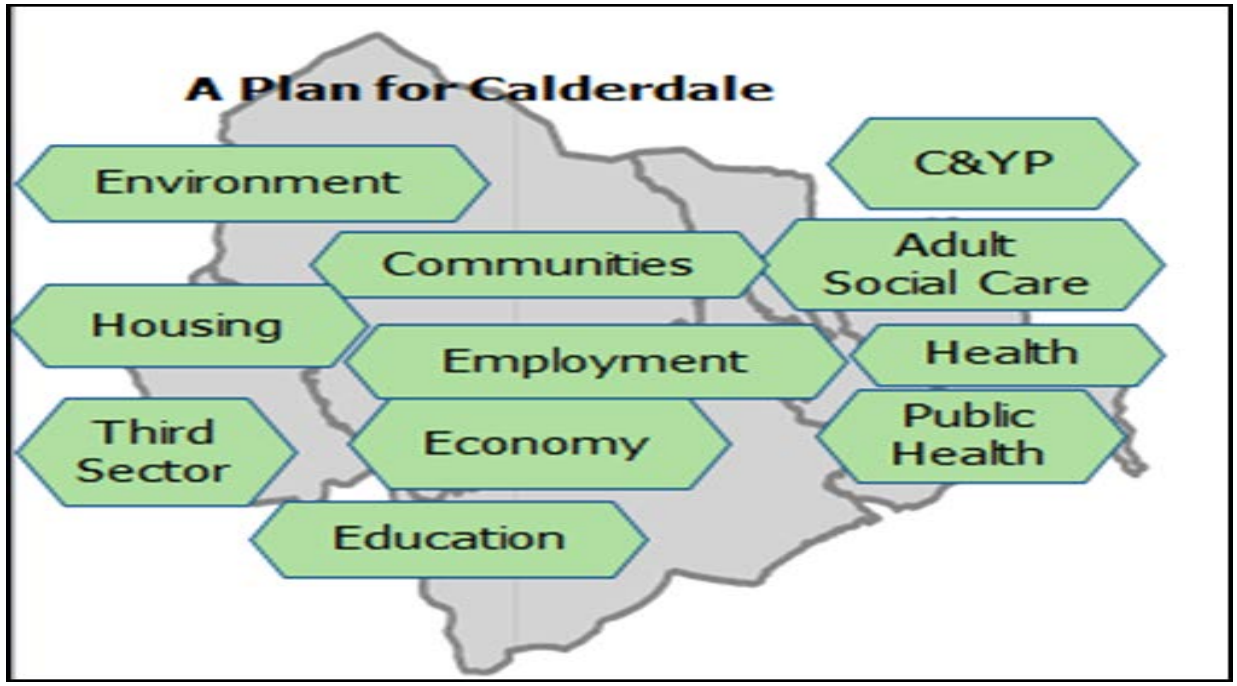
Calderdale CCG

Operational Plan 2017-19



Contents

Our Purpose (1)

- Deliver a triple aim; better health, better care, better value
- Lead the system back into sustainable financial balance
- Deliver a Single Plan for Calderdale that empowers individuals and communities and creates prosperous towns in harmony with the West Yorkshire Sustainability and Transformation Plan (STP)
- 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
- Deliver a new model of care which integrates the work and focus of health and care providers in our system

Our Purpose (2)

- 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

- Commission 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

- Do this in a way that commands the support, engagement and ownership of the people who will use those services

- Develop and deliver an Accountable Care Organisation as a vehicle for delivering integrated community services

Strategic Context

- We have started on a 5 year journey to create a sustainable future for our health system
- We have placed our organisation and our system into formal financial recovery - we have a significant challenge to deliver future financial resilience
- We recognise this will challenge our system and our relationships. Our 5-year STP reflects our ambitions, the scale of the task and alignment with the work of the Healthy futures Programme
- We have articulated our plans for 2017/2019. This includes:
  - Simultaneous delivery of two essential and large change programmes in acute and community settings
  - Leading system dialogue on the development of an accountable care organisation (ACO) that will form the basis for re-commissioning our Care Closer to Home (CC2H) programme
  - Establishment of an Integrated Commissioning Executive to fundamentally strengthen the commissioning of health and social care

