NHS Harrogate and Rural District
Clinical Commissioning Group

Commissioning Intentions
2017 - 2019
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1. Executive Summary

Commissioning Intentions provide a basis for on-going dialogue between NHS Harrogate and Rural District Clinical commissioning Group (CCG) and service providers, to inform business plans and contracts, service development and improvement plans. They are intended to drive improved outcomes for patients, and transform the design and delivery of care, within the resources available.

These commissioning intentions cover the years 2017/18 and 2018/19 and outline the interventions to improve the way we commission and contract, review and transform local health services. They are based on the Five Year Forward View goals of a fully integrated health service delivering the best possible outcomes, within the resources available, for our population as outlined in our local place based plan which set out what this would mean for people using local services:

- **Creating healthy places and healthy communities** ensuring that every place is child friendly and allows people to age well.

- **Preventing ill-health and looking after yourself** you’ll be given more support and information to **look after your own health and wellbeing to prevent ill-health** before it occurs. If you do need to access services, you’ll be supported to get to the right service and professional to meet your needs.

- **Primary and community services** you’ll see **more services being delivered locally**, to support you at home and in your community to manage your health and wellbeing, whether your need is planned in advance or you require urgent support, for your physical or mental health or social needs.

- **Ensuring our hospital services are stable in the long-term** - because more care will be delivered in communities and some specialist services are not delivering the best outcomes for people, **some of our hospital services (for physical and mental health) will need to look different and be delivered from different places** to make sure everyone gets the best care regardless of where they live.

- **Using technology to support populations and our staff** we can use the technology we use in our everyday lives to help both people using services and the people caring for them to deliver **care as close to home as possible** and to make sure you **tell your story only once**

To realise this vision we will have in place much closer collaboration between the CCG and local authority to facilitate integrated commissioning, as well as between commissioners and providers in the design and delivery of services.
2. National Requirements

NHS England has issued planning guidance that includes nine ‘must do’s’ for 2017/18 and 2018/19. They are summarised in the table below.

<table>
<thead>
<tr>
<th></th>
<th>Sustainability and Transformation Plans</th>
<th>Implementation of milestones and achievement of trajectories based on assessed metrics.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Finance</td>
<td>Deliver organisational and overall system control totals, implement STP plans, reduce demand support self-care and prevention, develop new care models, medicines optimisation and manage continuing healthcare processes.</td>
</tr>
<tr>
<td>3</td>
<td>Primary Care</td>
<td>Ensure the sustainability of General Practice, extend access and support General Practice at scale.</td>
</tr>
<tr>
<td>4</td>
<td>Urgent &amp; Emergency Care</td>
<td>Implementation of the Urgent and Emergency Care Review, deliver four-hour A&amp;E Standard and response times for ambulance and by November 2017 meet the four priority standards for seven-day hospital services.</td>
</tr>
<tr>
<td>5</td>
<td>Referral to treatment times and Elective Care</td>
<td>Deliver the constitutional standard for referral to treatment times, streamline elective care pathways, including outpatient redesign, 100 per cent use of e-referrals, and deliver the national maternity services review.</td>
</tr>
<tr>
<td>6</td>
<td>Cancer</td>
<td>Deliver cancer standards, implement the national cancer task force report, improve one year survival rates, roll out follow up pathways starting with breast cancer, and preparing for others; and ensure all elements of the recovery package are commissioned.</td>
</tr>
<tr>
<td>7</td>
<td>Mental Health</td>
<td>Deliver the implementation plan for the Mental Health Five Year Forward View, ensure delivery of access and quality standards, increase baseline spend on mental health and maintain dementia diagnosis rate of at least two thirds; eliminate out of area placements for non-specialist acute care.</td>
</tr>
<tr>
<td>8</td>
<td>People with learning disabilities</td>
<td>Deliver transforming care partnership plans, enhancing community provision, reduce premature mortality through improved access, education, and improve access to healthcare.</td>
</tr>
<tr>
<td>9</td>
<td>Improving quality in organisations</td>
<td>Implement plans to improve quality of care.</td>
</tr>
</tbody>
</table>
3. Harrogate and Rural District CCG Overview

Harrogate and Rural District Clinical Commissioning group was established in April 2013. The CCG represents 17 GP practices and serves a resident population of approximately 160,000 people. Led by clinicians we are responsible for commissioning, improving and designing health services including: primary care, community healthcare, secondary care, children’s services, and mental health and learning disability services.

Our vision is: “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 strategic priorities are:

**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, delivering more streamlined and integrated primary and community based services.

We are committed to achieving high quality care, better experience and better outcomes for patients.

Our values will guide what we do. We believe in: Respect and dignity; Commitment to quality of care; Compassion; Improving lives; Working together for patients; everyone counts.

Harrogate district covers 1,305 sq km (505 sq miles) and is characterised by being both rural and urban in nature, having large, sparsely populated areas alongside the major settlements of Harrogate, Knaresborough and Ripon.

Our case for change:

- **We have an ageing population** – 10 years ahead of the national aging curve with 1 in 5 people aged over 65. This is set to increase to 1 in 3 over the next two decades.

- **The working age population** (15-64) is shrinking as a proportion of the overall local population – with more outward migration of working population than inward migration. This has implications for the health and social care workforce. Workplace health initiatives can help address the two biggest causes of sickness absence across the NHS which are mental health and musculoskeletal problems.

- An increase in the number of people who have a **limiting long-term illness** and the number living with **dementia** by 2020.

- Life expectancy for both men and women is higher than the national average – but the life expectancy gap between the most affluent and most deprived is 8.38 years for males and 5.9 years for females.

- While the district is relatively affluent there are pockets of deprivation and rural isolation.

3.1 Engagement

Engagement is part of our core business. As commissioners we involve the public as well as patients when making changes to services or commissioning new ones. Patients have been involved in the development of CCG strategy as part of the annual planning process, with a recent focus on maternity services and with North Yorkshire County Council on the development of a dementia strategy. We also work closely with the third sector to gain a better insight into the needs of the community and have a number of existing forums/methods which we use to engage local
people in the work we undertake. We are committed to listening to our local population and building on our existing engagement to achieve good co-production of services as we design and implement new models of integrated care.

We recently ran a public engagement exercise around proposals to restrict the prescribing of gluten free products. Feedback from the engagement was analysed and considered before making a formal decision to restrict gluten free foods on prescription. Given the scale of the financial challenges faced we plan to engage with local people through a series of questions to help identify where demand can be reduced and costs curtailed, as part of our on-going commitment to engagement as our Quality, Improvement, Productivity and Prevention (QIPP) plans evolve and develop. We want to ensure that our communications set out clearly the choices we face:

- Improving efficiency, effectiveness and productivity.
- Reducing variation.
- Recommissioning for Better Value.
- Decommissioning (poor value services and those of limited clinical value).

### 3.2 West Yorkshire and Harrogate STP

In parallel with preparing the CCG’s Commissioning Intentions and Financial Recovery Plan, Harrogate and Rural District CCG have been fully involved shaping the development of the West Yorkshire and Harrogate Sustainability and Transformation Plan (STP). While the Recovery Plan looks at the short to medium term measures we can take to reduce financial risk and reduce spend we also need to ensure longer term financial stability and sustainability through service and system transformation as part of the STP.

The draft West Yorkshire and Harrogate Sustainability and Transformation Plan (STP) was published on Thursday 10 November and sets out the vision, ambitions and priorities for the future of health and care in the region and is the result of many months of discussions across the STP partnership.

The STP work programme is managed collectively and is restricted to that which can only be done at that level. We work in this way for one or more of these reasons:

- Services cut across the area and beyond the six local places. For example some services are not provided everywhere and require people to travel across local places i.e. stroke and cancer support.
- There is benefit from doing the work once and sharing, so we make the best use of the skill and expertise we have.
- Working together can deliver a greater benefit than working separately.

On this basis we have identified nine priorities for which we will work across a larger area, sharing best practice and identifying shared solutions to shared problems:

- Prevention at scale
- Primary and community services
- Mental health
- Stroke
- Cancer
- Urgent and emergency care
- Specialised commissioning
- Hospitals working together
- Standardisation of commissioning policies
It also allows us to work together on the delivery of specialised services across the area, for example specialised rehabilitation services for complex neurological conditions, vascular, stroke, cancer and urgent care.

It is also built from six local area place-based plans:

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

All of the local plans have a focus on prevention, early intervention, self-care, primary and community services and integration.

All of our proposals are about improvement and change. To do this we recognise we need a number of enabling work-streams:

- Workforce: Creating the right workforce, in the right place with the right skills, to deliver services at the right time, ensuring the wellbeing of our staff
- Communications and Engagement: Engaging our communities meaningfully in co-producing services and making difficult decisions
- Digital and interoperability: Using technology to drive change and create a 21st century NHS
- Innovation and best practice: Placing innovation and best practice at the heart of our collaboration ensuring that our learning benefits the whole population.
- Infrastructure: Ensuring we have effective commissioning structures to push through the change.

Pockets of deprivation and affluence across the area means where you live can determine your life chances. The draft STP aims to address this health and wellbeing gap with a focus on supporting people to live longer, healthier lives, and ensuring a good and equitable service for all, no matter where you live.

The draft proposals also stress the importance of improving people’s health, through better coordination of services, whilst improving the quality of care received.

An ageing population and people living longer with complex health and social care needs means demand is increasing faster than resources. The draft STP offers an initial view of how local and regional services can be improved, what this means for the health of people locally and how we will need to collaborate to ensure services are sustainable.
4. Historic Financial Performance and QIPP Programme

HaRD CCG has delivered sound financial governance since it was formally established in April 2013, achieving unqualified audit and value for money opinions during the period 2013/14 to 2015/16.

