benefits to patients, services users, local people and service providers and commissioners.

## **NHS Calderdale and Greater Huddersfield CCGs Commissioning Intentions – the Commissioners’ response**

Calderdale and Greater Huddersfield Clinical Commissioning Groups (CCG’s) are responsible for commissioning a range of services in Calderdale and Greater Huddersfield. The CCG’s need to ensure their commissioning intentions meet the needs of the local community to deliver these intentions, each CCG has a five year strategy based on what they already know about the community and the health needs in the area.

### **NHS Calderdale CCG – five year strategic plan**

NHS Calderdale CCG set out a five year ambition which includes a vision for the future. This vision is the Commissioners’ contribution to the delivery of change as a partner for ‘Right Care, Right Time, Right place’. The plan builds on the organisational aims, intelligence gathered from previous engagement and patient experience activity and clinical insights. The aim is to ensure changes needed to deliver the outcomes for local people are safe and of high quality.

The focus over the next five years is to continue the shift of services and resources from unplanned hospital care to integrated health and social care - delivered in community and primary care settings. In addition a number of improvement programmes will drive delivery over the next three to five years. These programmes are:

- Cardiovascular
- Diabetes
- Respiratory
- Alcohol conditions
- Musculoskeletal
- Cancer & tumours
- Mental health
- Strategic Review
- Better Care Fund

Each programme is described in more detail in the strategy and the aim is to ensure any plans reflect the needs of the local community.

### **NHS Greater Huddersfield CCG – two year operational plan and five year strategic plan**

Greater Huddersfield CCG has developed a two year operational plan and a five year strategic plan. The vision for the larger health and social care system in the next five years has been developed in partnership with North Kirklees CCG and Kirklees Council. The geographical footprint has been important when bringing together the partners to develop proposals for transformational change. The two year strategic plan is based on the contribution to ‘Right Care, Right Time, Right Place’.

Greater Huddersfield Clinical Commissioning Group’s operational plan sets out a unique and innovative vision of health and social care service delivery for the next two years in the area. The focus of this change programme is to continue the shift of

services and resources from unplanned hospital care to integrated health and social care - delivered in community and primary care settings. The outcomes delivered by these aspirations can be characterised into a number of themes:

- Increasing opportunities for self-care, especially for people with long term conditions
- Making best use of technology and innovation
- Optimising delivery in primary and community care by providing secondary care services or hospital services, in the community and thinking about innovative ways of doing this
- Optimising delivery in secondary care
- Building community capacity to deliver better health and wellbeing

As a result of this, local people can expect:

- Services delivered as close to home as possible
- Improved health and wellbeing
- Opportunities to have a say in the design of health and social care provision
- Accessible, non-discriminatory service provision
- Integrated services
- Services that maximise dignity and respect for vulnerable groups

The plan sets out the pathway for the organisation to navigate a course through external change and uncertainty towards stable, responsive and sustainable health and social care services for Greater Huddersfield now and in the future.

## **Legislation**

### **Health and Social Care Act 2012**

The Health and Social Care Act 2012 makes provision for Clinical Commissioning Groups (CCGs) to establish appropriate collaborative arrangements with other CCGs, local authorities and other partners. It also places a specific duty on CCGs to ensure health services are provided in a way which promotes the NHS Constitution – and to promote awareness of the NHS Constitution.

Specifically, CCGs must involve and consult patients and the public:

- In their planning of commissioning arrangements
- In the development and consideration of proposals for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and
- In decisions affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact

The Act also updates section 244 of the consolidated NHS Act 2006 which requires NHS organisations to consult relevant Overview and Scrutiny Committees (OSCs) on any proposals for a substantial development of the health service in the area of the local authority, or a substantial variation in the provision of services.

## **The Equality Act 2010**

The Equality Act 2010 unifies and extends previous equality legislation. Nine characteristics are protected by the Act, age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation. Section 149 of the Equality Act 2010 states all public authorities must have due regard to the need to a) eliminate discrimination, harassment and victimisation, b) advance 'equality of opportunity', and c) foster good relations. All public authorities have this duty so the partners will need to be assured that "due regard" has been paid.

## **The NHS Constitution**

*The NHS Constitution came into force in January 2010 following the Health Act 2009. The constitution places a statutory duty on NHS bodies and explains a number of patient rights which are a legal entitlement protected by law. One of these rights is the right to be involved directly or through representatives:*

- *In the planning of healthcare services*
- *The development and consideration of proposals for changes in the way those services are provided*
- *In the decisions to be made affecting the operation of those services*

## **Principles for Engagement**

NHS Calderdale and NHS Greater Huddersfield CCG both have 'Patient and Public Engagement and Experience Strategies'. These strategies have been developed alongside key stakeholders. The strategies set out an approach to engagement which describes what the public can expect from any engagement activity. The principles in both strategies state that the CCG will;

- Ensure that the CCG engage with public, patients and carers early enough throughout any process
- Be inclusive in all engagement activity and consider the needs of the local population
- Ensure engagement is based on the right information and good communication so people feel fully informed
- Ensure that the CCG are transparent in their dealings with the public and discuss things openly and honestly
- Provide a platform for people to influence thinking and challenge decisions
- Ensure any engagement activity is proportionate to the issue and that feedback is provided to those who have been involved in that activity

The strategy sets out what the public can reasonably expect the CCG to do as part of any engagement activity and the process required to preserve these principles to ensure public expectations are met.

## **Methodology**

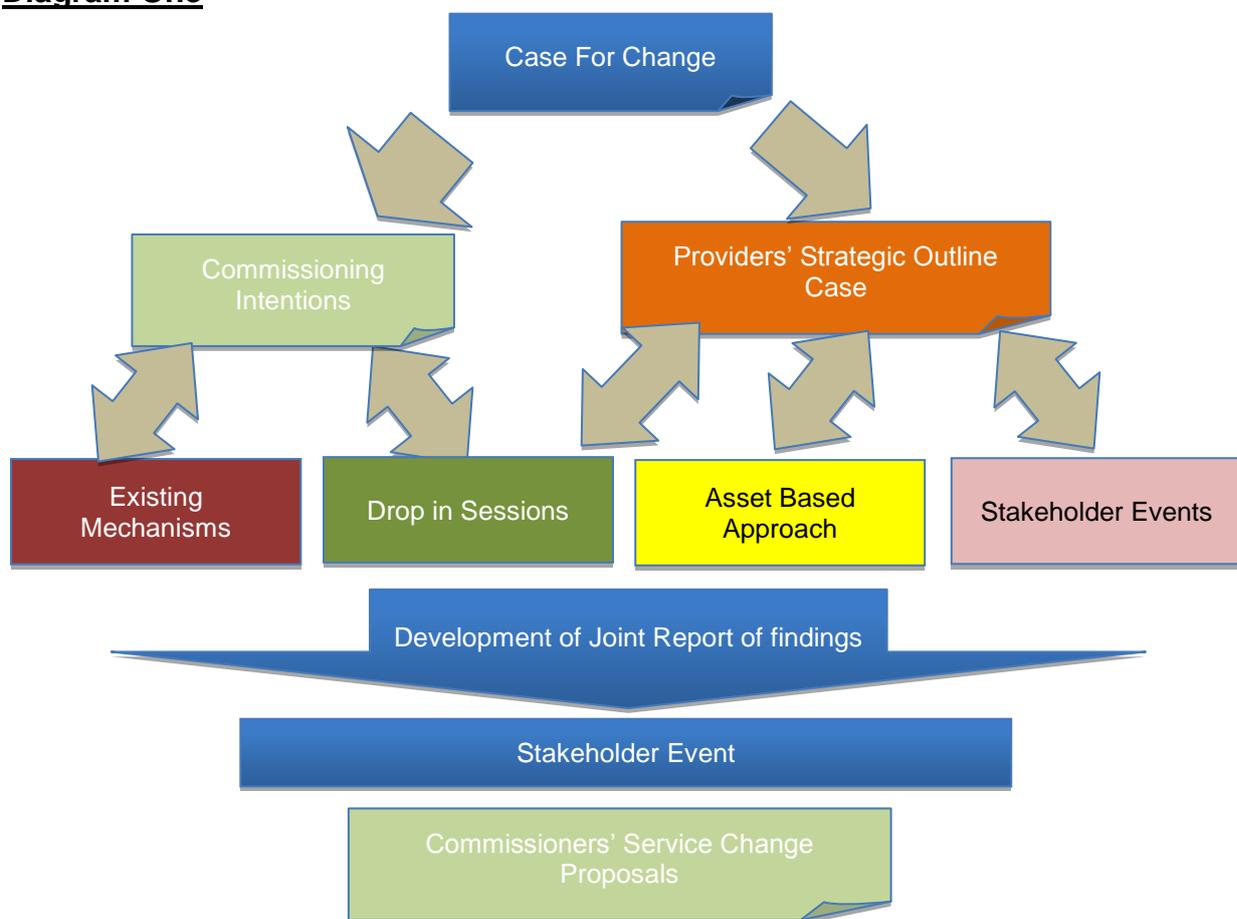
Both the Providers and Commissioners undertook engagement activity to identify if the SOC and the five year strategies were capable of delivering service

