



West Yorkshire and Harrogate Sustainability and Transformation Plan (STP)

**Draft proposals
October 2016**

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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 our 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.

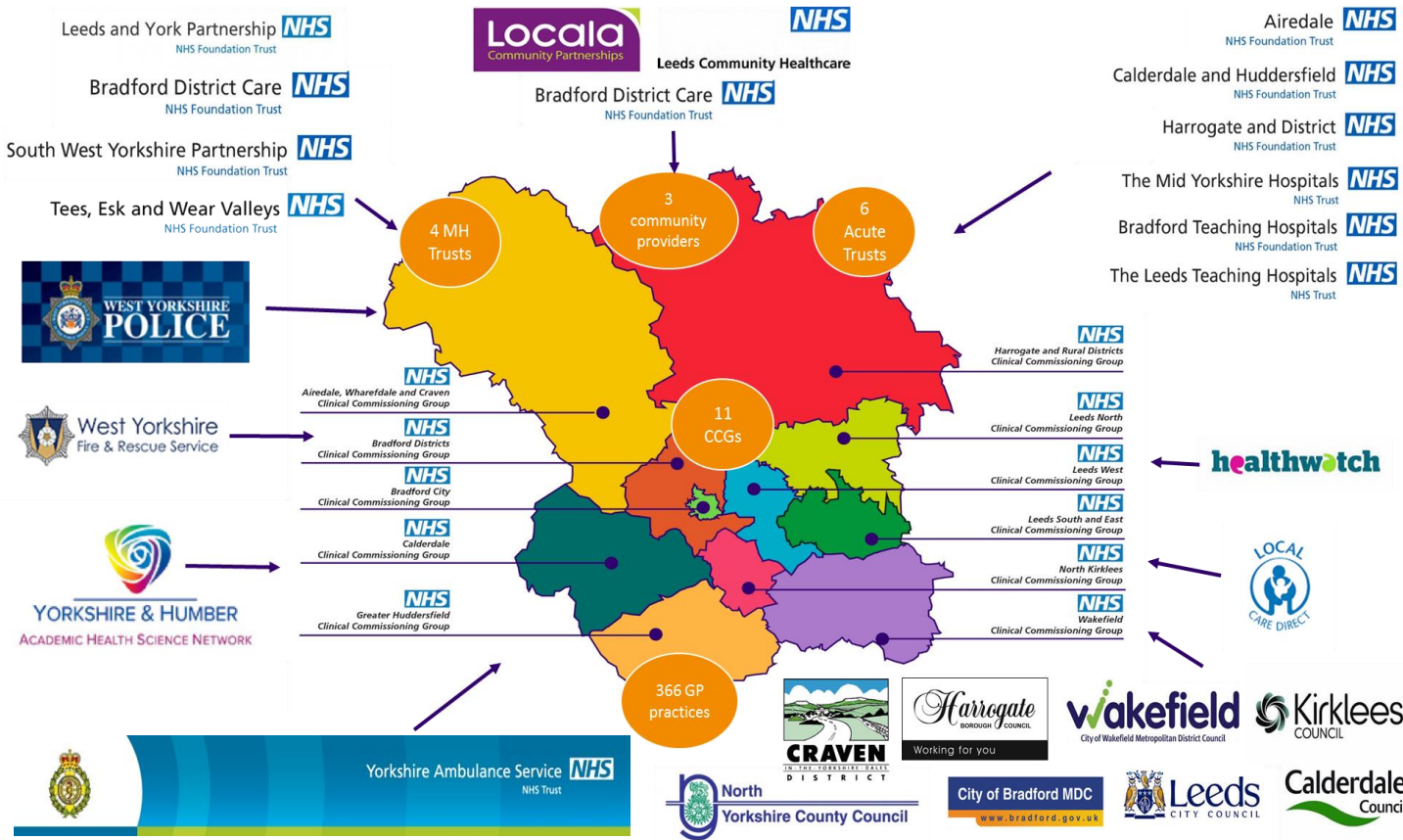
Rob Webster

On behalf of the leadership of West Yorkshire and Harrogate

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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:

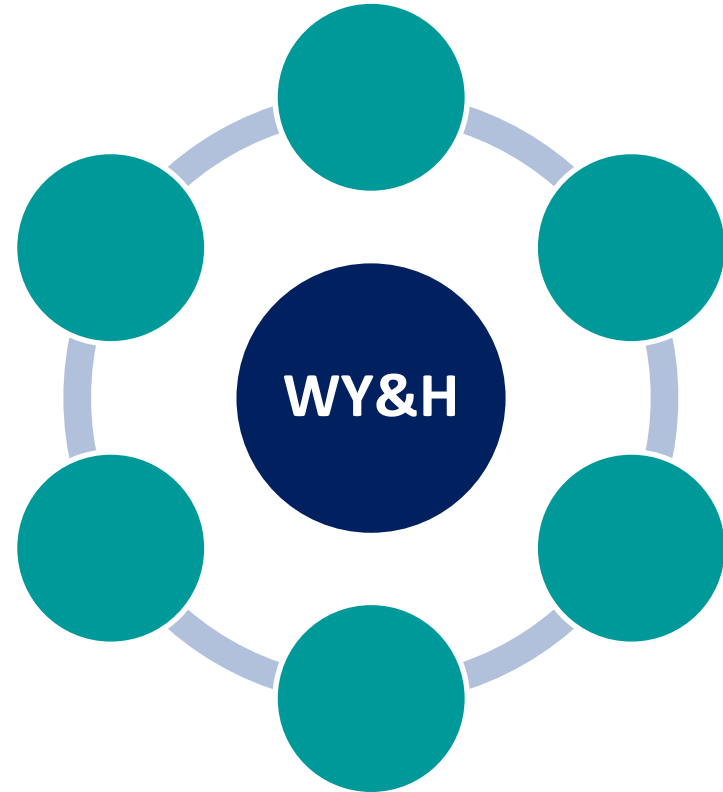
- To achieve a critical mass beyond local population level to achieve the best outcomes
- To share best practice and reduce variation
- To achieve better outcomes for people overall.

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

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

Regional



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

Care and quality

Finance and efficiency

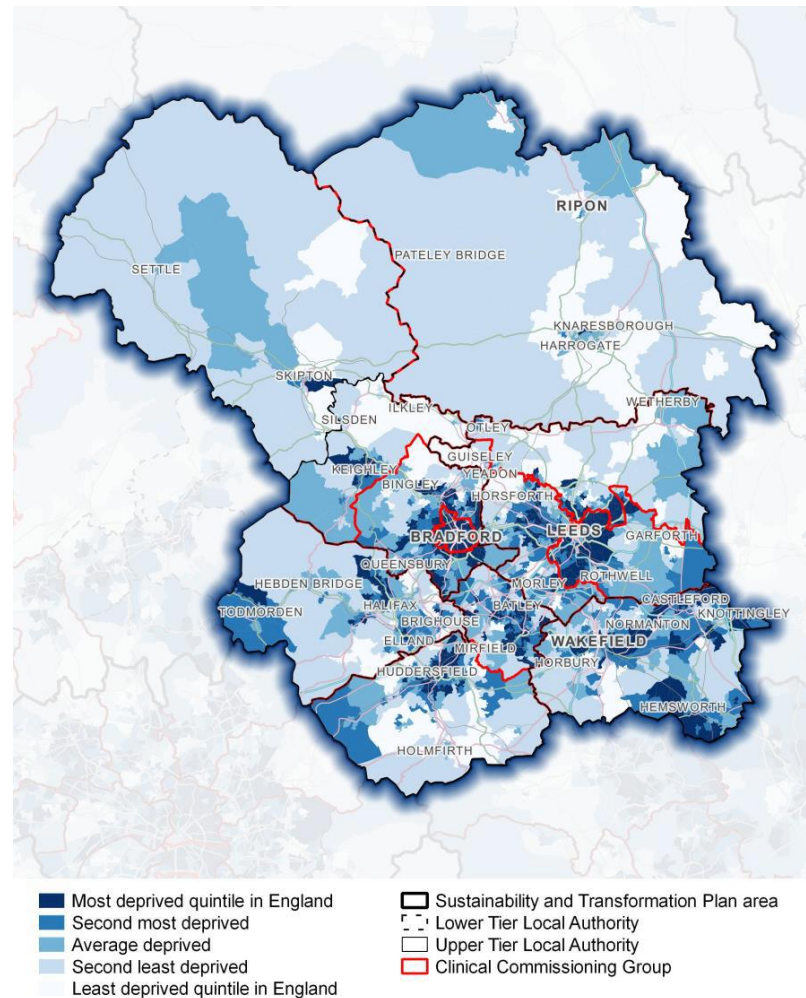
Health and wellbeing gap: Our challenges

