

Single Commissioning Plan 2011/12

Calderdale Council and NHS Calderdale

07/04/2011

Calderdale PCT/Calderdale Council Commissioning Plan 2011/12

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Calderdale Single Commissioning Plan - Executive Summary

I. Aim of the Plan

Our aim is to clearly identify those services and activities that will be commissioned during 2011/12 by Calderdale MBC and NHS Calderdale. So, this plan covers all health and social care commissioning across the two organisations. Sharing this plan will enable us to commission more efficiently and effectively. The Plan goes beyond organisational boundaries covering all health, adult social care and children and young people's services commissioning across both organisations. Drawing on a shared understanding of identified needs the Plan identifies priorities and the single, integrated commissioning approach to be taken in meeting them.

Principles

The plan is based upon some clear principles:

- We will focus on what is right for Calderdale and align the national agenda where this meets local needs
- We will ensure services commissioned are safe and high quality
- We will deliver a single plan that meets the requirements of both organisations and the GP commissioning consortium
- Where commissioning activity can be integrated it will be
- Statutory duties will be met
- We will maximise the impact of available resources
- Delivery of Quality Improvements and cost savings are integral to the plan
- Pre-commitments will be delivered wherever possible
- Emerging risks and pressures will be identified and managed
- We will ensure alignment with our transition plans
- We will ensure alignment with financial plans
- We will ensure engagement and clearly communicate with key stakeholders: (Patients, Public, Staff, Providers and Partners)
- Underpinning processes will be systematic, clear and well-understood

Underpinning the development of a single commissioning plan is a recognition that the systems within which we operate and the services that we commission are inter-related. Decisions taken by doctors, for example, can impact upon admissions to

residential care whilst decisions by social workers can help ensure that people do not subsequently have to be admitted to hospital. Children's services too are increasingly inter-related, as for example in the Family Nurse Partnership. Integrated Commissioning will improve services by helping us to make them patient/service user focused and by looking across the whole system in order to achieve the best and most cost-effective outcomes.

Headline changes

In order to deliver our high level outcomes there are some significant changes that we need to make in what we commission. Our "headline changes" are:

- The focus will be on; preventing ill health and promoting well-being,
- Better demand management around unplanned and urgent care in hospital
- Better demand management around home care in adult social care
- Healthy Child Pathways
- Disabled children Single point of Access
- Improvements in Intermediate Care services
- Better management of long term conditions
- Wider usage of TeleHealth and Telecare services
- New Mental Health Strategy in line with the national strategy
- New Autism strategy (as required by the Autism Act)
- Improved medicines management

II. Background

The Single Commissioning Plan seeks to identify together in one place the commissioning plans and intentions for Calderdale PCT and Calderdale council. For 2011/12 it includes all the commissioning intention of the PCT and those of the AHSC and CYP directorates.

It draws upon a range of existing plans and processes. Some of the key ones are:

- Existing Strategic Plans within the PCT, AHSC and CYP
- Identified areas of Performance Improvement
- Continuing business from 2011
- Identified Demand pressures
- Cost reduction programmes in both the PCT and LA (including demand management measures)

- Council and PCT budget allocations and financial plans for 2011/12
- NHS Annual Operating Plan

The plan follows a simple format and covers three distinct areas:

- *What do we commission now*
- *What do we know will be commissioned differently in 2011/12*
- *What we need to review in 2011/12 (with a view to commissioning differently)*

III. Financial Context

Also, in terms of background, there is the new financial context for all public services. For local authorities there has been a clear reduction in central funding that for Calderdale has required at least a £15m reduction in expenditure in 2011/12 compared to 2010/11. There will be similar further reductions in the next two years will be a further anticipated reduction and also the impact of significant changes in the structure of local government funding that could also have a big impact.

Whilst the Government has announced an overall increase in NHS funding in 2011/12, the increase is lower than in previous year. The overall impact in Calderdale is that both CMBC and the PCT are facing significant challenge in meeting their financial targets.

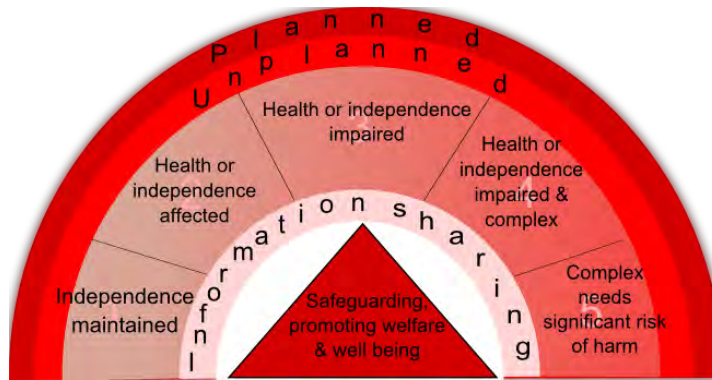
Our commissioning intentions are drawn from the analysis undertaken of need and demand for health and social care services, as described in the Joint Strategic Needs Assessment, in conjunction with our understanding of the context in which we will be operating during 2011/12 and beyond

The preparation and production of a Joint Strategic Needs Assessment (JSNA) is a statutory responsibility of the Directors of Public Health, Children's Services and Adult Social Services¹.

IV. Commissioning Framework

To assist in delivering the plan we have developed a shared framework within which we can identify all the various services commissioned and provided (not all in-house services are commissioned)

¹ *The Local Government and Public Involvement in Health Act (2007)*



This allows all services to be categorised on the basis of the needs being met and whether or not they require a planned or an unplanned service. The framework will allow us to see where resources are being allocated across the spectrum of need and how well preventative services are working. Overall we want to shift the emphasis towards the left hand side of the continuum and towards a more planned response.

V. Conclusions

For the first time in Calderdale we have a single plan this plan that sets out the commissioning intentions of NHS Calderdale and Children & Young People and Adults, Health & Social Care Directorates within Calderdale Council – and sets them within a shared framework.

It establishes clear commissioning intentions for 2011/12 on the basis of current activity, known changes and areas for review, change and transformation. It will conclude with a set of action plans, currently being developed, to be delivered across both organisations through single accountability structures and true joint commissioning.

1. Aim of the Plan

- 1.1 Our aim is to clearly identify those services and activities that will be commissioned during 2011/12 by Calderdale MBC and NHS Calderdale. So, this plan covers all health and social care commissioning across the two organisations. Sharing this plan will enable us to commission more efficiently and effectively. The Plan goes beyond organisational boundaries covering all health, adult social care and children and young people's services commissioning across both organisations. Drawing on a shared understanding of identified needs the Plan identifies priorities and the single, integrated commissioning approach to be taken in meeting them.
- 1.2 The plan is comprises of three elements:

- What we commissioned in 2010/11
- What we know we will commission differently in 2011/12
- Reviews that might result in us commissioning differently in 200/11

Taken together these three elements set out clearly our commissioning intentions for 2011/2012

- 1.3 Added to that is a further element that identifies and addresses changes in the commissioning process.
- 1.4 An enhanced version of this plan has been submitted to the SHA as the Four-Year Strategy for NHS Calderdale.

2. Underpinning Principles

- 2.1 Fundamental to the success of this plan is the extent to which it assists us in achieving the overall strategic aims and direction of travel of the two organisations and also the emerging GP commissioning consortium. Also, it sits alongside and reflects the financial plans of the Council and the PCT and specifically their respective budgets for 2011/12.
- 2.2 This plan reflects the Council priorities set out in "A Fresh Start" and also the requirements of the NHS Annual Operating Framework (AOF) for 2011/12, and it constitutes the Annual Operating Plan for NHS Calderdale in 2011/12. A summary of the AOF and a copy of "A Fresh Start" are attached as Appendices 2 & 3.
- 2.3 Whilst the Plan is firm and clear, regular review of progress throughout 2011/12 and beyond will ensure we remain focused on achieving the high

level outcomes set out in the plan. Risk management processes will identify emerging pressures and risks that need to be incorporated and addressed through the year.

2.4 The plan is based upon some clear principles:

- We will focus on what is right for Calderdale and align the national agenda where this meets local needs
- We will ensure services commissioned are safe and high quality
- We will deliver a single plan that meets the requirements of both organisations and the GP commissioning consortium
- Where commissioning activity can be integrated it will be
- Statutory duties will be met
- We will maximise the impact of available resources
- Delivery of Quality Improvements and cost savings are integral to the plan
- Pre-commitments will be delivered wherever possible
- Emerging risks and pressures will be identified and managed
- We will ensure alignment with our transition plan
- We will ensure alignment with financial plans
- We will ensure engagement and clearly communicate with key stakeholders: (Patients, Public, Staff, Providers and Partners)
- Underpinning processes will be systematic, clear and well-understood

Underpinning the development of a single commissioning plan is a recognition that the systems within which we operate and the services that we commission are inter-related. Decisions taken by doctors, for example, can impact upon admissions to residential care and decisions taken by social workers can impact upon admissions to hospital. Children's services too are increasingly inter-related, as for example in the Family Nurse Partnership. Integrated Commissioning will improve services by helping us to make them patient/service user focused and by looking across the whole system in order to achieve the best and most cost-effective outcomes.

3. High Level Outcomes of Plan

3.1 Our commissioning activity is intended to help us deliver our high levels outcomes, as set out nationally for the NHS and for Adults Social Care and Children and Young People:

1. Preventing deterioration, delaying dependency and supporting recovery particularly in relation to long-term chronic conditions and disabilities
2. Promoting personalisation and improve life-quality
3. Ensure a positive user/patient experience
4. Treating and caring for people in a safe environment and protecting them from avoidable harm
5. Reducing premature death

4. **Headline changes**

4.1 In order to deliver our high level outcomes there are some significant changes that we need to make in want we commission. Our “headline changes” are:

- The focus will be on; preventing ill health and promoting well-being,
- Better Demand management around non-elective care in hospital
- Better demand management around home care in adult social care
- Reduction in urgent /unplanned care
- Healthy Child Pathways
- Disabled children Single point of Access
- Improvements in Intermediate Care services
- Better management of long term conditions
- Wider usage of TeleHealth and Telecare services
- New Mental Health Strategy in line with the national strategy
- New Autism strategy (as required by the Autism Act)
- Improved medicines management

5. **Background**

- 5.1 The development of this plan takes place against a backdrop of unprecedented change in both the NHS and the Council. The White Paper “Equality and Excellence” is rapidly being implemented, impacting upon both organisations and the interface between them. It has also led to the establishment of the GP commissioning consortium, Commissioning Support Units developed through emerging Clusters, and the National Commissioning Board which between them will take over the functions of Primary Care Trusts and Strategic Health Authorities. The transfer of Public Health responsibilities to the Council and the development of Health and Well-Being Board are the major changes at the interface.
- 5.2 Other changes are also impacting upon the local authority, including the development of the “Big Society”, embodied most noticeably in the Localism Bill introduced into Parliament in December 2010.

