Public Document Pack

Leeds CITY COUNCIL

WEST YORKSHIRE
JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Meeting to be held in Civic Hall, Leeds, LS1 1UR on
Friday, 18th November, 2016 at 1.30 pm

MEMBERSHIP

Councillors

Councillor M Gibbons	-	Bradford Council
Councillor V Greenwood	-	Bradford Council
Councillor M Greenwood	-	Calderdale Council
Councillor C Pearson	-	Calderdale Council
Councillor J Hughes	-	Kirklees Council
Councillor E Smaje	-	Kirklees Council
Councillor B Flynn	-	Leeds Council
Councillor P Gruen (Chair)	-	Leeds Council
Councillor Y Crewe	-	Wakefield Council
Councillor B Rhodes	-	Wakefield Council

Please note: Certain or all items on this agenda may be recorded

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A G E N D A

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1			**APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS** To consider any appeals in accordance with Procedure Rule 25* of the Access to Information Procedure Rules (in the event of an Appeal the press and public will be excluded). (*In accordance with Procedure Rule 25, notice of an appeal must be received in writing by the Chief Democratic Services Officer at least 24 hours before the meeting.)	
2			**EXEMPT INFORMATION - POSSIBLE EXCLUSION OF THE PRESS AND PUBLIC** 1 To highlight reports or appendices which officers have identified as containing exempt information, and where officers consider that the public interest in maintaining the exemption outweighs the public interest in disclosing the information, for the reasons outlined in the report. 2 To consider whether or not to accept the officers recommendation in respect of the above information. 3 If so, to formally pass the following resolution:- **RESOLVED –** That the press and public be excluded from the meeting during consideration of the following parts of the agenda designated as containing exempt information on the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the press and public were present there would be disclosure to them of exempt information, as follows: **No exempt items have been identified on this agenda.**	

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3			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration. (The special circumstances shall be specified in the minutes.)	
4			**DECLARATION OF DISCLOSABLE PECUNIARY INTERESTS** To disclose or draw attention to any disclosable pecuniary interests for the purposes of Section 31 of the Localism Act 2011 and paragraphs 13-16 of the Members' Code of Conduct.	
5			**APOLOGIES FOR ABSENCE AND NOTIFICATION OF SUBSTITUTES** To receive any apologies for absence and notification of substitutes.	
6			**MINUTES - 21 DECEMBER 2015** To confirm as a correct record, the minutes of the meeting held on 21 December 2015.	
7			**DRAFT WEST YORKSHIRE AND HARROGATE SUSTAINABILITY AND TRANSFORMATION PLAN** To consider a report from the Head of Governace Services introducing the draft West Yorkshire and Harrogate Sustainability and Transformation Plan.	1 - 166
8			**WORK PROGRAMME** To consider reports and/or concerns identified by members of the Joint Committee and then agree its priorities and future work programme.	167 - 168
9			**DATE AND TIME OF NEXT MEETING** To be determined.	

Item No	Ward/Equal Opportunities	Item Not Open		Page No
			THIRD PARTY RECORDING Recording of this meeting is allowed to enable those not present to see or hear the proceedings either as they take place (or later) and to enable the reporting of those proceedings. A copy of the recording protocol is available from the contacts named on the front of this agenda. Use of Recordings by Third Parties– code of practice a) Any published recording should be accompanied by a statement of when and where the recording was made, the context of the discussion that took place, and a clear identification of the main speakers and their role or title. b) Those making recordings must not edit the recording in a way that could lead to misinterpretation or misrepresentation of the proceedings or comments made by attendees. In particular there should be no internal editing of published extracts; recordings may start at any point and end at any point but the material between those points must be complete.	

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: (0113) 247 4707

Report of Head of Governance Services

Report to West Yorkshire Joint Health Overview and Scrutiny Committee

Date: 18 November 2016

Subject: Draft West Yorkshire and Harrogate Sustainability and Transformation Plan

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. The requirements for local NHS commissioning organisations to develop and submit place-based local Sustainability and Transformation Plans, alongside the engagement with key stakeholders and the public, have been the subject of ongoing discussions and consideration.

2. The Draft West Yorkshire and Harrogate Sustainability and Transformation Plan (STP) was submitted to NHS England on 21 October 2016. The draft plan, alongside a public summary for consultation, was subsequently published on 10 November 2016.

3. The purpose of this report therefore is to introduce and present the Draft West Yorkshire and Harrogate Sustainability and Transformation Plan, for consideration.

4. A review of recent engagement activity across West Yorkshire and Harrogate has also been undertaken, which has informed the development of the draft plan and will help identify where further engagement on the proposals is needed.

5. The draft SPT, the public summary and the summary of recent engagement activity are appended to this report.

6. Appropriate NHS representatives have been invited to the meeting to discuss the details of the draft STP in more detail and address questions from members of the Joint Committee.

Recommendations

7. That the Joint Committee considers the details presented and agrees any specific scrutiny actions or activity that may be appropriate.

Background documents[1]

8. None.

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

West Yorkshire and Harrogate
Draft Sustainability and Transformation Plan (STP)

Public Summary

November 2016

Contents //

This is a public summary of the draft Sustainability and Transformation Plan. The draft plan submitted to NHS England on the 21 October, 2016, along with a number of other documents is available from **http://bit.ly/WestYorkshireSTP** You can leave a comment here too.

Simply click on a section title in the contents to go direct to the area of your choice.

To return to this menu - click the page number at the foot of the page

West Yorkshire and Harrogate STP //

Organisations involved include:

Clinical commissioning groups (CCG)

- NHS Airedale, Wharfedale and Craven CCG
- NHS Bradford City CCG
- NHS Bradford Districts CCG
- NHS Calderdale CCG
- NHS Greater Huddersfield CCG
- NHS Harrogate and Rural District CCG
- NHS Leeds North CCG
- NHS Leeds South and East CCG
- NHS Leeds West CCG
- NHS North Kirklees CCG
- NHS Wakefield CCG

Local authorities

- Bradford Metropolitan District Council
- Calderdale Council
- Craven District Council
- Harrogate Borough Council
- Kirklees Council
- Leeds City Council
- North Yorkshire County Council
- Wakefield Council

Care providers

- Airedale NHS Foundation Trust
- Bradford District Care NHS Foundation Trust
- Bradford Teaching Hospitals NHS Foundation Trust
- Calderdale and Huddersfield NHS Foundation Trust
- Harrogate and District NHS Foundation Trust
- Leeds Community Healthcare NHS Trust
- Leeds and York Partnership NHS Foundation Trust
- Leeds Teaching Hospitals NHS Trust
- Locala Community Partnerships
- The Mid-Yorkshire Hospitals NHS Trust
- South West Yorkshire Partnership NHS Foundation Trust
- Tees Esk and Wear Valleys NHS Foundation Trust
- Yorkshire Ambulance Service NHS Trust

Other organisations involved

- NHS England
- Public Health England
- Health Education England
- Healthwatch

Thanks also to the police, fire and rescue service, housing, independent, voluntary and charitable sector organisations involved in local plans and cross cutting programmes of work.

Foreword //

We can be proud of how our health and care teams have made major improvements to services over the past decade. The NHS is treating more people than ever before, providing services faster, more safely and in better environments.

Research and innovation is delivering world leading new treatments at the forefront of technology. Our integration 'pioneers' are joining up health and care. We are leading the way in developing new models of care that better meet people's needs in care homes, hospitals and local communities.

This history of improvement and innovation in public services is supported by a thriving third sector, excellent universities and engaged businesses.

Increasingly, we have been working together to ensure we can make the biggest changes we can to the lives of local people. We have done this with a keen eye on local variation in populations, people's needs and service delivery.

In 2016, we face the most significant challenges for a generation.

We know that we must keep innovating and improving if we are to meet the needs of our population in a tough financial climate. Demand for services is growing faster than resources. Services in some places are not designed to meet modern standards, and local people want things to be better, more joined up, and more aligned to their needs. This is clear from the continuous engagement we have with local people, as well as the changing world we live in.

Over the past six months, the leadership and staff of West Yorkshire and Harrogate health and care organisations have been working together on how we respond to these challenges.

We have been linking with existing plans and seeing how we deliver ambitious improvements for people in Bradford District and Craven, Calderdale, Harrogate and Rural District, Kirklees, Leeds and Wakefield.

This summary is an overview of our draft plan which sets out our high level proposals. These proposals are built on the ongoing work that has taken place locally through Health and Wellbeing Boards and local partnerships.

Over the next six months we will continue to work together to engage with Health and Wellbeing Boards, staff and the public, to further develop our draft plans and build on engagement activities to date, ensuring the involvement of everyone in future conversations around proposals for change.

The NHS and local councils in West Yorkshire and Harrogate commission care and treatment for 2.6 million people.

Every day a network of providers work across the whole social spectrum, engaging people from birth to death, head to toe, inside and out.

Our 113,000 staff are entrusted with a budget of £4.3 billion.

Rob Webster | CEO, South West Yorkshire Partnership NHS Foundation Trust

On behalf of the leadership of West Yorkshire and Harrogate.

Our vision //

Our vision for West Yorkshire and Harrogate is for everyone to have the best possible outcomes for their health and wellbeing. At the heart of this are the following ambitions:

Healthy places

- We will improve the way services are provided with a greater focus on **preventing illness**, or identifying and managing this at an early stage wherever possible.
- We will support people to manage their own care, where safe to do so, with **peer support** and technology provided in their communities to help with self-care.
- Care will be **person centred**, simpler and easier to navigate.
- There will be **joined-up community services across physical and mental health** as well as much closer working with **social care**.

High quality and efficient services

- **Hospitals** will work more closely together, providing physical and mental healthcare to a consistently high standard by organisations sharing knowledge, skills, expertise and care records, where appropriate.
- The way that services are designed and paid for will change. We will move to a **single commissioning arrangement** between Clinical Commissioning Groups (CCG) and local councils. This will ensure a stronger focus on local places and engagement. There will also be a stronger West Yorkshire and Harrogate commissioning function for some services.
- We will share our **staff and buildings** where it makes sense to do so; to make the best use of the resources we have between us and to help further service investment.

A health and care service that works for everyone, including our staff

- West Yorkshire and Harrogate will be a **great place to work.**
- We will always **work with people** in how we design, plan and provide care and support.
- West Yorkshire and Harrogate will be an international destination for **health innovation**.

Our approach //

In these tough times, we want to deliver the best outcomes we can for everyone. This will mean more emphasis on the places people live and on closer working between organisations. There will be less of a focus on competition as a means of driving change.

Closer partnership working is at the very core of our STP. Over the past six months the leadership and staff of the West Yorkshire and Harrogate health and care organisations have been working hard on how we respond to the challenges we face, whilst delivering quality care and working towards achieving our vision.

Our STP area covers eleven Clinical Commissioning Groups (which design, specify and buy care for local people), six local council boundaries, as well as services provided by a number of health and social care organisations, GP practices, mental health trusts, community therapy, care and nursing providers, and our hospitals. Over time these organisational differences will become less important. We want to put people and communities above individual organisational boundaries.

West Yorkshire and Harrogate STP area

West Yorkshire and Harrogate has a diverse population, with different health and social care needs. We believe that for the majority of services, these needs are best met on a local level through closer partnership working.

Our approach starts with these local places and Health and Wellbeing Boards, which have existed since 2012. They have been developing local health and wellbeing strategies based on the needs of local people. They bring together the NHS, public health, adult social care and children's services, including councillors and local Healthwatch. They plan how best to meet the needs of local people and tackle local inequalities in health. They provide a way of ensuring that local people have a strong voice.

The West Yorkshire and Harrogate STP is built from six local area plans: Bradford District & Craven; Calderdale; Harrogate & Rural District; Kirklees; Leeds and Wakefield. This is based around the established relationships of the six Health and Wellbeing Boards and builds on their local health and wellbeing strategies.

These six local plans are where the majority of the work happens. We have then supplemented the plan with work done that can only take place at a West Yorkshire and Harrogate level (see page 22). This keeps us focused on an important principle of our STP - that we deal with issues as locally as possible.

Our draft STP is based on a set of principles: we are ambitious; we do the work together; and we deal with issues as locally as possible.

What this draft plan means to you and your family //

In developing these proposals we have thought about health and care services in three ways:

- What do we need to do to help you stay healthy and well?
- What do we need to do to improve the quality of care and services you receive when you need them?
- What do we need to do to address the finance and efficiency challenge we face?

Health and wellbeing: helping you to stay well

With a population of 2.6 million people living in West Yorkshire and Harrogate, we know there are pockets of deprivation and areas of affluence. Where you live can determine your life chances and we need a new approach to make sure all people have the chance to live longer, healthier lives.

There are higher than average childhood obesity levels and 50% of people are overweight in West Yorkshire and Harrogate. Over 200,000 people are at risk of diabetes and we want to reduce this number by a quarter by 2021.

Alcohol is also a major concern. There are around 455,000 heavy drinkers across the area. This has a major impact on people's lives and the cost of care. We want to reduce the number of people admitted to hospital because of alcohol by 500 every year and also the number of ambulance call outs for related incidents.

Mortality is higher than average for those with serious mental health concerns and we want to work together to reduce the number of people taking their own lives. To do this will involve sharing information, awareness raising and local suicide prevention strategies.

West Yorkshire and Harrogate has significantly worse rates than other parts of England for cardiovascular diseases (CVD), which are conditions affecting the heart or blood vessels that cause damage to the brain, heart, kidneys and eyes. It is one of the main causes of death and disability in the UK, but it can often be prevented with a healthy lifestyle. We want to reduce 10% of CVD incidents across the area by 2021.

Where you live has a major impact on your quality and length of life, for example there is a 11 year difference for men depending on where they live in Leeds and a 10 year variation for women in Calderdale. This is clearly something we want to address.

People who smoke increase their probability of lung cancer, heart and respiratory disease, such as asthma and chest conditions. In the case of pregnancy this can lead to real health issues for both mum and child.

4 in 10 cancers are preventable through lifestyle choices. For example we would like to see 125,000 fewer smokers in West Yorkshire and Harrogate and increase the one-year survival rate from all cancers to 75% by 2021, with the potential to save 700 lives each year.

Some good work has already been done but we need to improve the health and wellbeing of both young and old, including those with physical and learning disabilities - so that we can improve people's quality of life and prevent them going in to hospital or care homes, unless absolutely necessary.

We know that people prefer to remain at home, independent and safe, for as long as possible and we want to fully support this.

Improving people's health and wellbeing

Reduce the number of smokers by **125,000** by 2021
226,000 people at risk of diabetes, we want to reduce this by a **quarter** by 2021
Reduce number of people admitted to hospital due to alcohol by **500** a year
Increase the one year survival rate of people with cancer to **75%** by 2021 with a potential to save **700** lives a year
By **2021** we want to adopt a philosophy that all suicides are preventable, aiming to reduce the number of suicides by up to 75% as part of the **five year** forward view for mental health.
Reduce the number of people experiencing a CVD incident by **10%** across the area by 2021. This would mean **600** people in Bradford alone.

Care and quality: making sure the right care is there when you need it

We want to ensure that the majority of our services remain high quality and offer a good personal experience. At the same time we want to address the fact that for some people and some populations the service falls below the standards and expectations we have set.

We want to make sure services work together to support you and your family. We will build on the prevention work outlined in the previous section to ensure that everyone gets the best start in life and has the opportunity to age well. This means joined up services for new mums and families that build on traditional health visiting, community services and sees education, health and care working together. This will include new "perinatal" services that give mental health support to new mums at their most vulnerable time.

Over 4 million people live with diabetes in the UK and this number is increasing. Thousands and thousands of others live with long term conditions, such as asthma and mental health problems like depression.

Increasingly, we will make sure that you are supported to self care, with technology and peer support networks providing better opportunities for monitoring and management of your health condition. We want to harness the power of peer supporters, expert patients and similar developments for everyone who would find this helpful.

Organisations, including the NHS, local councils, voluntary organisations and other public sector services, need to work closer together to deliver more 'joined-up' health and care. This coordination of services will help to improve the quality and experience of care.

This is particularly true for people with multiple issues and conditions. We will make sure that frail older people, children with complex needs and similar groups have a joined up team that supports them to live their lives. **In doing so we will have a modern health system that looks at people's physical, social and mental health needs.** We will increase access to psychological therapies for people with common mental health conditions (25% of people to receive these services by 2020/21), co-locating these services in primary care.

We will transform care standards for people with a learning disability, so that health assessments in general practices are the norm, good and safe specialist assessments for people are available and locally based residential care is there for people who need it.

We also plan to better organise and simplify urgent and emergency care so you get the very best care, at the right time, in the right place. This will mean clearer coordination and better organisation of urgent care services (including primary care, such as GP and pharmacy services, mental health, ambulances A&E and urgent care centres) so they work together and you know where to get the help you need.

We aim to improve on our four hour accident and emergency standard by March 2017 to ensure 95% or more of people are seen, assessed, admitted or treated and discharged within four hours, and we will continue to improve on this.

The demand for planned care (when you have a booked appointment to see a specialist or have an operation) is placing ongoing pressure on services.

Unfortunately as a result people are waiting longer for appointments - we aim to address this and ensure that we meet our 18 week referral to treatment standard over the next five years across the area. In addition, we will tackle hidden waits in mental health services to ensure that we meet modern standards for mental and physical health.

Improving patient experiences, choice and delivering high quality, safe care across seven days of the week is also a priority.

We want to reduce avoidable emergency admissions, and the reduction in time someone will stay in hospital unless absolutely necessary. Our intention is to support more people in the community so they don't end up being admitted or readmitted to hospital – this is where hospital avoidance schemes can make a huge difference alongside better alternatives to being in hospital.

Our targets for change

95% of people attending A&E will be seen in **4 hours**, by 2017
92% of people will be seen by a specialist within **18 weeks** and we will deliver these standards in physical and mental health services
Supported self care for **all people with a long term condition**, with peer support and access to technology designed for your needs
A move to **25%** of the appropriate population accessing psychological therapies in their community and increasing the levels of recovery
Regardless of where you live, your experience of services will have improved by **2021**
A new **28 days** standard to cancer diagnosis will be introduced
Reduce the number of people with mental health concerns going to A&E by **2021** and bring their care closer to home
Increased focus on common thresholds for care and treatment to meet standards and **reduce postcode variations** in care.

Finance and efficiency: making the money add up by 2020/21

It's great news that people are living longer than previous generations, but the reality is that up to two thirds of people in the UK could spend their retirement years in ill health.

An ageing population, people living longer with complex health and social care needs, means we have to change if we want to improve people's quality of life and meet the challenges we face together with the money we have available.

The health and social care economy in West Yorkshire and Harrogate has growing income in the coming years. This funding for the NHS is not growing as fast as demand for care and pressures on local council budgets continue, particularly in social care and public health.

The growth funding for the NHS allocated to our draft STP is also lower than the national average and funds for training doctors, nurses and therapists have reduced. This means, unless we change the pattern of demand and make services more efficient, we could face significant financial pressures in excess of £1billon between now and 2021.

We will approach this challenge together. We will develop solutions in our local areas as well as taking collective measures across West Yorkshire and Harrogate.

The way we will meet this challenge falls under the following categories:

We currently have an annual budget of £4.3 billion; by 2021 it will increase to £4.7 billion. However it's important to note that if we delivered care in the way we do today, with no change and no efficiencies, the cost would be at least an extra £1 billion every year by 2021.

Delivering care more efficiently, £0.5 billion
We will look to drive efficiencies in the way we deliver care, focusing on reducing duplication and differences in service delivery. This will include reviewing how and where services are delivered, sharing administration and releasing funding for front line care.

Providing the right care to everyone who use our services, £0.3 billion
This involves a different relationship and a new approach to the way we deliver services across both health and social care services. Our focus will be on early help and support, making sure the services we offer meet the needs of everyone sooner rather than later.

This will include helping you to take more control in the management of your care, where safe to do so.

Programmes delivering savings across the area, £0.1 billion
We will look to deliver savings by acting once across West Yorkshire and Harrogate. This will focus on our organisations working in partnership to deliver efficiencies, reducing variation in service provision, and working together to deliver better services for everyone at reduced cost.

Securing our fair share of sustainable funding, £0.2 billion
Our draft plan assumes that additional funding, called Sustainability and Transformation Funding, will be available to us so that we can deliver our plans. Some of this funding will be used to help make the changes happen, whilst some of this money will be used to support existing services

We know this isn't an easy message – it will be a challenge and difficult decisions will need to be made.

West Yorkshire and Harrogate local plans //

If we are to make the most of our resources, we need to focus on keeping people well through healthy places and joined up care in communities. By having six local plans, we can make progress on both.

Since 2012, local councils have been responsible for improving the public's health. This means a focus on health, education, housing, the environment, and the economy.

For people who need support, most of the care you and your family receive is delivered in communities. Social care, community therapy and nursing visits, GP contacts and trips to your local pharmacy, can reduce the number of A&E attendances. This community and home based care needs a greater focus and investment.

This is reflected in all six of our local delivery plans as they consider communities - from Luddenden to Laisterdyke, Harrogate to Honley, Wetherby to Wakefield and all points in between. Each plan is different as it reflects local people's needs. However, each plan also contains a number of common themes too. These are covered in the next section.

Prevention and early intervention

We are working in every one of our six areas to improve the way services are provided with a greater focus on early help and keeping people well. This involves helping people earlier rather than later, for example supporting people to stop smoking, when we know this is the major cause of cancer and working with families who have problems sooner rather than later.

Plans vary according to the needs of local people: this includes tackling obesity, smoking and heavy drinking; making sure that children get the best start in life; and that we reduce the risk of dementia through addressing lifestyle risks. Well targeted health support can help keep people in work. This in turn can improve people's wellbeing, including their mental health, preserving their livelihoods and keeping them in employment. It is also good for the region's economy.

Having a good coordinated set of prevention activities, for example working earlier with people at risk of diabetes, should result in a reduction in admissions to accident and emergency; decrease the numbers of people living with long term conditions and fewer avoidable early deaths.

We also know that early help for children, families and adults is not only better for the person but can prevent or delay the need for more costly social care services in the future.

For example Kirklees are developing a new early help model for children and families, so they get support sooner rather than later.

Spotlight on children

To address some of the biggest health and care challenges we face we will need to create stronger and broader partnerships within our towns and cities and across our region.

We already have great examples of where this is happening, like the Child Friendly City initiative in Leeds. Over the past four years the city has made a big effort to get more people involved in making a difference on some of the most important issues relating to children and young people, things like improving school attendance, increasing youth education, employment, training and keeping the most vulnerable children safe.

A positive and wide reaching campaign has led to major businesses, sports clubs, well-known people, public and third sector partners and even the local media, working together towards some common goals and doing more to support things like fostering and 'family and friends care'. A combination of new approaches and different attitudes have made an impact, for example by working with families and local communities, Leeds has safely and appropriately reduced the number of children and young people placed in care by around 250. This gives them better life chances and saves a significant amount of money. If we can take the support we've seen for children and young people and apply it to some of our other big health and care challenges we could see a real step change.

Recent engagement work has shown that people want clear, easy to understand information, more involvement with communities and investment in voluntary and community services. You have also told us that not being involved in care decisions about you, has a negative impact on your wellbeing and health professionals should communicate more with you. In delivering and designing services, we will ensure that there is significant engagement in plans to address these issues.

The development of a thriving voluntary community sector can help greatly with our focus on early help, for example healthy child programmes, which bring together, health visitors, school nursing, support for families, not only from health and social care, but from community organisations too.

Development of community support for families, preventing illness and elderly loneliness is also important.

A new alcohol liaison service at Pinderfields Hospital means we can target people with drink related illness and injury. The aim is to provide people with a seamless transfer from hospital into community support services to help them reduce the risk of alcohol-related problems in the future.

Primary and community services

Primary care includes a wide range of services supporting the health and wellbeing of everyone in the community, including your local GP, pharmacies, mental health and social care. We know that people's experience and trust of primary care services is generally very high, but we have also heard that services are not as convenient to some as they would like them to be particularly out of core daytime hours (8.30am to 6.30pm), and that some people would like to receive services on evenings and weekends.

Primary and community care has been the subject of a number of engagement activities across West Yorkshire and Harrogate. The content of conversations varies across the local area from broad engagement on primary care to specific service areas. In summary there are a number of themes that are emerging across the West Yorkshire and Harrogate area which need to be considered in future commissioning arrangements.

This includes improving access to appointments and buildings; in particular help for urgent care issues, looking at the delivery of walk-in centres and increasing the range of services available at GP practices. We believe that this will help to address the number of people who attend emergency departments when they could have seen a health professional near to where they live. There are already good examples of where this type of service is being provided during evenings and weekends, for example in Wakefield. We want to review and potentially build upon this across the whole of West Yorkshire and Harrogate to provide services that are convenient to everybody.

In the future we would like to have more care delivered in local community and primary care settings rather than needing trips to the hospital. This means many of the tests, investigations, treatments for minor injuries and minor surgery that are usually provided in hospital can be provided nearer to home. We will consider the use of our buildings and how well equipped they are. This will help us to plan where we can provide services nearer to you and your family and closer to your home. In addition, we want to take this opportunity to think about what other services could be provided under one roof. This could include physiotherapy and citizens advice services. This would mean that you would be able to receive a range of services in one location that could meet both your health and social needs.

We hope to see more GPs in training and working together more closely with community and mental health services. Our aim is for you to see the right person, in the right place at the right time. By working in teams, health and social care professionals can provide advice and treatment for you together, instead of you needing lots of appointments at different departments.

As GP practices work more closely together, they could in the future begin employing consultants who have the specialist skills to manage your health condition in the surgery. This will also provide the opportunity to develop services that include senior nurses, hospital doctors, geriatricians, paediatricians and psychiatrists to work alongside community teams. In addition to this we would also like pharmacists, psychologists, social workers, and other staff to be part of community teams as we develop our workforce.

Our aim is to keep people healthier for longer and enable them to stay at home and not in hospital. By developing and improving primary care services it will help you and your family stay healthy and independent.

We want to work with primary care to develop existing services that address lifestyle changes. This means supporting people to stop smoking, support for losing weight and how you can do more exercise to keep fit. This will mean less chance of you developing the kind of serious illness that needs hospital treatment in the future.

Our draft plans include how we will improve in-hours and out-of-hours access to primary care so that you can get the professional advice you need, when you need it.

Advice and support should be as convenient as possible for you to get, including making the best possible use of smart phones and digital technology. We want to work with our practices so that you can easily book an appointment and request a repeat prescription on line and if you want to, be able to see your medical records. As part of making the most of technology we will also think about video/skype type of appointments, which are being used successfully in other parts of the country already.

Bradford, District and Craven is known nationally for its work in digital healthcare, in particular providing 24/7 face to face consultations. This is something we want to do more of across the area.

In Harrogate and Rural District we want to reduce the number of children aged 10-11 years who are overweight.

We also want to increase the number of people in Leeds having bowel screening by 3%.

In Wakefield we want to reduce the number of young people not in education, employment or training.

Supported self-care
People with long term health conditions spend most of their time looking after themselves. We want to support them to do this as they want more focus on preventing illness, so they can stay well.

To support this they felt that more information about healthy lifestyle choices should be available with professionals having the relevant skills and knowledge to advise them on any changes they may want to make.

Each of our local plans support people to take greater control and management of their long-term health conditions.

Spotlight on self-care

Locala is a community health care provider. They use the term maximising independence (MI), which was originally informed by a listening exercise with staff, patients and carers to describe the approach they take to support people to be as confident and independent as possible when managing their own care in Kirklees.

Locala's integrated community health care teams include community matrons, district nurses and therapists.
The self-care work has involved a training programme that has helped over 1000 staff to use evidence based behaviour change and health coaching techniques. The training has helped people to manage their own care.

Evidence shows if more time is invested upfront with people to address their needs holistically then less time is needed on follow up visits. Most importantly this improves the care delivered and the person's quality of life.

Locala has also successfully used technology to improve how care is delivered, for example skype consultations.

Records are also shared between health and social care professionals so that people tell their story only once.

An outcomes framework has been developed by Wakefield Public Health which will provide a snapshot of data across the area. Several indicators refer to understanding how people feel they are supported to manage their condition, so they understand their long term conditions better, for example those with mental health concerns. This helps to identify further areas for improvement.

We will support self-care and preventing illness by helping you to manage your health safely. This will include training our workforce to work alongside you so that self-care and early support will be the norm.

