NHS
Greater Huddersfield
Clinical Commissioning Group

2016/17

# Operational Plan for High Quality Local Services

NHS Greater Huddersfield Clinical Commissioning Group

2016/17 revision

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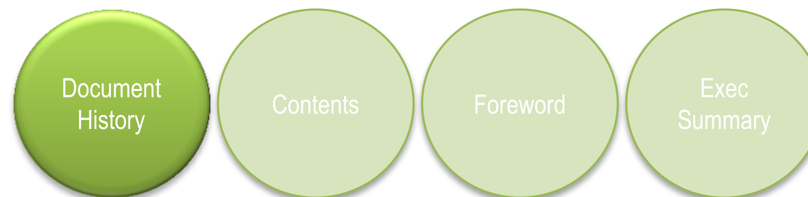


## Document History

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| Draft V0.1 | 10th February 2016 | N.Ackroyd | Outline framework |
| Draft v0.2 | 21st March 2016 | J.Lawreniuk/N.Ackroyd | Updated Finance Section |
| Draft v0.3 | 21st March 2016 | J.Giles | Updated Primary Care section |
| Draft v0.4 | 21st March 2016 | V.Dutchburn | Updated CC2H Section |
| Draft v0.5 | 13th April 2016 | N.Ackroyd | Updated following Governing Body |
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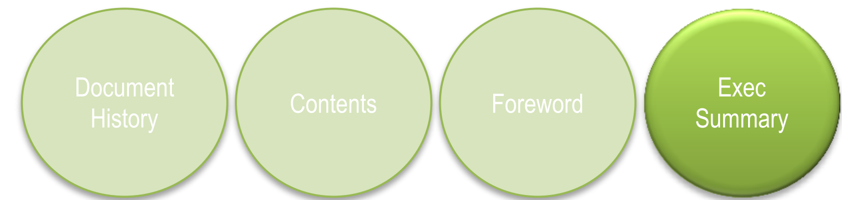
# Executive Summary




Our main focus of our work in 2016-17 is very much a continuation of the work started in 2015-16, and is to continue to commission services that deliver care in a timely way, closer to where people live and, as a consequence, reduce the occasions where hospital admission is required.

During 2015/16 we prioritised the commissioning of our Care Closer to Home service. We worked closely with service users, their families and local organisations to set our aims and ambitions for these services and have undertaken a procurement process to secure the right provider for these services. A new contract was awarded to Locala Community Partnerships and was operational from 1 October 2015.

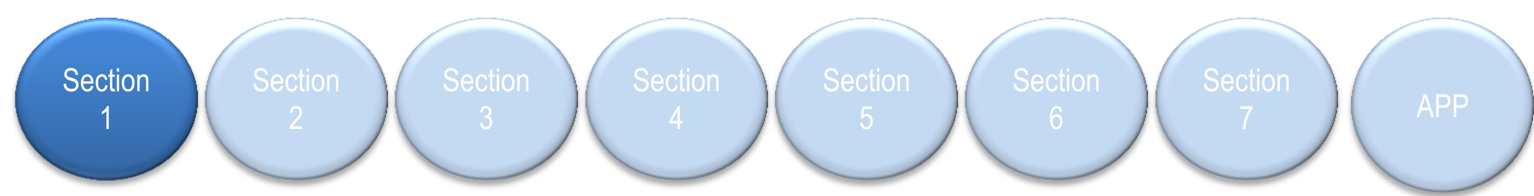
Fundamental to this transformation is the role of primary care, and GP practices. As a membership organisation, we will work with our member practices to help make the changes needed if primary care services in Huddersfield are to be the best that they can be. More information can be found in our **Primary Care Strategy**. During 2015 we have been updating our primary care strategy and will publish the revised version in April 2016 to coincide with our role in fully delegated primary care commissioning

Recent failings elsewhere in the NHS have reinforced the importance of keeping a strong focus on the quality of local services, ensuring they are safe, effective and delivered with care and compassion. Our approach to maintaining and improving quality concentrates on the following major areas:

- Patient experience: – both more effectively acting upon what patients tell us and strengthening their voice in service improvement and in targeting specific aspects of patients' experience, such as personal dignity and communication;
- Safety of clinical services: - targeting areas of concern raised by external or local intelligence including proactive assurance of performance against national standards and ensuring that we minimise unwarranted variation in the quality of service delivery;
- Good clinical practice:- Ensuring that clinicians and services are systematically working to accepted good practice guidelines to help reduce unwarranted variation, and that there are good systems of clinical communication that are timely, accurate, relevant and systematic;
- Agreed pathways of care:- ensuring the effective adoption by primary, community and secondary care services of agreed care pathways in GHCCG, with care indicators that measure the quality of a whole pathway of care; and
- Commissioning intentions: - implementing new models of service delivery and integrated commissioning.

Our financial position remains challenging. Limited increases in NHS funding over the next few years are not enough to cover demand growth, cost inflation, or increases in quality initiatives/better outcomes for patients; as such there is a need for a significant amount of year on year efficiency savings to be made. Over the next two years we need to continue to deliver savings of approximately £4m per annum in order to deliver break even.

We cannot deliver all of our ambitions by ourselves. For the past year, we have worked closely with other organisations in our area as part of the Calderdale and Greater Huddersfield **Right Care, Right Time, Right Place**; this programme will continue to be a key priority for us in the coming months. In 2014, we took the decision to focus initially on our Care Closer to Home model, with the aim of establishing strong community services for our residents. We acknowledged that changes to hospital services will need to be made, but that by getting improvements to community services in place first, we will be in a better place during 2015 to decide if we are ready to consult on any proposals relating to hospital services.




This Operational Plan sets out our priorities over the coming years in response to the Five Year Forward View. It will set out what we plan to do to deliver the vision for our organisation, and support the achievement of shared aims with public sector partners in our area.

The leading national health and care bodies in England have come together to publish 'Delivering the Forward View: NHS Shared Planning Guidance 2016/17 – 2020/21', setting out the steps to help local organisations deliver a sustainable, transformed health service and improve the quality of care, wellbeing and NHS finances. Some of what is needed can be brought about by the NHS itself. Other actions require new partnerships with local communities, local authorities and employers.

Every health and care system will come together, to create its own ambitious local blueprint for accelerating its implementation of the Forward View. Each place based footprint will produce a sustainability and transformational plan (STP). The STPs will cover the period between October 2016 and March 2021, and will be subject to formal assessment in July 2016 following submission in June 2016. The STP will span providers and commissioners, these plans will set out the mixture of demand moderation, allocative efficiency, provider productivity, and income generation required for the NHS locally to balance its books.