The CCG repaid the inherited share of financial deficit from predecessor North Yorkshire and York PCT in 2013/14 and delivered its 1% planned surplus in each year. However, the underlying position of the CCG has been deteriorating over this period as increased demand has outstripped the increase in allocations and delivery of QIPP savings.

The largest area of increased expenditure has been in Acute Care, mainly at Harrogate District Foundation NHS Trust, with significant over performance in each of the last three years. The CCG has delivered the overall (‘bottom line’) financial position each year by managing these overspends through release of contingencies and non-recurrent underspends in running costs and other commissioned services.

QIPP savings in the order of £12m will be required to achieve a surplus financial position in 2017/18, and to achieve the aim of fully meeting NHSE business rules in 2017/18. This level of annual efficiencies is only achievable if HaRD CCG, together with all providers in the system, work collaboratively.

The CCG’s overall strategy for Financial Recovery includes the following objectives for delivery:

- Focus on reducing waste and variation, improving efficiency and have a pragmatic approach to managing demand.
- Target areas of limited clinical value supported by a quality impact assessment.
- Focus on financing ‘essential’ services.
- Address radical options and consider ‘hard choices’.
- Ensure value for money for the public purse. This may involve delivering longer term improvements in health by making difficult decisions and choices in the short term.
- Be risk assessed to ensure there is sufficient capacity and capability to deliver the intended outcomes.
- Be congruent with the CCG’s overall commissioning strategy and Sustainability and Transformation Plan.

The following chart shows HaRD CCG’s expenditure by programme area:
All areas are required to deliver efficiencies of at least 6% in 2017/18, which may be through increased throughput, for the same inputs, removing costs from the system by fewer steps in the delivery of care; decommissioning clinically less-effective procedures, treatments and therapies; and price re-negotiation.

An overall summary of 2017/18 QIPP schemes is included within Appendix 1.
5. **Approach to Contracting**

The financial challenge for CCG commissioners and provider organisations over the next few years means that existing ways of working together, through contracts, are not sustainable. Our objective must be to take costs out of the system and not to continue to pass risk around the system.

We believe this can be achieved through mutual agreement of a financial approach with underpinning contractual terms in 2017/18 that share gain and risk equitably. There are a number of clinical services that lend themselves to this such as unplanned care and some areas of planned care i.e. musculoskeletal services.

Agreement of a financial approach could also include the following elements:

- Aligning commissioner QIPP and provider Cost Improvement Plans (CIP) with agreed outcomes;
- Commissioning end to end clinical pathways for planned care with a view to securing best in market value for money;
- Using methods of procurement of clinical services where this adds real value, for example value based or outcomes based contracting over longer durations.
- HaRD CCG will utilise its contractual powers alongside clinically based dialogue to secure high quality care for patients, including access to care within the NHS Constitution stipulated waiting times. It will, as a matter of course, agree contracts and contract variations using the NHS standard contract.
- Agreement of block values for services to reduce the need for a transactional approach to contracting as outlined in the planning guidance.

HaRD CCG has a commissioning intention to develop an agreed financial approach to underpin contracts in 2017/18 that will be progressed through the following business arrangements:

- Negotiations for the 2017/18 contracts will run from October 2016 until the end of December 2016.
- Governance arrangements for decision making and escalation of issues in dispute will be agreed before the negotiations commence.
- Contracts not agreed and signed by the end of December will go to NHS mediation/arbitration in line with the NHS dispute guidance.
- Any contract not agreed by 1 April 2017 will be paid monthly 1/12th of the first contract offer made by the commissioners until the contract is agreed and signed. Any required adjustments will be made retrospectively. If delays are significant the CCG will consider the use of a Non-Contracted Activity basis for making payments to providers.
- Financial sanctions for breaches of national and locally agreed contract, quality, information and other standards will be applied without exception.

5.1 **General Contracting Principles**

For contracts where HaRD CCG is the lead commissioner the general contracting principles and intentions will apply to all associate commissioners party to the contract. Where this is not the case this will be identified separately. All commissioners will agree to work collaboratively and manage contracts in a co-ordinated and consistent manner.

5.1.1 **National Contracts Requirements**

The CCG will use the 2017/18 NHS Standard Contract in line with the planning guidance and contract technical guidance.

Market Forces Factor (MFF) will be paid based upon that identified for the provider.
5.1.2 Contract Levers and Consequences

The CCG will have available to it the use all of the contractual levers as set out in the 2017/18 standard contract (or appropriate Deed of Variation). Where a consequence is mandated, this will be applied in line with the contract technical guidance. Where there is a national target, but the local consequence is for local determination, the co-ordinating commissioner will look to utilise the contract management process as laid out in the standard contract or to adopt an automatic financial penalty where this would be appropriate. This principle will also be adopted for any local quality and performance requirements agreed and included in the Quality Requirements schedule.

5.1.3 General principle of contract completeness

The CCG as co-ordinating commissioner will not agree or sign any contract that does not include all mandated contract schedules, or that has thresholds and trajectories that are still to be agreed.

Where no specific level of activity is agreed, the indicative plan and agreed contract value will be zero.

Providers are expected to notify commissioners in advance of all service changes / developments that could impact on activity, cost or service delivery. This will be discussed as part of contract management sub groups which include representatives from each organisation and will report directly to the Contract Management Board.

5.1.4 Contract Baselines

The Process for agreeing contracts for each financial year will be through discussion and negotiations with main providers. The process will apply to acute, community and ambulance contract providers and including independent sector organisations providing commissioned services.

The process will include:

- A review of 2015/16 and 2016/17 activity to date to inform the commissioning and contracting intentions for 2017/18 factoring any full year effects of QIPP.
- A review of any other adjustments transacted to ensure that the baseline position is representative of the actual position.

5.1.5 Finance and Activity Plans

The Commissioners' contract proposals for all providers will be based on a rolling 12 month period, adjusted to reflect the 2016/17 forecast outturn, costed at the 2017/18 tariff. Activity levels and costs will be adjusted as required for any changes in Payment by results (PbR) guidance and for any changes in commissioner responsibility in line with National Guidance. Joint Activity Management Plans, supported by transformational QIPP schemes, will be required to manage any growth in excess of these levels and the resources available to the CCGs.

Whilst the commissioners will review and consider the impact of counting and coding changes at service line level, the overall financial proposal for 17/18 would need to be considered ahead of any final agreement to individual service line changes. This also needs to be managed within service condition 28 as factored below under the contracting intentions.

5.1.6 Efficiency

In line with the draft 2017/18 PbR guidance the co-ordinating commissioner expects all local tariffs and non PbR arrangements currently proposed to be adjusted by 0.1% (net impact). If there is a change to this position following the release of the final tariff the CCG will discuss any further impact directly with the provider.
5.1.7 CQUIN

Commissioning for Quality and Innovation (CQUIN) will be managed and paid in line with the national CQUIN guidance.

5.1.8 High Quality Data and Information

The provider is expected to provide high quality, accurate timely and relevant information and any shortfalls in quality will be sanctioned in line with the contract. The CCG expects the universal adoption of the NHS Number and Practice Code as the primary identifier for all services provided and charged for. The CCG and its associates will not pay for activity where there is low quality or incomplete patient level information which prevents validation of the responsible commissioner and service provided.

5.2 Contracting Intentions

It is recognised above, that the CCG wants to progress a different way of contracting for 2017/18 however, until such time that discussions are progressed around a different contracting mechanism the CCG’s contracting Intentions for 2017/18 include the following:

- The CCG is planning to introduce a clinically led referral management system to support adherence and compliance to all referral guidelines. This will support referrals from both primary and secondary care.
- No payment above national tariff i.e. tariff plus.
- Any changes to counting and coding that are agreed will be subject to 6 months shadow monitoring before going live and will be cost neutral in the first year (unless agreed otherwise). This is in line with SC28.
- Any changes to counting and coding that providers wish to propose must be quantified and provided to the commissioner, no later than the end of October 2016, in order for commissioners to review.
- Any notifications received from providers will be evaluated in light of the financial challenges across the system and in light of work undertaken to agree the financial gap.
- The CCG will not fund Specialist Registrar posts as a separate block value. The CCG pay for any associated activity in line with PbR.
- 6 months’ notice is given to HDFT that following reviews of pricing in relation to the following block agreements, prices for these services may need to be reduced to demonstrate value for money. It should be noted that this list is not exhaustive:
  - Specialist Nurses
  - Community Rehab Team
  - Orthotics
  - GP Practice Rental Charges
  - CDC Assessments
  - Safety Catch Needles
  - Anticoagulation (Warfarin) Clinic
- The CCG needs to understand the spend on ‘ward attenders’ to inform the total cost of services and to fully understand end to end pathways.
- The CCG required that all providers code outpatient activity (including procedures) in line with the data definition. This is specifically around activity currently recorded as non-consultant led. For the avoidance of doubt the guidance states that ‘A Non-Consultant Led Activity is an ACTIVITY where a CONSULTANT does not retain overall clinical responsibility for PATIENT care’. It is anticipated that any subsequent change will impact on activity moving from a first attendance to a follow up attendance.
- Linked to the issue above, the CCG will negotiate a local price for all ‘non consultant led
activity’. The CCG will not agree to fund this activity at a default tariff which is the same as the mandated consultant price.

