Calderdale – Health and Care Economy

One Year Plan – 2016/17 (v4)

Content

Purpose, Context and Case for Change

Our Purpose

- Deliver a triple aim; better health, better care, better value
- Deliver a shift in care away from hospital base care towards community and supported self care to the financial value of at least 10% of the existing hospital spend
- Do this in a way that commands the support, engagement and ownership of the people who will use those services
- Deliver a new model of care which supports the delivery of the first two objectives in a way which integrates the work and focus of health and care providers in our system
- Work with the wider partnership to define, consult upon and deliver a new model for hospital based care which is sustainable and which delivers the best possible outcomes at the best possible value and which operates in harmony with Care Closer To Home
- Deliver measureable improvements in population health and reduce health inequalities within our system, having first defined and agreed the basis upon which we will prioritise and measure those improvements=
- Develop and test New Care Models which provide new organisational forms for both providers and commissioners

Calderdale Clinical Commissioning Group

Context - Overview

NHS

Focus for 16/17 - Delivery of three critical and interlinked pieces of work:

- **Calderdale Care Closer to Home Programme (our Calderdale Vanguard)**
- **Calderdale Primary Care Strategy**
- **Hospital Services Programme** *with Greater Huddersfield CCG*

Implemented in three inter-related phases over the next five years:

Phase 1 Strengthen existing community services in line with the Five Year Forward View

Phase 2 Further enhance community services – by creating new care models, new organisational forms and strengthening the role of primary care

Phase 3 Delivering the hospital changes and organisation change needed to make our system safe and sustainable

Delivered by working; on place and community-based activities within Calderdale, on an SRG/local acute footprint across Calderdale and Greater Huddersfield, and across West Yorkshire as part of the Healthy Futures programme.

Calderdale Clinical Commissioning Group

Context - Vanguard

NHS

With its Vanguard status, Calderdale is particularly well-placed to deliver its ambitious hospital change programme (Right Care) and community transformation (CC2H):

- Vanguard partners within Calderdale have agreed to develop a **new care model** for out of hospital care that is; person-centred, integrated, empowering - created in partnership with carers, citizens and communities and supported by volunteering and social action
- Our model is focused **on new integrated service offers** built around; prevention and healthy lifestyles (physical and mental health), supported self-care, a first point of contact for accessing services and a new integrated model of primary and community services. Supported by a number of enablers, this creates the infrastructure and environment needed for success. We believe this approach provides local sustainability and national replicability.
- Our approach to **developing a new organisational form will build on both MCP and PACs models**, creating an alliance model which delivers improved outcomes, experience and quality, built around the principles of Accountable Care Organisations, supported by new payment and contracting models. In 2016/7 we will develop; vision, principles, scope, outcomes & timelines/milestones, as well as being clear on capacity, capability and OD requirements. We will set out our high level milestones in the STP
- Built on a Partnership Agreement between the CCG and the NHSE, a Joint Committee sitting within the CCG's **governance structure** will oversee development of new models in its early stages, with Partnership Agreements between the CCG and the other partners reinforcing expectations on delivery through their individual governing bodies.

Calderdale Clinical Commissioning Group

Plan On A Page

NHS

STRATEGIC DIRECTION

Care Closer to Home(Vanguard) & Hospital Change Programmes

Key priorities/QIPP: Focus on reducing 'avoidable' unplanned admissions and moving care into primary and community settings

- Focus on prevention , healthy lifestyles and supported self-care
- New models of care in primary, community & hospital and community (urgent & planned) settings
- Long-Term Conditions:
  - Cardiovascular
  - Respiratory
  - Mental Health
- Frailty
  - Stratification & care planning
  - Quest for Quality in Care homes
- Children with Complex Needs
- Business as usual:
  - Musculoskeletal
  - Diabetes
  - Cancer
  - End of Life Care
  - Transfer of Care

Delivered by working across footprints

- 10 CCGs in West Yorkshire (Healthy Futures)
- Across the CHFT footprint; Right Care, SRG, Elective Improvement Board
- Placed based; GP membership, primary care, Pennine GP Alliance Better Care Fund, HWBB, local communities & people
- Personalisation with individuals