The STP encompassing Greater Huddersfield CCG will be produced jointly with North Kirklees CCG, to reflect the shared focus we have with Kirklees Council on improving the health and wellbeing of our residents. This document will be published as the Kirklees Sustainability and Transformation Plan. Together, we have a shared picture of the health needs of Kirklees residents in the Joint Strategic Needs Assessment. The Joint Health and Well Being Strategy seeks to address these needs by identifying shared priorities and clear outcomes for improving wellbeing and health inequalities; it also provides a framework and set of tools to support the innovative system changes required. Together, the two CCGs (ourselves and North Kirklees), along with the Council, oversee these shared work programmes in the Kirklees Health and Well Being Board (HWBB). The Better Care Fund plan has also been developed within the same planning footprint and overseen by the Kirklees HWBB.

As a commissioning organisation, we will transform the way our system currently operates so there is a greater focus on the prevention of ill health and the empowerment of citizens who will be able to manage their health and wellbeing and access integrated community, social and primary care services that are connected by effective pathways into acute settings when required. We are supportive of citizen engagement in developing our strategic plans and recognise that Public/patient participation is a key component of all commissioning activities we undertake and developing new models of care. Through the work already undertaken as part of the joint engagement activities to develop the 'Care Closer to Home' model, and the planned engagement activities which will be undertaken as part of the Calderdale and Huddersfield Right Care, Right Time, Right Place programme, we have involved local people in developing our strategic vision for the future, which is described in this document. We have also engaged with our local GP practices.

We are currently developing a new primary care strategy for Greater Huddersfield CCG which outlines the ambition for primary care by 2020 with a supporting implementation plan; the strategy at this stage is focused on general medical services with a view to expanding to including other primary care services in the future. This is being developed through a programme structure working collectively with the LMC and local GP Federations. The work streams for the strategy are focused on describing the primary care offer ('core', 'core plus' and 'advanced') and on the enablers; workforce, IT and technology, estates and engagement. The strategy will be completed for sign-off by the CCG Governing Body in mid-April 2016.

## Sustainability and Quality of General Practice

A key component of the strategy is the definition of the provision and standards required as part of a 'core offer' within general practice. The expectation is that all practices will deliver these services and standards to all patients. The aim of this is to reduce the variation and inequity of access and provision between the 37 practices in Greater Huddersfield. Whilst some practices are already successfully fulfilling the requirements and standards, this is not the case for other practices. The strategy outlines a support offer from the CCG to ensure that practices have access to the hands on support, toolkit, best practice and learning locally to enable them to deliver services to the required quality and standards.

The redevelopment of the strategy has been in response to a number of challenges, the most prevalent of these being the sustainability of primary care. Through our engagement with practices in developing the strategy, the key concerns relate to workforce in both recruitment and retention and the available funding for primary care. Workforce is a key component of the strategy identifying not only what will be delivered in primary care, but by who to deliver good clinical outcomes and efficiency. This workstream has identified several priorities for implementation:

- ✓ Alternative roles;
- ✓ Making efficiencies in current roles / processes;
- ✓ Collaboration;
- ✓ Working with / integrating with other services (particularly with community services as part of our new Care Closer to Home services);
- ✓ Retention, recruitment and long-term career and succession planning; and
- ✓ Patient education.

In terms of funding, there is a commitment that any services which move from another setting (e.g. secondary care) into primary care to support provision of Care Closer to Home and efficiencies of service delivery (advanced services) will be supported by funding following from the existing service provision. Receipt of full delegation will support with the redesign of enhanced schemes to fund local priority schemes.

## Enhanced Access (OOH, Weekends)

There has been significant learning through the Winter schemes offering extended access to primary care, particularly for urgent appointments working across 5 hubs in Greater Huddersfield. The evaluation of this will continue to inform the commissioning and provision of extended access to services. The CCG is also actively involved within the West Yorkshire Urgent and Emergency Care Vanguard programme, within which there is a workstream looking at urgent access and provision within primary care within the whole of West Yorkshire and Harrogate through the UEC Network.

The strategy has identified enhanced access as a key component of 'core plus' offer and the implementation plan and opportunities afforded by full delegation for commissioning general medical services will identify the approach for implementation and embedding across Greater Huddersfield.

## Delegated Authority

The CCG will receive full delegation on 1 April 2016. In support of this, the Primary Care Commissioning Committee will be revised from the current Joint Commissioning Committee. The refresh of the Primary Care strategy will ensure that the decisions of the Committee are in-line with the strategic direction and aspirations for primary care. Part of the delivery plan for the strategy will focus on how implementation can be supported through powers offered by full delegation, particularly to support the 'core plus' offer through redesign of current enhanced schemes.

Our overall vision as set out in the Joint Health and Wellbeing Strategy (link) is that for everyone who lives in Kirklees – "By 2020, no matter where they live, people in Kirklees live their lives confidently, in better health, for longer and experience less inequality."

The JHWS recognises that whilst there have been overall improvements in local health and wellbeing there are still significant health and care challenges set out in the JSNA (link). The most recent refresh of the JHWS has sharpened the focus on creating an integrated health and social care system that is capable to responding to these challenges. The Health and Wellbeing Board is leading the development of the Kirklees Sustainability and Transformation Plan. The draft objectives are shown in Fig 1, and these draw on the objectives we set out for our first BCF Plan in 15/16 and the NHS 5 Year Forward View.

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**Kirklees 2020 Vision**

### Objectives for local people

- ✓ People in Kirklees are as well as possible for as long as possible, both physically and mentally
- ✓ People can control and manage life challenges and are able to do as much for themselves and each other as possible
- ✓ People have a safe, warm, affordable home in a decent physical environment within a supportive community and a strong, sustainable economy
- ✓ People take up opportunities that have a positive impact on their health and wellbeing
- ✓ People who are informal carers are identified, supported and involved
- ✓ People experience high quality seamless health and social care that puts their individual needs, choices and aspirations at the heart of their care and support

### Objectives for local services

- ➢ The local health and social care system is affordable and sustainable, and investment is rebalanced across the system towards activity in community settings and in peoples own homes
- ➢ Integrated service delivery across primary, community and social care focusses on prevention and early intervention, and are available 24 hours a day and 7 days a week where relevant
- ➢ Strategic planning, commissioning, intelligence, technology, workforce and community planning are fully integrated
- ➢ New solutions are created through innovation and creative collaboration locally, regionally and nationally

