Strategic Plan
2014/15 to 2018/19

How to use this tool: You can either scroll through this plan like a typical document or click the tabs at the top of the page to navigate to specific sections. Click the CCG logo in the top right hand corner to navigate back to this page.
Welcome to our Strategic Plan

The Clinical Commissioning Group has come a long way since it came into being only one year ago. We have made some real progress in improving care and listening to patients. This plan helps us plan for the future. It sets out how we intend to deliver our strategic objectives over the next five years. It articulates how our objectives will lead to actual changes on the ground, and the benefits that these changes will bring to our patients, their families and carers. We are committed to work with our communities and partners to improve health outcomes for everyone with high quality health care in the right place, at the right time, delivered by the right people.

Amanda Bloor
Chief Officer

Dr Alistair Ingram
Clinical Chair
“The CCG has actively engaged with the Trust on the development of its 5 year Strategic plan. A number of interactive sessions have been held which have helped to inform the details of the plan. These discussions commenced with a Call to Action event in September 2013, a joint planning session in January 2014 and a follow-up event involving representatives from the Voluntary Sector in March 2014. Both organisations attended a joint session with the local Area Team on 19 May to give the Area Team assurance in respect of the local health economy’s clinical and financial sustainability. We received positive feedback to our respective proposals which showed that our strategic objectives are closely aligned to enable improvements to be made to health care in our local health economy.

Harrogate and District NHS Foundation Trust supports the proposals HaRD CCG has outlined and looks forward to working in partnership to deliver its Strategic Plan.”

Richard Ord, Chief Executive
Harrogate and District NHS Foundation Trust

“At Harrogate and Ripon Centres for Voluntary Service we have been encouraged by the CCG’s eagerness to establish strong links with the voluntary and community sector. Very positive dialogue has taken place to arrive at this point and with the new structures and plans in place we look forward to strengthening this relationship.”

Karen Weaver, Chief Executive
Harrogate CVS

“I would like to take this opportunity to thank the Chief Officer and colleagues of the CCG for the very effective way that they have involved staff from TEVV in the development of the Strategic Plan. In particular we are delighted at the CCG’s decision to invest funding to strengthen local mental health services. This is a very welcome and much needed investment. Staff of TEVV very much look forward to continuing to work with the CCG, the GPs and other stakeholders in the area to achieve the ambition set out in the shared vision for local services, ensuring improved outcomes for the local population.”

Martin Barkley, Chief Executive
Tees, Esk and Wear Valleys NHS Foundation Trust

“The CCG has embraced the opportunity to come together collaboratively with other public sector organisations to form the Harrogate District Public Services Leadership Board, the CCG taking vice chair. The Board will support a “One Public Service vision” and facilitate local agencies coming together seamlessly to deliver more cohesive, joined up and unified local services. Together the Board supports the delivery of quality services that are efficient, innovative and reflect the specific needs and priorities of our local communities; ensuring better outcomes and improving the lives of local people. Harrogate Borough Council continues to support the work of the CCG and will work together to aid the delivery of its 5 year Strategic Plan.”

Wallace Sampson, Chief Executive
Harrogate Borough Council

“North Yorkshire County Council has played an active part in the development of the CCG’s plan both though involvement in the Governing Body and in developing joint work at an operational level. Many of the outcomes within the plan can only be delivered by closer working relationships between health and social care and we look forward to jointly achieving these outcomes over the coming years.”

Richard Webb, Corporate Director
North Yorkshire County Council
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Summary

This strategy sets out how we will transform health care for the people of Harrogate and Rural District over the next five years. There are clear reasons for improving things:

- Society is ageing.
- People have changing health needs with more long term condition and lifestyle disease.
- There is variation in the quality and access, leading to a variation in patient outcome and experience.
- People have increasing expectations.
- The costs of providing the current model of care are increasing.
- Public finances are constrained.

Our vision will see the culture change from ‘see, treat and discharge’ to ‘identify, integrate and co-manage’. It will require health and social care commissioners and providers to work differently together, all putting the patient at the centre.

In future most of the care and support people need will be offered at home, by integrated teams, and medical help will be accessed at a local health centre, on the phone or online.

Our vision is that by 2020 the population:
- are physically and mentally healthy and are independent for as long as possible
- have the support to manage their long term conditions and mental health and receive care when they are ill by the right person at the right time in the right place and return to independence as quickly as possible
- have positive experiences from high quality, safe integrated health and social care services, irrespective of the day or time of the week and access to high quality cost effective elective care
- differences in health outcomes between population groups are minimised
- health and Social Care resources are sustainable

Our ‘plan on a page’ summarises the case for change and our commissioning priorities. These are aligned with the strategic priorities of North Yorkshire Health and Wellbeing Strategy (see page 47), our local acute provider Harrogate and District NHS Foundation Trust (improving quality, joint service strategy, integrated community teams) and our main mental health provider Tees, Esk and Wear Valley NHS Foundation Trust (improve quality, productivity, patient experience, patient outcome; evidence based care, long term recovery).

We have six priority areas:
- Urgent care
- Long term conditions
- Vulnerable people and mental health
- Elective care
- Health and Wellbeing
- Primary care
The specific improvement interventions in our plan include:
- The development of a joined up ‘urgent care centre’ to deal with all hospital based urgent care
- Seamless integrated out of hospital urgent care
- A review of community services
- The implementation of a referral support service to manage planned care referrals
- Investment in autism, improving access to psychological therapies (IAPT), and urgent mental health pathways
- Development of an enhanced psychiatric liaison service in hospitals (RAID)
- Implementation of a ‘Stop before your op’ stop smoking pathway
- Development of a primary care strategy

All of our priorities are aligned to achieve the seven improving outcome ambitions identified in Everyone Counts:
- Securing additional years of life for the people of England with treatable mental and physical health conditions.
- Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions.
- Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.
- Increasing the proportion of older people living independently at home following discharge from hospital.
- Increasing the number of people having a positive experience of hospital care.
- Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.
- Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.
### Vision
We will secure high quality services, in the most appropriate setting, making maximum use of available resources. Through clinical leadership and collaborative working we will achieve the best possible health outcomes for all our local population.

### Case for change
- **Ageing population**
- **Sustainability and Financial Balance**
- **Health Inequalities and Health Outcomes**
- **Preventing premature deaths**

### Enablers
- **Participation:** Improving individual and public engagement arrangements.
- **Quality Commission for quality and improve quality management information.**
- **Finance:** To create, with our partners, affordable and sustainable health services using financial enablers such as the contract, quality premium, CQUIN, non-recurrent funds.
- **Technology:** Increase capability and capacity to produce and share information and integrated systems to support better patient care.

### Priorities
- **Redesign integrated urgent care services.**
- **Manage care more effectively - integrated community teams.**
- **Improve mental wellbeing and move towards parity of esteem.**
- **Improve elective care to maximise quality, outcomes and value.**
- **Ensure equal opportunities to live healthy active lives.**
- **Care closer to home; improve quality and reduce variation in primary care.**
- **Identify primary care commissioning needs. Quality and variability. Develop the capacity and skill mix in primary care to support service improvements e.g. 7 day working, LTC management.**

### Outcomes
- **15% reduction in emergency activity (emergency admissions, re-admissions and length of stay).**
- **7 day working rolled out. Reduction in emergency activity. More older people supported by primary and community care. Improving people's experience of integrated care.**
- **Reduction in emergency activity. Improving access to psychological therapies. Early diagnosis and treatment of dementia. Improving access to autism diagnostic assessment.**
- **20% efficiency in elective care achieved. Improving quality and outcomes. Securing value for money. Improving the experience of care.**
- **Health inequalities are reduced within our communities. Reduction in acute activity. Increased partnership working.**

### Strategic Programmes and Improvement Interventions
- **Urgent Care**
  - Simplifying access: Urgent Care Centre, GP OOH, NHS 111. Early senior clinical input: A&E, CAT, Psychiatric Liaison.
- **Long Term Conditions**
  - Community Services Review. Neighbourhood Teams, Risk Stratification, Care Planning, Accountable GP for over 75s, senior clinician for 5% of LTCs, Self-care. Assistive technology. Community hubs. Personal Health Budgets.
- **Vulnerable People**
  - Improving the management of patients with physical and mental health needs, with the development of psychiatric liaison services (RAID). Dementia. Building effective relationships with nursing and residential homes. IAPT. Autism. Section 136, Special Educational Needs.
- **Elective Care**
- **Health and Wellbeing**
- **Primary Care**
  - Develop a strategy for primary care to secure continuous improvement in the quality of primary medical services and develop an integrated system necessary to deliver sustainable healthcare.
Road map for achieving this strategy

2014/15
- Complete reviews of urgent care
- Develop plans for urgent care centre
- Implement DVT pathway

2015/16
- Implement urgent care centre plans

2016-19
- To have created a fully functional 7 day urgent care centre

Urgent care

Long term conditions
- Implement care planning
- Complete community services review

- Increase risk stratification in GP practices
- Ensure integrated teams function better

- Integrated teams to be supporting more people to be at home

Planned care
- Implement referral management system
- Commission alternative ENT and community dermatology pathways
- Review cardiology and diagnostics

- Implement the findings from the Cardiology and diagnostics reviews

- Implement specialised services to run from centres of excellence
- Create a step change in the productivity of elective care

Vulnerable and Mental Health
- Implement RAID
- Implement One GP per Care Home
- IAPT expansion
- Section 136 pathways
- Mental health review

- Implement findings of mental health review
- Continue to increase the capacity of dementia services

- Reduce the health gap between people with mental health conditions and those who do not

Health and Wellbeing
- Implement Stop Before your op pathway
- Review the social prescribing project

- Implement the carers pathway
- Embed preventative lifestyle pathways

- The Community to engage more in its health
- Develop better access to preventative services for health professionals

Primary care
- Develop our primary care strategy
- Medicines optimisation

- Practices to work more closely together

- Primary care to ensure it is sustainable and can cope with the scale and the shift from secondary care to primary care
Who we are

Harrogate and Rural District Clinical Commissioning Group (CCG) is the NHS organisation that commissions health services for the residents of the Harrogate and Rural District locality. We represent 19 GP practices and serve a resident population of approximately 160,000 people.

**Our vision**
“We will secure high quality services, in the most appropriate setting, making maximum use of available resources. Through clinical leadership and collaborative working we will achieve the best possible health outcomes for all our local population.”

**Our aims**
To develop a strong and sustainable clinically-led commissioning group.

To use the resources we have to drive continuous improvement in service quality and patient outcomes.

To promote health and wellbeing for our population through a strong public health message, advocating self-care and embracing the Health and Well Being Strategy.

Our vision and aims are underpinned by the **values** laid down by the NHS Constitution that we adopted as our own:

- Respect and dignity
- Commitment to quality of care
- Compassion
- Improving lives
- Working together for patients
- Everyone counts

**Our strategic priorities**
Harrogate and Rural District CCG has six overarching strategic priorities that require specific focus in our local area. These are:

- Urgent Care
- Long Term Conditions
- Vulnerable People
- Elective Care
- Health and Wellbeing
- Primary Care

These strategic priorities are the focus of our two year operational plan and five year strategy.

**Governance**
An effective system of integrated governance exists within the Clinical Commissioning Group. This is described in the CCG’s Constitution which can be viewed on our website at: www.harrogateandruraldistrictccg.nhs.uk

Our Governing Body consists of:

- GP Clinical Chair
- Chief Officer
- 5 GPs
- Lay Member: Vice Chair and Chair of the Audit Committee
- Lay Member: Patient and Public Involvement
- Chief Finance Officer
- Director of Quality / Executive Nurse
- Secondary Care Consultant
- North Yorkshire County Council (co-opted member)

The Governing Body will be assured of delivery of the Strategic Plan Programmes via monthly reporting from the CCG Finance Performance and Commissioning Committee.
Who we are – Governance Structure

The governance and oversight arrangements for the Better Care Fund are via the Transformation Group which is comprised of one senior representative with delegated decision-making authority from each of the following organisations:

- Harrogate and Rural District CCG
- Harrogate & District NHS Foundation Trust
- North Yorkshire County Council (Health and Adult Services)
- North Yorkshire County Council (Public Health)
- Tees Esk and Wear Valley NHS Trust
- Voluntary Sector

The Transformation Committee will report to the North Yorkshire Integrated Commissioning Board and ultimately, North Yorkshire Health & Wellbeing Board and Governing Bodies/Boards within Harrogate District Foundation Trust, North Yorkshire County Council and Harrogate and Rural District Clinical Commissioning Group, as appropriate.

The arrangements are outlined opposite:
Our Vision for 2020

NHS services will not look the same in five years’ time. Health and Social Care organisational boundaries will gradually be broken down to ensure that care is co-ordinated across different care settings. The Better Care Fund will be used to invest significantly in an improved health and social care system, changing the way that health and social care services are funded and delivered to drive improvements in quality, access, outcomes and experience for elderly and vulnerable people.

In order to achieve this change, 24 hour, 7 day services will be required across the range of primary, secondary and social care services, supported by access to information.

Urgent care will be transformed to ensure that services are integrated and able to respond rapidly to unplanned care needs, across a range of environments, so that patients are supported outside of traditional hospital settings. National recommendations are moving towards commissioning serious and life-threatening emergency care services from centralised locations. This is already happening in our area for major trauma, procedures relating to some heart attacks and vascular surgery.

Primary Care and Community Services will be developed and integrated to support the proactive management of long term conditions to ensure that hospital services are used appropriately.

Elective care services will be streamlined to drive efficiencies and improvements to clinical pathways, to deliver truly productive elective care, which will improve services for patients. Specialised services will be concentrated in centres of excellence.

There will be an increasing focus on prevention and self-care, rather than reliance on hospital based care. A range of different technologies will be harnessed to enable and promote self-care and home-care provision of services where safe and clinically appropriate.
Our Vision for 2020

- have a decreased reliance on admission for urgent care
- have an increase in community capacity and effectiveness including scaled up primary care
- work well together at operational level, integrating across boundaries with patient centred care
- work in partnership at strategic level to improve health outcomes
- have IT systems that work effectively across all boundaries
- have fewer specialist centres of excellence

- has the right information at the right time to make the best decisions about and with their patients
- has the right skills and competencies for general and specialist care as needed
- has the right capacity in the right place to deal with changing needs
- has embraced seven day working
- uses assistive technology where appropriate

... is fully engaged in staying healthy and in managing illnesses
... has the right information at the right time to make good decisions about health and illnesses
... helps shape the future of services

Our vision for 2020

- The population:
  - Are physically and mentally healthy and are independent for as long as possible
  - have the support to manage their long term conditions and mental health and receive care when they are ill by the right person at the right time in the right place and return to independence as quickly as possible
  - have positive experiences from high quality, safe integrated health and social care services, irrespective of the day or time of the week and access to high quality cost effective elective care
- Differences in health outcomes between population groups are minimised
- Health and Social Care resources are sustainable

... will continue to co-develop and increasingly lead the primary care commissioning agenda
... has strong leadership of the local healthcare economy
... has the right capacity to facilitate transformational change
... is outcome based, to maximise health gain and value for money
What we will achieve

We aim to improve across all five NHS England outcomes:

We want to prevent people from dying prematurely, with an increase in life expectancy for all sections of society.

