APPENDIX 1

Report of the West Yorkshire and Harrogate Health and Care Partnership Lead Chief Executive to the West Yorkshire Joint Health Overview and Scrutiny Committee

A progress update on the West Yorkshire and Harrogate Health and Care Partnership and an outline of the next steps

Purpose

1. The purpose of this paper is to update the West Yorkshire Joint Health Overview and Scrutiny Committee (WY JHOSC) on the progress made and next steps on the West Yorkshire and Harrogate (WY&H) Health and Care Partnership since we last met with the WY JHOSC in March 2017.

2. It focuses on:

- Background to the partnership
- Communications and engagement
- Governance
- Programme update
- Finance and transformation funding
- "STP Progress Dashboard"
- Next steps

Background to the Partnership

3. The West Yorkshire and Harrogate Health and Care Partnership aims to deliver the best outcomes for people in West Yorkshire and Harrogate (WY&H) and the Five Year Forward View. This means a focus on health inequalities, unwarranted variation in care, and finances.

4. Our partnership is the second largest in the country in terms of population, and therefore it is right that the majority of work happens in each of our six places which build on existing relationships and health and wellbeing strategies. This principle of subsidiarity applies to everything we do.

5. Overview and Scrutiny Committee chairs will be familiar with their local Health and Wellbeing Strategies. These are:

- Bradford, including Airedale Wharfdale and Craven;
- Calderdale;
- Harrogate (as part of the North Yorkshire system);
- Kirklees;
- Leeds; and
- Wakefield District.

6. These plans form the bulk of our WY&H work. Where we work collectively at WY&H level it is for one of three reasons:

- We need to look at how we best provide services across a wider footprint than place.
- There is benefit in doing the work once and sharing.
- We have a collective difficult issue and working together would help solve it.

Communications and engagement

7. Strong communications and effective engagement are essential to the Partnership. We are working closely with Healthwatch in each place and at WY&H level.

8. Since our plan is formed from local place plans, it can be seen as a continuation of work that has been developed since 2012 at a local level, when Health and Wellbeing Boards were required to develop Health and Wellbeing Strategies. Therefore, in developing our proposals, we used all of the engagement and consultation across our six local places to guide us. When we published our plan, we included a compendium of the engagement and consultation work an easy read version and a public summary.

9. In August 2017 we published our engagement and consultation timeline – setting out our draft plans to engage and consult on the WY&H priorities and also the engagement and consultation timelines relating to each of the six local places. New work will be added to the timelines as the programmes develop so it is important to note these may be subject to change.

10. In September 2017, we published our draft communications and engagement strategy which sets out our principles for communications, engagement and consultation and our approach to working with local people. Engaging and communicating with partners, stakeholders and the public in the planning, design and delivery is essential if we are to get this right. We are committed to transparency and meaningful engagement in our work.

11. You can see an example of the way we work across WY&H in the engagement process on Stroke (see Stroke Section on page 9).

Governance

Clinical Commissioning Groups and the WY&H Joint Committee

12. We have consolidated the management structures of our 11 Clinical Commissioning Groups (CCGs). This means we have moved from 11 management teams to six, which makes CCG management structures co-terminus with their Local Authority partners in the six places in WY&H. This is a helpful step to supporting local plans.

13. The collaboration of the 11 CCGs across the area has been further strengthened by coming together as a Joint Committee. We have recruited an Independent Lay Chair and two lay member representatives for the Committee.

14. The third meeting of the Committee was held in public on the 7 November 2017 to discuss stroke, urgent and emergency care and elective care. The agenda, papers and a

recording of the meeting are available online at www.wyh-jointcommiteeccgs.co.uk**.** The next meeting in public will take place on the 9 January 2018.

West Yorkshire Association of Acute Trusts

15. An important part of the way we work is how our six Acute Trusts are working together. Our acute hospitals do this through the West Yorkshire Association of Acute Trusts (WYAAT). The board of each of the WYAAT trusts agreed to form a Committee in Common which is responsible for leading the work programme to deliver this ambition. Any case for change will be considered by the Committee in Common before being recommended to each of the individual trust boards for approval.