Financial Context

- Calderdale CCG is considered to be a CCG which is more than 5% over its target financial allocation. As such, the CCG will receive minimum growth over the period of the 5YFV. The CCG therefore will have to make efficiencies within its existing baseline over the period as allocation growth will not be sufficient to cover demographic growth and tariff inflation

- The CCG is planning to deliver a QIPP of approximately 2.5% which we believe is an achievable target, however actual cost pressures to the CCG exceed this amount. The CCG is therefore planning to draw down its cumulative surplus of £4m in 2017/18 and deliver a cumulative breakeven position. The CCG is aiming to maintain this cumulative breakeven position in 2018/19 and deliver a QIPP target of approximately 2.5%

- The direction and shape of our QIPP programme has been informed by the Right Care methodology and our participation in Phase 1 of the national programme. We have received positive assurance on the progress being made as part of the phase 1 work

Improving Quality (1)

We are:

- Working to support existing care home provision, including a pilot to support the early intervention for frail individuals who are admitted to acute care. Long term plans include a review of the way we commission care home provision in Calderdale

- Implementing actions in response to CQC Safeguarding Children and Children Looked After and work to strengthen provider assurance in relation to Outcomes

- Further developing our approaches to Engagement with member practices, with local people on Cancer, Mental Health and Care Homes and an expansion of our asset based approach to include young people and work places

- Considering Equality Panels to undertake Provider and CCG assessment in line with EDS2

Improving Quality (2)

We are:

- Supporting providers to work through the recommendations and actions outlined in the updated National Quality Board Guidance on safe staffing
- Working in partnership with providers across the system to improve services through learning from patient experience
- Continuing to promote Third Sector Organisations as partners in care delivery through the Quality for Health Programme
- Supporting carer friendly practices within health and social care organisations and exploring the adoption of the Carers Charter
- Key providers including Acute, Mental Health, Community and Ambulance Services have all undergone a CQC inspection in 2015/16. The focus during 2017/19 will be to monitor and test the implementation of action plans

Improving Quality (3)

We will ensure:

- That the quality and safety of our providers including primary care will continue to be routinely monitored, where concerns are raised the NHSE Assurance Process will be utilised

- Continued support to providers to strengthen the Mortality Review work, to include primary care involvement, and participate in the Learning Disability Mortality Review work

- In response to the increasing financial challenge and potential impact on Commissioning decisions we have strengthened the Quality Impact Assessment and will ensure it is embedded in the recovery process

- We bid to be part of the pilot for nursing associates across the health and social care economy

Risks

The table below provides a high level summary of risk aligned to delivery of our triple aim:

Triple aim: Improving Value
We do not deliver financial sustainability within our system due to a reduced financial allocation and a failure to deliver significant QIPP/CIP and avoidable admission reduction and transfer of care targets
We do not deliver the interventions to mitigate the financial gap identified in the Calderdale STP, and therefore cannot deliver our contribution to reducing the West Yorkshire STP financial gap
Triple aim: Improving Quality
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 – thereby reducing our ability to deliver the quality gap set out in the Calderdale STP and our contribution to the West Yorkshire STP
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
Triple aim: Improving Health
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 - thereby reducing our ability to deliver the health gap set out in the Calderdale STP and our contribution to the West Yorkshire STP
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

Our 5 Year Journey

Our Vision
Delivering the Triple Aim
Mitigating Gaps

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The 5 Year Vision

NHS

Calderdale Vision for place based health:

- People must be empowered to take greater control over their own lives, to influence personalised services and to take greater responsibility for their health outcomes
- All resources and assets in places must be used to support wider determinants of health and wellbeing outcomes – and the system is financially sustainable
- A system shift towards prevention and early intervention will require services to organise and professionals to behave in very different ways