In response to this, our ambition for securing additional years of life from conditions considered amenable to healthcare is to reduce our rate from 2071 per 100,000 population to 1826 by the end of 2018/19.

We want to make sure that those people with long-term conditions, including those with mental illnesses, get the best possible quality of life.

In response to this, our ambition for improving the health-related quality of life for people with long-term conditions is to improve the average EQ-5D score even more for people reporting having one or more long-term condition from 78% to 78.6% by the end of 2018/19.

We want to ensure patients are able to recover quickly and successfully from episodes of ill-health or following an injury.

In response to this, our ambition for reducing emergency admissions is from 1712.9 to 1462 indirectly standardised composite of avoidable admissions per 100,000 population by the end of 2018/19.

We want to ensure patients have a great experience of all their care.

In response to this, our ambition for the proportion of people reporting poor patient experience of inpatient care is to reduce this even more from 81.7 to 81.2 by the end of 2018/19. Also, our ambition is to reduce the proportion of people reporting poor experience of General Practice and Out-of-Ours Services from 4.5 to 3.9 by the end of 2018/19.

We want to ensure that patients in our care are kept safe and protected from all avoidable harm.

In response to this we have set ourselves an ambition to have 38 or fewer clostridium difficile infections during 2014/15.

In addition to improving the outcomes above, we have set ourselves challenging ambitions to increase the dementia diagnosis rate from 55.39% to 67.03% by the end of 2015/16; to increase the proportion of people that enter treatment for IAPT against the level of need in the general population to 15% by the end of 2015/16, with a 50% recovery rate; and to reduce the number of falls in the over 65’s from a directly standardised rate of 1952.9 to 1925.6 per 100,000 population.
The case for change - demographics

Harrogate and Rural District has a practice population of 160,611 people. It is a fairly rural district with a population density of 121 people per km², above the North Yorkshire average of 75 but well below the national average of 401.

It has three major towns or settlements with a population over 15,000; Harrogate town, home to 74,720 people, Ripon (17,180 people) and Knaresborough (15,410 people). 16.4% of households within the district do not own a car or van (compared to 25.8% nationally) and 6.7% of the population live more than 60 minutes away from a hospital. Most of the people who are registered to HaRD practices live in Harrogate District Local Authority (98%).

The most significant demographic fact for Harrogate is that it has a relatively older population when comparing it to England. Just over a fifth of all the population are aged over 65 years (20.7%) compared to 16.7% for England. This is reflected in the proportion of patients who are registered in nursing homes which is double the England average (1.0% vs 0.5%). Some practices have over four times the England average.

As the population gets older, this will impact on use of healthcare resources. It is estimated that there will be a 2.2% total increase in the population of HaRD over the next five years. However, there will be an estimated 10.9%, 13.7% and 20.8% increase in the age bands 65+, 75+ and 85+ years respectively. Because elderly people tend to use health services more than younger people, the total projected tariff costs are estimated to increase by 7.3% at today’s prices, and costs for emergency care will increase by 10.4% just as a result of these demographic changes.
The case for change - demographics

Relative to the national average, Harrogate is a prosperous area ranking 283 out of England’s 326 Local Authorities (where 1 = most deprived and 326 = least deprived) with an actual deprivation score of 10.4 (IMD 2012). However, there are pockets of deprivation with one Lower Super Output Area (LSOA) within the ward of Woodfield in Harrogate town ranked within the 20% most deprived in England. 33.8% of the population within HaRD live in the least deprived quintile of super output areas of North Yorkshire with just 7.1% living in the most deprived quintile.

The population of Harrogate has the highest estimated proportion of Black, Asian and Minority Ethnic (BAME) groups compared to the other districts in North Yorkshire with 10.4% of the population classified in other categories than ‘White British’ yet this is still lower than the national average of 17.2%. There are currently 2089 serving military personnel based in HaRD with an unknown number of veterans.

Lifestyle
Current estimates are that 20.7% of the adult population in Harrogate are obese and 14.5% smoke. These compare favourably to national estimates of 20.0% and 24.2% respectively. However, national estimates are that by 2025, prevalence of obesity is estimated to rise to 47% and 36% for males and females respectively. Smoking continues to be the biggest cause of preventable health inequalities. Alcohol is recognised (behind smoking and obesity) as the third largest lifestyle cause of cancer. The proportions of adults who are estimated as increased or higher risk drinking are higher than England (24.4 vs 22.3%).

Projected changes of key conditions
On top of increasing age, the prevalence of certain conditions is projected to rise. For diabetes, the 2012/13 recorded prevalence of diabetes for patients over 16 years is 5.0%. This is lower than the expected prevalence of 7.3% (i.e. a significant proportion of the population have diabetes and do not know it). This total is expected to rise to 8.0% of the population by 2020. This is partly due to the increasing age of the population and due to a rise in obesity levels.

Dementia prevalence is set to rise. Currently there are 1323 people registered with dementia (2012/13). However, it is estimated that there are 2299 people living with dementia in HaRD (i.e. there is a significant proportion of the population who have dementia but do not have a diagnosis) – and that this will increase to 3040 by 2020 – a rise of 130% from the current recorded figures.

Key points
The population is ageing and the impact on costs is greater given that healthcare utilisation is weighted towards the elderly.

There is a rising tide of certain conditions that will impact upon long term conditions, notably obesity, diabetes and dementia.
The case for change - outcomes

There are five outcomes which NHS England have prioritised for improvement. These are:

• Preventing people from dying prematurely,
• Ensuring that those people with long-term conditions, including those with mental illnesses, get the best possible quality of life.
• Ensuring patients are able to recover quickly and successfully from episodes of ill-health or following an injury.
• Ensuring patients have a great experience of all their care.
• Ensuring that patients in our care are kept safe and protected from all avoidable harm.

Against the outcome measures, we have compared our performance against England and also our peer CCGs (highlighted in orange and based on the peers identified through the commissioning for value packs).

Potential Years of Life Lost (PYLL) from Causes Amenable to Healthcare:

The CCG is placed in the interquartile range for both males and females, but with a higher potential for females. Against its comparators the CCG is at the high end, suggesting significant potential to reduce the indicator, especially for females. The time series for the CCG covers only a few years so the NYCC has been used as a proxy over an eight year period. This shows a steady, shallow fall in the indicator.

This indicator is our greatest challenge and as such we have mapped all our improvement interventions to ensure we maximise their potential to improve this outcome. We have specifically identified stroke (hyperacute pathway now in place), cancer (West Yorkshire review taking place), and coronary heart disease pathways (CHD review) as areas to improve this measure.

Ways to improve: through our long term conditions, elective care and prevention workstreams
The case for change - outcomes

Health-related quality of life for people with long-term conditions:

The CCG is at the high end of performance (better), and there is little headroom for improvement to the best levels currently measured nationally. However, the confidence intervals for this indicator are wide, therefore, in subsequent years the CCG’s central score may fluctuate considerably – something that should be taken into account when determining whether any significant change has occurred.

Ways to improve: through our long term conditions, vulnerable people and health and wellbeing work streams

Reducing the amount of time people unnecessarily spend in hospital - Combined Emergency Admissions:

The levels for the CCG are relatively low – around the lower quartile, but not in it. Comparison to cluster CCGs suggests scope for improvement. No time series from which trends can be determined is available.

Ways to improve: through our urgent care, long term conditions and primary care work streams
The case for change – outcomes

Patient experience of inpatient care:

The CCG performs very well on this indicator which is based largely on scores from HDFT inpatient patient survey. There is little headroom for improvement against the current national best scores.

Ways to improve: continued work through our quality agenda

Patient experience composite indicator, comprising GP services and GP Out of Hours:

The CCG performs well on this indicator. There is some headroom for improvement against the current national best scores.

Ways to improve: through our primary care and quality agendas
The case for change – outcomes

Improving health

Most people in Harrogate district die from cancer or heart disease (62%). When we look at deaths under the age of 75 years, with the implication that many of these are preventable (see the chart to the right), the proportion increases to 69% – meaning that it is important to focus on the preventable risk factors for these conditions.

Ways to improve: through our health and wellbeing workstreams

Health inequalities

The Slope Index of Inequality for Harrogate, which is a modelled estimate of the range in life expectancy at birth for the most to least deprived areas is 5.9 years for males and 3.9 years for females.

Ways to improve: through health and wellbeing and vulnerable people work streams
The case for change – outcomes

Parity of esteem

Having a mental health problem increases the risk of physical ill health, with higher rates of cancer, heart disease, respiratory disease and diabetes compared to the general population. People with mental health problems have higher levels of alcohol misuse and obesity than the population as a whole, and do less physical activity. Some 42% of all tobacco smoked is by people with mental health problems.

The CCG will look at improving the standards of physical health care within mental health in-patient facilities to support earlier diagnosis and treatment of common illnesses. This is vital to our on-going goal of reducing premature mortality.

We will:

- Encourage health care workers to promote healthy lifestyle and provide access to support to stop smoking, increase physical activity levels and eat a balanced diet.
- Encourage people with mental health problems to access routine health and dental checks, screening and immunisation.

The excess mortality in people under the age of 75 years who have a serious mental health illness (2010/11) is 1160, compared to 859 for England. This is in the highest quartile for England but not significantly different to our peer CCGs demonstrating room for improvement.

Ways to improve: through our vulnerable people workstream

Key points

Analysis of the outcome measures shows that there is more potential to improve:

- Potential years of life lost amenable to healthcare (particularly in women).
- Time spent in hospitals.
- Health inequalities.
- Parity of esteem.
The case for change – sustainability

In England, continuing with the current model of care will result in the NHS facing a funding gap between projected spending requirements and resources available of around £30bn between 2013/14 and 2020/21 (approximately 22% of projected costs in 2020/21). This estimate is before taking into account any productivity improvements and assumes that the health budget will remain protected in real terms.

For our CCG the ‘do nothing’ gap equates to £15.2 million by 2018/19.

The CCG is committed to developing a sustainable health system. To do this we must ensure that all resources are utilised to gain optimal benefit for our population and where this cannot be evidenced we will decommission services and re-direct resources to where most benefit can be gained.

The CCG will achieve this by:

- Rigorous financial management and predictive modelling to allow the CCG to flex its resources and shift funding.
- Rigorous contract management to ensure optimal outcomes for value for money investment.
- Benchmarking analysis to identify where the CCG currently invests or incurs costs disproportionately to its peers.
- Innovative commissioning to ensure appropriate levers and incentives in place to gain best quality, access, productivity and value for money.
- Effective working with all service providers.
- Decommission interventions and services which fail to produce effective outcomes.

Delivering a sustainable healthcare system will require striking the right balance between the three key areas of financial, social and environmental sustainability when making commissioning decisions.

By delivering care closer to home we will address the three key areas as follows:

- Environmental sustainability through a reduction in the use of transport;
- Economic sustainability by changing care settings;
- Social sustainability as we work with patients to manage their own care we will proactively plan and integrate care (social sustainability).
The case for change – patient experience

Areas identified through patient involvement

The CCG has a Communications and Engagement Strategy which explains “How we will listen to you, learn from your experiences and use this insight to guide what we do”.

It has developed ‘HaRD Net’ – a robust patient network and database to capture the contact details and particular interests of patients and the public within its commissioning area. It has also committed to running Public Involvement Forums, ongoing communications through newsletters and local press, working with key stakeholders including the Health Overview and Scrutiny Committee, Health Watch.

The first public involvement forum ‘Seeking Your Experience’ was held in July 2013 and proved to be very successful and was well supported by the local community. A total of 77 people attended the event. 53% were members of the public, 32% representing the voluntary/independent sector, 10% NHS and NYCC staff and 5% local councillors.

The second public involvement event was held on 11 March 2014. 90 people attended: 50% were members of the public, 20% representing the voluntary/independent sector, 30% NHS and North Yorkshire County Council staff.

The focus of the event was to share with people the progress made by the CCG in its first year and to demonstrate how local community’s feedback had contributed and helped shape the five year plan which was shared with attendees to gather their views and to see if the CCG had got it right. The evening was about members of the public guiding the CCG and helping to develop the thoughts based on their experiences and what health services they would like to see locally.

The format of the event was interactive breakout sessions based on the key strategic priorities of the CCG. Attendees had the opportunity to view the displays in each room, which highlighted the progress the CCG had made, details of further developments and the priorities. People were encouraged to speak on a one to one basis with CCG GPs, staff and key partners and provide their feedback via a questionnaire.

Displays from local voluntary and partner organisations were on show throughout the event, showcasing the work and facilities available within Harrogate and Rural District.

Respondents’ comments from the event included:

- “I think it has been a most successful year”.
- “I find HaRD to be a very responsive, listening, caring group. You also have the talent to make a difference”
- “A good listening event”
- “I feel I was listened to.”
- “Thoroughly enjoyed the event and being able to chat one to one with the professionals”
The case for change – patient experience

Feedback from the Call to Action Event included:

**Improving Mental Health Services**
Feedback from attendees in this group was positive about the service, although some highlighted that patients do sometimes have to travel quite a distance to access some services, such as psychological therapies. It was noted that some mental health patients feel very isolated, but the contribution from the voluntary sector is very important and valued.

**Redesigning Urgent Care**
Feedback from the group highlighted with HaRD CCG’s the desire to redesign urgent care. Discussions focussed on how the current system is muddled and can be difficult to understand. People are not sure which service to attend, GP out of Hours or A&E. The CCG’s plan is to simplify access to the urgent care service so that patients only need 3 telephone numbers: their GP Practice, NHS 111 and 999. Urgent care will be more co-ordinated, especially for older people, people with long term conditions or complex health needs. Members asked that clear guidance is made available to the public advising which service to attend for urgent medical problems.