STRATEGIC OUTCOMES

- Empowered citizens and communities
- Reduce preventable deaths
- Reduce health inequalities
- Improve quality of life
- Improve patient experience
- Maximise independence
- Ensure services are safe
- Reduce reliance on hospital based care

Case for Change

Outcomes

- Deprivation is higher than the national average and about 20.1% (8,200) children live in poverty
- Life expectancy for both men and women is lower than the England average and 9.3 years lower for men and 9.2 years lower for women in the most deprived areas
- Major improvements to be made in key disease groups such as respiratory disease, cardiovascular disease and cancer
- Competing pressures due to growing numbers of children and older people with increasing needs, whilst also meeting the requirements of external standards

Case for Change

Patient and Carer Experience

Through extensive engagement local people have told us they want to see:

- As many services as possible should be close to home in local settings such as a GP practice with improved waiting and appointment times
- Services that are coordinated and wrap around all the persons needs involving a range of partners and agencies
- More information available about health conditions and more communication about what is available to ensure people can make choices and have support to self-manage health care
- Barriers to; travel, transport and parking, addressed with a clear plan which takes account of diversity and locality
- Technology that people can use to reduce travel times and unnecessary journeys – particularly for young people
- Support and partnership working for mental health across all Adult and Children and Young People services.
- A multi-agency Single Point of Access to access services easily

Case for Change

Quality

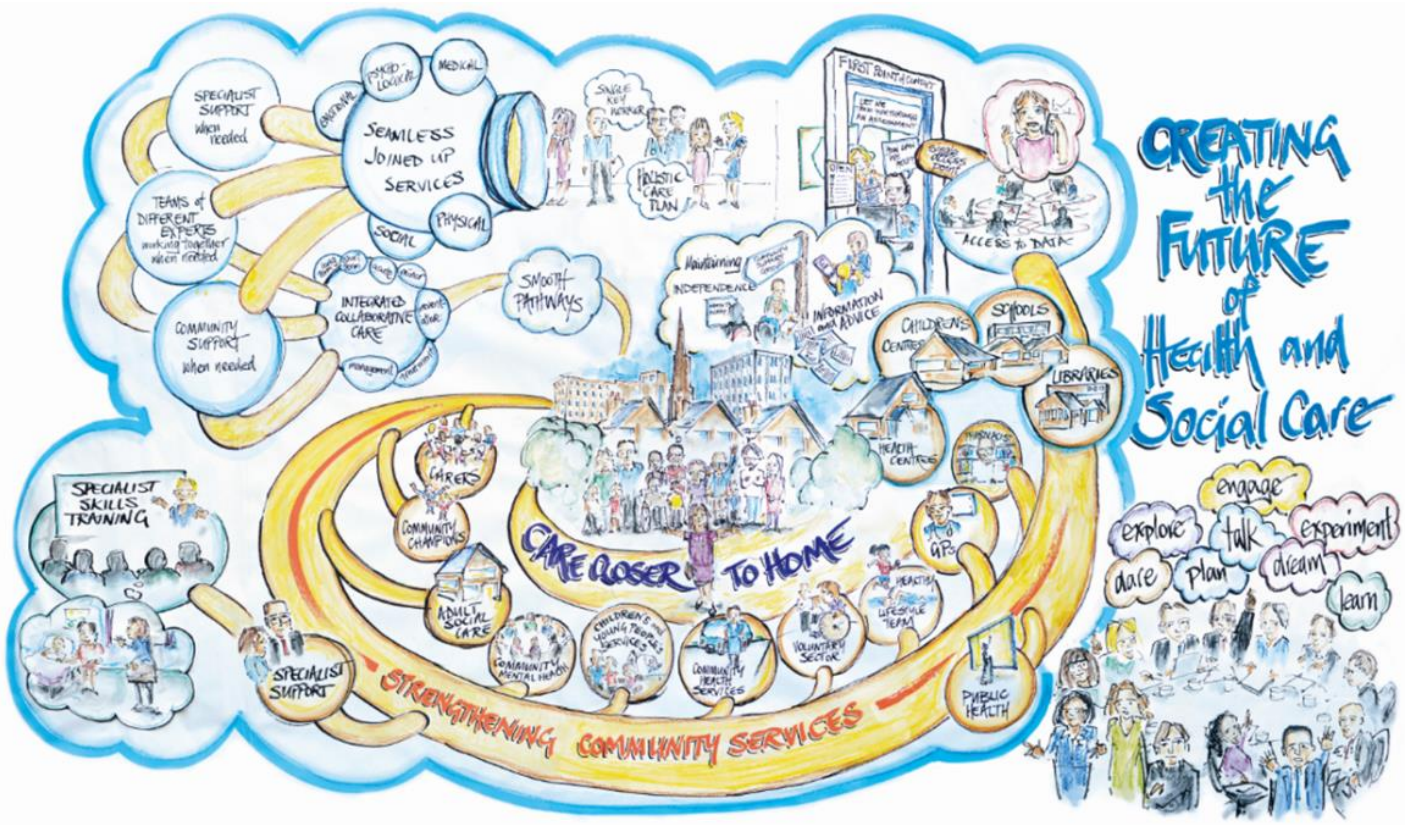
- We know that in Calderdale too many people:
  - Are dying prematurely and that this is worst in areas of Calderdale with high deprivation
  - Are dying in our hospitals. The hospital Standardised Mortality Rate is higher than the England average
  - Are admitted to residential or nursing home care
  - Stay longer in hospital than is clinically necessary
  - Are admitted to hospital with a condition which is considered nationally to be treatable or preventable within the community
  - Are readmitted within 30 days of discharge from hospital
  - Wait over 5 weeks for diagnostic services
  - Report they do not have a good experience when they attend A&E
  - Leave A&E without having been seen
- We have workforce issues relating to an ageing GP workforce, shortage of middle grade doctors in A&E and national recruitment issues across a range of specialties
- We have issues in delivering the capacity and capability in community beds, re-ablement, home-care and care homes that meets current and future demand