The focus must be on keeping people well for longer and, when they do become ill, supporting them to manage their conditions in the community, avoiding expensive institutional settings

Delivery of the Triple Aim

Our Intentions – Health Outcomes:

Support delivery of the West Yorkshire STP gap by delivering:

- 10% fall in mortality from causes considered preventable by 2020
- Increase number of physically active adults by 10% by 2020, equal to >9000 people
- Reduced health inequalities by focussing action with vulnerable communities. Right Care data suggests we can save 43 lives by working together on this
- Delivering on the opportunity set out in national benchmarks – adding 10-15 years to the lives of people with long term mental health needs

Delivery of the Triple Aim

Our Intentions - Care and Quality

Support delivery of the West Yorkshire STP gap by delivering:

- Increase in the proportion of people satisfied with access to care and continuity of care as reported in the GP Patient Survey and Friends and Family tests
- Reduction in the number of people admitted to hospital with a treatable or preventable condition within the community by 70% (1,695 admissions by 2021)
- In 4 years, achieve a 75% reduction in suicides and an ambition to reach zero
- A halving the number of patients who have extended LOS in hospital of between 11-100+ days (reduction from current 157 to 79 per quarter from Q1 16/17 baseline)

Delivery of the Triple Aim

Our Intentions - Finance & Efficiency

Support delivery of the West Yorkshire STP gap by delivering:

- The Calderdale STP solutions to reduce the financial gap for Calderdale in 2020/21 from £100m to £56m

- Support CMBC to review its medium term financial strategy to mitigate the deficit across the Council, including application of Better Care Fund (BCF). Work together as a system to mitigate the remaining Local Authority gap - for example through integrated commissioning arrangements – to reduce the financial gap currently forecast to be around £29m by 2020/21. This would reduce the total gap in Calderdale to £27m

- Subject to the development of a full business case – the Right Care Right Place programme will further reduce the gap by £11m in 21/22 to £16m

- Work with partners to create a balanced financial plan for West Yorkshire

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Mitigating Actions: Addressing the Gaps (1)

NHS

Scheme	Description	Health & wellbeing	Care & Quality	Efficiency & finance
New models of primary and community based care	• Prevention & Supported Self-care • Community, Primary Care and third sector • Integrated community model & first point of contact • 7 partners locality model • Maximise BCF opportunities	✓	✓	✓
Review hospital based care,	• To meet national standards	✓	✓	✓
Changes to primary care through the GP 5 Year Forward View	• Support and grow the primary care workforce • Improve access to general practice in and out of hours • Transform the way technology is deployed and infrastructure utilised • Better manage workload and redesign how care is provided • Maximise impact of Estates & Technology Transformation Fund	✓	✓	✓
7 day services (7DS), both within the hospital and across the community.	• 7DS principle to be incorporated into future developments • Review of large scale proposals • Pilot of Frailty 7DS model • Focus on reduced variation in care	✓	✓	✓

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Mitigating Actions: Addressing the Gaps (2)

NHS

Scheme	Description	Health	Care & Quality	Efficiency & finance
Alignment with Healthy Futures priorities (WY STP)	• Prevention, Cancer, Mental health, Stroke, Urgent and emergency care, Specialist commissioning, Primary and community care, Standardisation of commissioning policies, Acute collaboration	✓	✓	✓
Governance and performance management	• Oversight of STP deliver by the HWB, • Engagement with the public, carers, voluntary sector and staff on STP • Delivery STP outcomes	✓	✓	✓
Digitisation	• Joint work on shared records, • Self-care platforms • PGPA & CHFT joint working	✓	✓	✓
Workforce plans	• Joint work focused on new care models • National learning	✓	✓	✓
Changes to Social Care	• Meeting the Fair Cost of Care to be able to build a resilient social care system that is of high quality and avoiding inappropriate admissions and delays in discharge • Flexible contracting for support • Implementing the national vision for adult social work • Joint commissioning with the CCG • An asset based approach to community social work that focuses on preventative early intervention and wellbeing	✓	✓	✓

Delivery in 2017/2019

Strategic overview
Plan on a page
Enablers
What do we need to do in 2017/19?
What actions will we to take?
How will we measure success?