- 5.3 As part of our Kirklees and Calderdale 'Leading as Peers' work, led by CEOs across the health and social care economy, we have developed a Transformation Board. This is the heart of our transformational change agenda which includes representatives from NHS Calderdale, NHS Kirklees, CMBC, KMBC, CHFT, SWFT, and both Calderdale and Kirklees providers of community services.
- 5.4 The Transformation Board has established four work-streams to drive through this change:
- Vulnerable People/Long-Term Conditions
 - Urgent/Unplanned Care
 - Planned Care
 - Prescribing/Medicines Management
- 5.5 The works-streams focus on transformational change, and create links with activity and finance through the demand planning process. Further work is ongoing to strengthen the role of the Board and put it firmly within local governance and reporting frameworks.

Financial Context

- 5.6 Also, in terms of background, there is the new financial context for all public services. For local authorities there has been a clear reduction in central funding that for Calderdale has required a £15m reduction in expenditure in 2011/12 compared to 2010/11. There will be further large reductions in the next two years will be a further anticipated reduction and also the impact of significant changes in the structure of local government funding that could also have a big impact.
- 5.7 Whilst the Government has announced an overall increase in NHS funding in 2011/12, the increase is lower than in previous year. The overall impact in Calderdale is that both CMBC and the PCT are facing significant challenge in meeting their financial targets. In order to ensure their financial plans are robust, together we have undertaken a joint business planning process which has captured:
- Financial pressures for 2011/12
 - How these financial pressure align to delivery of national commitments and local priorities
 - How these financial pressures align with NHS QIPP plans over the next 4 years
 - How these financial pressures align with the budget announced by CMBC
 - Where the financial pressures provide an opportunity for change and redesign
- 5.8 The joint change agenda for Calderdale has been supported by funding for social care to be allocated via PCTs. In Calderdale this is around £2.5m in 2011/12 with a further £546K earmarked for re-ablement services. NHS Calderdale and Calderdale Council have agreed a process for investing the

£2.5m in social care in line with our priorities. We expect the outcome to demonstrate a reduction in the use of NHS services in line with NHS Quality, Innovation, Productivity and Prevention (QIPP) and service transformation programmes.

- 5.9 We are working closely with local providers in implementing these schemes to ensure the impact of the savings on reduced levels of activity/improved productivity. For the major NHS acute provider this work is managed by the Transformation Board (see above) whose remit includes aligning planning assumptions across the health economy as part of the whole systems approach. This is to ensure correct alignment of financial plans going forward.
- 5.10 A robust governance framework is in place to monitor progress against this plan and meetings are taking place to ensure savings are on track to deliver the required target. Clear responsibilities will be identified across the two organisations at Director Level and clear means of delivering the savings initiatives are being identified.

Planning

- 5.11 Whilst this plan is specifically for the 12 months of 2011/12, it is part of a wider planning framework within both the local authority and the NHS, including existing strategic plans for within both the NHS and the local authority. It will be followed up later in the year by the Health and Well-Being strategy that the shadow Health and Well-Being board will produce later in the year. That will be based upon the revised JSNA currently being developed, and will underpin future single commissioning plans.
- 5.12 Clinical leadership, driven by the newly formed GP Commissioning Consortium will have a significant impact on our plans for 2011/12 and beyond.

6. Scope

- 6.1 At this point the plan is shared by the PCT, Adults Health and Social Care and Children and Young People's services in the Council. Alignment with the Council's Safer and Stronger and Economy and Enterprise directorates will be sought wherever possible and elements of their commissioning activity may be more fully incorporated in due course.
- 6.2 The focus of the plan is on commissioning activity and it covers all those services that are, or will be commissioned by the NHS, AHSC and CYP. Given that focus it is as well to identify that there are a number of areas of activity not covered by this plan. It does not include, for example, the Transition work related to the NHS White Paper.
- 6.3 At the end of the Plan is a set of Action Plans which will supplement the routine commissioning activity and direct our future developments.

7. Commissioning Framework

- 7.1 In setting out the totality of what we commission we have worked to develop an agreed framework that gives us a common understanding and a common language to use when describing services.
- 7.2 Increasingly services are being categorised in terms of what proportion of the population they are aimed at and the means of access to them. This approach emphasises the links between preventative services (e.g. health improvement), universal services (e.g. community support) and more targeted services designed to meet more specialist needs and requiring more intensive interventions (including for example, the provision of community care services or hospital services). Overall the strategic intention in both organisations is to retain as much activity as possible at the lower levels of intensity, recognising that this is better for individuals and also the most effective way to deploy the available resources.
- 7.3 There are a number of ways in which such a framework can be depicted. In Calderdale we have chosen to describe our commissioning framework as a continuum of need against which a person's independence, health and/or developmental needs increase or decrease in dependency. Commissioning aligns against individual needs as tiers of activity from 1 to 5:



Figure 1: Commissioning Framework

- 7.4 The single framework provides a mechanism to ensure that both the Council and the NHS focus on the needs of the population, and that invariably our approaches are often inter linked and interdependent.
- 7.5 Supporting the local population and meeting our statutory duties as organisations requires us to both provide universal services to the population as a whole (the left hand side of the continuum) and to provide specific

services to meet the needs of those with specific health, independence or developmental needs (the right hand side of the continuum). Maintaining, health and independence and ensuring development are essential mechanisms for reducing the demand for services. Many areas of activity (for example the Dementia strategy) require action right across this framework.

- 7.6 Shifting the emphasis of our approaches more towards the left hand side of the continuum is one of our high level outcomes. Similarly, the framework identifies that our responses can be largely planned or unplanned; our intention is to move more towards planned service delivery, particularly around the centre and right hand side of the continuum.
- 7.7 Through the framework we are able to show that our shared aim is to promote the health and well-being of the population of Calderdale through:
- providing information, advice and guidance
 - services and activities open to everyone
 - Services and activities which increase their level of intensity to meet identified levels of need.
- 7.8 At the same time it is also helpful to identify whether these are planned or un-planned activities and services. All local authority and health services can be identified as being located somewhere within this framework.
- 7.9 A key feature of our approach as commissioners is to manage demand for specialist services and ensure that people receive care as close to home as possible. Accordingly, we are looking to give greater emphasis to universal and preventative and early Intervention services. Our approach towards managing demand is not, however, based on early intervention alone, but rather on a broad health and well being improvement approach which is expected to have an impact over time.

8. Determinants of change

- 8.1 As indicated above this plan is made up of three different elements

- What we commissioned in 2010/11
- What we know we will commission differently in 2011/12
- Reviews that might result in us commissioning differently in 2011/12

- 8.2 There are a number of key drivers that determine what we commission and what we will commission differently and/or review in 2011/12. They are:

- Existing Strategic Plans within the PCT, AHSC and CYP
- Continuing business from 2011
- Identified demand pressures
- Quality, Innovation, Productivity and Prevention (QIPP) programmes

- in both the PCT and LA (including demand management measures)
- Council and PCT budget allocations and financial plans for 2011/12
- NHS Annual Operating Plan and 'A Fresh Start' work

9. Need and Demand

Needs Assessment

- 9.1 Our commissioning intentions are drawn from the analysis undertaken of need and demand for health and social care services, as described in Joint Strategic Needs Assessment, in conjunction with our understanding of the context in which we will be operating during 2011/12 and beyond
- 9.2 The preparation and production of a Joint Strategic Needs Assessment (JSNA) is a statutory responsibility of the Directors of Public Health, Children's Services and Adult Social Services².
- 9.3 The JSNA provides a systematic method for reviewing the health and well being needs of a population, leading to agreed commissioning priorities that will improve health and well-being outcomes and reduce inequalities³. The relationship between the Calderdale JSNA⁴ and the Single Commissioning Plan is described in the diagram below:



Figure 2: Relationship of key plans to each other across the commissioning cycle

- 9.4 In future years the JSNA will provide the evidence base underpinning the Calderdale Health and Well Being Strategic Plan from which our Single Commissioning Plans in the future will be drawn. Whilst we have a single commissioning framework within which to operate, further work will be taking

² *The Local Government and Public Involvement in Health Act (2007)*

³ *Guidance on Joint Strategic Needs Assessment, DH, (2007)*

⁴ Calderdale's JSNA is under going a process of updating and refresh during 2011

place during 2011/12 to understanding need and demand within that framework. Also, a summary of some of the major areas of need and demand is contained in appendix 1.

10. What we commission now

- 10.1 Assessing and understanding the progress we made in 2010/11 has been the starting point to establish what will be required in 2011/12 and beyond. In pulling together this work, we have also provided a complete view of our commissioning activity and spend.
- 10.2 Accordingly, Appendix 3 contains details of all the Local Authority (AHSC & CYP) contracted and spot purchased activity for 2010/2011 (excluding any services that were de-commissioned during the year) and Appendix 5 lists all services provided by local authority in-house providers.
- 10.3 These schedules also include any services commissioned or provided on our behalf by other NHS commissioners or local authorities (e.g. commissioning of secure services within the NHS).
- 10.4 In 2010/11, £319M (92%) was invested in services through block and spot contracting arrangements, and £26.4M (8%) was invested across in-house services by NHS Calderdale and Calderdale MBC.

Spend within the Commissioning Tiers

- 10.5 To understand the spread of expenditure across the different tiers in the shown in the commissioning framework diagram (above), we have allocated each service to a tier, to show where the balance of investment currently stands across Calderdale. This clearly shows the amount of investment within the prevention/universal services (tier 1) compared to the tiers which represent increasing levels of intensity in provision (tiers 4 and 5). We have agreed to expand the investment in tier 1, therefore promoting health improvement and greater independence and development.
- 10.6 This also accords with our shared commitment to Calderdale Compact and recognition of the added value the third sector provides towards realising the high level outcomes for Calderdale residents (e.g. maintaining their independence, health and well being) is evidenced in our intention to sustain investment in third sector capacity building during 2011/12.