Case for Change

Finance

- There is a requirement to make long-term financial savings which make the system viable and sustainable
- Our system is over-reliant on emergency unplanned hospital activity compared to the rest of the country with high levels of 'avoidable' admissions
- By 2021/22 the financial challenge facing the area of Calderdale and Greater Huddersfield (health sector only) amounts to £281m
- There are significant social care financial challenges which impact both on the delivery of front-line care and investment in prevention & healthy lifestyle, and supported self-care interventions
- There is a potential to maximise community estate community buildings/libraries to support better community offers and delivery a better VFM

Key Priorities in 2016/17



"Learn, plan, explore, dare to dream…… The future of our organisations, the future of Calderdale"

Calderdale Clinical Commissioning Group

High Quality Care

NHS

The delivery of high quality care is our top priority and has a connection to all aspects of our work during 2016/17. Further details are included in individual elements of this plan:

What do we need to achieve in 2016/17?

- Services are safe, effective and provide a good experience ensuring that recommendations from significant national reviews are embedded
- Measures and processes in place to monitor the effect of current services and future reconfigurations to ensure that safety is maintained or improved
- Patient and public experience remain central and visible to all our planning service change
- Safeguarding remains an integral part of our business
- Deliver fit for purpose and sustainable models of urgent, emergency and planned care
- Implement the process for Deprivation of Liberty
- Deliver 7 days services where appropriate
- Continue to promote 3rd Sector organisations as partners in care delivery

What actions do we need to take?

- As service changes take place in line with the Right Care and Care Closer to Home programmes we will have measures in place to monitor the effect of the changes and ensure that safety is maintained or improved as a result of the service change, including the provision of seven day services
- Through our PPE Strategy, continue to develop relationships within the community and maintain dialogue on existing services and in the planning for future service delivery
- Continue to implement the Quality Assurance process for 3rd sector providers
- Ensure we include any learning from Year 1 of FGM mandatory reporting

High Quality Care

What actions do we need to take? (cont)

- Introduce mortality reviews in primary care, in order to strengthen learning
- Undertake a self-assessment and plan for implementation of the Maternity Services Review
- Deliver CCG Safeguarding Policy (adults and children), including West Yorkshire agreed processes, MCA and DoLS
- Ensure we address learning and monitor implementation of change following CQC Inspections

How will we measure success?