improvements and meeting the needs of the local population now and into the future by gathering public, staff and stakeholder views.

The process involved two conversations taking place simultaneously, one on the Providers' response and one on the Commissioners' response. The Commissioners' responsibility is to ensure they commission services from providers that will ensure the health and well-being of the local population of Calderdale. The Providers are commissioned to provide services that support that vision.

The engagement activity for both the Providers' and Commissioners' was supported by a joint delivery plan (see link on homepage) which was delivered during an eight to 12 week period. The Providers commenced engagement prior to Commissioners' and the process involved a number of planned engagement activities aimed at a variety of target audiences. The process followed is described in diagram one.

**Diagram One**



**How did we deliver the engagement plan?**

The purpose of all the engagement activity was to capture the views of local people with a specific focus on key stakeholders. Both the Providers' and Commissioners' engagement required different activities but both were brought together at 10 drop in sessions which took place in eight locations in Calderdale and Greater Huddersfield.

### **Existing Mechanisms:**

- Calderdale and Greater Huddersfield CCG both have a 'relationship matrix' which enables the CCG to engage with a number of key organisations. The matrix is a list of voluntary and community organisations which are willing to work with us to engage their clients and staff. These organisations are mapped by the target audience they reach and the protected characteristics they cover.
- Calderdale CCG also work closely with the third sector and have invested in 'health connections' a third sector hub which ensures they can engage with third sector colleagues providing support to health. Greater Huddersfield CCG work closely with third sector leaders and local authority colleagues to target specific communities.
- Third sector organisations were targeted using 'North Bank Forum' which has a regular e-newsletter and Voluntary Action Kirklees (VAK).
- Close working relationship with staff and member practices, including patient reference groups and work with the Calderdale Health Forum and Greater Huddersfield Patient Network have been utilised.
- Membership of the three provider organisations and the Right Care, Right Time, Right Place reference group were engaged through electronic or postal surveys.

### **Drop in sessions:**

- 10 Drop in sessions were set up in 8 locations across Calderdale and Greater Huddersfield to ensure all members of the community had an opportunity to have their say. Each session was delivered on a different day to give as many people as possible the chance to attend. The drop-in sessions provided a platform for the public to talk about commissioning intentions, the provider response and 'Right Care, Right Time, Right place'. The sessions were delivered between 2pm-7pm.
- Comments cards – These were available at the drop-in sessions and in other service areas for people to write down any comments, issues or concerns they may have.

### **Asset Based Approach:**

- Calderdale CCG use an 'asset based approach' to engaging with the local population, this means they train and fund local groups to talk to the public on their behalf using the methods and approaches appropriate to that community. The CCG work with over 40 groups in varying localities representing some of the most seldom heard residents in our area.
- A similar approach took place in Greater Huddersfield utilising community development workers from Kirklees Council to have conversations at a community level with existing groups and organisations who already have a good working relationship with staff in the area.

### Provider Stakeholder Events:

- A number of stakeholder meetings and events were arranged by the Provider organisations to gather views. These activities took place over a number of weeks and included conversations with the voluntary and community sector.

In addition to the engagement activity there was a number of other mechanisms operating in order to gather views, these are below:

- Dedicated website which contained information on how to contact the programme management office and also opportunities to post comments. This includes the use of social media such as Twitter.
- PALS and complaints service who were asked to capture public views as part of their customer facing role.
- Close working relationship with Healthwatch colleagues to ensure we listen to people's views through consumer champions.
- Existing consumer websites were reviewed including those attached to the

Target Audience	Delivery Method
Service users, general public, third sector	<ul style="list-style-type: none"> <li>• Partners' intranets, websites and social media platforms</li> <li>• Relationship matrix</li> <li>• Patient reference groups</li> <li>• Third sector umbrella organisations.</li> <li>• Patient groups and Carers groups</li> <li>•</li> </ul>
OSC/Health and Wellbeing boards	Meetings/ briefings
Staff	<ul style="list-style-type: none"> <li>• Internal bulletins</li> <li>• Staff Intranets</li> <li>• Cascades at meetings through managers.</li> </ul>
Healthwatch	Email and personal discussions Newsletter articles
Elected members / Councillors	Information to be circulated electronically – explanatory email with a link to web survey
Media	Proactive media releases Social media

local media, patient opinion and NHS Choices to gather feedback.

A variety of communication channels were used to disseminate information and provide opportunities for patients and the public to give their views. The methods below were supported by the communication leads for each organisation and centrally managed by the Programme Management Office. All communications have been centrally logged.

## Appendix 2: Stakeholder Event Invite

Dear All

We would like to invite you to the Right Time, Right Care, Right Place Stakeholder Participation Event which will be held on **Tuesday 12th August 2014, 09.30 - 15.00** at The Shay Stadium, Shaw Hill, Halifax HX1 2YS, [http://www.halifaxafc.co.uk/club/Shay\\_Guide/](http://www.halifaxafc.co.uk/club/Shay_Guide/) . Please can you kindly confirm if you will be attending yourself or please can you provide details of any other representative?

Please RSVP your attendance no later than Monday 28<sup>th</sup> July by following the link <https://www.surveymonkey.com/s/stakeholderevent>.

The purpose of the event is to provide you with an opportunity to discuss with NHS Calderdale and Greater Huddersfield Clinical Commissioning Groups (CCGs) the outcomes of the engagement process for Right Care, Right Time, Right Place.

This will include presentations from both CCG's around the findings and the common themes brought out from the engagement. Facilitated table discussions will take place to capture further views and allow us to identify any potential gaps. Both CCGs will also be discussing how this information has been used to inform their future plans to ensure stronger and better services to support the needs of patients in the community.