Strategic Overview

Focus for 2017/18 & 2018/19

Three interlinked pieces of work:

- **Strategy** — Single Strategic Plan/ STP for Calderdale
- **Delivery** — An Accountable Care Organisation – the delivery vehicle for Calderdale Care Closer to Home;
  Right Care, Right Time, Right Place *with Greater Huddersfield CCG;*
  Healthy Futures Programme
- **Commissioning** — Integrated Commissioning with CMBC;
  Healthy Futures Programme

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Place-Based Health in Calderdale

NHS

The plan on a page captures the model which brings together the things that are important to health and well-being in Calderdale

Enablers

There are a number of key enablers which will support delivery of our plans for 2017/19:

- Strategic Plans that align local and West Yorkshire STPs
- Financial Plans that aim to deliver sustainability and resilience
- A new Primary Care Strategy to support delivery of CC2H & GPFV
- Strong governance and leadership

Plus a number of key work-streams:

- New organisational models and payment mechanisms
- Communication and Engagement Strategies
- Workforce Strategy
- IT and agile working
- Estate Strategy
- Transport Strategy
- Measurement and Evaluation (linked to Right Care methodology)

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Calderdale STP

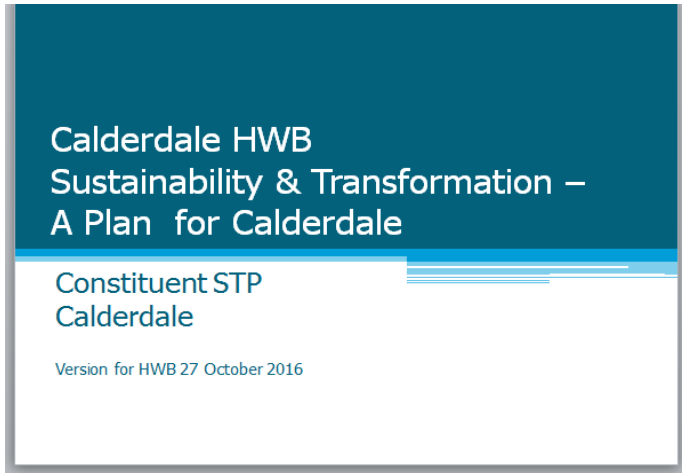
NHS

What do we need to achieve in 2017/19?

- A single strategic approach for Calderdale bringing together work done to address the wider determinants of health
- Delivery of key outcomes (improving; health, quality and value) in line with NHSE Operating Plan

What actions do we need to take?

- Approval and delivery of the Single Plan for Calderdale
- Ensure alignment with the West Yorkshire STP
- Continue oversight by Health & Wellbeing Board
- Commission an ACO as the vehicle for delivery of community services
- Agree and deliver of integrated commissioning executive
- Continue engagement with stakeholders and the public on local change



How will we measure success?

- Delivery of key performance metrics as set out in Calderdale STP and support implementation of West Yorkshire STP

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Urgent & Emergency Care

NHS

What do we need to achieve in 2017/19?

- Deliver improvement; ambulance response time, at front door (inc A&E streaming and ambulatory care), in primary care, in patient flow, at the back door (discharge) and access to diagnostics
- 7 day services, 4 hour standard and Winter Readiness

What actions do we need to take?

- Implement Integrated Urgent Care in line NHSE Commissioning Standards including a clinical hub that supports NHS 111, 999 and out-of-hours calls
- Initiate cross-system approach to prepare for forthcoming waiting time standard for urgent care for those in a mental health crisis
- Deliver 8 national high impact changes for Urgent & Emergency and Pilot direct booking into general practice from 111
- Involve people in travel, transport and estate solutions for urgent and emergency care

How will we measure success?