- 6 months’ notice is given to HDFT that following a benchmarking review of local pricing led by HaRD CCG that local prices will need to demonstrate comparative value for money and any that do not, will need to be reduced from 1st April 2017.
- Plain film x-ray – unless there is a mandatory tariff for plain film x-ray in 2017/18 the CCG propose to move to the non-mandatory tariff of £25 (consultation tariff).
- The CCG will commission and contract for outpatient follow ups to deliver efficiency savings across the system. This work will be developed and shared with providers in advance of April 2017/18.
- The CCG gives 6 months’ notice of their intent to undertake a review of the paediatric high dependency unit at HDFT to ensure that this is supported by the critical care network and in line with STP plans.
- 6 months’ notice is given to HDFT that following a review of pricing of critical care bed days the price charged by HDFT may need to be reduced to ensure that equitable pricing is in place that stands scrutiny.
- Waiting Lists and Waiting Times – the CCG commission activity to maintain a position that delivers in line with the national standards and do not agree to fund activity that delivers a much improved position.
- Procedures of Limited Clinical Value (PoLCV) – the CCG will only pay for procedures that adhere to the thresholds laid out in the PoLCV policy. The CCG will audit or introduce a process to ensure compliance and withhold funding if appropriate.
- The CCG expects the provider to be compliant with all medicines management policies and prescribing committees.
- 6 months’ notice is given to HDFT that HaRD CCG will undertake a review of high cost drug prices to ensure that pricing is appropriate in relation to acquisition cost and stands scrutiny.
- The CCG requires that any changes as a result of Nice Guidance where there is a financial impact are discussed and agreed (including timescales for implementation) prior to any changes taking place.
- Best Practice Tariffs – The CCG will only fund BPT on receipt of evidence to support the achievement. Where appropriate, evidence must be based on representative audits undertaken by the provider.
- The CCG will develop a proposal around consultant to consultant referrals (and other referrals generated within secondary care) to manage these in line with the CCGs overall demand management strategy.
- The CCG will work to ensure robust benchmarking of activity, costs and securing clinical efficiencies within 2017/18 contracts.
- 6 months’ notice is given to HDFT that HaRD CCG will undertake a review of contract exclusions to the main contract, and associated service lines, with a view to following national guidance and having no exclusions:
  - Community Geriatrician
  - Musculoskeletal (MSK)
  - Any Qualified provider (AQP) Podiatry
  - HMDS
  - Autism Assessments
### 5.3 Contract Negotiation Timetable (National and Local)

<table>
<thead>
<tr>
<th>Event</th>
<th>Timescale</th>
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<tbody>
<tr>
<td>Planning Guidance Issued</td>
<td>22nd September 2016</td>
</tr>
<tr>
<td>Providers share counting and coding changes</td>
<td>30th September 2016</td>
</tr>
<tr>
<td>Commissioners share contracting intentions (including any counting and coding changes)</td>
<td>30th September 2016</td>
</tr>
</tbody>
</table>
| Contract negotiation meetings to commence (schedule of meetings to be produced for each provider. The schedule will cover all elements of the contract including:  
  - Indicative activity plans  
  - National and local quality requirements  
  - CQUIN  
  - Information requirements (including DQIP)  
  - Service delivery improvement plan | w/c 10th October 2016      |
| Commissioners and Providers to share 1st cut activity assumptions for 2017/18 | 14th October 2016          |
| Commissioners and Providers to agree baseline positions for 2017/18 (pre adjustments) | 31st October 2016          |
| Commissioning intentions to be shared with providers                  | 31st October 2016          |
| Providers to Quantify any impact of coding and counting changes        | 31st October 2016          |
| Final contract published                                              | 4th November 2016          |
| First offer to be made to providers                                   | 4th November 2016          |
| Providers to respond to initial offers                                 | 11th November 2016         |
| Negotiation checkpoint                                                | Mid November 2016          |
| Weekly contract tracker to commence                                   | w/c 21st November 2016     |
| Negotiation checkpoint                                                | 2nd December 2016          |
| Where contracts at risk of not being signed by 23/12/16, local decision to enter mediation | 5th December 2016          |
| Negotiation checkpoint                                                | Mid December 2016          |
| Contract agreement and Sign Off                                        | 23rd December 2016         |
6. Commissioning Governance and Priorities

Programme Sponsor: Amanda Bloor, Chief Officer
Programme Board: Finance, Performance & Commissioning Committee
Operational Group: QIPP Delivery Group

Medicines Management
- Medicines waste
- Over the counter medicines
- Branded medicines
- Repeat prescription ordering
- Gluten free foods
- Prescribing formulary compliance
- National price adjustment
Accountable Lead: Director of Quality and Governance
Clinical Lead: Dr Tim Ryder

Planned Care
- Referral Management
- Clinical thresholds
- PoLCV
- Clinical pathways
- Outpatient follow ups
Accountable Lead: Director of Transformation and Delivery
Clinical Lead: Dr Bruce Willoughby

Integrated Community Services
- Prevention and self-care
- Enhanced primary care
- Local integrated community teams
- Community-focused management of unplanned care
- Health and social care wrap-around services
Accountable Leads: Director of Transformation and Delivery, Director of Quality and Governance
Clinical Leads: Dr Sarah Hay, Dr Rick Sweeney

Continuing Health Care / Mental Health / Learning Disabilities
- CHC and mental health care packages (various initiatives)
Accountable Lead: Director of Quality and Governance
Clinical Lead: Dr Rick Sweeney

Other
- Contract Management
- Financial Management
Accountable Lead: Chief Finance Officer
Clinical Lead: Dr Bruce Willoughby
6.1 Primary Care

Primary care is usually a patient’s first point of contact with the NHS. The CCG has delegated responsibilities for commissioning GP primary care services and in addition is working with wider Primary Care services such as pharmacists and optometrists.

HaRD CCG is responsible for improving the quality of local primary care services, working closely with NHS England. As the CCG is a membership organisation it has a unique working relationship with the local GPs and nominated clinical leads sharing management responsibilities for designated programmes of work.

Hard CCG Commissioning intentions for 2017/18 include the following:

- Continue to implement the Primary Care Strategy which aims to support patient care outside of hospital, aligns to the GP Forward View and complements the New Care Models programme.
- Improve access to general practice in and out of hours working with primary care providers to implement and deliver an equitable 7 day service in primary care.
- Support estates planning as part of it co-commissioning role with NHS England, including Primary Care Improvement funded projects that support the strategic direction of travel for further development of primary and community care.
- Transform the way technology is deployed and infrastructure utilised, using digital approaches to support new models of care in general practice
- Support better management of workload and release of time in the practice.
- Support and grow the primary care workforce.

6.2 Medicine Optimisation

HaRD CCG’s aspiration for medicines optimisation going forward into 2017/18 is to improve the quality of medicines management through evidenced based prescribing.

The new term 'Medicines Optimisation' is broadly defined as the approach by which the NHS optimises the use of medicines and ensures evidence based medication prescribing protocols based on shared decision making, informed consent, and the principle of 'do no harm' in all care settings. This is targeted at a multi professional approach inclusive of patients and carers. Self-care must be at the heart of the approach and decisions about medicines should be made jointly with patients.

The CCG aims to support effective medicines optimisation, helping people to get the most out of their medicines.

The medicines optimisation commissioning intentions and QIPP plans for 2017/8 build on existing work to drive improvements in quality and efficiency through effective medicines use. These include:

- **Medicines waste**: Aim to increase awareness of the public to cost of medicines waste by way of a communications campaign and importance of only ordering medicines that are required. The medicines management team will work with local community pharmacies and GP practices to collaboratively work together to improve present repeat prescribing systems. Work with care homes to improve their systems regards to ordering repeat prescriptions but also to promote medication usage reviews to frail elderly patients by community pharmacies/practice pharmacists and integrated pharmacists.

- **Over the counter medicines**: Promote patients to go to the community pharmacy in the first instance to get advice about management of minor ailments thus avoiding unnecessary GP appointments and A&E attendances. Self-care campaign to support prescribers to reduce prescribing of products that are prescribed to manage minor ailments.
• **Cost effective medicines**: Continue to review existing prescribing in both primary and secondary care to make sure the most cost effective treatment are prescribed first time.
  
• **Gluten free foods**: Only recommend prescribing of gluten free foods for vulnerable coeliac patients which is defined as patients on low income.
  
• **Joint formulary management**: Continue close working relationships with secondary care to support implementation of HaRD APC decisions and development of treatment guidelines to promote best practice and ensuring best health outcomes for our population.
  
**Antimicrobial Stewardship**: Antibiotic resistance poses a significant risk to public health. Therefore we need to:

• Reduce inappropriate prescribing of antimicrobials.
• Implement the prescribing in line with local antibacterial guidelines.
• Reduce the inappropriate prescribing of oral cephalosporins, quinolones and co-amoxiclav.

**Biosimilar medicines introduction**: Continue to work with secondary care to make sure that biosimilar medicines are introduced in a quick and efficient way.

**Specials**: Reduce use of expensive specially manufactured items by prescribing licensed preparations or licensed therapeutic alternatives.

### 6.3 Planned Care

Planned Care is the provision of routine services with planned appointments or interventions within community settings such as GP surgeries, health centres and other community facilities. This term can also encompass routine surgical and medical interventions provided in a secondary care setting and in some instances long term conditions such as diabetes and musculoskeletal conditions. Simply put, planned care refers to those services and treatments which are not carried out in an emergency.

The CCG will focus on planned care by ensuring that member practices refer the right patients for a specialist opinion and/or treatment in an outpatients setting, based on clinical effectiveness protocols through the development and effective use of a Referral Management Service (RMS). This should result in a reduction to the number of hospital based outpatients appointments and subsequent routine elective procedures.