    - Airedale NHS Foundation Trust
    - Bradford Teaching Hospitals NHS Foundation Trust
    - Calderdale and Huddersfield NHS Foundation Trust
    - Harrogate and District NHS Foundation Trust
    - Leeds Teaching Hospitals NHS Trust
    - Mid Yorkshire Hospitals NHS Trust

Mental health and community providers

16. Historically there is strong partnership working between the four providers of specialist mental health services across our area:

    - South West Yorkshire Partnership NHS Trust
    - Leeds and York Partnership NHS Foundation Trust
    - Bradford District Care NHS Foundation Trust
    - Leeds Community Healthcare NHS Trust [who deliver specialist Child and Adolescent Mental Health Services for WY&H]

17. This close working has been strengthened and reinforced through our partnership approach and the need to deliver the targets in the mental health programme. The group is considering the WYAAT committee in common model *(described in para 15 above)* as a way of formalising joint working

Local authorities

18. The West Yorkshire Health and Care Consultative Group is an informal forum to facilitate political consideration of the broad range of issues which impact on the efficiency and effectiveness of health and care services in West Yorkshire.

19. The Group adds value to formal, local decision-making structures (e.g. Health and Wellbeing Boards) by enabling politicians to consider and influence work at the West Yorkshire level.

20. Specifically, the Group is responsible for:

    - ensuring local government is an active participant in discussions about health and care services, and is clear that decisions are taken locally;

- sharing intelligence and information on health and social care issues where this has strategic implications for West Yorkshire;
- developing a vision for local government to lead different solutions for a sustainable health and care system that meets people's needs; and,
- coordinating any responses to central government on relevant matters.

21. The Group's membership is:

- Council leaders from the five West Yorkshire authorities; and,
- All portfolio-holders for health / adult social care from the five West Yorkshire authorities.

22. This means the Chair of each West Yorkshire Health and Wellbeing Board is a member of the Consultative Group. Local Authority Chief Executives are also invited to attend the Group's meetings.

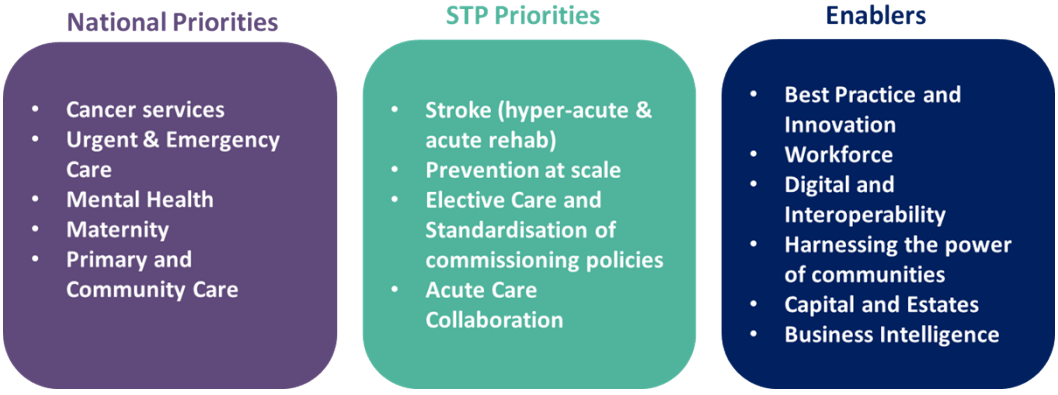
23. We are in the process of jointly appointing a senior officer hosted by Leeds City Council to work across the West Yorkshire to better support joint working.

System Leadership Executive Group

24. We have also established a System Leadership Executive Group, which includes representation from the above groups and each place. Although this group has no statutory decision making power in acts as a co-ordinating point for all of the work of the partnership.

Programme updates

25. We have established a set of programmes, which are split between national priority areas, local WY&H priority areas and enabling workstreams.



26. Since our last update we have added maternity as a "national priority" overseen by the partnership – in response to the national 'better births' strategy.

27. We no longer have a separate 'specialised commissioning' workstream. This work continues to be led by NHS England who has commissioning responsibility for these services. Our leadership continues to work closely with NHS England on this, particularly through Acute Care Collaboration programme.