- 95% standard in A&E
- Reduction in the proportion of 999 calls that result in transportation to an A&E department

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Urgent & Emergency Care – A New Model

NHS

This year we have commissioned more animations to communicate the stories that underpin the work we are undertaking to improve the lives of local people

We need to make changes to our urgent and emergency care services. We currently have an Accident & Emergency service at each hospital. Neither site is meeting national standards and guidance for emergency care. They're understaffed, struggling to recruit Doctors and specialist nurses; relying on temporary or junior staff, and they struggle with the overall number of patients. This situation isn't safe, and we need to think radically about making changes to our services, and what they would mean to you. There are a number of proposed changes:

- *A centralised Emergency Centre in Calderdale……, we can save more lives and improve outcomes for all patients who need emergency care..*
- *A brand-new dedicated specialist children and young people's Emergency Centre based in Calderdale would bring together medical and surgery services, for the first time.*
- *Two dedicated Urgent Care Centres….. for urgent, and non life-threatening conditions - fully staffed, meeting national standards, with a medically-led, 24 hours a day service, supported by teams specialised in urgent care….. We expect over 50% of people who currently go to A&E themselves, would have their needs better met, in the new Urgent Care Centres. If more specialist, emergency care is required, you would be transferred to the dedicated emergency care centre.*

What this would mean for you:

- You would ring 999 for potentially life threatening conditions, and 111 when you're not sure… you would be directed to the right place first time.
- Rapid access to senior medical staff for those with life-threatening illness, improves outcomes
- You would access the new Emergency Centre via 999, 111, your GP or a referral from the Urgent Care Centre.
- For everyone else… if you have an urgent condition, you can phone 111 who would book an appointment for you at the Urgent Care Centre
- We will not be losing services; we will be reorganising them so that they work better for local people and create safer, high-quality services, which will save lives.

Elective Care

What do we need to achieve in 2017/19?

- Achieve the NHS constitutional standards
- Change the current mode of acute elective care
- Manage demand and support the shift of services into primary/ community settings

What actions do we need to take?

- Continue the work of the Elective Care Improvement Board to ensure choice and access
- Streamline elective care pathways including outpatient redesign
- Tackle the variation in demand from general practice
- Introduce thresholds to care which deliver improved outcomes and value and avoid unnecessary follow-ups
- Introduce a new GP Portal as the vehicle to establish effective referral patterns

How will we measure success?

- Delivery of 18 week constitutional standards
- Deliver patient choice of first outpatient appointment; achieve 100% use of e-referrals by April 2018 in line with CQUIN and payment changes from October 2018

Primary Care

What do we need to achieve in 2017/19?

Delivery of GPFV plan submitted on NHSE in December 2016:

- Improve the levels of access to general practice
- Ensure funds for transformational support (as set out in the GPFV) will be created and deployed to support general practice
- How ring-fenced funding being devolved to CCGs to support the training of care navigators and medical assistants, and stimulate the use of online consultations, will be deployed

What actions do we plan to take?

- Agree what good access looks like
- Develop a view of urgent care
- Underpin the above with clear project plans to support delivery, underpinned by financial and workforce analysis and the identification clinical and managerial leads

How will we measure success?

- Use of national standards with the addition of a locally agreed set of outcome measures and metrics to measure progress

Frailty

What do we need to achieve in 2017/19?

- Commission integrated care offers for people at risk, due to their frailty, new integrated community models that support maintaining independence and maximising well-being as well as a reduction in the utilisation of unplanned and episodic hospital

What actions do we plan to take?

- Develop a First Point of Contact hub with partners to deliver a response when needed, both in and out of hours
- Develop MDT working, integrated care planning and shared records
- Strengthen Staying Well service in Primary Care, identifying a named worker to work with each practice to support earlier identification, prevention and support on hospital discharge
- Establish protocols for the use of the Electronic Frailty Index across all Calderdale Practices

How will we measure success?