The overall population outcome we are aiming to achieve through the BCF plan is:

**"People with health and social care needs feel supported and in control of their condition and care, enjoying independence for longer."**

This overall outcome is underpinned by four specific person centred outcomes:

- People who need support are in control of high quality, personalised support in their own home or community that enables them to stay safe, healthy and well for as long as is possible
- People who need care that can only be provided in a specialist setting are admitted and receive good quality specialist care only for as long as is clinically necessary
- People who receive care, regain, as far as possible, their skills, abilities and independence through enhanced reablement and rehabilitation support
- People with ongoing support needs manage their condition/needs as well as possible

The key performance measures we will use to measure our progress are:

1. A reduction in Non-elective admissions
2. A reduction in Permanent admissions of older people (65 and over) to residential and nursing care homes
3. An increase in the Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
4. A reduction in Delayed transfers of care from hospital
5. An increase in our Dementia diagnosis rates
6. Patient / service user experience Everyone Involved in my Care knows my Story: (i) Improvement in response Rate on completion of care episode, (ii) Increase in % of patients/carers reporting satisfaction about the level of information services have about them on transfer NB as this is a new measure there is currently no baseline data.

Each of the specific schemes within the Better Care Fund has been selected on the basis of their contribution to delivering these outcomes, their strategic fit and their impact on our key performance measures.

Over the next 5 years primary, community and social care teams will be commissioned to work together in an increasingly integrated way, with co-ordinated, holistic assessments and rapid and effective joint responses to identified needs, provided in and around the person's home and community. By improving the way we work with people to manage their conditions, we will reduce the demand not just on acute hospital services but also on nursing and residential care.

In 2016/17 the BCF will be used to build on the joint work already taking place using within the 9 schemes that form part of our overall strategy to deliver these changes:

### 1. Preventative Services

- continuing to invest in community based prevention and early intervention activities delivered by voluntary and community organisations that support people with their health and social care needs
- building on Kirklees' track record as a leader in self-care, including the development of an innovative web based 'hub' which will transform the way self-care information, support and resources are accessible to a wide range of people
- continuing to support specialist alcohol nurses working in hospitals to reduce alcohol related admissions and repeat presentations for health and care services.
- providing people with long-term conditions who are at risk of hospital admission or needing additional care services with short term support to build their confidence to manage their needs at home

### 2. Intermediate care (including Reablement Services, Bed Based Intermediate Care Services, Mobile Response Services)

- enhancing investing in and redesigning community based domiciliary services to support admission avoidance and hospital discharge arrangements and integrated crisis and rapid response services to avoid unplanned admission to secondary care services.
- investing in and redesigning where necessary our community bed base to facilitate early supported discharge and/or reduce need for admission to hospital if care can be provided closer to home. This includes additional investment in palliative and end of life care services.

### 3. Aids to daily living

- our new Integrated Community Equipment Service went live in April 2014, and will work alongside activity on undertaking minor adaptations to property to ensure people are able to stay in their own homes as long as possible

### 4. Carers Support Services

- investing in carer related support including respite care/short break activity and specified schemes for dementia related care etc.

### 5. Additional Community Health Services

- Additional investments into Care Closer to Home services enabling patients to remain within their own homes for as long as possible and facilitate their return to their own home as soon as possible should they be admitted to hospital.

### 6. End of Life

- increasing access to specialist high quality, responsive and holistic service palliative and end of life care for individuals, their carers and families to support personal preferences

## 7. Psychiatric Liaison Services

- ensuring adults experiencing mental health problems who attend the acute hospitals are sign-posted to the most appropriate care; receive parity of care for physical and mental health needs; are not admitted into hospital just to avoid breaching the emergency care target; and receive on-going psychiatric assessment so that they are ready to be discharged once medically fit.

## 8. Protecting Social Care

- Ensuring that those people with social care eligible needs can receive the care and support they need to maintain or regain their independence and reduce the risk of hospital admission, recognising that as more people have receive care out-of-hospital they will need additional social care support
- Implementing the Care Act, including the predicted increased volumes of assessments, carers assessment and associated packages of care

By offering integrated high quality services at times required to meet the needs of the community Kirklees wishes to reduce reactive, unplanned care and do more planned care earlier. The benefits that patients and their carers will see as a result of the changes and how these will impact on emergency attendances and hospital admissions. People will receive care which is more timely and organised to meet their specific needs. The services they need will be co-ordinated across providers where necessary; ensuring care is co-ordinated and seamless as one coherent package with a focus on helping recovery and promoting independence.

## Right Care, Right Time, Right Place

Both NHS Greater Huddersfield Clinical Commissioning Group and NHS Calderdale Clinical Commissioning Group are led by local GPs and it is our role to commission (plan and buy) the majority of hospital and community health services for our local population. It is our responsibility to ensure that the services we commission are high quality, safe and sustainable and that in doing so we manage our budgets efficiently and effectively.

We face substantial challenges to improve hospital and community health services and as such we are now consulting the public on some far reaching proposals.

The areas we cover are shown in the maps below. NHS Calderdale CCG shares the same boundaries as Calderdale Council and NHS Greater Huddersfield CCG and its neighbour, NHS North Kirklees CCG, come within the boundaries of Kirklees Council.

The areas of Calderdale and Huddersfield have seen many changes in recent years with populations and life expectancy increasing. Many people now live well into their 80s and 90s. Modern lifestyles are also creating new health issues. Smoking is still the UK's largest cause of preventable illness and early death. Obesity is increasing and brings health issues such as diabetes and cardiovascular disease.

Clinical commissioning groups and local authorities have drawn up Joint Strategic Needs Assessments (JSNA) which identifies some common themes that drive the health needs of the local populations. For Calderdale and Greater Huddersfield these are:

- **Population Growth:** The population for Kirklees is c. 434,000 and for Calderdale is c. 209,000, giving a combined population of c. 643,000 people. This is forecast to increase by 12% in Calderdale and 13% in Kirklees by 2037; which is consistent with England's expected population growth of 14%.
- **Ageing population:** The populations of Kirklees and Calderdale are ageing: in 2012 there were 102,000 people aged 65 years and over (16% of the population). This is forecast to increase to 169,000 people over the age of 65 years by 2037 (23% of the population). These increases represent a compound annual growth rate of 2% for the 65 plus age group and 0.5% for the full population. This is a significant challenge, as the likelihood of having long term conditions increases with age and so does the likelihood of having multiple conditions, increasing the demand on the health system. Kirklees Joint Strategic Needs Assessment 2013 report that by the age of 55-64, one in four people had at least one of the conditions identified in the Current Living in Kirklees 2012 survey. Additionally, by the age of 75, almost two in three had two or more conditions. In Calderdale and Kirklees it is estimated there are c.2,400 people and c.4,200 people respectively living with dementia. Statistics show that more people in Calderdale are admitted to long-term residential care than in other parts of the country.
- **Levels of deprivation:** There are high poverty and deprivation levels in Huddersfield along with higher rates of unhealthy eating and levels of exercise and higher disease burden. The infant mortality rate for Calderdale is significantly higher than England average (7.7 per 1,000 live births compared to 4.6 per 1,000 live births).
- **Health profiles:** The JSNA for the Greater Huddersfield area identified frailty, emotional welfare, obesity and cardio-vascular disease (CVD) as cause for specific concern locally. Priority areas for Calderdale in their JSNA include the management of long term conditions such as diabetes, asthma and epilepsy, mental health and the abuse of alcohol.
- **Lifestyle factors:** Smoking prevalence and the harm caused by alcohol and obesity is increasing. There is arising childhood obesity and it is estimated that 40% of all illness in Calderdale can be attributed to lifestyle factors. In the Greater Huddersfield area, 52% of adults are overweight or obese and 20% of children are overweight or obese.

The cost of health and social care in Calderdale and Huddersfield is now more than £600 million a year and while that figure is set to continue to grow, increasing demand, inflation and the introduction of new drugs and treatments mean costs are increasing faster. It is not just about how much money we have to spend, we need to look at how we spend it.

The Five year Strategic Plan for Calderdale CCG and the Joint Kirklees five year strategy for Greater Huddersfield CCG set out the focus of a 5 year change programme which will centralise key services to improve outcomes for patients and continue the shift of services and resources from unplanned hospital care to integrated health and social care - delivered in community and primary care settings.

As commissioners, we have developed proposals for what these future Community and Hospital services in Calderdale and Greater Huddersfield could look like. The proposals seek to transform the organisation of care and the infrastructure by which it is delivered and constitute major change under section 244 on the NHS Act 2006.

There are three interlinked pieces of work: Calderdale Care Closer to Home Programme; Greater Huddersfield Care Closer to Home Programme; and the Hospital services Programme.

These proposals will be implemented in three inter-related phases over the next five years:

Phase 1 - Strengthen existing community services in line with the new model of care;
Phase 2 - Enhance community services – which is likely to move more services closer to home.
Phase 3 - Hospital changes.

## Phase Three - In-Hospital Services

Calderdale CCG and Greater Huddersfield CCG have been developing their proposals for Hospital Services. In response to: our case for change; what our engagement has told us; our developments in relation to Community Services; the National Clinical Advisory Team's report in 2013; the KEOGH Review; and other emerging evidence and best practice, clinicians from both CCGs and CHFT have reached clinical consensus on a potential outline model of care.

## Why change is needed

Our ambition for the quality of care and outcomes delivered for our patients is high: we want to achieve the best outcomes for patients; for patients' experience of health services to be good; and for no harm to occur.

The overarching case for change (developed by the Strategic Review and articulated in the Outline Business Case) is clear – the demand for and cost of local health services is increasing at a time when the economic situation means resources will be limited for some time. If the local system is unable to redesign and transform services in a way that drives up quality within that available resource then our patients will experience poorer outcomes as a result.

Transformation of the current models of service delivery for our population is required in order to:

- Ensure the delivery of consistently safe, high quality care to all patients by meeting hospital standards
- Deliver care in the most appropriate and cost effective setting to meet patients' clinical needs

Aware of the growing pressures, we have begun implementing transformational schemes in order to improve the efficiency and quality of the commissioning and delivery of healthcare services, most notably Phase One – Strengthen Community Services.

## Quality and Safety Case for Change

Calderdale and Greater Huddersfield CCGs have articulated their over-arching aims on quality and safety as:

- Above average in comparison to peer groups within 3 years;
- 'Best in class' with peer groups within 5 years;
- Where performance is already above average, the aim should be to be 'Best in class' in comparison to peer groups within 3 years; and
- The Harm free care measure should be 100%, irrespective of performance of other providers.

As CCGs we recognise the need to measure and understand our current position against these ambitions and have discussed through its Quality Committees a set of Hospitals Standards. These Hospital Standards articulate the improvements identified by the CCGs on quality of services and patients' experience of care. These Hospital Standards cover emergency care, planned care, maternity care and paediatric care and have shared ownership with Calderdale and Huddersfield NHS Foundation Trust.

These Hospital Standards (detailed as 'inputs') can be summarised as:

- Improved pathways to best support timely access to senior staff and specialist skills, diagnostics and multi-professional support;
- Improved processes to support patients with their conditions and treatment;
- Clinical protocols with access times to routine investigations will be made available and followed by service providers;
- Improved access to senior clinical staff and improved clinical protocols to reflect co-located services, improved access to diagnostics and reduction in inconsistencies/differences in urgent and elective care pathways and standards and clearly defined responsibilities for Paediatric Assessment Units;
- Midwifery-led maternity pathway, with improved access to obstetric input and support, improved pathways and support to diagnostic and support services, including wider support services, and improved staffing levels, including for women in labour (maternity care); and
- Outcomes for patients on patient experience, compassionate care and safe and sustainable care across hospital services.

NHS Calderdale and NHS Greater Huddersfield Clinical Commissioning Groups (CCGs) are consulting people about some far reaching proposed changes to hospital services and further proposed changes to community health services. We need to understand the views of all patients, public, stakeholders and staff who live and work in Calderdale, Greater Huddersfield and others who for whom the proposed changes may have a direct impact (which may include patients, public and stakeholders in surrounding areas) about the way in which Emergency and Acute Care, Urgent Care, Maternity Care, Paediatric Care, Planned Care and Community Health Services are provided in the future.

This is so that by the end of September 2016 both CCGs can make an informed decision on progressing the future shape of hospital services ensuring that these are high quality, safe, sustainable and affordable and result in the best possible outcome and experience for patients, as well as on which services should be provided in the community, closer to where people live.

These proposed changes would secure the future of health services for both areas for the next 20 years. They would make sure that our hospital services were in line with national recommendations and guidance. They would also mean that more services were provided in the community, including some outpatient clinics, so that people only needed to go to hospital when they really had to be there.

Our proposed changes would help us to address some big challenges.