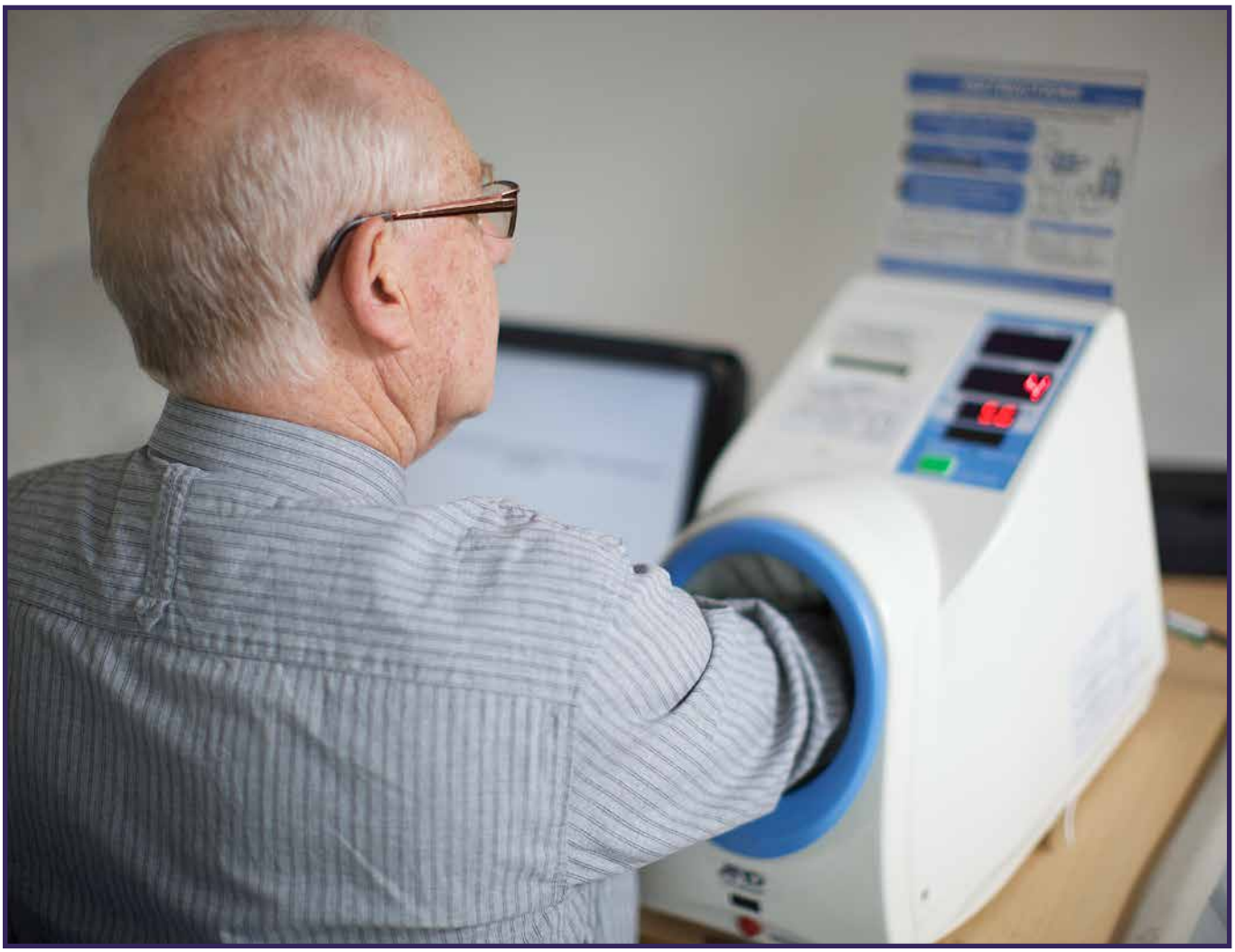
Around 15 million people in England have one or more long-term health condition. The number of people with multiple long-term conditions is predicted to rise by a third over the next ten years.

35% of people living with long-term health conditions have low knowledge, skills and confidence to self-care. This results in a rising demand in urgent and emergency care, including A&E attendances and emergency admissions.

Most importantly we know this is not what people want – they want to lead a healthy life as much as possible and supporting people to self-care can help.

People with long-term conditions are the most frequent users of health care services, accounting for 50% of all GP appointments and 70% of all inpatient bed days.

35% of people with diabetes live with diabetes plus other long-term conditions.



Joined-up services

When services are provided by different health and care organisations they often feel disconnected from one another. We have also heard that people want services that consider all of their needs together rather than different services for different conditions.

We are trialling new ways of providing services that bring together organisations to better meet peoples' needs. We believe that these new models have the potential to offer a better experience of care as well as being more efficient and cost effective. We will learn from these trials, rolling them out wider if they work well.

We're learning from our Vanguard programmes on urgent care, care homes and community services. We are building on the integration pioneer work done in Leeds and a long history of joint work in Calderdale, Kirklees and Bradford. Each plan sets out opportunities to look at new models which make these joined up services a reality for everyone.

Spotlight on community care

We are joining up care services for people who live in care homes or supported living accommodation. GPs, care home staff, volunteers, a specialist doctor, nurses, pharmacists, therapists and mental health workers are pooling their resources in about a quarter of care homes in Wakefield. The aim is to help people to have healthier lives, with a better sense of wellbeing so that they don't need to keep going in and out of hospital.

We will help you to better understand how pharmacies and on-line resources can help you deal with coughs, colds and other minor ailments without the need for a doctor appointment or accident and emergency visit.

West Yorkshire and Harrogate shared work //

Over the past six months the leadership and staff of the West Yorkshire and Harrogate health and care organisations have been working together on how we respond to the challenges we face.

To support our six local places we are carrying out a range of work collectively across the STP wide area.

When we work in this way it is for one or more of three reasons:

- Services cut across the area and beyond the six local places.
- There is benefit from doing the work once and sharing, so we make the best use of the skill and expertise we have.
- Working together can deliver a greater benefit than working separately.

On this basis we have identified nine priorities for which we will work across a larger area.

These are:

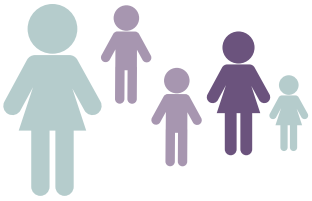
- Prevention
- Primary and community services
- Mental health
- Stroke
- Cancer
- Urgent and emergency care
- Specialised services
- Hospitals working together
- Standardisation of commissioning policies.

Prevention

Prevention has been identified as a priority in each of the six local plans. Given the importance of this work we are keen to share learning, skills and expertise to ensure best practice is rolled out across the area. We are doing this with a focus on the biggest causes of ill health.

This work is led by Directors of Public Health from across West Yorkshire and Harrogate and its focus is on smoking, obesity, alcohol, and ensuring that our workforce is supporting health promoting behaviours as it provides care to ensure every contact counts.

In our area there are



379,836 smokers

455,000 heavy drinkers

1.3 million people overweight

We want to make every health and social care contact count for you.

Primary and community services

Like prevention, our work at West Yorkshire and Harrogate level is designed to help local places take forward programmes to deliver better primary and community care. This work brings together primary and community care leaders to help design what the important parts of an effective system are. This includes breaking down organisational barriers, looking outside the clinical model to develop a service that meets social needs too - making sure people are always at the centre of their care.

We are currently working with local GPs to explore new ways of working. For example, some practices are working together in a hub to provide appointments on an evening and weekends. This means that people are able to see a doctor or other professional at a range of different times.

In other places teams of expert patients complement doctors to deliver peer and social support.

Mental health

We will work together locally and at a regional level, to make sure that mental health conditions are treated the same as physical health issues. Local mental health services will be integrated with physical health and care services. This will ensure we care and treat the 'whole' person tailoring care to the person's need; supporting people with long-term conditions to cope with anxiety or depression, and ensuring people only go to hospital when absolutely necessary.

We are developing services across the region to reduce difference in the quality of care people receive in order to improve their wellbeing and make services more effective and efficient for the future.

This includes working to introduce coordinated management of mental health in-patient beds across the area with the aim of reducing people being placed outside the region and eliminating this where better for the person. We know that people receiving care near their home and support network much improves their health and wellbeing. Our aim is that hospital stays will only take place where appropriate, and where needed only for a minimum length of stay.

Good progress has already been made on the development of services to improve the experience and care for people in crisis. For example 'Safer Spaces' have been developed so that adults and children and young people in crisis have a safe alternative to go instead of emergency departments, police cells or being admitted to hospital an in-patient unit. The plan is to roll these out to other parts of the region. We are also working to ensure that there is a service that places mental health nurses in police control centres, in place across the region assisting the police with people in crisis. This will include reducing by 50% the use of police powers around Section 136 of the Mental Health Act.

Alongside this a region wide multi-agency suicide prevention strategy is also being developed with awareness and understanding at the heart of this work. We will look at international best practices that have reduced the number of suicides by 50%.

Professionals in this area of expertise have also identified further services where working together at a West Yorkshire and Harrogate level would be beneficial. This includes attention deficit hyperactivity disorder (ADHD), autism, eating disorders and perinatal services (from when pregnancy begins to the first year after the baby is born). We will be working with our staff and people who use our services to develop and take forward our draft plans. This will impact on all parts of the system, including a 40% reduction in unnecessary A&E attendance.

Stroke

In 2013 there were 3,915 stroke admissions into West Yorkshire and Harrogate hospitals. 74% of people who had a stroke were in the 65+ age group with most aged over 75 years (52% of all strokes).

Nationally and locally lots of work has taken place to improve outcomes for patients who suffer stroke. Progress in improving stroke care over the past 10-15 years has also increased the demand for the provision of specialist services. This has led to some of our hyper acute stroke services experiencing difficulty in recruiting and retaining the skilled workforce needed to meet these demands.

Differences may exist in outcomes and quality of services for people. In order to reduce any differences we are working with local health professionals and those who have had a stroke to make sure care across services is working to meet the needs of people, from prevention, primary care and community services to stroke and after care.

Working differently together to transform services offers us new opportunities to meet increasing demands for stroke care and to make the most of our existing resources more effectively.

There will be a consistent approach determined by health professionals and stakeholders across West Yorkshire and Harrogate to reduce any differences.

We've already worked together to detect and treat atrial fibrillation. Atrial fibrillation causes a fast and erratic heartbeat which is a major factor of stroke.

In order to ensure sustainability across the area it requires that we focus on hyper-acute stroke services. We will work across the region to deliver the best possible outcome for those affected by stroke.

We currently have five hyper-acute stroke units in West Yorkshire and Harrogate and we know that this may not be viable for the future.

Depending on where you live, some people have better experiences and access to services than others. By changing the way you receive care after having a stroke, we can make our services safer and of a higher quality whilst also reducing your chances of living with a disability afterwards.

This may mean we will need to reduce the number of hyper-acute stroke units across West Yorkshire and Harrogate, so that our services are as safe as possible. In doing so, we will save more lives and ensure better care and quality of service for people, including a consistent service over 7 days.

Over the coming months we will work with you to understand the options for delivering stroke services.

Engagement and consultation with the public will follow in 2017 to ensure high quality sustainable hyper-acute stroke services for all.

Cancer

Cancer has been recognised as a particular big issue in West Yorkshire and Harrogate. Every week 250 people in West Yorkshire are diagnosed with cancer and sadly 115 people will lose their fight against this every week.

Cancer patients touch each and every part of the health and social care system and therefore to be effective we need to plan across the whole of the system and not in isolation. What cancer patients do not want, nor recognise, are artificial boundaries between organisations. Understandably, we all want the very best for ourselves and our families irrespective of which organisation is responsible at any given time point.

The STP process allows us to plan across boundaries and to put the person firmly centre stage. It allows us to wrap the system around people and in so doing improve the quality of care they receive.

If we work together, we can hope to realise our three key ambitions:

1. Prevent cancer where possible.
2. Make more cancer curable from 40% to 60%. This means 3,000 more people receiving survival enhancing treatments.
3. Increase the reach and impact of people's feedback to improve services.

Public Health England, NHS England, and Yorkshire Cancer Research will launch a new report this autumn, aimed at all stakeholders involved in commissioning, delivering, or receiving cancer services across the area. We will work closely with this partnership to take forward these important report findings.

With four in ten cancers preventable by changing lifestyles and behaviours, the risk factors like smoking, poor diet and physical inactivity, obesity and alcohol in our communities continue to cause concern. The cancer rate continues to increase at a faster rate than improvements in survival.

This makes it essential that all cancer health services, care providers and charities work together, especially in terms of prevention, risk reduction and people's experience.

Our aim is to make sure that 95% of all people referred for cancer investigation are diagnosed within 28 days.

Urgent and emergency care

There has been engagement or consultation on urgent care across specific areas of West Yorkshire and Harrogate.

People report high levels of satisfaction with the service they receive in A&E. They have confidence and trust in A&E and believe it provides the best place for them to get care, but urgent and emergency care is provided outside A&E by other health professionals.

Many people believe A&E provides a convenient place to go. It can provide reassurance that an injury or condition is not serious and does not need further treatment, and it is perceived as offering the highest level of expertise, with access to diagnostic equipment, such as x-rays. However medicine has changed – GPs, ambulance staff and people working in a wider range of services can and do provide urgent and emergency care.

We know that this is a challenging area of work. Getting the balance of who and why people attend A&E, and putting other safe options in place, will mean that fewer people need to be admitted to accident and emergency services.

Our vision for urgent and emergency care is that we should provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients, carers and families. For those people with more serious or life-threatening emergency care needs, we should make sure they are treated in centres with the right expertise and facilities to maximise the prospects of survival and a good recovery.

We will continue to engage with our staff, and the public about these proposals and what this will mean for you.

People are worried that proposals to change the way emergency services are currently provided will lead to further problems, including increased mortality rates, longer waiting times and greater demand on services.

We are working together to ensure that there is excellent, quality, integrated emergency and A&E services in and outside of hospitals, providing the best care for people.

Our work is focused on:

- 'Hear, See and Treat' – delivery of a Clinical Advice Service (CAS), 111 and out of hours service, working across Yorkshire and Humber to integrate 999 with 111 services, and developing the ambulance service to provide a treatment service by March 2017. So that people get the right access to the right people at the right time.
- Primary care – building on the local development and delivery of new care models to manage the urgent needs of people and the delivery of direct booking from 111 and out of hours to extended and in-hours services.
- Delivery of a Pharmacy Urgent Repeat Medication Service (PURMs) across West Yorkshire in partnership with chemists .
- Work together to deliver seven day services across the clinical priority areas (vascular, stroke, hospital paediatrics and cardiology).
- Technology - improving access to a person's care record with an increasing amount of information available. Remote working facility for clinicians, a care record for 999 staff and direct booking arrangements.

A&E proposals require a lot more consideration and we need to raise public awareness around the difference between urgent and emergency care services. People want to see 24/7 access to include an out of hours primary care service / urgent care service that is co-located with A&E. Through the co-location of urgent care services on one site, people can be assessed appropriately to the necessary emergency or urgent care service. It would relieve the pressure in the A&E. Further work is underway.

The West Yorkshire and Harrogate Urgent and Emergency Care Network oversee the improvement of urgent and emergency care for everyone who lives here.

Healthwatch delivered an engagement programme on 'Hear, See and Treat'.

Overall, 147 face to face sessions were held across the area, supported by a social media campaign that reached over 300,000 people. The majority of people who responded were supportive of the proposed model. They felt that it would ensure that only those people that needed to attend A&E would do so. It was thought that this would lead to a reduction in the inappropriate use of ambulance services and reduction in A&E admissions. This would mean people would be seen quicker, which would result in an improvement of care.

Specialised commissioning

We are working to ensure that specialised services are designed to ensure that they are located where they are needed and we have enough of them to meet local people's needs, for example patient care, mental health support for young people, specialised weight loss, help for people with brain injury and HIV services.

Specialised services are those provided in relatively few hospitals, accessed by small numbers of patients but with catchment populations of usually more than one million. These services tend to be located in specialised Hospital Trusts that can recruit a team of staff with the appropriate expertise which helps them to develop their skills. These include a range of services from renal dialysis and secure inpatient mental health services, through to treatments for rare cancers and life threatening genetic disorders.

Our approach to commissioning specialist services is two-fold. First to manage the demand for specialist services e.g. reduce the increasing demand for the treatment of obesity surgery through preventative approaches to tackle weight management across the whole of West Yorkshire and Harrogate, which is planned and delivered by local places in line with the needs of local people.

Secondly the provision of specialist services and how this is planned and delivered to make sure services are sustainable and fit for the future. This will mean services will be provided through a networked approach. To do this we must plan together at a Yorkshire and Humber level.

We have a proud history of world leading research and development of ground breaking treatments in mental and physical health. We will continue to ensure that these are supported through specialist networks.

Hospitals working together

There are significant challenges across the area for our hospitals.

Local hospitals will work in partnership with one another to give you access to the very best facilities and staff. This could mean care will be provided by a team of expert medical staff who work together across a number of hospital sites within a single, high quality service. All hospitals within the single service will benefit from this networked approach. You would receive the very best care - at your nearest hospital wherever possible and at a centre of excellence if required. This approach has been proven to save lives.

Local people have been involved in the proposals for how hospital and community services will be provided in the future, such as Calderdale and Huddersfield, Wakefield and North Kirklees.

We are working with our hospitals to see how they deliver care together. Our hospitals have created the West Yorkshire Association of Acute Trusts, involving Leeds, Bradford, Calderdale and Huddersfield, Airedale, Mid-Yorkshire and Harrogate Trusts. They will look at consolidating back office and support functions, for example payroll and estates. They will also review clinical services, including hyper-acute stroke, head and neck cancer, vascular, pathology and radiology services. Working together they will ensure we 'get it right first time', with standard procedures. They will support centres of excellence delivering world class care.

These plans will mean higher standards of care, for example reducing waiting times in accident and emergency as well as the length of wait before you get to see a senior doctor.

Hospitals already specialise in providing certain types of care. For example, some specialise in stroke, others in cancer care. In the future we will see single services with hospitals specialising in emergency general surgery for patients with life threatening conditions – creating these centres of excellence networked with local hospitals will help to save more lives.

Working in this way ensures that doctors working within these teams are performing the same procedures day in, day out, building up excellent levels of expertise in treating these complex conditions.

If you call an ambulance, paramedics will decide which hospital to take you to for the specialist care you need. If you attend hospital yourself, doctors there will assess you and, if you need to go to another hospital, they will arrange for you to be taken to the appropriate one. If you are transferred to a specialist hospital, once you are well enough, you will be transferred to your local hospital or home to recover. Extensive work will be carried out to make sure that you and your family will be able to get to any of the specialist hospitals within a reasonable time.

Standardisation of policies

There is a big opportunity to standardise our commissioning policies and reduce difference for people receiving health and social care across West Yorkshire and Harrogate – often referred to as a 'postcode lottery'. This helps to ensure that what care people receive is fair and consistent no matter where you live. It also supports the work of hospitals and the professional support available and given. This is divided into four key areas:

- Health and wellbeing – making sure that people are as well as they can be before surgery.
- Clinical thresholds – which determine an appropriate treatment.
- Follow up management – making sure you are only invited for a hospital follow up appointment when necessary and making the most of technology to provide further consultation as needed.
- Prescribing treatment and medicines – making sure they are best value for money.

Our proposals will take into account all of the West Yorkshire and Harrogate area, and will connect to the work of local Clinical Commissioning Groups.

We will be having more discussions with Health and Wellbeing Boards about these proposals over the coming months. We aim to have a standardisation of commissioning policies in place across West Yorkshire and Harrogate by 2021.

We have started community conversations via Healthwatch in some of our local areas. This has included asking for people's views on:

- Gluten-free foods
- Procedures for managing individual funding requests and restricted treatments
- Branded medicines
- Medicines management
- 'Stop before your OP' – a campaign to encourage people to stop smoking to support people prior to having a procedure.

Supporting change //

All of our proposals are about improvement and change.

To do this we must:

- Create the right workforce, in the right place with the right skills, to deliver services at the right time, ensuring the wellbeing of our staff.
- Engage our communities meaningfully in co-producing services and making the right choices, including on difficult decisions.
- Using technology to drive change and create a NHS fit for the future.
- Place innovation and best practice at the heart of what we do, making sure that our learning benefits the whole of the area.
- Ensure we have the best commissioning structures in place to push through change.

Strategic commissioning

This draft STP has been developed through a network of organisations working together. Over the next year, we will be working on strengthening the decision making to make sure we have the right infrastructure to invest over £4billion of public money. Within this, the commissioning arrangements, for example how services are planned, designed and paid for – will change. We will seek to retain the best of our clinical leadership and enhance the role of local government. We will make the most of our expertise and capacity to make sure decision making happens at the right level. This means we will increasingly move to:

- A West Yorkshire and Harrogate wide commissioning / contractor function dealing with acute hospital and some specialist services. This will include low volume, high cost treatments in mental and physical health, hard pressed specialties and common standards to end the postcode lottery.
- A place based commissioner in each of our six areas bringing together the functions of local councils, Clinical Commissioning Groups and NHS England (primary care) commissioning. This will make sure the right ambitions and outcomes for local people, with a key focus on prevention, supported self-care and joined up services in communities; as well as local hospitals.
- A transfer of some local 'commissioning' functions will be embedded within new models of care and providers of care. This reflects the move across the region to new joined up providers who will increasingly plan service delivery together in ways currently reserved for commissioners. This will include risk management, performance and development.

These changes will take time to fully develop but our intention is to ensure progress is visible from the 1 April 2017 and to ensure that we continue to meet our principle that decisions are always taken at the right level. In doing this, we believe we can reinvigorate commissioning – to be a process about engagement, need, design, innovation and delivery in service.

Communities

New and existing relationships

Every local place-based plan has been built up from a wealth of information, where people have told us about their local services.

Local plans have been developed and approved by local Health and Wellbeing Boards (or equivalent structures).

We will also establish a new relationship with our communities built around good work on the co-production of services and care. Our proposals link to building community capacity, resilience and thriving community sector organisations across West Yorkshire and Harrogate.

The voluntary and community sector (VCS) has a strong presence in our communities. They have an important role to play, especially at a local level, and in many cases they are much better placed to do this than statutory organisations. We will build on the work that has taken place, and look at how we can ensure the involvement of the wider VCS in future planning and delivery of services.

We want to form new relationships, support innovative ways of working, and the development of community capacity building. This will include working more closely with third sector leaders, social enterprise organisations and community interest groups.

Healthwatch is a key partner in our STP and provide leadership, assurance and challenge, acting as the voice of the patient.

We will create a new way of working with the voluntary sector and will ensure we work closely for the benefit of everyone across West Yorkshire and Harrogate.

Innovation

The STP will be successful if it can create a vehicle for sharing and nurturing innovation, including the talent in the region and across our communities. We see this already in change labs and new programmes of delivery.

We will work with the Yorkshire & Humber Academic Health Science Network (AHSN) and all partners to create an infrastructure for innovation that will make us a global destination for innovation. This will include working with our universities, the independent sector, our local authorities, health and care institutions.

Leeds has been working successfully for several years across health and social care to develop an integrated health record which enables more seamless care for local people.

This improves the experiences of people receiving services making sure information is collected from people only once. This also reduces duplication as set out in the Getting It Right First Time (GIRFT) programme and Carter Review. We are talking to Connected Yorkshire (Leeds University) to see how we can use our data to understand people's health better so that we can bring greater benefits

Digital

We are also developing social movement through our Digital Health & Wellbeing Ecosystem. This is a platform for health and social care, education, industry, the voluntary sector and patient organisations, to work together and increase the uptake of digital health technology.

There are a number of overarching key themes, including technology to support knowledge, education, self-care, direct booking, telehealth and telecare.

We are already seeing this in the digital space with the development of the mHealthhabitat programme for mental health, sponsorship of the #YHDigitalcitizen programme and the People Driven Digital Movement.

Our workforce //

We need to create a health and social care workforce that can deliver services in new ways.

Our priority is to retain them and their skills, whilst recruiting new staff for the future.

Our workforce are our biggest asset and our biggest investment. Our approach is based on:

- Being a model employer to ensure we retain our staff and help them deliver good care.
- Developing skills in teams for the 21st century. This includes good training and development, new roles like nurse associates and advanced practitioners and pharmacists in primary care.
- Recruiting new staff, to replace people leaving, so we fill the gaps, so reducing agency spend.
- Having the capacity to deliver this in our organisation.

We have close working relationships with local universities and the Local Workforce Advisory Board, made up of NHS and other care organisations including Health Education England. Our workforce plan means working together, rather than competing with each other for staff. We will do this in a number of groupings.

- Primary, community and public health staff.
- Registered staff like therapists, nurses, midwifery and doctors.
- Non registered staff like apprentices and care support workers.
- A forum for helping staff to stay well and be ambassadors for prevention.

The result will be more of the right staff, with the right skills, to support great care.

Our workforce is getting older and we have difficulty recruiting and keeping staff in some professions, such as care homes. Health and social care needs to become a career of choice and will be looking at how best we can achieve this across all areas of health and social care, including the recruitment of local GPs.

We have a Workforce Action Board, which considers your health and social care needs whilst working towards an affordable, skilled workforce that is fully supported and fit for the future.

Having your say //

How you can get involved?

You can get involved in the NHS in many ways locally, by becoming a member of your local NHS Foundation Trust, joining a Clincial Commissioning Group, Public Patient Involvement Panel or becoming a member of Healthwatch. You can also contact us with any questions you may have. Our contact details are on the back cover.

Engaging and consulting with local people

We are committed to using all the information you have already told us and have reviewed our recent engagement activity across West Yorkshire and Harrogate. This information has informed the development of our draft plans to date and will help identify where further engagement on our proposals is needed.

This has included face to face conversations, and public and staff surveys produced by local health and social care services, Healthwatch, care providers, and The Patients Association and Patient Opinion.

A full report is available here: **http://bit.ly/WestYorkshireSTP**

We will use this information to inform our plans and make sure that any future proposals will build on this work rather than duplicate effort.

We all know that plans are better when they are developed with people and communities; our commitment is to do that so that we can embed the changes and make them a reality

We will continue to actively engage with you around any change proposals, listening to what you say, to develop our proposals further.

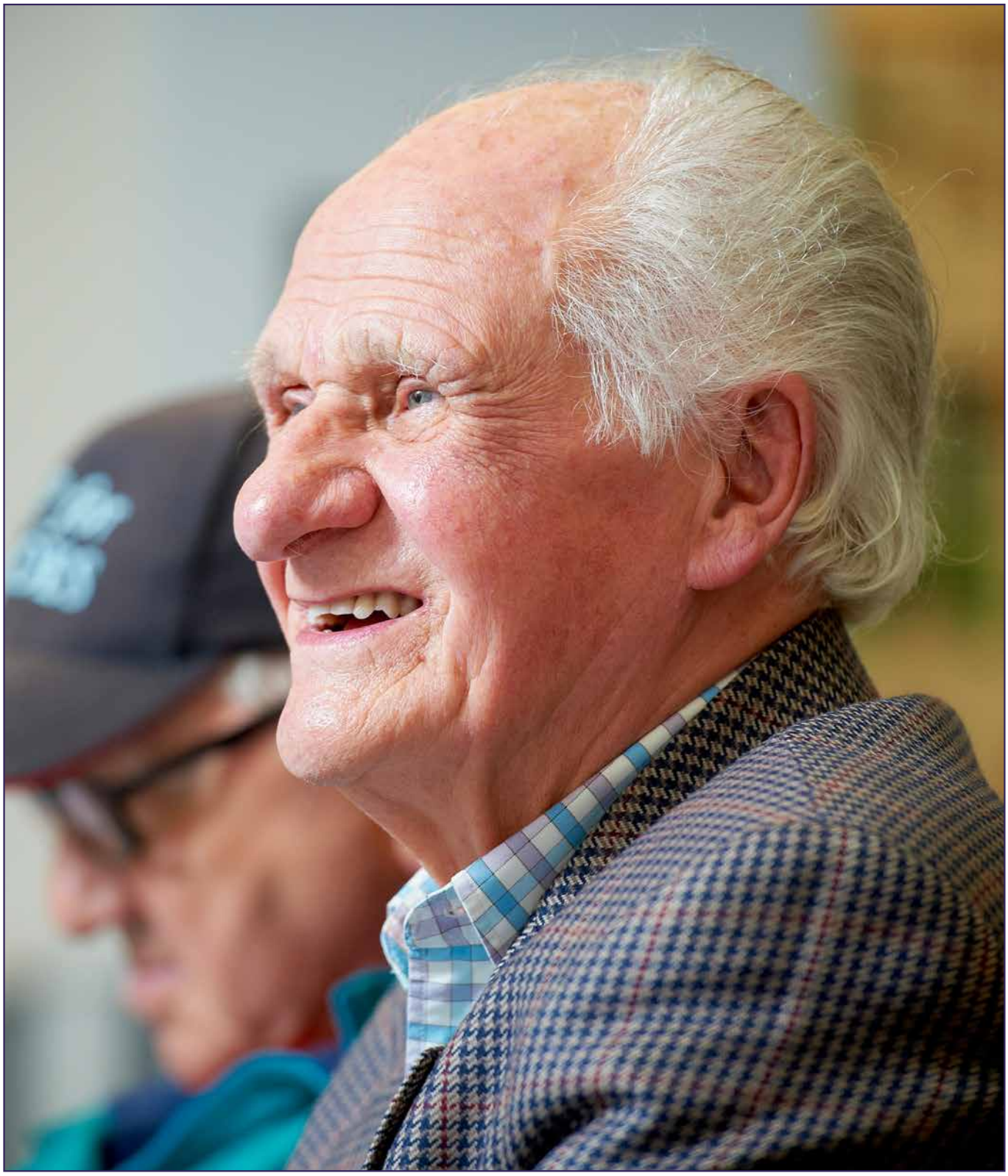
We are starting to develop our plans around how we will involve, engage and consult with all stakeholders, including you, and how it will work across the future planning process and the role of the Health and Wellbeing Boards.

We will ensure the involvement of everyone in future conversations.

This will include further work with Healthwatch and our voluntary sector partners to make sure we connect with all groups and communities.

We will consider views and feed these back into our plans before any further work takes place.

Our focus now shifts to building on the conversation we have with you over the coming months so that together we can develop more detailed plans.



Our vision for West Yorkshire and Harrogate is for everyone to have the best possible outcomes for their health and wellbeing.

If you would like more information or this document in another format, please call **01924 317659** or email **westyorkshire.stp@nhs.net**

This information was published November 2016.

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West Yorkshire and Harrogate Sustainability and Transformation Plan (STP)

Draft proposals
October 2016

Contents

Foreword

The NHS and social care system in West Yorkshire and Harrogate provides care and treatment to 2.6 million people. Every day we work across the whole social spectrum, engaging people from birth to death, head to toe, inside and out. Our 113,000 staff are entrusted with a budget approaching £5bn.