National Priority Programmes

Urgent and emergency care

28. UEC is one of the national service improvement priorities highlighted in the *'Next Steps on the Five Year Forward View'*. Targets for NHS 111 Online, 111 calls, GP access and urgent treatment centres. Targets have also been identified for the Ambulance Response Programme, and ensuring people only stay in hospitals for as long as need be. Specifically, our plans include:

    - **NHS 111:** Roll-out of NHS 111 online to cover 30% of people by March 2019; increasing clinical contact through NHS 111 calls to 50% by March 2018, and expand direct booking to GP practice sites from NHS 111.
    - **GP access:** Increase extended access so that 100% of people have evening and weekend appointments by March 2019.
    - **Ambulance services:** Increase hear, see and treat services, to reduce the need for people being taken to hospital.
    - **Hospital services:** Including delivery of the 95% four hour A&E waiting time standard; co-located GP support; consistent adoption of the frailty pathway and SAFER bundle and 50% of trusts having psychiatric liaison in place by October 2018
    - **Improving hospital to community care:** Reducing the rate of delayed transfers of care to a minimum of 3.5%; increasing the number of continuing healthcare assessments in the hospital; and delivering effective discharge consistently across West Yorkshire and Harrogate.

29. The WY&H Urgent and Emergency Care Board (UECPB) builds on a firm foundation of partnership working, shared learning and leadership to deliver the ambitions of WY&H Health and Care Partnership. It connects all urgent and emergency care services together so the overall physical and mental health and social care system becomes more than just the sum of its parts.

30. The WY&H UECPB submitted a milestone tracker in June 2017 to NHS England. This sets out the expected milestones and achievements over the next two years in order to implement the national plan.

Maternity

31. In support of NHS England's National Maternity Review, we have developed the WY&H Local Maternity System Board. The Board's vision for maternity services is to further improve safety for mum and baby, personalisation, choice and family friendly care. We believe every woman and their partner should have access to information to enable them to make decisions about care; and every woman and baby should be able to access support that is centred around their needs and circumstances.

32. We also believe that all staff working in maternity care should be supported to deliver care which is women centred. They should work in high performing teams, in organisations which are well led, and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries.

33. To achieve this, we will be:

- Developing a local vision for improved maternity services in order to ensure that there is access to services for women and their babies, regardless of where they live
- Ensuring women and their babies can access seamlessly the right care, in the right place at the right time
- Making sure that providers in WY&H, such as NHS hospitals and other health services, work together so that the needs and preferences of women and families are paramount.
- Putting in place necessary infrastructure to support services to work together effectively.
- Making sure that women, their partner, their families and local communities are involved in designing maternity services.
- Supporting a learning culture between NHS staff, partners and fostering workforce co-ordination and training.

Primary and community care

34. Strong primary and community services are an essential part of the WY&H Health and Care Partnership. This means broadening the definition of primary care and supporting the model to build resilience for professionals and the public. The programme of work is taking shape to address and make links to local plans and GP access. There is also a strong a focus on the *General Practice Forward View* and workforce. Our priorities are as follows:

- **Sustainable and resilient general practice:** Working to strengthen the resilience of general practice, for example through improving the condition of the estate to facilitate working at scale; closer working with community pharmacy, to make the most of existing capacity; effective use of the GP resilience fund, to support vulnerable practices and collaborative working.
- **Workforce:** Developing new roles non-registered workforce in Primary Care which includes practice management, care navigators, apprentices in primary care, medical assistants and Mental Health support workers; international recruitment; and flexible employment models.
- **Investment:** Higher rate of growth in investment in primary and community care - 15% growth to 2020-21.
- **New models of primary care:** Building on the learning from the vanguard programmes, to develop new integrated models of service delivery.
- **Improving access to general practice:** Extending the hours that general practice is open – so that 100% of the population has access to extended opening hours by April 2019.

35. We have a strong track record of innovation in this area, particularly through our participation in the national vanguard programme. Our partnership is helping facilitate the spread and adoption of what we know works well.

Mental health

36. In WY&H we are developing a local service framework for mental health and strong partnership on child and adolescent mental health services, forensics and suicide. Our ambitions include:

- A 40% reduction in unnecessary A&E attendance
- A zero suicide approach to prevention (75% reduction in numbers in mental health settings by 2020-21)
- A reduction in Section 136 place of safety episodes both in police and health based places of safety. Section 136 gives the police the power to remove a person from a public place, when they appear to be suffering from a mental disorder, to a place of safety
- Elimination of out of area placements for non-specialist hospital care within 12 months
- A reduction in waiting times for autism assessment.