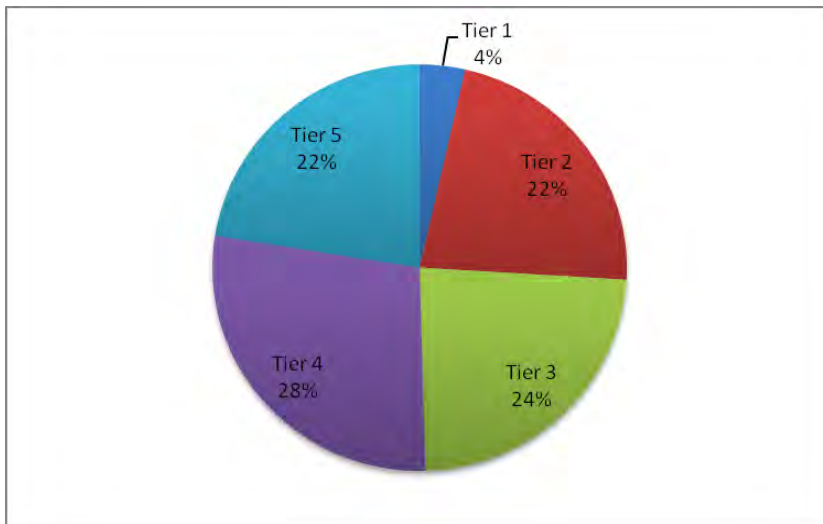


Figure 6: Alignment of investment across the Tiers for block and spot purchased activity 2010/11

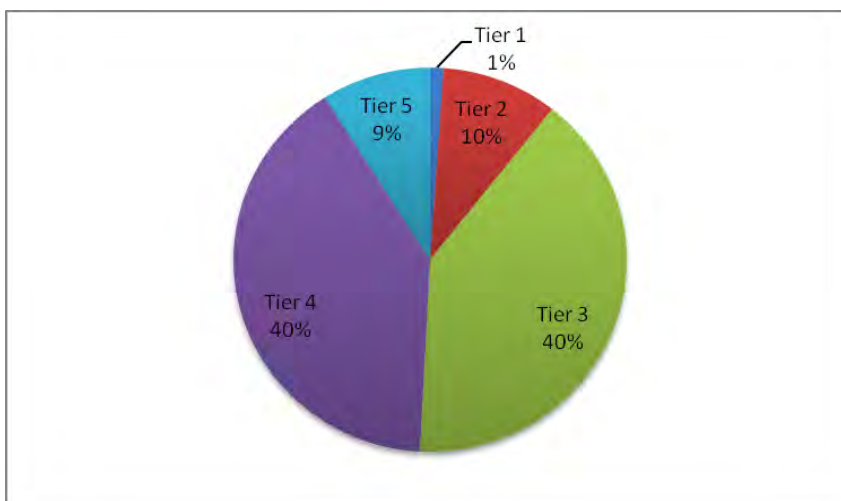


Figure 7: Alignment of investment across the Tiers for in-house services 2010/11

Three quarters (75%) of block and spot contracted activity procured during 2010/11 by NHS Calderdale and Calderdale MBC and 89% of in-house services were focused on those whose health, development or independence was impaired and/or had complex care and support needs. This does indicate a strong need to re-prioritise resource allocation to enhance and strengthen the investment in activities that maintain good health and prevent poor health.

11. What we know we want to Commission Differently in 2011/12

- 11.1 Appendix 7 identifies those areas, where there are commissioning decisions taken already, how they are to be implemented and who is responsible for that. It includes areas of change already identified in previous plans and changes carried forward from activity in 2010/2011.
- 11.2 Also, for the local authority it reflects the decisions made in the Council budget for 2011/12.
- 11.3 For the PCT it reflects the 2011/12 impact of the longer term QIPP plans, which are set out their submission to the SHA.

12. Reviews that will result in us Commissioning Change

- 12.1 There are a number of areas where we will be looking at what we commission with a view to doing it differently at some point in 2011/12, either through a QIPP process (see above) or as a result of service re-design or demand management activity. Those review areas and the services likely to be affected by them are set out in Appendix 8. Again, these show the area of review, how it is being carried out and who is responsible for it.
- 12.2 Some of the key areas for review are;
 - Supported Living
 - Day services
 - Intermediate Tier services
 - CAMHS
 - Child Health Pathways 0 – 5 and 5 – 19
 - Single point of access for disabled children
- 12.3 These schemes are clearly joint in terms of; delivery and outcomes and enable us to maximise the impact across the system in ways that have traditionally not been possible. Through our single commissioning approach we consider that the wide ranging system transformation needed in Calderdale will be achieved.

13. Changes in Commissioning

- 13.1 Given the changes ongoing locally, it has been agreed that identified work areas and targets will be allocated a Senior Responsible Officer who will lead delivery across both organisations and directorates within them, and be accountable to the Calderdale Commissioning Executive/Health and Well-Being board, as appropriate.
- 13.2 As delivery of this joint plan is critical, there are a number of key areas which will be priorities for us during 2011/12, including:
- Alignment of commissioning and transition processes
 - Personalised commissioning
 - Moving away from block contracts wherever possible
 - Taking a market facilitation approach – stimulating a more open market within which a wider range of providers are able to offer and deliver their services.
 - Commissioning both for and with schools and GP commissioners
 - Incorporation of new and existing public health commissioning functions into the CMBC
 - The potential for collaborative working with neighbouring Authorities
 - Sustainable procurement and the role of the Third Sector
 - Ensuring that residents are participating and that their voices are influencing all aspects of the commissioning process
- 13.3 In addition to these changes, we will be looking to shift to an outcomes focus for commissioning across both the NHS and CMBC, and with a greater emphasis within the contract process on activity levels and payment by results as opposed to block contracts. There will also be a greater emphasis on Value for Money as both the CMBC and NHS respond to the changing financial climate and the Comprehensive Spending Review.

Transforming Community Services

- 13.4 A key change for commissioners and providers is that NHS Calderdale's Provider Services TUPE transfer out of the PCT with effect from 1 April 2011. Some **employees** will transfer to Calderdale & Huddersfield NHS Foundation Trust (CHFT) and others to South & West Yorkshire Partnership Foundation trust (SWYPFT).
- 13.5 This change provides a real opportunity to maximise transformation change, particularly in relation to:
- Long-term conditions – strengthening case finding and case management
 - Planned care – development and delivery new evidenced-based pathways.
 - Prevention and promotion – delivering the shift towards preventive models of improving health and well-being

- Developing integrated provider services between the local authority and the NHS

Work will continue to ensure we maximise these opportunities.

14. Performance and Quality

Quality

- 14.1 Calderdale has established a good track record in commissioning quality health and social care services that are safe and can be readily accessed by the local population. The level of progress has been reflected in the assessments Calderdale has received from the Care Quality Commission (CQC).
- 14.2 Commissioners will continue to work with providers to improve quality and performance. However providers will continue to be expected to be compliant with the Essential Standards of Quality & Safety and meet the registration requirements of the Care Quality Commission and the Office for Standards in Education.
- 14.3 From April 2011 CQC registration will also be introduced for NHS and Independent providers of primary dental services. Primary Care services that directly provide GP services (NHS) will also be required to register with CQC from April 2012. Until that time, we expect these providers to comply with the outgoing Standards for Better Health and other relevant standards. If they fail to achieve full registration, we expect them to have robust action plans in place to achieve compliance and ensure the necessary level of assurance.

Performance

- 14.4 The current pressures in the system - the increased demand for services and the increased costs associated with health and social care, combined with the economic downturn - are changing the context in which Calderdale operates.
- 14.5 At the present time both the local authority and the NHS are looking to respond to the reductions in the numbers of national indicators, the introduction of new Outcomes frameworks (for social care, Public Health and the Health Service) and the increased emphasis on local priorities. Developing this response will be a major activity in 2011/2012.

Annual Operating Framework

- 14.6 Appendix 2 sets out our response to NHS Annual Operating Framework targets. Our local response has been shaped by our strategic intention and focus on what is right for Calderdale. For each of the AOF targets we have used a locally agreed prioritisation model to determine what level of aspiration fits in relation to our plans to improve health and well-being in

Calderdale. This approach has the full support of the PCT Board (which includes representation from CMBC in the shape of the Leader of the Council and the Council's Chief Executive)

15. Equality Impact Assessment

- 15.1 An Equalities Impact Assessment has been undertaken for this plan and it is attached as Appendix 6. In addition to that assessment many of the areas and actions have already been covered by equality assessments, and further work will be done as individual action plans are progressed.

16. Monitoring

- 16.1 As indicated areas of this plan will be allocated to a Senior Responsible Officer who will be accountable to the Calderdale Commissioning Executive. Detailed action plans will be drawn up for each of the areas identified in appendices 6 and 7 and these will then be monitored through the Council's I Performance System

17. Conclusion

- 17.1 For the first time in Calderdale we have a single plan this plan that sets out the commissioning intentions of NHS Calderdale and Children & Young People and Adults, Health & Social Care Directorates within Calderdale Council – and sets them within a shared framework.
- 17.2 It establishes clear commissioning intentions for 2011/12 on the basis of current activity, known changes and areas for review, change and transformation. It will conclude with a set of action plans, currently being developed, to be delivered across both organisations through single accountability structures and true joint commissioning.

