Sustainability and Transformation Plan: Harrogate District (5.3)

Draft Working Document v13

Nominated Lead: Amanda Bloor, Chief Officer (amanda.bloor@nhs.net)

Organisations within the STP Footprint: NHS Harrogate and Rural District Clinical Commissioning Group, North Yorkshire County Council, Harrogate Borough Council, Harrogate and District NHS Foundation Trust, Tees, Esk and Wear Valleys NHS Foundation Trust, Yorkshire Health Network.
Our collective leadership aim is to achieve the best possible outcomes for the population through delivery of the Five Year Forward View

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

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

**What does this mean for people using our 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.

**Priority areas:**

- Prevention at Scale
- Mental health
- Stroke
- Cancer
- Urgent and emergency care
- Specialised commissioning
- Primary and community services
- Acute reconfiguration
- Standardisation and reducing variation
2. OUR CASE FOR CHANGE
Serving a population of approximately **157,200***

- Harrogate Borough Council
- Harrogate and District NHS Foundation Trust
- Harrogate and Rural District Clinical Commissioning Group
- Harrogate College
- North Yorkshire County Council
- North Yorkshire Police
- North Yorkshire Fire & Rescue Service
- Office of Police and Crime Commissioner North Yorkshire
- Department of Work and Pensions
- Tees, Esk and Wear Valleys NHS Foundation Trust
- Yorkshire Health Network
- Yorkshire Ambulance Service
- Yorkshire & Humber Academic Health Science Network
- 17 GP Practices
- 81 registered care homes (residential and nursing home).
- Extra Care Housing
- 2 Independent Sector Healthcare Providers (in-patient)
- Healthwatch North Yorkshire
- Harrogate & Ripon Centres for Voluntary Services
- Volunteer Centre
- Numerous community and voluntary organisations
- 250 Support Groups

*ONS mid-2014 population estimate (JSNA Refresh, 2016)

A total allocation of **£293m** across health and social care in 2016/17, rising to **£323m** by 2020/21.
## NHS Constitution Requirements

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Target</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance waits: Red 1 &amp; 2 responded to within 8 minutes (YAS)</td>
<td>April 2016</td>
<td>75%</td>
<td>Red 1: 69.1% Red 2: 74.2%</td>
</tr>
<tr>
<td>A&amp;E (All): wait time within 4 hours (HDFT)</td>
<td>May 2016</td>
<td>95%</td>
<td>95.5%</td>
</tr>
<tr>
<td>18 weeks Referral to Treatment (HDT)</td>
<td>May 2016</td>
<td>92%</td>
<td>96.2%</td>
</tr>
<tr>
<td>Diagnostic test Waiting Time: longer than 6 weeks (HDT)</td>
<td>May 2016</td>
<td>&lt;1%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Cancer 1st consultant appointment &lt; 2 weeks (HDT)</td>
<td>May 2016</td>
<td>93%</td>
<td>96.05%</td>
</tr>
<tr>
<td>Cancer: decision to treat &lt; 31 days (HDT)</td>
<td>May 2016</td>
<td>96%</td>
<td>96.97%</td>
</tr>
<tr>
<td>Cancer: treated within 62 days of urgent GP referral (HDT)</td>
<td>May 2016</td>
<td>85%</td>
<td>93.10%</td>
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## Population Health Characteristics

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>England</th>
<th>HaRD CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity: QOF prevalence (16+)</td>
<td>2014/15</td>
<td>9.0</td>
<td>7.5</td>
</tr>
<tr>
<td>% of physically inactive adults</td>
<td>2014</td>
<td>27.7</td>
<td>19.3</td>
</tr>
<tr>
<td>Est smoking prevalence (QOF)</td>
<td>2014/15</td>
<td>18.4</td>
<td>15.0</td>
</tr>
<tr>
<td>Smoking cessation support and treatment</td>
<td>2014/15</td>
<td>94.1</td>
<td>97.1</td>
</tr>
<tr>
<td>Alcohol-specific hospital admission</td>
<td>2014/15</td>
<td>374</td>
<td>323</td>
</tr>
<tr>
<td>Hypertension: QOF prevalence (all ages)</td>
<td>2014/15</td>
<td>13.8</td>
<td>14.8</td>
</tr>
<tr>
<td>Depression: QOF prevalence (18+)</td>
<td>2014/15</td>
<td>7.3</td>
<td>8.2</td>
</tr>
<tr>
<td>Learning disability: QOF prevalence</td>
<td>2014/15</td>
<td>0.4</td>
<td>0.6 (high)</td>
</tr>
<tr>
<td>Premature mortality from coronary heart disease</td>
<td>2014</td>
<td>40.0</td>
<td>23.6</td>
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<tr>
<td>Premature mortality from stroke</td>
<td>2014</td>
<td>13.5</td>
<td>15.7</td>
</tr>
<tr>
<td>Premature mortality from respiratory disease</td>
<td>2013</td>
<td>28.1</td>
<td>15.4</td>
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## National Child Measurement Programme: Indicators