- Further develop dashboards to ensure the ability to monitor safety and patient experience measures
- Monitor the effect of the changes and ensure that safety is maintained or improved as a result of change,
- Increasing numbers of the population of Calderdale will be reporting a positive experience when coming into contact with local health services
- Safe, effective services will be delivered over 7 days
- An increased number of 3rd sector providers are partners in the delivery of health care having completed accreditation on the Quality for Health programme
- Delivery of Constitutional Standards, including Cancer.
- More services will be delivered closer to where people live and work
- Avoidable mortality and one year mortality rates will be reduced across Calderdale
- All commissioned providers are able to demonstrate compliance with safeguarding standards
- Working towards reducing the number of excess deaths at weekends through meeting clinical standards

Calderdale Clinical Commissioning Group

Prevention & Healthy Lifestyles

NHS

What do we need to achieve in 2016/17?

- Joint Prevention and Healthy Lifestyle Plan with Public Health (Smoking, Nutrition, Exercise and Alcohol) as part of the new integrated community model)
- Implement the Calderdale Obesity Strategy and action plan and reduce the number of people entering the pre-diabetic at risk population
- Introduce proportionate universalism to ensure we target areas of high health inequalities
- Deliver the Plans we have committed to as part of our Vanguard Programme

What actions do we plan to take?

- Multiple actions to tackle obesity across all parts of the system
- Changes to the food, physical activity and social environments
- Introduce new brief interventions training for staff and target at high risk groups
- Train course facilitators for Youth Champion Training
- Introduce new health trainer service and multi-media support packages
- Improve prevention of diabetes through a targeted programmes

How will we measure success?

- Performance against Prevention Strategy and related action plans
- Quarterly reviews of services commissioned, performance monitoring processes and reviewing pathways
- Delivery of the commitments made as part of our Vanguard Value Proposition
- Contribution to delivery of reductions in Health Inequalities

Supported Self-Care

What do we need to achieve in 2016/17?

- Improve outcomes by introducing new supported self managed care programmes as part of the CC2H model, and delivery of plans set out in our Vanguard Value Proposition as part of the new integrated community model

What actions do we plan to take?

- Develop and increase the number of providers able to support the self-care programme in Calderdale
- Develop community peer support groups within communities
- Implement technology based solutions to support delivery of plans, ensuring support is available in a range of media which is accessible 24/7
- Ensure provider staff are well-trained and deliver accurate and appropriate support
- Ensure interventions are targeted to reduce periods of ill health and exacerbation

How will we measure success?

- Improvements in outcomes, experience and quality for those supported by local initiatives.
- Delivery of the commitments made as part of our Vanguard Value Proposition
- Contribution to delivery of reductions in Health Inequalities across the 5 Years of our STP

My name is Andrew, I'm 82 years old, and I use telehealth monitoring at home to help me manage my COPD. This is my story of Care Closer to Home.

"Sometimes I wake up feeling really poorly and I do my readings and my machine tells my Nurse if he needs to contact me, and if he doesn't call within the hour, I know my readings are ok today. Before I would have just rung the Doctors. If I am feeling ill I don't panic now, because I know that my Nurse will be keeping an eye on me. This year… since the new system, I've only been in hospital twice.
It's really reassuring for me. Like a pair of arms around me when I need them most."

For full animation: http://www.calderdaleccg.nhs.uk/your-health/care-closer-to-home/

Primary Care Strategy

What do we need to achieve in 2016/17?

- Improve patient access to general practice
- Improve recruitment and retention across the primary care workforce
- Deliver care in settings which are fit for the future and geographically coherent Primary medical services, community services, social care & specialised care are integrated as part of the new integrated community model
- Improve the use of shared learning across Calderdale

What actions do we plan to take?