Over the past decade we can be proud of how our health and care teams have made major improvements to services. The NHS is treating more people than ever before, providing services faster, more safely and in better environments. Research and innovation is delivering world leading new treatments at the forefront of technology. Our integration "pioneers" are joining up health and care. Our seven vanguards have been leading the way in developing new models of care that better meet people's needs in care homes, hospitals and local communities.

This history of improvement and innovation in public services is supported by a thriving third sector, excellent universities and engaged businesses too. Increasingly, we have been working together to ensure we can make the biggest changes we can to the lives of local people. We have done this with a keen eye on local variation in populations, needs and service delivery.

In 2016, we face the most significant challenges for a generation. We know that we must keep innovating and improving if we are to meet the needs of our population in a tough financial climate. Demand for services is growing faster than resources. Services in some places are not configured to meet modern standards. And local people want things to be better, more joined up, and more aligned to their needs. This is clear from the continuous engagement we have with local people, as well as the changing world we live in.

Over the past six months, the leadership and staff of West Yorkshire and Harrogate health and care organisations have been working together on how we respond to these challenges. We have been combining existing plans and seeing how we deliver ambitious improvements for people in Bradford, Calderdale, Kirklees, Leeds, Harrogate and Wakefield. In doing so, we want to close the health gap that persists between communities; the care gap that leads to unwarranted variation; and the financial gap that we see opening up in future. In doing so we will deliver tour contribution to the national "Five Year Forward View".

This document sets out our high level proposals. These are built on the ongoing work that has been taking place locally through Health and Wellbeing Boards and local partnerships. They mean an emphasis on prevention, supported self care and joined up services in communities. They mean a genuine focus on people and their mental, physical and social care needs. They mean better cooperation between hospitals to deliver good care that is safe-sized. They mean changes to the commissioning of services, to be much more joined up so that we maximise the power of our finances. They mean a much better compact with local people and local third sector organisations – changing the deal with our communities to build on their assets. And they mean making West Yorkshire and Harrogate a place people want to work and innovate.

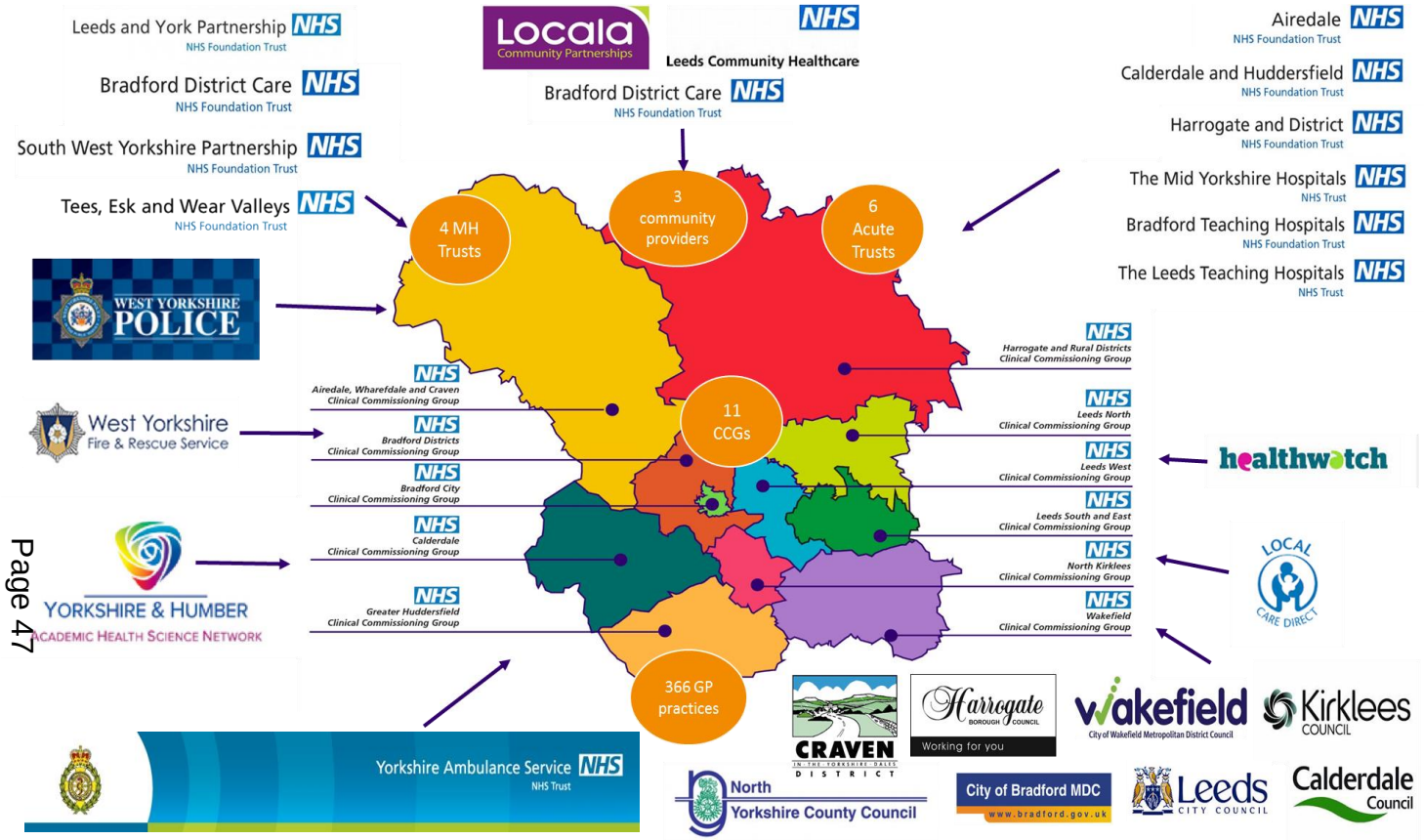
Over the next six months we will keep engaging with staff and the public, to further develop our plans and build on engagement activities to date, ensuring the involvement of everyone in future conversations around proposals for change.

Rob Webster

On behalf of the leadership of West Yorkshire and Harrogate

Section 1: Introduction and our approach

Our health and care economy



- Serving a population of 2.64m
- With a total allocation of £4.7bn across health by 20/21
- And 113,000 health and social care staff

Plus…

- 650 Care homes
- 319 Domiciliary care providers
- 10 hospices
- 8 large independent sector providers
- Thousands of Voluntary & Community Sector organisations

A vision for health and care in West Yorkshire and Harrogate

We have worked together to develop a shared vision for health and care services across West Yorkshire and Harrogate. All of our proposals, both local and at STP level support the delivery of this vision:

- Every place will be a **healthy place**, focusing on **prevention, early intervention and inequalities**
- We will work with local communities to build **community assets** and resilience for health
- People will be **supported to self-care,** with **peer support** and technology supporting people in their communities
- Care will be **person centred,** simpler and easier to navigate
- There will be **joined-up community services across mental & physical health and social care** including close working with voluntary and community sector
- Acute needs will be met through services that are **"safe sized"** with an acute centre in every major urban area, connected to a **smaller number of centres of excellence providing specialist care**
- In some areas local services will evolve into **accountable care systems** that collaborate to keep people well
- We will move to a **single commissioning arrangement** between CCGs and local authorities and have a stronger West Yorkshire and Harrogate commissioning function
- We will **share back office functions and estate** where possible, to drive efficiencies to enable investment in services
- West Yorkshire & Harrogate will be **great places to work**
- We will always **actively engage people** in planning, design and delivery of care
- West Yorkshire and Harrogate will be an international destination for **health innovation**

Leadership and guiding principles: a new way of working….

This STP has been created through our collective leadership. Our aim is to achieve the best possible outcomes for people through delivery of the Five Year Forward View

We have guiding principles that shape everything we do as we build trust and delivery

- We will be **ambitious** for the populations we serve and the staff we employ
- The West Yorkshire and Harrogate STP belongs to **commissioners, providers, local government and NHS**
- We will **do the work once** – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict
- We will undertake **shared analysis** of problems and issues as the basis of taking action
- We will apply **subsidiarity** principles in all that we do – with work taking place at the appropriate level and as near to local as possible

These are critical common points of agreement that bind us together

Our approach is built on the principle that we do the work as close to local populations as possible…

West Yorkshire and Harrogate has significant pockets of deprivation and affluence. Populations with higher levels of deprivation continue to experience health inequalities and achieve worse outcomes. We have a large population of children and young people with 1 in 5 growing up in poverty and parts of the region such as Harrogate & Rural District and Craven have populations of older people growing faster than the national rate.

Our region has densely populated urban areas around the cities of Bradford, Leeds and Wakefield and large towns of Huddersfield and Halifax. Large rural areas cluster around the district of Craven.

Our different diversity of geography and communities makes West Yorkshire and Harrogate a diverse footprint and because of this it is important that we plan our health and care services to meet the needs of these different communities. The best way to do this is by planning and delivering services with and as close to these local populations as possible.
To support us in this process, we have strong local relationships through our six Health and Wellbeing Boards and most of our transformation work is planned and delivered at this local level – based on people's needs and circumstances. This work is a collaboration of commissioning and provider organisations across physical and mental health, social care, voluntary and community sector and Healthwatch in these local areas of Bradford District and Craven, Calderdale, Harrogate and Rural District, Kirklees, Leeds and Wakefield.

There are some areas where we need to work on a bigger scale in order to be successful. We apply three tests to determine when to work at this level:

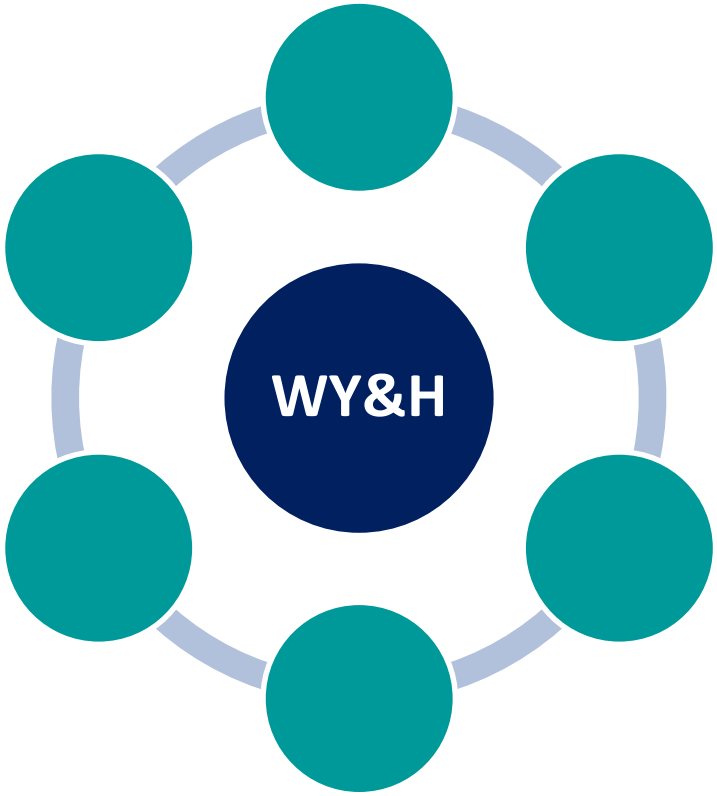
- To achieve a critical mass beyond local population level to achieve the best outcomes
- To share best practice and reduce variation
- To achieve better outcomes for people overall.

Relationship between the West Yorkshire and Harrogate led work programmes and our six localities…

The connection between the West Yorkshire and Harrogate level work streams and the six ‘places’ is critical.

The planning, leadership and increasingly the decision making for these work programmes will be taken at a West Yorkshire and Harrogate level jointly through collaboration of statutory organisations.

Implementation is delivered through the six localities to an agreed set of principles and standards.



From vision to impact

Local

Regional

VISION

- Prevention and early intervention;
- Community assets;
- Supported self care,
- Integration across mental and physical health;
- Working with our population

- Acute services safe sized;
- Specialist care centres of excellence
- New commissioning arrangements
- Sharing of back office functions and estate
- Innovation and best practice

APPROACH

- Planned and delivered through six places, working in partnership locally across commissioner and provider functions.
- West Yorkshire and Harrogate work programmes support this local planning and delivery

- Work planned at West Yorkshire and Harrogate level – connected to the six places for local delivery

IMPACT ON 3 GAPS

- Greater focus on prevention, turning the trend major killers and long term conditions

- Reduced demand on acute services, reduced costs and improvement in access standards

- Greater resilience of acute services; improved quality safety and reduced variation
- Efficiencies through standardisation of good practice, lower cost of estate and back office

There are a number of common actions to drive impact in our place based plans…

Prevention and early intervention	• Programmes focused on locally relevant challenges with most areas prioritising areas such as obesity, smoking, cardiology, respiratory, mental wellbeing and frail elderly.
Supported self care	• Evidence based, person-centred approaches, which support people to take greater control and management of long-term health conditions. Training of the workforce to facilitate this elevated level of independence.
Primary and community care	• Increasing access to primary care in hours and out of hours through primary care at scale and new models of care in the community. A new compact with the voluntary and community sector. Commitment to implement the GP and Mental Health Forward Views. Managing demand for acute services.
Joined up services	• A variety of models and options for integrating services to make them more efficient and better aligned to the delivery of people's health and wellbeing outcomes and person centred care.

And we have identified the following priorities for working together at West Yorkshire & Harrogate level…

- Cancer services
- Urgent and emergency care
- Specialist services
- Stroke (hyper-acute and acute rehab)

We work together because of the need for critical mass

- Standardisation of commissioning policies
- Acute collaboration
- Primary and community services

We work together to reduce variation and share best practice

- Mental health
- Prevention at scale

We work together to achieve greater benefits

The evolution of these plans is built on previous work and future planning processes…

The foundation of these proposals is the six place based health and wellbeing strategies.

These strategies are grounded in a clear understanding of local population needs and preferences.

The development of a West Yorkshire and Harrogate collaborative programme after application of the 'three tests'.

Nine programmes planned at West Yorkshire and Harrogate level and delivered locally.

As part of the current 2 year planning process , organisations will develop detailed plans for delivery in years 2 and 3 of the 5 year STP time line

Section 2: The triple aim

The triple aim: Closing the gaps

There are three gaps outlined in the Five Year Forward View these relate to health and wellbeing, care and quality of services and finance and efficiency.

Our approach is to ensure that we can improve outcomes in health and wellbeing and care and quality whilst delivering within the resources available.

We consider all three gaps as equally important, with finance as a servant of the other two gaps. All our plans are focused on closing these three gaps in West Yorkshire and Harrogate.

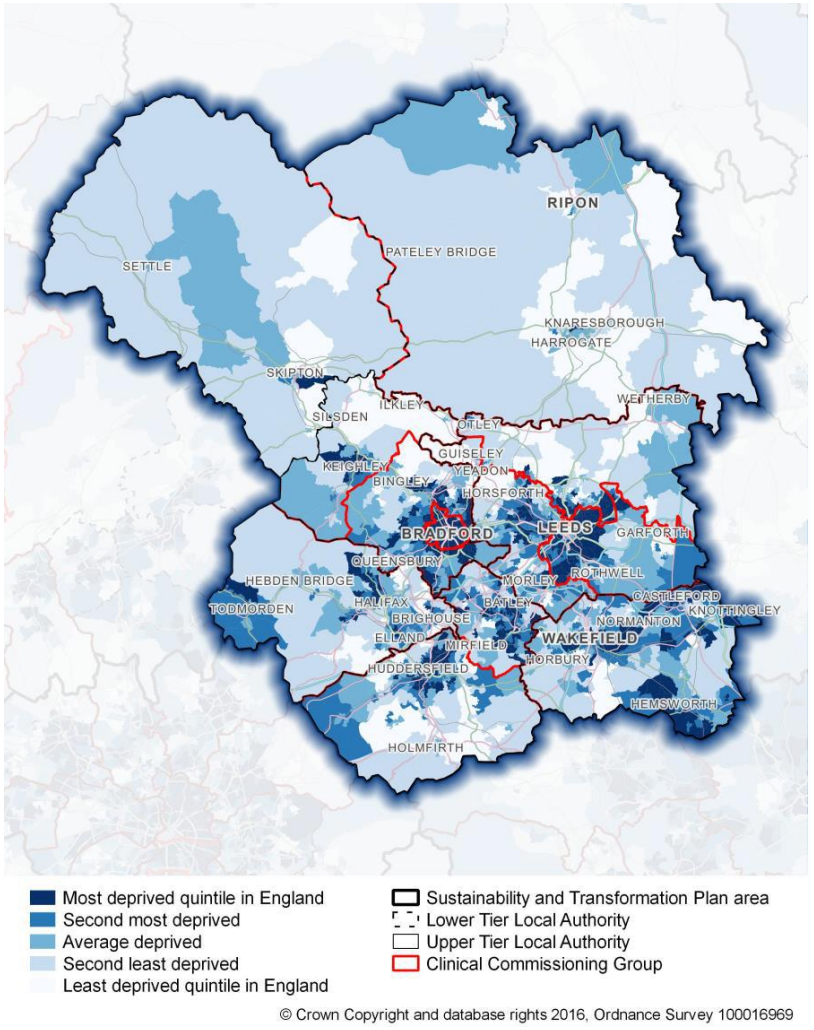
Health and wellbeing gap: Our challenges

We have made significant progress on many health and wellbeing indicators of recent decades but there are still major challenges.

Where you live still has a significant impact on your life chances and health and care outcomes, for example:

- There is an 11 year variation in life expectancy for males across Leeds
- There is a 10.2 year variation in life expectancy for females across Calderdale
- We have higher than average rates of adult obesity
- We have higher than average rates of smoking, including maternal smoking at delivery.

Deprivation across Wet Yorkshire and Harrogate STP footprint



Health and wellbeing gap: Our aspirations

Health and inequalities

THEME	ISSUE	ASPIRATION
Smoking	18.6% of our population smoke. This is higher than average and is the main preventable cause of cancer.	To reduce smoking rates to 13% by 2020-21 - approximately 125,000 fewer smokers compared to 2015-16.
Obesity	8 of 11 CCGs have significantly higher than average childhood obesity levels. 1.3 million people (50% of population) are overweight.	There are 226,000 people at risk of diabetes in West Yorkshire and Harrogate. Our aspiration is that 50% of these are offered diabetes prevention support, with a 50% success by 2021.
Alcohol	There are around 455,000 binge drinkers in West Yorkshire and Harrogate. This has major health consequences and adds significant burden on services.	To reduce alcohol related hospital admissions by 500 a year and achieve a 3% reduction in alcohol related non-elective admissions.
Cancer	Only around half of all cancers are diagnosed at a curable stage. Significant inequalities in outcomes across ethnic groups.	Increase in survival rate to 75% by 2020-21, with the potential to save 700 lives each year.
Mental Health	We have a higher prevalence of anxiety disorders and depression and a higher than average suicide rate.	A zero suicide approach to prevention, aspiring to a 75% reduction in numbers by 2020-21
CVD & Stroke	All West Yorkshire Authorities have significantly worse rates for CVD mortality in under 75s when compared to England.	Reduce cardiovascular events by 10% by 2020-21 e.g. in Bradford District & Craven this will mean a reduction in cardiovascular events for 600 people

Care and quality gap: Our challenges

- The significant majority of services are high quality, timely and offer a good experience for service users.

- Performance against key standards has dipped in recent times and patient experience for some services remains below average, for example:
  - Performance against the accident and emergency 4 hour waiting standard and the 18 week referral to treat standard have been deteriorating over time across most of the STP area.
  - Delayed transfers of care are a problem for patients and the system. They are one of the biggest challenges for acute providers in terms of performance and quality. Without action this position will deteriorate further.
  - There still differential experiences and worse outcomes for those people with mental health issues when compared to others
  - People's experience of health and care services varies considerably by service and community.
  - Half of people over 65 are not satisfied with the level of social contact they have

Care and quality gap: Our aspirations

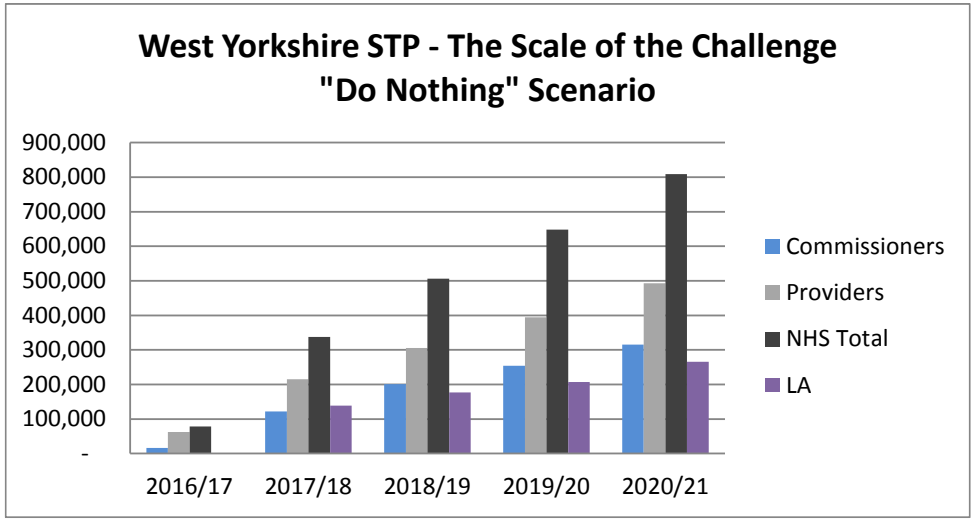
THEME	ISSUE	ASPIRATION
Urgent and Emergency care	The urgent and emergency care system is complex and difficult to navigate. A&E performance is deteriorating. Pathways are often unnecessarily complicated.	To deliver the 95% 4 hour A&E standard in March 2017, and consistently thereafter. 30% all calls to 111 transferred to a clinical advisor in March 2017.
Planned care	The increasing demand for planned care is placing an unsustainable burden on the acute system leading to a deterioration in the referral to treatment standard.	To deliver the 92% 18 week referral to treatment standard consistently.
Patient experience	There are significant variations in patient experience across services, population groups and local geographies	To deliver an aggregate improvement in patient experience for all major services by 2020/21
Cancer services	There are currently a number of access standards for cancer services depending on pathway. Performance against these standards are variable.	Deliver a new 28 days to diagnosis standard for 95% of people investigated for cancer symptoms
Mental Health	People with mental health concerns are better served in the community rather than through A&E – yet A&E use is still relatively high. People needing acute mental health care are still too often placed many miles away from home.	A 40% reduction in A&E attendances for people with mental health issues by 2020-21 Elimination of out of area placements by end 2017

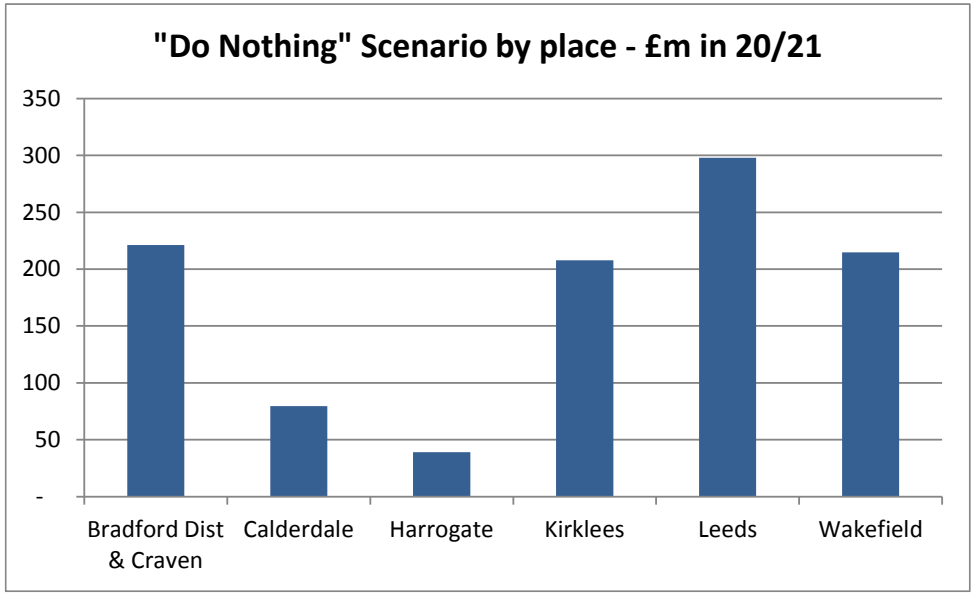
Finance and efficiency gap: The financial challenge

- Resources across the health sector grow from £4.2bn to £4.7bn by 2020-21. This is lower than the national average, and is far outstripped by the demand for services over the same period

- Demand for and cost of services, if unmanaged will drive a gap of £1.07bn by 2021 for health and social care – based on a bottom up analysis built up and owned by the individual organisations.

- This has captured the "Do Nothing" challenge for 2016/17 to 2020/21 which equates to £809m for the NHS plus a further £265m for social care and public health.





Finance and efficiency gap: Our solutions by 2020/21

Our solutions are developed as part of the place based planning - with West Yorkshire and Harrogate programmes supporting local delivery. The high level position for 2020-21 is as follows:

- The total value of our solutions is £983m across health and social care by 2020-21 each of which requires some further development to strengthen confidence. We are factoring in £78m of STF monies in 2020-21 towards closing the gap, and £94m for the cost of change.
- Our overall position is a deficit of £91m, made up of an NHS surplus of £43m, and a gap of £135m in social care.
- Local authorities are statutorily required to break even and we are working together to understand how this pressure can be mitigated.

£m

Do Nothing	**(1,075)**

Solutions	
1. Operational Efficiencies:	
Provider efficiencies: Carter programme - Estates	8
Provider efficiencies: Carter programme - All other	93
Provider efficiencies: Non-Carter	329
Primary medical care (GP)	7
CCG other efficiencies (e.g. CHC, prescribing, admin, other)	102
2. Activity Moderation Efficiencies:	
Specialised commissioning QIPP	30
Urgent and Emergency Care (UEC)	10
New Care Models (NCM)	34
RightCare	36
Self Care	1
Prevention	31
Low value interventions	1
3. Social Care	131
4. West Yorkshire Programmes & Opportunities	93
Gross Solution Total	**906**
less STF used to deliver change	(95)
Net Solution Total (as visible in the template)	**811**
STF Monies	172
Total	**983**

Residual Do Something Surplus / (Deficit)	
NHS	43
LA	(135)
Total	**(91)**

Finance and efficiency gap: Our approach

- We recognise the need to work collaboratively towards a West Yorkshire and Harrogate control total and are exploring how best to do so and manage our collective opportunities and risks.

- Due to our growth and the underlying financial position of some of our organisations, the scale and scope of our transformation needs to be early and radical, and requires significant revenue and capital investment in the early years.

- There is an assumption that organisations collectively will deliver their control totals in 2016/17, which would bring significant risk to the outer years if these are not achieved.

- Transformational capital is required to enable the service reconfiguration and back office efficiency gains of our provider sector, to deliver financial sustainability and tackle the long term structural challenges.

- Release of Transformation Funds in the early years will enable an faster implementation of our solutions and bring them forward from the later to the earlier years of our STP plan.

In order to deliver the proposals in this document, our preferred approach is that the available transformation resources for our footprint are devolved for management at a West Yorkshire and Harrogate level. This would give us the ability to plan ahead collectively, deploy transformation funds towards our greatest opportunities and enable rapid change.

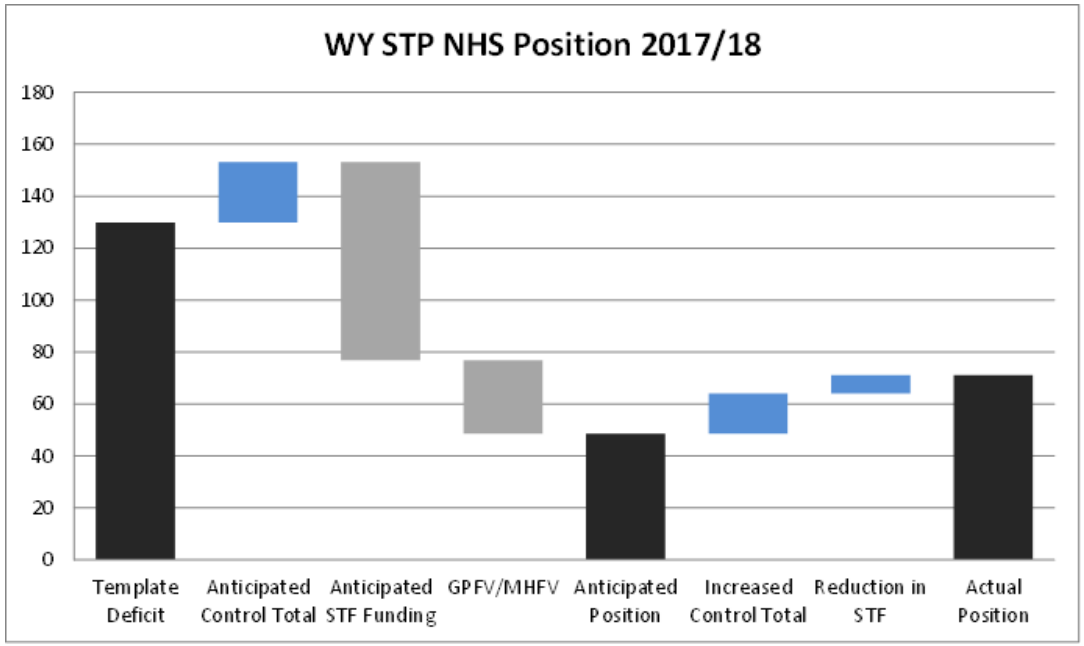
Our NHS Position in 2017/18

- The challenge facing West Yorkshire and Harrogate in 2017/18 is significant. The ability to deliver the financial position in 2016/17 will have a material impact on our plans heading in to 2017/18.