- Improved outcomes, experience and quality for this population
- Reductions in avoidable admissions for this patient cohort
- Deliver agreed QIPP targets
- Deliver local transfer of care/discharge targets

Mental Health

What do we need to achieve in 2017/19 ?

- Develop a Calderdale plan that outlines how we will deliver the implementation plan for the Five Year Forward View for Mental health

What actions do we plan to take?

- IAPT - continue to strengthen as an early implementer site
- Perinatal Mental Health - develop specialist services which will enhance local pathways.
- Early Intervention in Psychosis (EIP) - deliver local model
- Review Crisis services to achieve best outcomes
- Review dementia care pathways in line with FYFVMH recommendations
- Eliminate out of areas placements for acute placements
- Development of Children and Young Peoples Plan with key stakeholders with a focus on improving CAMHS services and development of the THRIVE model
- Review baseline spend, efficiencies and opportunities to enable delivery of FYFVMH

How will we measure success?

- Improved outcomes, experience and quality for children/young people and adults of all ages who require support with mental health problems.
- More people receiving the right advice/support and care in the community
- Increase in the numbers of people with SMI having their physical health needs met
- Early Intervention in Psychosis (EIP) - meet the 53% access to treatment target
- Maintain the dementia diagnosis rate

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Mental Health – Case Study

NHS

This year we have commissioned more animations to communicate the stories that underpin the work we are undertaking to improve the lives of local people

My name is Debs. I am 47 years old and I have used mental health services in Calderdale since being a young child. This is my story of Care Closer to Home

"When I was 8 years old I had bad nerves and panic attacks. When I asked for help, the responses I got were either quite traumatic or just to take medication. My doctors made decisions for me, without me in the room. Hospital staff didn't seem to understand mental health…. In my early 40s I was running out of hope. I was on pills for the side effects of my other medication….I was desperate for help and didn't get it. I felt I was of no use….. I thought about killing myself……

Then I met Jodie, my key worker. My treatment reviews went from being behind closed doors to group meetings with everyone, including me, coming up with a plan together. I also got appointments much faster and near to where I live. We talked on the phone about how to move forward. She showed me lots of new options…we looked at Life Skills, Mindfulness and Art Therapy….. I don't think in terms of good days and bad days anymore… when I come up against a problem… It's like 'Right, come on, how are we going to deal with this!'… I'm off benefits and I've even got a fantastic job.

Learning Difficulties

What do we need to achieve in 2017/19?

- Deliver our plans for the Transforming Care Partnership (TCP)

What actions do we plan to take?

- Develop flexible and responsive community services underpinned by access to a 24hr Intensive Support Team and a 'crisis space' in the community
- Work with providers to develop services for people with autism and/or challenging behaviour and enhance the skills of the workforce
- Develop new models through co-production with service users/families and carers
- Early identification of and intervention with people identified as 'at risk of admission'
- Improve the health and wellbeing of people with learning difficulties through the new LD health pathway which has a focus on prevention and early intervention

How will we measure success?

- A reduction in the number of people requiring admission to hospital
- Improved health outcomes, experience of services/support and access to local high quality services, for people of all ages with a leaning difficulty
- Reduce the need for inappropriate admissions hospital for people with learning difficulties and/or autism who have a mental illness or whose behaviour challenges services

Cancer

What do we need to achieve in 2017/19?

- Continue to commission and deliver high quality cancer services that meet constitutional standards (CWT)
- Formulate a local place-based implementation plan to deliver the Cancer Alliance sponsored West Yorkshire Cancer Delivery Plan (WYCDP) including contributing to planning work-streams and defining diagnostic capacity
- Determine and strengthen local governance arrangements

What actions do we plan to take?

- Establish local place-based cancer delivery group focussing on priority areas from the WYCDP (National Cancer Strategy)
- Identification of clinical and managerial leads
- Quantify diagnostic capacity required to support WY delivery plan
- Commission all elements of the cancer recovery package in line with available resources

How will we measure success?