Access

- Evaluate the outcomes of the extended access pilot in North Halifax
- Review patient experience on extended general practice outside of core hours
- Work closely with two pilot practices to improve access
- Develop tools and techniques to capture and use real time patient feedback
- Adapt traditional funding and contracting approaches to support future primary
- Develop and pilot the use of an alternative to QOF

Workforce Development

- Develop and implement a local GP Career Start scheme
- Structured training and professional development
- Step down/retirement support programme
- Financial support to maintain and increase the number of GP training practices
- Implement the General Practice Nursing career framework

Primary Care Strategy

Estates & Infrastructure

- Ensure premises are of a sufficient standard, supporting collaborative working
- Undertake a feasibility study re the development of community hubs & a 6 facet survey of GP premises
- Roadmap for the introduction of fully interoperable digital records
- Manage the district wide record sharing framework and sign up from practices to one Data Sharing Agreement

Integrated Working

- Invest in leadership development in Calderdale
- Actively encourage new working arrangements between practices
- Work with the Pennine GP Alliance to look for opportunities to provide services at scale.

Culture and Shared Learning

- Implement mechanisms that spread learning rapidly across the system

How will we Measure Success?

- Improve patient access to general practice
- Improve recruitment and retention across the primary care workforce
- Improve usage of premises to delivery CC2H plans and reductions in void space
- Evidence of learning being shared with across practices
- All practices to achieve, as a minimum, a CQC rating of 'good'

Planned Care

What do we need to achieve in 2016/17?

- Deliver across SRG footprint new fit for purpose models of planned care that can deliver and sustain the NHS constitutional commitments, including cancer commitments and standards related to cancer and develop new care models as part of CC2H

What actions do we plan to take?

- Develop a new community/primary care-based CC2H planned care offers, including MSK
- Consult the public on new models of hospital based planned care
- Work with WY Healthy Futures programme to ensure alignment of plans
- Ensure the continued delivery of high quality planned care services during the move to future models, and ensure the system is working together particularly during periods of system pressure.
- Continue to lead the multi-agency Elective Care Improvement Board to ensure the entirety of the system's capacity is utilised to meet demand
- Continue work on a system dashboard that provides oversight of performance & quality
- Work with practices to implement the suspected cancer guidance, and raise awareness of cancer screening programmes to encourage uptake
- Implement the National Cancer Strategy and develop the cancer model for CC2H

How will we measure success?

- Delivery of NHS constitutional targets, particularly referral to treatment waiting times and diagnostic waiting times and supporting capacity
- Deliver any QIPP potential in–year in pressured specialties.
- Improve one-year survival rates and uptake figures for cancer screening programmes

My name is Megan, I'm 14 years old, and I have a skin condition called Psoriasis. I used to get teased about it - I never thought it would get better… This is my story of Care Closer to Home.

"She (my keyworker) helped me and my mum make a plan for getting appointments and with how to keep track of my Psoriasis and all the different things I could do, so it gets better. But it's more than that. She found me a support group. I spend quite a lot of time there now, we go and do things together and it's just nice to find people that understand what I'm going through! I like being useful too, helping other people in the group. I feel more like everyone else...I'm more confident, happier, and have less problems with my Psoriasis. I feel like my whole world has changed for the better."

For full animation:

http://www.calderdaleccg.nhs.uk/your-health/care-closer-to-home/

Calderdale Clinical Commissioning Group

Long-Term Conditions

NHS

What do we need to achieve in 2016/17?

- Focus on two key conditions which account for significant levels of avoidable admissions and QIPP delivery as part of the new integrated community model
- Continue to embed the work and investment already made in Diabetes
- Dependent upon the outcome of public consultation – continue the shift of service from hospital to primary and community service (Phase 2 CC2H)

What actions do we plan to take?

- Delivery of the new community respiratory services, building on 15/16 investment
- Continue development and delivery of the CVD programme – shifting the balance of services from hospital to community
- Work with partners to develop the care closer to home model for diabetes for delivery in 2017/18, with public health to develop a local diabetes prevention pathway and participate in Wave 1 of the National Diabetes Prevention Programme (if our bid is accepted)
- Delivery new models of end of life care for those with a LTC

How will we measure success?