- The current STP plan forecasts a £4m surplus for CCGs, before any investment in the GP 5YFV and the MH 5YFV. This is broadly in line with national expectations.

- The provider position is currently £36m from breakeven (prior to any transformation funds being received). This means a further £39m would be required to achieve the control totals that have been set by NHS Improvement.

- We believe this position will improve as the discussions around control totals continue and through receipt of transformation funding.



Section 3: Place based proposals

Place based plans: Our approach

The foundation of our proposals is the six place based health and wellbeing strategies.

West Yorkshire and Harrogate has a diverse population with a range of health and social care needs. We believe that for the majority of care and services, these needs can be best met by developing and delivering plans locally through local partnership working – rather than a top-down approach.

The following slides provide an overview of each place based plan. These plans have strong local buy-in and have been approved by the relevant Health and Wellbeing Board.

Our six 'places'

- Bradford District and Craven
- Calderdale
- Harrogate and Rural District
- Kirklees
- Leeds
- Wakefield

Bradford District & Craven: Overview of place and plans

Bradford District and Craven has a large geographic footprint incorporating significant deprivation, some affluence, urban, rural and city living. Our population is one of the most diverse nationally and significant health inequalities still exist across the different areas of the district. People, especially women, live a significant proportion of their lives in poor health and more than 33,000 children live in relative poverty. The District is known nationally for its work in digital healthcare in particular providing 24/7 face to face video consultation.

High level overview of plans

- Prevention and early intervention at the first point of contact with a specific focus on children, obesity, type 2 diabetes, CVD, cancer, respiratory and mental wellbeing
- Creating sustainable, high impact primary care through our primary medical care commissioning strategies and commissioning social prescribing interventions
- Supported self-care and prevention by maximising our community assets to support individuals and train our workforce to empower and facilitate independence
- Provision of high quality specialist mental health services for all ages and early intervention mental wellbeing support services.
- Delivering population health outcomes and person centred care through new contracting, payment and incentives in line with accountable care models elsewhere. This includes specific interventions that transform services to address the physical, psychological and social needs of our population, reducing inequalities and addressing the wider determinants of health.
- Developing a sustainable model for 24/7 urgent and emergency care services and planned care.

Bradford District & Craven: The triple aim

Health and Wellbeing

By 2020/21 we will:

- Reduce childhood obesity by 5%
- Reduce smoking prevalence by 5%
- Train 10% of the workforce to support people to better self-care
- Prevent cardiovascular events for 600 people
- Screen an additional 5500 women for breast cancer
- Screen an additional 1500 people for bowel cancer
- Screen an additional 500 women for cervical cancer
- Recognise and value peoples mental wellbeing and take an early action to maintain their mental health (indicators as per the mental wellbeing strategy 2016-2021).

Care and Quality

By 2020/21 we will:

- Save 150 lives by reducing variation in care
- Reduce non-elective admissions by 4%
- Develop a sustainable care market and create a sustainable model of planned and emergency/urgent care that meets clinical and constitutional standards including seven day services in the 4 priority areas as a minimum.
- Commission primary medical care that ensures seven day access achieved for 100% of population
- Have all-age MH liaison teams in place in all acute providers and meet the “Core 24” standards
- 90% of people who access Psychological Therapies will engage through direct self-referral.
- Ensure 70% of people with diabetes experience the 8 care processes

Finance and efficiency

By 2020/21 we will have implemented plans to close the £221m gap as follows:

- £106.7m of provider and commissioner efficiencies, transforming care programmes in acute and community service areas
- Utilising £18.1m of Sustainability and Transformation Funding (STF)
- Creating the opportunity to shift additional resources into primary care (£1.8m by 2018/19)
- £46.1m of efficiencies through further work on clinical thresholds, procedures of limited clinical value, reducing unwarranted variation and further West Yorkshire and Harrogate opportunities

Through our transforming care programmes we will seek to mitigate the £50m pressure in social care.

Bradford District & Craven: Progress and next steps

Progress so far

- In 2016/17 we established provider alliances, including primary medical care at scale, and together with the commissioner alliance are progressing to our ambition of improving population health outcomes and person centred care.
- Addressing the holistic needs of patients with multiple comorbidities through complex care models across the patch. AWC is a pioneer site and has seen a 2% reduction in non-elective admissions. We are a Vanguard site (Enhancing Health in Care Homes) and are evaluating video consultation in care homes and the Gold Line service for patients at the end of life.
- Developing our first population health outcomes type of contract for Bradford ; accountable care accelerator programme in AWC designing new contracting models .
- Aligned our three CCGs under single accountable officer and chief finance officer with further shared arrangements over the next twelve months.
- Ensured the shift of secondary to primary care activity over the last ten years have been mainstreamed through the PMS review alongside improvements in primary care access .
- Our crisis care concordat and first response services have received national recognition and we have had no mental health out of area placements in over a year.
- We have a nationally recognised digital shared care record across health and social care.
- We have a big lottery funded programme Better Start Bradford aimed at improving life chances for children through a comprehensive programme of interventions and activities which will improve outcomes.

Next steps

- Building on the transformation of complex and enhanced primary care programme, AWC will move to a shadow accountable care system in April 2017 with a 'go live' aim of April 2018.
- Structured collaboration for Bradford out of hospital clinical and social care model commenced in September 2016 with intention to create a new contracting model in 2017.
- Procurement of a new model of care for diabetes awarding one outcomes-based accountable care contract in April 2017.
- We aim for a total population coverage of accountable care by 2021.
- Sign off of our mental wellbeing strategy including the Children and Young People's Mental Health Transformation Plans implementation 2016/17 & 2017/18.
- Develop a sustainable care market and a sustainable model of planned and emergency/urgent care that meets clinical and constitutional standards including seven day services in the four priority areas as a minimum for Bradford and Craven that takes account of the West Yorkshire and Harrogate acute collaboration work, workforce challenges and quality standards. Programme scope agreed by Autumn 2017.
- Review investment in Public Health expenditure by December 2016 for implementation with effect from March 2017
- Workforce strategy for the health and care system by December 2016.
- As part of the one public estate programme we will have an estates strategy for the health and care system by March 2017.
- Digital technology strategy for the health and care system by June 2017.

Calderdale: Overview of place and plans

Calderdale has a plan to improve the health of local people, and the quality and efficiency of local services. We are reimagining a new health and wellbeing system which promotes personalisation, supports healthy decisions, enables physical activity and encourages responsibility by focusing on preventative services, self-care and early intervention, and providing interventions in the community, and using community assets, we can reduce the public need to visit hospitals

High-level overview of plans

- Our system is over-reliant on emergency unplanned hospital activity compared to the rest of the country with high levels of 'avoidable' admissions - £9m avoidable admissions per annum.
- Local people tell us they would prefer to receive care closer to home, with good access to appointments and continuity of care
- Our workforce is getting older and we have difficulty retaining and recruiting in some professions.
- By focusing on preventative services, self-care and early intervention, and providing interventions in the community, and using community assets, we can reduce the public need to visit hospitals and contribute to the triple aim
- By pursuing our dual aim of changes to hospital based care and changes to primary and community based care we aim to improve care and quality of services for the people of Calderdale

Calderdale: The triple aim

Health and wellbeing

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

Care and quality

- Increase proportion of people satisfied with access to care and continuity of care in the GP Patient Survey and Friends and Family tests.
- Reduce number of people admitted to hospital with a treatable or preventable condition within the community by 70% to 1,695 admissions by 2021.
- In 4 years we will achieve a 75% reduction in suicides, with an ambition to reach zero
- 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)

Finance and efficiency

- Deliver the Calderdale STP solutions to reduce the financial gap for Calderdale in 2020/21 from £79m to £56m.
- Council would review medium term financial strategy to mitigate the deficit across the Council, including application of BCF, then work together as a system to mitigate the remaining Local Authority gap for example through integrated commissioning arrangements, reducing the financial gap currently forecast to be around £29m by 2020/21. This reduces the total Calderdale gap to £27m.
- Subject to CCG decision making on 20 October Right Care Right Place programme will further reduce the gap by £11m in 21/22 to £16m
- Work with partners across West Yorkshire and Harrogate to create a balanced financial plan for West Yorkshire and Harrogate

Calderdale: Progress so far and next steps

Progress so far

- We have engaged and consulted on large scale hospital change
- Community and primary care with other partners developing a fully integrated locality approach
- Created Calderdale Vanguard new care model
- We have a full value assessment/logic model of the care closer to home model including prevention and self care management
- Through the Better Care Fund we have an integrated Gateway to Health and Social Care, an integrated team managing transfer of care from hospital, an agreed approach to transforming care for people with learning difficulties, use of the NHS number as a single identifier across our system, an agreed approach to integrating our monitoring and performance management.

Next steps

- Strengthening our primary care delivery plan for Calderdale in the light of development of the General Practice FV – Ongoing
- Consultation on future provision hospital and community healthcare - CCG decision to progress October 2016
- The first point of contact for health and social care will be delivered by Spring 2017
- Roll out of integrated community services through the implementation of 5 localities by Spring 2017
- Full implementation of new care model in community and primary care by 2018.

Harrogate & Rural District: Overview of place and plan

Within the district there are pockets of deprivation and issues relating to rural isolation. We have an aging population – 10 years ahead of the national aging curve with 1 in 5 people aged over 65. There is likely to be an increase in the number of people who have a limiting long-term illness and the number living with dementia by 2020. Our population use more elective and non elective services than peer CCGs and have a positive experience of care.

High-level overview of plans

- Self care, prevention and early intervention, specific focus on evidence based lifestyle prevention services, falls prevention, stroke prevention and mental health and wellbeing.
- Supporting individual and community resilience through our Stronger Communities and My Neighbourhood programmes, and social prescribing interventions.
- Integrated, expanded community-based teams capable of supporting the person's needs holistically, including physical, mental health and social needs. Person-centred and led care, optimised through proactive management, with people supported to manage their conditions in the way that suits them and are enabled to self-care.
- Redesigning out of hospital care - primary care and community services, with enhanced access and primary care working at scale.
- System approach to reducing demand and variation in elective care.
- Developing a sustainable 24/7 urgent care system.
- Stabilising the care market, improving availability and quality.
- Developing new approaches to personal care at home to address challenges facing us now, including an ageing workforce, increase in demand for care and the complexity of this care, and a shortage of people joining the profession.
- Redesigning the way care is commissioned.

Harrogate & Rural District: The triple aim

Health and wellbeing

- 95% of patients supported by a locality Integrated Team have a single care plan by March 2017.
- 72.2% of people with a long-term condition feel supported to manage their condition in 2016/17.
- Increase in the number of people with diabetes diagnosed less than a year who attend a structured course (national av. currently 5.7%).
- Increasing the proportion of people using social care who receive self-directed support and those using direct payments.
- Increasing the number of people using personal health budgets, focusing initially on learning disabilities, mental health and children and young people with long-term healthcare conditions.
- Reduce % of children aged 10 or 11 (Year 6) who have excess weight.

Care and quality

- Develop affordable model for planned care that supports delivery of NHS constitutional standards
- 60% of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral by 2021.
- 75% people referred to IAPT begin treatment within six weeks, and 95% within 18 weeks, with a 55% recovery rate from treatment
- Long term support needs met by admission to residential and nursing care per 100,000 population aged 65+ reduces year on year.
- Increase % of new cases of cancer diagnosed at stage 1 and 2.
- Increase % of people whose blood pressure is controlled to 150/90.

Finance and efficiency

- Delivery of all organisational control totals in the local systems' organisations in 16/17 is expected
- There are recognised pressures in the system at a local level. There is currently £3.1m unmitigated risk
- Delivery required of £38.9m efficiencies against 'do nothing' trajectory (assumes no in year in risks materialise)to contribute towards delivery of financial balance across the wider system by 2020/21.
- Current local 'do something' plan identifies £17.6m 20/21 gap
- Reduction in A&E attendances by 11% by 2018/19
- Reduction in emergency admissions by 16% by 2020/21.

Harrogate & Rural District: Progress so far and next steps

Progress so far

- Implementation of our New Care Model: 'What Matters to Us'. By November 2016 we will have 4 community care teams, covering the whole district, aligned to clusters of GP practices, linked to adult social care services, ten additional community beds to support discharges from hospital and to prevent avoidable admissions and an Acute Response and Overnight Service
- Use of Calderdale framework to assess skills needed within the new care model. A clinical skills trainer is enabling staff to bring new skills into their repertoire and provide more holistic and coordinated care.
- We have engaged with our population on the design and delivery of the model.
- We are using Right Care methodology, the Elective Care Rapid Testing Programme (100 day challenge) and work on clinical thresholds to reduce elective demand and variation.
- We are working with our GP Federation and 17 practices on the GP Forward View Transformation Plan to deliver extended access and primary care at scale.
- We have discussed and agreed our local plan within our Harrogate Health Transformation Board and agreed a Memorandum of Understanding.
- We are exploring organisational forms and contractual options and having early discussions on integrated health and social care commissioning and delivery models.

Next steps

- Referral Management Service with clinical review in place (January 2017).
- Roll-out of diabetes prevention programme (during 2017/18)
- Evaluation of our New Care Model during 2017/18 to ensure it is delivering the right place-based solution of integrated care.
- Agreement on scope of Integrated Health and Social Care Commissioning arrangements (Q4 2016/17).
- Development of Out Of Hospital Strategy – to include Primary and community estate strategy to meet changes in demography and demand for healthcare services (2017/18).
- Evaluation and decision on organisational form and affordability of new care model.
- Local Digital Roadmap implementation.

Kirklees: Overview of place and plan

Kirklees has a diverse population that includes both urban and rural areas. The population is ethnically diverse, with some areas experiencing high levels of deprivation. There is variation in healthcare outcomes. The two Kirklees clinical commissioning groups: North Kirklees and Greater Huddersfield are within a single local authority footprint. Each CCG shares a main acute provider with another CCG in a different local authority; this adds complexity to the system. Some people in Kirklees wait too long to be seen for diagnosis and treatment, stay in hospital for too long and many of our patients don't have a good experience in our hospitals.. Whilst we face many challenges locally we are a forward thinking and innovative area. Our focus has been on driving integration across health and social care services and our first big step change in this was through the commissioning of an integrated model for community services across Kirklees providing a care closer to home model.

High-level overview of plans

- Early Intervention and Prevention Programme including the development of a thriving voluntary and community sector;
- Implement and build on the Healthy Child Programme;
- Development of an adult wellness model in Kirklees;
- Improving the capacity and quality of primary care (including GP Forward View);
- Making social care provision more sustainable and more effective, including the development of vibrant and diverse independent sector;
- Development of business models to encourage providers to maximise independence;
- Change the configuration of acute services to improve quality and create efficiencies through the implementation of RCRTRP, Meeting the Challenge and Healthy Futures plans (UEC, Cancer, Specialist MH, acute stroke etc.);
- New approach/model for how to support people with continuing healthcare needs;
- Implementation of the Transforming Care Programme for people with learning disabilities;
- Changes to the commissioner landscape, including more integrated approaches; and
- Changes to the provider landscape to move towards adopting new models of care across health and social care and developing alliances.

Kirklees: The triple aim

Health and wellbeing

- Improve independence of vulnerable adults and year-on-year gains in self reported QOL for adults and carers in receipt of adult social care
- Childhood Immunisations – continue to achieve the 0-5years childhood Immunisation target of 95%.
- NCMP – 86.2% Reception children measured.
- Maximising Independence: 86% reported confidence in managing own condition on exit from our therapy services which exceeds the commissioner's target of 80%.

Care and quality

- 19% reduction in hospital admissions.
- 95% of patients demonstrate a maintained or improved level of functioning on exit from therapy services
- 98% of patients report a positive outcome on conclusion of care episode from Community Nursing, Specialist Nursing and Intermediate Care.
- 91% of patients clinically appropriate to remain at home are still at home following assessment and intervention at 24 hours
- Work with partners across the system to Reduce NEA back to 2014/15 levels (focus on care homes, frailty and LTC)
- Increase the number of people who die in their preferred place
- Increase screening rates across all cancers to national average
- Reduce number of emergency presentations for cancer

Finance and efficiency

- 'Do nothing' gap of £208m.
- Programmes in place to close that gap include the re-configuration of acute service delivery (Right Care Time Place), second stage development of community services (Care Closer to Home) and implementation of the primary care strategy.
- The outstanding 'do something' NHS gap by 20/21 is £40m. Subject to CCG decision we expect implementation of Right Care Time Place in 21/22 would significantly reduce that gap. NHS and LA are working on the 'Kirklees plan' to close the remaining social care gap.

Kirklees: Progress so far and next steps

Progress so far

- Early Intervention & Prevention model agreed, based on complex, targeted and community plus levels, and programme entering Year 2, critical part of shift to 'New Council'.
- Healthy Child Programme in procurement phase.
- Model for an adult wellness model across Kirklees has been developed. Links to diabetes prevention.
- Both CCGs have co-produced primary care strategies. Plans are in development to produce local GPFV delivery plans.
- Models developed to deliver primary care at scale through a hub and spoke approach.
- CCG resources are being targeted at supporting practices to collaborate and be stronger together through federations.
- Kirklees Vision for Social Care agreed. Commitment to single approach to supporting the independent care sector.
- Strengths based social care practice training underway.
- Public consultation around changes to acute services at CHFT undertaken. Decision regarding next steps taken in Oct 2016.
- Partners across the MYHT health economy are mobilising the final year of the planned changes to acute services. Some changes are already in place to rationalise/centralise.
- Number of workstreams identified to manage demand, promote recovery and longer term sustainability at MYHT.
- Joint Chief Officer post is being piloted across NKCCG and Kirklees Council. A similar arrangement is also being piloted across the acute interface in North Kirklees.
- Procurement and mobilisation of an integrated community model across Kirklees

Next steps

- Decision to proceed to Full Business Case on CHFT acute changes taken in October 2016
- Local delivery plans for the GPFV in place by December 2016
- Meeting the Challenge Year 3 changes to be made by April 2017 (pending further evaluation of system risk)
- Implementation of new Early Help Model for Children and families (2017/18)
- Models to deliver primary care at scale to be worked up (2017/18)
- Implementation of Healthy Child Programme (April 2017)
- New domiciliary care contract in place (April 2017)
- Roll out of new Frailty Model in North Kirklees (2017/18)

Leeds: Overview of place and plan

Leeds is ambitious: we want to be the Best City in the UK by 2030. Our vision is that 'Leeds will be a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest'. We have the people, partnerships and placed-based values to succeed.

We will be the place of choice in the UK to live, to study, for businesses to invest, for people to come and work, and as the regional hub for specialist health care.

Our services will provide a minimum 'universal offer' but will tailor specific provision to the areas that need it the most. These are bold statements, in one of the most challenging environments for health and care in living memory. We need to do more to change the way we have conversations across the city and develop our infrastructure and workforce to be able to respond to the challenges ahead. Much will depend on changing the relationship between the public, workforce and services, and ensuring that we work 'with' and not 'doing to'. We need to encourage greater resilience in communities so that more people are able to do more themselves. This will reduce the demands on public services and help us prioritise our resources to help those most at need. We recognise that we will have to continue to change the way we work, becoming more enterprising, bringing in new service delivery models and working more closely with public, partners and workforce in Leeds, and across the region, to deliver shared priorities.

High-level overview of plans

- Investing more in prevention, targeting those areas that will reap the greatest reward.
- Building on our 13 integrated neighbourhood teams, we will develop new models of working, increasing and integrating our primary and community offer for out-of-hospital health and social care, providing proactive care and rapid response in a time of crisis: Self Management and Proactive Care, Efficient and Effective Secondary Care, Urgent Care / Response.
- Increasing sustainability and transformation of general practice as the cornerstone for New Models of Care (NMC) designed around GP registered lists.
- Using existing estate more effectively, ensuring it is fit for purpose, and disposing of surplus estate.
- Reviewing our procurement practices and top 100 supplier organisation spend to ensure that we get best value in spending for the Leeds £, and are benefitting from economies of scale.
- Engaging 'One Workforce' to work collaboratively and promote a 'working with' approach across all partners within the Health and Social Care system to provide high quality seamless services to support the delivery of new models of care to meet the population needs.
- Work collaboratively across the system to attract recruit, retain, develop the workforce through leading edge innovation and education and optimise the use of new roles, apprentice and skills mix.
- Having nationally pioneering integrated digital capabilities being used by a 'digitally literate' workforce.
- Digital capabilities and consistent information to support effective discharges, referrals, transfers etc. self and assisted care and integrated intelligence to inform better whole-system operational and strategic decisions.
- Use our high quality education, innovation and research to strengthen service delivery and its outcomes.
- Creating a citywide culture of shared responsibility between citizens and services; working with' people at every stage of change through clear communications and engagement.

Leeds: The triple aim

Health and wellbeing

- Progress the twelve priorities in the Leeds Health and Wellbeing Strategy to reduce premature morbidity and mortality and help narrow the health inequalities gap
- Reduce smoking rates from 21% to 13% by 2020/21 (for adults aged 16 years +)
- Breast cancer screening: increase uptake to England average of 75% by 2020
- Bowel cancer screening: increase uptake by 3% by 2020
- Bring the Leeds suicide rate down below the national average by 2020/21
- Support 2880 people who have been identified to be at risk of developing diabetes to attend the NHS National Diabetes Prevention Programme by 2019/20

Care and quality

- Ensure 60% on Severe Mental Illness (SMI) registers undergo a physical health check each year
- Eliminate acute mental health out-of-area placements by 2020/21
- Deliver of the Emergency Care Standard
- Reduce the numbers of patients admitted as emergency cases for bed-based care
- Reduce bed days lost due to delayed discharges to 2.5% of the acute bed base by 2020/21
- Reduce the numbers of learning disability inpatient placements to 40 per million population by 2019/20
- Reduce the staff capacity gap by building multi-disciplinary teams and ensuring wider skills base for specific functions (e.g. care home worker)
- Ensure that 80% of people with a diagnosis of dementia will have been offered information and support to live with the condition, and a named contact with a 'care navigator' role, by 2020

Finance and efficiency

- Our forecast for 2020/21 across Health and Social Care is a 'do-something' deficit of c£46m.
- The partners in the city are investing resources in the continued development and implementation of our local improvement plans. Our assumption is that we will receive our 'fair share' of national Sustainability and Transformation Funds and that our gap will be bridged through a combination of this funding, further local developments and the Leeds share of benefits delivered through the West Yorkshire and Harrogate workstreams.

Leeds: Progress so far and next steps

Progress so far

- A number of New Models of Care testbed sites across the city; 13 Integrated Neighbourhood Teams and Discharge teams launched.
- 'Choose Leeds' pan-sector recruitment campaign ongoing with events supported collaboratively across the seven Leeds partners; 'Citywide Workforce Database' established. Health and Care Academy plans initiated.
- Identified opportunities to pilot a One Workforce approach across the Health and Social Care system.
- Leeds Care Record in place, with ongoing developments to link to other health and social care record systems
- Plans underway to align workforce engagement with the wider culture change ambition.
- Phased estates review underway and early recommendations for site re-configurations being taken forward.
- Citywide Procurement review covering transport, utilities, agency staffing, stationery, catering and security underway.
- National Diabetes Prevention Programme (NDPP) pilot commenced July 2016 with 66 practices recruited so far and referrals commenced.
- Significant progress on the informatics agenda through the national Pioneer informatics network, led by Leeds
- Successful bid for innovation monies for projects such as digital literacy in the workforce, health coaching, development of provider governance tools and evaluation of the proactive telecare pilot (approx. £200k).
- Digital discovery workshops held on Prevention and House of Care; and Rapid response at time of crisis (0-4hrs) set in the context of the Urgent Care strategy, with findings validated with Leeds citizens.

Next steps

- National Diabetes Prevention Programme pilot: GP practices have access to referrals process – October 2016.
- Integrated discharge service live from January 2017.
- Expand Leeds role as a centre of excellence for precision medicine during 2016-17 including the launch of the Centre for Personalised Medicine and Health in February 2017.
- New models of care pilot: Interim evaluation report and recommendations – September 2017.
- Phased Communications plan completed and enacted by December 2017.
- Early Implementer of 7 day services (LTHT site) 2017-18 and roll out of extended access to Primary Care in 2018/19 and 2019-20.
- Further development of integrated out of hospital care based on NMC work to date exploring potential new community contract models.
- Leeds General Infirmary, significant site re-development planned to support major trauma and consolidation of children's hospital as part of development of the Leeds innovation district.

Wakefield: Overview of place and plan

Our aspiration for 2020/21 is that we want people in Wakefield to have healthier, happier and longer lives with less inequality. Wakefield continues to have significant health issues despite much progress being made. Our JSNA reaffirms to us that our Health and Wellbeing Board priorities of early years (with a focus on childhood obesity, and maternal smoking at delivery), long term conditions (including diabetes, respiratory and circulatory diseases), Mental Health (including dementia and self harm) and older people (including reducing social isolation and falls) will address the health and wellbeing gap for Wakefield. We need to continue to tackle variation in care and to reduce health inequalities across the district. Constitutional indicators such as Referral to Treatment and A&E waiting times also will have a significant focus over the next five years to ensure we provide the best quality of care to our patients.

High-level overview of plans

- Continue to implement our reconfiguration of hospital services across the Mid-Yorkshire Hospital footprint through the Meeting the Challenge programme, working towards delivery of seven day services for all acute care.
- Building on Meeting the Challenge, further transforming the provision of acute care at the regional or sub regional level.
- Develop a local network of urgent Health and Social Care Provision including out of hours provision, walk in and minor injuries, emergency departments, ambulance services, hyper acute centres and effective utilisation of 111 services.
- Further collaborative working with Mid-Yorkshire Hospital to develop a demand management approach to our planned care cohort.
- Collaborate with practices and Health and Social Care providers to develop and deliver high quality, evidence based, out of hospital services including advanced diagnostic testing, maternity care, specialists doctors, nurses and therapists and viable smaller hospitals
- Deliver a collaborative approach to working across the health and social care sector to ensure integrated care across primary and community providers.
- Prevention and early intervention with a specific focus on obesity, smoking prevalence, cardiology, respiratory, mental health and frail elderly working towards a collective prevention resource across the health and social care system.
- Implement a new Multi-Speciality Community Provider led Accountable Care System in Wakefield.
- Develop an ambitious co-owned strategy for ensuring safe and healthy futures for children and young people.
- Develop a new business model for the provision of corporate functions and corporate services across Wakefield, including estates, workforce and digital.
- Ensure person-centred primary care through our deliver of the the GP Forward View.
- Deliver a collaborative approach to self care.

Wakefield: The triple aim

Health and wellbeing

- Reduce Smoking prevalence by 2.4% by 20/21 bringing it lower than the current West Yorkshire and Harrogate average.
- Reduction of physical inactivity in adults from a baseline of 29.8% (2015) by 4.8% by 20/21 bringing it below the current England average.
- Reduce premature mortality from CHD to 42 per 100,000 by 20/21.
- Reduce premature mortality from COPD to 19.5 per 100,000.
- By April 2017 to achieve access standards for Early Intervention Psychosis service of >50% of people with a first episode of psychosis receiving treatment within 2 weeks, 75% referred to IAPT being treated within 6 weeks and 95% within 12 weeks.
- By 2020/21 to have reduce Injuries from falls in people aged 65 and over to 1827 per 100,000 population.
- By 2017 we will reduce our percentage of young people who are Not in Education, Employment or Training (NEET) to 4.5%.
- As part of the Integrated Pioneer programme, roll out a workplace wellness check service for 1,000 Wakefield System employees per year from January 2017.

Care and quality

- Working collaboratively across MYHT, the LA and the CCG to reduce DToC by 3.5%.
- Increase and maintain dementia diagnosis to 67% by 2020.
- Increase the number of GP practices signed up to carrying out health checks on adults with learning disabilities from 37 to 40.
- Maintain our performance around diabetes, sharing learning and taking part in the diabetes prevention programme.
- By April 2017, reduce maternal smoking at delivery to 18%.
- Agreed with MYHT, non face-to-face telephone appointments as the default booking approach for follow-up appointments, with defined exceptions to this, with effect from 1st October 2016.
- From 1st October 2016 agreement with MYHT for e-consultation to be the default option for GPs to access outpatient care, via specialist advice and opinion, in Cardiology, and then Gastroenterology; Ear, Nose and Throat, and Pain Management.

Finance and efficiency

- Delivery of £229m efficiencies against the 'do nothing' trajectory to deliver financial balance across the Wakefield system by 2020/21. Local contribution estimated as £185m and with additional measures at West Yorkshire & Harrogate level.
- Delivering a fully integrated model of accountable care of which a financial business case in development.
- An optimised back office for Wakefield, including workforce, IT and estates.
- Collaboration between acute care providers both on a regional and sub regional level.
- Fulfilling our statutory duties locally to achieve constitutional targets, in particular A&E 4 hour wait, 18 week Referral to Treatment and working towards our 28 day diagnosis standard.
- In addition, delivery of financial opportunities including RightCare, partnerships with public health making savings through better health and wellbeing outcomes, care home vanguard, Urgent and Emergency care redesign and planned care reform through a collaborative approach to demand management.