A key part of the demand management strategy is to manage and streamline activity through a single point of access into the system and a RMS is the central point through which referrals should be routed. This will ensure that:

• All agreed pathways and Patient Decision Aids have been followed prior to referral to acute trust
• All relevant diagnostics are attached
• The purpose of the referral is clear
• Any lack of clarity can be clarified with the referring GP in advance
• The patient is referred into the correct service according to their clinical need
• Patients are not required for unnecessary follow ups and can be seen and treated/diagnosed in one appointment where possible.
• Any sudden changes in referral activity can be identified early, and where appropriate, mitigating actions are put in place.

Part of the demand management plan will include outpatient follow up attendances. The CCG spends approximately £9m per year on an outpatient follow ups, with an average follow up ratio of 2.25 at an aggregate level. From 2017/18 the CCG will commission a follow up ratio of 1:1.8 (or lower if already agreed with provider) for all follow ups to deliver a more efficient approach to overall outpatient care.
HaRD CCG’s vision is to achieve the best health and wellbeing for everyone and to achieve this will continue to enable, encourage and support the people that it serves to make healthy lifestyle choices. Hence the CCG will introduce active interventions regarding smoking cessation, alcohol and weight management prior to referral to surgical specialties as part of a holistic approach to optimising health prior to surgery.

- All non-urgent referrals to surgical specialties with a BMI≥30 will be offered a referral to Tier 2 weight management to enable completion of a period of health optimisation for 6 months before commencement of surgery.

- All non-urgent referrals to surgical specialties where the patient is an active smoker to be offered a referral to a stop smoking service, for example, Smokefree Life North Yorkshire for smoking cessation to enable completion of a period of health optimisation for 6 months before commencement of surgery.

HaRD CCG will also be reviewing Procedures of Limited Clinical Value (PoLCV) and a number of clinical pathways to ensure that patients receive the right care in the right place at the right time. When the CCG is considering pathway transformation, it will take into account all components of the pathway to understand the impact of any potential service changes on other providers.

As part of the planned care agenda, the CCG will need to work with providers on considering when it would be appropriate to spread local services over 7 days using existing resources. Nationally there is evidence that many patients are not discharged from hospital at weekends when they are clinically fit, because the supporting services are not available to facilitate discharge.

The CCG as the lead commissioner for non-urgent patient transport services will be reviewing the existing ‘eligibility criteria’ in line with national guidance.

As part of the 2017/18 plan, the CCG intends to review the current Pathology, Gastroenterology, Cardiology, MSK/ Orthopaedics, Audiology/ ENT and Ophthalmology services to inform future commissioning plans.

**Specialist Rehabilitation Services**

The CCG awaits the outcome from the NHSE Yorkshire and Humber review of specialised rehabilitation services for complex neurological conditions and will appraise the options for the future commissioning of these services. We will aim to work collaboratively to support the development of the Yorkshire and Humber wide commissioning pathway with standards as set out in the NHS England Specialised Rehabilitation for patients with complex needs service specification.

During 2017/18, Phase one of the delivery plan will address NHSE specialised commissioning and the preferred option will be presented to SCOG on the 2nd December.

Phase two in 2018/19 will address the neuro-rehabilitation services that are commissioned by CCG’s.

The aim the review is to improve and standardise the quality and availability of specialised rehabilitation for patients with complex needs due to acquired brain injury by providers able to meet the requirements as set out by the British Society of Rehabilitation Medicine (BSRM) and the Commissioning Guidance for Rehabilitation (NHS England 2016 https://www.england.nhs.uk/ourwork/qual-clin-lead/ahp/improving-rehabilitation/)
There is evidence within ‘The Commissioning Guidance for Rehabilitation’ that maximising an individual’s independence and activity levels will reduce care costs, keep them in work and reduce the risk of their acute admission.

Collaborative commissioning is important, but so is collaborative delivery; complex neuro-rehabilitation lends itself to cross system delivery partnerships.

6.4 Cancer Services

Cancer services will be commissioned in line with the requirements of NICE Improving Outcomes Guidance and NICE quality standards (QS), the London Model of Care for cancer services and the National Cancer Survivorship Initiative (NCSI).

The CCG has already implemented a number of interventions (planned care) to reduce lifestyle risk factors including stopping smoking, increasing physical activity, improving diet and reducing obesity. This will support the CCG to continue to deliver the national performance standards by focusing on preventative interventions.

The focus of the West Yorkshire and Harrogate STP Cancer programme is to deliver the national cancer strategy in a way that makes sense in our region, ensuring that we deliver the best outcomes and experience. This includes an Alliance Delivery Plan to be agreed April 2017 including a 5 year diagnostic capacity building plan and new strategic approaches to commissioning and provision of cancer care. Our CCG focus in 2017/18 – 2018/19 is:

**Preventing cancer by addressing cancer risk factors.**
Continue to work with colleagues in the local authority on the prevention agenda: reducing lifestyle risk factors including reducing smoking prevalence and embedding ‘Making Every Contact Count’ into everyday practice.

**Diagnosing more cancers early**
Increase rates of uptake of breast, bowel and cervical screening programmes, particularly targeting rural and older populations and people with learning disabilities.

Ensure that 85% of patients continue to meet the 62 day standard, identify any 2017/18 diagnostic capacity gaps, increasing GP direct access to diagnostics (blood tests, chest x-ray, non-obstetric ultrasound, MRI, CT, endoscopy) and planning for a 7% per year level of headline growth in diagnostics up to 2020/21 within available resources.

Understand the gap in diagnostic capacity required locally and across the WY STP footprint, to deliver our ambition in relation to a shift in stage of diagnosis:

- Increase 1 year survival from 72.6% in 2015/16 to 75% in 2020/21
- Increase stage 1 and 2 diagnoses from 52.4% in 2015/16 to 62% in 2020/21.
- Reducing the proportion of cancers diagnosed following an emergency admission.

**Improving cancer treatment and care**
Increase delivery of the Recovery Package interventions, understanding current coverage and agreeing a plan so that by 2020 every person with cancer will have access to elements of the Recovery Package, and stratified pathways of follow up are in place for common cancers. Priorities for 2017/18 are: holistic needs assessment and care plan at the point of diagnosis; treatment summary sent to the GP at the end of treatment; implementation of cancer care reviews in primary care within 6 months of diagnosis.

We will commission stratified pathways of care for people living with or beyond cancer. Risk stratified follow up care for breast cancer patients will commence in 2017/18 and prostate and colorectal patients in 2018/19.
This will ensure that:

- With the focus on health and wellbeing, patients are supported to take back control of their lives as soon as they are able.
- There is a reduction in unnecessary outpatient appointments for those who no longer require face to face appointments.
- A supported self-management pathway with remote surveillance and with guaranteed re-access should now be offered as standard practice for these tumour groups following treatment for cancer.

We will work with providers to ensure that all cancer patients, with a primary, secondary or metastatic diagnosis, have access to a clinical nurse specialist or other key worker.

6.5 Unplanned Care

Unplanned care is the provision of emergency or unplanned services including accident and emergency, a minor injury unit, 999 emergency services, NHS 111 services and emergency admissions to a hospital. The term can also include advice on self-care, telephone advice, or an emergency that can be dealt with in a primary care setting. In summary, unplanned care refers to those services and treatments that are carried out as an emergency or were not planned.

The CCG will focus on unplanned care to ensure that patients receive the right care, at the right time and in the right place. The priority is to move towards an Integrated Urgent Care system as a result of the Urgent and Emergency Care Review (2013) and its proposal for 24/7 integrated access, assessment, advice and treatment services. This will include working with NHS 111, Out of Hours Services, emergency departments and ambulance services.

The CCG’s priorities are to sustain the continued performance of the 4 hour A&E standard and the standards for ambulance response times through the West Yorkshire Acceleration Zone. In 2016/17 the overall measure of success is to achieve 95% A&E 4 hour standard at the level of the West Yorkshire system for the month of March 2017 and achievement of 30% callers to 111 referred to a clinician for review, by March 2017. This work also includes the continuation of the Ambulance Response Programme pilot to deliver a reduction in proportion of ambulance 999 calls that result in avoidable transportation to an A&E department.

As part of the HaRD A&E Improvement Plan, partnership work will continue in 2017/18 on:

- Pre-hospital care including NHS 111 Clinical Hub, with the enhancement of clinical advice, direct booking into GP practices, and review of mental health frequent attendances at A&E.
- Streamlining ED and increasing the use of ambulatory care to review, diagnose and treat ambulatory type patients with the aim to not admit them or to discharge earlier.
- Flow and discharge to rapidly roll out the SAFER bundle to improve the flow through hospital and discharge to reduce length of stay. The use of a ‘Purple Bag’ scheme in care homes and trusts, to include patient information and end of life care plans to avoid inappropriate admissions to hospital.

HaRD CCG will be part of the West Yorkshire Urgent Care Accelerator site from December 2016 to pilot the use of telemedicine kits into a number of care homes to support the staff with a prompt consultant opinion to enhance self-care or early diagnosis, as well as providing reassurance to staff. To reduce inappropriate admissions to hospital and enable preferred place of death.

The CCG will continue with work on the Better Care Fund to reduce A&E attendances and emergency admissions. This will include the continuation of linking HaRD GP practices with care homes, the voluntary sector schemes to support patients in the community and a Mental Health advisor based in A&E to assess and treat patients.
Work has also begun in 2016/17 between system partners on Delayed Transfers of Care, this includes review of the escalation process, ‘Home First’ – discharge to assess policy and work on trusted assessors. The work links with the roll out of the SAFER bundle to improve the hospital flow.