### What's happened So far

- Reaffirm key facts from the case for change and why services can't stay the same
- The difference between consultation and engagement and an overview of the engagement process

### Options for Healthcare in Calderdale and Greater Huddersfield

- Who we have been talking to and what people are telling us
- What are the common themes that have come out from our engagement and how is this fed into the CCG's proposals for change
- Overview of the CCG's evaluation criteria

### Next Steps

- Current thinking around what the engagement is telling us and the proposals for change
- Next steps

## Appendix 3: Comments received from the Opinion Boards

This section shows participants who agreed or disagreed with comments made from other tables in relation to each activity

### Presentation 1 – What’s happened so far?

Comments receiving a green dot (agree) vote

- 3rd sector engagement event at VAC by hospital re changes/ideas, left poor confidence. There were no note takers - it was a 'deaf ear'. – **Agree x 4**
- All information needs to be in easy read formats and the same with the feedback process – **Agree x 4**
- The engagement process felt rushed. – **Agree x 4**
- How far do we go to prolong life if the quality isn't there? – **Agree x 4**
- Publicity could have been better drop in sessions – **Agree x 3**
- Transport may be the biggest issue over higher standard of care.- **Agree x 2**
- Prescriptions take too long to prepare in secondary care. – **Agree x 2**
- Mental health care needs to be integrated into general health. It touches so many - may help avoid stigmatism. – **Agree x 2**
- The NHS geography doesn't reflect our geography. – **Agree x 2**
- Pleasing to see supported self-care but perhaps people talk more about taking control of their health / lives – **Agree x 1**
- Self-care & ability to share information is key to this working. This is a key theme. – **Agree x 1**
- This needs to be more local but need infrastructure – **Agree x 1**
- More of the routine follow ups can be done locally – **Agree x 1**
- Can't believe 2.4 thousand from 40 thousand responses is seen as a "good response!!!" – **Agree x 1**
- Only 1% of population engaged. Does the other 99% agree? – **Agree x 1**
- Pitch - of language too difficult in white booklet.- **Agree x 1**
- People needed an easier way to understand the future. Such as a film - such as an animation. NEED A FLOW CHART. – **Agree x 1**
- In terms of population of Calderdale & GH % of people actually consulted is quite low. – **Agree x 1**
- Need to be clear what is specialist and what is community. – **Agree x 1**
- Concerns about vulnerable people and carers having to travel via public transport from outlying districts – **Agree x 1**
- Cannot understand why only 3% of Huddersfield showed their opinion on record. Was this due to questionnaires filled in unsupported? – **Agree x 1**
- People concerned over travel distances - **Agree x 1**
- Communication is key. – **Agree x 1**
- Need to be clear about when care closer to home cannot be applied e.g. relevant to travel. – **Agree x 1**
- Downgrade A&E in Calderdale would be acceptable if infrastructure correct and available. – **Agree x 1**
- Is there a real understanding of the financial pressures on the system? – **Agree x 1**
- Transport / terrain affecting physical access to services. – **Agree x 1**

- GP's need to use 3rd sector to address issues around well-being (not just prescription pad!) – **Agree x 1**
- Utilise voluntary & community sector to help.- **Agree x 1**
- Helpful to continue to explain the difference between consultation and engagement - specifically when CCG proposals are ready to be shared. – **Agree x 1**

Comments receiving a red dot (disagree) vote

- Despite engagement will commissions make decisions despite public disagreement! – **Disagree x 1**
- Care closer to home can be more costly. - **Disagree x 1**
- Got to sort out the difficult ethical issues, can't dodge forever. Cost of a year of life? Recognising we all will die eventually. – **Disagree x 1**
- Publicity dreadful substandard. POSTERS. – **Disagree x 1**
- The engagement process felt rushed. – **Disagree x 1**

How far do we go to prolong life if the quality isn't there? – **Disagree x 1**

## Presentation 2 – The Community Models

Comments receiving a green dot (agree) vote

- Don't have enough info and facts to say yes or no – **Agree x 1**
- Better scoring system re procurement for 3rd sector – **Agree x 1**
- Want real stories, case studies to explain the model now and how this could improve – **Agree x 1**
- Primary care as part of the model - needs to be key NHSE role – **Agree x 1**
- Families and carers to be included all ages cultural differences – **Agree x 1**
- Agree but need to put this into practice – **Agree x 1**
- Single point of access, who is single point of access going to be? What? How? Triage? – **Agree x 1**
- Are we asking each patient what they want every time they contact services? – **Agree x 1**
- Need a map of services and how they relate – **Agree x 1**
- Language is hard to understand - model, function (NHS talk) Real life examples would help – **Agree x 3**
- Could it create inequality rather than increase it? – **Agree x 2**
- Quality of service from single point of access is a concern – **Agree x 2**
- GP waiting times how is that being fixed? – **Agree x 1**
- 3rd sector 'blue sky thinking' with CCGs – **Agree x 3**
- Confusing, this sounds like A&E where is the community model? – **Agree x 1**
- Balance between targets and delivering the core needed – **Agree x 1**
- Test the models through focus groups, ask the right questions and the language used – **Agree x 1**
- Social care needs to be aligned with health care. Building bridges with LA – **Agree x 2**
- More detail on triage - who is most appropriate person / skills? – **Agree x 1**
- Very impressed with the Calderdale model – **Agree x 1**

Comments receiving a red dot (disagree) vote

- Join up JSNA strategies with NHS strategies – **Disagree x 1**
- VCS - social prescribers. Other services (prevention) loneliness, depression etc. – **Disagree x 1**
- Connecting the models with public health and social care. Self-care hub – **Disagree x 1**
- Cultural change for public and professionals – **Disagree x 1**
- Coordination needs to involve community matrons, not enough of them – **Disagree x 1**
- The model does not reflect access into the model – **Disagree x 1**
- Need to consider the whole chain i.e. patient/carer etc. – **Disagree x1**
- Advice support and sign posting 24/7 – **Disagree x 1**
- Children and young people are trialling this? Records – **Disagree x 1**
- 10pm - 6am no discharge from hospital unless exceptional circumstances – **Disagree x 1**
- Information accessible to suit patients' needs – **Disagree x 1**
- A holistic approach to care and support to meet the needs of the patient – **Disagree x 1**
- The model provides access to preventative services. Self-care self-management – **Disagree x 1**
- 24/7 working including pharmacy (community and hospital) – **Disagree x 1**

### **Presentation 3 - Hospital Standards**

Comments receiving a green dot (agree) vote

- Elderly discharge verification of care available at home – **Agree x 1**
- Appropriate public transport – **Agree x 1**
- Where are mental health standards? - **Agree x 1**

There were no comments receiving a red vote in this category.

### **Washing Line**

Comments receiving a green dot (agree) vote

- The public do not understand that the community model is not about moving hospital services into the community. This needs to be explained! - **Agree x 1**
- There are currently 7 buses an hour directly linking Huddersfield to the Calderdale hospital. There is only 1 bus an hour directly linking Halifax to the Huddersfield hospital. Transport links must be considered – not everyone has a car - **Agree x 1**
- More information required - **Agree x 1**

There were no red (disagree) dots against any of the clothes line comments.

**Appendix 4 - Equality Data Collection Form**

This information will be kept confidential and you do not have to answer all of these questions, but we would be very grateful if you would.

**Postcode** (1<sup>st</sup> part only) \_\_\_\_\_  **Prefer not to say**

**Sex**  
 Female  Male  **Prefer not to say**

**Age**  18-25  26-40  41-55  56-65  66-75  76+  **Prefer not to say**

**Ethnicity – what is your ethnic group?**

**Asian or Asian British**

- Indian
- Pakistani
- Bangladeshi
- Chinese
- Other Asian background
- .....
- ....

**Black African/Caribbean or Black British**

- African
- Caribbean
- Any other Black/ African/ Caribbean background
- .....
- .....

**Mixed/ multiple ethnic groups**

- White and Black Caribbean
- White and Black African
- White and Asian
- Any other mixed/multiple ethnic group
- .....

**White**

- British – English, Scottish, Welsh, Northern Irish
- Irish
- Gypsy/Traveller
- Any other white background
- .....
- .....
- Any other background
- .....