Wakefield: Progress so far and next steps

Progress so far

- We have centralised surgery and paediatrics as part of the ongoing Meeting the Challenge programme of service reconfiguration in Mid-Yorkshire Hospital Trust.
- We have developed the Wakefield Connecting Care Integrated Workforce Framework to support our transformation work.
- We have successful care home and MCP vanguards that have brought both commissioners and providers together to support and agree a joint committee for our MCP.
- Our new model of integrated care has been comprehensively evaluated and has highlighted that 96% of our patients felt that they were treated with kindness and compassion.
- Our five GP Federations are working in partnership with us to execute the Five Year Forward View and are fully aligned to development of an Accountable Care System.
- We have developed strong governance and accountability through our Health and Wellbeing Board supported by our STP which has clear lines of accountability
- We are better at meeting the needs of some of our most vulnerable patients having commissioned Mental Health workers in each of the Connecting Care Hubs.
- We have commissioned Mental Health Navigators in collaboration with Wakefield District Housing to support their tenants with a wide variety of mental health needs.
- Working with West Yorkshire Police we have been successful in securing £140k funding to implement a Street Triage scheme which will provide better support both to patients and police and lead to less patients inappropriately being held in s136 or custody suites and getting timely support.
- We have maintained a focus on our children and young people through our Children and Young People IAPT programme and our Future in Mind programme.

Next steps

- By January 2017 we will have an operational plan which is aligned to activity and interventions with clear lines of accountability.
- Development of a Joint Committee in across commissioners and providers for our MCP by January 2017 to support the development of an Accountable Care System.
- Final business case approval for the MCP October 16.
- Engagement process for MCP starting Oct 16 and market engagement Dec 16.
- Develop Accountable Care Organisation by 2020/2021 bringing provision and integrated commissioning together to improve quality of delivery for community care.
- Business case for integrated support services through Local Services Board 2017.
- Full implementation of the Meeting the Challenge reconfiguration of services to deliver 7 day services for all acute care by 2019

Section 4: West Yorkshire & Harrogate proposals

Prevention at Scale

Smoking

- **Reduce smoking related admissions and demand on services**
- Systematic implementation of NICE guidelines in acute and MH services
- Effective communications across multiple media to support quit attempts

Alcohol

- **Reduce alcohol related admissions of those placing disproportionate demand on A&E and hospital beds**
- Systematic implementation of hospital based alcohol liaison services, in-reach by community alcohol services and assertive outreach

Obesity

- **Reduce the number of people currently at high risk of diabetes from going on to develop diabetes and reduce future demand on services**
- Systematic early identification and intervention
- Annual review and access to healthy living services including intensive lifestyle behaviour change programmes

Workforce and prevention

To enhance the health and social care workforce contribution to place based preventative care and lifestyle behavioural change

- Embedding 'Making Every Contact Count' into everyday practice
- Embed the principles and standards of Health Promoting Hospitals

Prevention at Scale

Key milestones and decisions

- **Nov 2016** Workforce workshop to work up priorities & plan
- **Nov 2016** Leeds NDPP all practices to have access to referral process
- **Nov 2016** Calderdale, Wakefield, Kirklees NDPP bid submitted
- **March 2017** Follow up on Alcohol Care team Review with partners to identify next steps
- **March 2017** Review alcohol related A&E data to understand barriers to implementing Cardiff model
- **Summer 2017** Workforce regional conference with 3rd sector, emergency services
- **Summer 2017** New e-learning resource to support MECC
- **2017** Harrogate to be 3rd wave NDPP
- NICE guidance on smoking:
- **Mid 2017** Communications and marketing
- **End 2017** implementation community /MH Trusts
- **End 2018** Implementation Hospital Trusts

Impact

Health and wellbeing

- ↓ Alcohol related mortality reduced
- ↓ Reduce smoking prevalence from 18.6% to 13% by 2020 (or by 105,000 smokers)
- ↓ Reduce cardiovascular mortality
- ↓ Reduce cancer mortality
- ↓ Reduce numbers of high risk of developing diabetes by 30-60% by 2020

Care and quality

- ↓ Reduce alcohol related hospital admissions (narrow & broad measure) by 3%
- ↓ Reduce smoking attributable admissions in people over 35yrs
- ↑ Increase successful quit rates at 4 weeks per 100,000 smokers
- ↑ Increase numbers of identified at high risk of diabetes by 20% from baseline
- ↑ Numbers of attending NDPP programme and number of referred to Health Living Services
- ✓ Progress on meeting Health Promoting Hospitals standards
- ✓ Increased numbers of staff trained in Making every contact count

Finance and efficiency

- ↓ An investment of £825k for five Alcohol Care Teams would lead to a reduction of 500 alcohol related admissions a year, resulting in a £3.17m ROI per year (Note: does not account for current services – that is variable)
- ↓ An investment of £450k would lead to a reduction of 50,000 smokers over 5 years at a saving to the NHS of £9m. Maintenance of current investment is required to continue a similar decline and savings over the same time period.
- ↓ Diabetes cost between £1107 – £2836 per year. West Yorkshire and Harrogate has an estimated 226,000 people at high risk of diabetes, if 50% attend and 50% do not go on to diabetes the savings are £62.5m - £160m over 5 years.

Primary and community services

It is fundamental that primary care is locally planned and delivered to best meet the needs of local populations and deliver the commitments of the GP and MH Forward View documents (as set out in our six place-based plans). By working at a West Yorkshire and Harrogate level we can add value through:

- Sharing best practice and innovation
- Collectively determining what good care looks like
- Agreeing shared principles and operating to these.

In West Yorkshire and Harrogate we consider primary care to encompass a wide range of services supporting the health and wellbeing of the population, this includes general practice, community provision to meet physical health, mental health and social care. Many services delivered by councils and the third sector sit firmly within our definition of primary care.

We have defined these principles with representatives from general practice, community services, mental health services, social care, voluntary and community services with Healthwatch.

Leadership for this work is provided through two Chief Executives of community provider organisations, our RCGP Ambassador for West Yorkshire and Harrogate STP and Medical Advisor (Primary Care Strategy, NHS England Yorkshire & Humber) chairing the primary and community workforce group for West Yorkshire & Harrogate.

Next steps

The transformation of hospital care is predicated on the ability for all of primary care to work differently and collaboratively with patients' needs at its heart.

We must focus our energy in the right places and this means defining a few areas of focus in collaboration with our acute providers. These areas will be defined by:

a) good quantitative evidence at West Yorkshire and Harrogate level that this is a material issue and can deliver benefit.
b) evidence on a West Yorkshire level that the population's healthcare needs can be addressed in the community both effectively and sustainably.

Primary and community services

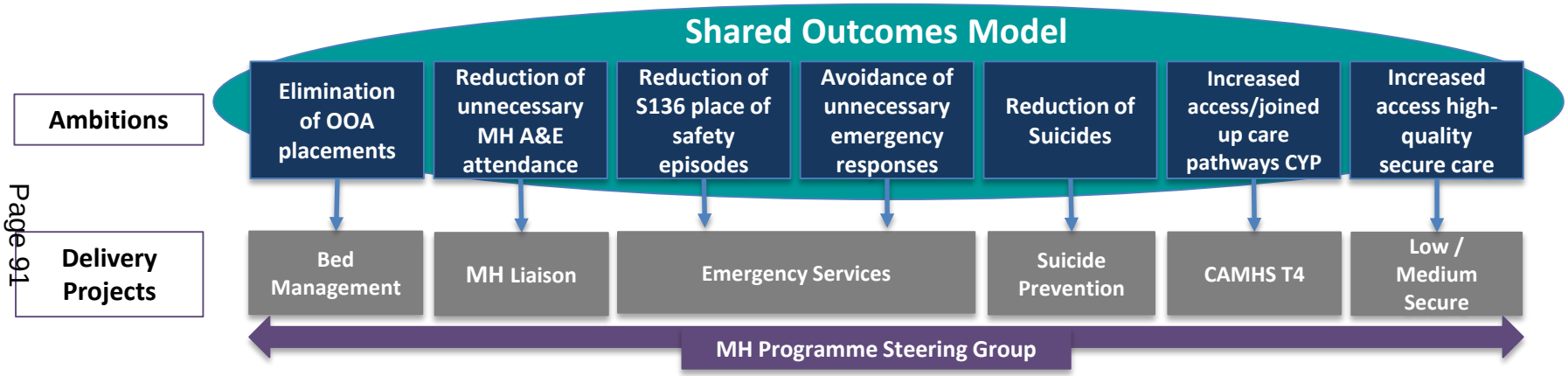
Our principles for high quality primary care in West Yorkshire and Harrogate:

- We will deliver good quality integrated primary care to local populations, with 24/7 services that meet the needs of that local population, ensuring that services are organised around peoples' needs. This will be planned around a population size of c.30,000 – 50,000 (locally determined) with all resources focused on the holistic and community oriented care of that population.
- We will be bold in the adoption of the prevention at scale transformation to create a system-wide 'left shift' as a central philosophy, which will mean a fundamental move to enabling people to self-care and stay well for longer
- We will embrace new and existing technology to support people using services, their carers (paid and unpaid) in their care
- People will be partners in their care and engaged and involved at every level – this could mean the scaling of health coaching and or asset based approaches to care
- We will breakdown the culture of organisational silos and barriers to give the best care to our populations, focusing on the values of those people who work in primary care
- We will stop medicalising issues and ensure people get the right support from the right professional. We will look outside the clinical model to deliver a more holistic service to our local populations and achieve better outcomes; prescribing will not be the default position.
- We will ensure that we have the right workforce, in the right place, to deliver services. The people who make up the workforce will be energised, happy and fulfilled in their work and not limited in their ability to care
- We will create the space for primary care thought leadership which will allow innovation to flourish for the benefit of our patients. We will recognise and better share the real examples of transformation, best practice and new ways of working. In West Yorkshire and Harrogate we have great people doing great things, we will harness and share this, learning from one another.
- We must be bold in rationalising our estate where this mutually agreed and evidence shows that this in the interests of patient care and integrated working, ensuring that more public sector estate is utilised cohesively and to best value.

Mental health

The providers of mental health services, working with commissioners and partners, are developing a **Shared Outcomes Model** to reduce variation in quality, improve outcomes and drive efficiency to ensure the sustainability of services.

Collective system ambitions and outcomes include: delivery of 7-day services, reducing out of area placements, ensuring people in crisis get the multiagency care they need, more care delivered in the community and full system pathway integration. Also key to achieving this ambition will be shared models for support services e.g. workforce planning and IT. Additional clinical areas have been identified as areas to be planned and developed at a West Yorkshire and Harrogate level these are; ADHD, Autism, eating disorders and perinatal services. The delivery of the Five Year Forward View for Mental Health is through interconnecting plans of the West Yorkshire and Harrogate level programmes and the six place-based plans. The focus of this programme is the delivery of acute/in patient services, specialist services that can be delivered over a larger footprint or where the pathway requires a full system approach.



Progress so far…

- ✓ A new Safe Haven has been established in Bradford for people experiencing mental health crisis, with work underway to evaluate and inform roll out of similar models in other parts of West Yorkshire and Harrogate.
- ✓ Safer Spaces pilot for children and young people which will be rolled out to other parts of West Yorkshire and Harrogate, ensuring that young people requiring crisis care do not end up in police cells or A&E
- ✓ Introducing a model that places mental health nurses in police control rooms to establish effective ways of ensuring people in crisis receive the appropriate mental health support they need.
- ✓ Mental health screening tool and approach to mental health training across acute wards as an in-reach approach to driving a coherent, integrated and comprehensive mental health assessment for all patients is in development
- ✓ A system-wide multi-agency suicide prevention strategy is in development

Mental health

Key milestones and decisions

Quarter 4 2016/17:

- Business case for control room MH nurses
- MH Liaison service proposal developed
- Suicide strategy and plan developed
- Business case for safer community spaces for adults and children
- Target operating model developed for provider trust support services

Quarter 1 2017/18:

- Plan developed CYP in patient units (integrated with local pathways) eliminating inappropriate placements
- Plan developed for Low/medium secure services and associated pathways

Quarter 2-4 2017/18:

- Bed management proposal developed to support reduction in out of area placements
- Proposal developed for standard approach to commissioning acute mental health services across West Yorkshire & Harrogate
- Provider alliance governance to be formalised

Impact

Health and wellbeing

↓ Reduction in mortality rates for mental illness

↓ A zero suicide approach to prevention, aspiring to a 75% reduction in numbers by 2020-21

Care and quality

↓ Reduction in local variation of quality in services

↓ Elimination of out of area placements for non specialist acute care within 12 months

↓ 50% reduction of S136 PoS episodes both police and health based places of safety

↓ 40% reduction in unnecessary A&E attendance

✓ Deliver waiting time standard for CYP eating disorder service

✓ Deliver EIP target across West Yorkshire and Harrogate

↑ Increased access rates to IAPT services

↑ Increased access to 24/7 urgent and emergency mental health services for CYP

↑ Increased access to specialist perinatal mental health healthcare

Finance and efficiency

✓ Delivery of the 5YFV for MH will require investment in services.

✓ This programme will support the delivery of system and provider cost improvement programmes reinvested in mental health care

Cancer

The focus of the Cancer programme is to deliver the national cancer strategy in a way that makes sense in our region, ensuring that we deliver the best outcomes and experience. This includes:

Define **the characteristics of high quality primary care services** in support of the cancer ambitions

Understand the gap in diagnostic capacity required to deliver our ambition in relation to shift in stage of diagnosis.

Develop and deliver pathways for95% of patients referred with suspicious symptoms to have a. **diagnosis within 28 days**

Develop approaches to **using feedback from people affected by cancer** & **engaging them directly in service improvement**, e.g. pilot real-time interactive patient portal

Delivering the pledge to on **recovery package interventions and risk stratified follow-up** by 2020

Improvement in treatment services driving out variation in practice and outcome, based on best available evidence, focused on chemotherapy in first instance.

Agree protocols for MDT working to **release clinical resource** without compromising quality.

Develop and pilot more **strategic approaches to commissioning and provision of cancer care.**

Progress so far…

- ✓ Re-establishment of local system leadership, securing stakeholder agreement for a chief executive-led Alliance Board reflecting multi-disciplinary and geographic diversity at a senior level & supporting programme infrastructure with strong executive buy-in.
- ✓ Secured agreement for the Alliance Board to develop a single delivery plan for cancer for West Yorkshire and Harrogate with a dual emphasis on delivery of the clinical priorities in the national cancer strategy and the system behaviours and requirements to facilitate this through more collective, strategic approaches to provision and commissioning.
- ✓ Successful in bidding to host two pilot sites for multidisciplinary diagnostic centres and a 28 day standard test site.
- ✓ Cross system deep dive to agree local priorities April 2016, baseline inventory of activity against the 96 Cancer Taskforce recommendations.

Cancer

Key milestones & Decisions

2016/2017

- Agree headline diagnostic growth and cancer content for 2 year operational plans

2017/2018

- Sign off Alliance Delivery Plan (April) including 5 year diagnostic capacity building plan.
- Commit to local action plans to deliver Recovery Package & risk stratified post-treatment pathways by 2020
- Produce option appraisal for service model for strategic diagnostic growth. Agree preferred model.
- Develop and agree to pilot new strategic approaches to commissioning and provision of cancer care.

2018/19

- Implementation planning for new diagnostic models including consultation as necessary.
- Roll out new protocols for MDT working.
- Agree implementation plans for delivery of 28 day Faster Diagnosis Standard.
- Begin implementation of commissioning policy to address variation in chemotherapy prescribing.

2019/20

- All cancer patients to have tailored support to live well and as independently as possible beyond diagnosis.

2020/21

- 95% of people referred for investigation of cancer symptoms to have diagnosis within 28 days.

Impact

Focus of the Cancer Programme is on spending the West Yorkshire and Harrogate pound as cost effectively as possible to deliver the highest possible outcomes and experience.

Health and wellbeing

↓ Reduce adult smoking rates from 18.6% to 13% resulting in c105,000 fewer smokers and c11,250 averted admissions.

↑ Increase 1 year survival from 69.7% to 75% equating to c700 lives per year.

↑ Increase stage 1&2 diagnoses from 40% to 62% offering 3,000 extra people the chance of curative or life extending treatment.

Care and quality

↑ Increased % of patients formally invited to feedback to improve services over and above CPES (target TBC)

✓ Deliver the 28 days to diagnosis standard for 95% of people investigated for cancer symptoms to deliver faster diagnosis for c5,000 people currently diagnosed with cancer through RTT pathways.

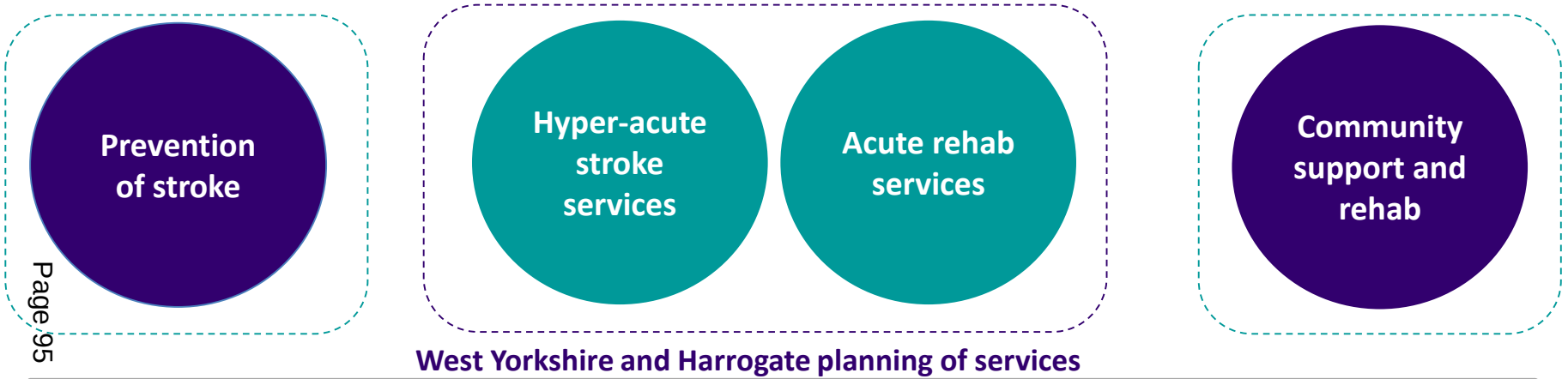
Finance and efficiency

↓ Estimated savings of up to £12million over 5 years based on lower treatment costs associated with earlier stage diagnosis for many forms of cancer.

↑ Delivering this efficiency will require growth in diagnostic capacity of c2-3% additional to that in local baseline trajectories.

Stroke

Considerable progress has been made to improve outcomes for stroke patients across West Yorkshire and Harrogate. Variation continues to exist in outcomes and quality of services. Our work focuses on the whole stroke pathway with stroke prevention and community rehabilitation and support delivered in local places to meet the needs of the specific populations; these elements will be locally planned with a consistent approach determined by clinicians and stakeholders across West Yorkshire and Harrogate to reduce variation. We've already worked together on preventative measures to detect and treat atrial fibrillation. In West Yorkshire and Harrogate, future sustainability and patient flow requires that we focus on hyper-acute stroke services and acute rehabilitation together on a regional basis to deliver the best possible outcomes for those people affected by stroke.



West Yorkshire and Harrogate planning of services

We currently have five hyper-acute stroke units in West Yorkshire and we know that this is not sustainable for the future. The Strategic Clinical Network has produced an in-depth blueprint which details service models to ensure delivery of the best clinical outcomes for patients who need hyper-acute stroke care. This indicates that we will need to reduce the number of hyper-acute stroke units across West Yorkshire and Harrogate, so that our services are safe and resilient. In doing so, we will save more lives, reduce ongoing disability and ensure better care and quality of service for patients, including provision of a consistent service over seven days.

Our plan:

- Work with key stakeholders to understand the options for delivering stroke services – we've started this process.
- Formal consultation with our population on the configuration of hyper-acute and acute rehabilitation of services
- Because of our geography, we'll be working closely with our colleagues across the wider Yorkshire and Humber footprint to ensure high quality, sustainable hyper-acute stroke services for all.

Stroke

Key milestones & Decisions

End December 2016 - Stage 1 NHSE Assurance - Strategic Case for Change (SCfC) assurance and sign off

End January 2017 - Stage 1 NHSE Assurance - SCfC sign off by NHSE

End April 2017 - Stage 2 NHSE Assurance – Outline Business Case sign off (subject to Stage 1 NHSE approval to proceed)

End May 2017 - Stage 2 NHSE Assurance – OBC sign off by NHSE and approval to proceed to Formal Consultation

End September 2017 - Stage 3 Assurance – Formal Consultation completed (Subject to NHSE Stage 2 approval)

End December 2017 - Stage 3 Assurance – Consultation outcome and recommendation considered by HF Collaborative Forum (Subject to NHSE Stage 1 and 2 approvals)

End February 2018 - Stage 4 Assurance – Delivery Plan prepared and signed off

2018/19 Mobilisation to commence subject to completion of all of above & dependent on procurement approach.

Impact

Improving access to high quality, safe, sustainable and resilient emergency & urgent stroke care for patients across the West Yorkshire and Harrogate footprint in line with agreed vision for stroke:

To reduce the incidence of stroke and avoidable deaths due to stroke, across the West Yorkshire and Harrogate health economy, minimising the long term effects and improving the quality of life for survivors. This will be achieved by providing consistently high quality care that is responsive to individual needs and through encouraging healthier lifestyles and reducing inequalities in risk factors of stroke.

Health and wellbeing

- ↓ Under 75 mortality rate from CVD NUMBERS
- ↓ Reduce hypertension QOF prevalence all ages national / West Yorkshire and Harrogate / CCG
- ↓ Reduce premature mortality from stroke
- ↓ Reduce incidence of stroke (e.g. anticoagulant treatment – for every 25 patients with AF receiving an anticoagulant, we can avoid one stroke every 18 months)

Care and quality

- ↓ Reduce median time between clock start and thrombolysis
- ↑ Increase proportion of stroke patients assessed by a stroke specialist consultant physician and nurse trained in stroke management within 24 hours of clock start
- ↑ Increase proportion of patients given swallow screen within 24 hours of clock start
- ↑ Increase proportion of patients scanned within 12 hours
- ✓ Implementation of 7 Day Standards (2, 5, 6 and 8) for stroke services

*Increase from Blueprint SSNAP performance data (Oct – Dec 2015)

Urgent and emergency care

Our vision for Urgent and Emergency Care is for:

- adults and children with **urgent care needs**, we should provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients, carers and families
- those people with **more serious or life-threatening emergency care needs**, we should ensure they are treated in centres with the right expertise, processes and facilities to maximise the prospects of survival and a good recovery

Our work is focused on:

- **Hear, See and Treat –** delivery of a Clinical Advice Service (CAS), integration of 111 and out of hours services, working on a Yorkshire and Humber basis to integrate 999 with 111 services, developing the ambulance service to provide a treatment service rather than conveyance function only by March 2017. So that people get the right access to the right people at the right time
- **Primary Care –** building on the local development and delivery of primary and community new care models to manage the urgent needs of patients in community settings - the delivery of direct booking from 111 extending from out of hours to extended and in-hours services. Delivery of a Pharmacy Urgent Repeat Medication service (PURMs) across West Yorkshire and Harrogate in partnership with community pharmacies.
- **Designation –** develop and deliver plans for configuration of services across West Yorkshire and Harrogate
- **7 day services** - work collaboratively to deliver sustainable 7 day services across the clinical priority areas (Vascular, Stroke, Acute Paediatrics and Cardiology)
- **Technology/inter-operability** – improved access to a patient's summary care record with an increasing amount of information available. Remote working facility for CAS clinicians. Delivery of a care record for 999 staff. Direct booking technology.

Progress so far…

- ✓ Out of hours booking facility improved. In-hours booking tested with EMIS. Remote access tested. SCR access improved for 111 staff.
- ✓ Pilot in hours booking of appointments from NHS 111 to GPs due to go live imminently with further roll-out in Quarter 4 2016/17.
- ✓ Pharmacy Urgent Repeat Medications enabling NHS 111 to direct callers to local pharmacy live
- ✓ Strong engagement in the Hear, See & Treat programme with face to face sessions in hospital and GP practice waiting rooms; meetings with voluntary and community groups and attendance at sports days, colleges and care homes. We received 2,585 completed surveys either via face to face engagement activities or social media advertising. The results show us that the majority of people that responded support the proposals. The engagement work reached over 300,000 people in West Yorkshire and Harrogate.

Urgent and emergency care – Acceleration Zone

West Yorkshire and Harrogate has been identified as the only urgent and emergency care 'acceleration zone' nationally in September 2016. We have developed some proposals (awaiting approval) which build on our existing work with the target to achieve 95% 4 hour A&E target and 30% 111 calls transferred to a clinical advisor in March 2017. The trajectory will be dependent on resources available which are yet to be confirmed.

Programmes	Main Projects
Pre-hospital Care Increase availability of primary care, 111 and other alternatives to avoid A&E attendances	**Primary care :** Increase access to primary care out of hours **111 :** Mobilisation of enhanced clinical advisory (mental health, palliative care, pharmacy and generic advice) and home-working; direct booking proof of concept to 20 GP practices; West Yorkshire and Harrogate marketing campaign to promote 111 **999:** Continuation of Ambulance Response Programme pilot; call centre access to A&E consultant **Care homes (major 999 users):** 111 and telemedicine in care homes **Mental health:** Pilot high volume service user team in Leeds
Streaming and Ambulatory Care Increase access to alternatives to A&E and access to ambulatory care once patients attend the emergency department	**Streaming:** Pilot NHS Pathways Reception Point ("Blackpool model") at Dewsbury and Bradford EDs; implement trust schemes to deliver primary care streaming at EDs without 111RP; pilot online NHS Pathways app at EDs without 111RP **Ambulatory Care:** Implement trust schemes to increase access to ambulatory care pathways (aiming for 12 hours 7days) **Mental health:** Increase access to mental health liaison as part of MH Vanguard
Flow and Discharge Improve flow through hospital and discharge from hospital to reduce length of stay	**SAFER wards:** Implement SAFER bundle across all trusts: early senior review; red/green day and afternoon huddle **Discharge:** Implement trust schemes to deliver Discharge to Assess and Trusted Assessor; rollout pharmacy discharge and re-admission avoidance **Care homes:** Purple bag scheme in care homes and trusts; end of life care plans; daily bed state

Urgent and emergency care

Key milestones & Decisions

October 2016: Defining and delivery of the WY UEC Acceleration Zone in the four key areas

January 2017: Agree outline approach to designation

March 2017

- 30% of calls transferred to a clinical advisor through NHS 111 by March 2017
- System delivery of the 95% A&E 4 hour standard across Acute providers
- Meet the four priority standards for 7 day services
- Pilot direct booking from 111 in 22 GP practices in-hours and further roll-out

Ongoing work: 2016/17 and 2017/18

- Significant improvements in the development of the clinical advice service which supports NHS 111, 999 and out-of-hours calls
- Reconfiguration of services, priority pathways and wider STP work
- Ongoing benefits realisation work & ROI working with YHEC and the AHSN

Impact

Health and wellbeing

↓ Reducing mortality rates

Care and quality

✓ Improve patient experiences substantially, including patient choice

✓ Provision of high quality and safe care across all seven days of the week

↓ Reduce ambulance conveyances to ED by 12% by 2021 (23,033)

↓ Reduce avoidable emergency admissions by 3% by 2021 (1,693)

↓ Management of demand and expected growth of ED attendances - reduce ED attendances by 4% by 2021

↓ Reduction in average length of stay

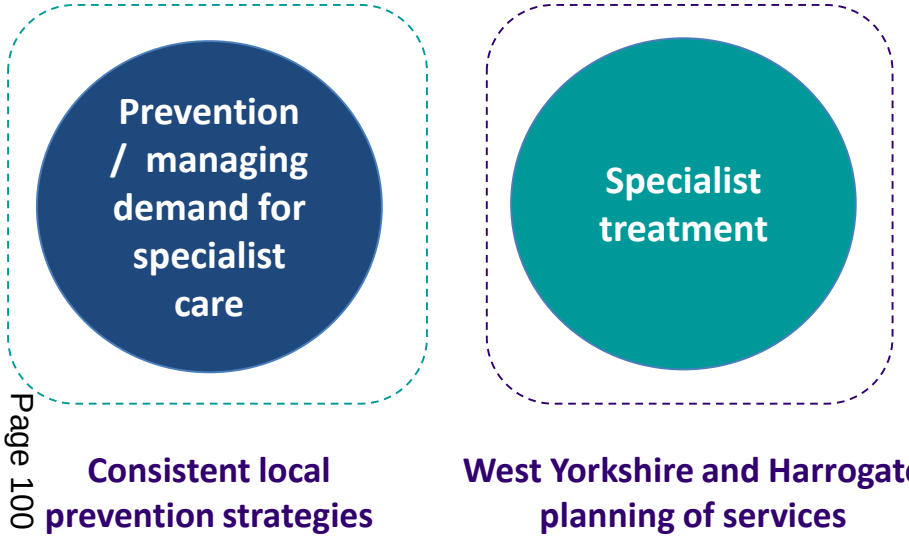
↓ Reduction in avoidable readmissions

Finance and efficiency – including planned savings and planned investment required

✓ The Vanguard ROI is expected to be £12m by 2020/21 (excluding the Imaging Collaborative) focused on the eight elements of integrated urgent care (IUC)

✓ Integrated urgent and emergency care services that manage demand more effectively have the potential to be significantly more cost-effective than existing arrangements

Specialised commissioning



Our approach to specialised commissioning and provision of specialist services is two-fold. Firstly to manage the demand for specialist services e.g. reduce the increasing demand for bariatric surgery through consistent preventative approaches to tackle obesity and implementation of consistent weight management services across West Yorkshire and Harrogate. This is primarily being planned and delivered by local places in line with the needs of their local population. The second element is the provision of specialist services and how this is planned and delivered to ensure services are sustainable and fit for the future. This will mean services will be provided through a networked approach. To do this we must plan collaboratively at a West Yorkshire and Yorkshire and Humber level.