Currently our patients don't always receive the best possible care. Our hospital services are stretched, with some being split between Calderdale Royal Hospital (CRH) and Huddersfield Royal Infirmary (HRI) sites. Some don't meet national guidance, such as those for children and young people in emergency care. We transfer sick people between hospitals on a daily basis so they can get the care they need. We need to improve our hospital mortality rates which means reducing the number of patients who die in our hospitals. We have difficulty recruiting doctors and therefore rely heavily on temporary (agency) doctors. Like other places around the country, we have an increasing number of older people living longer, often with more than one long term condition who need the right care and support to help them stay well and independent. We need to move with advances in medicine and technology and make sure that our patients get access to the latest treatments.

Alongside all of this we have big financial challenges, which mean we need to make substantial savings so that we can manage within the money available to us as well as achieving the improvements needed going forward.

Our proposed changes are the result of local discussions that began over three years ago to develop a new model of care to resolve some of these challenges. And we have been clear that leaving services as they are would not allow us to deliver the quality of care that local residents deserve, nor would it provide either of our hospitals with the financial sustainability needed to deliver that care.

During our early discussions with patients, the public and our partner organisations, a very clear message received was that before any changes could be made to our hospitals, there needed to be considerable improvements to community services. People said they wanted as much care as possible provided close to home. They wanted more and better services in the community to help them stay well and independent. They wanted these services to be more joined up which would mean health and social care organisations working much more closely to meet the needs of individual patients and to save patients and their families from having to find their way through what can be a very complicated system.

And this is exactly what we have done. We listened and used local feedback to shape our plans to enhance and strengthen community services. As such, Care Closer to Home programmes are being delivered in both Calderdale and Greater Huddersfield which are already transforming the way that care is provided to the people who need it most, particularly elderly and frail people, those living with long term conditions such as heart disease, chronic chest conditions and diabetes and children with complex needs.

These are making great progress and are supporting people of all ages to stay well and independent and we want to do more to make sure that people receive the care they need at home or in the community and are admitted to hospital only if they really need to be there. When they do have to come into hospital we want to make sure that patients can be discharged as soon as they are well enough with the right support at home.

While we have been laying the foundations for strong community services we have been developing a model for hospital services. In shaping this model there have been many more discussions with patients, the public and local organisations and with hospital doctors and nurses, GPs and other healthcare professionals working in the community. We have also had two independent reviews from expert clinicians.

We are proposing investments at both of our hospital sites, so that they become state of the art hospitals. CRH would become an Emergency Centre and the Acre Mills site at Huddersfield a dedicated hospital for planned care. We are also proposing to develop Urgent Care Centres at both hospitals. These developments would cost more than £291m but would generate efficiencies to close the financial gap the system is facing.

The Emergency Centre would bring together on the CRH site all of the emergency and acute services that people need when they become seriously ill or have injuries which can be life threatening. It would also have the services people might need when they become unwell and are admitted to hospital for tests and treatment. We would have a Paediatric Emergency Centre which brings together in one place all of the medical and surgical services for children. We would also continue to have consultant-led maternity services at CRH, again so that they could be in the same place as all of the necessary supporting services should these be needed.

The Urgent Care Centres would be open 24/7, staffed by doctors and emergency care nurses and would have x-ray facilities. These would be the front door to care for people who make their own way to hospital with injuries and illnesses. However, while patients could decide themselves to go to the Urgent Care Centres we would be encouraging them to ring NHS 111 first so that they go to the right place first time and get the care they need as quickly as possible.

The new hospital development on the Acre Mills site at Huddersfield would be for routine procedures and operations that don't need to be done as emergencies but still should be done as soon as possible. This would be a big development with around 120 beds and ten new operating theatres.

We know that people will have questions about our proposed changes and we look forward to meeting with local people and explaining why we feel that this is the right model for hospital services going forward.

The CCGs' GP leaders and the senior clinical staff at Calderdale and Huddersfield NHS Foundation Trust have worked together to develop this new model and support the proposed changes.

## 7 day services

**NHS Services open seven days a week: everyday counts, November 2013.**

www.nhsiq.nhs.uk/.../every-day-counts-seven-day-services.aspx

In this guidance, NHS England sets out new clinical standards which describe the standard of care all patients should expect seven days a week, each supported by clinical evidence and developed in partnership with the Academy of Medical Royal Colleges. They describe, for example, how quickly people admitted to hospital should be assessed by a consultant, the diagnostic and scientific services that should always be available, and the process for handovers between clinical teams.

Through both patient and clinical engagement events we have identified services that are required on a 24/7 basis and those that are not. We will continue to refine service provision through a lead provider model delivering our Care Closer to Home strategic vision. General practices will be the cornerstones of care organising inputs from integrated health and social care services to get the best outcomes for their patients, with a greater range of care locally, 24 hours a day, 7 days a week.

The hospital changes detailed proposes to have Urgent Care Centre, available 24/7.

## Reducing excess deaths

The number of patients dying in our hospitals is higher than average. The Trust's hospital mortality rates are higher than the England average. This means that more people are dying in our hospitals than would be expected. There is an increased national focus on mortality which means that many more acute Trusts are making significant progress. This brings down the overall England average so that Trusts that are currently outliers, such as Calderdale and Huddersfield NHS Foundation Trust have to reduce mortality even further to move closer to the national average.

Mortality: CHFT's most recent mortality figure is 113 (HSMR one-year rolling data to June 2015). The Trust's most recent SHMI mortality figure was 108.9 (March 2015), against an expected benchmark of 100. Whilst the Trust did achieve a reduction in its mortality rate during 2014-15, it is not been able to narrow the gap to a mortality rate (HSMR) of 100, the accepted national standard for which acute Trusts aim. The reduction was also not sustained in 2014-15 and the mortality rate is back to the near 107 mark from the start of the year3. During the last two years, a national focus on mortality means that many more acute trusts have made significant progress in mortality, bringing down the overall England average and means that Trusts that are currently outliers, such as CHFT, have to reduce mortality even further in order to move closer to the national average – just to move in to the 'as expected' range.

In numerical terms, and in relation to the CCGs' position and outcomes for the CCGs' patients, it can be anticipated that 2015-16, on the current configuration of services, would deliver a reduction in mortality, based on targeted work on acutely ill patients and earlier interventions in sepsis care and medication administration, but not predicted to be at the 100 national benchmark rate and whether reductions are able to be maintained.

## Bringing Services and Support Closer to Patients

Greater Huddersfield CCG began to develop the plans to shift services and resources closer to people's homes in 2012, the result of which is a flagship collaborative (with North Kirklees CCG) programme which manages the transition from hospital to community with Phase one services going 'live' on 1 October 2015.