- Improve outcomes, experience and quality for this population
- 15% year on year reduction in avoidable admissions(ACS and CNRA)
- Deliver QIPP target
- Deliver commitments made in our Vanguard Value Proposition
- Improved rates of delivery of eight diabetes care processes and achievement of treatment targets (measured through QOF) and measures to be defined in the National Diabetes Prevention Programme
- Delivery of improvements related to End of Life Care
- Test out the use of PHBs

My name is Tarique, I'm 38 years old, and I have recently been diagnosed with Diabetes. At first, I didn't understand how to live with it, but that's changed now…this is my story of Care Closer to Home.

"I feel I am managing my Diabetes now and I understand it. And because he sorted it so I can see the Specialist Nurse and Consultant at my local practice instead of at the hospital… I don't have to go anymore! David also arranged for me to see a 'Social Prescribing Volunteer'. As I used to be in a chess club he teamed me up with my local school and I now run an after school chess club. This makes me feel that I'm putting something back into my local area… I'm much happier now."

For full animation: http://www.calderdaleccg.nhs.uk/your-health/care-closer-to-home/

Mental Health

What do we need to achieve in 2016/17?

- Develop an plan to delivery FYFV for Emotional Wellbeing and Mental Health in Calderdale' as part of the new integrated community model
- Fully accredited IAPT for Children and Young People.
- Delivery of parity of esteem mental health commissioning and investment

What actions do we plan to take?

- Work with stakeholders including Children, Young People and Adults to co-produce an action plan with clear outcome measures and timescales.
- Agree an implementation plan with a provider that delivers the EIP standard
- Complete a tendering process and implement a fully accredited CYP IAPT service in line with a new Specialist CAMHS service specification and service model that will deliver the new access standards.
- Implement a local Adults and CYP Eating Disorder service using the national NHSE guidance.
- Develop and implement a Multi-Agency Single Point of Access for Specialist CAMHS referrals.

How will we measure success?

- Improved outcomes, experience and quality for this population
- KPIs in Action Plan to deliver 5YFV for mental health
- Achieve the new access and waiting time standards for 2016
- Deliver agreed QIPP targets

My name is Alice, I'm 16 years old, and have experienced mental health issues – I used to self-harm, and had a breakdown. This is my story of Care Closer to Home.

Carole took me to the 'Sure Start' centre – where I can join in loads of activities. She found websites and an online support group for young people like me. They help me… and I can help them. We talk it out. We are always there for each other… through an app on my phone… Even my parents have an online group… Everything's better.
I still see a Counsellor, but if I need more than the hour, we just keep talking… I don't hate school anymore and I'm doing better! I'm going to go on and take my A-Levels. I have confidence again… And I'm learning how to enjoy life!"

For full animation: http://www.calderdaleccg.nhs.uk/your-health/care-closer-to-home/

Frailty

What do we need to achieve in 2016/17?

- Develop and commission integrated care offers for people at risk due to their frailty, supporting independence and well-being and reducing utilisation of unplanned hospital care as part of the new integrated community model

What actions do we plan to take?

- Work with Vanguard partners to develop new care offers – piloted in the Upper Valley (5 practices)
- Roll-out the use of the Electronic Frailty Index across all Calderdale Practices
- Develop MDT working, integrated care planning and shared records
- Develop a First Point of Contact hub with partners to deliver a response when needed, both in and out of hours.

How will we measure success?

- Improved outcomes, experience and quality for this population
- Reductions in avoidable admissions for this patient cohort
- Delivery of commitments made in the Vanguard Value Proposition
- Deliver agreed QIPP targets
- Deliver DTOC targets

My name is Betty, I'm 82 years old, and have been in and out of hospital because I kept falling at home… This is my story of Care Closer to Home.