Impact

A West Yorkshire and Harrogate Specialised Services Steering Group (CCGs, Cancer Alliance Board reps, Providers and NHSE Specialised Commissioners) has been established to take forward collaborative approaches to planning and transforming services and work in 2016/17 has already commenced on:

- **CAMHS Tier 4 Beds** – aim to improve outcomes for CAMHS patients and reduce out of area placements - West Yorkshire and Harrogate Review to commence early 2017
- **Vascular –** implement the optimum model of service provision across Yorkshire & Humber that best meets the needs of patients and improves patient outcomes, addresses inequality of access and ensures quality of service provision in line with the national specification - Clinical Senate Review Nov 2016
- **Complex Neuro-rehab –** develop and agree a Yorkshire & Humber wide collaborative strategy for specialised rehabilitation for adults with acquired brain injury (ABI) which is intended to address under-provision of level 1 or 2a facilities. This will improve patient experience and reduce delays. Service review completed Q3 2016/17
- **HIV –** review arrangements to ensure future resilience and sustainability of HIV provision and improve patient access.
- **Specialist weight management** - identification and implementation of transformational opportunities for services and pathways prior to entry to tier 4 services set in the context of place-based obesity strategies.

Acute Collaboration

Clinical standardis-ation for efficiency

- 'Centres of excellence' approach to higher acuity specialties eliminating avoidable cost of duplication and driving standardisation
- WY standardised operating procedures and pathways. Building on current best practice and using GIRFT to drive out variation in quality as well as operational efficiency.
- Elective centres to increase quality, maximise efficiency and reduce cost
- Operational clinical networks and alliances as a vehicle for sustainable services (e.g. HAS, head and neck cancer, vascular, pathology and radiology)
- Workforce planning at scale and managing workforce risk at system level supporting free movement of bank and agency staff under single shared Bank arrangements.
- Deliver economies of scale in corporate services e.g. procurement, pathology services, estates & facilities management , informatics and other infrastructure

WY Pathology Strategy

Including specialist services and integrated IT platform

Workforce planning at scale

Focused on securing the pipeline of 'fit for purpose' staff and improved productivity

WY Strategy Corporate Services

Inclusive of:

- Procurement
- Estates & facilities management
- Finance
- HR
- Informatics

The default position for these services is collaboration. This is being explored with other providers in order to increase scale / economies of scale.

Progress to date:

- ✓ Consultation on CHFT strategy completed
- ✓ Phase 2 of MYHT reconfiguration implemented
- ✓ Diagnostic and case for collaboration jointly commissioned by WYAAT
- ✓ Established working groups for Estates & Facilities, Finance Procurement, HR & Workforce
- ✓ WYAAT Radiology Collaborative established
- ✓ Collaborative strategy and supporting programme infrastructure in development
- ✓ Proposed operating model for WYAAT alternative service delivery models in development
- ✓ Establishing Committee in Common

Acute Collaboration

Key milestones and decisions

October 2016

- Commence development of Case for change for Pathology & Corporate Services
- CHFT reconfiguration

December 2016

- Business Case for Acute Collaboration programme

December 2016

- Acute collaboration decision making Framework

March 2017

- Establish programme infrastructure
- Pathology and Corporate Service plan agreed

May 2017

- Final phase of MYHT implementation

June 2017

- Clinical standardisation plan and Timescales developed
- LGI masterplan for specialist services
- ASDM for corporate services established

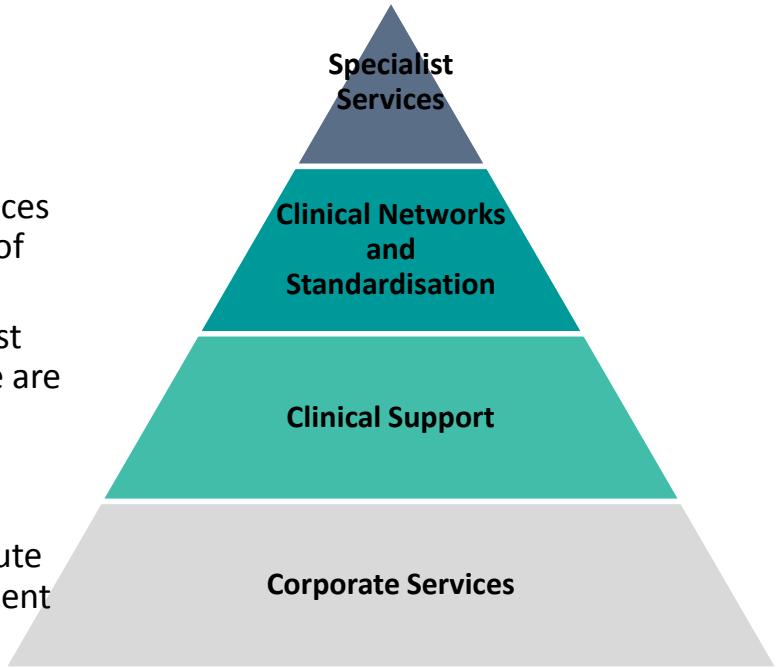
2017-2021

- 3 year programme for clinical and non-clinical transformation with milestones agreed to 2021

Impact

There are significant challenges in the acute sector and through collaborative working, standardisation and operational networks acute providers will reduce variation and improve resilience. Delivering efficiencies will require standardisation in the wider system of out of hospital care focusing on an integrated approach to demand and patient flow (Delayed Transfers of Care). The impact of the acute collaborative strategy and wider system alignment will be to fundamentally underpin our ambitions to close the three gaps in West Yorkshire and Harrogate, including:

- Consistent delivery of constitutional targets
- Improved patient experience
- Improved safety in services by consistent adoption of good practice
- Ensuring services in West Yorkshire and Harrogate are more resilient
- Reduce reference cost variation
- Underpin delivery of acute provider cost improvement programmes

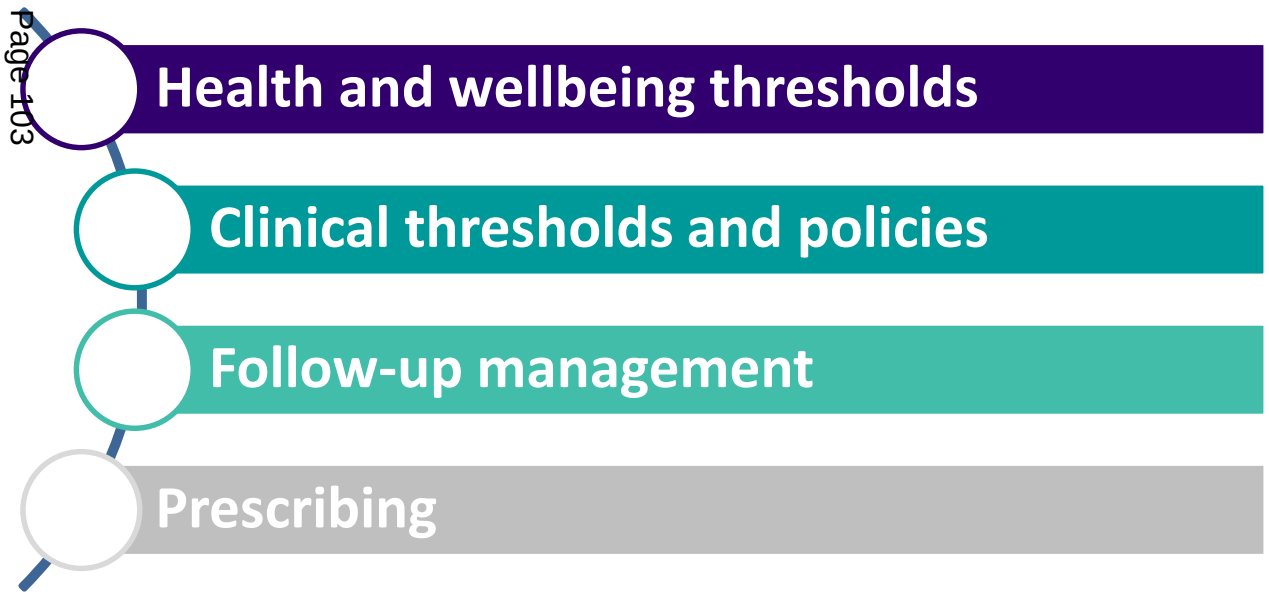


Standardisation of commissioning policies

This work supports our ambition to reduced unwarranted variation and standardise clinical practice across West Yorkshire and Harrogate. We will utilise RightCare methodology, commissioning for value data and evidenced-based clinical thresholds which will enable us to commission to ensure:

- Maximum health gain from each intervention
- Consistency of access and outcomes
- Delivery of the constitutional Referral to Treatment Time (RTT) standard

This work will allow us to ensure our elective capacity is 'right-sized' and sustainable across our acute provider network. This supports the acute collaboration approach to clinical standardisation. The programme is divided into four key workstreams covering elective hospital based care, follow-ups and prescribing. The prescribing workstream is focused on reduced both costs in relation to waste medicines and prescribing. It will cover over the counter medicines, primary care and hospital based prescribing costs.



Progress so far…

- ✓ Agreed collective approach at a West Yorkshire and Harrogate footprint
- ✓ Local 'Place' and CCGs progressing earlier (e.g. 'Linking Prevention and Better Health to elective care' in Harrogate & Rural District CCG)
- ✓ Agreement of consistent implementation across West Yorkshire and Harrogate by 2020/21
- ✓ Provider and commissioner chief executive SROs in place
- ✓ Commenced discussion with Healthwatch and in some local communities
- ✓ Approach to health optimisation and reduction in variation supported by NHS England
- ✓ Identified resources to support programme work plan development and delivery

Standardisation of commissioning policies

Key milestones and decisions

Dec 2016: 'First wave' procedures signed-off by Healthy Futures Collaborative Forum

Jan 2017: Final agreement of future phasing of roll-out and scope of interventions

2017 – 2021: Quarterly rolling process of development, agreement and implementation of commissioning policies

2021: Standardisation of commissioning policies in place across West Yorkshire and Harrogate footprint

Impact

- ✓ Support delivery of the West Yorkshire and Harrogate targets in relation to smoking and obesity
- ✓ Support delivery of Referral to Treatment Time (RTT) standards
- ✓ Dovetail with the development of acute, mental health and provider collaborations to secure improvements in service delivery
- ↑ Clarity for patients and the public
- ↑ Improved cost effectiveness in prescribing
- ↓ Reduced variation in eligibility
- ↓ Planned savings of £50m delivered through consistent reduction in low value clinical procedures and interventions and ensuring patients are optimised for surgery

Section 5: Enabling workstreams

Context

All of our proposals are about improvement and change. To do this we must:

- Create the right workforce, in the right place with the right skills, to deliver services at the right time, ensuring the wellbeing of our staff
- Engage our communities meaningfully in co-producing services and making difficult decisions
- Using technology to drive change and create a 21st century NHS
- Place innovation and best practice at the heart of our collaboration ensuring that our learning benefits the whole population
- Ensure we have effective commissioning structures to push through the change.

Workforce

Challenges

70-80% of the West Yorkshire & Harrogate resource is spent on workforce. Every one of our STP workstreams has workforce implications

90% of the workforce we will have in 5 years' time already work for us

- **Longstanding shortages of clinical and support staff**
- **Development of new skills to deliver new ways of working**
- **Affordability of current pay bill – high locum and agency spend**
- **Variation in team productivity**
- **Insufficient integration across sectors**
- **Concerns for staff wellbeing**

Actions

Establishment of West Yorkshire and Harrogate STP Local Workforce Action Board
Chair: Dr Ros Tolcher (Chief Executive, Harrogate and District NHS Foundation Trust)
Co-chair: Mike Curtis (Health Education England)

Vision: West Yorkshire and Harrogate will have an affordable, skilled and resilient workforce providing sustainable health and care
Mission: To ensure that the workforce is a positive enabler and not a constraint to achieving the ambitions of the West Yorkshire and Harrogate STP

Primary and community care, and public health	Registered workforce initiatives	Non-registered workforce initiatives	Prevention at Scale	Workforce flexibility and enablers
Dr Andrew Sixsmith	**Philip Marshall**	**Sandra Knight**	**Dr Ian Cameron**	**Jo Carr**

Workforce

Programme outlines	Primary Care, Community Care and Public Health	Registered Workforce Initiatives	Non-registered workforce initiatives	Prevention at scale	Workforce flexibility and resilience enablers
Vision	Plan and secure a transformed workforce for Primary and Community care. Make Every Contact Count. *Working with the Primary Care & Community Services Group*	Plan for foreseeable demand for registered workforce capacity. Transform existing roles and influence new training programmes and supply for advanced practice and new roles.	Plan for foreseeable demand for non-registered workforce capacity. Transform existing roles and ensure supply of new training programmes	All sections of the health and care workforce contribute to the prevention agenda as a priority for future	Optimise the efficiency of HR processes through standardisation; reduce the cost of workforce gaps
Core outputs	• A Primary and Community care workforce strategy • Quantify demand for future workforce & investment required • Specify adaptation requirements for primary and community care to deliver new ways of working	• Quantify demand for registered nursing and ACPs and secure right capacity of training to achieve a pipeline of ACPs for all sectors • Quantify and address gaps in OPD workforce • Strategy for medical specialty shortages	• Proposal for career escalator • Development of a WY Excellence Centre • Optimise use of apprenticeship levy	• Making Every Contact Count Framework and Plan for WY&H. • Health Promoting Trusts proposal (TBC) • Workforce development strategy for prevention priorities.	• Savings from internal agency • Savings from standardisation
Workstreams to be developed	Primary Care Workforce working in General Practice - workforce analysis Investment plan – for wider roles in primary care (adaptation and innovative roles) nurses, pharmacists, advanced practitioners, physicians associates, clinical support workers, care navigators New Care Models, new ways of working Support for self care, expert patients & volunteers	ACP supply • ODP function supply • Endoscopists • Physicians Associates • Social workers Nurse recruitment strategies at WY&H level	Development of the West Yorkshire Excellence Centre • Pathway for B1-4 • Support to the primary care workstream • Working with Advanced Training Practices	Development of an STP Prevention at Scale plan • Priorities TBC (Nov 16) • Workforce development of all prevention priorities. • MECC • Health Promoting Hospitals/Health and Care (TBC) • Support and links to primary care	Development of Internal Agency Workforce passports Improve quality and value for money of GP locum market Standardisation of HR processes & streamlining Adoption of digital & technology solutions

Digital and interoperability

Building on the six Local Digital Roadmaps, there are some key themes where we know digital solutions can drive change across our health and social care economy and support our overarching aims, including:

Development **Record Sharing technology across West Yorkshire and Harrogate** to ensure **access to individuals' health and care information across all care settings** improving safety, experience and clinical effectiveness

Technology to support **knowledge, education and self-care** to ensure **people are empowered to manage their own health and wellbeing**

Technology implementation to support **clinical models e.g. clinical advice hub, direct booking, telehealth / telecare**

In addition, the digital support is fundamental to delivery of our transformation plans in local places and to our collaborative workstreams. Some of this work has already started and further priorities will be identified as the draft proposals for our workstreams are further developed.

Progress to date

- ✓ **CIOs Group** – Establishing a group of Chief Information Officers across CCGs, local authorities and NHS providers and expanding to form a network of Clinical Chief Information Officers (CCIOs)
- ✓ **Established digital leadership** with director leadership from commissioner and provider organisations and GP sponsor
- ✓ **Designing a data sharing architecture** this as a priority workstream with sign-up from all our acute providers. We have also formally secured the input from NHS Digital to this at a senior level. This work underpins anything that we will need to do around integrated and shared records, capabilities such as cross-organisational appointment booking etc.
- ✓ Themes across 6 **Local Digital Roadmaps** under review to identify consolidated opportunities to use technology to support STP delivery
- ✓ **UEC Vanguard** - A full technology work programme is in place and opportunities reviewed as part of the Acceleration Zone
- ✓ Technology to **assist the implementation of Carter efficiencies**

Harnessing the power of communities

We will establish a new relationship with our communities built around good work on the co-production of services and care. Our proposals to support people to self-care, prevent ill-health, implement the GP 5YFV and join up community services require a new relationship that sees people as assets not issues. They are fundamentally linked to building resilience through community assets, local populations and the large numbers of thriving voluntary and community sector organisations across West Yorkshire and Harrogate.

We are already seeing this in the digital space with the development of the mHealthhabitat programme out of mental health, sponsorship of the #YHDigitalcitizen programme and the People Driven Digital movement. These are also reflected in local vanguards and the AHSN is sponsoring a developing social movement through our Digital Health & Wellbeing Ecosystem. This is a platform for health and social care, academic, industry, the voluntary sector and patient organisations, to collaborate to increase the uptake of digital health technology. This will enhance patient care and participate in shared learning across the ECHAlliance International Permanent Network of Ecosystems.

We already rely on the involvement of the wider VCS in strategy development, leadership, engagement and service delivery. We will form new relationships, support innovative ways of working, and the development of community capacity building. This will be supported by new compact with the 3rd sector.

people drive digital

YORKSHIRE & HUMBER ACADEMIC HEALTH SCIENCE NETWORK

Leeds CITY COUNCIL

European Health Futures Forum

ECHAlliance

Harnessing the power of communities

Principles

- We will work together on a **'no surprises'** basis and set out a realistic case for change at both a local and regional level.
- Our emerging plan draws on existing **insight** and local **intelligence**. We want to build on the engagement and consultation work already underway and consider what we have already been told.
- Starting **conversation with the public** about their role in managing their own care
- Secure **political and public buy-in through a compelling case for change**
- **Nurture** our partner, stakeholder relationships and develop new to achieve our ambition together.
- Engaging our **health and social care workforce** is critical if we are to reach realistic improved outcomes
- We will **formally consult** where there is a proposal for significant service change

Progress to date

- ✓ Every local place-based plan has been built up from a wealth of information which local people have told us about local services
- ✓ Local plans have been developed and approved by local Health and Wellbeing Boards (or equivalent structures)
- ✓ Healthwatch is a key partner in our STP and provide leadership, assurance and challenge acting as the voice of the patient and has supported our Vanguard engagement e.g. reaching over 300,000 on our Hear, See and Treat proposals
- ✓ We will always fulfil our legal duties to consult and we are already consulting formally with our populations on some of our proposals e.g. reconfiguration of hospital and community services in Calderdale and Huddersfield
- ✓ A strategic communications and engagement lead has been employed to support engagement and communication with all our stakeholders across the STP. This role is embedded within the STP Programme Management Office and works closely with the STP Lead
- ✓ This role is supported by an established multi-agency communications and engagement regional network to ensure the approach is embedded in all organisations and existing communication channels are used to full effect.

Sharing our proposals

- Local place-based plans have been designed and approved by all local Health and Wellbeing Boards (HWB) or equivalent and are in the public domain. Council leaders and Chairs of the HWB meet on a regional level
- We are fully committed to sharing all proposals with our population and will publish our plan and public summary during the week commencing 31 October 2016
- Sharing our proposals will start a series of public engagement activities.

Harnessing the power of our communities

In line with our principles, we have reviewed our recent engagement activity across our CCG footprints which is identified below. This information has informed the development of our plans to date and will support us in identifying where further engagement work is required with populations on some of our proposals. This will be a fundamental part of our developing proposals further.

	Airedale, Wharfedale, Craven	Bradford City	Bradford District	Calderdale	Greater Huddersfield	Harrogate and Rural District	Leeds North	Leeds South and East	Leeds west	North Kirklees	Wakefield	Key themes
Prevention		E	E	E	E	E C	E	E	E	E	E C	Care Closer to Home, Vanguard, Bowel Cancer, Smoking, Personal Health Budgets, Long Term Conditions Care Planning, Self-Care, Early Intervention and Prevention, Winter Health Strategy Consultation, Autism Strategy for North Yorkshire, Learning Disabilities Strategy Consultation, Healthy Weight, Healthy Lives Strategy Consultation, Shared Decision Making
Primary and community services	E	E C	E C	E C	E C	E	E	E	E	E	E	Care Closer to Home, Right Care, Right Time, Right Place, Our Street, Unplanned Care, Walk in Centres, GP services - extended hours/changes/closures and access (including enhanced access), NHS Dentist, Care Homes, Winter Campaigns, What Matters to us, Integrated Care, Community Equipment Services, Enhanced Care, Access to primary care for people with a learning disability, Scribble live, Anti-coagulation, Closure of GP practice, Endoscopy and Gynaecology services, PMS and PBSR, ENT, Ophthalmology, Discharge, Connecting Care, IAPT, Primary Strategies, APMS, Adult Hearing Services, Gynaecology, ENT, Year of Care, Single point of access
Mental Health	E	E C	E C	E	E	E	E	E	E	E	E	Children and Young people (CAMHS), Crisis Intervention, Section 136, SWYFHT Transformation, Mental Health strategies, The Future in Mind, Autism, bereavement services
Stroke	E	E	E C			E					E	Improvements to Stroke Services, Reconfiguration of Services, patient surveys
Cancer				E	E	E	E	E	E			Breast, Gynaecological, Prostate, Colorectal, Childhood and Young Adults services, Cancer Services CHFT, living with and beyond cancer project, surviving cancer
Urgent & Emergency care	E	E	E	E C	E C	E	E	E	E	E C	E C	Urgent and Emergency Care Strategy, Right Care, Right Time, Right Place, Meeting the Challenge, What Matters to us, Urgent Care Transformation Programme
Specialised commissioning		E	E									Eating disorders, Specialised Mental Health
Acute reconfiguration		E	E	E C	E C					E C	E C	Meeting the Challenge, Right Care, Right time, Right Place, Accountable Care
Standardisation		E C	E C	E	E		E	E	E	E	E	Patient Transport, Talk Health, IVF, Stop Before your OP, Medicines Management, Gluten Free, OTC medicines, cows' milk intolerance

Innovation and best practice

Our ambition is to become an international destination for health innovation

Experiments

- Seven Vanguards Three pioneers
- AHSN LAHP
- Digital innovation
- Research and clinical innovation
- Urgent & Emergency Care Acceleration Zone
- Centre of Excellence (workforce)

Infrastructure

Innovation infrastructure

The STP will need a vehicle for sharing and Nurturing talent with change labs and new accelerators:

- Harnessing assets of our universities and health and care institutions
- Creating vehicles for "one conversation" with the sector
- Using AHSN and similar Capacity

Impact

- Innovation
- Adoption
- Diffusion

Case Study

Airedale has been working successfully for several years across health and social care to develop an integrated health record which enables more seamless care for the population. This provides an integrated workflow across providers and improves the experiences of people accessing services ensuring information is collected from people only once. This also supports reduced duplication as set out in the Getting It Right First Time (GIRFT) programme and Carter Review. We are talking to Connected Yorkshire (Leeds University) to see how we can use our data to understand our population health and bring the biggest benefit through health and care interventions.

Section 6: Creating the infrastructure for delivery

Creating an infrastructure to deliver

These proposals require a different way of working across organisations in West Yorkshire and Harrogate.

There are a number of components to this:

- Establishing appropriate governance arrangements to allow us to work more closely and take decisions collectively across commissioners, providers, health and social care
- Evolving our current commissioning arrangements so that there is a great emphasis on place and a stronger infrastructure at a West Yorkshire and Harrogate level
- Rapidly expanding capacity and resources to do the work through realignment of existing roles and functions, both at local organisation and Arms Length Body (ALB) level

The following section sets out our proposals for taking this forward.

Strategic commissioning

A West Yorkshire & Harrogate wide commissioning / contractor function dealing with acute and some specialist services

- Design of evidence based pathways and service standards
- System wide outcomes and payment incentives
- Extension / formalisation of the CCG joint committee arrangements
- Identification of services that need to be commissioned on a WY basis

and…

A place based commissioner bringing together the functions of LAs CCGs and NHS England (primary care) commissioning

- Organisations collaborate on a defined geographic footprint – collective accountability
- Essential that we maintain 'connection' between West Yorkshire and Harrogate and place based commissioning

And / or…

A local 'commissioning' function embedded within ACO models

- ACOs working to a capitated budget will need to make decisions about how resources are used to best meet population needs.
- Therefore some 'commissioning' competencies required aligned to strategic function of organisation.

Example services

WEST YORKSHIRE & HARROGATE

- Low volume, high cost, high risk planned care
- Emergency centres and co-dependencies
- Specialised & tertiary services
- Inpatient mental health services
- 'Hard Pressed' specialties
- Specialised diagnostics
- High volume, low cost, low risk planned care

Shared view of strategic intent and planning

LOCAL

- Diagnostics
- Primary and community care
- Social care
- Long term conditions management
- Frailty services
- Community Mental Health

Governance and decision-making

- Health and Wellbeing Boards are the key mechanism for taking decisions on place based proposals at local level. Alongside our partnership with Local Authorities, this will continue to be an important way of ensuring our proposals represent the views and interests of local people.

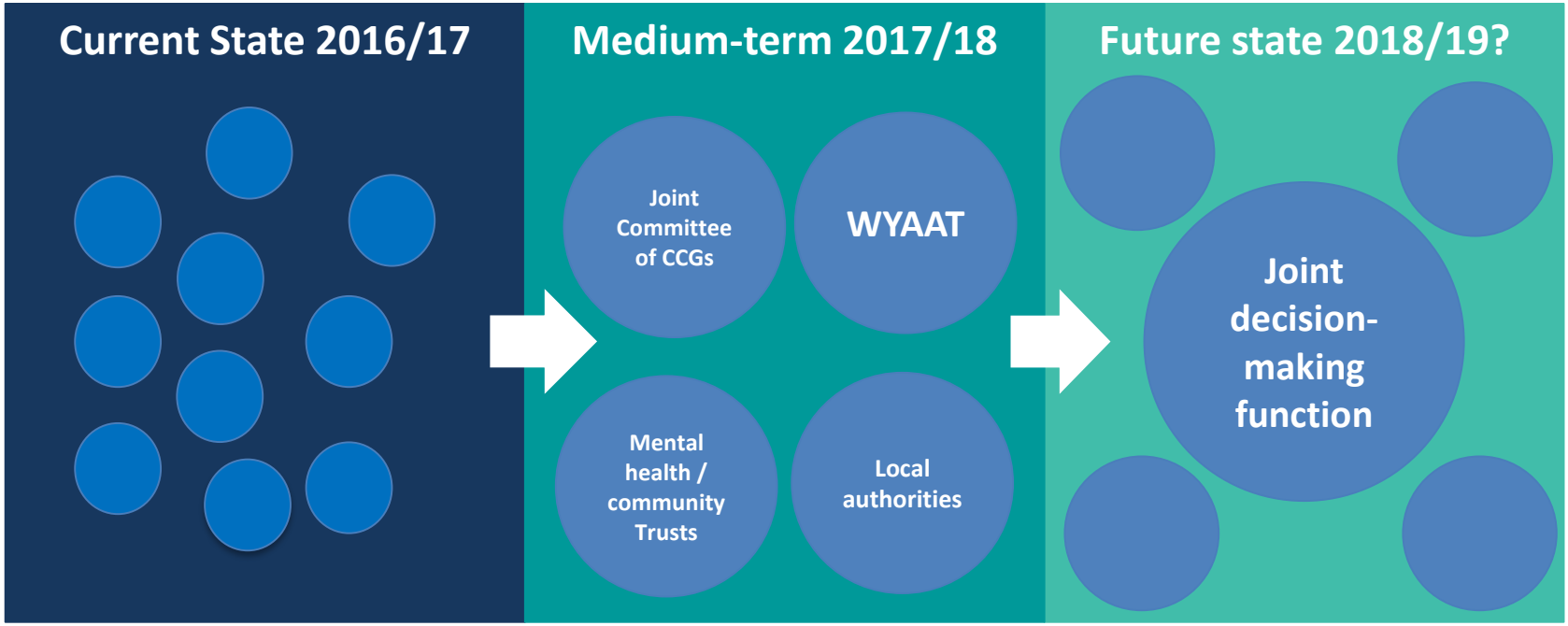
- We have developed an approach based on collaboration and partnership – leadership group, steering group, CCG forum and clinical forum. These have been important vehicles to move the STP forward – but they have not been tested in terms of challenging decisions and they do not go far enough given the expectations placed on the STP as a planning area.

- The arrangements are therefore changing in line with the increased responsibilities placed on STP areas. Over the course of the next 12 months we will move to more formal joint decision making arrangements within sector in order to support collective decision making.

- Beyond that, we recognise that closer working and decision making across traditional sector boundaries will become increasingly important as we take decisions that put place over organisation. As a leadership group we are considering mechanisms to facilitate place based governance and decision making.

- The following slide illustrates this journey.

Moving forward we intend to formalise the current arrangements and move towards joint decision making



- Single statutory organisations
- Some groupings / informal collaboration of providers and of commissioners

- Formalised collaborative structures of commissioners and providers to support collective decision-making
- Run new commissioning model in shadow form

- Joint decision-making function where appropriate, or in the best interests to do so representing commissioners and providers joint-decision making function
- Supported by formal collaborative structures established in 2017/18

Section 7: Conclusion

Conclusion

We are committed to delivering the vision set out in this document. The STP sets out the strategic context in West Yorkshire and Harrogate and high-level proposals for how we might get there.

Our focus now shifts to building on conversations we have already had with our communities to developing meaningful coproduction for turning these high-level proposals into more detailed implementable plans.

Our next important milestone is the two-year operational NHS planning process through which we will translate into delivery.