**Long Term Conditions**
Integrated Community Teams - It was clear that attendees recognised the need for patients to take ownership of their own care plans and long term conditions, with close support from their GP. Social prescribing was also discussed and viewed as a positive. This is an approach that seeks to improve health by referring patients with social or emotional needs to a range of non-clinical services and support. Utilising technology was also a big talking point, with people discussing where we are now and what we may need, or be able to do, in the future.

**Improving Health and Well-being**
This group highlighted how people in rural areas can feel socially isolated, and this needs to be addressed (work is already underway in this area). Lifestyle advice such as dietary guidance, diabetes management were discussed, but it was agreed that there is not a ‘one size fits all’ approach. Comments were also made around how services across health and social care need to be better joined up.

Engagement Summary Report “Public Involvement Forum 11 March 2014”
All the feedback gathered from the event will be used to influence the future strategic direction of HaRD CCG, and what services are commissioned locally.

When attendees were asked if the CCG were making the right service improvements, 80% were in agreement.
Comments received “I think it has been a most successful year”. “Word on the street is that the CCG are doing well and organized. Seem to be engaging and seeking opinion so as long as this input into decision making the right service improvements should be made!”

The remaining 20% were unsure as to whether the CCG were making the right service improvements with one member expressing concern around mental health services. The CCG has and will continue to invest and make service improvements in Mental Health.

This engagement event has once again proved to be a great success for the CCG in gathering feedback and speaking face-to-face with members of the public with 100% of responders reporting to find the event to be either very useful/quite useful.
<table>
<thead>
<tr>
<th>‘you said…’</th>
<th>What we are doing about it…?</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Patients with acute mental health problems having to wait in accident and emergency units, which is the wrong setting.’</td>
<td>We are commissioning psychiatric liaison services, which will work with patients in A&amp;E and on the wards.</td>
</tr>
<tr>
<td>‘What are you doing about adult mental health services?’</td>
<td>We are commissioning more psychological therapies, a crisis services that is accessible and responsive to peoples’ individual needs and circumstances and a comprehensive liaison service responsive to people in A&amp;E and on general wards in the acute hospital. We also want to commission a recovery pathway that maximises quality of life and social inclusion.</td>
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<tr>
<td>‘Health care services are not truly integrated.’</td>
<td>We are prioritising integration in our 5 year strategy and we will have integrated teams linked to GP practices. (Long Term Conditions)</td>
</tr>
<tr>
<td>Feeling that you are battling against NHS Systems that you don’t understand</td>
<td>We will be simplifying access to the service so that patients only need telephone number: their GP practice, NHS 111 and 999. (Urgent Care) Care will be more co-ordinated, especially for older people, people with long term conditions or complex health needs.</td>
</tr>
<tr>
<td>The problem caused by the current arrangement of GP care provided to Care Homes was one of the issues that came from meetings with the Care Homes,</td>
<td>Integrated Teams include proposals for Care Navigators. (Long Term Conditions) From this we are developing the linking of GP practices to Homes. (Vulnerable People)</td>
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Enablers - quality

Response to Francis, Berwick and Winterbourne review

Regarding Winterbourne, we have an action plan in place under the Concordat and are working on enhanced quality framework to ensure placements are appropriate. Our response to Francis involves an organisational action plan which is monitored quarterly. It is a contractual requirement of our providers to implement recommendations which we monitor. In future years the CCG will take responsibility to monitor staffing reports from their providers on a six monthly basis (as in 2014/15 contract). The Nursing and Midwifery Council (NMC) response to the Francis review provided the 6 C’s. We have already started with working with our main acute provider on the nursing 6 C’s which we will expand across other providers.

Patient Safety

Building on the existing work with providers (Harrogate District NHS Foundation Trust and BMI the Duchy), the safety thermometer as part of the national CQUIN will be monitored across other providers (as in 2014/15 contract). The safety thermometer will likely be rolled out across mental health services and the care home sector too over the next year.

We require all providers to report any serious incidents (national guidance) and require assurances that any lessons learned from such incidents are implemented. Monitoring of the number of incidents is transparent and reported to Governing Body.

Patient Experience

Both Friends and Family (FFT) and the twice yearly GP survey results are measured in our performance dashboard. Drawing on comparative work on the Friends and Family test to benchmark our main acute provider, we will continue to monitor performance both within inpatient care and from September 2014, add the Primary Care FFT results to existing measures. We also have an ambition to use local soft intelligence and triangulate with other data sets including patient experience and complaints to identify where Primary care practices may need additional support.

We need to develop processes with our providers to generate patient insights; some of this will come from the insight dashboard generated from FFT, but we are also exploring the possibility of ‘theme clouds’ from qualitative comments within the FFT. We are also keen to triangulate other sources of data from organisations including Care connect, Patient Advice and Liaison Service (PALS) and Healthwatch alongside our own soft intelligence network.

Compassion in Practice

We have already started with working with our main acute provider on the nursing 6 C’s which we will expand across other providers – there is a further challenge to extend the principles across all professional disciplines for organisations from whom we commission care. We need to do further work on how we will establish whether this is being implemented effectively.

Staff satisfaction

From our providers, we will be seeking information to assure the CCG that our providers are good employers and have mechanisms in place to monitor staff satisfaction (including friends and family recommendations).

We also have plans to deliver and develop benchmarking analysis to compare across our providers according to their peer groups.

Within the CCG, we have established a Staff Engagement Group who, in addition to the annual staff survey, conducted a values survey which will be repeated on an annual basis to benchmark progress and highlight improvement areas.
Enablers - quality

**Seven day services**
We are monitoring the SHMI for weekends compared to within the week and will use this as a proxy indicator along with other metrics. We are still working on determining the right measures to use but seven day working will need to include clinical outcomes, patient safety as well as seeking assurance that staffing ratios are adequately maintained. We have already started some of this work, driven by the inception of the recently commissioned Stroke Service locally.

This extends to the development of any future joint working, policies and training in partnership with our local authority colleagues.

The CCG has an established team of Designated Professionals for Safeguarding Children (i.e. covering both the Child Protection and Looked After Children agendas) to work across the North Yorkshire and York CCGs, provider organisations and the Area Team as per the recommendations in the NHS England Accountability and Assurance Framework (2013).

The Designated Professionals Business Plan (set out in the Annual Report 2012-13) describes priorities for future working across the CCG area to strengthen and further embed safeguarding children arrangements, drive up practice in relation to child safeguarding and to address any service gaps.

**Safeguarding**
We are undertaking a review of adult safeguarding currently, and once the review is complete, we will ensure that any development plans are adequate to ensure we can properly provide adult safeguarding across the locality.

We are already demonstrating local partnership working arrangements and have signed up to the multi-agency policies and procedures for adult safeguarding.

We are developing our plans around the PREVENT agenda, which includes a CCG specific PREVENT policy and training package to meet the national requirements. In relation to the Mental Capacity Act, we continue to demonstrate our commitment to working to support its implementation.

There are clear governance and assurance pathways within the CCG and in relation to commissioned services. The CCGs also have safeguarding policies and agreed arrangements for representation on multi-agency partnership bodies (both the Local Safeguarding Children Board and the LAC Strategic Partnership for North Yorkshire).

The CCG has audited its arrangements for safeguarding children against the statutory requirements set out in Section 11 of the Children Act (2004).
Enablers - participation

‘The NHS belongs to the people. It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill, and when we cannot fully recover, to stay as well as we can to the end of our lives.’  
* NHS Constitution

The story so far

We have developed a Communications and Engagement Strategy which sets out full details of our approach. We want to offer people a genuine opportunity to influence local NHS commissioning so we ran focused engagement exercises for projects that fall under each of the CCG’s strategic priority areas. Some of the examples of our engagement work include:

- HaRD Net - a network of local people, patients, carers, voluntary sector representatives and other partners who have the opportunity to influence local health services
- Seeking Your Experience - Public Involvement Forum.
- Call to Action events.
- Consultation on service changes for older people’s mental health service.

Next steps

We will continue to ensure that public, patient and carer voices are at the centre of our healthcare services, from planning to delivery – informed by insightful methods of listening to those who use and care about services.

NHS England has released new guidance called “Transforming Participation in Health & Care” which will help the CCG to ensure:

- Patients and carers can take in planning, managing and making decisions about their care and treatment
- The public can take part in the commissioning process itself, making sure services meet the needs of local people

It includes a range of tools, resources and case studies that we will use to support our work. Please see the next page for details.
Enablers - participation

1. Individual participation

- Ensuring that every person with a long-term condition or disability has a personalised care plan supporting them to develop the knowledge, skills and confidence to manage their own health.
- People with NHS continuing care will have the right to ask for a personal health budget, including a direct payment, by April 2014.
- Roll out personal health budgets and approaches to personalisation so that anyone who can benefit will be able to have a personal health budget and care plan by April 2015.

Why: By putting patients in control and sharing decision making with their doctors, it will help people live more independently in the community, improve outcomes, improve quality of life and provides value for money.

2. Public participation in decision making

- Build upon existing structures and relationships, using tried and tested methods to involve patients, carers and the public - especially those who represent excluded or marginalised groups.
- Work with the Health and Wellbeing Board and Healthwatch to plan shared approaches.
- Seek feedback from our partners and communities about what is working well and areas for improvement and feedback about the impact of their involvement, and the difference they have made.
- Aim to achieve at least 80% satisfaction from stakeholders regarding the ways in which we have involved people in planning and commissioning services.

Why: It will give people a say on how services are developed locally and nationally, to ensure their communities have the services they need. Improves outcomes, improves quality, builds partnerships, provides insight.

3. Patient insight and feedback

- Surveys – local and national.
- Roll out the Friends and Family Test to cover all NHS services by the end of April 2015.
- Patient Centred Outcome Measures.
- Patient stories.
- Focus groups.
- Engage with patients, carers and the public when redesigning or reconfiguring healthcare services, demonstrating how this has informed decisions.
- Publish evidence of patient and public voice activity and the impact and difference it has made.
- Publish the feedback received from local Healthwatch.

Why: it will give the CCG a clearer and more accessible picture of what people are saying about our service. Improving patient experience, improving health services, improving health outcomes.
Enablers - technology

Technology is seen as a key enabler to the transformation programme. Developments include:

**Better care through the digital revolution**
- Online access to their own health records held by their GP, supported by national information standards for health and care to support integration.
- Online booking of GP appointments and ordering of repeat prescriptions.
- The option of e-consultations becoming more widely available.
- More people with long-term conditions being able to benefit from telehealth and telecare by 2017.
- Care Connect, an initiative to test how telephone and social media channels can improve public participation.

**Transparency and sharing data**
- Reporting outcomes data.
- The systematic development of clinical audit and patient-reported outcome and experience measures.
- Using technology to make it easy for patients and carers to give feedback on their care and see reviews by other people.
- care.data this will safely join up existing clinical data sets, so that they provide the data that the CCG need to support the delivery of high quality care and improved outcomes.
- Universal adoption of the NHS number as the primary identifier by all providers.
Enablers – finance

Better Care Fund (BCF)
The Government has created a £3.8bn pooled budget for 2015/16, intended to help move care out of hospital and into the community and improve working and integration between Health and Social Care.

BCF has the potential to improve sustainability and increase quality, including by reducing emergency admissions to hospital. Hospital emergency activity needs to reduce by 15% over the next 5 years and we must make progress towards this target during 2014/15.

The BCF plans must be specific about how the integration fund will:
• Provide 7 day services.
• Enable data sharing – using the NHS number as primary identifier plus other data sharing requirements.
• Enable joint assessments and accountable, lead professionals.

Locally the Better Care Fund will be worth £9.56m in 2015/16.

Shift in funding to primary care
A modern model of integrated care is needed for vulnerable and elderly people. We will support general practices to provide a comprehensive and coordinated package of care on over-75s and those with complex needs and provide funding to reduce avoidable admissions. It is proposed that additional CCG funding (around £5 per head of practice population or equivalent to £50 for patients 75 and over) should be given to practices to commission additional services to improve quality of care for older people. In future years this is likely to be extended to those with long-term conditions. We are currently finalising the details of this investment locally.

Contracts
The NHS Standard Contract is a key lever for the CCG to secure improvements in the quality and cost-effectiveness of the clinical services we commission. While the contract retains the same structure as 2013/14 changes have been introduced:

• Greater flexibility to determine the duration of the contract they wish to offer, within the national guidelines and regulations on procurement, choice and competition;
• A move away, by agreement with providers, from rigid national prices, to different payment models based more on quality and outcomes and less on activity;
• Utilising innovative contracting models such as the prime provider approach.

These changes have been introduced to support longer-term, transformational, outcomes-based commissioning approaches. Providers will be required, as part of their NHS Standard Contract, to agree an action plan for innovation during 2014/15.
Enablers – finance

Quality Premium
The ‘Quality Premium’ is intended to reward CCGs for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities.

The quality premium paid to CCGs in 2015/16 – to reflect the quality of the health services commissioned by them in 2014/15 – will be based on six measures that cover a combination of national and local priorities. These are:

- Reducing potential years of lives lost through causes considered amenable to healthcare and addressing locally agreed priorities for reducing premature mortality (15%);
- Improving access to psychological therapies (15%);
- Reducing avoidable emergency admissions (25%);
- Addressing issues identified in the 2013/14 Friends and Family Test (FFT), supporting roll out of FFT in 2014/15 and showing improvement in a locally selected patient experience indicator (15%);
- Improving the reporting of medication-related safety incidents based on a locally selected measure (15%);
- A further local measure that should be based on local priorities such as those identified in joint health and wellbeing strategies (15%).

(CQUIN) 2014/15
The CQUIN scheme provides a national framework through which organisations providing healthcare services under the NHS Standard Contract can earn incentive payments of up to 2.5% of their contract value by achieving agreed national and local goals for service quality improvement.

The national element includes:

- Friends and Family Test
- Improvement against the NHS Safety Thermometer
- Improving dementia and delirium care
- Improving diagnosis in mental health

Procurement
Better procurement, better value, better care sets out details of the NHS Procurement Development Programme, which aims to help the NHS save £1.5 billion by 2016.
Enablers – workforce

Workforce

We recognise the central importance of workforce to all aspects of the successful implementation of this strategy and to sustaining high quality services and operational delivery during transformational change.

While this is principally a matter for providers and Health Education England we will be cognisant of workforce opportunities and constraints locally, ensuring there are mechanisms to link local strategic planning to workforce planning to get the right people, with the right skills, in the right place at the right time, by:

• Assessing how many and what type of staff are required.
• Identifying how these staff will be supplied.
• Determining how a balance between demand and supply can be achieved.