**Other ethnic group**

- Arab
- .....
- Prefer not to say

**Disability - Do you consider yourself to be disabled?**

The Equality Act 2010 states that a person has a disability if: 'a person has a physical or mental impairment, and the impairment has a substantial and long-term adverse effect on that their ability to carry out normal day-to-day activities'

Yes (detail below)  No  **Prefer not to say**

**If yes, please tick impairment below (tick more than one if relevant).**

- Physical or mobility  
 Mental health  
 Other  
 .....
- Visual  
 Hearing
- Learning disability  
 Long-standing illness or health condition e.g. cancer, diabetes, HIV  
 **Prefer not to say**

**Transgender - Is your gender identity different to the sex you were assumed to be at birth?**

- Yes                       No                       **Prefer not to say**

**Sexual orientation – what is your sexual orientation? (Please tick)**

- Bisexual (both sexes)  
 Other
- Lesbian (same sex)
- Gay man (same sex)  
 **Prefer not to say**
- Heterosexual (opposite sex)

**Religion and belief – do you consider yourself to belong to any religion?**

- Yes (please tick below)     No                       **Prefer not to say**

- Christianity (including Catholic, Protestant or any Christian denomination)  
 Judaism  
 Sikhism
- Buddhism  
 Islam
- Hinduism

**Carer**

Do you provide care for someone, such as family, friends, neighbours or others who are ill, disabled or who need support because they are older?

- Yes                       No                       **Prefer not to say**

**Thank you for taking the time to complete this form.**

## Appendix 5 – Full list of all raw data collected at the Event

### Activity 1 - What has happened so far?

#### Your thoughts

- What are your general views on what people have already told us?
- What do you agree with, or disagree with?
- Is there anything you don't understand in this section?

#### Agree

- Was quite surprised to see most of the ideas I had heard, during doing questionnaires were actually heard and listened to.
- Pleasing to see supported self-care but perhaps people talk more about taking control of their health / lives – **Agree x 1**
- Themes sums up pretty well such as A&E, Community Services seems to make sense.
- Self-care & ability to share information is key to this working. This is a key theme. – **Agree x 1**
- Agree with broad themes but there is a rider on this.
- Accept need for change. Inevitable so should be done in best manner.
- Cost implications must be met.
- Care closer to home principle.
- Patients don't want to go into hospital unless absolutely necessary – **Agree x 2**
- Aligns with SWYPFT plans and strategic direction.
- Very happy that what has been said today reflects previous sessions.
- All agree to focus on prevention
- Everyone agrees with 24/7 access when in emergency.
- None
- This needs to be more local but need infrastructure – **Agree x 1**
- More of the routine follow ups can be done locally – **Agree x 1**
- Visits by GP's to local groups.
- Prevention needs to be foremost.
- Use the third sector to engage people.
- Agree but constraints around money
- Need path for mental health but needs more resource.
- Agree travel is an issue.
- Agree need education and information.
- Can we make information sharing work
- None
- Closer to home locality
- Community model will work if community led (locality)
- Services should be local and if not information access readily available.
- Has to be community led.

#### Disagree

- Publicity could have been better drop in sessions – **Agree x 3**

- Can't believe 2.4 thousand from 40 thousand responses is seen as a "good response!!!" – **Agree x 1**
- It would be useful to know more headlines from the report.
- We need a higher percentage of people engagement to ensure all opinions are considered.
- Only 1% of population engaged. Does the other 99% agree? – **Agree x 1**
- None
- None
- Questionnaire people just put yes or no. Not engaged enough to expand.
- Even easy read version - needed to do a training session on.
- Pitch - of language too difficult in white booklet.- **Agree x 1**
- A&E was not agreed on as everyone wants A&E close to them.
- People needed an easier way to understand the future. Such as a film - such as an animation. NEED A FLOW CHART. – **Agree x 1**
- None
- 3rd sector have been heard but need to actually use the services!
- Ambulance service not involved at present.
- Gap between engagement process & consultant is too long. We need a second engagement that asked people about realistic choices OR we end up saying "we heard what you have said but you cannot have it"
- In terms of population of Calderdale & GH % of people actually consulted is quite low. – **Agree x 1**
- Need to balance equality with local delivery and can't always do that. Quality not quantity.
- Cost is factor in delivery.
- Need to be clear what is specialist and what is community. – **Agree x 1**
- 3rd sector engagement event at VAC by hospital re changes/ideas, left poor confidence. There were no note takers - it was a 'deaf ear'. – **Agree x 4**
- Audiology. Equalities in the area. Same service accessibilities in areas.
- It's not a one size fits all for the area.

### Questions / Comments

- The provider document - 9 meaty glossy papers that took a long time to read and understand. This put people off completing the 3 questions at the end. It was hard to pick out salient points.
- More information needed about the alternatives.
- Asked for details & information at drop in events and was promised an email would be sent but nothing delivered. (How many people used A&E in both Calderdale & Huddersfield)
- Care 'closer to home' - can't do this for all. The patients I've spoken to want care provided by one provider, not several.
- Nothing has been mentioned about quality of services is equal access all services/providers.
- Concerns about vulnerable people and carers having to travel via public transport from outlying districts – **Agree x 1**
- Results seem to be 'health' focussed rather than social care - isn't RC, RT, RP supposed to be both?

- Time consuming process - staff & volunteers had to spend a lot of time explaining the consultation. Some people not interested. Asked because they needed support about their crisis issue not wanting to be asked about the process and consultation.
- Clear about what the evidence is for better outcomes e.g. transport time.
- Get chronic care right in comm ahead of working on hospitals.
- Presentation v 'health' not social care
- Questions at the end were far too broad. E.g. do you have suggestions for changing health & community services? Hard to get feedback on this from people who don't have a specialist interest.
- Cannot understand why only 3% of Huddersfield showed their opinion on record. Was this due to questionnaires filled in unsupported? – **Agree x 1**
- How can you deliver locally to chronic conditions?
- Services in women centres. We have midwives there but it could be broader.
- S/U information shared between services and USERS in the correct way!
- How will you build on the positive comments / ideas as they help shape commissioning?
- All information needs to be in easy read formats and the same with the feedback process – **Agree x 4**
- Independent academic study needed on 1: A&E closure - Sheffield University. 2: On the needs of ageing population. The "age time-bomb that isn't" - BMJ article 2014.
- Working together from hospital to community. More involvement in community.
- Observations that people didn't know the themes. What actions are there to change that at community level?
- People concerned over travel distances - **Agree x 1**
- Fate a complete with A&E therefore people resigned.
- Will this report be circulated? Yes on internet.
- Only info through the local paper. We need information from another source.
- Emotional response to change. We may need to understand logical argument.
- Communication - where to find out.
- Influence the press.
- Share the evidence and reasons why.
- Despite engagement will commissions make decisions despite public disagreement! – **Disagree x 1**
- Who delivers the message on the SOC - The positives and the negatives for the case for change.
- Of 85% comment on the SOC how much of the percentage was about A&E closure in Calderdale?
- Austerity finance - money. How can we sustain what we have?
- How do we manage the expectation? Need to be clear & open around givens e.g. money, best practice etc...
- Values based approach - what is value?
- Need engagement process to be clear of the issues and provide information to support this.
- Transport may be the biggest issue over higher standard of care.- **Agree x 2**
- DNA Understanding issue geographical location.