Annex

Annex A: Glossary 1

Item	Description
ABI	Acquired Brain Injury
ACO (also ACS)	Accountable Care Organisation / System. ACOs are an approach to population-based commissioning for outcomes as opposed to activity.
ACP	Advanced Clinical Practitioner
ADHD	Attention Deficit Hyperactivity Disorder
AF	Atrial Fibrillation
AHSN	Academic Health Science Network. AHSNs are organisations which link different parts of the health system to ensure that health improvement initiatives are considered and evaluated using proven methodology.
ASDM	Alternative Service Delivery Model
AWC	Airedale, Wharfedale and Craven
A&E	Accident and Emergency [department]
BD&C	Bradford District and Craven

Item	Description
CAMHS	Child and Adolescent Mental Health Service
CAS	Clinical Advice Service
CCG	Clinical Commissioning Group. CCGs are organisations that commission most of the hospital and community NHS services in the local areas for which they are responsible.
CCIO	Chief Clinical Information Officer
CHD	Coronary Heart Disease
CHFT	Calderdale and Huddersfield NHS Foundation Trust
COPD	Chronic Obstructive Pulmonary Disease
CPES	Cancer Patient Experience Survey
CVD	Cardiovascular Disease
CYP	Children and Young People
DToC	Delayed Transfer of Care

Glossary 2

Item	Description
ED	Emergency Department
EMIS	A supplier providing electronic patient record systems to primary care
ENT	Ear, Nose and Throat
FYFV	Five Year Forward View. This national document, published in October 2014, sets out a new shared vision for the future of the NHS based around new models of care.
GP	General Practice / Practitioner
GPFV	General Practice Forward View. This national document, published in April 2016, setting out intentions to improve general practice.
GIRFT	Getting it Right First Time
HAS	Hyper-acute Stroke
HFCF	Healthy Futures Collaborative Forum. A collaborative meeting of all the 11 CCGs across the West Yorkshire and Harrogate STP.

Item	Description
HIV	Human Immunodeficiency Virus
HWBB	Health and Wellbeing Board. Hosted by local authorities, these boards bring together the NHS, public health, adult social care and children's services, including elected representatives and Local Healthwatch, to plan how best to meet the needs of the population.
IAPT	Improving Access to Psychological Therapies
IUC	Integrated Urgent Care
IVF	In Vitro Fertilisation
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
LTC	Long Term Condition
LTHT	Leeds Teaching Hospitals NHS Trust
LOS	Length of Stay

Glossary 3

Item	Description
MCP	Multispecialty Community Provider. This is a new model of care focusing on bringing together services operating in the community.
MDT	Multi-disciplinary Team
MYHT	Mid Yorkshire Hospitals NHS Trust
MECC	Making Every Contact Count
MH	Mental Health
MHFV	Five Year Forward View for Mental Health. This national document, published in February 2016, sets out 59 recommendations of the Mental Health Taskforce aiming to improve Mental Health service provision.
NCMP	National Child Measurement Programme
NEET	Young people who are “Not in Education, Employment of Training”
NHS	National Health Service

Item	Description
NHSE	NHS England
NICE	National Institute for Health and Care Excellence
OBC	Outline Business Case
ODP	Operating Department Practitioner
OP	Outpatient
OTC	Over the Counter
PBSR	Practice Based Services Review
PMS	Personal Medical Services [contract]
PoS	Place of Safety
PURMs	Pharmacy Urgent Repeat Medication service
QOF	Quality and Outcomes Framework
QOL	Quality of Life

Glossary 4

Item	Description
ROI	Return on Investment
RTT	Referral to Treatment Time (a national legal right to start non-emergency NHS consultant-led treatment within a maximum of 18 weeks from referral, unless a patient chooses to wait longer or it is clinically appropriate that they wait longer.)
SCfC	Strategic Case for Change
SCR	Summary Care Record
SSNAP	Sentinel Stroke National Audit Programme
STF	Sustainability and Transformation Fund
STP	Sustainability and Transformation Plan. Every health and care system in England will produce a multi-year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next five years.

Item	Description
SWYPFT	Also; SWYFT / SWYFHT – South West Yorkshire Partnership NHS Foundation Trust
UEC	Urgent and Emergency Care
Vanguard	Vanguards are a group of organisations and partnerships which will take a lead on the development of new care models which will act as the blueprints for the NHS moving forward, piloting new models of care identified in the Five Year Forward View.
WYAAT	West Yorkshire Association of Acute Trusts
WY&H	West Yorkshire and Harrogate
YAS	Yorkshire Ambulance Service
YHEC	York Health Economics Consortium

West Yorkshire & Harrogate STP

A partnership between, health services, clinical commissioning groups, care providers, local councils, and Healthwatch

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WEST YORKSHIRE & HARROGATE SUSTAINABILITY AND TRANSFORMATION PLAN (STP)

ENGAGEMENT AND CONSULTATION MAPPING

OCTOBER 2016

WEST YORKSHIRE & HARROGATE STP

A partnership between health services, clinical commissioning groups, care providers, local authorities and Healthwatch

Contents

Section 1: Introduction to the report

Purpose of the report

The purpose of this report is to present the findings from all relevant engagement and consultation activity which has taken place during April 2012 to October 2016, across Calderdale, Bradford, Harrogate, Kirklees, Leeds and Wakefield. The report captures intelligence collected from engagement and consultation activities and will support commissioners to:

- Provide information on work which has already taken place or is underway to avoid duplication
- Highlight any gaps in activity across West Yorkshire and Harrogate and Rural District
- Understand some of the emerging views gathered from local people across West Yorkshire and Rural District
- Ensure that any future plans have a baseline of engagement intelligence to support the work

In addition, the report can be a working document which is added to as projects progress. The intelligence collected will ensure we meet our legal requirements and ensure we:

- Consider the views of patients and the public as part of service redesign; and
- Ensure the feedback is considered in the development of any future options to change the way a current service is provided or delivered
- Highlight patient and public priorities and ensure these priorities are in line with current thinking and ensure commissioners can consider all public views

Background

West Yorkshire is one of 44 footprints across the country working to address the three gaps set out in the NHS Five Year Forward View and sets out three areas for improvement:

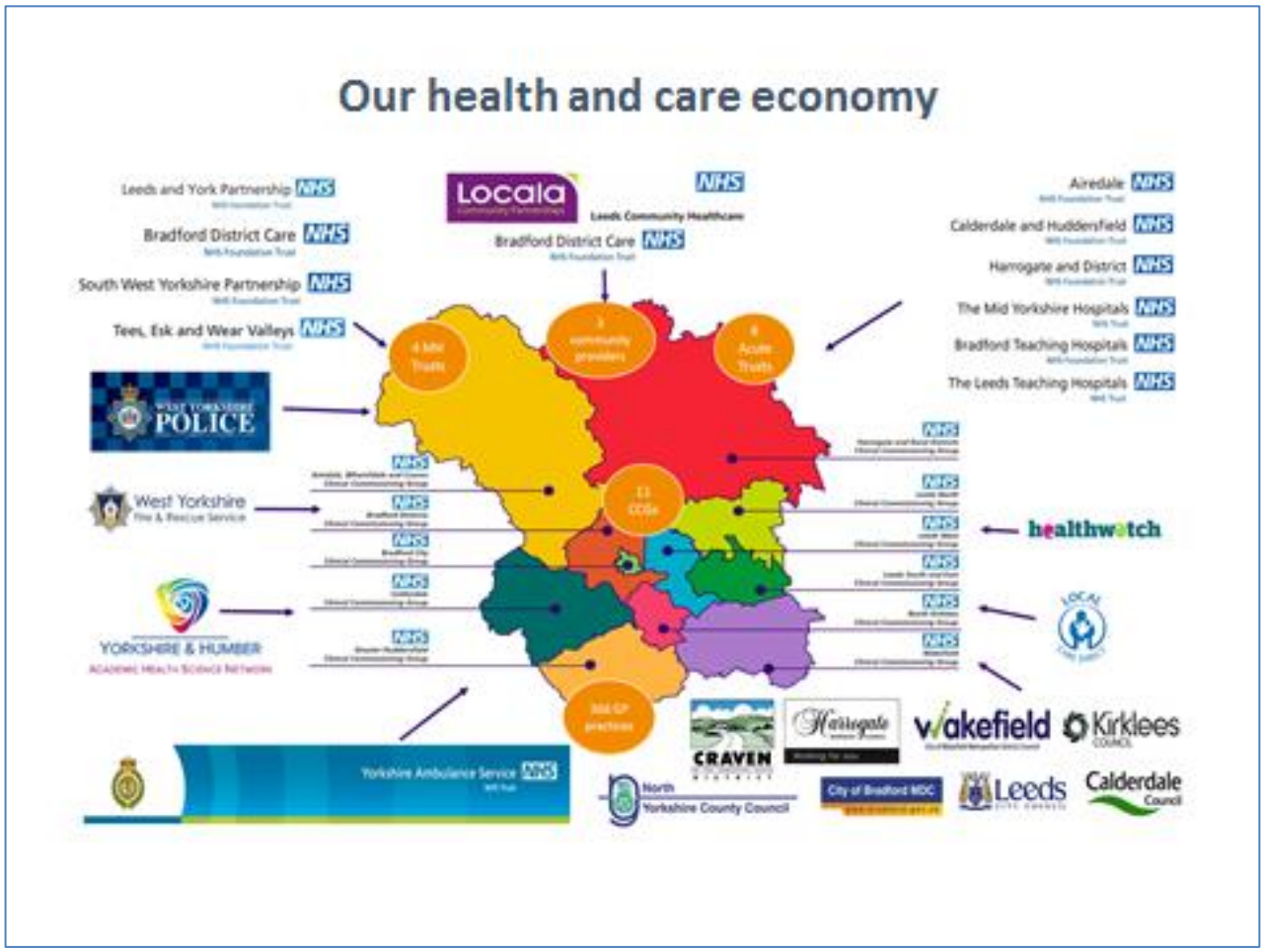
- Health and wellbeing
- Care and quality
- Finance and efficiency

The West Yorkshire footprint is made up of six local areas, all of which are developing individual plans to respond to the 'Five Year Forward View'. The plans are known as sustainability and transformation plans (STPs). These plans set out a vision for the next 5 years (until 2020/21). The timeline, process and assurance of the local plans will be provided by national organisations such as NHS England, NHS Improvement, Public Health England and the Local Government Association.

The West Yorkshire and Harrogate STP will build on existing partnerships to support the delivery of these plans. Partnerships will be based on common values, shared decision making, mutual accountability and place based prioritisation. Networks of organisations and relationships to deliver the West Yorkshire and Harrogate plan will include:

- West Yorkshire Association of Acute Trusts
- Mental health and community providers
- Single committee for 11 clinical commissioning groups
- Yorkshire Ambulance Service
- Local authorities
- Emerging primary care federations and GP groupings
- Collaboration through Vanguard programmes
- Healthwatch organisations across West Yorkshire

Below is a map of all the organisations involved in the West Yorkshire and Harrogate STP.



The West Yorkshire and Harrogate STP will focus on the delivery of 9 areas of priority. These areas are:

- Prevention
- Primary and community services
- Mental Health
- Stroke
- Cancer
- Urgent and Emergency care
- Specialised commissioning
- Acute reconfiguration
- Standardisation of policies

Each of these areas will be looked at on a West Yorkshire and Harrogate Rural District wide footprint.

West Yorkshire and Harrogate engagement and consultation activity at a glance

In order to deliver the nine priority areas in West Yorkshire and Harrogate Rural District it is essential that partnership networks work together to understand the view of local populations.

A number of organisations across West Yorkshire and Harrogate Rural District have already started to host conversations about the priority areas at a local level, this information needs to be considered and used so we are not over consulting our local populations. Using the mapping exercise included in this section it is clear to see that there is already a wealth of information and intelligence that can be used to support any future commissioning decisions.

Where there are gaps in this information we can progress to have further conversations based on what we already know. This means that any future service provision uses what we already have, prevents duplication of existing conversations and ultimately has the public at the centre of everything we do.

In addition, work done regionally should not confuse the public who may have given their views at a local level. The communications supporting any further engagement and consultation activity needs to be managed with this mapping in mind.

The table below sets out the conversations already hosted across West Yorkshire and Harrogate Rural District, the topics of those conversations and where further plans may benefit from local intelligence. For the purpose of the mapping we wanted to know;

- Any engagement completed over the last four years which would provide intelligence.
- Any formal consultation which has ensured a service is in the process of being changed based on the engagement activity.

Each of the nine priority areas is then looked at in more depth drawing on the information from each local area. This is based on what we already know but may not be exhaustive.

West Yorkshire and Harrogate engagement and consultation activity at a glance (E= Engagement, C = Consultation)

	Airedale, Wharfedale ,	Bradford City	Bradford District	Calderdale	Greater Huddersfield	Harrogate and Rural	Leeds North	Leeds South and East	Leeds west	North Kirklees	Wakefield	Key themes
Prevention	E	E	E	E	E					E		Care Closer to Home, Vanguard Self-care, early intervention and prevention
Primary and community services	E	EC	EC	EC	EC	E	E	E	E	E	E	Care Closer to Home, Our Street, Unplanned Care, Walk in Centres, GP extended hours and access (including enhanced access), NHS Dentist, Care Homes, Winter Campaigns, What Matters to us, integrated Care, Community Equipment Services, Enhanced Care, access to primary care for people with a learning disability, Scribble live, Anti-coagulation, Closure of GP practice, endoscopy and gynaecology services, PMS and PBSR, ENT, Ophthalmology, discharge, IAPT, Primary strategies, APMS
Mental Health	EC	EC	EC	E	E		E			E	E	Children and Young people (CAMHS), Crisis intervention/care concordat, Section 136, IAPT, Transition, SWYFHT Transformation, MH strategies.
Stroke	E	E	E									Improvements to stroke services, reconfiguration of services
Cancer		E	E	E	E		E	E	E			Breast, gynaecological, prostrate, colorectal, childhood and young adults services, cancer services CHFT
Urgent and Emergency care	E	E	E	EC	EC	E	E	E	E	EC	EC	Urgent and Emergency Care Strategy, Right Care, Right Time, Right Place, Meeting the Challenge, What Matters to us, Urgent Care Transformation Programme
Specialised commissioning		E	E									Eating disorders, specialised mental health
Acute reconfiguration		E	E	EC	EC					EC	EC	Meeting the Challenge, Right Care, Right time, Right Place, Accountable care
Standardisation		EC	EC	E	E					E	E	Patient Transport, Talk Health, IVF, Stop Before your OP, Medicines Management, Gluten free,

Our responsibilities, including legal requirements

Our responsibilities

Engaging people is not just about fulfilling a statutory duty or ticking boxes, it is about understanding and valuing the benefits of listening to patients and the public in the commissioning process.

By involving local people we want to give them a say in how services are planned, commissioned, delivered and reviewed. We recognise it is important who we involve through engagement activity. Individuals and groups play different roles and there needs to be engagement opportunities for both.

A West Yorkshire and Harrogate Rural District Communications and Engagement Strategy underpins the principles by which the engagement and consultation will operate, and highlights the commitment to good practice in delivery. Engaging people who use health and social care services, and other stakeholders in planning services is vital to ensure services meet the needs of local communities. It is also a legal requirement that patients and the public are not only consulted about any proposed changes to services, but have been actively involved in developing the proposals.

Legal requirements

There are a number of requirements that must be met when discussions are being made about the development of services, particularly if any of these will impact on the way these services can be accessed by patients. Such requirements include the Health and Social Care Act 2012 and the NHS Constitution.

Health and Social Care Act 2012, sets out the Government's long-term plans for the future of the NHS. It is built on the key principles of the NHS - a comprehensive service, available to all, free at the point of use, based on need, not ability to pay. It sets out how the NHS will:

- put patients at the heart of everything it does, ‘no decision about me, without me’
- focus on improving those things that really matter to patients
- empower and liberate clinicians to innovate, with the freedom to focus on improving healthcare services

It makes provision for CCGs to establish appropriate collaborative arrangements with other CCGs, local authorities and other partners, and it also places a specific duty on CCGs to ensure that health services are provided in a way which promotes the NHS Constitution - and to promote awareness of the NHS Constitution.

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

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

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

The duties to involve and consult were reinforced by the NHS Constitution which stated: 'You have the right to be involved directly or through representatives, in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services'.

The Equality Act 2010 unifies and extends previous equality legislation. Nine characteristics are protected by the Act, age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation. Section 149 of the Equality Act 2010 states that all public authorities must have due regard to the need to a) eliminate discrimination, harassment and victimisation, b) advance 'Equality of Opportunity', and c) foster good relations. To help support organisations to meet these duties a set of principles have been detailed in case law. These are called the Brown Principles;

- The organisation must be aware of their duty.
- Due regard is fulfilled before and at the time any change is considered as well as at the time a decision is taken. Due regard involves a conscious approach and state of mind.
- The duty cannot be satisfied by justifying a decision after it has been taken.
- The duty must be exercised in substance, with rigour and with an open mind in such a way that it influences the final decision.
- The duty is a non-delegable one.
- The duty is a continuing one.

An Equality Impact Assessment (EQIA) will need to be undertaken on any proposals for changes to services that are developed through the programme, in order to understand any potential impact on protected groups and ensure equality of opportunity. Engagement must

span all protected groups and other groups, and care should be taken to ensure that seldom-heard interests are engaged with and supported to participate, where necessary.

Secretary of State's key tests

Any service change proposals are expected to comply with the Department of Health's four tests for service change. These are:

1) Strong public and patient engagement;
2) Consistency with current and prospective need for patient choice;
3) A clear clinical evidence base; and
4) Support from proposals from clinical commissioners

For significant service changes, NHS England operates an assurance process whereby they provide support and guidance to commissioners so that they can demonstrate compliance with the four tests and other best practice checks. The assurance process concludes with an assurance checkpoint at which time NHS England provide a recommendation regarding whether the tests have been met.

Section 2: Findings from engagement April 2012 – October 2016

Engagement process and use of existing data

A review has taken place of all relevant engagement and consultation that has taken place between April 2012 and October 2016. This work builds on the comprehensive mapping exercise which took place for the West Yorkshire urgent and emergency care Vanguard. Additional information has been added to this work to include the main areas of focus for the wider West Yorkshire and Harrogate STP work. The areas for transformation and work streams are:

- Prevention
- Primary and community services
- Mental Health
- Stroke
- Cancer
- Urgent and Emergency care
- Specialised commissioning
- Acute reconfiguration
- Standardisation of policies

The initial mapping consists of over 80 documents, including final reports, survey results and annual summaries. Some were produced by the CCGs, others came from Healthwatch, providers, The Patients Association and Patient Opinion. Additional information has been added and the intelligence refocussed to meet the requirements of this work.

Each document was summarised, and the key themes and details were written up in to an evidence summary. Each of these evidence summaries can be found as a separate document which catalogues the activity and findings in more detail (this forms part of the original report). The majority of the work included in this document has been thematically analysed by the organisation submitting the information, and in those cases, the themes were copied and summarised.

After summarising all of the documents, the key themes from those documents were reviewed and a list of the key themes for each of the work streams was created.

Main themes and findings

From all the information gathered so far across the West Yorkshire and Harrogate STP there are a number of emerging themes for each of the nine priority areas. Each of the nine areas are set out below with the key emerging themes from existing engagement and consultation:

Prevention

- Clear accessible information and communication
- Involve communities and invest in voluntary and community services
- National messages and local initiatives
- Early intervention and education
- Change NHS culture
- Innovative opportunities
- Involving patients and families in care plans
- Support self-management and help make positive changes to behaviour

Primary and community services

- Improve access to appointments and buildings, in particular access for urgent care issues
- Increase the availability of services at the evening and weekend
- Raise awareness of the most appropriate services to access
- Support people to manage their own health
- Look at the provision of walk-in centres
- Increase the range of services available at GP practices
- Improve access for those with different communication needs, including different formats
- Introduce an urgent care triage line
- Improve access to routine dental care
- Introduce an out of hours primary care service that is co-located with A&E
- Single point of access
- Better communication and appropriate staff

Mental health

- Improve the level of understanding of mental issues amongst staff
- Increase awareness with providers of services available
- Provide a seamless service
- Ensure appropriate support and services are in place to prevent a crisis occurring
- Provision of more outreach services
- Improve ability to access crisis support
- Improve the appropriateness of care provided in a crisis
- Improve quality of crisis intervention
- Improve access to CAMHS

- Improve transition from CAMHS
- Ensure mental health patients access appropriate transport in a crisis
- Provide a co-ordinated approach between services upon discharge

Stroke

- Concerns about discharge including lack of consistency for aids and adaptations
- More emotional support for patients, carers and family members
- Journey time and distance for both patients and visitors, cost of parking at the hospital
- Journey time to receive treatment is a concern
- Transfer times to receive treatment if presenting at other hospital sites not BRI
- Inadequate staffing levels impacting on care and treatment and outcomes
- Staff without the right skills and poor attitude
- Information and communication need to be improved across services
- Information and communication for patients and relatives requires improvement including using appropriate forms of communication
- Under provision of speech therapy and physiotherapy

Cancer

- Getting an appointment quickly
- Give patients clear explanations of clinical tests
- Follow up care is really important and provides assurance and access to specialists
- Patients like a named clinical nurse lead and specialist
- Face to face contact is a really important aspect of care, including being able to pick up the phone and contact someone
- Involve patient fully in care and treatment
- More information and communication on life-style and practical post treatment advice
- Deliver care through competent ward nurses, allowing the patient to have trust in them
- Plan and deliver effective discharge from care
- Coordinating with the GP practice so care is ongoing
- Electronic tools and new technology were not favoured for support and follow up
- Emotional and Financial support
- Input and impact of supportive therapies

Urgent and emergency care

- Consider travel and transport to access services including ambulance services
- Consider the capacity to provide urgent care services closer to home – particularly in GP practices
- Consider the use of 111 as a gateway to urgent and emergency care and whether satisfaction ratings with the service lend themselves to this being the right gateway
- Consider ambulance journey times and road and transport networks
- Consider the availability of walk-in centres to relieve pressure on A&E

- Convenience and location of A&E can be a concern
- Raise awareness of the most appropriate services to access
- Introduce an out of hours primary care service that is co-located with A&E
- Concerns about centralising emergency services
- Lack of information about the difference between urgent and emergency care

Specialised commissioning

Bradford City and District have completed a few pieces of work on eating disorders and specialised mental health. The reports and findings need to be included in a future version of this report.

Acute reconfiguration

- High levels of satisfaction with services
- Improve the quality of discharge planning
- Increase the provision of services closer to home
- Consider travel and transport to access services
- Raise awareness of the most appropriate services to access
- Provide ongoing care and support to prevent admissions

Standardisation of policies

- the cost and effectiveness of medicines and treatments should be taken into account when making decisions
- people should pay for medicines that are widely available in local shops at low cost, rather than getting them on prescription (Although you are concerned about the financial impact on people with low incomes)
- you want consistency in funding decisions across Kirklees to avoid a 'postcode lottery'
- patients should not be refused treatment because of lifestyle choices, unless this impacts on the success of their treatment
- we could save NHS money by educating people about how to prevent ill health, manage their own health conditions and use health services appropriately.

Themes in more detail

Prevention

Reference to engagement for prevention was made in reports from most areas across West Yorkshire, Harrogate and Rural District. This included work on a wide range of service areas, campaigns and prevention strategies.

The key themes raised across West Yorkshire and Harrogate and Rural District were:

- Clear accessible information and communication
- Involve communities and invest in voluntary and community services
- National messages and local initiatives
- Early intervention and education
- Change NHS culture
- Innovative opportunities
- Involving patients and families in care plans
- Support self-management and help make positive changes to behaviour

- Recurring themes of people not having enough accessible information or support to understand health issues.
- They tell us that access to interventions within their communities, both social and focused on particular issues, helps avoid deterioration of their mental and physical health, and reduces social isolation.
- People feel that not enough money is being spent on prevention initiatives and should be a national commitment.
- Access to early intervention support is vital to prevent situations worsening. Education is a key process which could improve outcomes and be an essential element in prevention.
- People want to be given the information they need to help manage their own health and wellbeing. They wanted more focus on prevention and innovative opportunities to keep themselves well.
- Alternatives to prevention are limited, particularly around early intervention and prevention support. People wanted more focus on prevention and innovative opportunities to keep themselves well or be educated, particularly at a young age
- Many of the patients told us they were not involved in their care plan. People said, that not being adequately involved in care decisions had a negative impact, and that where appropriate they felt that health professionals should communicate better with carers / support workers when doing this would have been in the person's best interests.
- More access to weight management services and support to increase physical activity levels.

	Clear information and communication	Involve communities and invest in voluntary and community services	National messages and local initiatives	Early intervention and education	Change NHS culture	Innovative opportunities	Involving patients and families in care plans	Support self-management and behavior change
Calderdale and Huddersfield Hospital and Care Closer to Home	x	x		x	x	x		x
NHS Greater Huddersfield CCG - Call to Action Engagement September 2013	x	x	x	x	x	x		x
NHS Calderdale CCG - Call to Action Engagement September 2013	x	x	x	x	x	x		x
NHS Calderdale CCG - Calderdale MBC engaged with Voluntary sector representatives to support the development of prevention plans 2016	x							
Healthwatch Wakefield - Public Voice Report to the Health and Wellbeing Board July 2016	x		x	x				
NHS Wakefield CCG - Personal Health Budget engagement reportMarch 2016							x	
NHS Wakefield CCG - Report of feedback from commissioning maze events 2015/16	x		x	x				
North Yorkshire County Council – Winter health strategy consultation				x		x	x	
North Yorkshire County Council – Autism strategy for North Yorkshire	x		x					
North Yorkshire County Council – learning disabilities strategy consultation				x			x	x
North Yorkshire County Council - Healthy weight, healthy lives strategy consultation		x				x		x
NHS Harrogate RD CCG – Shared decision								x
Research and Deliberative Event to Inform Five-Year Plan June 2014	x			x				
NHS Leeds West CCG ENT & Ophthalmology community services and audiology aid service review Oct 2014							x	

Primary and community care services

Primary and community care has been the subject of a number of engagement and consultations across West Yorkshire and Harrogate Rural District. The content of conversations varies across the local area from broad engagements on primary care services to specific service areas. In summary there are a number of themes that are emerging across the West Yorkshire and Harrogate Rural District footprint that need to be taken into account in any future commissioning arrangements.

The key themes raised across West Yorkshire and Harrogate Rural District were:

- Improve access to appointments and buildings, in particular access for urgent care issues
- Increase the availability of services at the evening and weekend
- Raise awareness of the most appropriate services to access
- Support people to manage their own health
- Look at the provision of walk-in centres
- Increase the range of services available at GP practices
- Improve access for those with different communication needs, including different formats
- Introduce an urgent care triage line
- Improve access to routine dental care
- Introduce an out of hours primary care service that is co-located with A&E
- Single point of access
- Better communication and appropriate staff

- The need to increase the availability of urgent same day GP appointments. When patients had an urgent healthcare need, they generally wanted to speak to a healthcare professional about it on the same day, and to be able to speak to someone that could see their notes and be able to prescribe. Difficulty in accessing urgent appointments led to some people seeking care elsewhere, either at walk-in centres or A&E.
- Increased opening times to enable patients to access services early morning, evenings and weekends. At the weekend, most patients said that they would want an appointment on a Saturday morning.
- People weren't always aware of the services that were available to them, few viewed pharmacists as a source of medical advice. There is a need to raise awareness of the most appropriate service to access, where and how to access these services.
- Provision of information to support people to help manage their own health, including signposting to voluntary and community services (which would hopefully reduce the pressures on A&E).
- For those people that had attended a walk-in centre, they did not want to have to wait until they could get an appointment with their own GP, they wanted their condition to be treated as soon as possible at a time and location that was convenient to them, if the walk-in centre had not been available a significant proportion would have attended A&E.

- Increase the range of services available at GP practices, such as, including x-rays, minor surgery, and support groups.
- Improve access for those with different communication needs by providing access to language and BSL interpreters. The provision of bilingual staff and deaf awareness training should support this.
- There was support for the introduction of an urgent care triage line, where a health professional assesses patient needs and signposts people to the most appropriate service. It was important that the person on the phone could see the patient records.
- Difficulties in accessing routine dental care resulted in the need to access urgent dental care.
- There is a genuine feeling that A&E should be for emergencies only and instead resources should be spent improving access to care at GP practices, particularly improving the availability of appointments.