Summary of need and demand in key areas

Primary Care

- 1.1 Primary care refers to services provided by GP practices, dental practices, community pharmacies and high street optometrists and accounts for approximately £80m of PCT expenditure each year.
- 1.2 In Calderdale around 90 per cent of people's contact with the NHS is via primary care, the majority of which is coordinated through general practice:

- 29 practices treat approximately 3000 people a day
- 31 dental practices treat approximately 1500 NHS patients a day
- An estimated 10,000 people visit one of the 43 pharmacies each day; 8,000 do so for health-related reasons
- Over 200 NHS sight tests are carried out each day

- 1.3 Primary care services are the cornerstone of the NHS within Calderdale. Good access to primary care is strongly linked with reducing health inequalities. Over 99% of the residents in Calderdale are registered with a general practice. Recent patient surveys on primary care reported good levels of access to GPs and high levels satisfaction that scored over 80% satisfaction on a range of indicators relating to opening times, access to a GP of their choice and getting through on the phone. Over 70% of practices also offer extended opening hours. The quality of care – as measured by the national quality and outcomes framework – is also strong, achieving 94%.
- 1.4 Our aspirations to continue to develop and invest in primary care are critical to our plans for system transformation. This is a particular element of our QIPP plans for; planned care, urgent care and prescribing.
- 1.5 Work has been undertaken over the last few months through practice visits to share information about how much each individual practice has used secondary care. For 2010/11, the comparison of usage has been based on local and national benchmarking, however from 2011/12 onward, the piloting of devolved budgets and notional practice targets will signify a move towards true primary care engagement in commissioning, demand management and reducing variation.

Acute Care

- 1.6 Expenditure on acute care accounts for £140m of PCT spend per annum. In line with national trends, the demand and costs of acute have been

increasing year on year in Calderdale with particularly rapid growth noted in the numbers of emergency short stay admissions.

- 1.7 Responses from the public, patients and carers in Calderdale have expressed a desire for better access to good quality services locally and for improvements to take place within intermediate tier services which focus on preventing unnecessary hospital admissions or helping people to be safely discharged from hospital.
- 1.8 In Calderdale, between 80-90% of people who need access to acute care will attend the local acute hospital, Calderdale and Huddersfield NHS Foundation Trust. Annual activity figures provided by the trust indicate:
- Over 22,000 patients attended A&E
 - Over 60,000 attended a 1st outpatient appointment
 - Over 22,000 required a planned inpatient stay
 - Over 27,000 required an unplanned admission to hospital
- 1.9 Health services commissioned from the local acute trust have established a good reputation for ensuring that patients can access good quality care. The acute trust was recently named the hospital of the year at the HSJ Awards 2011:
- Year on reductions in healthcare acquired infections
 - Minimised the number of breaches associated with mixed sex accommodation
 - Ensured that waiting times for routine treatment are within the national standards (less than 18 weeks)
 - Ensured that the majority of patients (>98% in 209/10) are seen and treated in A&E in under 4 hours
- 1.10 Current utilization of secondary care services in Calderdale is neither affordable nor sustainable to the local health and social care economy. Transformation plans developed through Transformational Board work-streams are developing broad-ranging plans that will challenge the historic use of hospital services. The focus will be on; preventing ill health and promoting well-being, ensuring those with a chronic condition receive support and care to manage their condition, to prevent hospital admission wherever possible, and to ensure that those who need urgent or planned care receive an evidenced-based service that is delivered as efficiently as possible.

This is underpinned by our four-year plans for activity, finance and workforce.

Children and Young People

- 1.11 The Children and Young People's Commissioning Strategy for 2011- 2012 includes the following identification of need in the Borough that uses a similar framework to the one outlined above:

- | | | |
|--|---|--|
| <ul style="list-style-type: none"> • There are about 50,000 Children and Young People aged 0 – 18 and 61,000 aged 0-25. • About 2,500 births per year and the under 15 population is projected to increase rapidly in both 2014 and 2019. • There are over 33,000 children enrolled in 101 Calderdale Maintained Schools of which there are 87 Primary and 14 Secondary (Including Special Schools). • 18.5% of the school population are from a minority ethnic group. • 76.5% (1997) of students achieved 5 A*-C GCSE's, in 2010 • In 2009-10 the obesity rate for children in reception was 7.7%, however for children in year 6 it increases to 17.4% and this rate is increasing. | <ul style="list-style-type: none"> • Approximately 8000 children live in households with no-one in employment. • 5046 children are eligible for Free School Meals. • As of 30 November 2010 there were 399 (6.4%) 16 and 17 year olds who were not in education, employment or training, down from 524 (8.6%) in 2009. • There are an estimated 1500 young carers, of which 280 are known to the Young Carers service. • Approximately 3000 children and young people aged 5-16 will have an identifiable mental health problem • 48% of young people in the electronic health needs assessment that they had experience of being bullied. • For 2006/08 Calderdale had an Infant Mortality Rate of 5.8 compared to an England rate of 4.8. • In 2010 2238 children were present at 1251 Domestic Violence incidents (WY police). | <ul style="list-style-type: none"> • The quarterly teenage conception rate for quarter 3, 2009 was 48.3; this is a drop of 9.6% from the 1998 baseline. • 918 pupils have a Statement of Educational Need. • Approximately 156 Children have a Child Protection Plan • There are approximately 775 Disabled Children with a range of needs (based on a census in November 2008). • As of 31 March 2010 there were 270 Looked after Children. • For the period 2006-10 over 130 young people were referred to the child sexual exploitation co-coordinator. |
|--|---|--|

1.12 The diagram below maps the geographic levels of child well-being across the Borough.

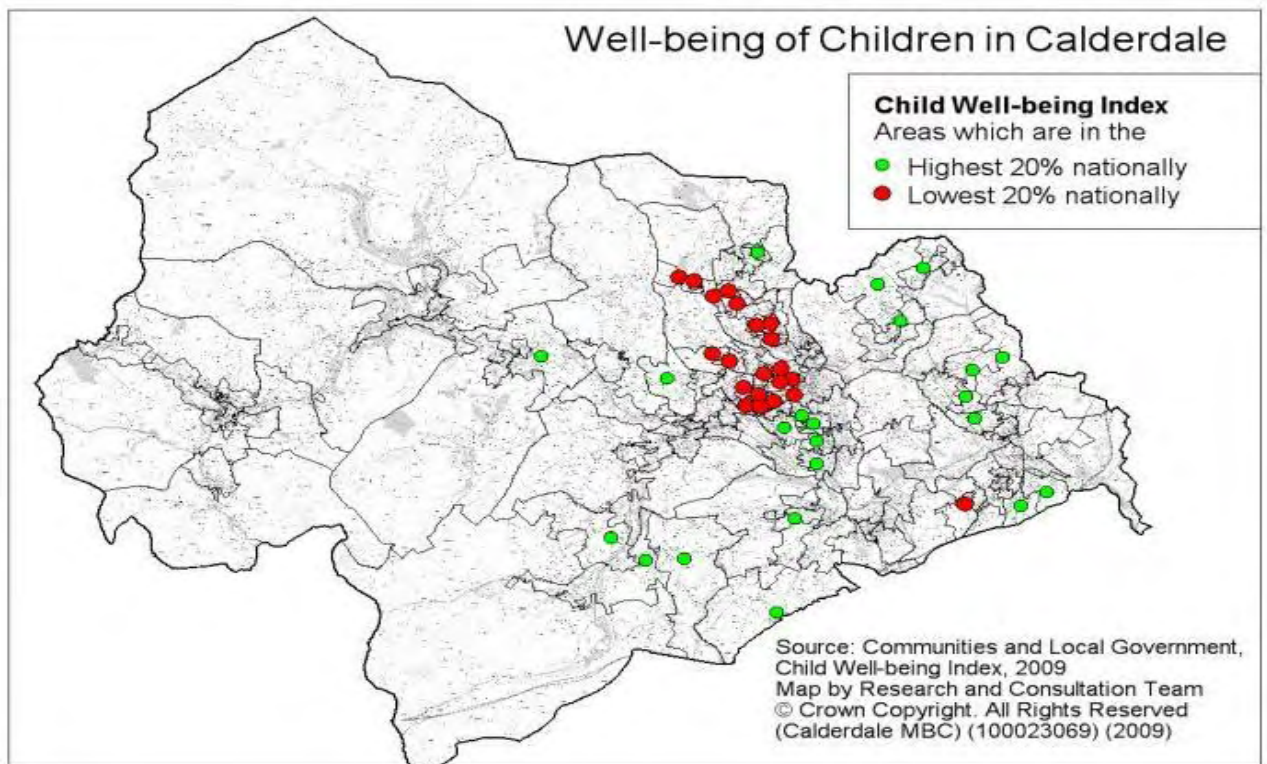
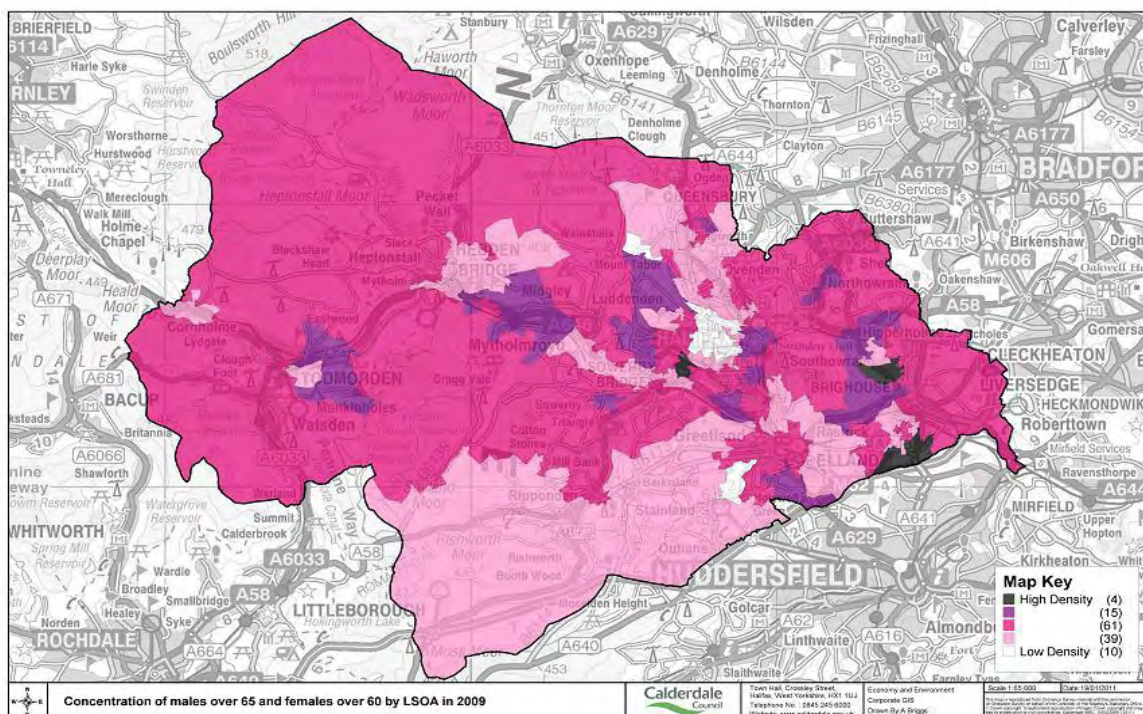


Figure 3: Distribution by Lower Level Super Output Areas of high and low levels of child well-being in Calderdale

Older People and Physical Disabilities

1.13 There are 32,200 people over the age of 65 living in Calderdale, 11% of whom received care and support through Calderdale Council. 2% were of black, Asian minority ethnicity which is broadly in line with the population (3%). It is estimated that 3.6% of older people in Calderdale self fund their own care and support. In contrast to older people's funded care services where national modelling has been attempted, little is known of the self funding learning disabilities, physical disabilities or mental health market.