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

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

Health and care inequalities



Care and quality gap: Our challenges

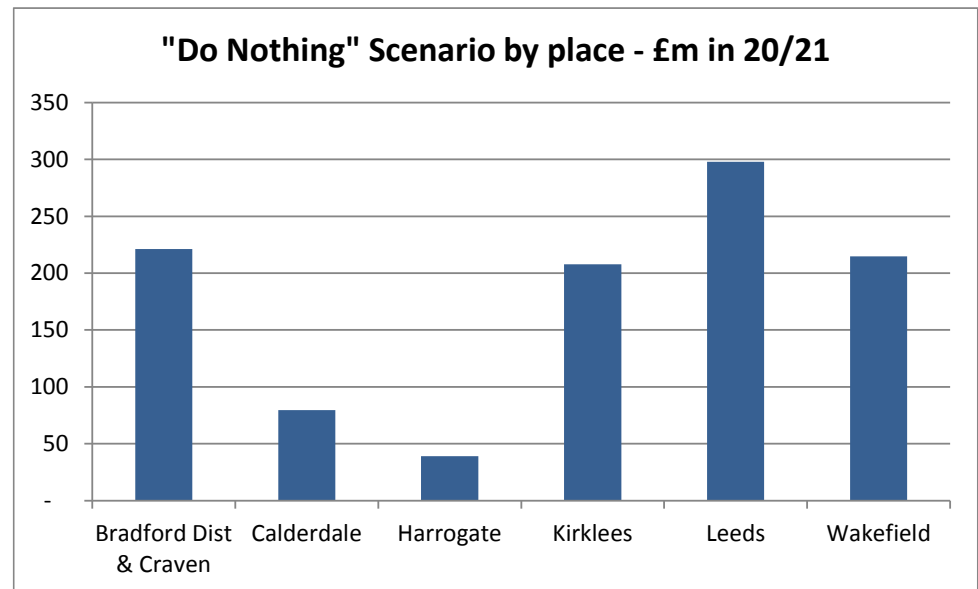
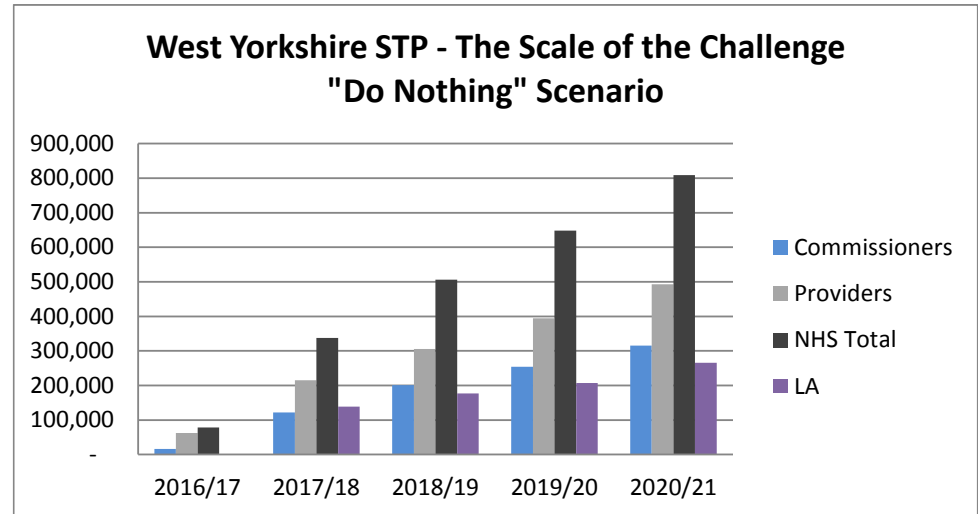
- The significant majority of services are high quality, timely and offer a good experience for service users.
- Performance against key standards has dipped in recent times and patient experience for some services remains below average, for example:
 - Performance against the accident and emergency 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

£m

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.