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<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>England</th>
<th>NYCC</th>
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<tbody>
<tr>
<td>Reception: Prevalence of underweight</td>
<td>2014/15</td>
<td>0.96</td>
<td>0.52</td>
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<tr>
<td>Reception: Prevalence of healthy weight</td>
<td>2014/15</td>
<td>77.2</td>
<td>78.4</td>
</tr>
<tr>
<td>Reception: Prevalence of overweight (including obese)</td>
<td>2014/15</td>
<td>21.9</td>
<td>21.1</td>
</tr>
<tr>
<td>Reception: Prevalence of obesity</td>
<td>2014/15</td>
<td>9.1</td>
<td>8.1</td>
</tr>
<tr>
<td>Year 6: Prevalence of underweight</td>
<td>2014/15</td>
<td>1.42</td>
<td>1.04</td>
</tr>
<tr>
<td>Year 6: Prevalence of healthy weight</td>
<td>2014/15</td>
<td>65.3</td>
<td>68.9</td>
</tr>
<tr>
<td>Year 6: Prevalence of overweight (including obese)</td>
<td>2014/15</td>
<td>33.2</td>
<td>30.1</td>
</tr>
<tr>
<td>Year 6: Prevalence of obesity</td>
<td>2014/15</td>
<td>19.1</td>
<td>15.2</td>
</tr>
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## Antimicrobial Resistance

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>England CCG Median</th>
<th>HaRD CCG</th>
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<tbody>
<tr>
<td>Reduction in the number of antibiotics prescribed in primary care</td>
<td>April 2016</td>
<td>1.094</td>
<td>0.915</td>
</tr>
<tr>
<td>Reduction in the proportion of broad spectrum antibiotics prescribed in primary care</td>
<td>April 2016</td>
<td>9.7</td>
<td>6</td>
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</table>
2.3 The Case for Change: Engaging with patients, carers and the wider community in everything that we do.

Using **existing engagement information** to inform all of our plans and priorities

**National Surveys**
- Adult Inpatient Survey
- Accident & Emergency Survey
- Community Mental Health Survey
- GP Patient Survey
- Staff Survey

**Friends and Family Test**
- 10 million pieces of feedback nationally
  - In May 2016 patients recommended local services as follows:
    - Inpatient care – 97%
    - A&E – 95%
    - Primary care – 87%
    - Community care – 94%
    - Mental Health – 87%
    - Maternity – 96 to 100% (4 Questions)
    - Outpatients – 96%

**Local Surveys**
- Gluten Free Prescribing Survey
- Dementia Strategy Survey
- Discover! Maternity engagement project
- Engagement events and survey with people with autism and their families in North Yorkshire
- Community Engagement
- Patient Participation Groups

**Local Strategy Development**
**Example: 2020 North Yorkshire Care and Support Where I Live Strategy.** In 2014 we asked people what they thought of our plan.
- “They said we should help people to live independently in their own homes.”
- “They said we should make sure people could have good quality homecare.”
- “They said we should provide more extra care housing.”
- “We should help people with home adaptations to make it easier for them to live on their own.”
- “We should make sure people could get good information and advice. We should help people to stay safe in their home. This could include giving them special equipment or provide Telecare.”

**New Care Models**
- “**What Matters to Us**”
  - “I have easy-to-understand information about care and support which is consistent, accurate, accessible and up to date, in order to prevent illness, remain as independent as possible and in times of need”
  - “I know who to contact to get things changed”
  - “I am in control of planning my care and support and respected as understanding my own health and conditions”
  - “I feel safe receiving preventative, long term condition management, crisis and end of life care closer to home”
  - “I am supported by a team of people who are confident, happy, coordinated, know what they are doing and trust each other so I don’t need to tell my story again and again”
2.4 The Case for Change

The Harrogate and District STP is a description of the local approach to the West Yorkshire STP priorities and the system response to the uniqueness of the population.

Health and Wellbeing:

• **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 – 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 – with **children living in poverty and households in fuel poverty**.

• There were a total of 90 **excess winter deaths** reported in Harrogate in 2013-14. For every excess winter death it is estimated that there are an additional eight emergency admissions to hospitals.

Quality and Care:

• 1 in 5 acute admissions could be managed in less acute settings, 2 in 3 acute beds occupied by people whose needs could be met in a less acute environment.

• There is a fragile residential and nursing care market with issues of quality and affordability. There are a number of factors for this including workforce retention, providers leaving the market and the physical standards of buildings not meeting regulations.

• People’s changing expectations about what they need, and how they want to live their lives.

Finance and Efficiency:

The health care system faces a **funding gap of £42.2m by the end of 2020/21** – based on ‘do nothing’.