8 Figure 4: Distribution of people who are over traditional retirement age (60 for women, 65 for men) in mid-2009 by Lower Super Output Areas

- 1.14 Since 2001 there has been a steady rise in Calderdale’s population, to an estimated 202,000 in 2009; a 4.8% increase over the previous 8 years. The population in Calderdale is forecast to continue growing with the total population set to rise by 16.7% over the 20 years from 2009 to 2029 (or by 20.5% by 2033) if recent trends continue . The rate of growth in the older population is set to rise at an even faster rate than the general trend with the 75+ population projected to rise to 25,900, a 69% rise on the mid-2009 mid-year estimates⁵.
- 1.15 This positive demographic growth trend also means that part of the population in Calderdale will have greater and more complex needs. Commissioning intentions will need to be responsive to these changes. In particular it is anticipated that there will be an increase in the numbers of people requiring support due to complex challenging behaviours, complex manual handling needs or carer breakdown resulting from continence, COPD, dementia and stroke.

Adult Learning Disabilities

- 1.16 As of February 2011 there was an estimated 3,701 adults in Calderdale with a learning disability⁶ of which 18%, (648) were in receipt of a care/support package arranged through Calderdale Council. 597 received care and support within the Borough, 29 in neighbouring authorities (counting Lancashire as a whole upper-tier authority) and 22 were supported through

⁵ Sub-national Population Projections (SNPP) are published every 2-3 years, the latest being 2008 based on mid-year population estimates.

⁶ PANSI modelling drawn from ONS

national placements. 45% of adults with learning disabilities were over the age of 45, 4% of whom were living with their parent(s).

- 1.17 Partially due to advances in medicine, improved clinical practice and closures of long stay hospitals children born with a learning disability have increasingly positive life chances. Clinical advances are also resulting in a small but significant number of highly premature babies who present with profound and multiple disabilities.
- 1.18 There are also a small but significant number of young people who have autism or Aspergers Syndrome currently being supported by children services that are due to enter adult social care in the next few years in Calderdale. Whilst transition planning from 14 – 25 is carefully planned between children and adult social care services a proportion of young people with a learning difficulty will drop out of contact at the point of transfer making it more difficult to predict their long term care and support needs.
- 1.19 Adults with a learning disability are experiencing increased longevity and the population is as a whole is ageing which is also partially due to a reduction in the proportion of children born with a learning disability. By 2031 a quarter of the learning disabilities population will be over the age of 65. As the population ages there will be an increasing trend of older adults with learning disabilities with increased levels of frailty due to age requiring support, including those whose parents have been caring for them but can no longer do so due to their own increasing frailty as they age to which commissioning intentions will need to be responsive.
- 1.20 People with learning disabilities are known to have additional health needs around both their physical and mental health. Accordingly they require additional regular health checks and to be specifically accounted for within 'mainstream' health programmes and services.
- 1.21 The geographic distribution of people with learning disabilities across the Borough is shown in the diagram below. This distribution reflects both demographically based location and that of residential and supported living services.

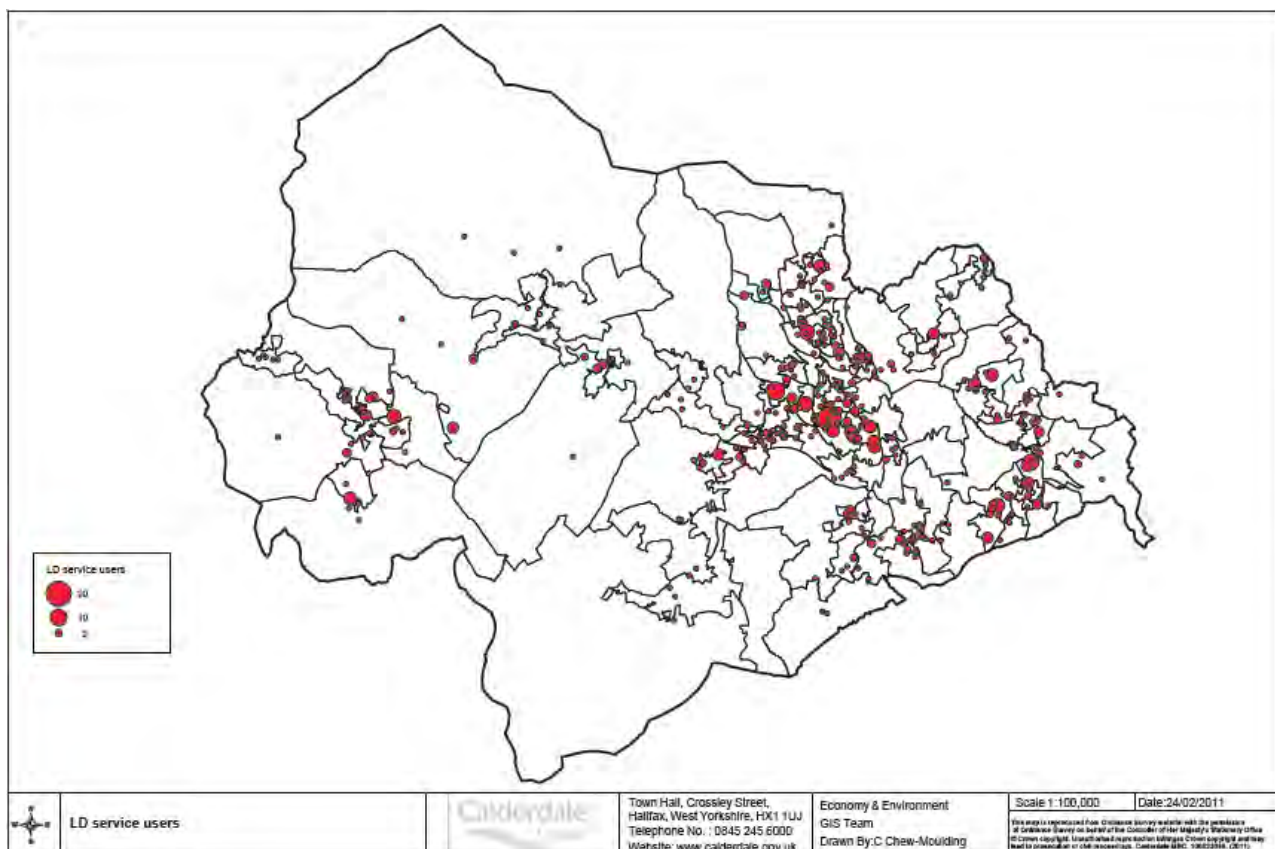


Figure 5: Distribution of adults with learning disabilities known to Calderdale Council as of February 2011

Mental Health

1.22 The level of demand for mental health services as indicated by access to services is outlined in the table below.

Level of need	Estimated numbers of people in Calderdale 2010/11 ⁷	Indicator used
Health and independence affected	25,922	Number of people who have depression and/or anxiety disorders (Psychiatric Morbidity Survey)
Health or	4,188	Number of people receiving

⁷ This estimate is derived by taking average numbers for Q1, Q2 and Q3 and multiplying by 4. Another important indicator of mental need is local suicide rates. A recent retrospective audit of suicides by Calderdale residents in the period 2005-2009 indicated that while Calderdale is on course to achieve the target of a 20% reduction in suicide rates over a base line calculated on date from 1997. However it also identified disappointing discrepancies with national data in respect of rate of change in younger age groups, and by some methods such as jumping from height and even in some occupational categories. [An action plan has been agreed for addressing this discrepancies]

independence impaired		psychological therapies
	890	Number of patients registered with GPs as having dementia
Health or independence impaired & complex	191	Number of people on CPA discharged from in patient care
	80	People placed in EMI residential settings
Complex needs and significant risk of harm	288	People admitted to SWYFHT acute in patient wards

Table 1: Numbers of people accessing mental health services by type during 2010/11

- 1.23 Work has been done to produce a mental well-being index. Calderdale sits in the middle of the range but with high scores for both positive and negative factors.
- 1.24 NHS analysis has identified the national prevalence of a number of significant mental health conditions. Altogether the NHS Information Centre's survey identified 13.2% of the population as having one of the mental health problems identified in the survey, which also looked at alcohol, drug use, gambling common disorders not requiring treatment. If the national figure is replicated locally in Calderdale around 21,000 people would have mental health problems requiring treatment or intervention.

Condition	England – prevalence as % of adult population	Extrapolation of national prevalence to Calderdale
Common mental disorders – needing treatment	7.5%	12,000
Suicidal thoughts in last year	4.3%	6,880
Self Harm	4.9%	7,840
ADHD	8.2%	13,120
PTSD	3%	4,800
Psychosis	0.4%	6,400
Anti-Social Personality Disorder	0.3%	4,800
Borderline Personality Disorder	0.4%	6,400

Table 2: Number of people in Calderdale potentially affected by psychiatric needs

Long-Term Conditions

- 1.25 A long term condition is one that cannot be cured but can be managed through medication and/or therapy. These include conditions such as, diabetes, asthma, coronary heart disease, chronic obstructive pulmonary disease (COPD) and some mental health issues. Approximately 8% of the Calderdale population has a long-term condition –This equates to 16,000 residents. Of these we believe that 3-4% of this number would require a more intensive approach to managing their condition at some point in their care (640 residents). Many also can be supported to live independently by social care services

Appendix 2 Delivery of Annual Operating Framework Commitments 2011/12 – 2014/15

2011/12 will be a very demanding year as the NHS takes on the challenge to deliver high quality care for its patients, whilst at the same time initiating the transition to the new system envisaged in Equity and Excellence: Liberating the NHS.