37. To help ensure that we meet these ambitions the four provider of specialist mental health services in WY&H are working together, alongside CCGs, to strengthen partnerships and share delivery of specialist mental health services. Through these closer working arrangements we will share best practice across the region, for example reducing out of area placements for non-specialist hospital care over the next 12 months. We are already achieving this in some areas across the partnership. Our aim is to ensure that people are supported in the least restrictive environment, ideally in a community setting close to home, rather than in hospital.

38. Our partnership has recently been successful in becoming a national new care model site for tertiary mental health services. This means that secondary mental health providers will manage care budgets for tertiary mental health services (currently commissioned by NHS England Specialised Commissioning) under a central programme taking an 'accountable care system' approach to managing and redesigning care for the local population. The combined budget for the two services is c£12m.Leeds Community Healthcare NHS Trust will be the lead provider for CAMHs T4 and Leeds & York Partnership Foundation Trust will be the lead provider for Adult Eating Disorders. This is an opportunity to develop high quality integrated services locally, in the least restrictive setting close to home, eliminating costly and avoidable out of area placements.

39. Earlier this year, a new perinatal mental health service has been launched which provides specialist care for pregnant women and new mothers. Pregnancy and childbirth is a uniquely vulnerable time for women where there is a substantially increased risk of developing an episode of mental illness – the most likely time in a woman's life. This new service will help to raise the awareness of perinatal illness within mental health services and improve access for women to appropriate specialist interventions from specially trained staff. The new perinatal mental health service will provide specialist and tailored care to pregnant women, new mothers and their families in Barnsley, Calderdale, Kirklees and Wakefield.

Cancer

40. Our cancer work is delivered through a partnership of health, social care, patients and charities called the WY&H Cancer Alliance and our published delivery plan sets out how we will deliver our objectives in greater detail. Five streams of work make up the delivery plan:

    - Tobacco control
    - Patient experience
    - Early diagnosis
    - Living with and beyond cancer
    - High quality services

41. We have established a West Yorkshire and Harrogate Cancer Alliance Board to oversee the implementation of our cancer plan. This includes representation from each place and health and care sector as well as the patient voice. The Board provides leadership, direction and assurance for the local delivery of the ambitions of the national cancer strategy, on behalf of the partnership. This includes agreeing, coordinating and assuring constituent local delivery plans.

42. We have recently secured £13.5 million of national funding to support work to improve early diagnosis and make more cancers curable through a range of projects. We have also secured £840,000 of additional transformation funding to support people living with and beyond a cancer diagnosis, and in particular to improve access to the four elements of the so-called Recovery Package – a holistic needs assessment and care plan; a treatment summary; a cancer care review and access to health and wellbeing events.

43. The focus of our programme is to deliver the best possible outcomes and experience for people affected by cancer, while spending the West Yorkshire and Harrogate pound as effectively as possible through delivering value for money care and treatment. We will do this through a set of clear ambitions and targets for improvement:

    Health and wellbeing

    - Reduce adult smoking rates from 18.6% to 13%, resulting in around 125,000 fewer smokers and preventing around 11,250 admissions to hospital
    - Increase 1 year survival from 69.7% to 75% , equating to around 700 lives per year
    - Increase the proportion of cancers diagnosed early (stages 1 and 2) from 40% to 62%, offering 3,000 extra people the chance of curative or life extending treatment.

    Care and quality

    - Increase the number of patients actively involved in providing feedback and contributing to service improvement over and above the annual national Cancer Patient Experience Survey (CPES)
    - Improve the patient's care journey to ensure current cancer waiting times standards are met and go further to deliver a '28 day to diagnosis' standard for 95% of people investigated for cancer symptoms. This could deliver faster diagnosis for

around 5,000 people currently diagnosed with cancer through the routine referral to treatment 'pathway'.

Finance and efficiency

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

WY&H priority programmes

Acute Care Collaboration

44. Our six Acute hospitals do this through the West Yorkshire Association of Acute Trusts (WYAAT). More info about WYAAT is detailed in paragraph 15 above.

45. WYAAT has a joint work programme which includes four work streams:
    - specialist services;
    - clinical standardisation and networks;
    - clinical support; and
    - corporate services.