The CCG will work with Healthwatch and NYCC Scrutiny of Health Committee, looking at end of life care in the Harrogate district, with the aim to reduce unnecessary hospital admissions at the end of life. We will also implement an electronic Palliative Care co-ordination system, develop training for New Care Model teams and work with the Ambulance Service to improve care co-ordination.

6.6 Developing High Quality, Responsive and Integrated Community Care

HaRD CCG aims to support local people to receive the right care in the right place, at the right time. Our New Care Model, ‘What Matters to Us’ is an essential part of this right care, right place, right time strategy.

Our New Care Model will dissolve the boundaries between primary, community, acute, mental health and social care services locally. Existing clinical teams are coming together to operate as a single team around the person (and their carers) whilst also embracing the benefits of both community and voluntary sector organisations to enhance local services.

The CCG’s immediate priorities include:

- Community Geriatrician appointed to provide high level clinical management and optimised care of frail older people.
- Establish local Integrated Teams with mental health nurses and social care staff as well as District Nurses and the Voluntary and Community sector working together to address a person’s needs in the community in collaboration with GPs.
- Package of primary care resources, including practice-based pharmacy support, developed to free up GP time to allow GPs to collaborate with Local Integrated Teams, Response and Overnight Service and community beds to keep their patients safe and well in the community.
- Response and overnight team expands and functions 24/7 across the district.
- Establishing and managing community beds that provide wrap around care and rehabilitation as an alternative to acute hospital based care.
- Implement the Calderdale Framework process to support the identification of opportunities to reduce duplication and streamline services in our community health and care system.
- Improve end of life care in the community recognising how improvements in end of life care can have a high impact on patient experience as well as experience of family members and carers – offering a gold standard of care for people with a serious illness who may be in their last year of life. We want to develop a single point of contact for help and advice that patients and their carers can access 24/7 supporting people in their preferred place of care wherever possible.

The CCG will be working with partners to transform how patients receive care at home and in community settings. Within our local Harrogate and District place based plan we set out our aspiration to move to a new model of integrated commissioning and integrated service delivery.

The current arrangement for the delivery of community health care is via a number of isolated contractual agreements with providers. The fragmentation of budgets, using different payment models, can create contradictory incentives.
The impact of this fragmentation is:
• Duplication e.g. care provided in a person’s home, is funded by different commissioners.
• Gaps because there are no combined or holistic services to meet many individuals’ complex needs.
• Silo working, with different budgeting processes leading to different priorities.
• Lack of coordination with each organisation having differing processes, timescales for delivery and capacity levels for different roles and functions.
• Delays because decision-making involving more than one commissioner takes longer as multiple agreements are needed.
• The wider determinants of health are not taken into account as much as they should.

We need to radically change the way care is commissioned and will be considering options for implementation from 2017/18 onwards.

Achieving our ambitions for integrated community services needs to build on the work undertaken through the New Care Model. While the pilot project is having a qualitative impact a strong return of investment has not yet been evidenced and the current model needs to evolve so that, while it remains focused around the places where people live and the primary care services they use, it has the critical mass to operate at scale.

As we work together to create an integrated community health and social care system that substantially improves the health of people living within Harrogate and Rural District at the heart of the service are three core components;

• **Proactive advice, prevention and self-care:** With a single point of access to these services and social prescribing at its core.
• **Redesigned pathways between hospitals and the community:** With the potential to bring together existing health and social care teams and to deliver a different range of services within the community.
• **Locality based integrated teams:** Multi-professional teams, with direct links to community mental health and home care services, wrapped around clusters of GP practices and identifiable local communities. People using these services would be able to access personal health and/or social care budgets and direct payments.

Our overall objectives are defined in terms of “Prevent / Reduce / Delay” and in particular to:

• Reduce unplanned attendances and admissions into hospitals.
• Reduce admissions to permanent 24 hour care.
• Reduced delayed transfers.
• Reduce hospital excess length of stay.
• Delay the need for packages of care by keeping people independent and well.

6.7 **Mental Health/ Learning Disabilities**

Mental health is about physical, emotional and social wellbeing outcomes. The CCG aims to prioritise those people with the most acute need and who also account for the majority of costs. The CCG will ensure consistent models of care for mental health is delivered with a consistently high level of quality of care across the local health economy and to ensure productivity opportunities are delivered.

The CCG will be working to review mental health crisis services and the urgent care pathway to improve access across all ages with an emphasis on home treatment and avoiding unnecessary admissions to hospital. This will include improved access to mental health liaison services in the acute hospital to reduce unnecessary hospital stays and to expand community-based services to prevent avoidable admissions and support ‘step down’ and ongoing recovery in the community as close to home as possible.
A key aim will be to support the development of Improved Access to Psychological Therapy with a specific emphasis upon the management of long term conditions increasing access to 25%. This will support primary care and early intervention models. In 2017/18 work on access to specialist services such as perinatal mental health and veteran mental health will be a priority. The CCG will work on providing timely access to diagnosis and evidence based person centered care for people with dementia. We will also develop timely access to evidence-based, person-centered care for people with first episode psychosis, which is focused on recovery and integrated with primary and social care and other sectors.

The CCG will work to develop pathways for physical health screening and interventions for those with severe mental illness (SMI) to enable more people having their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention each year.

We will also continue the work to limit admissions to hospital for those with a learning disability and seek to develop a range of community based alternatives including the management and support of those in crisis. The CCG will develop pathways for improved access to healthcare for those with a learning disability to receive annual health checks and reduce premature mortality and support around their physical health care.

The CCG will be supporting people and families with mental health problems to access personal health budgets to allow for independence and choice of the management of their care.

6.7.1 Children and Young People’s Emotional and Mental Health

A workforce development plan will be developed and implemented for all agencies to access training to support children and young people. The whole of the children’s workforce needs to be trained and every contact made with a child or young person counts.

The use of digital tools presents an opportunity to make information and services more accessible and engage children and young people in new ways. The CCG will work with schools and will explore and engage with young people how we do this, for example the use of websites and Apps.

Over the year the CCG will review CAMHS crisis pathway, allowing an increase in the capacity of the crisis teams to offer better our-of hospital provision and incorporating an Intensive Home Treatment team, to reduce the need for an admission.
7. **Enablers**

7.1 **Co-design with public and partners**

We will work in partnership with local organisations and local people to meet the following objectives:

- Improve the health and wellbeing of the population by commissioning new and improved collaborative pathways of care which address the health needs of the population.
- Ensure that residents are put at the centre of the CCG’s decision-making process and are able to influence commissioning decisions and the design of local health services.
- Commission high quality, responsive services working in partnership with the patient public to make best use of the available resources.

We will work closely with Healthwatch North Yorkshire, supporting their work and driving engagement with members of the public, working in partnership efficiently to engage with patients and carers. We will extend our proactive engagement with voluntary and community partners, both as providers of services and as parties with an interest and influence in local health care.

Our local authority partners, North Yorkshire County Council and Harrogate Borough Council, are key corporate stakeholders and we will continue to strengthen relationships and partnership work between organisations within the health and social care community to improve the well-being of our residents.

In relation to involving people, our commitments are:

- To involve the public early in our decision making about commissioning new services and re-designing existing ones
- To listen to what people tell us and ensure so far as is possible that public views are acted upon
- To feed back what we have done to take account of patients’ views, and where we have not made any changes to explain why.
- Make sure that the organisations we commission services from have effective public engagement and systems in place to gather patient views and patient experience information
- Make sure that everyone who works with us will share our views about the importance of involving the public.

7.2 **Our Approach to Quality**

The CCG is committed to improving the quality of care for our patients and therefore assessing, measuring and benchmarking quality remains a key focus.

To do this we align quality from our strategic objectives to the point of care delivery, ensuring quality is not some abstract concept but a relentless focus on how we can positively transform services for people of Harrogate and Rural District.

The three domains of quality - patient safety, clinical effectiveness and patient experience - are monitored through routine internal contractual processes, clinical governance structures and external sources such as CQC, peer reviews, national surveys.

The CCG requires a Quality and Equality Impact Assessment (QEIA) for all changes to commissioning services, including service redesign and any areas of CCG business where it is appropriate to assess the impact of the proposed piece of work.
The QEIA process provides a focus on quality, encompassing learning from reports such as Berwick, Keogh and Francis.

The CCG has taken the decision to combine Quality and Equality Impact Assessments into one tool that can be used to assess both areas. This allows CCG staff to complete one integrated impact assessment covering dual responsibilities of quality and equality.

The QEIA forms part of the CCGs governance process to ensure the impact of changes made to policies and services deliver improvements. Where negative impacts are identified actions are taken to reduce these to an acceptable level.

**7.2.1 NHS Serious Incidents Framework**

Patient safety is inherent to clinical quality and the Serious Incident (SI) Framework is vital to its management. It was reissued in April 2015 and its impact will be monitored and managed throughout the financial year 2017/18. During this time, the CCG aims to work collaboratively with providers to ensure that the SI Framework is embedded and that providers are adhering to the policy.

**7.2.2 NICE technology appraisals**

One measure of clinical effectiveness is through the National Institute for Health and Care Excellence (NICE) technology appraisals which ‘assess the clinical and cost effectiveness of health technologies, such as new pharmaceutical and biopharmaceutical products, to ensure that all NHS patients have equitable access to the most clinically and cost-effective treatments that are available.

Regulations require clinical commissioning groups, NHS England and local authorities to comply with recommendations in a technology appraisal within 3 three months of its date of publication’.