- Access crucial in relation to choice.
- Roll out of technology for results. This should not replace staff (choice).
- Early intervention for MH problems is crucial. Timely access.
- Communication is key. – **Agree x 1**
- Clarity of what training staff means!
- Care closer to home can be more costly. - **Disagree x 1**
- Need to be clear about when care closer to home cannot be applied e.g. relevant to travel. – **Agree x 1**
- Got to sort out the difficult ethical issues, can't dodge forever. Cost of a year of life? Recognising we all will die eventually. – **Disagree x 1**
- Potential for minor injuries and walk in services at Calderdale hospital.
- Ethics need to be considered in decisions.
- Prescriptions take too long to prepare in secondary care. – **Agree x 2**
- Nice to see thoughts and views captured on intro slides.
- Downgrade A&E in Calderdale would be acceptable if infrastructure correct and available. – **Agree x 1**
- Need to shift from focussing on crisis/urgent need to a preventative focus - transformational change.
- Cold site (Calderdale) - Older generation need support locally.
- With shortage of GP's pending in a few years, more advanced nurse practitioners could take on some of the GP role within surgery.
- How far do we go to prolong life if the quality isn't there? – **Agree x 4 & Disagree x 1**
- Safety concerns re: A&E in Calderdale plus acute admissions.
- Principle of care closer to home and exactly what that means.
- Other areas have further to travel and it works well.
- Small percentage of people engaged with.
- Publicity dreadful substandard. POSTERS. – **Disagree x 1**
- Publicity appalling. Drop in Todmorden scripted rather than engagement.
- Difficult to understand the white booklet. People didn't understand.
- A worry that drop in centres too expensive & will close.
- People didn't understand where it works. NO CONTEXT. People not understood what happens today.
- People don't understand, so they want everything.
- 35% of GP's retiring - people aren't coming into do general practice. Need more incentive.
- Not enough brochures. One copy of simplified only.
- Asian population who are older more positive due to bench marking back abroad to poor expensive health service.
- Strike a balance between what patients want and what patients need.
- Too much talking. Need to take decisions. Start to make it work.
- Older people not really represented and these are people who use health services increasingly. Other engagement around other areas going on capturing some of these views.
- As an engagement champion. I didn't feel informed enough to answer any questions that parents/carers had about the engagement.
- Is there a real understanding of the financial pressures on the system? – **Agree x 1**

- No real surprises in feedback. People want local, speedier services from people well trained & good communication.
- More need for leading voluntary sector organisation involvement. Closer partnership approach to cascade shared vision.
- Positive communication and publicity with the local media!
- View of the silent majority needs to be heard over noisy minority views.
- Marketing the design and the delivering of the strategic review.
- Sensationalism in the newspapers - hits the majority. The minority attend consultations to hear the 'truth'. GP's need to write to every individual patient - to pass on the message.
- Too many councillors and politicians seem to be taking the opportunity to score cheap points ahead of the election by presenting misleading information during this consultation.
- Work towards getting rid of mixed messages. Focus on communicating right messages across to wide spectrum of audiences.
- We feel the consultation exercise and the good communication involved is at odds with the 'day to day' communication we experience within the NHS.
- Mental health care needs to be integrated into general health. It touches so many - may help avoid stigmatisation. – **Agree x 2**
- We need to consider long term conditions as well as disability in equality monitoring.
- Consider late onset disability.
- Not much transport that is accessible.
- Transport / terrain affecting physical access to services. – **Agree x 1**
- We need to remember it's the People's NHS!
- GP's are a private business as they provide a wide range of services from practice. This brings much greater business focus into care/service provision. Change nature of NHS in unpredictable way.
- GP's need to use 3rd sector to address issues around well-being (not just prescription pad!) – **Agree x 1**
- Need to link to loneliness and isolation work.
- There needs to be more honesty/transparency as to asking the public what they would like but actually very little, not all of it can be delivered.
- Need clear and simple pathways that the public understand - someone who uses simple language to help people through the pathways.
- People need to understand what is out there - what they can access.
- Money - is there enough money in the system to meet people's aspirations?
- The engagement helped people to understand (Healthwatch)
- Health focussed.
- The NHS geography doesn't reflect our geography. – **Agree x 2**
- Shortage of GP's, nurses, managers & health care assistants across the primary care workforce.
- Is community mental health affordable?
- Utilise voluntary & community sector to help.- **Agree x 1**
- Young people (under involved) & older people gaps in engagement.
- Can further consultation or engagement give us confidence in being listened to. – **Agree x 1**
- The engagement process felt rushed. – **Agree x 4 & Disagree x 1**

- Helpful to continue to explain the difference between consultation and engagement - specifically when CCG proposals are ready to be shared. – **Agree x 1**
- Engaged enough. Get on with it!
- Finance needs to be transparent.
- Information access. Services in community should be accessible.
- Comms need to be simple & understandable.

## Activity 2 – Community Model

### 0 - outside target

- Don't have enough info and facts to say yes or no – **Agree x 1**
- Timescales on engagement - poor, impact on trust
- Media 'noise'
- Gateway to care - online in person
- Nice waste of ink
- Info / advice etc. and discharge - health / care staff training in what is available
- Nothing about self-choice and self-control in the models
- Nothing
- Better scoring system re procurement for 3rd sector – **Agree x 1**
- New providers into system 3rd sector barriers PQQ
- Innovation is not always good
- Navigators, enablers and volunteers to support and empower
- Social care being explicitly described as missing
- Can't know connection between model and engagement results
- Rising costs - where will £ come from?
- The models seem to be the comments have been translated to a professional language but is not understandable by everybody
- Support attitude change to their own health
- The models are too vague to explain to us Joe Blogs/ patients / service users
- Vulnerable people who have no access to these services. Health but where is social care and wellbeing?
- Want real stories, case studies to explain the model now and how this could improve – **Agree x 1**
- Access and delivery for children
- Nothing about drop in as delivery
- Choice - other alternatives that people might access on their own
- More patient stories to help us engage with the model
- Join up JSNA strategies with NHS strategies – **Disagree x 1**
- VCS - social prescribers. Other services (prevention) loneliness, depression etc. – **Disagree x 1**
- Cultural change for public and professionals – **Disagree x 1**
- Dentists and Optometrists where are they?
- 24 hours unrealistic target. Where is the money and workforce to achieve this?
- Are we developing a postcode lottery?

- Very medical model
- Calderdale - Personalised budgets linked with direct payment and community model
- Access to information, don't just rely on computers
- Person centred integration (not just organisation integration)
- Not innovative enough
- Coordination needs to involve community matrons, not enough of them – **Disagree x 1**
- Primary care as part of the model - needs to be key NHSE role – **Agree x 1**
- Health and social needs connection social prescribing
- Families and carers to be included all ages cultural differences – **Agree x 1**
- Need to use common language to ensure the message that the overall outcome for the patient is consistent across both CCGs
- Will support services on discharge late at night be available? Should not be about bed pressure, needs to remain patient focused.
- Patient examples here now what services will the individual receive?
- Good on paper but needs to be put in practice. Identify strengths and weaknesses
- Training and staff how do you prove that level of care?
- Agree but need to put this into practice – **Agree x 1**
- Single point of access, who is single point of access going to be? What? How? Triage? – **Agree x 1**
- Both Calderdale and Kirklees models to be shown as qualitative and rational for service placement with reasoning. Equality is reflected in both models
- How do we free money up from the hospital to implement community model?
- Data Sharing is way off target and is a key enabler
- The model is dependent on self-care, prevention, early interventions to reduce the amount of people needing expensive interventions/services.
- Focus more on Keep well, stay healthy. Early prevention models/educational opportunities to be introduced
- Have PHB been considered? WE don't know how much money will be taken out of the pot as cash for individuals
- How do we educate/inform people about how to stay healthy, keep well, when there is so much conflicting health advice in the media?
- Risk assessment where and who takes the risk? Risk of not doing something - Calderdale and greater Huddersfield
- Will there be enough premises to accommodate the locality services?