46. WYAAT is driving forward nine different projects .These include:

    - Developing a West Yorkshire Vascular Network - Clinical representatives from each Trust have been working together to develop a model for how we can develop a West Yorkshire vascular team and network. Developing the service as a single network will improve recruitment to local services and provide opportunities for staff to specialise in different aspects of vascular surgery.
    - Improving the pharmacy supply chain - pharmacy teams from acute trusts in west, north and east Yorkshire (covering WY&H and Humber, Coast and Vale) are working collaboratively to explore opportunities for optimising efficiency and value by establishing a shared medicines supply chain from the point of ordering to the point the medicine is available for use in clinical areas. Not only will the project bring efficiency savings, it will bring about supply chain performance improvement, release clinical time for patient care and support in managing any risk around supply shortages.
    - The WYAAT programme management office has been developing a range of governance and assurance processes to support the progression of the different programmes of work.

Stroke

47. We want to make sure our stroke services are 'fit for the future' and make the most of the skills of our valuable workforce and new technology whilst maximising opportunities to improve quality and outcomes for local people.

48. We also want to ensure that care across the whole stroke pathway is working effectively to meet the current and future needs of our population. At the last Joint

Committee of CCGs meeting an ambition of 89% identification and management of Atrial Fibrillation was agreed – this has the potential to save 190 lives over the next 3 years.

49. We have developed a strategic case for change for stroke which sets out a clear case for why we need to look at stroke care.

50. Our work has been informed by an extensive programme of engagement. Over 1,500 people gave their views via an online survey, outreach sessions with voluntary and community groups, and interviews with people in GP practices, rehabilitation units, stroke wards, and libraries. Stroke consultants also took part in sessions so that people could hear first-hand about the care and support available from health professionals.

51. We are developing proposals to determine the 'optimal' service delivery models, standardised pathways and clinical standards for our specialist stroke services (the care our patients receive in the first few hours and days after having a stroke)

Prevention at Scale

52. Preventing ill health is at the heart of our work and a theme that runs through all of our work. We want to develop a new relationship with communities, health and care services, so that there is an increased recognition that it is also choices and behaviours that can make and keep you well, rather than the services you receive. We have built into the way we work through Director of Public Health involvement in all programme structure.

53. In our November 2016 proposals we set ambitions relating to smoking, alcohol, people at risk of diabetes and workforce. Progress is as follows:

- *Smoking*: We set an ambition to reduce smoking from 18.6% to 13% (a reduction of 125,000 smokers). The recently published figures show we have reduced from 18.6% (2015) to 17.3% (2016). This equates to 23,300 fewer smokers. Using recent work by the Healthy London Partnerships on prevention and savings, this reduction will give £17.1m of healthcare savings over the next five years. This is good progress overall but masks differences across our area.

- *Alcohol*: Addressing alcohol related harm; including reducing alcohol related hospital admissions as well as a focus on primary prevention are part of our plan. This requires a joined up approach with all partners and highlights the importance of balancing the range of local need and inequalities.

- *High risk of diabetes*: We are adopting and applying the National Diabetes Prevention Programme to reduce the numbers of people with high risk of becoming diabetic. The programme provides education on healthy eating and bespoke physical exercise programmes to support people to lose weight – a key risk factor for type 2 diabetes. Leeds and Bradford are up and running. The remainder of the partnership operating as a single area has now signed up and

has overachieved referrals in its first month. Progress is satisfactory and there has been shared learning across the three patches.

Elective care and standardisation of commissioning policies

54. This programme supports the ambitions of the *Next Steps on the Five Year Forward View* document through reducing demand and meeting need more appropriately. This will increase the responsiveness of services to people in WY&H, improved access and support and achievement of clinical ambitions such as 18 week referral to treatment targets.

55. An objective of this programme is to achieve standardisation of key commissioning policies and protocols across the WY&H CCGs by 2020/21 and with the ambition of achieving the equivalent of approximately £50m in financial efficiency gains through managing demand to a more affordable level. It is agreed as an underpinning principle that not all CCGs will move to revised policies at the same time. The expectation is that there will be a rolling programme of implementation, resulting in an end-point where all CCGs are taking the same approach.

56. The approach we are taking was approved by the Joint Committee of CCGs at its 7 November 2017 meeting. The agenda, papers and a recording of the meeting are available online at www.wyh-jointcommiteeccgs.co.uk.