Do Nothing	(1,075)
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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)

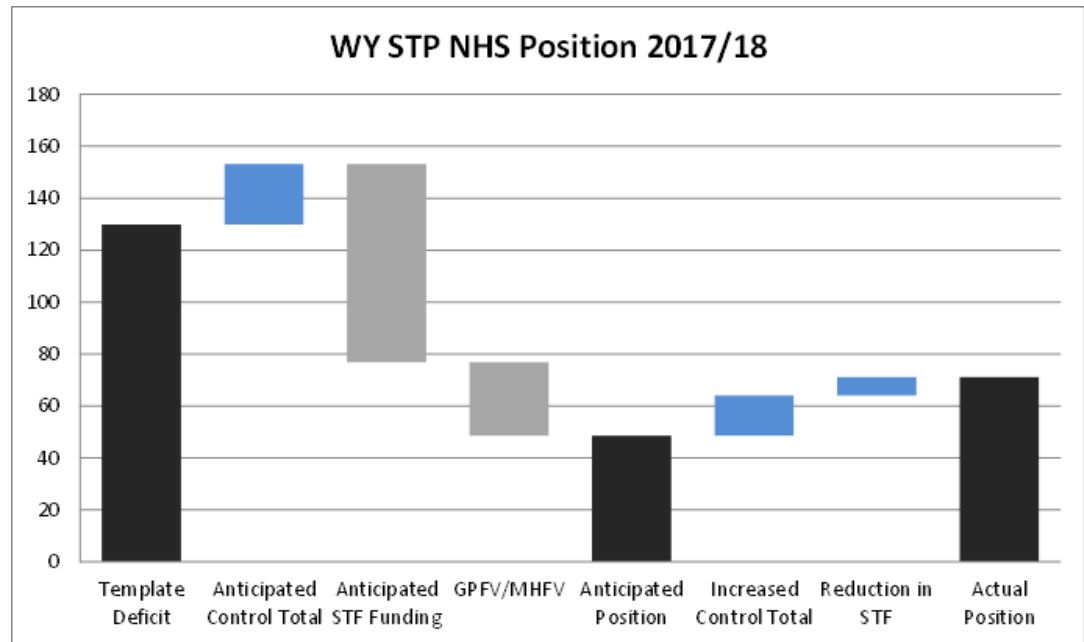
Finance and efficiency gap: Our approach

- 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

379,836
smokers

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

455,000
binge
drinkers

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

1.3 m
overweight

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

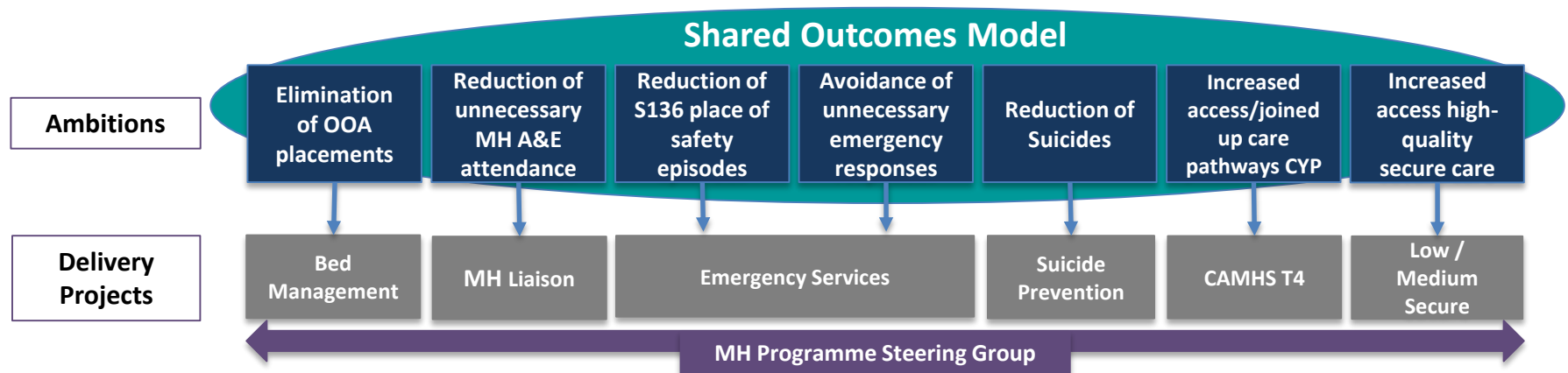
Our principles for high quality primary care in West Yorkshire and Harrogate:

- 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 for 95% 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.