To support this, the NHS Operating Framework sets out a number of service priorities which PCTs and clusters will be held to account during the period 2011/12 – 2014/15. These are incorporated into Appendices 7 and 8.

Annual Operating Framework Commitments 2011/12 – 2014/15

Ref	Annual Operating Framework	SRO	Manager	Action	Outcome
New Commitments					
HRS08	Health Visitors – development of an effective health visiting service with sufficient capacity to deliver the Health Visitor Implementation Plan 2011-2015 – A Call to Action	Sue Cannon	Chris Jewsbury	Plan developed	Prevention
	Family Nurse Partnership – expansion of the programme to improve outcomes for the most vulnerable teenage mothers and their children.	Sue Cannon	Chris Jewsbury	Plan developed	Prevention
	Cancer Drugs Fund – the fund will help NHS patients to get the additional cancer drugs that doctors recommend.	Matt Walsh	Rhona Radley	Fund nationally	Prevention/ Supporting Recovery
	Services for people with autism – assess the needs of people with autism and the development of plans as appropriate to meet that need locally	Graham Wardman	Mick Mellors	Led to by CMBC	Personalisation
	Dementia services – implementation of the National	Graham	Mick Mellors	Led to by CMBC	User experience

Ref	Annual Operating Framework	SRO	Manager	Action	Outcome
	Dementia Strategy in partnership with social care	Wardman			
	Support for carers – development of plans with the CMBC to support carers through the provision of direct payments or pooled budgets	Sue Cannon	TBA	TBA	Personalisation Choice
	Healthcare for people with learning disabilities – continue the momentum with improve care and outcome for people with learning disabilities in the light if the Six Lives Progress Report	Graham Wardman	Mick Mellors	Delivery via local LES	Prevention Quality of life
	Children and young people’s physical and mental health – support the needs of children, young people and families, particularly the management of transition and in particular those groups with specific needs e.g. disabled children, CAMHs	Graham Wardman	Mick Mellors	Led to by CMBC	Positive experience Safe environment
SQU23	Diabetes – support patients with diabetes by ensuring they are offered screening for retinopathy, they can access insulin pumps and new diagnosed patients are supported through structured education programmes	Matt Walsh	Rhona Radley	LTC programme	Prevention Quality of life
HRS06 SQU28 SQU29	Respiratory disease – continue to identify patients with conditions such as COPD much earlier so that they can be managed more effectively	Matt Walsh	Rhona Radley	LTC programme and QIPP	Prevention Quality of life

Ref	Annual Operating Framework	SRO	Manager	Action	Outcome
	Physical activity – work with partners to support and embed community physical activity initiatives for all ages	Graham Wardman	Gaynor Scholefield	Plan developed	Prevention
SQU27	NHS Health Check programme – implement the programme to identify and manage people with heart disease, stroke, diabetes and kidney disease with a focus on reducing health inequalities is associated with vascular disease	Graham Wardman	Paul Butcher	Plan developed	Prevention
	Abdominal aortic aneurysm screening	Graham Wardman	Paul Butcher	Implement the screening programme	Prevention
	Fragility fractures in the elderly – ensure patients, particularly women have a bone health assessment and treatment when they first show clear signs of being at risk	Matt Walsh	Rhona Radley	Joint programme with CMBC	Prevention Quality of life

Ref	Annual Operating Framework	SRO	Manager	Action	Outcome
Maintaining Quality Improvements					
HQU05 – 07 SQU24 - 26	Referral to treatment times – ensure that patients can access services within the maximum waiting times under the NHS Constitution	Matt Walsh	Debbie Graham	Planned Care QIPP	Patient Experience
HQU09 - 13	Accident and emergency services – new clinical quality indicators	Matt Walsh	Rhona Radley	Urgent-care QIPP	Patient Experience
SQU03	Ambulance services – new series of indicators on clinical quality	Sue Cannon	Fiona Brompton	Joint development work	Reducing premature death
HQU01 - 02	Healthcare associated infections	Graham Wardman	Gill Manojlovic	Action Plan	Safe Environment
HQU08	Eliminating mixed sex accommodation – all NHS providers are expected to eliminate same sex accommodation	Sue Cannon	Penny Woodhead	Continue monitoring	Positive Experience
SQU02	End of life care – continue to ensure patients are offered the choice of where they wish to be cared for as the approach the end of life	Matt Walsh	Rhona Radley	Urgent-care QIPP	Positive Experience
HQU14 - 15 SQU05 SQU20 - 21	Cancer reform – implementation of the Improving Outcomes for Cancer Strategy ensuring that patients have timely access to diagnosis and treatment	Graham Wardman	Jill Farrington	Extension of breast and bowel screening	Reducing premature death

Ref	Annual Operating Framework	SRO	Manager	Action	Outcome
					Prevention Patient Experience
SQU06	Stroke	Matt Walsh	Rob Lees	Continue the Accelerating Stroke Improvement programme	Prevention Patient Experience
SQU13	Access to psychological therapies	Graham Wardman	Jeevan Bhadare	Expand access	Prevention Patient experience
	Safeguarding children – ensure that partnership working arrangements are maintained and handed over to new organisations in good order	Sue Cannon	Debra Turner	Action Plan	Protection
SQU09	Dentistry – continue to improve access and efficiency through the management of dental contracts	Matt Walsh	Ian Waugh	Action Plan	Patient Experience

Appendix 3

A Fresh Start for Calderdale Adults, Health & Social Care and Children & Young People

Ref	Calderdale Coalition Programme	Member Lead Councillor:	SRO	Programme/Project Manager	Links with:
OGEC3	Regular all-party briefings on key Cabinet issues	Janet Battye	Owen Williams	Peter Burton	
CASC1	Prompt action to implement Ofsted and PwC action plans inc ensuring every child at risk is allocated a social worker	Olwen Jennings	Janet Donaldson	Fiona Fitzpatrick	
CASC2	Strengthening preventive services including family support – development of the early intervention and prevention strategy	Olwen Jennings	Anne Scarborough	Steve Woodhead	Adult Health and Social Care
TR2	'Narrowing the gap' through targeted support to communities and individuals most in need	Tim Swift	Graham Wardman (NHS)	Paul Butcher (NHS)	
SCYP1	Invest in imaginative	Olwen Jennings	Anne Scarborough	Carol Stone	

Ref	Calderdale Coalition Programme	Member Lead Councillor:	SRO	Programme/Project Manager	Links with:
	youth activity schemes				
SCYP2	Lead an effective review of secondary education, with a tight timetable	Olwen Jennings	Janet Donaldson	David Whalley	
SCYP3	Trinity Academy	Olwen Jennings	Janet Donaldson	David Whalley	
SASC1	Ensure services targeted to the most vulnerable are protected (see following areas)	Bob Metcalfe	Jonathan Phillips	Mick Mellors	
SASC2	Ensure the three year Putting People First plan is completed on time	Bob Metcalfe	Jonathan Phillips	Ann Ogilvie (temporary)	
SASC3	Reduce the waiting times for major adaptations to homes	Bob Metcalfe	Jonathan Phillips	Phil Shire	Economy and Environment
SASC4	Further joining up of Adult Social Care with the NHS -	Bob Metcalfe	Jonathan Phillips	Mick Mellors	NHS

Ref	Calderdale Coalition Programme	Member Lead Councillor:	SRO	Programme/Project Manager	Links with:
	Commissioner				
SASC5	Further joining up of Adult Social Care with the NHS – Provider	Bob Metcalfe	Jonathan Phillips	Phil Shire	NHS
CVM1	Transformation and Change: To carefully plan the nature and profile of services within the context of potentially challenging budget constraints – includes Better Working Better Services	Janet Battye	Owen Williams	Diane Cheesebrough	
CVM4	Respond to Government Cuts - Launch all-party budget review and challenge process	Janet Battye	Owen Williams	Pete Smith	
CVM9	Joining up NHS and the Council	Janet Battye	Owen Williams	Chris Dowse	Adult Health and Social Care

A Fresh Start for Calderdale – High Level Priorities

Get the Basics Right

Open Government and Effective Consultation

Children and Adults Safeguarding and Care

Tackling the Recession

Stronger Communities

Supporting Children and Young People

Supporting Adult Social Care

Climate Change and Environmental Action

Fair Enforcement

Change and Value for Money

Health and Well Being High Level Outcomes:

Outcome	Reference
Preventing deterioration, delaying dependency and supporting recover particularly in relation to long – term chronic conditions and disabilities	1
Promoting personalisation and improving quality of life	2
Ensuring a positive child/adult/patient experience	3
Treating and caring for people in a safe environment and protecting them from avoidable harm	4
Reducing premature death	5

Appendix 4 - Contracted and spot purchased activity 2010/11

Service	"Tier"	Funding 2010/11	Which Outcomes were impacted on?
Luncheon Clubs	1	£14K	1
Meals Services	2, 3	£45K	1, 2, 3
Day Services (Older People)	2, 3	£540K	1, 2, 3
Carers Support	2 – 5	£145K	1, 2, 3
Mobile Response	2 – 5	£190K	1, 2
Home Care	3, 4	£5.4M	1, 2, 3
Care Home Placements	4, 5	£7.3M	1, 4, 5
Substance Misuse Services	3, 4, 5	£3.54m	1, 4, 5
Housing Related Support	1, 2, 3	£5.5M	1, 2
Acute Care	2 – 5	£140M	1, 2, 3, 4, 5
Mental Health Services	2 – 5	£30M	1, 2, 3, 4, 5
YAS	3 - 4	£8.6M	1, 2, 4
SCG Providers	2 - 4	£12.5	1, 2, 4
Cancer	2 – 5	£1.9M	1, 2, 3, 4, 5
Yorkshire Cancer Network	2 - 5	£1.5M	1, 2, 3, 4, 5