"Because I have Jayne, my Keyworker, it was different. She really helps me and my son feel less anxious. She and I made a care plan. We talked about me going into a care home for a while, but I didn't want that. Jayne made it so that I could stay at home, but with some improvements… Jayne also arranged for me to have a falls pendent which I can press if anything happens – this makes my son feel less anxious. She also arranged for someone to come and assess my home for other equipment that might stop me having another fall. As I got better, everything slowly got back to normal. Things are so much better now."

For full animation: http://www.calderdaleccg.nhs.uk/your-health/care-closer-to-home/

Children with Complex Needs

What do we need to achieve in 2016/17?

- Develop and commission integrated care offers for children with complex needs and their families supporting independence and well-being and reducing utilisation of unplanned hospital care as part of the new integrated community model

What actions do we plan to take?

- Work with Vanguard partners to develop new care offers – piloted in Calderdale
- Work closely with partners providing care to this group of children to ensure new service offers that provide a more seamless service journey, integrated working, timely and appropriate signposting and referral on.

How will we measure success?

- Improved outcomes, experience and quality for this population
- Reductions in avoidable admissions
- Deliver of commitments made in the Vanguard Value Proposition
- Deliver agreed QIPP targets (CNRA)
- Deliver reductions in DTOC associated with children

Learning Disabilities

What do we need to achieve in 2016/17?

- Compliance with National requirements in line with Implementing 'Building the right support', including closing unnecessary inpatient provision by March 2019
- Ensure the final implementation of the new health pathway for adults with a learning disability

What actions do we plan to take?

- Deliver a Transformation Plan for Learning Disability and/or Autism that will meet the national outcomes.
- Involve all stakeholders in defining the future model, with the embedding of co- production and personalisation as principles.
- Commission a 24 hour crisis support service

How will we measure success?

- KPIs in Transformation Plan
- Achievement of KPIs by providers which evidences improved outcomes for service users.
- Improved experience of people, their carers and families which supports their health and well being
- Reduced hospital admissions for crisis and increased community activity

Urgent Care

What do we need to achieve in 2016/17?

- Introduce, through the SRG, fit for purpose models of urgent and emergency care that can deliver and sustain NHS constitutional commitments
- Ensure alignment with CC2H – particularly the new integrated community model

What actions do we plan to take?

- Develop a new community/primary care-based CC2H urgent care offer, including a new primary care offer (linked to our Vanguard Programme)
- Consult the public on new models of hospital based urgent and emergency care
- Work with WYUECN and UEC Vanguard to ensure alignment of plans
- Ensure the continued delivery of high quality urgent care services during the move to future models.
- Ensure the system is working together collectively and holding itself to account for improvements in patient care and ways of working – particularly during periods of system pressure.
- Continue work on a system dashboard that provides oversight of; demand, access and quality

How will we measure success?

- Delivery of NHS constitutional targets , particularly the 4-hour waiting time standard in A&E and ambulance response times
- Continued progress related to improvements in Delayed Transfers of Care
- Reductions in avoidable unplanned activity in line with QIPP targets
- Delivery of improvements in end of life care indicators
- Delivery of commitments made in our Vanguard Value Proposition

Calderdale Clinical Commissioning Group

Continuing Healthcare

NHS

What do we need to achieve in 2016/17?

- CHC systems and processes are in alignment with the: National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care
- Work of the CHC team is aligned with the NHSE Operating Model for NHS Sufficient quality and capacity within the care home sector to meet need

What actions do we plan to take?

- Lead formal eligibility decision making processes including completion of the Decision Support Tools (DSTs)
- Capture data using the online Continuing Healthcare Assessment Tool (CHAT)
- Identify improvements required in local care homes
- Development of a care home strategy

How will we measure success?