Enabling programmes

Innovation and best practice

57. WY&H includes areas of national best practice. Health innovation is a significant part of the local economy and our partnership needs to consider how it secures opportunities for future growth.

58. Our partnership is also the vehicle for transforming health and social care at scale and we are building our experience of working together but we need to increase the scale and pace of change across the system - we need to be flexible, adaptive and willing to try new things. We are working closely with the Yorkshire and Humber Academic Health Science Network (AHSN) – the body that brings together industry, the NHS, universities and local government to:

- Map AHSN innovations and improvements to meet priorities, gaps or challenges
- Plug in programmes to other AHSN innovations and opportunities e.g. the local improvement academy, innovation exchange, national innovator accelerator,
- Co-create an improvement approach with each programme
- Create an understanding of analytic health economic and other input/support required
- Support the development and delivery of the sharing workshops/summits

53. An example of this is our stroke work. The AHSN have identified that by applying best practice we could increase the number of people with atrial fibrillation who are

effectively diagnosed and managed in primary care to 89%. We estimate that this would save around 190 lives over the next three years.

Workforce

59. Our workforce is our most important asset. Around 70% of the £5bn we spend each year pays for our workforce. In recent years they have made a huge contribution to ensure that services continue to deliver in very challenging times.

60. There are approximately 113,000 people working formally in health and care, and more than double that it informal unpaid carer roles. The total number of staff has been increasing year on year, but it is also true that the pressure and complexity of work has increased, and the ongoing pay restraint has made it particularly challenging for staff recruitment and retention. There are specific specialties and staff groups, such as emergency medicine; psychiatry; medicine; specialist radiology; gastroenterology; microbiology, histopathology where we know there are significant recruitment and retention issues.

61. Our Local Workforce Action Board (LWAB) is developing a WY&H workforce strategy which describes the issues and challenges we face and sets out our plans for action. It includes 10 recommended actions:

- ***Maximising the contribution of the current health and social care workforce***
  - Improving recruitment and retention in all areas
  - Exploiting skills development
  - Improving health and wellbeing of the workforce

- ***Getting more people training for a future career in health and social care***
  Increasing the numbers in training to work in health and social care roles, specifically focusing on support workers, the registered workforce (nurses, doctors and allied health professionals) and advanced clinical practitioners.

- ***Growing the general practice and community workforce to enable the 'left shift'***
  Increasing the numbers, developing new roles and changing the makeup of staff in primary and community care

- ***Transforming teamwork***
  Strengthening capability to implement new 'workforce team' models.

- ***Making it easier to work in different places and different organisations***
  Developing flexible employment models across organisations – including lead employers for some contracts, and new models of employment contracts

- ***Agreeing and tracking workforce productivity measures***
  Including a number of specific targets for productivity measures, including reductions in sickness absence, bank and agency spend and turnover.

- ***Strengthening workforce plans***
  Ensuring that the workforce issues are built into all of the WY&H work programmes, taking in to account national strategies and priorities.

- ***Establishing a workforce investment plan and fund***
  We will develop a comprehensive workforce investment plan and a strategic workforce investment fund. This will bring together employers, commissioners and national bodies around a sector wide approach.

- ***Establishing a 'workforce hub' in partnership with Health Education England***
  This hub would provide the infrastructure for joined up workforce planning and training across WY&H. It will undertake strategic workforce planning, education and development; a point of co-ordination across programmes and each place; and ensure improved workforce information and analysis.

- ***Establishing effective workforce infrastructure in each Place***
  We will strengthen workforce partnerships that exist in each place.

Digital and Interoperability

62. A significant focus of our work to date has been establishing an effective digital infrastructure which enables IT systems and organisations to connect. Our approach is based on the 'anytime, anywhere, any place' philosophy. This will allow health and care professionals to work across public sector buildings. We are taking forward three programmes of work:

    - We are procuring (buying) a Health and Social Care Network which will replace the separate health and local government networks that connect buildings to the required IT systems across the area. This procurement is being managed as a programme across the partnership completing in spring 2018 and then moving in to mobilisation. We will then be able to look at the current state of multiple connections in to shared buildings, with costs.
    - Funding has been made available to allow all our GP Practices to apply wifi. The programme is designed to give everyone access to wifi in the GP practices. This is currently live in Leeds and our intention is to roll out to the rest of the area in the next 12 months. Our ambition is that two thirds of practices will have wifi by March 2018. This will be free to use by the public, and also help by pointing them to health and care advice.
    - We are implementing something known as Govroam across the area. Govroam allows people visiting another organisation connected to govroam to log on to the wifi of the using the same username and password they use at their own organisation. This will realise savings on lost staff time spent arranging for connectivity and issuing temporary passwords. It will also save costs on procuring wireless networks, sharing multi-department spaces, and making the most of our buildings.