From the outset the Care Closer to Home programme was developed based upon intensive and wide engagement with patients, GP member practices, the public, professionals and partners. Our engagement work told us that people wanted services that are delivered closer to people's homes (although not necessarily within a patients' home) and ensure that fewer people are admitted to hospital.

The vision of how the services should be delivered required dialogue with providers to enable the most economically advantageous and innovative services to be commissioned whilst ensuring collaboration and, where appropriate, joint services across the Kirklees area.

Together with North Kirklees CCG we undertook a joint procurement exercise during 2014 culminating in the appointment of a lead provider for Care Closer to Home, finalised during July 2015. Locala Community Partnerships in conjunction with partners, commenced delivery of the new Care Closer to Home service on 1 October 2015.

The Integrated community service model with its emphasis on the role of helping people to stay healthy and shifting the balance towards prevention and support for people with complex needs, will contribute towards the priorities of the Kirklees Health and Wellbeing Board

## Population Covered

NHS Greater Huddersfield CCG is responsible for commissioning health care services for a registered population of approximately 245,000 people across 39 GP practices.

The population is rising and will continue to grow, especially in the older age groups. This creates health and social care challenges as more people live longer and with long term conditions, and it brings economic and social challenges as the proportion of working age people reduces. 1 in 6 of the adult population and more than 1 in 4 under 18s are of south Asian ethnicity.

By 2030 the population of Greater Huddersfield will be 278,700. 16% of the current population is aged 65 years or over, 7.2% is over 75 years old. By 2030, people aged over 65 are expected to make up a quarter of the population – a 70% increase from 2010 to 2030.

Dementia accounts for more years of disability than any other condition. It is estimated that in Kirklees nearly 4,500 people aged over 65 had dementia in 2012, and that this is projected to rise to nearly 5,500 by 2020. Approximately 2/3 of these individuals will be supported in the community and are likely to require treatment/support for other long term physical and mental health conditions.

There is now an increasing need for services that promote independence and wellbeing for patients. Delivery of effective services across Greater Huddersfield will require an integrated approach involving health, social care and third sector organisations.

## What is the model?

The Care Closer to Home vision is for integrated community-based healthcare services for all, from children and young people through to and including the frail, vulnerable and older people and also end of life care. It is crucial that we make lasting changes to our health and social care system to ensure that services are fit for purpose and sustainable in the future. Key characteristics of Care Closer to Home are:

- Improved primary and community care providing the right care at the right time in the right place
- Provision of services in the community that promote independence and wellbeing for patients so they can support themselves by exercising self-management, choice and control
- Integrated high-quality services at times required to meet the needs of the community
- Providing more planned care earlier thereby reducing reactive, unscheduled care
- Care provided as one coherent package, with a focus on individuals and helping people to get better

The main elements of the model are:

- Risk assessment to identify people who are most vulnerable and most likely to be admitted to hospital
- Proactive care management by multi-disciplinary teams
- High quality local information and support to enable people to manage their own condition and access the most appropriate care
- Person centred care delivered through a single assessment process and single care plan 24/7
- Care at or near home wherever possible

The overall ambition for the Care Closer to Home Service is outlined below:

- Care is co-ordinated and seamless
- Nobody is admitted to or will remain in hospital or residential care unnecessarily
- People are supported and in control of their condition and care, optimising their independence to enable them to live better quality lives for longer

The following list shows the overarching national principles:

- Reducing avoidable emergency admissions for those conditions that are amenable to healthcare
- Reduction in the need for urgent care

- Reduction in time spent in unnecessary days spent in hospital
- Increase in health related Quality of Life for patients with long term conditions, including mental health
- Value for money
- Increased patient and carer satisfaction with services, including improved responses to the Friends and family Test for local services
- Reduced mortality - potential years of life lost for conditions amenable to healthcare

The outcomes for care closer to home which have been developed with local stakeholders, including patients and carers, are:

- I'm seen at the right time by the right person
- More of my care happens nearer to home
- Me and my carers know how to manage my health and wellbeing
- Everyone involved in my care knows my story

## Vision of the model

The vision for Greater Huddersfield CCG is to ensure delivery of integrated services through the model commissioned. That our primary and community care can provide the right care in the right place, at the right time, first time, by staff with the competencies and skills to meet the needs of patients/service users, which compliments and works together with acute care services. By offering integrated high quality services at times required to meet the needs of the community we will reduce reactive, unscheduled care and do more planned care earlier. People will receive care which is more timely and organised to meet their specific needs. The services they need will be co-ordinated across providers; providing a flexible pattern of delivery across health and social care and the wider partnerships and assets within local communities, ensuring care is co-ordinated and seamless as one coherent package with a focus on prevention, helping recovery and promoting independence.

The key functions of the Care Closer to Home Service are:

- Initial contact handling for any health or social care worker or patient/service user to include contact handling; information gathering within given parameters; using information to determine next steps; referral; involvement of clinical/professional senior decision making;
- Providing professional and clinical decision making and accountability;
- Managing resource allocation and demand;
- Prioritisation, delegation and transfer of care;
- Proactive tracking and care navigation throughout the whole patent/service user journey;
- Proactive reviewing of the effectiveness and efficiency of the care pathway.

An important part of doing things differently in greater Huddersfield, is how we refocus health and social care to help people do more to help themselves, whatever their level of vulnerability or ill-health.

## Vision for Self-Care

The vision is that people are increasingly independent, self-sufficient and resourceful to confidently manage their needs, thus reducing dependency on the health and social care system and improving their wellbeing and lifestyle.

The principles for self-care are to:

- Ensure people who use services are able to have greater control and be empowered to co-produce their support plans.
- Raise knowledge so front-line staff have the opportunities to develop and apply 'practical skills' in self-directed support.
- Motivate, encourage and support people to feel confident in their approach to managing their health and wellbeing.
- Embed the importance of 'information' and 'sign posting' - as a route to self-care opportunities for people with long term conditions.
- Further the role of Assistive Technologies for people using at home services.