The CCG will ensure that providers evidence their compliance with and implementation of NICE directives through the Clinical Quality Review Groups (CQRGs), to fully develop the review of these new technologies in the individual healthcare settings and ensure these are visible to all parties.
## 8. Appendix 1 Commissioning Intentions 2017/18 – 2018/19 Schemes

### Prevention

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<tr>
<th>Strategic Aims</th>
<th>Specific targets</th>
<th>What we are planning to do</th>
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| Smoking        | To reduce smoking rates to 13% by 2020-21 | - Completion of a CLeaR tobacco control peer assessment.  
- Completion of NICE PH48 self-assessment by community, acute and mental health providers.  
- Embed the implementation and delivery of NICE Public Health Guidelines 48, 45 and 26 in local plans and strategies and utilise commissioning levers to maximise achievements of NICE Guidance.  
- Maintain investment in local tobacco control - in particular stop smoking services. |
| Alcohol        | Reduce prevalence of health harms associated with alcohol whilst reducing alcohol related hospital admissions (by 3%). | - A focus on prevention utilising Making Every Contact Count, including with young people.  
- Improve prevention through brief interventions in primary care services.  
- Improved data collection and sharing from A&E departments and Yorkshire Ambulance Service.  
- Preventing ill health by risky behaviours – alcohol and tobacco – is included in the mandated CQUIN scheme in community and mental health in 2017-19 and acute in 2018/19. |
| Obesity        | Reduce the number of people currently at high risk of type II diabetes (non-diabetic hypoglycaemia) as identified by the NHS health check and in primary and secondary care from going on to develop type II diabetes | - Participate in Wave 2 of the National Diabetes Prevention Programme from April 2017 to better target people at risk of type II diabetes.  
- Reduce the prevalence of physically inactive adults as per the National Physical Activity Strategy ‘Everybody Active, Everyday’.  
- Embed the North Yorkshire Healthy Weight, Healthy Lives Strategy. |
| Workforce      | To enhance the health and social care workforce contribution to place based prevention care and lifestyle behavioural change. | - A local plan for Making Every Contact Count.  
- Health Promoting Hospital - maintaining a focus on health promoting workplace initiatives.  
- The national CQUIN indicators on improving staff health and wellbeing is retained from the 2016/17 scheme as this remains a priority for the NHS. |
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| Right Care - Reducing demand and unwarranted variation in Planned Care Utilisation | Deliver the NHS Constitution standard that more than 92% of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment (RTT).  
Deliver patient choice of first outpatient appointment, and achieve 100% of use of e-referrals by no later than April 2018 in line with the 2017/18 CQUIN and payment changes from October 2018.  
Streamline elective care pathways, including through outpatient redesign and avoiding unnecessary follow-ups. | The Harrogate Clinical Board (CCG, HDFT and YHN) has been established to better understand elective care demand, which has been consistently above the England average for the past 5 years. We are utilising tools available through RightCare to undertake benchmarking and identify opportunities for value and savings. The priorities are:  
• **Referral Management Service (RMS):** to commission a single point of access for referrals, to ensure all agreed pathways have been followed, all relevant diagnostics results included, that the patient is referred to the correct service, feedback and appropriate guidance is provided to the referring clinician to redirect referrals away from secondary care, when not needed to the most appropriate setting.  
• **Consultant to consultant referrals (C2C):** all C2C referrals to be managed through the RMS, excluding: 2 week waits, those patients on a cancer pathway and urgent referrals, to ensure patients receive the care they need in the most efficient and effective way.  
• **Clinical Thresholds:** continue to support patients with health optimisation programmes, including weight management, smoking cessation and alcohol management for planned routine non-urgent procedures.  
• **Procedures of Limited Clinical Value:** to continue to only pay for procedures that adhere to the thresholds laid out in the Procedures of Limited Clinical Value policy. The CCG will audit or introduce a process to ensure compliance.  
• **Outpatient Follow Ups:** to commission an outpatient follow ratio of 1 to 1:8, working with providers to implement patient initiated care including patient passports with clear action plans.  
• **Share decision making:** to embed the process in which patients, when they reach a decision crossroad in their health care, can review all the treatment options available to them and participate actively with their healthcare professional in making that decision. This will include the use of Patient Decisions aids in both primary and secondary care.  
• **Transforming outpatient appointments:** we will work with providers to explore alternative formats for outpatient appointments to reduce demand (e.g. virtual... |
clinics and one-stop clinics).

- **Integrating technology:** using technology to improve access to specialised expertise; increase patient engagement; and facilitate information sharing between care settings. 100% use of e-referrals by April 2018 in line with the 2017/18 CQUIN.

- **Diabetes:**
  - Increase the proportion of diabetes patients that have achieved all of the NICE recommended treatment targets.
  - Increase the proportion of people with diabetes diagnosed less than a year who attend a structured education course.
  - Rollout the Wave 2 Diabetes Prevention Programme during 2017/18.

- **Diagnostics endoscopy and cardiology:** review the current service to inform the future commissioning.

- **ENT and audiology:** review of the pathway to inform future commissioning.

- **Elective Care Rapid Testing:** A pilot to change the follow-up of people with chronic or relapsing gastroenterological problems has been initiated through the programme, aimed at improved patient pathways and closer working with secondary care. It is planned to roll the model out across all specialities from January 2017.

- **A community based phlebotomy service** will be commissioned from January 2017 from all GP practices, improving equity and ease of access for all patients and speeding up investigation while reducing demand on Secondary Care (target reduction of 50%).

- **Practice Based Budgets:** to continue to share with practices quarterly data packs including; Outpatients, elective care, non-elective care and highlighting areas to focus on. To deliver action plans agreed with practices.
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| **To deliver an Integrated Urgent Care System so that:**                    | **Continued delivery of the four hour A&E standard.**                                                                                                                                                    | **New Care Models:** to deliver co-ordinated and integrated teams in primary and community services across the locality to optimise care for patients at home by increasing the skill mix and commissioning a Response and Overnight team expanding to a 24/7 facility. Commission dedicated step up/step down beds.  
**Seven day services:** By autumn 2017, four clinical standards will be implemented to cover all urgent network specialist services (vascular surgery, stroke, major trauma, STEMI heart attack, and children’s critical care).  
  - Timely consultant review.  
  - Improved access to diagnostics.  
  - Consultant directed interventions.  
  - Ongoing review in high dependency areas.  
**Ambulance services:** to review the function of ambulance service by providing more responsive treatment at home.  
**Co-located and coordinated Urgent Care Service:** to review access to walk in minor illness and minor injury services, to include telephone consultations; to review out-of-hours GP services in 2017/18 in light of extended access to primary care and implementation of the New Care Model and as part of West Yorkshire and Harrogate STP Urgent and Emergency Care workstream.  
**Paediatrics:** to review the Paediatric service to work closely with GPs, Urgent care and Out-of-Hours to assess children rather than be immediately admitted.  
**Telemedicine:** roll out of telemedicine into care homes to support staff 24/7 with immediate access to a consultant opinion to reduce unnecessary need to take a patient to hospital.  
**NHS 111 Clinical Hub:** to increase the use of NHS clinical hub into 2017/18 for patients to be transferred to a clinical advisor for triage and advice.  
**End of Life Care:**  
  - Implement an Electronic Palliative Care Coordination System (EPaCCS).  
  - Develop End of Life Care awareness training for New Care Models teams, including training on having difficult conversations – supporting all staff to have skills and confidence to care for patients at End of Life.  
  - Engage with Yorkshire Ambulance Service through A&E Delivery Group and... |
| People with urgent care needs, including mental health crisis, receive a highly responsive service that delivers care close to home, minimising disruption and inconvenience for patients and their families. | **Reduction in A&E attendances by 11% by 2018/19.**  
**Reduction in emergency admissions by 16% by 2020/21.**  
**Reduction in readmissions.**  
**Reduction in delayed transfers of care.**  
**Reduction in the proportion of ambulance 999 calls that result in avoidable transportation to an A&E department**  
**Collaborative workforce solutions across WY&H** | **Co-located and coordinated Urgent Care Service:** to review access to walk in minor illness and minor injury services, to include telephone consultations; to review out-of-hours GP services in 2017/18 in light of extended access to primary care and implementation of the New Care Model and as part of West Yorkshire and Harrogate STP Urgent and Emergency Care workstream.  
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  - Engage with Yorkshire Ambulance Service through A&E Delivery Group and... |
| Those with more serious or life-threatening emergency care needs, receive treatment in centres with the best expertise and facilities to maximise the chances of survival and good recovery. | | **Telemedicine:** roll out of telemedicine into care homes to support staff 24/7 with immediate access to a consultant opinion to reduce unnecessary need to take a patient to hospital.  
**NHS 111 Clinical Hub:** to increase the use of NHS clinical hub into 2017/18 for patients to be transferred to a clinical advisor for triage and advice.  
**End of Life Care:**  
  - Implement an Electronic Palliative Care Coordination System (EPaCCS).  
  - Develop End of Life Care awareness training for New Care Models teams, including training on having difficult conversations – supporting all staff to have skills and confidence to care for patients at End of Life.  
  - Engage with Yorkshire Ambulance Service through A&E Delivery Group and... |
urgent care work streams, to improve care co-ordination.

- Work with local pharmacies regarding access to medication – checking stock, keeping primary care, OOH and Integrated Community Teams informed and clarifying Care Home training requirements and expectations around End of Life care for those in receipt of Free Nursing Care or Continuing Healthcare funding.