Service	“Tier”	Funding 2010/11	Which Outcomes were impacted on?
Programmes	2 – 5	£2.2M	1, 2, 3, 4, 5
Primary Commissioning	2 – 5	£450K	1, 2, 4
Continuing Care - Learning Disabilities	4, 5	£5.6M	1, 4, 5
Continuing Care - Non LD	4, 5	£15.8M	1, 4, 5
Continuing Care - Equipment	3 – 5	£400K	1, 2, 4
Environmental Controls	2 – 4	£38K	1, 2, 4
Drugs Misuse	3 – 5	£490K	1, 4, 5
General Medical Services	2 – 4	£20.1M	1, 2, 3, 4, 5
Primary Medical Services	2 – 4	£4.5M	1, 2, 3, 4, 5
APMS	2 - 4	£1.4M	1, 2, 3, 4, 5
Out of Hours Health	3, 4	£1.58	1, 5
Home Oxygen	3, 4	£324	1, 2, 4
Ophthalmic	2 - 4	£1.75M	1, 2, 4
Other Primary Care	2 – 4	£950K	1, 2, 4, 5
Dentistry	2 – 4	£9.6M	1, 2, 4, 5
Children & Maternity Services	2 – 5	£37.5M	1, 2, 4, 5

Service	“Tier”	Funding 2010/11	Which Outcomes were impacted on?
Children & Maternity Services CAHMS	2 - 5	£1.99M	1, 2, 4, 5
Young People’s Substance Misuse	4 – 5	£380K	1, 2, 4, 5
Access and Transport	1	£1.4M	1, 2
Children’s Social Care	3 – 5	£165K	1, 2, 3, 4
Fostering and Adoption	3 - 5	£3.5M	1, 2, 3, 4
CAHMS Tier 2	2	£32K	1, 2, 4, 5
LAC CAHMS Tier 2 and 3	2, 3	£147K	1, 2, 4, 5
Children’s Residential Placements	4, 5	£3.5M	1, 4, 5
Children’s Fund Activities	2 - 4	£1.7M	2, 3
Children and Young People’s Participation	1	£100K	2, 3
Safeguarding Review	4, 5	£80K	1, 4, 5
Calderdale Schools Ltd	1	£6.7M	2, 3
Calderdale College	1	£2.2M	2, 3
Family Support Services	2 – 5	£4.5M	2, 3, 4
Family Services – Direct Services	3, 4	£27K	2, 3, 4
Family Services – Early Years Development	1	£630K	2, 3, 4

Service	“Tier”	Funding 2010/11	Which Outcomes were impacted on?
Inclusion Services – Behaviour Support	3, 4	£146K	2, 3, 4
Inclusion Services – Disabled Children	3, 4	£58K	2, 3, 4
Sensory Support	2 - 4	£194K	2, 3, 4
Special Educational Needs	2 - 4	£2.5M	2, 3, 4
Young People’s Service – Central Halifax	1	£39K	2, 3
Youth Offending Team	3 - 5	£175K	1, 4, 5
Standards Fund YPS Family Support	1	£290K	2, 3, 4
Adult Learning	1	£90K	2, 3
Inclusive Learning	3 - 4	£546k	2, 3, 4
Learning Services	1	£120K	2, 3
Music Service	1	£40K	2, 3
Standards Fund	1	£1.9M	2, 3

Further breakdown of these services into identified contracts is available from NHS, AHSC and CYP contract teams. Contract values may be withheld as being commercially sensitive

Appendix 5 - Local Authority In-house services provided in 2010/11

Service	“Tier”	Funding 2010/11	Which Outcomes were impacted on?
Community Learning Disability Services	3	£5.1M	1,2
Supported Living	4	£2.7M	2,4
Learning Disability Day Services	3	£920K	1,2
Gardening Service	3	£87K	1,2
Independent Living Support Team	3	£59K	1,2
Asylum Support Team	2	Net nil	2,3
Client Financial Services	3 - 5	£83K	2,4
Gateway to Care	1 - 5	£150K	2,3
Older People Day Services	2/3	£1.4M	1,3,4
Shared Lives	3 /4	£194K	2,4
Rapid Response	4/5	£135K	4,5
Out of Hours	4/5	£375K	1,4
Extra Care	2 - 4	£730K	1,2,4
Maintenance Home Care	3/4	£780K	4,5
Support in Mind	4	£150K	1,4
Neighbourhood Schemes	1 /2	£80K	2,3

Service	"Tier"	Funding 2010/11	Which Outcomes were impacted on?
Union Housing	3/4	Net nil	1,4,5
Wells House	2 - 5	£77K	1,4
Lyndhurst	4/5	£160K	1,4
Housing Related Support	3/4	£63K	1,4
SHARE	5	£464K	1,4,5
Ebenezer Day Centre	3, 4	£280	1, 4
Older People and Physical Disability Assessment & Care Management (Localities & Hospital)	3 – 5	£2.5M	1,2,3,4,5
Supported Living	4	£2.7M	2,4
Learning Disability Day Services	3	£920K	1,2
Residential Care Homes	4	£1.2M	4
Reablement	2 – 4	£2.1M	1, 2, 4
NHS Calderdale Provider Services	2 - 5	£25.5M	1, 2, 3, 4, 5
Home to School Transport	1	£145M	2, 3
Post 16 Transport	1	£36K	2, 3
Aiming High - Short Breaks	1	£24K	2, 3
Commissioning Connexions/Children's Fund	1	£132K	1, 2, 3

Service	“Tier”	Funding 2010/11	Which Outcomes were impacted on?
Young Carers	3 – 4	£30K	1, 2, 3
Education for LAC	3 – 4	£35K	1, 2, 3
T A M H S	3 - 4	£13K	1, 2, 3
Young People’s Service- North & East Halifax	1	£25K	2, 3
Youth Offending Team	3 - 5	£10.5K	1, 4, 5

- Preventing deterioration, delaying dependency and supporting recovery particularly in relation to long-term chronic conditions and disabilities
- Promoting personalisation and improve life-quality
- Ensure a positive user/patient experience
- Treating and caring for people in a safe environment and protecting them from avoidable harm
- Reducing premature death



Equality Impact Assessment

Full assessment form

Directorate:

AHSC & CYP

Title of policy, function or service:

Calderdale PCT/Calderdale Council
Commissioning Plan 2011/12

Lead Officers:

M Mellors/S Rumbold

People involved with completing the EIA:

Arif Sain

Type of policy, function or service:

Existing

New/proposed

Changed

Step 1 – Make sure you have clear aims and objectives

Give a brief summary of your policy, project or service

The aim of the Calderdale & PCT Council Commissioning Plan 2011/12 is to clearly identify services and activities that we will commission in 2011/12. It covers all health and social care commissioning across the two organisations. Sharing this plan will enable us to commission more efficiently and effectively.

What outcomes do you want to achieve?

The joint commissioning activity is intended to help us deliver our high levels outcomes, as set out nationally for the NHS and for Adults Social Care and Children and Young People. These are:

- Preventing deterioration, delaying dependency and supporting recovery particularly in relation to long-term chronic conditions and disabilities,
- Promoting personalisation and improve life-quality,
- Ensure a positive user/patient experience,
- Treating and caring for people in a safe environment and Protecting them from avoidable harm,
- Reducing premature death

Step 2 – Collecting your information

What existing information/data do you have?

We have drawn upon a range of information held in a variety of places, including the JSNA, other public health and demographic and population data, performance data, council budget options, PCT Quality, Innovation, Performance and Prevention (QIPP) plans and a range of exiting strategies and programme data.

Using your existing data, what does it tell you?

The data sources used reinforce some key messages around the health inequalities of ethnic minority communities and also the needs of:

- Children with disabilities
- People with learning disabilities
- Older people from all communities but particularly the south Asian communities
- Children and Young People in identified pockets of the borough
- People with Aspergers syndrome

Step 3 – What's the impact?

Race or ethnicity

There is an acknowledgement that BME groups may not have take up services, comparison to other groups and therefore there is a recognition of different outcomes for different people. For example, mortality from CHD, Diabetes type 2, is higher for the South Asian population as compared with non-Asian population requiring targeted work and awareness raising initiatives especially in the most deprived areas, e.g. Park Ward.

There is also a need to ensure commissioned services can demonstrate that all groups can access their services and they have the resources and skills to be able to target services at particular groups. Further work will be needed to ensure all sections of the population benefit from planned improvements and do not suffer disproportionately where changes are made and/or disinvestment takes place

Gender

Mortality rates and premature death rates are different for men and women. There is a need to ensure that providers can ensure that where possible there is need to cater for the specific needs of women and men.

Age

The PCT/Calderdale Council Commissioning Plan has a clear relevance to older people, as when people get older their dependency for support will increase as they will encounter a number of illnesses and disabilities. Therefore, there is a need to ensure that services are commissioned continually assess how older and people are targeted. Specific actions identified in the plan relate to older people and other actions will clearly also impact positively upon them

Disability

One of the key outcomes outlined in the plan is preventing deterioration, delaying dependency and supporting recovery particularly in relation to long-term chronic conditions and disabilities. We know that many disabled people suffer from long-term conditions that often may not be identified and treated as early as possible. Specific actions identified in the plan relate to disabled people and other actions will clearly also impact positively upon them

Religion or belief

The PCT/Calderdale Council Commissioning Plan 2011/12 does not have an adverse or negative impact on people with different religion or beliefs.

Sexual orientation

Research conducted by Age Concern found that lesbian and gay people are less likely to access services due to caution created by past experience, and if they do so, only on limited terms. Diminished support networks for lesbian and gay people in times of crisis and presumption that all people who use services are heterosexual by mainstream providers, can cause isolation and lead to needs remaining unmet. Evidence from GALYIC suggests that young LGBT people suffer from discrimination and harassment may experience problems as a result.

Other socially excluded groups or communities, e.g. rural communities, carers, areas of deprivation

There is considerable evidence that suggests that communities which live in areas of deprivation are more likely to suffer from health inequalities, such as higher rates of smoking, diabetes (T1 & T2), obesity etc. Therefore, there is a need to ensure that the commissioning function ensures that providers target these areas. Also, Calderdale has one of the largest geographic areas for a metropolitan borough and one of the smallest populations. There are relatively remote and isolated communities who may have difficulty accessing services.

Step 4 – What are the differences?

Are any groups affected in a different way to others as a result of the policy, project or service?

The Calderdale PCT/Calderdale Council Commissioning Plan 2011/12 does not aim to adversely affect any group. The outlined actions are developed with the aim to ensure our commissioning function ensures that the services provided, target groups which have higher rate of health inequalities and other groups whose needs are different.