We have recognised that there are four enablers for achieving better self-care:

- **Skills**; self-advocacy, goal setting, motivational support to increase self-awareness, resilience, understanding psychosocial needs and identifying and managing risks, creating a self-authored management plan
- **Resources;** accessing information and networks so people, their families and carers can talk to others in similar situations. Also information technology, development of skills, knowledge, getting help and monitoring own health
- **Behavioural and cultural change in systems** Timely, consistent and effective experience of support, enable risk management and risk taking to maximise independence and choice. Organisations need to put in resources to support this emphasis across their staff, IT and management systems
- **Communication;** at the front line with an individual, throughout services and across communities

## Care Closer to Home Service Description

Through the ongoing implementation, primary and community services are being brought together and provided by linking with appropriate professionals across health and social care using staff and resource flexibly which will be provided at a variety of levels such as:

- Primary care involving local GPs and practice nurses
- Community care; promoting the independence and wellbeing of individuals
- Integrated working between community health provider and third sector /social care providers
- Specialist care; giving access to specialist services

- Medicines Management and Community Pharmacy
- Minor injuries type care in the community, for example staff are able to deal with a skin tear preventing an un-necessary trip to A&E

Supporting proactive prevention, the 'crisis intervention' and 'early supported discharge' elements will be managed through a 'crisis co-ordination' / single point of access facility that will help field initial calls/referrals for intervention, advice and support. The model also embraces the principles and scope of a frailty and intermediate care model, these principles thread through all aspects and elements of the services rather than being individual services which require specific criteria to be met.

We are currently exploring the opportunities offered through Personal Health Budgets and work alongside social care Direct Payments.
Primary care is an essential part of integrated care providing a cornerstone of the locality teams and working with partners to assess and meet the needs of the population. With patient consent and full discussion with patients and carers, multidisciplinary teams are working together in a better, coordinated way to assess need, plan and implement plans to ensure the provision of the best possible services for each patient. There will be individual health and social care summaries available for patients with the key information available to all providers 24hrs a day, seven days a week, as appropriate to meet clinical need and reduce the need for unnecessary hospital admission.

## Ongoing Service Phasing Plan

We are well on our journey to achieve **Phase one** of our plan – A strengthened community model has been procured and has started to deliver robust, enhanced community-based health services.

We have developed a Service Improvement Plan, with our service provider to move into **Phase two -** To further enhance community services and begin to move services out of hospital that can be provided more appropriately in the community. Working with our Provider(s) we are continuing with stakeholder engagement to ensure that service improvements are being delivered in the most appropriate way and that risks and potential unintended consequences are identified and mitigated.

# Our approach to Quality, Safety and Engagement

## 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 and service delivery
- Safeguarding remains an integral part of our business ensuring that the safeguarding standards are implemented for each commissioned service.
- Implement the process for gaining deprivation of liberty authorisations from the Court of Protection for health funded domestic / supported living placements
- Ensure we include any learning from Year 1 of FGM mandatory reporting
- Introduce mortality reviews in primary care, in order to strengthen learning
- Deliver 7 days services where appropriate
- Improve access to General Practice and grow the medical and nursing workforce.
- Continue to promote 3rd Sector organisations as a partner in care delivery
- Deliver fit for purpose and sustainable models of urgent and emergency

## 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 Patient and Public Engagement and Experience Strategy, we will continue to develop relationships within the community and maintain dialogue on existing services and in the planning for future service delivery
- Consider and develop proposals to implement the General Practice Nursing Career Framework in Greater Huddersfield to improve recruitment and retention of the nursing workforce in Primary Care
- Establish and implement mechanisms with General Practice to ensure that when things go wrong, we can demonstrate that the lessons learned are spread rapidly across the system
- 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 Inspection of our provider services

## How will we measure success?

- Further develop dashboards to ensure the ability to monitor safety and patient experience measures across the local health economy
- 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
- Increasing numbers of the population of Greater Huddersfield 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 will partners in the delivery of health care having completed accreditation on the Quality for Health programme
- Deliver 62 day cancer waiting times and 1 year mortality
- Access to general practice will be improved across Greater Huddersfield
- More services will be delivered closer to where people live and work
- Learning from incidents in general practice will be shared across the member practices
- Avoidable mortality will be reduced across Greater Huddersfield
- 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

## The ‘must dos’ for 2016/17 for every local system:

1. Get back on track with **access standards for A&E and ambulance waits**, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots.

   Calderdale and Huddersfield Foundation Trust (CHFT) delivered the 95% access time for A&E in Quarters 1-3 of 2015/16. Performance in Quarter 4, January through to March has presented a significant challenge. Through the Urgent Care Board and System Resilience Group, performance is monitored through a dashboard where partners come together to discuss the system wide cause and impact. In 2016/17 we will 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. We will continue work on enhancing our system dashboard that provides oversight of; demand, access and quality.

   Yorkshire Ambulance Service (YAS)…………………

2. Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from **referral to treatment**, including offering patient choice.

   CHFT delivered the national standard for 18 weeks referral to treatment consistently throughout 2015/16. Performance across all providers was variable but overall Greater Huddersfield CCG also delivered the access standard. This meant that 92% of patient’s in Greater Huddersfield waited no longer than 18 weeks from referral to commencing treatment. In 2016/17 GHCCG will consult the public on new models of hospital based planned care ensuring that the views of those patients using the NHS are expressing their views. We will continue to 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. Together with Calderdale CCG, we will continue to lead the multi-agency Elective Care Improvement Board to ensure the entirety of the system’s capacity is utilised to meet demand with use of a system dashboard that provides oversight of; demand, access and quality.

3. Deliver the NHS Constitution **62 day cancer waiting standard**, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving **one-year survival rates** by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.

   Performance against all cancer waiting time standards has been achieved consistently throughout 2015/16 for Greater Huddersfield patients.

   What will we do in 2016/17?

   - ✓ Continue to work with Healthy Future programme to ensure alignment of plans across West Yorkshire;
   - ✓ Work with our member practices to implement the NICE suspected cancer guidance;
   - ✓ Raise awareness of cancer screening programmes and encourage uptake;
   - ✓ Work with NHS England on the recommendations set out in the National Cancer Strategy; and
   - ✓ Work with partners to develop the model for cancer as part of care closer to home.

4. Achieve and maintain the **two new mental health access standards**: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a **dementia diagnosis** rate of at least two-thirds of the estimated number of people with dementia.

   Parity of Esteem – we will ensure that there remains a focus on mental as well as physical health to ensure that patients with mental health problems do not suffer inequalities. We have enhanced our Mental Health Liaison Team Service to ensure that it meets the core national standards. Through our joint commissioning arrangements we are committed to the integrated approach to commissioning across Adult's and Children's Health and Social Care and Public Health. We will continue to work with our partners prioritising the integrated commissioning group for Emotional & Mental Wellbeing and Independence including learning disability, mental health, emotional wellbeing etc.