63. There is huge potential for digital technology to support healthier lifestyles, allow people to manage their own healthcare, wherever safe to do so, and enable people to benefit from more fully from health and care services. We have recently developed a partnership with the Good things foundation to develop and test digital way of working to support people with seeing and hearing difficulties to receive health

services in a way that works better for them. This pilot is backed with £50,000 of national funding.

Harnessing the power of communities

64. Working alongside our communities is an important part of our partnership - seeing the people we serve as assets and partners, and not as problems. We want a changed relationship with local people, built on trust and empowerment, where the benefits of self-care and prevention strategies can really flourish. This is an important part of our primary and community care programme.

65. We have good leadership from the voluntary and community sector, and we are attracting support from Healthwatch, NHS England, Nurture Development and National Voices to help us to think about our next steps. To make sure our work adds the greatest value possible and supports existing projects and groups across the area we started with a number of design workshops in the summer. The aim of these were to agree a shared set of principles and a common understanding of what we mean by 'communities doing more for themselves', 'co-production', 'asset based community development', 'co-design', and what the shared ambition for working with communities should be.

- We held our first Voluntary and Community Sector (VCS) event on the 6 November 2017 which brought together our WY&H programme leads to discuss VCS involvement in all the work streams. A follow up session will take place on the 1 December 2017.
- Healthwatch are currently exploring how we can generate different types of conversations with communities using social media.
- Healthwatch are keen to understand how we can take some of the social value ideas that exist in local government procurement and explore how they relate to NHS commissioning.
- We are holding an event on the 14 December 2017 to discuss how best WY&H programmes can embed our aspirations in respect of unpaid carers into all that we do.

Capital and estates

66. We have recently established a programme of work to understand how we can best work together to develop a better understanding of our estates and capital requirements to meet the requirement of changing clinical service models. Owen Williams, Chief Executive at Calderdale & Huddersfield NHS FT has agreed to lead this piece of work.

67. The organisations in WY&H are clear that in order to deliver the required transformational changes, we will need to work together and collaborate on those aspects of the change agenda which are better achieved across a wider footprint. We are also clear that in relation to our capital plans, we need to work together on the totality of our NHS capital plans.

68. There has been a process across 2017 to develop a prioritised list of capital proposals to be considered against the £325m that was announced as part of the Spring 2017 Budget and the capital resource that may become available as part of the Autumn 2017 Budget.

69. Our prioritised submission to NHS England and NHS Improvement in September 2017 contains schemes with a combined value of £185m. These included the following schemes:

- those which have a clear transformation impact across the West Yorkshire and Harrogate footprint, including the capacity of inpatient services for young people with mental health issues, developments around the way in which diagnostics services (radiology and pathology) are provided across West Yorkshire and Harrogate, an expansion of telemedicine and care services into care homes, and ambulance requirements given hospital services changes already underway;

- those related to priority acute reconfigurations across West Yorkshire and Harrogate. These include the scheme to develop the Calderdale Royal Hospital / Huddersfield Royal Infirmary sites and the redevelopment of the Leeds General Infirmary site;

- other schemes which impact across a more limited number of organisations, including schemes at Airedale General Hospital and Dewsbury District Hospital, as well as a number of provider digitisation schemes;

- a number of other schemes were not submitted but remain in view including a potential urgent care hub in Bradford, a potential development linked to better use of NHS capacity, a number of mental health schemes, a radiotherapy planning system, and the development of person-held care records.

70. We expect to hear shortly whether these proposals have been successful.

Finance and Transformation funding

Finance

71. We are refreshing our financial plans, from those submitted in October 2016. The October 2016 submission was high level proposals that preceded the 2 year planning and contracting round, and was an integrated financial plan covering NHS, public health and social care expenditure. We aim to have this work completed in the next few months.