### **1 - outside / white line on target**

- Self-care - skills gap for staff to empower
- Is it deliverable?
- Gap - no-one to support people in early stage of diagnosis and treatment
- Concern - additional journey time to A&E resulting in poorer outcomes for patients and greater disability or need for long term care
- Greater financial and work for adults health and social care
- Some support and services already delivered by 3rd sector but more could be done to give better access

- Achievability?
- Supported self-management needs to be something provided to all health and social care staff in community and hospitals teams
- Are we asking each patient what they want every time they contact services?  
– **Agree x 1**
- Components not described in the model which keep people out of hospital
- Is it amalgamations of GPs in Greater Huddersfield?
- Need a map of services and how they relate – **Agree x 1**
- Where are the community and voluntary sector? They should be 4th point of access
- Why is specialist hospital access not core within the community?
- Accessibility how does it work?
- What are the outcomes expected for the functions? Have they been defined?
- Connecting the models with public health and social care. Self-care hub –  
**Disagree x 1**
- Technology will be critical - do patients trust it?
- Supported transfer and access good idea but needs more bones (transport)
- Define locality
- Define community
- Use the case study "the ackroyds" or "dons" - the N Kirklees cartoon - our street
- Is the Calderdale community model presented as well? The Huddersfield model is clearer
- Access to triage too difficult to understand - need to explain who is single point of contact
- Is the access and triage diagram too confusing to understand?
- Is it really 24 hour service when you say in and out of hours?
- Language is hard to understand - model, function (NHS talk) Real life examples would help – **Agree x 3**
- Could it create inequality rather than increase it? – **Agree x 2**
- Quality of service from single point of access is a concern – **Agree x 2**
- GP waiting times how is that being fixed? – **Agree x 1**
- Have recent experience of mental health nurse being unable to access records on a Sunday, 24 hours access will be a positive thing
- Expectation management - are people going to be let down or feel let down?
- Would like to have consistency of access to see their GP throughout Calderdale and greater Huddersfield

## 2 - white on target

- Consortium of 3rd sector to provide
- Calderdale community model does not include early intervention, info giving and care model rather than whole picture
- Flow chart of information needed
- What does 24 hours access mean?
- Locality not flexible enough - monitoring of LTCs could happen in church halls
- Need good websites for professionals and public
- The model does not reflect access into the model – **Disagree x 1**

- We need enough care to support people and home provides practicalities e.g. home care food basics etc.
- Why are we separating the GH & C models and can they be developed to be understandable?
- Estates - concern about estates can we provide services
- LA's and NHS need to work seamlessly

### 3 - white / black line on target

- 3rd sector 'blue sky thinking' with CCGs – **Agree x 3**
- There are services available in the community but this information is not shared
- Confusing, this sounds like A&E where is the community model? – **Agree x 1**
- Not quite sure what the difference?
- Implementation plan will be critical
- Commissioners need to find a way of explaining discussing the model with different focus groups
- Continuity and seamless services, accessibility stretches across C&H footprint models need to be seamless

### 4 - black on target

- Travel and transport closer to home need to consider carers too
- Balance between targets and delivering the core needed – **Agree x 1**
- Self-care needs to be across whole model, link to technology and choice
- Skills appropriate for all staff
- Transport needs to be taken into consideration when choosing the localities - they may look geographically close / suitable but may still be hard to get to without a car - do buses run past the localities chosen
- Test the models through focus groups, ask the right questions and the language used – **Agree x 1**
- Model description and outlines require clarity and explanation

### 5 - black / blue line on target

- Reflects engagement
- Worried about touch screen. Need to see receptionist first. Human contact is important
- People not making use of Todmorden health centre but being sent to Halifax
- 24 hours is this realistic?
- Estates
- Pathways need to be explained in true form of a patient journey
- Collaborative working wasn't brought out in the presentations - confusion re the similarities in the models
- Single assessment - mindful of how info is used and shared and capture that
- Greater recognition of connections between different elements of services.
- Nice to see intention is there but can it be delivered?

- Need to consider the whole chain i.e. patient/carer etc. – **Disagree x1**
- Work together with GPs to implement this
- Social care needs to be aligned with health care. Building bridges with LA – **Agree x 2**

## 6 - blue on target

- Advice support and sign posting 24/7 – **Disagree x 1**
- Closer to home now and model extended, avoiding hospitals
- More emphasis on multi agency working to prevent re telling
- 24 hour access, how will it work? Star view
- Hospital specialists - Access gained through GPs - not sure whether this is it?
- More detail on triage - who is most appropriate person / skills? – **Agree x 1**
- Postcode lottery - if localities do well then this is better in this area
- Children and young people are trialling this? Records – **Disagree x 1**
- Greater Huddersfield - Patient centred (flexible)
- Not just transferring the hospital to community
- ? Interface with A&E departments. Patients will still attend A&E departments will there be services in place to ensure they're seeing the most appropriate person e.g. primary care clinician?
- 10pm - 6am no discharge from hospital unless exceptional circumstances – **Disagree x 1**

## 7 - blue / red line on target

- Calderdale holistic approach bit is really good approach but needs primary care to align
- Coordination of care is essential across services. Needs to be explained more explicit in the model
- MH appears to have considered some services can be more community focussed and others shouldn't be
- Like "enables" on Calderdale model
- Like cluster type approach, appears more doable
- Federation working is seen as accessible services being available
- Ensure partnership links and use partners to work together
- Identification of journey / needs on 1st point of contact
- Health connections - services integrated in the community

## 8 - red on target

- Core community functions positive description
- Calderdale - 5 enablers
- Single point of access. Idea on target needs continuity and shared information. Local knowledge
- Greater Huddersfield - personalised budget follows the patient - aligns with direct payments on one framework
- Community model reflect high level. But the level of detail needs to explain if hit the target

- Single assessment - saying things once and passing information on
- Delivery of a focus on the community and delivery of a holistic integrated care offered to patients
- Discharge plans should be in place upon admission - preparing for discharge
- Keeping services in the community - engagement with federation
- Estate - use community settings i.e. church halls
- Information accessible to suit patients' needs – **Disagree x 1**
- Really like the new model and it fits really well with the Calderdale social care model around prevention, self-care, early intervention and complex care.
- Where possible supporting people to stay in their own homes
- Very impressed with the Calderdale model – **Agree x 1**
- A holistic approach to care and support to meet the needs of the patient – **Disagree x 1**

### 9 - red / yellow line on target

- twenty four seven
- 24 hour access, rapid response
- Sharing information (only once)
- Access - carer could be family member or someone who supports the individual
- Individual location (groups 4 GP practices) reflecting the needs of each patient group i.e. COPD services in one area diabetes care in another

### 10 - yellow bulls-eye on target

- Hospitals good discharge supported
- Single assessment
- Single point of access but isn't joining up with current services e.g. 111, gateway to care
- Model address the themes in engagement
- Using correct language (not self-care) supported self-care
- The model provides access to preventative services. Self-care self-management – **Disagree x 1**
- The model reflects access to services (SPA) and remaining primary care as key coordinator
- Extended hours for GP 7 days waiting
- Huddersfield focused on what is important to people first
- 24/7 working including pharmacy (community and hospital) – **Disagree x 1**
- Locality team reflects patients views
- Moving with the times and investing in the community

### Activity 3 – In hospital model

#### 0 - outside target

- Future patients - those who are healthy, how have they been spoken to?
- Patients could accept lower standards for local services, continuing compromise

- If you want to keep standards to a level, things have to change
- What service users have been spoken to?
- Communication - what services are available?
- Does it cover transition from children's to adult's services? And different agencies to different services?
- Utilise flexibility of tariff to promote the right pathway being delivered
- Does it cover discharge at point of planning admission?
- How do the hospital standards apply when a service is transferred to community?
- How keep it up to date?
- How join up hospital standards with community model
- Be explicit about mental health acute service and parity of esteem
- Standards in litigation
- List of services doesn't have mental health
- Independence of assessment
- How do you police the standards? Walk the floor, Holistic care, Reasonable adjustments
- Provision of information
- Can't comment because we haven't seen the standards
- How have the standards been developed?
- Do the standards cover the pathway?
- What does CQC do? Assurance of management of hospitals.
- Holistic patient care
- Need diversity to meet the needs of the population
- Are the standards published?
- Patient journey need a standard for this
- Consider a two tier service so that real emergencies get the right care at the right time and right place
- What happens before you get to hospital? Ambulance involvement in standards
- Access to deliberator in community i.e. sports facilities
- Will a standard trigger need to go to a different hospital?
- If all standards were met it would be excellent - not enough information to make an informed decision
- Much more work needed if this area of hospital standards is to be explained to the public at large
- There's still a lot of work to do to explain what the hospital standards actually are
- Are there hospital standards engaged with patient satisfaction / friends and family test input?
- Are we being asked to "rubber stamp" something we don't understand
- GP Practice standards - changing my doctor improved my health due to asthma clinic educating me to live and control condition
- Are we being asked to "rubber stamp" something we don't understand
- Feels like engagement is being undertaken just to tick a box not thought out
- No financial standard - wards focus on care not saving money
- Make it more understandable for the lay person
- Is there a standard for a robust discharge process?