**What will we do in 2016/17?**

- ✓ We will improve mental health services, in line with the forthcoming mental health taskforce report, to ensure measureable progress towards parity of esteem for mental health;
- ✓ We will continue to increase investment in mental health services each year at a level which at least matches their overall expenditure increase;
- ✓ We will agree an implementation plan with a provider that delivers the EIP access standard;
- ✓ We will secure additional years of life for the people of England with treatable mental and physical health conditions;
- ✓ We will improve the health related quality of life for the 15 million plus people with one or more long term condition, including mental health conditions;
- ✓ We will continue to increase the number of people with mental and physical health conditions having a positive experience of care outside of hospital, in General Practice and the community; and
- ✓ We will support the Local Authority in the retender of the CAMHS

5. Deliver actions set out in local plans to transform care for people with **learning disabilities**, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.

   The Calderdale, Kirklees, Wakefield and Barnsley (CKWB) Transforming Care Partnership has been formed to collaboratively develop a programme that will transform our community infrastructures and reshape services for people with a learning disability and autism. The plan will be framed around Building the Right Support and the National Service Model October 2015 and it will be developed to ensure the needs of the five cohorts below are included as well as the wider population when transforming services.

   1. A mental health problem, such as severe anxiety, depression or a psychotic illness which may result in them displaying behaviours that challenge;
   2. Self-injurious or aggressive behaviour, not related to severe mental ill-health, some of whom will have a specific neurodevelopmental syndrome with often complex life-long health needs and where there may be an increase likelihood of behaviour that challenges;
   3. 'Risky' behaviour which may put themselves or others at risk (this could include fire-setting, abusive, aggressive or sexually inappropriate behaviour) and which could lead to contact with the criminal justice system;
   4. Lower level health or social care needs and disadvantaged backgrounds (e.g. social disadvantage, substance abuse, troubled family background), who display behaviour that challenges, including behaviours which may lead to contact with the criminal justice system; and
   5. A mental health condition or whose behaviour challenges who have been in inpatient care for a very long period of time, having not been discharged when NHS campuses or long-stay hospitals were closed.

   The CKWB region was rated as the 6th highest for CCG commissioned inpatient beds in July 2015 and although work has been ongoing and the number has reduced, we are still well over the national planning assumptions for inpatient beds. For NHS England commissioned beds, the region was mid table, but following several discharges since July 2015, the numbers are now within the national planning assumptions.

Each area within the partnership had already developed programmes locally to transform services, but it has been acknowledged that the partnership will prove invaluable to harness the collective knowledge and experience to further build on progress already made and to use our resources more effectively and efficiently to gain more momentum in the delivery of new models of care and support for the most complex people.

### The key aims for our plan will be:

- ✓ Reduction of inpatient beds, delivering a 60% reduction across the partnership by 2019
- ✓ Developing better/new/broader range of specialist community services that are flexible and responsive to manage crisis better and prevent admission
- ✓ Developing capable communities to enable people to live in their own homes
- ✓ Developing a better understanding of our local populations with complex needs and how best to support them in a crisis
- ✓ Ensure people with a learning disability and autism have the opportunity to live meaningful and fulfilled lives

### Population and Demographics

| Area | Total population | Adult population | LD/Autism Population | LD/Autism known to services |
|---|---|---|---|---|
| North Kirklees CCG & Greater Huddersfield CCG | 434,000 | 335,826 | 7,912 | 1,530 |

There are currently 12 people in inpatient beds in Greater Huddersfield, this is more than double the national planning assumption level, however by the end of year 1 this will have reduced by 45% and by the end of year 2 we will have achieved better than the levels suggested of inpatient beds across the partnership.

## Care and Treatment Reviews

Care and Treatment Reviews (CTR) have been developed as part of NHS England's commitment to transforming the services for people with learning disabilities and/ or autism who display behaviour that challenges, including those with a mental health condition. The CTR ensures that individuals get the right care, in the right place that meets their needs, and they are involved in any decisions about their care.

## What a CTR covers

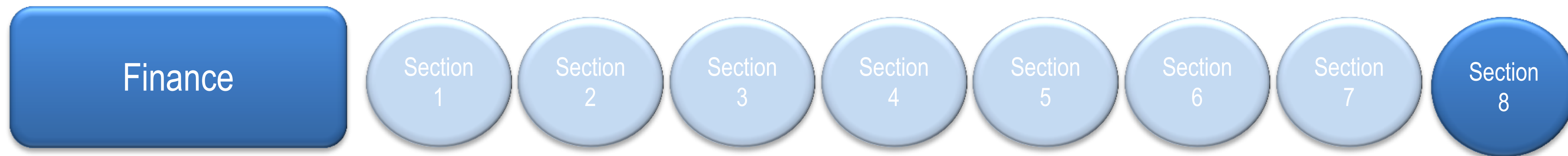
The CTR focuses on four areas: is the person safe; are they getting good care; do they have a plan in place for their future and can their care and treatment be provided in the community. They are carried out with:

- people receiving care in a specialist learning disability or mental health hospital – to see if they can move to a community setting;
- people who are at risk of being admitted to a specialist hospital – to see if there are any other options to prevent an admission; and
- for people who do need specialist hospital care – to ensure they have a care plan with clear outcomes from the start, that focuses on transferring them back to a community setting as soon as they are ready, to prevent unnecessarily lengthy hospital stays.

The CTR team involves the commissioner and two expert advisors – an individual or family member with experience of learning disability services (an 'expert by experience') and an independent clinician – to ensure that care plans meet individuals' needs. It also involves those who are providing their current care. Following the CTR, the review team makes recommendations, with follow-up checks to ensure the activity is being delivered.

The developments for LD and ASD align with the transformation to develop an early response and support for children and young people, and will support a reduction in in-patient services and minimise the impact of pre-admission CTR (care and treatment review).

The Care and Treatment reviews will ensure a clear and co-produced pathway and personalised and flexible packages will be available to ensure the transition is appropriate to meet the individual's needs. Personal health budgets will be offered whenever appropriate as the default choice for procuring a package to support the individual.




- 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
- The 2016/17 financial plan is more challenging than in previous years. It includes:
  - An allocation uplift of £8.6m
  - Draw down of £2.9m of our cumulative surplus
  - A £1.6m (0.5%) contingency fund to manage in year risks
  - A £3.2m (1%) non recurrent reserve
  - A £3.7m QIPP requirement (building on the Right Care approach)
  - Delivery of a break-even position in year.
- We have developed a recovery plan that sets out how we will deliver finance sustainability
- 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.

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. |