**Angio pathway:** review the current urgent care pathway with HDFT and providers to ensure patients can have diagnostic procedure and if required subsequent intervention in the same encounter.

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### Stroke

<table>
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<tr>
<th>Strategic Aims</th>
<th>Specific targets</th>
<th>What we are planning to do</th>
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</table>
| To reduce the incidence of stroke and avoidable deaths due to stroke across the WY&H health economy, minimizing the long term effects and improving quality of life | To reduce smoking rates to 13% by 2020-21 Reduce under 75 mortality rate from cardiovascular disease (CVD) Reduce hypertension QOF prevalence all ages national / West Yorkshire & Harrogate/ CCG Reduce premature mortality from stroke Reduce incidence of stroke Increase identification & treatment of Atrial Fibrillation (AF) with oral anticoagulants (OACs) | • Continue to work with colleagues in the local authority on the prevention agenda: reducing lifestyle risk factors including reducing smoking prevalence, obesity and alcohol related admission and embedding ‘Making Every Contact Count’ into everyday practice.

• Improve the identification and management of anti-coagulation for known patients with Atrial Fibrillation (AF).

• Improve the identification and management of patients with hypertension by increasing the uptake of NHS health checks, increase the % of people whose blood pressure is controlled to 150/90.

• Work with key stakeholders to understand the options for delivering hyper-acute and acute rehabilitation of services.

• Formal consultation with our population on the configuration of services during 2017/18. |
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</table>
| Primary Care Transformation – ensuring primary care is sustainable for the future, delivering more streamlined and integrated primary and community based services: | Extended access to primary care evenings and weekends in 2017/18. | • Improving access to general practice in and out of hours
• HaRD practices to commence offering evening and weekend appointments to general practice between April and September 2017.
• Provision of access will be delivered through pre-bookable and same day appointments.
• Clear communication and advertisement of extended access by practices and CCG.
• Use of digital approaches to support new models of care in general practice.
• Appointments being provided within hubs to support practices working at scale.
• Roll out of direct booking of patients identified via NHS 111 into GP in hours appointments in practices (part of the West Yorkshire Urgent Care Vanguard).
• Technology
• Use of digital approaches to support new models of care in general practice including online General Practice consultation systems
• Growing the primary care workforce
• New roles to support GP consultations e.g. clinical pharmacists within practices, development of practice staff e.g. Training Care Navigators and Medical Assistants, Practice Manager Development
• Better management of workload and release of time in the practice
• Looking at opportunities to share back office functions, the first of the 10 high impact areas to be taken forward locally will be:
  • Active signposting
  • Develop the team
  • Partnership working
  • Social prescribing
  • Support self-care
• Develop QI expertise
• Development of primary care estate |
### Strategic Aims

- **Implement the cancer taskforce report:**
  - Preventing cancer by addressing cancer risk factors.
  - Diagnosing more cancers early.
  - Improving cancer treatment and care.

- **Deliver the NHS Constitution 62 day cancer standard**

- **Make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.**

- **Ensure all elements of the Recovery Package are commissioned**

### Specific targets

<table>
<thead>
<tr>
<th>What we intend to do</th>
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<tbody>
<tr>
<td>- Continue to work with colleagues in the local authority on the prevention agenda: reducing lifestyle risk factors including reducing smoking prevalence and embedding ‘Making Every Contact Count’ into everyday practice.</td>
</tr>
<tr>
<td>- Increase rates of uptake of breast, bowel and cervical screening programmes, particularly targeting rural and older populations and people with learning disabilities.</td>
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<tr>
<td>- Ensure that 85% of patients continue to meet the 62 day standard, identify any 2017/18 diagnostic capacity gaps, increasing GP direct access to diagnostics (blood tests, chest x-ray, non-obstetric ultrasound, MRI, CT, endoscopy) and planning for a 7% per year level of headline growth in diagnostics up to 2020/21 within available resources.</td>
</tr>
<tr>
<td>- Increase delivery of the Recovery Package interventions, understanding current coverage and agreeing a plan so that by 2020 every person with cancer will have access to elements of the Recovery Package, and stratified pathways of follow up are in place for common cancers. Priorities for 2017/18 are: holistic needs assessment and care plan at the point of diagnosis; treatment summary sent to the GP at the end of treatment; implementation of cancer care reviews in primary care within 6 months of diagnosis.</td>
</tr>
<tr>
<td>- We will commission stratified pathways of care for people living with or beyond cancer. Risk stratified follow up care for breast cancer patients will commence in 2017/18 and prostate and colorectal patients in 2018/19.</td>
</tr>
<tr>
<td>- Work with providers to ensure that all cancer patients, with a primary, secondary or metastatic diagnosis, have access to a clinical nurse specialist or other key worker.</td>
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## Strategic Aims

<table>
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<tr>
<th>Strategic Aims</th>
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<th>What we intend to do</th>
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</thead>
</table>
| Increase access to high-quality evidence based mental health care treatment for children and young people so at least 32% of children with a diagnosable condition are able to access evidence-based services by April 2019. | Increase access by 7% in each of 2017/18 and 2018/19 (to meet 32% of local need in 2018/19). | The CCG is supporting the implementation of a number of developments including:  
- The **Single Point of Access** to CAMHS to:  
  - Simplify access for referrers and service users  
  - Allow the service to work to a single operating model  
  - Make best use of expertise at the first point of contact.  
- The CCG has supported North Yorkshire County Council in commissioning a pilot for a school based assessment and intervention tool to increase emotional resilience of vulnerable children and young people. The evaluation from the pilot will be shared in summer 2017 to inform any future commissioning intentions.  
- A hub and spoke model supported by a single multi-disciplinary team across North Yorkshire to meet the needs of children and young people with eating disorders.  
- **A School Mental Health Project** across North Yorkshire to improve and strengthen the support to children and young people emotional and mental health issues in schools. This is a new service and Implementation is expected to be January 2017.  
- Co-ordinated approach across WY&H to local transformation plans and wider system approach to integrated pathway development:  
  - Working as a system to eradicate out of area placements and children on adult wards.  
  - WY&H approach to improvements in ADHD and Autism (children and adults) pathways. |
| Increase access to evidence-based community eating disorder services          | 95% of children in need receive treatment within one week for urgent cases, and four weeks for routine cases | • Commission dedicated eating disorder teams in all areas.  
• Join the national quality and accreditation network for community eating disorder services (QNCC ED) to monitor improvements and demonstrate quality of service delivery.  
• Baseline current performance against the access and waiting time standard 2016/17 and plan for improvement from 2017/18.  
• Develop joint agency plans with the provider to achieve targets. |
| For in-patient stays for children and young people to only take place where clinically appropriate, to have the minimum possible length of stay, and to be as close to home as possible to avoid inappropriate out of area placements. | By 2020/21 elimination of in-patient stays where clinically inappropriate. Zero out of area placements for non-specialist acute care. Zero use of beds in paediatric and adult wards | • Implement actions resulting from collaborative commissioning plans with NHS England’s specialist commissioning teams to be published by December 2016. These plans will include locally agreed trajectories for aligning in-patient beds to meet local need and where there are reductions releasing resources to be redeployed in community-based services. • NHS England is leading a new programme, announced in the Planning Guidance 16/17, that aims to put local clinicians and managers in charge of both managing tertiary budgets and providing high quality secondary care services. Tees, Esk and Wear Valley Foundation Trust was selected as one of the providers selected as the first-wave sites, working towards a go-live date in October 2016 to cover the North East and North Yorkshire. This will provide the incentive and responsibility to put in place new approaches which will strengthen care pathways to:
  o improve access to community support
  o prevent avoidable admissions
  o reduce the length of in-patient stays and,
  o eliminate clinically inappropriate out of area placements. • Move towards all general in-patient units for children and young people to be commissioned on a ‘place-basis’ by localities, so that they are integrated into local pathways • Utilise money released from pump-priming of 24/7 crisis resolution and home treatment services to achieve further improvements in access and waiting times • Develop joint agency plans with the provider to achieve targets |

| For all areas to be part of CYP IAPT including taking part in workforce capability programme. | National target for at least 1,700 more therapists and supervisors to be employed to meet additional demand. | • Commission CYP IAPT in all areas in 2017/18 • Ensure that all services are working within the CYP IAPT workforce programme. • Implement joint agency plans between CCGs and providers to ensure continuing professional development of staff |

| To ensure availability of 24/7 urgent and emergency mental health services for children and young people. | • Collect data to create a 2017/18 baseline. • Commission effective 24/7 crisis response and home treatment teams as an alternative to acute admissions. • Develop joint agency plans with the provider to achieve targets. |

**Perinatal mental health**
### Strategic Aims

<table>
<thead>
<tr>
<th>Specific targets</th>
<th>What we intend to do</th>
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<tbody>
<tr>
<td>Increase access to evidence-based specialist perinatal mental health care</td>
<td>100% access by 2020/21</td>
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</table>
| • The specialist perinatal mental health community services development fund was launched in August 2016, to promote service development and quality improvement and increase the availability of high-quality care for women and families. Local bids were unsuccessful as part of the wave 1 development.  
• Planning for service development will be undertaken in 2017/18 for inclusion in commissioning intentions 2019/20.  
• Support a collaborative approach. |