- Links to primary care standards
- Who monitors the standards?
- Not enough in for to provide thoughts/views need more detail
- You won't meet the standards if you don't consider workforce
- 92 standards need to be slimmed to a number people can know and relate to and act upon
- The standards to not take account of the 2 sites

### **1 - outside target / white line on target**

- What do people expect from their services e.g. named nurse seeing consultant
- How plan to bridge the gaps and the timescales?
- Conflict between NICE and the standards in some examples
- Patients charter "fundamental standards"
- Better use of expensive equipment i.e. scanners running 24/7
- Impact on resources to achieve all the standards
- Initiatives like lions green cross scheme in more patients homes
- Specific standards for specific conditions like diabetes / mental health / LD
- Public assume quality is going to be covered. Cannot expect the public to be interested in 95 standards
- Need detail on community standard
- Consistent standards are required on both sites
- Where is the discharge standard?
- Elderly discharge verification of care available at home – **Agree x 1**
- Fragmented managerial aspect within hospitals

### **2 - white on target**

- Where are the compromises?
- Bronze? Silver? Gold? Would patients and providers agree?
- Are people willing to expect lower standards for different facilities
- Where is Urology?
- Financial implications need to be considered
- Standards to be based on basics like communications
- Workforce issues, right amount i.e. nurses and agency
- Appropriate public transport – **Agree x 1**
- What are the common standards now and how do the new ones compare?

### **3 - white / black line on target**

- What else is needed to make it a positive experience
- More technology to monitor conditions
- How well are patients informed of "quality standards"? How effectively is it going to be to monitor/measure if clarity is missing?
- Who will be monitoring the standard /quality?

### **4 - black on target**

- When something hasn't been resolved there should be opportunity to continue at hospital not start at beginning with a new referral
- system currently prioritises medical staff time not the patients time
- 7 day services, which bit, for who, which patient at what cost?
- Recognise what is good right now and how it could get even better
- Where are mental health standards? - **Agree x 1**

#### **5 - black / blue line on target**

- Not clear what we are being asked to do?
- Customer service delivery experience of standards and outcomes - patient perspective, hospital standard perspective
- Of monitoring standards to ensure meeting these standards and taking on board in improving the current standards where there is no additional cost to the service delivery

#### **6 - blue on target**

- What are the 95 standards? Can we have a list?
- Information sharing
- Standards provide evaluation of care via patient experience
- One model service - meeting various of community mix
- GP good practice should be shared patient spoke about caritas
- Royal college guidelines should be considered but they are not LAW

#### **7 - blue / red line on target**

- Can we configure services that keep standards up
- At what point do people know they need to access care sooner or later? Information is key.

#### **8 - red on target**

- Support standards as a decision criterion
- How will we identify the gap?
- re hospital care mixture, different experiences, some good some not so good
- Discharge standards are these included?
- Utilisation of Royal College? Is essential to a robust approach
- approach to developing quality standards

#### **9 - red / yellow line on target**

- Twenty four seven
- 24 hour access, rapid response
- Yes sounds good A3 but is it achievable within the resources available?
- What are the standards now? How is this changed or improved?
- Put something into the curriculum in high schools

## 10 - yellow - bullesye on target

- Hospitals good discharge supported
- Single assessment
- Reflects model
- Incremental process - not over night
- Works for what is best for the patients
- Delivery of best standard of care for the patient

### Activity 4 – Evaluation Criteria

- No. 13 is the more important criteria than 11 and 12.
- Case examples of criterion to illustrate the previous success of a company.
- How collaboration has taken place - evidence & examples. What engagement?
- It would be helpful to have some examples of ways the evaluation criteria could be applied.
- Evidence of research /consultation with relevant partner agencies.
- How can (and will) voluntary sector orgs be engaged in the evaluation process?
- Single assessment - no progress since 2001!?!)
- The headings are right but it's critical that the questions under them are right. And we don't have them.
- Barriers to data sharing.
- Encourage single assessment process.
- How will self-care achievements be measured & tested?
- Use of case studies to demonstrate criteria.
- Where appropriate quality marque evidence or work in progress.
- How will the evidence of the working with the voluntary sector be tested. Case studies and proof??
- How will the providers enable LA/GC/3rd Sector to work together. NO. 11 & 13.
- Self-management - How do provider help with self-management.
- Track record - more specific 'work with 3rd sector to deliver real outcomes' timescale? (12)
- Patient experience track record leading to improvements.
- Advance consent' clarity to data sharing
- Add engaging patients in their care (incl carers)
- What are estates?
- Broader wins for the public - technology
- Clear descriptions of criteria to enable good answers.
- How people experience being 'cared for'. Keep asking people what they need from service.
- Effectiveness - VFM. - Outcomes. Which constitutes effectiveness?
- Why work in partnership - delivery of results - improvements.
- Do we share with Police - if clinically relevant?
- Giving people chance to take control of their lives (re take).
- Add 'patient choice' somewhere (19) - (7) - Effectiveness.

- What capacity? For what? Who? People? Eh?
- Who's local? What do they understand by need? Which populations?
- Explain the risks & benefits to people - safeguards.
- It is about human contact. Tech cannot replace everything.
- To provide seamless care.
- Why do we want them to work in partnership?
- Specific plans to engage local voluntary organisations.
- Single assessment care planning & reviewing (6) & (1) & (3)
- Like (11) but needs more detail - who with?
- More engagement & listening to smaller groups to evaluate the criteria.
- Effective data sharing across all partners on a need to know basis only.
- Simplify terminology. Explain the evaluation criteria.
- What does it mean number 2? More detail.
- Need benchmarking to comment on it.
- Need more explanation of the criterions.
- Break down the criteria i.e. Demonstrate patient focus. What is that?
- Why are points in number 1 joined together?
- Adequately trained staff used effectively. Replace effective utilisation of staff expertise.
- Improves patient experience.
- Increase accessibility and offer choice where appropriate.
- Remove number 12.
- Impact of staff and stakeholders - why is it a higher priority? Identified the need to respect existing staff.
- Partnership working (9)
- Demonstrate effective and innovative use of estates
- Delivers value for money
- Operating model - achievement of agreed outcomes.
- QIPP should be included.
- Effective use of technology.
- Effective data sharing with all partners.
- Whose opinion on criteria & awarding contract.
- It's more than just evaluating it's also about the work in contract & delivery.
- It's about simplicity. Understandable & simple language.
- Transparency. I.e. weightings of each section etc.
- Be clear on the intentions.
- Decision making. Who is the panel?
- Needs face to face! Not just PC process. Partnership working.
- Support with the bid!
- Practical as well as theory.
- Language! Simplify, don't hide behind words.
- Provide examples for the criteria
- Don't create Unnecessary barriers to future bids
- Estates
- Better care fund fit in - join in with process.
- Sustainability services made up by providers - as a whole.
- Demonstrate value for money