	Improve access to appointments and buildings	Available evening / weekend	Raise awareness of the most appropriate services to access	Support people to manage their own health	Provision of walk-in centres	Increase the range of
CKW – Minor Injuries Service						X
NHS Calderdale CCG – Review of unplanned	X	X				
Calderdale CCG – Co-commissioning in	X			X		X
Leeds Involving People - Shakespeare Walk-in	X	X	X	X	X	X
Healthwatch Wakefield – Young people's GP	X					
Healthwatch Leeds – GP extended hours in Leeds	X	X	X			
Greater Huddersfield CCG – Co-commissioning in Primary Care	X	X	X			X
Healthwatch Kirklees and Bolton – Oral health in residential care homes						
Healthwatch Kirklees – Why can't I find an NHS dentist in Kirklees?						
Healthwatch Kirklees – Why can't I get an appointment with my GP?	X					
Healthwatch Kirklees – Welcome to my world						
Healthwatch Calderdale – GP appointments	X					
Healthwatch Bradford and District – A&E at BRI	X		X			
Healthwatch Bradford and District – Enter and View - Holycroft Surgery	X					
Healthwatch Bradford and District – Enter and View - North Street Surgery	X					
Healthwatch Bradford and District- 'Invisible at the desk'	X		X			
Brainbox Research - Evaluation of the 2013-14 Winter Awareness Campaign	X	X	X	X		
Leeds Improving Access to Primary Care – LD March 2015	X					
Leeds – Single point of access October 2014		X				
Leeds – ENT review October 2014	X					

	services available at GP practices	Improve access communication needs, accessible formats	Introduce an urgent care triage line	Difficulties in accessing dental care	Out of hours primary care service	Single point of access	Better communication and appropriate staff
CKW – Minor Injuries Service							
NHS Calderdale CCG – Review of unplanned							
Calderdale CCG – Co-commissioning in		X	X		X		
Leeds Involving People - Shakespeare Walk-in		X	X				
Healthwatch Wakefield – Young people's GP							
Healthwatch Leeds – GP extended hours in Leeds		X					
Greater Huddersfield CCG – Co-commissioning in Primary Care			X		X		
Healthwatch Kirklees and Bolton – Oral health in residential care homes				X			
Healthwatch Kirklees – Why can't I find an NHS dentist in Kirklees?				X			
Healthwatch Kirklees – Why can't I get an appointment with my GP?			X		X		
Healthwatch Kirklees – Welcome to my world		X					
Healthwatch Calderdale – GP appointments							
Healthwatch Bradford and District – A&E at BRI							
Healthwatch Bradford and District – Enter and View - Holycroft Surgery		X					
Healthwatch Bradford and District – Enter and View - North Street Surgery							
Healthwatch Bradford and District- 'Invisible at the desk'		X	X				
Brainbox Research - Evaluation of the 2013-14 Winter Awareness Campaign							
Leeds Improving Access to Primary Care – LD March 2015		X					X
Leeds – Single point of access October 2014						X	X
Leeds – ENT review October 2014					X		X

Mental health

Reference to mental health was covered in reports for Calderdale, Kirklees, Wakefield, Leeds and Bradford. Specific work on mental health as part of transformation programmes tended to focus on crisis intervention and CAMHS.

The key themes for West Yorkshire were:

- Improve the level of understanding of mental issues amongst staff
- Increase awareness with providers of services available
- Provide a seamless service
- Ensure appropriate support and services are in place to prevent a crisis occurring
- Provision of more outreach services
- Improve ability to access crisis support
- Improve the appropriateness of care provided in a crisis
- Improve quality of crisis intervention
- Improve access to CAMHS
- Improve transition from CAMHS
- Ensure mental health patients access appropriate transport in a crisis
- Provide a co-ordinated approach between services upon discharge

Crisis intervention

- Many causes of crisis are non-medical, including issues around housing, benefits and a range of social issues. It was felt that these crises can only be resolved and prevented by addressing non-medical causes in a joined-up way.
- There was a need to provide ongoing support for people and to do more to help people to stay well. There was a feeling that people should be able to access more services earlier to help prevent a crisis occurring.
- People felt that crisis services were difficult to access and were only interested in those that were 'severe'. They felt that staff needed to recognise that even though someone may not meet the official guidelines for crisis intervention, they still need a rapid response, which will likely prevent an actual crisis from developing.
- People felt that crisis care was not of a high enough standard, they cited a lack of 136 suites and not always being treated by the most appropriate service.
- Some felt that A&E was not the place to be treated during a crisis, unless life-saving treatment was needed. There is a need for an alternative resource for people to be seen in a safe, friendly and compassionate centre especially for people in a crisis. It was also recognised that there is a need for services to cater for those with dual-diagnosis.
- People reported difficulties in being able to access the most appropriate transport, at times this has seen patients in crisis being transported in police cars rather than by ambulance.
- It was felt that a lack of understanding of mental health issues and the services available has resulted in patients not being able to access the most appropriate care.

- In their interaction with mental health professionals, service users and carers felt they had faced a greater level of stigma and assumption about their mental health.

Co-ordination of care and provision of ongoing support

- There is a need to have more co-ordinated, flexible and responsive services to support people once they are discharged. GP's are sometimes not informed when their most vulnerable patients have been discharged from hospital, leaving those patients without the support and follow - up they need.
- Have more outreach services, based where people already access services. These should be accessible evening and weekends. Mental health problems can often be worse at night-time and weekends.
- There is a need to improve co-ordination of care between agencies, so patients receive the best care in a seamless way.

Children and young people

- Many children and young people felt that they wait too long for the right support, particularly within specialist CAMHS. They mention the lack of support and communication from services during their wait and the detrimental impact of the wait on their mental health and family relationships.
- There was concern amongst professionals about the threshold for referral to CAMHS being too high, and that only referrals for children and young people with the most serious issues were being accepted. Young people, parents and professionals rated highly the quality of services offered by CAMHS for those children and young people that 'got through the door' but felt that some of the most vulnerable children and young people were 'slipping through the net'.
- Key gaps in services were mentioned, such as access to crisis support and the gap between TaMHS and CAMHS, where young people needed more support than TaMHS could offer but didn't meet the criteria for CAMHS. The transition to adult services was also an issue for young people. The need for an improved transition process as people move from young people's to adult mental health services.

	Healthwatch Kirklees – When life is already tough…	Healthwatch Kirklees Understanding patients' views of Section 136	Healthwatch Leeds – CYP Mental Health Services in Leeds	Leeds Involving People - Shakespeare Walk-in Centre	BAWC CCGs - Urgent and Emergency Care Strategy	BAWC CCGs – Future in mind.	CCCCG & GHCCG RTRCRP Engagement Phase	CCCCG & GHCCG RTRCRP findings from all engagement and pre-	CCCCG & GHCCG RTRCRP - UNPLANNED CARE	NHS Leeds CCG - Urgent Care in Leeds	Leeds South and East CCG - Emotional and Mental Health Services for CYP	NHS Wakefield CCG - Mental Health	NHS Wakefield CCG - Joint Mental Health Strategy and Community	Together We Can - What is crisis care in Leeds really like for us?	Kirklees Healthy Child Programme	Calderdale CAMHS transformation	YHCS - Call to Action	South West Yorkshire Partnership NHS Foundation Trust -Feedback from the transformation events
Improve the level of understanding of mental health issues amongst staff	X	X	X	X	X			X			X	X	X	X		X	X	X
Increase awareness with providers of services available		X			X						X	X		X		X	X	X
Provision of a seamless service		X			X	X	X				X			X	X			X
Prevention of a crisis	X	X							X		X			X	X	X		X
Provision of outreach services	X					X					X	X		X	X	X		X
Difficulty in accessing crisis support		X	X								X		X	X				
Improve the appropriateness of care provided in a crisis	X	X								X				X			X	
Improve quality of crisis intervention		X								X				X				
Improve access to CAMHS			X			X					X				X	X		
Improve transition from CAMHS			X			X					X				X	X		
Inappropriate transport in crisis		X																
Provide a co-ordinated approach between services upon discharge	X														X	X		

Stroke

Reference to stroke was made in only a few of the reports reviewed. The areas covered were Airedale, Wharfedale and Craven and Bradford.

The key themes raised were:

- Concerns about discharge including lack of consistency for aids and adaptations
- More emotional support for patients, carers and family members
- Journey time and distance for both patients and visitors cost of parking at the hospital
- Journey time to receive treatment is a concern
- Transfer times to receive treatment if presenting at other hospital sites not BRI
- Inadequate Staffing levels impacting on care and treatment and outcomes
- Staff without the right skills and poor attitude
- Information and communication need to be improved across services
- Information and communication for patients and relatives requires improvement including using appropriate forms of communication
- Under provision of speech therapy and physiotherapy

The engagement exercise identified five key themes in relation to both people's concerns and suggestions for improvement. These are detailed below:

Discharge and aftercare

Concerns were raised about aspects of discharge, rehabilitation and aftercare. These covered a wide range of specific issues including a reported under provision of speech therapy and physiotherapy; gaps in the provision of emotional support for patients, carers and family members, along with a lack of consistency when providing aids and adaptations to patients.

It was suggested there should be an increased focus on re-enablement and recovery and that more resources be put into rehabilitation and aftercare services as getting the right information and support were deemed important to aid patient recovery and relieve anxiety and stress for patients and carers.

Travel, transport and parking

The distance, time and cost to travel, along with the challenges of parking at BRI, were a concern. People were worried not only about how the extra journey time could affect the treatment and outcome for stroke patients living in Airedale, Wharfedale and Craven but also how this would impact on the ability of carers and families to visit their loved one at this critical time, particularly those reliant on public transport.

Suggestions to address the concerns highlighted included providing help with travel costs for immediate family members e.g. a travel card, extended or open visiting times in order to avoid peak travel times, and some level of concession for parking.

Treatment and care

There were concerns about moving the existing HASU at AGH to BRI and the impact, the additional distance, time and potentially different levels of service could have on the treatment and outcome of stroke patients living in Airedale, Wharfedale and Craven. Concerns were also raised for those people who self-present at AGH A & E not realising they are having a stroke; then having to be transferred to BRI before receiving treatment.

Suggestions proposed in relation to improving treatment and care included improving ambulance response time, ensuring there is a sufficient number of acute beds and creating a joined up fast track service from 999 and arrival through to assessment, tests and treatment.

Staff

Whilst there were many positive comments in relation to staff and the care they provide, especially on Ward 5 at AGH, there were concerns about inadequate staffing levels, particularly specialist stroke staff and how staff shortages can result in delayed response time and limited contact time for patients. Also raised was whether general and agency nurses had the level of knowledge and skill, required for stroke care. There were also concerns raised in relation to the poor attitude of some staff and the impact of this on the patient/carer experience.

It was suggested that more specialist stroke staff were needed and that stroke training should be provided for general and agency nurses and, A & E staff.

Information and communication

The need for improved information and communication between staff, patients and carers and between departments and across organisations were highlighted. In particular was the need of stroke patients and carers' to understand what has happened to them/their loved one during and after the stroke. Also raised was the need for appropriate forms of communication to be used with those patients whose ability to communicate has been impaired by the stroke.

It was suggested more information and advice about strokes and after care was required and that the patient information currently provided is reviewed to ensure it is easily understood and fit for purpose.

	Bradford and District	Bradford city	Airedale, wharfedale and Craven
Concerns about discharge including lack of consistency for aids and adaptations	x	x	x
More emotional support for patients, carers and family members	x	x	x
Journey time and distance for both patients and visitors cost of parking at the hospital	x	x	x
Journey time to receive treatment is a concern	x	x	x
Transfer times to receive treatment if presenting at other hospital sites not BRI	x	x	x
Inadequate Staffing levels impacting on care and treatment and outcomes	x	x	x
Staff without the right skills and poor attitude	x	x	x
Information and communication need to be improved across services	x	x	x
Information and communication for patients and relatives requires improvement including using appropriate forms of communication	x	x	x
Under provision of speech therapy and physiotherapy	x	x	x

Cancer

Leeds has done a considerable amount of work looking at specific cancer services. In addition Calderdale and Huddersfield Foundation Trust and Harrogate and Rural District completed a specific piece of engagement on cancer services. The key themes are below:

- Getting an appointment quickly
- Give patients clear explanations of clinical tests
- Follow up care is really important and provides assurance and access to specialists
- Patients like a named clinical nurse lead and specialist
- Face to face contact is a really important aspect of care, including being able to pick up the phone and contact someone
- Involve patient fully in care and treatment
- More information and communication on life-style and practical post treatment advice
- Deliver care through competent ward nurses, allowing the patient to have trust in them
- Plan and deliver effective discharge from care
- Coordinating with the GP practice so care is ongoing
- Electronic tools and new technology were not favoured for support and follow up
- Emotional and Financial support
- Input and impact of supportive therapies

Colorectal

- Follow-up patients believed they are receiving high quality follow-up care. Finding out the results, getting quick test results and having regular discussions with the clinical nurses positively contribute to the reassurance patients get from follow-up care.
- Some patients experienced pre-appointment anxiety because the scans, procedures and blood tests they have before their follow-up appointment could identify concerning changes in their cancer. However, patients believed the reassurance provided by follow-up and getting positive results far outweighed this disadvantage.
- Patients thought that some face-to-face follow-up is very important at the start of the follow-up pathway but that telephone follow-up is more acceptable over time.
- Although most participants had not needed to contact the clinic between appointments, they found it highly reassuring that clinical nurse specialists were available by telephone to support them if they needed it.
- Most patients believed that the clinical nurses gave sufficient information and adequately explored patients' health and wellbeing during follow-up appointments. Some patients were interested in getting more information about healthy lifestyles and practical post-treatment information through an education and support programme.
- Patients believed that holistic support sessions should be an addition to current care. Follow-up use of Q-tools was rejected by patients it loses the "personal touch" and some patients did not use computers or did not trust the security.

Children

- Long-term follow-up patients believed they are receiving excellent quality follow-up care at St James's Hospital. They believe that without regular follow-up appointments they may not get easy access to specialist care.
- Patients think the current system of clinical nurse specialist care effectively assesses patients' health, wellbeing and wider holistic needs. They described the importance of the in-depth discussion between the nurse and the patient that explores these areas.
- Patients explained how they find it useful to have regular reminders of the late effects of treatment and specialist advice about how they can maintain or improve their health.
- Patients believed that the clinic staff are experts who deliver personalised care in a supportive and friendly way. Patients found it highly reassuring that their named clinical nurse specialist who they had built a relationship with were available by telephone to support them if they needed it.
- Patients preferred the method of follow-up they had experienced, either face-to-face or telephone appointments.
- Patients did not believe that diagnostic test results and the risk and symptom questionnaire alone would capture enough detailed and useful information about the patient to help the clinical team assess them.

Breast cancer

- At present participants access the breast clinic through GP referral. Generally, women are able to get a GP appointment quickly, although some experience delays.
- Participants prefer to be able to access the breast clinic directly rather than going through their GP. Most prefer an appointment system as they fear that a walk-in clinic would involve long waits, although some walk-in slots should be available. Extended opening hours are required, particularly evening clinics.
- Many women who were diagnosed with cancer are happy they were referred by their GP because their GP is aware of what is happening and can offer support throughout.
- Participants would be happy to access a specialist nurse-led clinic, either attached to a group of GP practices, or to the breast unit, that can answer questions. It should be staffed by expert clinical staff rather than call centre operators, who can give accurate advice and who can understand how anxious patients can feel.
- Many women want to book their own appointment so that they can organise it around their commitments and, if they wish, arrange for somebody to accompany them. Some would prefer to arrange their clinic visit with more than two weeks' notice.
- Participants wanted information about what to expect at the clinic. A breast unit webpage would be useful, including a video of the clinic, the staff you might meet, and the tests you might have. Alternative formats would also need to be available.
- Most women appreciate that where they go for tests is the same place as where they go for surgery however, some would prefer to go to a health clinic rather than a hospital.
- Parking is a major anxiety for women as they don't know how long they will be at the breast unit for and the nearest car park has a four-hour maximum stay.
- Participants were clear that they wanted to feel welcome when they arrived at the clinic.

- Participants with disabilities and restricted mobility described difficulties in getting in the positions required for the mammogram and that the radiographers could be impatient, insensitive or lack compassion.
- The wait between having tests and getting the results is full of anxiety and reducing this wait would have the biggest impact on improving the patient experience

Gynaecology

- Patients were reluctant to consider alternative models of care that involve reduced direct face-to-face contact with the clinic because they did not think these will provide the same level of reassurance and continuity of care.
- Patients wanted to feel that they have specialist care from experts and any cancer recurrence or new cancer would be detected and acted upon rapidly.
- Despite some ladies having never phoned the specialist nurses, patients found having the option of contacting their key worker nurse reassuring.
- Follow-up using Q-tools was dismissed by most patients, a few participants would be interested in follow-up via technology such as Skype or Facetime that could facilitate face-to-face interaction with health professionals during appointment.

Prostate

- Patients wanted to feel that they had specialist care from experts
- Patients thought that face-to-face follow-up is very important at the start of the follow-up pathway but that telephone follow-up is more acceptable over time.
- Most patients thought that appointments were often brief but covered patients' test results, general health and queries in sufficient detail. Patients relied on follow-up discussions to prompt them to think about symptoms they could be experiencing.
- Although most participants had not needed to contact the clinic between appointment, they found it highly reassuring that clinical nurse specialists were available by telephone to support them if they needed it.
- Younger patients who had experienced treatment believed that follow-up care should offer more holistic support for patients, particularly psychological support.
- Patients found it convenient that they had a choice about where blood tests are done. However, some believed that the GP and hospital information systems could be better integrated to facilitate transfer of patients' blood results.
- Some patients were interested in getting more information about healthy lifestyles and reducing cancer risk through an education and support programme.
- Follow-up using Q-tool was dismissed by most patients due to concerns that it loses the "personal touch" of human interaction, may require skills and a computer (which older men may not have) and security concerns.

	Leeds North	Leeds west	Leeds South and east	Calderdale and Huddersfield	Harrogate and Rural District
Getting an appointment quickly	X	X	X		X
Give patients clear explanations of clinical tests,				X	
Follow up care is really important and provides assurance and access to specialists	X	X	X		
Involve patient fully in care and treatment				X	
Face to face contact is a really important aspect of care	X	X	X		
Deliver care through competent ward nurses, allowing the patient to have trust in them	X	X	X	X	
Patients like a named clinical nurse lead and specialist	X	X	X		
Plan and deliver effective discharge from care	X	X	X	X	
Coordinating with the GP practice so care is ongoing	X	X	X	X	
More information and communication on life-style and practical post treatment advice	X	X	X		
Electronic tools and new technology were not favoured for support and follow up	X	X	X		
Emotional and Financial support					X
Input and impact of supportive therapies					X

Urgent and emergency care

Reference to emergency and urgent care including specific engagement or consultation is available from work across the West Yorkshire and Harrogate STP. Most areas have had some engagement or consultation on this area and work to identify urgent and emergency care services should use existing intelligence to inform future proposals.

The key themes across the area are:

- Consider travel and transport to access services including ambulance services
- Consider the capacity to provide urgent care services closer to home – particularly in GP practices
- Consider the use of 111 as a gateway to urgent and emergency care and whether satisfaction ratings with the service lend themselves to this being the right gateway
- Consider ambulance journey times and road and transport networks
- Consider the availability of walk-in centres to relieve pressure on A&E
- Convenience and location of A&E can be a concern
- Raise awareness of the most appropriate services to access
- Introduce an out of hours primary care service that is co-located with A&E
- Concerns about centralising emergency services
- Lack of information about the difference between urgent and emergency care

- People report high levels of satisfaction with the service they receive in A&E. They have confidence and trust in A&E and believe it provides the best place for them to get care.
- People believe A&E provides a convenient place to go, it can provide reassurance that an injury or condition is not serious and does not need further treatment, and it is perceived as offering the highest level of expertise, with access to appropriate diagnostic equipment, such as x-rays.
- The two main themes raised under travel were travel times and travel access.
- Many people want to see their GP for urgent care services, there are a lot of concerns about the effectiveness of 111.
- Respondents to the right care, right time, right place consultation raised concerns about the roads and were particularly worried about the potential for an increasing number of deaths because of this. This led some to question the information provided on travel times.
- Respondents from Greater Huddersfield argued that emergency care should be retained in the area because of its large and growing population, the presence of the university and because people are living longer.
- Most respondents were concerned about proposals to centralise emergency services and doubted whether it was feasible. Many questioned the resources and staffing required and asked how staff would be recruited.
- Many believed felt that proposals to change the way emergency services are currently provided would lead to problems, including increased mortality rates, increased waiting times (which was linked to access) and greater demand on services.

- A high proportion of respondents to the right care, right time, right place consultation indicate that services should remain the same.
- Respondents often stated that they believed the proposals would put lives at risk, due to increased travel times and distances.
- A&E offers the 24/7 access people want and there is support for this to be developed further to include an out of hours primary care service / urgent care service that is co-located with A&E. Through the co-location of urgent care services on one site, patients can be triaged appropriately to the necessary emergency or urgent care service. It would relieve the pressure in the A&E departments and give people faster access to more effective treatment.
- A significant proportion of people that had used a walk-in centre would have attended A&E if the walk-in centre had not been available. Many patients valued the provision of treatment outside of A&E departments, in minor injury units or walk-in centres. These were often popular because they were seen to avoid long waits, although sometimes led to frustration if the service was unable to deal with the presenting condition.
- People want to be seen by the most appropriate person, quickly and in a setting that is close to home. They didn't want to be travelling long distances when they needed urgent or emergency care.
- GPs and community-based health care were often closed when the patients needed to access them, forcing them to go elsewhere, despite their preferences to use these services. Other access issues, most commonly related to availability/choice of appointments.
- Whilst people state that they know A&E is for emergencies only, many nevertheless believe they have no alternatives. There is a need to raise awareness of the most appropriate service to access, where and how to access these services.
- Concern was expressed about the long waits in A&E and not being told how long they would have to wait/ reasons why, and some patients were concerned that they received no, or inadequate pain relief.

A&E proposals require a lot more consideration and people need to know the difference between urgent and emergency care services. People want to see 24/7 access to include an out of hours primary care service / urgent care service that is co-located with A&E. Through the co-location of urgent care services on one site, patients can be triaged appropriately to the necessary emergency or urgent care service. It would relieve the pressure in the A&E. For urgent care services this is evidence that people want to see their GP or go to services closer to home.

	BAWC CCGs – UEC Strategy	CKW – Urgent Care Services	Healthwatch Wakefield – Enter and View A&E	Healthwatch Leeds – people's experience in A&E	Healthwatch Bradford and District – A&E at BRI	Healthwatch Kirklees – Welcome to my world	Leeds Involving People - Shakespeare Walk-in Centre	NHS Wakefield CCG - Meeting the Challenge	NHS Calderdale CCG – Review of unplanned care	CKW – Minor Injuries Service	Right care, right time, right place – engagement	Right care, right time, right place – pre- consultation	Right care, right time, right place – consultation
Consider travel and transport to access services including ambulance services					X			X			X	X	X
Consider the capacity to provide urgent care services closer to home	X			X				X	X		X	X	X
Re -consider the use of 111 as a gateway to urgent and emergency care													X
Consider the availability of walk-in centres to relieve pressure on A&E					X		X		X		X	X	
Consider ambulance journey times and road and transport networks	X			X	X			X			X		X
Convenience and location of A&E can be a concern					X			X					X
Raise awareness of the most appropriate services to access		X	X	X		X	X			X			X
Introduce an out of hours primary care service that is co-located with A&E	X			X			X			X			
Concerns about centralising emergency services													X

Specialist care

From the evidence gathered there is only reference to a limited number of engagement and consultations on specialist service areas. Whilst this may not be the complete picture for West Yorkshire and Harrogate Rural District further work should be completed to identify any work carried out during the four year mapping period.

Areas who delivered engagement are Bradford City and Bradford and District who have hosted conversations on eating disorders and specialised mental health.

Due to the limited data analysis a table of themes is not provided. This area could require further West Yorkshire and Harrogate wide engagement.

Acute reconfiguration

Reference to acute care and acute reconfiguration was made in a number of the reports reviewed. These covered Calderdale, Kirklees, Wakefield, Leeds and Bradford.

The key themes raised were:

- High levels of satisfaction with services
- Improve the quality of discharge planning
- Increase the provision of services closer to home
- Consider travel and transport to access services
- Raise awareness of the most appropriate services to access
- Provide ongoing care and support to prevent admissions

Discharge process

- There were occasions where people felt that they had been inappropriately discharged from A&E and were subsequently readmitted to hospital shortly afterwards.
- Patients described being told in the morning that they were to be discharged that day, there was a feeling that a proper assessment of their needs had not taken place, with patients mentioning arriving home to an empty house with no food or medication, late at night.
- There is a need to provide follow-up care once patients are discharged, to assess whether the care put in place met their needs. In some cases, if an appropriate level of care had been in place at home, patients felt that they may not have been admitted to hospital in the first instance or subsequently readmitted.

Outpatient appointments

- Where clinically appropriate people would prefer to see a specialist in a community based setting as opposed to a traditional hospital outpatient setting. The most common reasons given by respondents for preferring a community based setting was that it was quicker and easier for them to get to. Public transport, particularly to major hospitals, is a challenge to many people. People could neither afford the time to travel; the cost, or find suitable parking on premises.
- Some patients commented that they didn't know which clinic they would be attending or which consultant they would be seeing. Having this information is particularly important where patients have multiple health conditions and attend a few different clinics.

Meeting the Challenge		X	X	X	X		X
Right care, right time, right place – engagement		X	X	X	X		X
Right care, right time, right place – pre-consultation		X	X	X	X		X
Right care, right time, right place – consultation		X	X	X	X		X
CKW – Discharge to assess		X	X	X	X		X
CKW – Proposals for Mid Yorks				X	X		
NHS Calderdale CCG – Review of unplanned care					X		
Leeds Involving People - Care Closer to Home				X			
Healthwatch Wakefield - Speaking to Outpatients		X		X	X		
Healthwatch Wakefield - Gate 12		X					
Healthwatch Wakefield - Mid Yorkshire		X			X		
Healthwatch Kirklees, Hospital discharge into care homes			X				
Healthwatch Kirklees – When life is already tough…			X				
Healthwatch Calderdale – GP appointments	X						
Healthwatch Bradford and District – Enter and View - North Street Surgery	X						
Brainbox Research - Evaluation of the 2013-14 Winter Awareness Campaign	X	X				X	
	Increase availability of GP services	Satisfaction with services	Quality of the discharge planning	Provision of services closer to home	Travel and transport to access services	Raise awareness of the most appropriate services to access	Provision of ongoing care and support to prevent admissions

Standardisation of policies

There are a number of engagement and consultations currently taking place across the West Yorkshire and Harrogate Rural District footprint on standardisation. These are ongoing conversations and only a few areas have been able to share the findings from engagement activity. The key emerging themes so far from areas such as Kirklees are:

- the cost and effectiveness of medicines and treatments should be taken into account when making decisions
- people should pay for medicines that are widely available in local shops at low cost, rather than getting them on prescription (Although you are concerned about the financial impact on people with low incomes)
- you want consistency in funding decisions across Kirklees to avoid a 'postcode lottery'
- patients should not be refused treatment because of lifestyle choices, unless this impacts on the success of their treatment
- we could save NHS money by educating people about how to prevent ill health, manage their own health conditions and use health services appropriately.

More information needs to be gathered from other local areas who are delivering conversations. Other conversations across the area include:

'Talk health Kirklees' – a campaign in Kirklees which is consulting with local people on

- Over-the-counter and pharmacy-only medicines
- Gluten-free foods
- Procedures for managing individual funding requests and restricted treatments
- Branded medicines

'Stop before your OP' – a campaign in Harrogate and Rural District to encourage people to stop smoking to support people prior to having a procedure.

Medicines management - in Wakefield and Harrogate and Rural District

Gluten free products -in Wakefield, Bradford City and Bradford District (and Kirklees as part of Talk health Kirklees)

Overarching themes

There are a number of overarching themes in all the information gathered. The themes are summarised below. The key themes from all the intelligence provided are:

- Improve the provision of information on self-care and prevention
- Provide more care closer to home
- Staff to treat patients with dignity and respect
- Improve the availability of services at evenings and weekends
- Provide patients with information to enable them to make informed choices
- Ensure services are joined up
- Increase the involvement of the voluntary and community sector
- Provide services that meet the needs of a diverse population
- Consider travel and transport to access services
- Involve the public in the design of services
- Raise awareness of the services available
- Increase staffing levels

- The need to use a wide range of communication methods to raise awareness of the services available, when and how to access them. It was felt that this would help people select the most appropriate service for their needs.
- Need to improve access to services and appointment systems, with greater availability at evening and weekend.
- People wanted to see more care closer to home and in a variety of community settings, delivered by the right staff.
- Consideration needs to be given to travel and transport, as people could neither afford the time to travel; the cost, or find suitable parking on premises. It was felt that there should be an adequate number of parking spaces available at any site, with special focus on making sure there is enough disabled parking available. The car park should be in a safe location and the price of parking should be as low as possible. Public transport, particularly to our major hospitals, is a challenge to many people.
- People want to receive clear and good quality information to help them to make informed choices about their treatment, and they want to be involved in decisions about their care.
- To ensure high standards of care, efficiency and good patient experience there is a need for services to be joined up, underpinned by effective communication between services and staff-patient.
- To ensure that patients consistently receive high quality care throughout the different services, there is a need for staff to be friendly, helpful and to treat patients with dignity and respect.
- People want to be given the information they need to help manage their own health and wellbeing. They wanted more focus on prevention and innovative opportunities to keep themselves well. They felt that more information about healthy lifestyle choices should be available with professionals being provided with the relevant skills and knowledge to advise and

support individuals with any changes they may wish to make. It was suggested that there could be education programmes in schools so younger people learn to take responsibility.

- Support available through the voluntary sector was praised. People said there should be more groups to support people, and reported concerns about local support groups having their funding cut.
- We have a diverse population and we need to consider all our population when designing new services, current services still don't address patient needs in terms of access, culture, information and communication. Some suggestions were to improve access for those with different communication needs by providing access to language and BSL interpreters. The provision of bilingual staff and deaf awareness training should support this.
- Staffing levels were felt to be under stress by some, and there was reference to the need to recruit more staff and to ensure their morale and motivation was maintained, however there was concern with regards to the availability of trained staff and the financial viability of this.
- The need to ensure that we give the public the opportunity to be listened to, and be involved in the design and delivery of services in their communities.

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A partnership between health services, clinical commissioning groups, care providers, local authorities and Healthwatch

OCTOBER 2016

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Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 24 74707

Report of Head of Governance Services

Report to the West Yorkshire Joint Health Overview and Scrutiny Committee

Date: 18 November 2016

Subject: Work Programme

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. This report provides an opportunity for members of the West Yorkshire Joint Health Overview and Scrutiny Committee to consider reports and/or concerns identified by members of the Joint Committee, and then agree its priorities and future work programme.

Recommendations

2. Members are requested to consider the issues raised at the meeting and agree the priorities and future work programme of the West Yorkshire Joint Health Overview and Scrutiny Committee.

Background documents[1]

3. None

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

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