Prevention
of stroke

Hyper-acute
stroke
services

Acute rehab
services

Community
support and
rehab

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
<p>Pre-hospital Care</p> <p>Increase availability of primary care, 111 and other alternatives to avoid A&E attendances</p>	<p>Primary care : Increase access to primary care out of hours</p> <p>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</p> <p>999: Continuation of Ambulance Response Programme pilot; call centre access to A&E consultant</p> <p>Care homes (major 999 users): 111 and telemedicine in care homes</p> <p>Mental health: Pilot high volume service user team in Leeds</p>
<p>Streaming and Ambulatory Care</p> <p>Increase access to alternatives to A&E and access to ambulatory care once patients attend the emergency department</p>	<p>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</p> <p>Ambulatory Care: Implement trust schemes to increase access to ambulatory care pathways (aiming for 12 hours 7days)</p> <p>Mental health: Increase access to mental health liaison as part of MH Vanguard</p>
<p>Flow and Discharge</p> <p>Improve flow through hospital and discharge from hospital to reduce length of stay</p>	<p>SAFER wards: Implement SAFER bundle across all trusts: early senior review; red/green day and afternoon huddle</p> <p>Discharge: Implement trust schemes to deliver Discharge to Assess and Trusted Assessor; rollout pharmacy discharge and re-admission avoidance</p> <p>Care homes: Purple bag scheme in care homes and trusts; end of life care plans; daily bed state</p>

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



Prevention
/ managing
demand for
specialist
care

Consistent local
prevention strategies



Specialist
treatment

West Yorkshire and Harrogate
planning of services

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 standardisation 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

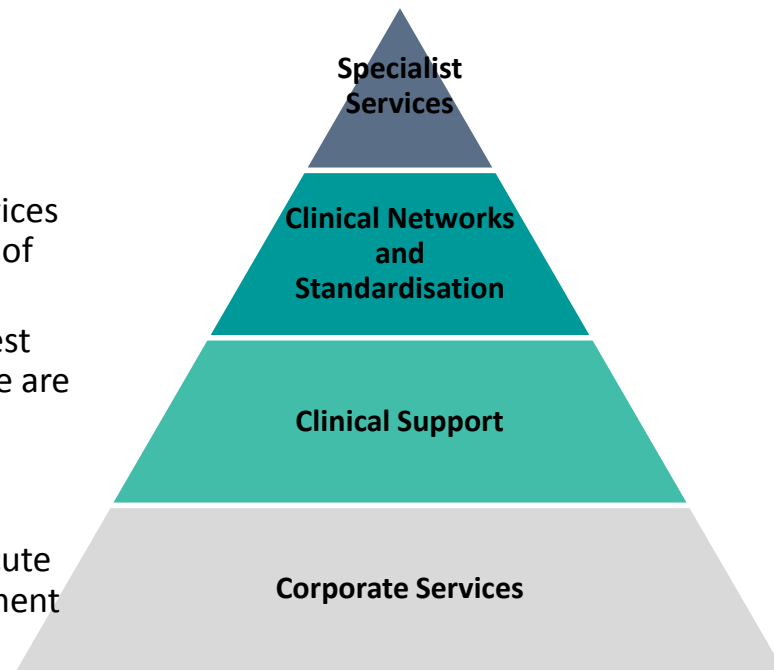
2017-2021

- 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.

Health and wellbeing thresholds

Clinical thresholds and policies

Follow-up management

Prescribing

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

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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
Dr Andrew Sixsmith