With support from North Yorkshire and Humber CSU we will assess the workforce implications of the shift from secondary to primary care and the medium to long term workforce and service planning required to achieve our strategic plan.

We are increasingly engaging with secondary care consultants through clinician to clinician meetings to facilitate changes in line with our plan, recognising that working with our partners to change clinical behaviour is important to achieving our aims.

We will work with NYH CSU and Health Education England (Yorkshire and Humber) to understand the annual workforce planning submissions of the provider organisations and the medium to longer term workforce implications, milestones and risks to achieving care closer to home across health and social care.

Through the development and use of new and innovative workforce planning tools such as the GP data collection tool (HEE YH) and through the provision, analysis and interpretation of data from across the health and social care sector we will gain an understanding of the current and future workforce requirements across Yorkshire and Humber.

We will proactively work with Yorkshire and Humber Local Education and Training Board and the Strategic Workforce Planning service of NYH CSU to gain a comprehensive understanding of how the annual workforce planning submissions of provider organisations (Schedule 3) are used to inform the priorities for LETB education commissions and how these will support the delivery of our Strategic Plan.
Our priorities

As part of our strategy development, we have identified six priority areas:

- **Urgent care** – ensuring safe, effective and timely unplanned care where clinically appropriate
- **Long term conditions** – ensuring people with long term conditions are supported to maintain their independence for as long as possible
- **Vulnerable people and mental health** - improving mental wellbeing and moving towards parity of esteem
- **Elective care** – ensuring that planned care is safe, cost effective and provided in the right location
- **Health and Wellbeing** – working with our partners to prevent ill health
- **Primary care** – ensuring primary care is sustainable for the future and scaled up to provide care out of the hospital

We have described what we are doing on each area in each of the priority chapters. The tabs on the left hand side can be clicked for easy navigation through the chapters.
Redesign urgent care

Our milestones are:

By end 2014/15
• Complete reviews of urgent care
• Develop plans for urgent care centre
• Implement DVT pathway

By end of 2015/16
• Implement urgent care centre plans

By end of 2016/19
• Implement urgent care centre plans

Nationally and locally urgent care services have particular significance for commissioners because of the:
• Increasing demand for some services, particularly A&E and ambulance services.
• Complexity of navigating service provision.
• Duplication in the system.
• Changing expectations and experience of patients.
• Challenge to make efficiency savings in the NHS.
• High profile political and media interest.
• Quality and safety issues.

The current system is fragmented and difficult to navigate, so patients contact the more accessible and visible parts of the system, such as A&E or ambulance services, rather than primary, community or social care services.

Consequently patients contact urgent care for anything along the spectrum from information and advice about self-care to life-threatening treatment for stroke, heart attack or major trauma.

Locally people access urgent care in a variety of ways, via:
• A visit to the pharmacy.
• An urgent or booked appointment at their GP, dentist or optician.
• Out of Hours Service.
• Minor Injury Unit.
• Mental Health Services.
• Social Care.
• A&E.
• 999/NHS 111.

In addition, reducing the number of avoidable emergency admissions to hospitals is one of the key challenges facing the NHS. The Urgent Care Board has been established to oversee a transformational redesign programme of deliverable work-streams that ensure the health and social care economy delivers high quality, cost effective care services for the local population, ensuring each patient is seen in a timely manner by the most appropriate clinician to meet their needs.

The Board will determine the footprint of the urgent and emergency care network in 2014/15.
Redesign urgent care

Our improvement interventions:

**Urgent Care Centre**
The fragmentation of services, with different organisations working alongside each other without any clear and shared agreement about governance, puts both staff and patients at risk. The Urgent Care Board has been established to oversee a transformational redesign programme of deliverable work-streams that ensure the health and social care economy delivers high quality, cost effective care services for the local population, ensuring each patient is seen in a timely manner by the most appropriate clinician to meet their needs.

Included in the work programme is the development of an Urgent Care Centre in Harrogate. This would see existing services co-located and coordinated, addressing the problems associated with the current fragmented service provision.

Patients would still be able to access their GP practice for urgent and non-urgent care, as this is the first place that most people go when they have a health problem.

This would support the co-location of community-based urgent care services in a co-ordinated Urgent Care Centre which is a key recommendation of the Keogh Report.

**Clinical Assessment Team – 7 day service**
Having senior clinical decision making at the front end of the system ensures swift assessment and onward movement through the emergency pathway by having senior assessors available to make decisions, treat promptly and transfer patients back in their homes as soon as they are medically fit, with appropriate support, or refer them on for the correct specialist treatment. By recognising that blockages in A&E are actually a symptom of the wider healthcare system failures, they are able to reduce costs, save lives and move care to where it most suits the patient.

The Better Care Fund (BCF) plan includes additional resource into the Clinical Assessment Team (CAT) so that it is a 7 day service with speedier access to diagnostics and appropriate medical assessment for more patients.

**Centres of Excellence**
Ensure that those people with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery. Two levels of hospital-based emergency centre, with standard centres and a tier of ‘major emergency centres’ with consistent levels of senior clinical staffing and more specialist capability.
Redesign urgent care

Our improvement interventions:

**Review GP Out of Hours**
We have been undertaking a systematic review of all elements of the urgent care system. As part of the process we will be focusing on GP Out of Hours in 2014/15 to ensure that it forms part of an integrated system.

**NHS 111**
NHS 111 is nationally commissioned. As a result of the Keogh Report NHS 111 will have an enhanced role, with a greater range of clinicians with access to patient medical information and the ability to book appointments with a local service, where appropriate.

The enhanced service will go live in 2015/16 with calls to 999 being focussed on emergencies. Paediatric urgent care pathway review to provide recommendations for the management of children presenting at A&E with acute breathing difficulties.

All of these measures will support delivery of the NHS Constitution Measure that patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department (target 95%).

Our priorities for integrated urgent care are that it:

- Provides consistently high quality and safe care, seven days a week.
- Delivers the best outcomes and is clinically and financially sustainable.
- Is simple to access and guides good choices by patients and clinicians.
- Provides the right care in the right place, by those with the right skills.
- Is based on need, rather than traditional patterns of demand.
- Has senior clinical decision making at the front end of the system.
Manage care more effectively - integrated community teams

Our milestones are:

By end 2014/15
• Implement care planning
• Complete community services review

By end of 2015/16
• Increase risk stratification in GP practices
• Ensure integrated teams function better

By end of 2016/19
• Integrated teams to be supporting more people to be at home

A significant proportion of admissions to hospital are related to long term conditions, such as diabetes, asthma and congestive heart failure. Maintaining health and independence in the community helps to prevent deterioration in conditions and results in better health outcomes and patient experience. For patients with long term conditions it is possible to prevent acute exacerbations through active, planned management: better self-management or lifestyle changes, behavioural change programmes, social prescribing, case management and care co-ordination by integrated health and social care teams.

To the left we’ve explained what people tell us they want and our response it to the right:
Our vision for acute integrated care

The Integrated Care Team
- will be aligned to GP practice population
- will comprise a core team to include START, Community Fast Response and Rehab, Community Matrons, Case Manager, Social Care Assessor, District Nurses, Reablement Assistants
- will link in to specialist services such as therapists, voluntary sector, Specialist Nurses, Practice Nurses, NYCC Assessment teams, mental health services, community stroke team
- will have an identified senior coordinator for the team
- will have a single point of access and standard operating procedures

The person
- will have a single shared care plan, developed in full collaboration with the person / their carer
- will have an identified key worker, who coordinates all their care –across both organisations.
- will be fully informed on how it is proposed that their care is managed when they have given informed consent.
Manage care more effectively - integrated community teams

We developed our vision at a multi-agency planning day, early in 2012:

"We will commission integrated care teams that support patients with a range of conditions in their own homes. These patients may have health or social care issues or a mixture of the two. The infrastructure will be aligned to GP practices across the locality. The integrated team will be the gateway and there will be a central point of access to a range of services, determined through a single assessment process."

We have identified a number of approaches aimed at ensuring that the people we service are supported in maintaining their own health and wellbeing:

- Care Planning – central to our vision is patient-owned Care Plan. This will allow patients to fully understand their condition, and crucially to shape the management of their condition and establish goals according to their needs. This will require a transformation of Primary Care, and collaboration to ensure the Plan is recognised and contributed to by all organisations.
- Support with Independent Living – we have identified a number of Social Prescribing projects aimed at addressing the social, emotional and practical needs of our population by embedding voluntary and community sector partners in Primary Care. By alleviating loneliness and social isolation, it is anticipated that this work will reduce demand on both health and social care services.
- Healthy Ripon Wellbeing Collaborative – this proposal originated from a collaborative consultation with residents of Ripon and its surrounding area, identifying areas in which joint working could more efficiently contribute to their wellbeing. In addition the scheme offers clearer signposting to community facilities, and opportunities for self-care. Should this scheme be successful the ambition would be to expand it across the district, promoting disease prevention and healthy lifestyle.

In the event of an acute illness or crisis, we again propose responding with a collaborative approach. We will offer an alternative to hospital admission wherever possible, and where this is not an option ensure timely discharge, avoiding unnecessary use of residential care. This includes the development of an intermediate care service operating 24 hours a day, 7 days a week.

We have been working with North Yorkshire County Council, community providers and the voluntary sector to develop our Better Care Fund (BCF) plan for a single pooled budget to support health and social care services to work more closely together in our local areas.
Framework Agreement to Promote the Integration of Health and Care Services in North Yorkshire and the City of York

This Agreement reflects the commitment of local government, NHS commissioners and providers in North Yorkshire and the City of York to work together to integrate services to significantly improve outcomes and eliminate the fragmentation of services across health and social care. This will improve the services and support for patients, service users and carers.

Work is already underway at a local level in different parts of North Yorkshire and York to experiment and learn how integration can be developed and sustained within local teams. This includes local programmes of organisational development where staff from different organisations have been brought together to build a shared sense of identity and the agreement of common priorities and solutions. Taking forward and properly embedding such large-scale organisational development and change will require continued commitment and energy over an extended period.

Our programme includes:
• Community services review
• Risk stratification
• Integrated Care Teams/Community Hubs
• Care planning
• Accountable GPs for the over 75s (senior clinician for long term conditions)
• Self care
• Assistive technology

Manage care more effectively - integrated community teams

Future System Experience
The case study on the next page shows how patients experiences will change over the next five years.

Future system experience
Informed / empowered patient
Named GP / Clinician
Agreed & operational care plan
Care closer to home
Improved patient experience
Better outcome
Manage care more effectively - integrated community teams

**Case study:** Mary is 73 with both chronic obstructive airways disease and diabetes:

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<th>Health Service response now</th>
<th>Integrated Health and Social Service response within 5 years’</th>
</tr>
</thead>
<tbody>
<tr>
<td>She becomes ill on Friday with breathing difficulties and thinks she will wait until after the weekend. She’s mislaid her supply of emergency tablets.</td>
<td>Mary becomes ill on Friday with breathing difficulties. She users her pulse oximeter to monitor her O₂ saturation and thinks she will wait until after the weekend. Mary understands her condition, knows what she is looking for when monitoring her condition and how to adjust her medication.</td>
</tr>
<tr>
<td>She becomes worse and calls the out of hours GP. She is assessed over the phone and the GP feels she needs an X-ray.</td>
<td>She becomes worse overnight and phones her GP practice on Saturday morning. She talks to the GP over the phone and is able to provide oximetry reading for the past 24 hours. Mary and the GP both have access to her personalised care plan.</td>
</tr>
<tr>
<td>She is sent to the hospital and they are concerned about her diabetes as well as her COPD and so she is admitted.</td>
<td>The GP feels she needs an X Ray and he arranges an appointment later that day at the Urgent Care Centre. They arrange the X Ray and a review of her diabetes is arranged in the community Access to a specialist clinician at an early stage means that Mary is confident about the changes being made to her medication.</td>
</tr>
<tr>
<td>She has an X-ray and is started on new medication</td>
<td>The Integrated Care Team set up a support package to enable her to go back home that day to complete her treatment. Early intensive support enables Mary to go back home the same day</td>
</tr>
<tr>
<td>She is discharged home on the Monday with a review by the COPD nurse from the hospital, scheduled for later that week.</td>
<td>The hospital isn’t aware of all the services available in the community Her care plan is reviewed on Monday at the joint multidisciplinary team meeting. Mary will be involved in any changes to her care plan.</td>
</tr>
</tbody>
</table>
Manage care more effectively - integrated community teams

Our priorities for managing care more effectively are:

- Provides consistently high quality and safe care, seven days a week.
- Delivers the best outcomes and is clinically and financially sustainable
- Provide better support for people to self-care
- Integrated, multi-professional teams based around general practices for better care coordination.
- Senior clinician taking responsibility for active care coordination. All people aged 75 and over have a named, accountable GP who is responsible for overseeing their care
- Comprehensive and personalised care plan, that supports integrated care.
- Risk stratification to pro-actively identify people who could benefit from the input of the Integrated Team.
- People with LTC have the option to hold their own personal health budget as a way to have even more control over their care.
- Uses assistive technology where appropriate
- Home based care.
- Carers have access to information and advice about the support available.
Improve mental wellbeing & move towards parity of esteem

Our milestones are:

By end 2014/15
• Implement RAID
• Implement One GP per Care Home
• IAPT expansion
• Section 136 pathways
• Mental health review

By end of 2015/16
• Implement findings of mental health review
• Continue to increase the capacity of dementia services

By end of 2016/19
• Reduce the health gap between people with mental health and those who do not

We have recognised that there is a significant proportion of our population who are marginalised through mental health. We have developed one of our strategic priorities around improving mental wellbeing and moving towards parity of esteem. Our planned interventions are below.

Develop psychiatric liaison services (RAID)
A shortcoming in the existing system is the separation of care for mental and physical illnesses, in service provision, payment systems and clinical training.

This separation is at odds with the close relationship between mental and physical health, reflected in the high frequency with which illnesses of both kinds overlap in an age of multi-morbidity.

Psychiatric liaison services provide mental health care to people being treated for physical health conditions in general hospitals. Rapid Assessment Interface Discharge (RAID) is an award-winning service which offers comprehensive mental health support, available 24/7, to all people aged over 16 within the hospital. The service is being jointly commissioned and funded by the Better Care Fund.

This reflects our goal to have crisis services, including liaison psychiatry services, which are as accessible, responsive and high quality as other health emergency services.