72. There are increasing resources going into health and social care - £5.7bn by 2020-21. We also know that need for care and services are growing at a faster rate than the money we have. If we delivered care in the way we do today, with no change and no efficiencies, the cost would be at least another £1billion by 2021. We need to make the best use of every £ we spend.

73. In November 2016 we set out in our draft proposals how we planned to deliver this level of efficiency improvement. We categorised these into a number of categories:

- "organisational" efficiencies (£0.6bn) in providers, CCGs and social care/public health
- "activity moderation" efficiencies (0.1bn)
- "West Yorkshire and Harrogate programme" efficiencies (£0.1bn)
- use of Sustainability and Transformation Fund (STF) income (£0.2bn)

74. As part of the financial planning assumptions used nationally, there is an expectation that NHS providers will be required to generate "organisational" efficiencies (£0.4bn) £through limiting clinical and operational variation, and ensuring that organisations actively seek out and address opportunities to obtain better value from resources available. Key to deliver of these efficiencies is the work being done locally through the West Yorkshire Association of Acute Trusts work programme, as well as the national programmes being undertaken locally (specifically the Carter efficiency programme and the "Getting It Right First Time" programme).

75. CCGs will also continue to drive efficiency improvements in all areas of their expenditure commitments, including continuing healthcare, prescribing, administration costs and in the commissioning of health services (£0.1bn). The planning also included an assessment of the efficiencies required and being planned in social care/public health (£0.1bn).

76. In addition to these "organisational" efficiencies, joint plans across our six "places" identified areas where the supply and demand for health services could be managed in a different way ("activity moderation" efficiencies). This included work on New Care Models (linked to the vanguards being undertaken in WY&H), opportunities presented through RightCare (a nationally-sponsored programme looking at resources and outcomes), self-care and preventing ill-health, and demand management.

77. The plans also included assumptions around the level of efficiency savings that could reasonably be expected from the WY&H programmes (described earlier in this briefing paper) and the availability of STF income (currently being accessed directly by providers in 2017/18 and 2018/19).

Transformation funding secured

Transformation funding secured	
West Yorkshire Acceleration Zone (2016/17)	£8.6m
West Yorkshire Acceleration Zone (Q1 of 2017/18)	£4.3m
Primary care extended access (2016/17)	£1.7m
Mental Health Liaison (2017/18)	£0.2m
Mental Health Liaison (2018/19)	£0.6m
Diabetes (2017/18)	£2.7m
Cancer (2017/18)	£6.7m
Cancer (2018/19)	£6.8m
Total	**£32m**

"STP Progress Dashboard"

78. In July 2017 NHS England published a progress dashboard. The dashboard gives a composite rating (1 outstanding – 4 needs most improvement) for each of the 44 STPs. Performance Indicators reflect NHS England priority areas but the scope is narrower than our partnership and is NHS focused.

79. West Yorkshire and Harrogate was assessed as category 3 – making progress. We appear to be doing worse than average on the following areas:

- Emergency admissions rate
- Emergency bed days rate
- GP extended access
- MRSA rates
- C Diff rates

80. Rating has been positioned as a 'baseline' assessment – reflecting the fact that these partnerships are relatively immature and unlikely to have been able to significantly influence the majority of the indicators in the time they have been in existence. There is one measure which is a direct judgement of our 'system leadership' – our partnership scored category 2 of 4 on this measure, our leadership is 'established' defined as 'systems are working together at the system level, with organisations aware of the importance of effective system-level working and taking action to drive integration'.

Next steps

81. We will be producing and publishing our response to the *'Next Steps on the Five Year Forward View'* document early in the new year. This will describe our plans to improve health and outcomes for the people in our region, and the governance and capacity arrangements we are putting in place to deliver them –since publishing our draft proposals in November 2016. We will also publish an easy read version, information in audio and BSL.

82. We are developing a WY&H Finance Strategy. This is a really important piece of work, building upon the work that has already taken place by our Finance Directors across WY&H, providing a coherent summary of the actions we will be required to undertake to deliver financial sustainability as one of the three key aims set out in the *Five Year Forward View*. The continuing ownership of the agenda and numbers will help ensure the success of the partnership.

83. Throughout everything we do we will continue to:

- develop and support our staff;
- have conversations with people who use services and their carers;
- work with our politicians, council leaders, Overview and Scrutiny Committees, Health and Wellbeing Board Chairs; and
- work at pace to implement positive change.