- Improved satisfaction from clients and families and a reduction in appeals for funding
- Evidence provided through the use of the CHAT tool
- Current levels of local capacity in care homes will be maintained.
- Homes will be able to evidence that they provide a good standard of care
- KPIs in new care home model/Strategy
- Delivery of agreed QIPP targets
- Delivery of DTOC commitments and use of PHBs

Enablers for Delivery of our 2016/17 Plans

Enablers

There are a number of key enablers which will support delivery of our plans for 16/17. The enablers support delivery of our CC2H plans and are in line with commitments made in our Vanguard Value Proposition and Better Care Fund Plans;

- Financial Plans that provides sustainability and resilience
- Primary Care Strategy
- Communication and Engagement Strategies
- Workforce Strategy
- IT and agile working
- Estate Strategy
- Transport Strategy
- Measurement and Evaluation (linked to Right Care methodology)
- New organisational models and Payment Mechanisms
- Strong governance and leadership

We will be working across the STP footprint to ensure alignment with the West Yorkshire Healthy futures Programme

Finance

- The 2016/17 financial plan is more challenging than in previous years. It is complaint with the planning guidance and includes:
  - An allocation uplift of £4m (minimum growth)
  - Draw down of £1m of our cumulative surplus
  - A £1.5m (0.5%) contingency fund to manage in year risks
  - A £2.8m(1%) non recurrent reserve
  - A £3.4m QIPP requirement (building on the Right Care approach)
  - Delivery of a £5.4m (1.7%) surplus
- We continue to work collaboratively with our main providers to ensure a joined up approach to financial planning and a joint understanding of the system financial position.

Calderdale Clinical Commissioning Group

Better Care Fund

NHS

What do we need to achieve in 2016/17?

- Develop and deliver an integrated BCF commissioning plan in partnership with the Council which confirms our commitment to commissioning out of hospital health, adult social care and housing services.

What actions do we plan to take?

- Our plan has to be jointly agreed with the Council at the Health & Well Being Board
- We will secure sustainability of our community services offer through maintaining the level of local protection given to adult social care and 7 days services to effect discharge
- We are improving our shared business intelligence through NHS Number matching between health and social care via the Demographic Batch Service
- sharing learning on our Digital Maturity with Leeds to inform our Digital Plan/Roadmap for commissioning systems

How will we measure success?

- Reductions in the volume of avoidable hospital admissions
- Reduction in the number of people who experience poor longer term re-ablement outcomes as a result of experiencing delays in their transfer of care
- Reduction in the overall number of delayed transfers of care
- Reduction in the number of people who end up in care homes and experience poor quality care including safeguarding concerns

Risk

We are currently developing a full view of risk for 2016/17
The table below provides a high level summary of risk related to our current Board Assessment Framework (BAF)

Risk
We are unable to commission high quality, safe services across the system due to a failure to ensure we have the support of partners, stakeholders and the public for our plans
We do not improve health outcomes in line with our plans due to a lack of focus on the wider determinants of health and/or a failure to ensure we have the support of partners, stakeholders and the public
We do not improve patient experience in line with our plans due a failure to use appropriate PPE intelligence to support service improvement and plans to change service models
We do not deliver improvements in independence and recovery for our population due to a failure to focus on improving care and people with long-term chronic conditions (physical and mental health), those who are at risk due to their frailty and children with complex needs.
We do not deliver health improvements for our population due to our failure to commission services to prevent ill health and encourage supported self-management, particularly services in primary and community settings.
We do not deliver improvements in health and well-being due our failure to address significant workforce pressures, particularly within clinical settings
We do not deliver financial sustainability within our system due to reduced financial allocation and a failure to deliver significant QIPP/avoidable admission reduction targets.

Sustainability and Transformation Plan

- This One Year Plan is the first step in developing our STP
- West Yorkshire is identified as the footprint to develop a place based, multi year plan built around the needs of the local population
- The Healthy Futures programmes across West Yorkshire and their links to Calderdale will be developed across the following areas:
  - Cancer
  - Specialised commissioning
  - Urgent and emergency care (including the mental health aspects of the UEC vanguard programme)
- A place based sub-chapter for Calderdale will be developed using HWBB as the geographical basis
- This 2016/17 One Year Plan, and the Vanguard Value Proposition provide the backdrop to development of an STP for Calderdale

Summary

- We have started on a critical journey to create a sustainable future for our health system
- Delivering two large change programmes in acute and community settings simultaneously will bring challenge, but is essential
- We recognise this will challenge our system and our relationships
- Our Vanguard status will provide us with the support on the journey to develop new care models and organisational forms which will be part of a new future