Clinical outcomes have been evaluated:
• Very strong patient and staff satisfaction ratings
• 14% increase in the proportion of older people at home 91 days after discharge
• 97% increase in discharge rate of older patients into their own homes rather than institutional care

Financial outcomes have been evaluated:
• 74% lower readmissions rate for mental health patients using RAID compared to those not using it
• 8.7% reduction in inpatient bed-days
Improve mental wellbeing & move towards parity of esteem

**Dementia**

Only about one third of people with dementia receive a formal diagnosis. When a diagnosis is made it is often too late for those suffering with the illness to make choices. Diagnosis is also often made at a time of crisis which could have been avoided if a diagnosis had been made earlier. In 2012 there were 1,236 people on GP registers with a diagnosis of dementia. This is 0.77% of the population.

Approximately one in four patients in acute hospitals has dementia. Once in hospital, people with dementia have poorer outcomes than those without dementia.

We will develop a Dementia Strategy in line with North Yorkshire County Council that will build on the work of the Dementia Collaborative, but additionally look to develop Dementia Navigators, support for community teams, and increased capacity at the memory clinic. Ultimately we aim to have a fully integrated network model to:

- Improve early detection and diagnosis
- Improve outcomes and quality
- Achieve efficiencies

The expected outcomes include:

Patients will:
- Be able to make sense of their change of behaviour
- Get an earlier diagnosis.
- Be able to make informed choices about their future – how they want to live and how they want to die.
- Be able to learn coping mechanisms – for the person with dementia and their family and friends.
- Be able to arrange for support to help them maintain their independence for as long as possible.
- Have an improved quality of life.
Improve mental wellbeing & move towards parity of esteem

Building Effective Relationships with Nursing and Residential Homes
1.2% of the Harrogate and Rural District population live in Care Homes. These people account for 5.5% of all unplanned hospital admissions (8.8% of total cost). 61% of admissions occur between 08.00 and 18.30hr, and 70% follow a 999 ambulance call, rather than Primary Care assessment and direct admission to a ward. 23% of admissions stay in hospital for 3 days or less and 66% of these admissions are due to chest infections, urinary infections, confusion/delirium, gastroenteritis, catheter problems, falls and minor injury. 34% of all admissions die in hospital and of these 25% die within 24hr of admission.

Currently many Care Homes may have as many as 10 GP Practices looking after residents in the Home, and each Practice may have patients in up to 20 Homes. This discourages regular review, anticipatory care, good doctor/patient relationship and close working with the Care Home staff. We want to see designated GP Practices linked to Care Homes and enable GPs to provide a level of care over and above that commissioned through their current contract.

Children
We will work in partnership with local authority colleagues and co-commissioners to enable children and their families to have the best start in life and achieve improved health outcomes, and reduced health inequalities. This includes commissioning integrated maternity services for the local population which are safe, effective and high quality. In adopting a life course approach there will be a strong focus on early intervention, especially for our most vulnerable groups, so that all children are able to achieve positive lives and receive appropriate health care, at the right time and in the right setting.

By developing and commissioning modern models of integrated care, including jointly with partners where this will add value, we will ensure that children and young people with complex and additional health needs, including Special Educational Needs, receive high quality services which support them, and their families.
Improve mental wellbeing & move towards parity of esteem

Emotional health and well-being is a prerequisite for good general health and well-being and essential for ensuring children have a good start in life and achieve their optimum potential. In line with “No Health without Mental Health”, emotional health and wellbeing will be a cross cutting theme for inclusion within all children’s partnership commissioning and care pathways development. Particular care will be taken to identify vulnerable groups to ensure there is timely access to preventative, early interventions and treatment services across all ages.

Special Educational Needs (SEN)
Too many children and young people who are identified as having SEN have poor outcomes in life, and they and their families can struggle to get the help and support they need. From September 2014, all local authorities, the NHS and their partners will begin to provide a new system of support to children and young people with SEN up to age 25 and their parents. The Partnership Commissioning Unit (PCU) are ensuring we are able to deliver our statutory responsibilities around this important agenda.

Improving Access to Psychological Therapies (IAPT)
IAPT is currently provided by Leeds and York NHS Partnership Foundation Trust (LYPFT). We are reviewing the current contractual arrangements and redesigning the service model, to one which offers better integration between IAPT and mental health and primary care. We want to improve access, quality and outcomes as a result of the review so that we commission a service that provides a range of therapies from low level primary and community settings that is responsive, accessible and meets the national target of 15% accessing IAPT who meet the criteria. The services will:
- Have one point of access.
- Be responsive and accessible, with an aim of waiting times of no more than 2 weeks.
- Offers choice of therapies (1-1, group work or technology based).
- Provide timely and informative feedback to primary care (GPs) on the outcomes of the treatment provided.

The expected outcomes include:
- A greater number of people will experience recovery and greater independence.
- People will have been supported to return to, or maintain optimal independence and wellbeing that enables them to participate in a social and productive life according to their needs and wishes.
- People will have been supported to access education and employment.
- Reduction in escalation to a crisis situation.

Improve Autism Services
At the first public involvement forum ‘Seeking Your Experience’ there was a lot of comment and discussion about Autism Service. As a result of the issues raised and this is being reviewed by the Partnership Commissioning Unit to bring the pathways in line with NICE guidance and to provide an equitable service for children and young people from the age of 0-19 years.
Improve mental wellbeing & move towards parity of esteem

The Harrogate Dementia Collaborative
This collaborative was established in 2012 to bring together the different agencies, service users and carers for the purpose of improving Dementia care. The focus was on large scale cross-organisation change to improve services for people who have a dementia and some of the successes include:

**Improved quality of care for people with dementia in general hospitals:**
- The environment on Byland Ward at Harrogate Hospital has been improved so people with Dementia are better able to orientate themselves.
- Information to enable clinician’s to better care for patients with Dementia is available.
- Decision making is more structured and focused.

**Living well with dementia in care homes:**
- Improving communication and decision making processes has reduced admissions by 58.3% in four care homes.

**An informed and effective workforce:**
- Dementia Awareness training has been provided across all the sectors.
- Introduction of a multi-agency community assessment (MACA).

**Early intervention and diagnosis for all:**
- Evidence shows that early diagnosis and treatment of dementia helps people remain independent for longer and prevents unnecessary admissions into hospital or care homes.
- The memory management service is giving local people access to good quality assessment and early diagnosis and treatment of dementia.
- Formal shared care arrangement between specialist services and primary care introduced December 2013.

**Implementing New Deal for Carers:**
- Improved information about the key services accessed by people living with Dementia has been created and is available through the community teams.

**Future System Experience**
The case study on the next page shows how patients experiences will change over the next five years.
### Improve mental wellbeing & move towards parity of esteem

**Case study:** Doris is 83. She lives alone and is independent and active:

<table>
<thead>
<tr>
<th>Health Service response now</th>
<th>Integrated Health and Social Service response within 5 years’</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doris had a fall at home while in the garden. A neighbour calls an ambulance and she is taken to hospital.</td>
<td>Doris had a fall at home while in the garden. A neighbour calls an ambulance and she is taken to hospital.</td>
</tr>
<tr>
<td>Doris hasn’t been to the GP for a few months – she has been worried that she has been more forgetful and routine things have been more difficult for her.</td>
<td>Doris has had a named GP who has undertaken routine health checks and has diagnosed the early stages of dementia. She has care plan and has been attending the local Memory Service.</td>
</tr>
<tr>
<td>She is assessed in A&amp;E and following an X Ray is admitted with a fractured neck of femur.</td>
<td>She is assessed and following an X Ray is admitted with a fractured neck of femur.</td>
</tr>
<tr>
<td>The staff in A&amp;E do not have access to her clinical records.</td>
<td>Doris has a personalised care plan and the team at the hospital have access to her clinical records.</td>
</tr>
<tr>
<td>Following her operation Doris becomes very confused and is put on medication. She becomes even more confused and aggressive and her medication is increased. She is becoming dehydrated.</td>
<td>Following her operation Doris becomes mildly confused and the psychiatric liaison service provides advice on behavioural and environmental strategies.</td>
</tr>
<tr>
<td>Doris is frightened by the hallucinations she has been having and although the nurses have tried to reassure her she</td>
<td>A member of the Rapid Assessment Interface and Discharge service is involved from admission. The hospital ward is dementia friendly and Doris has been able to sleep and keep hydrated – which reduced her level of confusion.</td>
</tr>
<tr>
<td>After several days on the ward a referral is made to the Community Mental Health Team. Following assessment her medication was stopped and behavioural and environmental interventions recommended. Her confusion subsides.</td>
<td>There is a delay between referral and assessment as the Community Mental Health Team are based in a separate building and do not have dedicated staff to cover the hospital wards.</td>
</tr>
<tr>
<td>There is a delay between referral and assessment as the Community Mental Health Team are based in a separate building and do not have dedicated staff to cover the hospital wards.</td>
<td>Doris is discharged home after a few days, with support from the Integrated Team who assessed her support needs on discharge.</td>
</tr>
<tr>
<td>Doris is transferred to the Community Hospital for two weeks prior to returning home. Overall Doris has spent 5 weeks in hospital.</td>
<td>Doris is discharged home after a few days, with support from the Integrated Team who assessed her support needs on discharge.</td>
</tr>
<tr>
<td>Doris has been anxious to get home.</td>
<td>Hospital team confident that they can discharge Doris as she has good support from the GP / Integrated Team. Discharge processes have changed from ward based to ‘discharge to assess’. Doris is involved in reviewing her care plan.</td>
</tr>
</tbody>
</table>
Improve mental wellbeing & move towards parity of esteem

Our priorities for improving mental wellbeing & moving towards parity of esteem are:

• Provide consistently high quality and safe care, seven days a week.
• Deliver the best outcomes and is clinically and financially sustainable.
• Reduced health inequality.
• No health without mental health - parity of esteem.
• Develops integrated health and social care:
  • Risk stratification to pro-actively identify people with complex needs including dementia
  • Joint assessment and joint support planning
• Improves the quality of care in residential and nursing homes.
• Improves services for people with Dementia (early diagnosis, carer support, advice and information).
• Improved outcomes for people with Learning Disabilities
  • Joint commissioning and pooled budgets
  • Early diagnosis of Autism
• Improved access to psychological therapies.
• Improved services for carers.
Improve elective care to maximise quality, outcomes & value

Our milestones are:

By end 2014/15
- Implement RSS
- Commission alternative ENT and community dermatology pathways
- Review cardiology and diagnostics

By end of 2015/16
- Implement the findings from the Cardiology and diagnostics reviews

By end of 2016/19
- Implement specialised services to run from centres of excellence
- Create a step change in the productivity of elective care

The aim of this programme is to reform elective care ensuring that good quality care is provided in the right place at the right time by the right person, first time. The need for strategic planning on a broader footprint than the CCG has been acknowledged for specific workstreams. We are participating in a West Yorkshire Review for some key services including:
- Urgent and emergency care.
- Stroke.
- Cancer
- Paediatrics

The strategy for the West Yorkshire Review (called 10CC) can be found in Appendix 1.

In relation to Specialised Services, the CCG is working with NHS England to develop Specialised Services. The outline strategy for specialised commissioning is shown in Appendix 2.

In addition CCGs and acute hospital trusts within the Northern Yorkshire and Humber (NYH) region are working proactively to consider the implications of transformational change on clinical networks, alliances and joint integrated working.

On top of these transformational changes are the background of a rise in elective care with outpatient referrals currently rising by 13.8% compared to 2012/13. Commissioning for Value has adopted the NHS Right Care approach, which is to focus on clinical programmes and identify value opportunities, as opposed to focussing on organisational or management structures and boundaries. The process began with a review of indicative data to highlight the top priorities (opportunities) for transformation and improvement. Triangulation of the data balances Quality, Spend and Outcome and ensures robust assessment.

The programme areas that appear to offer the greatest opportunity in terms of both quality and spending are: Circulation Problems (CVD), Cancer and Tumours, Neurological System Problems, Respiratory System Problems and Musculoskeletal System Problems. In depth analysis of these priority pathways is being undertaken to determine the current and the optimal system for the service area.
Improve elective care to maximise quality, outcomes & value

We will work towards the 20% productivity improvement requirement in elective care over the next five years. Improving access to services electively will, in the long term, reduce demand for urgent and non-elective care as patients are treated earlier and more proactively for a range of conditions. Through pathway redesign, clinically-led reviews and innovative commissioning, we will drive productivity and efficiency. We have identified a number of interventions which are either being or will be implemented by 2019:

Review referrals
We are implementing a referral management systems to stem the rise in elective care to reduce unwanted variation in referrals. Using experience from other areas we will use this tool to identify new areas where there is ambiguity in the pathways, or to identify unmet need.

Shift parts of elective care into the community and improving access
We have already identified an opportunity for repeat PSA testing to be performed and monitored within General Practice rather than by secondary care. We will scope the potential to bring elective care closer to home by offering assessment clinics prior to surgery. We will look at diabetic outpatient services to explore whether there are opportunities to move more care into practices, and ensure care is delivered closer to home.

Enhance GP decision making support
We are reviewing our pathways and thresholds so that GPs have the right information at the right time in order to make better decisions as patients navigate either urgent or planned patient pathways.

Implementing Patient Decision Aids
We have already embarked on a pilot of Patient Decision Aids for GPs and are exploring other opportunities for their use in secondary care and other settings (e.g. optometrists). We recognise that patients who have better information make better decisions and are happier with the outcome. We will learn from these pilots to ensure more patients are supported.

Review End of Life Care
Ultimately our aim is to be able to maximise patient choice by providing as much treatment and support in the home or community as possible through an integrated, multidisciplinary community-based team. This would include:

- Agreed care plans for patients, with a quarterly review of care plans
- Shared electronic record designed to improve end-of-life care and help patients to die in the location of their choice
- More patients die in their place of choice: as those involved in care are aware of the patient’s wishes
- Less frequent A&E attendances for patients
- Decreased hospital admissions

This would support the NHS Constitution pledge that “You have the right to be involved in discussions and decisions about your health and care, including your end of life care, and to be given information to enable you to do this.”
Improve elective care to maximise quality, outcomes & value

Our priorities for improving elective care are:

- Improved health outcomes
- Better access
- More patients managed in primary care
- Sustainable delivery of productivity improvements
- More patients meaningfully engaged in making decisions about their care.
Ensure equal opportunities to live healthy active lives

Our milestones are:

By end 2014/15
• Implement Stop Before your op pathway
• Review the social prescribing project

By end of 2015/16
• Implement the carers pathway
• Embed preventative lifestyle pathways

By end of 2016/19
• The Community to engage more in its health
• Develop better access to preventative services for health professionals

We know that there are health inequalities within our district with a difference in life expectancy at birth for the most to least deprived areas of 5.9 years for males and 3.9 years for females. We also know that there is a rising tide of conditions anticipated to become more prevalent in the future that will impact upon long term conditions, notably obesity, diabetes and dementia. Smoking, obesity and alcohol are the three major causes of preventable cancers, lead to cardiovascular disease, and are major contributors to health inequalities. Reducing smoking, increasing physical activity and reducing alcohol all help prevent or reduce the complications from those conditions, including dementia and diabetes and have a positive impact on mental health wellbeing.