### Adult mental health

<table>
<thead>
<tr>
<th>Specific targets</th>
<th>What we intend to do</th>
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</table>
| That by 2020/21, there will be increased access to psychological therapies for people with common mental health conditions with the majority of new services being integrated with physical healthcare. | 19% access in 2019  
25% access in 2020/21  
(National target of 3000 therapists to be co-located with GPs by 2020/21)  
75% accessing therapy in 6 weeks (2020)  
95% accessing therapy in 18 weeks (2020) |
| • Commission IAPT services with mental health therapists being co-located in primary care.  
• Develop joint agency plans with the provider to meet access and timeframe targets.  
• Implement the pilot in Harrogate for Integrated IAPT Early Implementer.  
• Participation in NHS England programme for digitally-enabled IAPT (details to be available autumn 2016). |

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<thead>
<tr>
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</table>
| To provide timely access to evidence-based, person-centred care for people with first episode psychosis, which is focused on recovery and integrated with primary and social care and other sectors. | 53% of people experiencing a first episode to begin treatment with a NICE-recommended package with a specialist early intervention in psychosis (EIP) service within 2 weeks of referral (2018/19)  
25% of teams rated as good in CCQI assessments (2018/19) |
| • Develop joint agency plans with the provider to meet quality and timeframe targets following national audit for 2017/18. |

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<thead>
<tr>
<th>Specific targets</th>
<th>What we intend to do</th>
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<tbody>
<tr>
<td>A reduction in premature mortality of people living with severe mental illness (SMI).</td>
<td>30% of people with SMI registered with a GP to have physical health screening / interventions (2017/18)</td>
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<tr>
<td>We will commission, in line with 2017/18 CQUINs, cardio metabolic assessment based on the Lester Tool and treatment for patients with psychoses in the following areas:</td>
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<tr>
<td>Task Description</td>
<td>Target</td>
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<tr>
<td>Increase access to Individual Placement Support enabling people with severe mental illness to find and retain employment.</td>
<td>Increase by 25% in 2019 against 2017/18 baseline</td>
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<tr>
<td>For all areas to provide crisis resolution and home treatment teams (CRHTTs) that are resourced to operate in line with recognised best practice – delivering a 24/7 community-based crisis response and intensive home treatment as an alternative to acute inpatient admissions.</td>
<td>To meet recommended best practice guidelines.</td>
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<tr>
<td>Eliminate inappropriate out of area treatments (OATs) for acute mental health care</td>
<td>Elimination of out of area placements for non-specialist acute care (2020/21)</td>
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<tr>
<td>Provision of ‘core 24’ mental health liaison services in emergency</td>
<td>Liaison mental health teams to be in place in all acute hospitals (2020/21) ‘Core 24’ services to be in place in 50% of acute</td>
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<tr>
<td>Department/Service Area</td>
<td>Description</td>
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<td>departments and inpatient wards in acute hospitals (2020/21)</td>
<td>hospitals (2020/21)</td>
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</table>
| Provision of armed forces / veteran mental health services.                             | By 2020/21, all NHS-commissioned mental health providers will have armed forces champions and a specific named clinician with an expertise in military trauma.                                             | • Develop joint agency plans with the provider 2017/19  
• Support co-commissioning work with NHS England for the national procurement of local specialist community services, and investment in research to improve the evidence base on effective interventions for the armed forces community. 2017/18 |
| Expand community-based services for people who require them to prevent avoidable admissions and support ‘step down’ and ongoing recovery in the community as soon as appropriate for the individual and as close to home as possible. |                                                                                                                                             | • Evaluate current pathways in and out of mental health secure care with a focus on expanding community-based services                                                                                     |
| Reduction in suicide levels                                                             | Reduction of 10% against 2016/17 baseline                                                                                                                                                               | The North Yorkshire Suicide Audit 2010-14 identified five recommendations which are used to inform the North Yorkshire Suicide Prevention Implementation Plan 2016-18: 1. Reduce the risk of suicide across the North Yorkshire population, particularly targeting high-risk groups 2. Recognising that ‘multiple stresses multiply risk’: enhance service provision in relation to common stressors 3. Improve support for those affected by suicide in North Yorkshire in the days, months and years after a death. 4. Further develop data collection and monitoring 5. Training and Awareness We will continue to implement the local multi-agency suicide prevention plans together with local partners. |
A West Yorkshire and Harrogate STP system-wide multi-agency suicide prevention strategy is in development.

<table>
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<tr>
<th>To provide timely access to diagnosis and evidence-based, person-centred care for people with dementia</th>
<th>By 2019 half of CCGs should have diagnosed 67% of estimated local prevalence. By 2020 the number being diagnosed and starting treatment should be increased by over 5% compared to 2015/16 baseline.</th>
<th>• Review of services against forthcoming NHS implementation guidance focusing on post-diagnostic care and support and development of a plan to address the gaps. Maintain or improve on current diagnostic rates, which exceed the national targets</th>
</tr>
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<tbody>
<tr>
<td>Data quality and transparency</td>
<td>• System wide approach to benchmarking and performance. • Development of shared outcomes for mental health in WY&amp;H. • Assure that providers are submitting a complete, accurate data return for all routine collections in the Mental Health Services Data Set, IAPT MDS and to any ancilliary collections.</td>
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### Learning Disability

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<tr>
<th>Strategic Aims</th>
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<tbody>
<tr>
<td>Implementation of Transforming Care Partnership plans</td>
<td>By 2019 there is a national target of a reduction of CCG-commissioned beds to 10-15 per million and of NHS-commissioned beds to 20-25 per million.</td>
<td>The North Yorkshire Transforming Care Partnership’s (TCP) plan focuses on how it will: • Improve and expand the services it provides in the community. • Provide new homes locally for people who are suitable to be discharged from long stay hospital placements. Make sure the TCP has the right staff with the right skills to provide this new type of service 24 hours a day, seven days a week and that they work closely with local community clinical teams.</td>
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<tr>
<td>Reduction of LD inpatient bed capacity</td>
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<td>The North Yorkshire and York Transforming Care Partnership is scoping an alternative community model, providing • An ‘Enhanced’ Community Learning Disability Team Service; extending operating hours to 7 days per week including Positive Behavioural Support (PBS) expertise and a Home Intensive Treatment (HIT) service providing an urgent care response into people’s homes and the community. • ‘New home’ housing option(s) with 24/7 Positive Behaviour Support (PBS) trained carers; with contingency living units/facilities to provide ‘interchangeable’ stepped up/down, crisis and also respite care.</td>
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<tr>
<td>Improved access to healthcare</td>
<td>75% of those with LD on a GP register to receive an annual health check</td>
<td>Promote <strong>annual health checks</strong> in primary care for people with Learning Disabilities.</td>
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<tr>
<td>Reduction of premature mortality for those with autism and/ or LD</td>
<td>• Work with partners to reduce mortality by improving access to health services, education and training of staff and by making reasonable adjustments</td>
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### Maternity

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<tbody>
<tr>
<td>Implement the national maternity services review, Better Births through Local Maternity Systems.</td>
<td></td>
<td>The <strong>Yorkshire and Humber Clinical Network</strong> work programme priorities are based on national, regional and local priorities for the commissioning of maternity services:</td>
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<tr>
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<td>• Focusing on reducing stillbirths and improving services for bereaved families</td>
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<td></td>
<td>• Reviewing and improving perinatal mental health care provision</td>
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<td></td>
<td>• Reviewing and improving maternal enhanced and critical care services</td>
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<td>• Yorkshire and Humber Maternity Dashboard supporting the development of improved data collection</td>
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<td>• Supporting implementation of the Maternity Transformation Programme based on the National Maternity Review</td>
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<td>• Working collaboratively with stakeholders</td>
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<td>• Ensuring appropriate user involvement in work programme activities</td>
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<td>Following the Discover! Maternity engagement project to provide local level information and the possible options for extending choice for the local population we will use to feedback gathered to:</td>
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<td>• Develop a maternity commissioning strategy in response to the national maternity review in 2017/18.</td>
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<td>• Implement service redesign.</td>
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<td>• Monitor implementation of provider action plans, detailing how they will implement the recommendations by 2020/21.</td>
</tr>
<tr>
<td>Reduce stillbirths, neonatal and maternal</td>
<td>Measurable reduction by 2020 and 50% by 2030.</td>
<td>The National Team has agreed 4 elements for inclusion in the National Stillbirth Care Bundle: Smoking Cessation / Reduced Fetal Movements / Small for</td>
</tr>
</tbody>
</table>
deaths and brain injuries caused during or soon after birth.

Gestational Age / cardiotocograph (CTG) Interpretation.
Locally we will work with providers to implement all aspects of the ‘Saving Babies Lives’ care bundle.

Other areas

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<tr>
<th>Strategic Aims</th>
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<tbody>
<tr>
<td>Increased levels of patient satisfaction as recorded by the Friends and Family test</td>
<td>Maintain or increase the number of people recommending services (currently 88-96%)</td>
<td>• Work with providers to ensure feedback improves services</td>
</tr>
<tr>
<td>Increase uptake of Personal Health budgets</td>
<td>1-2% of population to have a personal health budget by 2020</td>
<td>• Review and implement action plan developed by Personal Health Budget Steering Group</td>
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<td>• Work with CCGs to promote the PHB service</td>
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<tr>
<td>Support delivery of a 24/7 integrated care service for physical and mental health</td>
<td>An integrated care service for physical and mental health should be implemented by March 2020 in each STP footprint including a clinical hub that supports NHS 111, 999 and out-of-hours calls.</td>
<td>• Work with partners to develop a delivery plan including using a cross-system approach to prepare for a forthcoming waiting time standard for urgent care for those in a mental health crisis.</td>
</tr>
<tr>
<td>Use of new payment approaches linked to quality and outcomes.</td>
<td></td>
<td>• Implement for adult mental health in 2017/18.</td>
</tr>
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</table>