Registered workforce initiatives
Philip Marshall

Non-registered workforce initiatives
Sandra Knight

Prevention at Scale
Dr Ian Cameron

Workforce flexibility and enablers
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. <i>Working with the Primary Care & Community Services Group</i>	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	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Proposal for career escalator • Development of a WY Excellence Centre • Optimise use of apprenticeship levy 	<ul style="list-style-type: none"> • Making Every Contact Count Framework and Plan for WY&H. • Health Promoting Trusts proposal (TBC) • Workforce development strategy for prevention priorities. 	<ul style="list-style-type: none"> • Savings from internal agency • Savings from standardisation
Workstreams to be developed	<p>Primary Care Workforce working in General Practice - workforce analysis</p> <p>Investment plan – for wider roles in primary care (adaptation and innovative roles) nurses, pharmacists, advanced practitioners, physicians associates, clinical support workers, care navigators</p> <p>New Care Models, new ways of working</p> <p>Support for self care, expert patients & volunteers</p>	<p>ACP supply</p> <ul style="list-style-type: none"> • ODP function supply • Endoscopists • Physicians Associates • Social workers <p>Nurse recruitment strategies at WY&H level</p>	<p>Development of the West Yorkshire Excellence Centre</p> <ul style="list-style-type: none"> • Pathway for B1-4 • Support to the primary care workstream • Working with Advanced Training Practices 	<p>Development of an STP Prevention at Scale plan</p> <ul style="list-style-type: none"> • Priorities TBC (Nov 16) • Workforce development of all prevention priorities. • MECC • Health Promoting Hospitals/Health and Care (TBC) • Support and links to primary care 	<p>Development of Internal Agency</p> <p>Workforce passports</p> <p>Improve quality and value for money of GP locum market</p> <p>Standardisation of HR processes & streamlining</p> <p>Adoption of digital & technology solutions</p>

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.



YORKSHIRE & HUMBER
ACADEMIC HEALTH SCIENCE NETWORK



Leeds
CITY COUNCIL

European Health Futures Forum



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.