The North Yorkshire Health and Wellbeing Strategy used evidence from the JSNA that highlights a number of behaviours for change including:
• Tackling the wider determinants of health.
• Improve partnership working.
• Make better use of community assets.
• Prevention is better than cure.
• Achieving better outcomes with less money.

Priorities identified in the Health and Wellbeing Strategy are:
• Ill health prevention
• Healthy and sustainable communities
• People with long-term conditions
• Children and young people
• Emotional health and wellbeing
• People living with deprivation

The CCG has aligned its strategic priorities with these areas such as vulnerable people, long term care, primary care and urgent care programmes (e.g. reducing social isolation through care closer to home and integration, engaging with the North Yorkshire carers strategy to help people manage their long term conditions, reducing admissions for long term conditions). However, for the purposes of this programme we have focused on partnership working for health improvement and reducing health inequalities. We are working to ensure that the Equality Delivery System 2 (EDS2) is implemented locally.
Ensure equal opportunities to live healthy active lives

Working in partnership with the Health and Wellbeing Board our programme has identified priorities for action and will work with the North Yorkshire public health team to using the principles set out in Commissioning for Prevention:

**Reduce the prevalence of smoking**
Practices are actively involved in offering smoking cessation services and referral to specialist stop smoking services. We are developing a plan to implement ‘Stop Before your Op’ – to reduce smoking in people undergoing elective surgery. We know that people are more likely to make behaviour changes when faced with an illness, that smoking increases complication rates from surgery, and that stopping smoking before surgery reduces those complications to the same as a non-smoker.

**Reducing the prevalence of obesity**
There has been a lack of obesity and weight management services locally. We will work with North Yorkshire Public Health to help develop and implement weight management services in the community. Our role can be more strategic by helping develop pathways, and operational by identifying patients who are obese and referring to services.

**Reducing harmful and hazardous drinking**
Identification of patients who drink at harmful levels with brief advice already occurs with new patients registering at practices.

However, we recognise that more identification and evidence based brief intervention is needed. We will contribute to the development of the North Yorkshire Alcohol strategy (due Spring 2014) and to its implementation.

**Reduce health inequalities**
We know that lifestyle factors contribute to preventable causes of health inequalities. We will ensure interventions are targeted to where the need is greater, and that vulnerable groups are not marginalised. Cardiovascular disease and cancers remain the largest cause of difference in death rates between the most and least deprived areas within Harrogate District. We have supported and will work with partners around the development of community navigators within North Yorkshire to ensure people who need further support to manage lifestyle risk factors equal opportunities. We will also ensure that NHS Health Checks uptake is increased across the whole population. Increasing uptake of NHS Health Checks fits with the National Audit Office recommendation to increase statins uptake, smoking cessation and drugs to reduce blood pressure as key interventions to reduce health inequalities.

**Develop a local response to the North Yorkshire Carers strategy**
The North Yorkshire Carer’s Strategy is currently being finalised.
Ensure equal opportunities to live healthy active lives

Our priorities for ensuring equal opportunities are:

• Working in partnership with the Health and Wellbeing Board.
• Reducing smoking prevalence.
• Reducing rates of harmful and hazardous drinking.
• Reducing rates of obesity.
• Reducing health inequalities.
• Local plan for carers.
We will bring care closer to home and improve quality and reduce variation in primary care

**Our milestones are:**
By end 2014/15
• Develop our primary care strategy
• Medicines optimisation
• Developed a co-commissioning model around primary care

By end of 2015/16
• Practices to work more closely together

By end of 2016/19
• Primary care to ensure it is sustainable and can cope with the scale and the shift from secondary care to primary care

Scaling up primary care’s ability to coordinate care for patients closer to home is key to the CCG’s ambition to increase integration of services and reduce unnecessary admissions to hospital. Primary care, with the correct resourcing, and strategic development, can play a more important role in improving health outcomes. This links with the Long term Conditions and Urgent Care programmes. Primary care in this context should not be just GP services, but incorporate community pharmacists and other parts of primary care.

On top of scaling up primary care, NHS England and CCGs have a joint responsibility to drive up all aspects of quality within primary care. We are applying to NHS England to develop a co-commissioning model locally.

HaRD practices consistently deliver high quality primary care with most (17/19) achieving higher than average England total QoF scores (2012/13), and CCG average for % patients who would recommend their practice being higher than England (86.2% vs 79.9%). There are no practices that have five or more outliers on the primary care web tool. However, there is variation across the CCG between practices which is multifactorial. For example the range in % patients recommending their practice is from 70.7% to 98.1%, and the range in differences in practice specific male and female life expectancy is 3.3 years and 4.2 years respectively (2006-2010 SOA weighted estimates).

The drivers to enable a change in primary care are through:
• An introduction of accountable GPs for older than 75s and an ambition to introduce this for other high risk groups in the future
• Co-commissioning of primary care with NHS England
• Risk profiling
• Case management
• 7 day working
• A review of locally enhanced services (LES)
• The shifting of money equivalent to £5 per head of population to primary care
• The Better Care Fund
• System resilience funding
We will bring care closer to home and improve quality and reduce variation in primary care

We are working in partnership with NHS England to develop our primary care strategy. The prime focus is on three areas:

- Ensure continual improvement and reduce variation.
- Develop an integrated system necessary to deliver sustainable healthcare.
- Ensure Primary care is skilled and has the capacity to be part of integrated care teams and community hubs.

Following a workshop facilitated by NHS IQ which 41 local GPs and Practice Managers attended along with the NHS England Area Team, we have agreed the four aims which will underpin our achievement of those goals:

- Workforce development
- Improving mental health
- Reducing avoidable admissions
- Access to primary care

We used the NHS Quality and Service Improvement driver diagrams tool to generate the ideas collaboratively.

Workforce development

It is not only the scale of primary care that needs to change. The shape of primary care is changing and we need to ensure we have the right skill mix available at the right place at the right time. This means we need to work with the Area Team to determine what the primary care workforce should look like, and assess whether the current workforce meets this need, and if not, how we will ensure it can. Work through the Alliance can help reduce duplication and free up more clinical time.

As part of this we will need to continually improve the competence of the workforce leading to continuous improvement in quality and reduction in variation.

This will involve working with the Area Team to review how intelligence around the quality of primary care can be improved and shared, to identify potential areas of improvement, and consequently putting in place quality improvement programmes for example through peer support and challenge between practices.
We will bring care closer to home and improve quality and reduce variation in primary care

**Improving Mental Health**

The need to increase the capacity within primary care around mental health, with greater collaboration between specialist services and primary care to improve the diagnosis and management of people with mental health issues was recognised.

**Reducing avoidable admissions**

The part that primary care plays in this important agenda is recognised. It cross references to the need to develop the workforce, care planning, integrated teams development, 7-day working and consistent pathways across all primary and secondary care.

In doing so we want to create an environment which enables primary care to play a greater role, as part of an integrated system of care, in:

- Proactive co-ordination of care, particularly frail elderly, people with long term conditions and complex health problems.
- Shifting the balance of care from unplanned to planned care.
- Ensuring fast responsive access to care which prevent avoidable A&E attendances and emergency admissions.
- Ensuring patients are more fully managing their own conditions.
- Ensuring high quality, safe and effective care.

**Access to primary care**

As part of increasing the sustainability of primary care, and improving patient experience, we need to ensure that access to appropriate advice for patients is timely. Better use of clinical time dealing with urgent needs frees up capacity to improve more long term outcomes. There are various drivers which can help facilitate this including improving more self-management, use of assistive technology and greater sharing of records.

Our priorities for bringing care closer to home through our primary care strategy are:

- Ensure continual improvement and reduce variation.
- Develop an integrated system necessary to deliver sustainable healthcare.
- Ensure Primary care is skilled and has the capacity to be part of integrated care teams and community hubs.
We will bring care closer to home and improve quality and reduce variation in primary care

Our priorities for bringing care closer to home are:

• Ensure continual improvement and reduce variation.
• Building on our expression of interest in co-commissioning primary care
• Develop an integrated system necessary to deliver sustainable healthcare.
• Ensure Primary care is skilled and has the capacity to be part of integrated care teams and community hubs.
Improvement interventions

We have modelled how we anticipate our improvement interventions impacting on activity based on realistic assumptions to meet our 2014/15 financial gap. The modelling has used sensitivity analyses so that we understand the tolerance.

<table>
<thead>
<tr>
<th>Harrogate and Rural District CCG</th>
<th>Plan Date:</th>
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<tbody>
<tr>
<td><strong>Strategic Programme</strong></td>
<td><strong>Improvement Interventions</strong></td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
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<tr>
<td>Urgent Care Centre Review including:</td>
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<tr>
<td>GP OOH Review</td>
<td>Review</td>
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<td>NHS 111</td>
<td>Review</td>
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<td>A &amp; E</td>
<td>Review</td>
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<td>Paediatric Review</td>
<td>Review</td>
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<td>DVT Pathway</td>
<td>Preparation</td>
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<td>BCF Fund:</td>
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<tr>
<td>Intermediate Tier Service, HDFT/NYCC</td>
<td>Planning</td>
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<tr>
<td>CAT &amp; Telehealth, HDFT/NYCC</td>
<td>Planning</td>
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<tr>
<td>Care Planning</td>
<td>Implementation</td>
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<tr>
<td>Community Services Review</td>
<td>Review</td>
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<td>Integrated Care Teams &amp; Self Care</td>
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<td>Risk Stratification</td>
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<td>Accountable GP for over 75s</td>
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<td>Care Home - GP link</td>
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<td>Review of ENT, dermatology, and ophthalmology</td>
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<td>Referral Management (including POLCV and threshold for hip, knee)</td>
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<td>Referral Management data to practices including price list and meetings</td>
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<td>Other Acute Contracts</td>
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<td>YAS</td>
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**Activity**
- Non electives >75 years

**Financial impact**
- £464k: elderly medicine, general medicine, trauma and orthopaedic specialities
- £750k: based on phased implementation targeting 11 specialities in first wave
- £1.705m: based on achieving best practice in the majority of specialities, supported by agreed clinical pathways
- £1.6m: across numerous schemes and health economy sectors
Direct commissioning

Not all the services accessed by patients in Harrogate and Rural District are commissioned by the CCG. In addition, NHS England commissions primary care services, specialised services, services for members of the armed forces and offender healthcare. It has 27 local area teams but acts as one single organisation operating to a common model with one board.

Commissioning of public health services is carried out by Public Health England (PHE) and local authorities, although NHS England commissions, on behalf of PHE, many of the public health services delivered by the NHS.

Public Health
The public health services NHS England commissions directly are:
- National immunisation programmes.
- National screening programmes.
- Public health services for offenders in custody.
- Sexual assault referral centres.
- Public health services for children aged 0-5 years (including health visiting, family nurse partnerships and much of the healthy child programme).
- Child health information systems.
- Work is also in hand on developing single operating models for the commissioning of offender health, military health and specialised services.

Primary Care
NHS England is also responsible for primary care support services (also known as family health services) and is currently running a transformation programme which will change the way these are provided.

In addition the Area Team are reviewing priorities in medical, dental, pharmacy and eye care focusing on workforce planning (recruitment, retention, skill mix, continuous professional development) and the contribution all professional groups can make to the shift of work from secondary care to primary care.

The CCG has submitted it’s proposal to become co-commissioners of primary care.

Specialised Commissioning
Specialised services are healthcare services commissioned by the NHS for patients with rarer health conditions and diseases. They are provided by a small number of specialist centres typically covering populations of more than one million people.

The conditions treated range from long-term conditions such as renal (kidney) disease, some mental health conditions and neonatal care, to more specialised treatments for uncommon cancers, burns care, medical genetics, morbid obesity surgery, cardiac surgery and some children’s conditions.

Nationally, 143 specialised services have been defined. These are grouped into 74 Clinical Reference Groups (CRGs) and five National Programmes of Care (NPoCs):
- Internal medicine: digestion, renal, hepatobiliary and the circulatory system
- Cancer and blood: infection, cancer, immunity and haematology
- Trauma: traumatic injury, orthopaedics, head and neck, rehabilitation
- Women and Children: women and children, and congenital and inherited diseases
- Mental Health

Since April 2013, the direct commissioning of specialised services has been carried out by NHS England through the North Region Specialised Commissioning Team, which has a catchment population of approximately 5.7 million, encompasses 23 Clinical Commissioning Groups and has contracts with 37 providers.

A summary of the Yorkshire and Humber Specialised Services plan is shown in Appendix 2.
Transformational change – making it happen

Change Model
• Improving people’s lives and experience of care is at the heart of what matters to us and helps to drive the change we want to see.
• Digital and other technologies create opportunities for new and innovative service models.
• The NHS currently faces massive financial challenges.
• Our aging population and increasing rates of multiple morbidities have created a higher demand for health, care and integrated services.
• Our current speed of change across health and social care, including the spread and adoption of innovation is too slow.

The NHS Change Model has been developed to provide a common framework for delivering a service that is agile and sustainable in the face of these challenges.

• Engagement to mobilise: building commitment around a shared purpose
• Leadership for change: building commitment around a shared vision
• Spread of innovation: the spread and adoption of good practice and evidence based solutions
• Improvement methodology: using an evidence based model such as Lean or Total Quality Management
• Rigorous delivery: programme management

information available so that patients can exercise choice
• System drivers: incentivising change

We have access to a range of improvement tools through NHS Quality Improvement.

Programme Management Office (PMO)
Programme and Project Management is supported by North Yorkshire and Humber Commissioning Support Unit, based on Prince2 and Managing Successful Programmes principles. Lean methodology is applied to any project that requires change and process improvement.

The overarching principles will be of “task and finish” projects with rapid implementation. The PMO provides:
• Continuity and maintenance of standards.
• Overview and scrutiny of all delivery activity within the organisation.
• Increased skills development and transfer.
• The ability to share lessons learned between the initiatives.

Innovation
Many of the initiatives outlined in this plan have been tried and tested in other parts of the country e.g. Urgent Care Centres, Integrated Teams, Rapid Assessment Interface Discharge, IAPT. They have been evaluated in terms of their specific health economy we know that by adopting them the health system becomes more productive – and we can deliver more health benefit within the resources available to us.