- Delivery measured against 62 day CWT standard (85%)
- Establishment of local place-based delivery group with agreed Terms of Reference and membership
- Delivery / achievement of implementation plan against key milestones

Children and Young People

NHS

What do we need to achieve in 2017/19?

- Develop and commission integrated care offers for children and young people and their families to improve emotional health and wellbeing for Children and Young People (CYP) within the agreement of the CYP Local Transformation Plan

What actions do we plan to take?

- Complete and submit to NHSE the Local Transformation Plan Year 2 and make available on both the CCG and CMBC websites
- Build upon our collaborative approach with partners to improve emotional health and wellbeing for CYP providing a more seamless journey through integrated working and timely and appropriate signposting and referral onwards
- Continue to develop the local commitment to improving access to services, developing new and innovative ways to meet mental health needs whilst building up resilience in CYP and their families in their schools and wider communities to improve outcomes

How will we measure success?

- Improved outcomes, experience and quality for this population
- Reductions in avoidable admissions
- Deliver agreed QIPP targets (CNRA)

Maternity Services (1)

What do we need to achieve in 2017/19?

- Better Births' is a national initiative which aims to improve safety and quality of maternity care over the next 5 years

- The vision for maternity services across England is for them to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred around their individual needs and circumstances

- All staff to be supported to deliver care which is women centred, working in high performing teams, in organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries

Maternity Services (2)

What actions do we plan to take?

- Work has already begun to implement the aims within the national initiative at a local level; to date we have assessed compliance against the recommendations in 'Better Births' to gain an understanding on where we need to focus to improve the defined outcomes
- In response to the analysis, a comprehensive programme plan has been developed - a stakeholder analysis has been completed and the engagement work that has been completed through the hospital reconfiguration and by Healthwatch for the local maternity provider - to provide commissioners with insights into women and their families views
- We are planning with the Midwifery Service Liaison Committee women's involvement throughout the transformation to ensure services are co-produced
- Implementation is mandated to take place over a 'locally defined maternity area' (locally defined footprint). Discussions are taking place through the Regional Maternity Clinical Network and across the STP to define what this footprint will be. A decision has to be made by April 2017, Calderdale CCG are actively involved in these discussions

How will we measure success?

- Progress with the recommendations outlined in Better Births

Better Care Fund

What do we need to achieve in 2017/19?

- Develop/deliver an integrated BCF commissioning plan which confirms our commitment to commissioning integrated community services

What actions do we plan to take?

- Refresh our plan and agree with the Health & Well Being Board
- Develop a new Integrated Commissioning Executive
- Improve our shared business intelligence through NHS Number matching between health and social care via the Demographic Batch Service
- Review BCF schemes against delivery of BCF indicators for reductions in Delayed Transfers and Non-elective admissions (activity and cost)
- Continue to strengthen work and deliver local trajectory for the transfer of patients out of hospital

How will we measure success?

- Reductions in the volume and costs 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 and non-reportable transfer of care
- Reduction in the number of people permanently admitted to care homes and experience poor quality care including safeguarding concern
- Increase capacity and capability in homecare and assessment functions

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Planning Assumptions

NHS

Our plans for 2017/19 are underpinned by the following assumptions:

- Modelling has applied the NHS definitions to support the production of activity baselines/ FOT for 2016/17
- CCG has adopted the NHS England profiling tool to support the development trajectories for 2017/18 and 2018/19
- Waterfall chart includes the use of the reconciliation factor for EM11 Non Elective Admissions to ensure alignment with NHS England values
- Applied 1% demographic growth across all points of delivery in line with the contract offer made to providers
- Plans include activity required to support the delivery of the Constitutional Standards
- Using Right Care methodology, CCG QIPP plans have identified over £10m opportunities for transformation for 2017/18. The activity assumptions supporting QIPP are currently informing contract negotiations with key providers
- Activity assumptions within the plan reflect the stage of the negotiation process to agree contracts. It is anticipated the CCG will enter arbitration with Calderdale and Huddersfield Foundation Trust
- QIPP schemes continue to be developed to support transformation in 2018/19