Does your policy, project or service either directly or indirectly discriminate?

Yes No

If yes, how are you going to change this?

Detailed action plans will be developed to deliver the actions identified in the Plan, and these will be subject to further focussed Impact assessment. Generally, the draft actions outlined in the action plans aims to further target our services to target groups which have higher rates of health inequalities and meet forthcoming legal obligations outlined in the Equality Act 2010.

Step 5 – Consultation

Who have you consulted with?

The Commissioning Plan is largely drawn from strategies and actions already identified by the PCT and/or the local authority. As such there has been wide-ranging consultation on many of the areas covered. An broad example of this is the very wide-ranging consultation exercise undertaken by the Council over the setting of its budget for 2011/12.

More focussed examples include the consultation undertaken by the PCT around the Learning Disabilities “Big Health Check Up” and the local authorities consultation around services for older people from the Asian communities the

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If you have not consulted yet, please list which specific groups or communities you are going to consult with and when

The Plan as a whole will be consulted on with members of Calderdale Councils Community Equality Forum. As indicated above, detailed action plans will be developed to deliver the actions identified in the Plan, and these will be subject to further focussed Impact assessment.

Step 6 – Conclusions and Recommendations

What areas of the policy, project or service have you changed or improved as a result of this assessment?

The action plan outlines a number of draft proposals which include:

- how the commissioning of services continually meets the needs of our communities and,
- that our equality data illustrates how we are tackling health inequalities in Calderdale.

How are you going to monitor the policy, project or service, how often and Who will be responsible?

It is envisaged that both the Council and the Primary Care Trust will be jointly responsible for actions.

This EIA has been approved by: Cabinet

Date: 18 April 2011

Contact number: 01422 393864

Please send an electronic copy of the EIA to:

1. Equality Lead in your Directorate

2. Council's Equality Team who will publish it on the Council's website

Action Plan

The required Actions will be taken forward as part of the implementation of the Plan and the individual action plans

Appendix 7 - What we know we want to commission differently in 2011/12

Action	Tiers	Change Planned 2011/12 Outcomes	Outcomes covered	Lead Responsibility
Health Visitors	3	Development of an effective health visiting service with sufficient capacity to deliver the Health Visitor Implementation Plan 2011-2015 – A Call to Action	1	PCT/CYP
Family Nurse Partnership	1-3	Expansion of the programme to improve outcomes for the most vulnerable teenage mothers and their children.	1	PCT/CYP
Cancer Drugs Fund cancer drugs that doctors recommend.	4-5	the fund will help NHS patients to get the additional	1,2,3,4	PCT
Support for carers – development of plans with the CMBC to support carers through the provision of direct payments or pooled budgets			2	PCT
Healthcare for people with learning disabilities	1-5	improved care and outcome for people with learning disabilities	1,2	PCT

Action	Tiers	Change Planned 2011/12 Outcomes	Outcomes covered	Lead Responsibility
Children and young people's physical and mental health	1-5	Improved support for the needs of children, young people and families, particularly the management of transition and in particular those groups with specific needs e.g. disabled children, CAMHs	1,2	PCT
Diabetes	3-4	Support patients with diabetes by ensuring they are offered screening for retinopathy, they can access insulin pumps and new diagnosed patients are supported through structured education programmes	1,3	PCT
Respiratory disease –	2-4	identify patients with conditions such as COPD much earlier so that they can be managed more effectively	1,3	PCT
Physical activity		work with partners to support and embed community physical	1,3	PCT

Action	Tiers	Change Planned 2011/12Outcomes	Outcomes covered	Lead Responsibility
		activity initiatives for all ages		
NHS Health Check programme	1-3	Implement the programme to identify and manage people with heart disease, stroke, diabetes and kidney disease with a focus on reducing health inequalities is associated with vascular disease	1	PCT
Abdominal aortic aneurysm screening				PCT
Fragility fractures in the elderly		Ensure patients, particularly women have a bone health assessment and treatment when they first show clear signs of being at risk	4	PCT
Referral to treatment times		Ensure that patients can access services within the maximum waiting times under the NHS Constitution	2,3	PCT
Accident and emergency services		Deliver new clinical	3,4	PCT

Action	Tiers	Change Planned 2011/12 Outcomes	Outcomes covered	Lead Responsibility
		quality indicators		
Ambulance services		Deliver new series of indicators on clinical quality	3,4	PCT
Healthcare associated infections				PCT
Eliminating mixed sex accommodation		all NHS providers are expected to eliminate same sex accommodation	2,4	PCT
End of life care		Continue to ensure patients are offered the choice of where they wish to be cared for as the approach the end of life	4,5	PCT/AHSC
Cancer reform		implementation of the Improving Outcomes for Cancer Strategy ensuring that patients have timely access to diagnosis and treatment	1,3,4	PCT
Access to psychological therapies		Extend to cover Children and Young People	1	PCT

Action	Tiers	Change Planned 2011/12 Outcomes	Outcomes covered	Lead Responsibility
Safeguarding children in Health organisations		Ensure that partnership working arrangements are maintained and handed over to new organisations in good order	4	PCT
Dentistry		Continue to improve access and efficiency through the management of dental contracts	3	PCT
Implement Dementia Strategy	1-5	A range of changes and service developments as set out in the strategy	1,2,3	AHSC
Implement Intermediate Tier Review	1-3	New Strategy to be implemented	1,2,3	PCT/AHSC
Develop Older People's Housing options	1-3	New Schemes developed	1-4	AHSC
Implement Learning Disabilities Accommodation Strategy	1-5	New Strategy implemented	1-4	AHSC
Implement Learning Disability Challenging Behaviour Strategy	3-5	New Strategy Implemented	1-4	PCT

Action	Tiers	Change Planned 2011/12 Outcomes	Outcomes covered	Lead Responsibility
Implement recommendations from review of residential and in-patient care in mental health	4-5			PCT/AHSC
Building Savings & Efficiencies into Contracting regime	1-4	Reduction in expenditure	Efficiency	AHSC
Remove under occupancy/use in Block Contracts	2-3	Reduction in expenditure	Efficiency	AHSC
Reduce peoples dependency on care services	2-4	Reduction in expenditure	Efficiency	AHSC
Review of Supporting People Contracts	2-3	Reduction in expenditure	Efficiency	AHSC
Savings in contracted services through more effective commissioning	2-4	Reduction in expenditure	Efficiency	AHSC
Demand Management from Telecare	2-4	Reduction in expenditure	Efficiency	AHSC
Stroke Targeted Intervention	3, 4	Improved pathways for Stroke victims after hospital	1, 2	AHSC
Assistive Technology Targeted Intervention	3, 4	Greater take up of assistive technologies and reduction in Home care demand	1, 2	AHSC

Action	Tiers	Change Planned 2011/12 Outcomes	Outcomes covered	Lead Responsibility
Develop Independent Living Centre	2, 3	New Centre in place and reduction in demand for services	1, 2	AHSC
Third Sector Capacity Building	2, 3	More efficient and effective 3 rd sector providers	1, 2, 3	AHSC
Day Services (PDSIS)	3, 4	Service re-tendering to give greater efficiency	3,4	AHSC
LD Respite Services	3, 4	Service re-tendering to give greater efficiency	1, 4	AHSC
Healthy Child Pathway 0-5	1	Subject to review	1, 2, 3, 4, 5	CYP
Healthy Child Pathway 5-19	1	Subject to review	1, 2, 3, 4, 5	CYP
Disabled Children – Single Point of Access	1	Subject to review	1, 2, 3	CYP
External Placements for LAC	5	Review and explore regional approach	1, 2, 3, 4, 5	CYP
Prescribing	System QIPP	Savings	1,2,3	PCT
Elective Care	System QIPP	Savings	1,2,3,5	PCT
Mental Health	System QIPP	Savings	1-5	PCT
Continuing Care	Joint QIPP		1,3,4	PCT

Action	Tiers	Change Planned 2011/12Outcomes	Outcomes covered	Lead Responsibility
Urgent Care	System QIPP	Savings	1,2,3,4,5	PCT
High Cost Drugs	System QIPP	Savings	2,3,4,5	PCT
Procurement	System QIPP	Savings	4	PCT
Running Costs	Joint QIPP	Savings	NA	PCT

Appendix 8 - Reviews that will result in us commissioning differently

Area subject to review?	Is it a QIPP or Council savings programme?	“Tier”	Which Outcomes will be impacted on?
New Autism strategy	No	1-5	1,2,3
New Mental Health Strategy	No	1-5	1,2,3
CAMHS – review of tiers 2 and 3	2, 3	Subject to review	1, 2, 3, 4, 5
Learning Disability Day Services	Council Saving Programme	3	1,2
Prescribing	System QIPP	2 – 5	1, 2, 5
Elective Care	System QIPP	2 – 4	1, 2, 4
Mental Health	System QIPP	2 - 5	1, 2, 4, 5
Continuing Care	Internal QIPP	4, 5	1, 4, 5
Intermediate Tier	Both : Potential efficiency savings across the partnership	2 – 5	1, 2, 3, 4, 5
CAMHS – review of tiers 2 and 3	Potential efficiency savings across the partnership	2, 3	1, 2, 3, 4, 5
Healthy Child Pathway 0-5	Potential efficiency savings across the partnership	1	1, 2, 3, 4, 5

Healthy Child Pathway 5-19	Potential efficiency savings across the partnership	1	1, 2, 3, 4, 5	
Disabled Children – Single Point of Access	Potential efficiency savings across the partnership	1	1, 2, 3	
Prescribing	System QIPP	2 – 5	1, 2, 5	
Elective Care	System QIPP	2 – 4	1, 2, 4	
Mental Health	System QIPP	2 - 5	1, 2, 4, 5	
Continuing Care	Joint QIPP	4, 5	1, 4, 5	
Unplanned Care	System QIPP	1-5	1,2,4,	
High Cost Drugs	System QIPP	4-5	1,2,4	
Procurement	System QIPP	4-5	4	
Running Costs	Joint QIPP	NA	NA	
CAMHS – review of tiers 2 and 3	Potential efficiency savings across the partnership	2, 3	Subject to review	1, 2, 3, 4, 5
Early Intervention Grant	Potential efficiency savings across the partnership	1		