The adoption and diffusion of new models and technologies traditionally takes a long time to roll out in the NHS. We will use multiple levers to remove the barriers to success:

• National requirements: policy, regulation, incentives, CQUIN, procurement.
• Participation: patient and public demand for quality and accessibility, for transparency, for information.
• Collaboration: commissioners, providers, voluntary and community.

Organisational Development
Ultimately, transformational change can happen if we have a workforce which is engaged and committed to new ways of working across organisational boundaries. We are working with partners around changing clinical behaviours. This is in the primary, secondary and community settings leading to fully integrated care.
Transformational change – making it happen

**Map of Medicine**

**Issue:** a need to ensure clinicians were able to apply best practice to local care approaches

**Action taken:** localised care maps developed using the Map of Medicine tool

**Outcome:** Clinicians are able to quickly access locally agreed, best practice pathways at the point of care

To enable clinicians to always apply best practice to local care, North Yorkshire and Humber Commissioning Support Unit (CSU) have provided the CCG advice and support in developing localised care maps in the Map of Medicine tool. Map of Medicine provides local health communities with customisable care maps, consolidating local service information and best practice into easy to use, online flow charts. It offers the following benefits:

- Reduced unwanted variations in care.
- Reduced unplanned admissions.
- More appropriate referrals.
- Adherence to QOF defined best practice.
- Continuing professional development.

Examples of pathways the team are currently developing include diabetes, COPD, heart failure, dementia and MSK management.
Transformational change – making it happen

Research

GP practices within the CCG collaborate with the Primary Care Research Network, participating in various pieces of original research each year. The Northern and Yorkshire Primary Care Research Network (PCRN) has recently recruited its 500,000th patient into primary care research studies. This is a significant milestone for the team, one of eight regionally-based local research networks making up the National Institute for Health Research Primary Care Research Network in England and working to support research to make patients better and improve the NHS.

The Northern and Yorkshire team are hosted by the North Yorkshire and Humber Commissioning Support Unit. They primarily work within GP practices to support GPs undertaking research. Practical support available from the team includes:
• reducing red-tape in setting up studies;
• enhancing NHS resources by funding the people and facilities needed to carry out research on the ground;
• helping researchers to identify suitable NHS sites and recruit patients to take part in research studies; and
• advising researchers on how to make their study work in the NHS primary care environment.

In our CCG, we have eight practices (40%) actively recruiting into up to 13 NIHR research projects with three other practices having also expressed an interest to recruit. Accruals (patient recruitments) increased from 568 in 2011/12 to 864 in 2012/13.

Practices also have the opportunity to feed up ideas regionally for new research projects. Harrogate and District NHS Foundation Trust is involved in a number of research studies. In 2012/13 there were 71 recruiting studies, covering 17 different clinical specialties and involving 2043 patients, aiming to ensure that all treatment given is based on the best research evidence.

This represents a significant commitment to research locally and a positive baseline against the Yorkshire and Humber Academic Health Science Network aim to increase participation in studies by working with patients, public and partners to measure and promote involvement in research. The CCG is a member of the network.
Summary

This strategy sets out an ambitious plan for improving healthcare in Harrogate and Rural District in particular integrating out of hospital care. We need to move quickly to implementation in order to make early improvements in care for our patients and to realise the scale of savings.

We have started implementing some of our initiatives and key enablers. Others will be implemented over the next 12 months. As a result of our plan patients and the public can expect to see over the next three to five years:

- A fully functional 7 day urgent care centre.
- Integrated teams support more people to be at home.
- Specialised services are in centres of excellence.
- There has been a step change in the productivity of elective care.
- The health gap between people who have mental health conditions and those who do not, will be reduced.
- The community is more engaged in its health and wellbeing.
- Health professionals have more access to preventative services.
- Primary care has the scale to cope with the shift from secondary care and is more sustainable.

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Appendix 1: 10CC West Yorkshire Chapter

Introduction

In 2013 the West Yorkshire Commissioning Collaborative known as 10CC was established to enable the ten member Clinical Commissioning Groups (CCGs) to work with each other and the NHS England Local Area Team. It provides 10CC with a forum to make collective decisions on the planning, procurement and review of services provided for populations larger than an individual health economy, where there are cross boundary implications and clear benefits can be achieved.

10CC have initiated a programme of work to plan and commission collectively for specific health services in collaboration with other public bodies. This recognises that there are opportunities to improve outcomes for patients if the healthcare system is looked at from a broader geography, extending beyond the current units of planning and individual CCGs. Harrogate and District CCG have been included as an associate to the programme, recognising the potential impact on a significant proportion of their population.

This chapter represents the progress and engagement of the programme to date. During this phase we have engaged with a limited group of commissioners and providers who contributed knowledge and views reflecting local engagement.

The next phase of the programme – "Engagement and Decision-making" – recognises the significant levels of broader stakeholder consultation and engagement required to test, develop and evolve the strategy prior to implementation. This approach recognises the need for effective communication and engagement described in the constitutions of the participant CCGs. As the programme develops a mechanism will be put in place to secure structured provider, clinician, public, patient and carer engagement.

The document sets out a five year strategy for the population of West Yorkshire for the following priority areas:

• Stroke;
• Cancer Services;
• Emergency/Urgent Care; and
• Paediatrics.

This chapter is a strategic statement of intent for the eleven CCGs. It sets out our guiding principles as healthcare organisations in West Yorkshire and a cohesive vision for each of the four priority areas. It articulates our aspirations and describes how we intend to use our resources to provide safe, high quality and sustainable health services in order to deliver improved health outcomes for the people of West Yorkshire. The chapter concludes with an overview of the mechanism that will be used to deliver our vision.

A more detailed version of this chapter is available on request. This provides:

• Additional contextual information about the population of West Yorkshire, the make-up of the health system and the challenges it faces;
• Detailed versions of the strategies for each priority area that include more information about the potential benefits that can be delivered;
• Further information on the next steps including risks to delivery.
Our Values

In order to deliver against the vision for each of the priority areas, the following principles and values will be used to guide the development of opportunities outlined in this chapter:

• Work collegiately to drive forward opportunities where we have potential to improve service quality and safety, increase efficiency, or reduce costs;
• Ensure consistency / alignment between Health and Wellbeing strategies and individual CCG / Units of planning commissioning strategies and plans;
• Guide opportunities by a clear understanding of the populations needs, diversity, existing inequalities, and evidence based practices;
• Focus on prevention and early intervention at every opportunity ensuring that consideration is taken of the role of building community capacity and self-management in developing models of care / pathways;
• Ensure that where appropriate as much care as possible is provided closer to home and outside of hospital and institutional settings;
• Ensure that the voice of the patient is at the heart of the programme, putting patients first, not organisations;
• Work with third sector and cross-regional organisations, such as the Local Education and Training Board (LETB), NHS England Local Area Team, Strategic Clinical Networks to ensure they are consulted and informed in the work of the Programme;

• Provide a strong focus on leading edge practice, innovation and the use of technologies to continuously improve services;
• Be transparent and open with regard to the challenges we face and in sharing our cost saving schemes;
• Commit to represent each other positively and treat each other with mutual respect;
• Take action as necessary to ensure that decisions are implemented and benefits realised quickly; and
• Commit necessary resources and support to the programme in a timely fashion, working to agreed deadlines and honouring our individual roles and responsibilities.

The following sections contain the first drafts of the evolving strategies for each of the priority areas. These describe how the CCGs, NHS England, the clinical networks, and providers across West Yorkshire are committed to working collaboratively together to deliver against a shared vision.

These complement national / local strategies and recognise that there is a significant opportunity to plan and commission health services on a broader footprint to improve outcomes for patients, the health and wellbeing of the population, and the sustainability of the health system.

Stroke Strategy

Stroke is the third leading single cause of death in the United Kingdom and has a devastating impact on the lives of people in West Yorkshire, their families and carers. Although the incidence of stroke is declining, stroke survivorship is creating significant challenges to the health and social care system, the society – and most importantly – stroke survivors, their families and carers.

The health economy across West Yorkshire is already responding to these challenges through a number of initiatives. These include the work of the Yorkshire and The Humber Strategic Clinical Network for Cardiovascular Disease, hospital participation in The Sentinel Stroke National Audit Programme, the rollout and application of the GRASP-AF (Atrial Fibrillation) risk profiling tool and the implementation of a variety of local Clinical Commissioning Group (CCG) initiatives. These initiatives are having a positive impact on people’s lives.
The 10CC and its key stakeholders are committed to working collaboratively together to deliver against the shared vision for stroke:

“To reduce the incidence of stroke and avoidable deaths due to stroke, across the West Yorkshire 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.”

This draft of the strategy focuses on how we can work together to adopt a coherent and consistent approach to stroke prevention. As this strategy evolves, it will articulate our commitment to improvement in the other stages of the stroke pathway.

Development and implementation of a strategy for the prescribing and management of anti-coagulation for known patients with AF

We know that the prevalence of AF across West Yorkshire is considerable - approximately 10% of people who are admitted into hospital with a stroke have AF. These patients stay longer in hospital. It is widely recognised that the presence of AF can increase the risk of medical complications following stroke and that it has a greater impact upon the quality of life for stroke survivors.

By developing and implementing an evidence-based strategy to the prescribing, management and monitoring of anticoagulant medication, we believe there is the potential to improve the management of AF to reduce the incidence of stroke. The strategy will aim to increase the prescribing of appropriate anticoagulants for known patients with AF.

This will be built on the guiding principles of patient choice and control, personalised care planning, self-care and ownership of treatment. This will also deliver an effective and sustainable model of support for people on anticoagulants. This will be flexible to future advancements in medication and deliver care closer to home when it is safe and cost effective to do so. As part of the strategy, we will ensure that healthcare professionals have access to specialist input into patients’ care.

Improving the management of patients with hypertension

Hypertension is the single most common cause of stroke. Across West Yorkshire the prevalence of hypertension is high and approximately 18% of stroke admissions to hospital have a secondary diagnosis of hypertension. We also know that within primary care there is unwarranted variation in the diagnosis and management of hypertension across West Yorkshire.

We will initiate a programme of work that provides additional support and guidance to primary care to improve the management of patients with hypertension. This work will focus on identifying and managing high risk and difficult to control patients. We will also ensure that primary care has access to specialist input into a patients’ care so that they receive the highest quality of care and to reduce their risk of stroke.

A single voice of commissioners within Health and Wellbeing Boards

We know that certain lifestyle factors increase the likelihood of stroke. West Yorkshire is significantly behind the national average across a number of key indicators, as highlighted by the Public Health framework. These include adult obesity, smoking prevalence and the percentage of physically active adults. Encouraging our people to make healthy lifestyle choices is critical if we are to reduce the incidence of stroke.

We will work together to develop a single voice across Clinical Commissioning Groups to engage Health and Wellbeing Boards in the stroke prevention agenda. This has the potential to influence what public health services are commissioned at a local level, how local policies are set and to shape what service providers of health care offer around lifestyle management. By pro-actively exerting influence in these areas, there is an increased chance of raising awareness across communities of the lifestyle factors that increase the risk of stroke. This will influence people to make healthy lifestyle choices.
We have identified two key critical enablers to help us to deliver against our vision

We will ensure that healthcare professionals have quick and easy access to specialist advice and support. This will enable specialist input a patient’s treatment without requiring a face-to-face appointment, delivering an improved patient experience and optimal management of their condition. This will leverage rather than constrain the talents and energies of the broader healthcare workforce.

We recognise the critical role that general practice plays in supporting patients to manage long term conditions that increase the risk of stroke. We are committed to securing continuous improvement in quality and reducing variation across practices. We will proactively build on our understanding of the quality and unwarranted variation and seek out opportunities to continually improve it. This will involve working with the Local Area Team to review intelligence around the quality of primary care to identify potential areas of improvement, and consequently putting in place innovative quality improvement programmes, for example through peer support and challenge between practices.

Cancer Services Strategy

Over 265,000 people in England are diagnosed with cancer every year and around 130,000 die from the disease. This diagnosis figure is projected to rise to 300,000 by 2030. The expectation of greater longevity, following diagnosis, is due to the availability of new treatments. The estimated total UK cancer expenditure was £5.86 billion in 2009/10 which makes cancer the third largest area of health expenditure. Despite recent improvements in survival rates, cancer outcomes in England remain poor when compared with the best outcomes in Western Europe and a significant gap remains in both survival and mortality rates.

In 2010 there were 11,500 new cases of cancer diagnosed across West Yorkshire. The local prevalence of cancer by type is consistent with the national picture. In line with the national trend, between 1996 and 2010, there has been an increase in the overall incidence of cancer in West Yorkshire. By 2022 it is predicted that there will be 14,000 new cases of breast, bowel, lung and prostate cancer alone.

The 10CC and its key stakeholders are committed to working collaboratively together to deliver against the shared vision for cancer services:

“To provide world class cancer services that deliver improved outcomes and survival rates of the patients of West Yorkshire such that they meet and where possible exceed those of comparative global healthcare systems.”

This strategy’s focus rests upon improved smoking cessation and preventing people starting smoking, early diagnosis of cancer, the rapid access to that diagnosis, and, ultimately, improving survivorship. The specific opportunities for collaboration are grouped into themes which concentrate on the four main cancers, by prevalence and expenditure, which are: Bowel, Breast, Lung and Prostate cancers.

Early Diagnosis - Awareness & Education

We will work collaboratively to increase early diagnosis rates for cancer by improving the education and awareness of both healthcare professionals and the public. We will focus on raising local public self-awareness through campaigns increasing initial presentations to GPs and screening rates. The further education and training of healthcare professionals will enable an appropriate response to patients. Through embedding evidenced based assessments we will ensure consistency in direct access, assessment and referrals processes. The benefits of these opportunities include an increased probability of appropriate referrals, earlier cancer diagnosis and improved patient survival rates.
Rapid Access to Diagnosis

The aim of achieving earlier diagnosis and treatments for patients will be accomplished through improving access to leading edge, early diagnostics and detection services. A system wide review of the current access to diagnostics, and the existing diagnostic processes, will be undertaken and the recommendations implemented. It is anticipated that the review will highlight opportunities to provide near patient testing, rapid access to diagnostic staging, implement straight to test tumour site pathways, and move away from sequential testing where it is not appropriate. By providing rapid diagnoses there is the potential to reduce waiting times, and improve survival rates and efficiency.