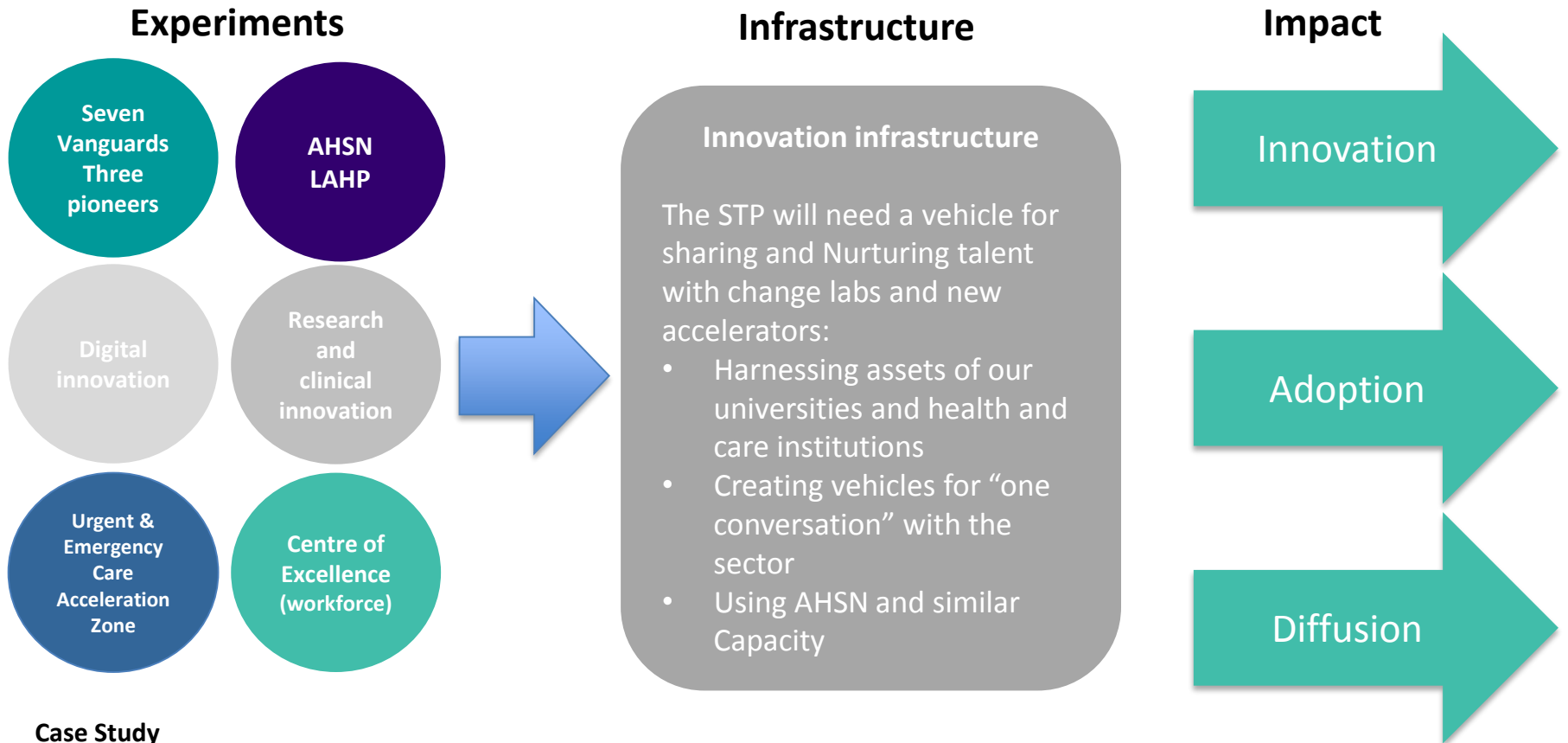
Harnessing the power of our communities

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	Harrrogate 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	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



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

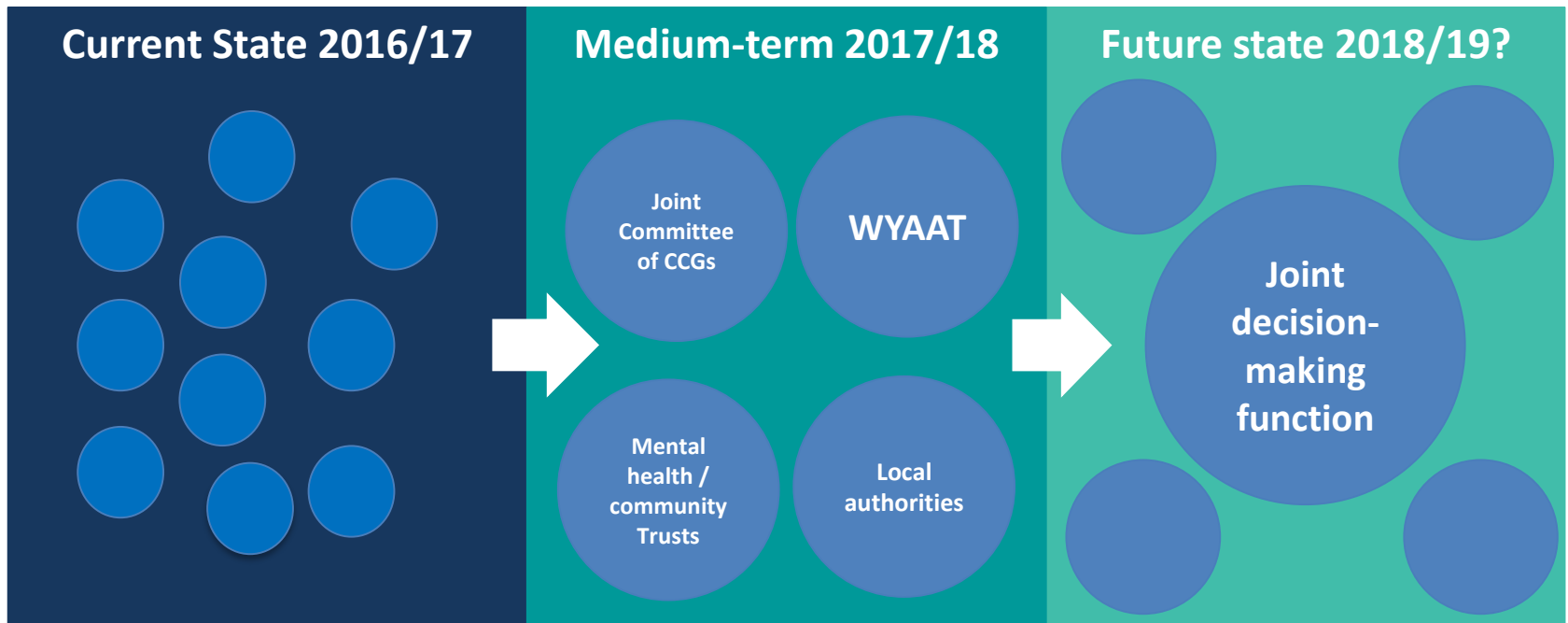
LOCAL

- 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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