- Evaluation of hospital services connectivity!! To and from community services.
- IT System for effective data sharing?? How many??
- Transparency & honesty with information to patients.
- 1 - Service continuity contingency - staffing levels (capacity)
- 1 - Change the word promotes to 'deliver'.
- 2 - Change words to: Demonstrates. Continual improvement.
- 2 - Participates in research and encourage self-development/innovation.
- 3 - Continued development of staff. Define expertise!
- 4 - Demonstrate or deliver rather than promote.
- 5 - Deliver rather than support. Would this section be subcontracted?
- 5 - Prevention work could be done in community with existing organisation.  
(Need to understand working with community)
- 5 - Need to consider rural settings. Understand the area.
- 6 - Patient centred care - patient at the heart of the process.
- 6 - Evidence of patient focus in previous work.
- 6 - Need engagement & involvement in development of services.
- 6 - Patient experience surveys
- 7 - Promoting informed choice
- How would access be delivered 24/7?
- Demonstrate understanding of local needs including diverse population link to existing local organisation.
- What does that mean? Who are they? Do you mean members of the public?
- Is this the same as 1 in continuity and staffing levels?
- Demonstrate capability of staff.
- Change engagement to partnership.
- Not just flexibility. Should show previous examples of work previously.
- Visibility of highest to lowest ratio of staff pay.
- Reallocation of resource not just savings. Evidence of large scale delivery.
- Including existing buildings. Including community building link in housing etc.
- Change word optimisation to promotion & innovate.
- Demonstrate ability to data share effectively.
- How do we recognise 'value added'?
- How do the criteria link to the KPI's & contracting monitoring?
- Do we know weighting for each of the criteria?
- Patient (person) centred service with patients at centre.
- Values of the organisation.
- How do you define, develop capacity? Too Broad
- Corporate social responsibility.
- Define productivity - what do we really mean?
- If financially non-viable then do the other criteria really matter?
- Do all criteria need to meet for the proposal & what weight they have?
- Value for money
- Auditing of contractors
- Need to feedback to the PRGN & Calderdale Health Forum
- Feedback into the Northbank forum for newsletter
- Feed back to both healthwatch.
- Calderdale assembly - What feedback needs to go there?

- Test a pilot proposal through evaluation criteria
- What is the timeline to achieve what they are proposing?
- How determine optimum length of contract for each/all services
- Can't split lucrative from costly i.e. no cherry picking.
- Is the patient engagement reflected in the evaluation criteria? How should it be?
- How ensure delivery to timescale & stats as promised.
- How test credibility of what tenders are saying
- Need clarity on who is commissioning now & clarity of how join up in future & overall ambition for integrated commission & provision.
- Are we clear/future proof? Commissioning of health & social care from one provider (check detail under 13)
- Integration with all relevant providers
- Delivers productivity - what does that mean?
- Clinical safety & effectiveness - should be renamed: Clinical Quality, Safety & Effectiveness
- Quality & value for money need to be recognised.
- Meeting patient needs' instead of service user responsiveness.
- Staff training & development in clinical safety and effectiveness.
- No mention of social value in financial viability & sustainability.
- 8 - Demonstrate responsiveness to local need & patient feedback.
- 11 & 13 are VERY similar.
- 9 - Needs to go as commissioners should decide whether it is acceptable before they tender.
- Sustainability has to be viewed in the long term as opposed to short/midterm.
- Social value on investment to the wider local community. Spend money looking.
- Evaluation criteria read as if professionals have written them in the room together. Are they tested against all the engagement information?

### **Questions/Views from the *Clothes Line***

- The public do not understand that the community model is not about moving hospital services into the community. This needs to be explained! ●
- Can Social Care support the model? Very medical model.
- Litigation – Can we control this? Is it getting worse? Will it be worse in the new system?
- Application of hospital standards. We expect these will apply for all our patients wherever their services are delivered or in a direct or sub contact arrangements. i.e. our 'tender' will cover say 90% of patients but the other out of area/choose & book patients need to know they will get the same standards.
- Need to describe who is on the multi-disciplinary team – is this with social care?
- Is there a need for a shared common language?

- Surely to me, the principle is about giving the choice to access services based on an informed choice. Independence and choice is paramount for S/U's.
- 24 hour access – is this walk in or telephone only (or extend to virtual face to face). Concern re generating demand might reduce people self caring because services are 'too' accessible.
- Access to GP appointments is the biggest problem in the system!
- Given the demographic changes is this affordable?
- Single point of access Ex. Idea – how will it deliver the benefits in practice -
  - - Evidence }
    - - Pros/Cons } Needed first
  - Multiple point confusing and unhelpful BUT need to be sure a single point will deliver benefits.
- What are we doing to address drug and alcohol misuse?
- If Kirklees (GH) & Calderdale are working towards same goals, using same or similar models – why can, or do they, not work together? Commissioning savings? Invention of one wheel? Saving opportunities?
- There are currently 7 buses an hour directly linking Huddersfield to the Calderdale hospital. There is only 1 bus an hour directly linking Halifax to the Huddersfield hospital. Transport links must be considered – not everyone has a car. ●
- If this can be realised then our healthcare will be fantastic!
- Transition from old to new model will need services to run together for a time. Do we have the money to do this?
- More information required. ●
- Innovation is not always good – why change it if it already works?
- As we move to personalisation and Phb – will this be a risk to the model. i.e. people choosing and buying provision elsewhere i.e. LTC.
- Hospital Services – Planned beds – if someone needs 2 weeks in hospital this needs to be in their locality to be able to benefit from visits. It relieves stress and anxiety from the patients and their families. It will also cause financial hardship in terms of travel costs/time issues. I feel distressed even thinking about it!
- Only telling information once – needs clarifying. What about when needs/circumstances change?
- Where are single point of access\_sites going to be? Will it be same single point of access for urgent and non urgent?
- Self care seen at preventative/start of model. Assistive technology and technology as an enabler?
- Public understanding of current standards – Empowers patients as they know the standards they should expect / deserve.
- Risk – we know our responses are skewed because the equality & diversity analysis of responses e.g. greater % of minority ethnic responses – so risk we may base our model on a disproportionate view of what the population has

said it needs. This risk can be mitigated by targeting the less represented groups in the next stages of engagement.

## Appendix 6: Evaluation Form



# Right Care, Right Time, Right Place Stakeholder Event - 12<sup>th</sup> August 2014

## Evaluation Form

**Name & Organisation** (Optional)

.....

<b>Presentations</b> (including content and presenter) – Was the information presented in a way that you could understand?	Please rate by circling the appropriate number - 1 being no understanding at all and 10 being completely understand
Presentation 1 – What’s happened so far?	1 2 3 4 5 6 7 8 9 10
Presentation 2 – Community Models	1 2 3 4 5 6 7 8 9 10
Presentation 3 – Hospital Standards	1 2 3 4 5 6 7 8 9 10
Presentation 4 – Evaluation Criteria	1 2 3 4 5 6 7 8 9 10
Is there anything else you would like to tell us?	

<b>Activities</b> (including facilitators) – were you able to contribute fully, tell us everything you wanted to and feel that you were listened to?	Please rate by circling the appropriate number - 1 being no not at all and 10 being yes completely
Activity 1 – Your thoughts	1 2 3 4 5 6 7 8 9 10
Activity 2 – Your views	1 2 3 4 5 6 7 8 9 10

Activity 3 – Your views	1 10	2	3	4	5	6	7	8	9
Activity 4 – Your feedback	1 10	2	3	4	5	6	7	8	9
Is there anything else you would like to tell us?									

<b>Please rate the following by ticking the appropriate box</b>	<b>Very good</b>	<b>Good</b>	<b>Poor</b>	<b>Very Poor</b>
Registration				
Welcome				
Introduction				
Other ways in gathering your views (i.e. comments cards, washing line)				
Food				
Venue				
Is there anything else you would like to tell us?				

Any other general comments?
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**Thank you for taking the time to complete this form**