Smoking Prevention

Smoking is the single largest preventable cause of cancer mortality, accounting for around one third of all cancer deaths, with West Yorkshire having one of the highest national prevalence rates. Studies suggest that there is a positive correlation between raising public awareness and the earlier diagnosis of lung cancer.

We will work together to develop a single voice across Clinical Commissioning Groups to engage Health and Wellbeing Boards to fund preventative services and reinforce healthy lifestyle choices. This will maintain a public health focus on smoking cessation and promoting the benefits of never starting smoking. The introduction of incentivising improved outcomes will contribute to strengthening the whole system approach to a reduction in the prevalence of smoking. We will also implement General Practice regional benchmarking to create a competitive environment that encourages GPs to support patients to maintain a healthy lifestyle and stop smoking.

Survivorship

We will improve services that support patients, carers and their families beyond the diagnosis and treatment of cancer. This will minimise the physical, psychosocial and the economic impact of the disease. We want to enhance patient health and well-being and reduce the burden of follow-up care on the health system by commissioning follow-up pathways for those patients at greatest risk of cancer recurring, supported by a ‘recovery pack’. We will design follow-up treatment pathways to address the holistic recovery of the patient limiting the broader impact of cancer beyond the medical treatment of the condition.

Through developing and implementing remote patient monitoring, patients’ conditions will be proactively and regularly reviewed. Monitoring will be supported by follow-up pathways that facilitate rapid access to secondary care and treatment, where it is needed. Consequently, patient independence, wellbeing and quality of life will improve.

Urgent and Emergency Care Strategy

The need to improve urgent and emergency care services has been set out as a clear case for change described in the national review (Keogh, NHSE 2013). The reasons for the growing pressures that emergency departments are experiencing have been well rehearsed. Two things in particular are often cited:

“Firstly, an ageing population with increasingly complex needs is leading to ever rising numbers of people needing urgent or emergency care. Secondly, we know that many people are struggling to navigate and access a confusing and inconsistent array of urgent care services provided outside of hospital, so they default to A&E. The reality is that millions of patients every year seek or receive help for their urgent care needs in hospital who could have been helped much closer to home. The opportunities for bringing about a shift from hospital to home are enormous. For example, we know that 40% of patients attending A&E are discharged requiring no treatment at all; there were over 1 million avoidable emergency hospital admissions last year; and up to 50 per cent of 999 calls requiring an ambulance to be dispatched could be managed at the scene. To seize the opportunities these numbers present, we will need to greatly enhance urgent care services provided outside of hospital.”
The review confirmed and summarised several clear themes:

- Demand for urgent care services is rising as are people’s expectations;
- People find the current urgent care system confusing;
- There are many opportunities for meeting people’s urgent care needs closer to home;
- The term ‘A&E’ – is widely used to describe very different services.

Within the national and local context a number of health economies across West Yorkshire are already grappling with and responding to this agenda. Two strategic reviews of services are already underway - Mid Yorkshire Hospitals Trust (Meeting the challenge) and Calderdale and Huddersfield Health and Social Care Strategic Review (Right Care, Right Time, Right Place). These have major implications for future provision of urgent care across West Yorkshire.

Additionally, the Yorkshire and Humber Academic Health Sciences Network (AHSN) has identified urgent care as a priority in their two year operational plan. The Improvement Academy (IA) sits within the AHSN and offers a region-wide clinical improvement network using proved methodologies to deliver change and improvement in health care services.

In the absence of a Specialist Clinical Network (SCN), the first priority has been to establish a West Yorkshire Urgent and Emergency Care Network. The network has brought together a group of representative stakeholders from the existing five Urgent Care Working Groups in West Yorkshire plus Harrogate, with the common purpose of planning and delivering improvements in urgent and emergency care services in the context of the recent national review.

The network will ensure collective responsibility and co-operation across the footprint of the 10CC in developing urgent and emergency care services in the context of Everyone Counts: Planning for Patients 2014/15 to 2018/19 (NHSE 2013) and Transforming urgent and emergency care services in England (end of phase 1 report, NHSE 2013).

A number of priorities have been agreed:

1. To gain an understanding of the current and possible future urgent and emergency services within WY;
2. To support the transformation of Yorkshire Ambulance Service (YAS) to deliver the vision of more care delivered closer to home and less people being transported to hospital;
3. Consideration of the future model of out of hours primary care should be included in the scope of the network.

It is recognised strategically by the network that the West Yorkshire offer will be developed in line with the expectations of the national review (NHSE 2013). The aspiration is that our population will be able to access enhanced primary and community care services and will learn through their consistent experience of these services, that attending emergency departments (ED) (A&E) is only needed in the case of a medical or trauma related emergency. This may mean that the current number, type and location of emergency departments could change.

The opportunities are in their initial stages of development and require broader provider, public, patient and carer involvement. This is in line with the commitment to effective engagement and communication which is enshrined within each CCG’s constitution.

**Gaining an understanding of the current and possible future urgent and emergency services across West Yorkshire**

The network, on behalf of the 10CC, will bring together a detailed picture and understanding of:

- patient flows;
- the number and location of emergency and urgent care facilities;
- the services they provide;
- the urgent and emergency health care needs of the WY population.
This will inform the future strategy regarding the structure and function of the components of the urgent care system across West Yorkshire. Phase 2 of the national review is expected in summer 2014. This will provide further guidance for commissioners on implementation.

**Supporting the transformation of Yorkshire Ambulance Service**

The national review phase 1 report described the untapped potential of ambulance services and the opportunity to transform them from a transport to a treatment service, functioning as an integral component of an urgent care network. The desired strategic direction for YAS is to bring about change in the operation, culture and workforce in order to deliver more ‘hear and treat’ and ‘see and treat’ resulting in less patients conveyed to hospital.

The network will have to support the CCGs in developing guaranteed and timely access for YAS to patient information and care plans; to primary care, mental health provision, social care and specialist advice 24/7.

**Future model of out of hours primary care**

Out of hours primary care is currently commissioned across West Yorkshire as a sub contract of the NHS 111 contract and runs until March 2018. It is proposed the network supports the lead commissioner in considering future options for this service as an integral component of the urgent care system.

**Paediatric Services Strategy**

There were over 3 million child (0-16) attendances in UK emergency departments in 2006/7. This figure rose to over 4.5 million by 2010/11. Owing to the current and projected birth rate of 8% the pressures on paediatric services will continue increase.

The increasing population will give rise to the number of children with disabilities alongside a growing prevalence of long-term conditions such as asthma, diabetes and epilepsy. In the UK there is a rising prevalence of obesity and mental health conditions in children. Compared to the rest of Western Europe the UK has moved from average to the worst position for ‘all cause’ childhood mortality and survival rates for childhood cancer. The NHS funding gap is projected at £30bn between 2013 /14 and 2020 /21, thus requiring service efficiencies to maintain financial sustainability.

The provision and transformation of high quality, safe services depends on a sustainable, competent workforce. The workforce shortages in West Yorkshire will result in a failure to meet Royal College of Paediatrics and Child Health Service Standards for Paediatric Units.

The 10CC and its key stakeholders are committed to working collaboratively together to deliver against the shared vision for paediatric services:

“To promote the best healthcare for Children and Young People in West Yorkshire through the provision of innovative, high quality, integrated and sustainable services in an appropriate environment that is as close to home as possible, allowing them to fulfil their potential and supporting the best health and wellbeing outcomes.”

The specific opportunities for collaboration are grouped into three main themes. These themes focus on the opportunities in the areas of Care Closer to Home, Configuration of Acute Services, and Appropriate Access to Urgent / Emergency Care Services.
Care Closer to Home

This theme focuses on the provision of services to sick children in the most appropriate setting. This opportunity aims to reduce pressure on acute services by preventing accident and emergency / short-term admissions and supporting the safe and earlier discharge of patients into an appropriate environment. Specific focus will be placed on community-based solutions to long-term complex and acute conditions. Access to Child and Adolescent Mental Health Services for Looked After Children will improve the quality and provision of emotional and mental health services for looked after children. Increasing access to specialist advice for Clinicians will provide community health professionals with rapid access to paediatric specialist advice.

Unnecessary accident & emergency attendances will be reduced through the improved provision of Parent/Carer Advice which will be achieved through the effective education and redirection of parents and carers to access that advice. The benefits include increased independence, confidence and empowerment in the self-management of long term complex and acute conditions for parents and patients.

Configuration of Acute Services

The focus of this theme is the identification and development of a sustainable service model for acute paediatric services. The aim of the theme is to address the known issues such as current and projected paediatric workforce shortages. This specific opportunity will focus on a strategic review of acute paediatric services across West Yorkshire.

Undertaking a strategic review of the acute paediatric service configuration across West Yorkshire will ensure the delivery of timely and efficient patient access to high quality health services and appropriate professionals with the knowledge and skills to treat and manage children. The benefits delivered will include a sustainable acute paediatric workforce model for West Yorkshire and long term service sustainability.

Appropriate Access to Urgent / Emergency Care Services

We will enhance current services and commission new services which provide fast and flexible access to appropriate advice and consultation within the community. This specific opportunity focuses on out-of-hours service provision. This will complement and enhance the existing out-of-hours primary and community paediatric care service provision across West Yorkshire. Consequently this provides parents and carers with a viable alternative to attending acute settings.

In addition to improving access to paediatric services out-of-hours, this would also channel demand away from pressurised acute environments and improve patient experience. A key benefit delivered by this will be the dissemination of paediatric knowledge and skills from paediatric specialists to other medical professionals and the community workforce increasing confidence within the whole system to manage and support conditions outside of hospital settings.

Next steps

The effective planning, commissioning and delivery of the proposed opportunities will require the development of a robust methodology to manage delivery and implement agreed changes. The number, scale and complexity of the opportunities is significant and these factors are compounded further when overlaid with an extensive stakeholder landscape.

Adopting a programme management methodology provides a framework to support the robust planning and implementation required to deliver the strategic objectives. It will facilitate the monitoring and reporting of actual progress and costs against plan, improving transparency, coordination and control, and delivering a seamless transitions to new ways of working and benefit realisation. The methodology will allow the effective co-ordination and control of shared resources across complex interdependent activities to work alongside existing change initiatives coordinating synergies and avoiding duplication.
Programme Organisation and Structure

A programme structure utilising the established Leadership teams has been proposed based on the approach used to develop the West Yorkshire chapter. It is anticipated that dedicated project teams will be required to support delivery. Teams will consist of a group of individuals with appropriate and complementary professional and technical skills to carry out the work detailed in their respective plans.

It is also envisaged that working groups to support delivery of the projects will be assembled as and when required. These will include representatives from a broad group of stakeholders including commissioners, providers, primary and secondary care clinicians and patient representatives.

Moving into the next phase of the programme

In mobilising the resources for the next phase of the programme in September we will place particular emphasis on developing strong links with patient representative forums and front line staff. Co-design of services is critical to the success of the programme. This will support the understanding of effects of proposed models of care on staff and patients.
Appendix 2: Direct Commissioning – Specialised Services

Context

- South Yorkshire and Bassetlaw Area Team currently hold contracts with 37 providers including Acute, Independent sector provider and Mental Health providers (for a full list, see Appendix 1).
- We have a contract portfolio of £1.2 billion and within our provider portfolio we have two of the largest specialised tertiary hospitals in the country.
- This can be split in the following ways:
  - 23 Acute Providers – 14 NHS and nine IS.
  - 14 Specialist Mental Health Providers – 8 NHS and 7 IS.
- There are broadly three sub-configurations of acute specialised services in Yorkshire and Humber, centred around the three centres of Leeds, Sheffield and Hull, which are broadly consistent with the areas covered by the three CCG Collaboratives and indeed the three NHS England Area Teams – West Yorkshire, South Yorkshire and Bassetlaw, and North Yorkshire and the Humber.
- In South Yorkshire, the two tertiary centres of Sheffield Teaching Hospitals and Sheffield Children’s Hospitals constitute the “hub” of specialised services, with a significantly more centralised model of care in place than in the other two sub-regions. This poses a challenge to the commissioning system regarding the potential de-skilling of the surrounding district hospitals, and raises questions about long-term viability and sustainability, which are being addressed through a formal collaborative work programme.

Strategic commissioning approach

As part of the ‘Call to Action’, NHS England is developing a five year strategy for specialised services, which is in early stages of development. This will address the service specific objectives for the next five years, overarching strategic objectives for the provision of a system of specialised healthcare as a whole and the impact of co-dependency between service areas.

NHS England is committed to a six strand strategic commissioning approach:
- Ensuring consistent access to the effective treatments for patients in line with evidence based clinical policies, underpinned by clinical practice audit.
- A clinical sustainability programme with all providers focused on quality and value through:
  - Achieving and maintaining compliance with full service specifications, and making changes to service provision where there is no realistic prospect of standards being met;
  - Refreshing and focusing Commissioning for Quality and Innovation (CQUIN) schemes to directly contribute to improving outcomes with challenging, but achievable goals; and
  - Providing transparency in service quality through the continued development of service level quality dashboards and improvements in data flows.
- An associated financial sustainability programme with all providers, focused on better value through a two year programme of productivity and efficiency improvement.
- A systematic market review for all services to ensure the right capacity is available, consolidating services where appropriate, to address clinical or financial sustainability issues.
- Adopting new approaches to commissioning care where it promotes integrated care and clinical oversight for patients, in particular services and care pathways to include a prime contractor model and co-commissioning with CCGs.
- A systematic rules-based approach to in-year management of contractual service delivery.
Appendix 2: Direct Commissioning – Specialised Services

Strategic Aim
Specialised services are currently being delivered out of too many sites, with too much variety in quality and at too high a cost in some places. Through NHS England’s direct commissioning we shall be looking to reduce significantly the number of centres providing NHS specialised services, require standards of care to be applied consistently across England and maximise synergy from research and learning. Our strategy for specialised services is still in the early stages of development, but we can foresee a concentration of expertise in some 15 to 30 centres for most aspects of specialised care. Academic Health Science Networks will play an important role as the focus for many of these.

Local Work
As ground-work for this national strategy, SY&B AT will carry out work in Yorkshire and Humber in 2014-15 to stock-take the current arrangements in a number of key specialised services which are currently in derogation from the national service specifications. These include vascular, morbid obesity, cardiac and interventional cardiology, cancer, and specialised neurological services. We will work closely with the CCGs in assessing what the issues and risks are within these services, understanding how they impact on the local communities, and agreeing joint and collaborative work going forward. The project areas for this work are listed in more detail in the Specialised Commissioning 2 year Operational Plan 2014-16, available upon request.