The STP builds on existing priorities and plans to deliver the Harrogate Health Transformation Board vision. The locality is already developing a **New Care Model**, implementing Integrated Care Teams from four community based hubs which include GPs, community nursing, adult social care, occupational therapy, physiotherapy, mental health and the voluntary sector. Boundaries between primary, community, acute, mental health and social care will be removed and acute hospital beds will be used only when they are truly needed. The locality is also one of eighteen **transformation areas** nationally in 2016/17 focussing on technology, GP access, urgent and emergency care reform and mental health. The next phase in the transformation of out of hospital care is the transformation of current primary care to a sustainable model of primary care at scale, including extended access and links to out of hours and an urgent care facility.
3. OUR PRIORITIES
3. Our Priorities – Delivering the Triple Aims

1 Sustainability and Transformation Plan for West Yorkshire, made up of:

6 local plans:
- Bradford and Craven
- Calderdale
- Harrogate and Rural District
- Kirklees
- Leeds
- Wakefield

West Yorkshire wide priority areas:
- Prevention at Scale
- Mental health
- Stroke
- Cancer
- Urgent and emergency care
- Specialised commissioning
- Primary and community services
- Acute reconfiguration
- Standardisation and reducing variation

West Yorkshire wide enabling workstreams:
- Workforce
- Digital
- Leadership and OD
- Communications and engagement
- Finance & Business intelligence
- Innovation and best practice
- Commissioning

Our Harrogate and Rural District Priorities

- New Care Model: ‘What Matters to Us’
- Prevention is Better Than Cure
- Primary Care Transformation
  - 10 High Impact Actions to Release time to Care
  - Primary Care at Scale
  - Enhanced Access
- RightCare / Reducing Variation:
- Mental Health
  - Early Intervention Psychosis
  - Improving Access to Psychological Therapies
  - Local Transformation Plans for Children and Young People
  - Dementia
  - Building the Right Support
- Cancer
  - Prevention: Promoting lifestyle changes
  - Maximising screening uptake
  - Supporting early diagnosis of cancer
  - Living With and Beyond Cancer
- Stroke
  - Prevention: Promoting lifestyle changes
  - Hypertension
  - Atrial Fibrillation
  - Early Supported Discharge
- Integrated Urgent Care
- Care Market: Availability and Quality
- Integrated Health and Social Care Commissioning and Service Delivery
- Finance and Efficiency
- Our Enablers
  - Digital Transformation Workforce
  - Estate and Assets
3 Our Priorities – Where will we be in five years time?

Network of providers.
Consolidation of specialist care.

New models of care that make a real difference to people’s lives.
Integrated, teams supporting the person’s needs holistically, (physical, mental health and social).
Primary care operating at scale with enhanced access through community hubs.

Community-based services to reduce lifestyle risk factors - stopping smoking, increasing physical activity, improving diet and reducing obesity.

Improved access
Sustained quality of care
Reduced variation
More co-ordinated care pathways
Standardisation
Clinical thresholds / referral protocols

Better out of hospital care reducing demand for emergency admissions and follow-ups.
Reduced variation.

Engaged and informed people.
Better access to information and education.
Better outcomes.
Our New Care Model will dissolve the boundaries between primary, community, acute, mental health and social care services locally. Existing clinical teams will come together and operate as a single team around the person (and their carers) whilst also embracing the benefits of both community and voluntary organisations to enhance local services.

We are transforming the experience of care, underpinned by:

- Integrated, expanded community-based teams capable of supporting the person’s needs holistically, including their physical, mental health and social needs. Our touchstones are person-centred and led care, care optimised through proactive management, and people supported to manage their conditions in the way that suits them and are enabled to self-care.
- More capacity and enhanced skills to respond rapidly when a person is very unwell and to support them at home whenever this is safe.
- Prevention and early intervention are embedded in our community collaboration with an empowered and active voluntary sector.
- Development of a needs-based information portal to help people and professionals navigate and explore services, in particular those of the voluntary sector, to help maximise independence and self care.
- We are investing in IT to create a sustainable infrastructure that will enable integrated assessment and care planning and monitoring of costs and quality indicators across the entire health and social care system.

This will be achieved through case-finding and optimization of care at home and a rapid response service which will divert admissions and provide intensive support, including overnight care. We have also opened additional community beds to provide step-up intermediate care as an alternative to non-elective admissions.

Our 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 person 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.
- Giving stability to the residential and nursing care market by agreeing fee structure up to 2020 and improving healthcare support to providers through primary care.
- Improved **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 the experience of family members and carer - 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.

We anticipate that the implementation of the new care model will reduce non-elective admissions by 16% by 2020/21 and A&E attendances by 11% by 2018/19.
### 3.1 Our Priorities New Care Model - What Matters to Us

<table>
<thead>
<tr>
<th>Principles</th>
<th>Priorities</th>
<th>Outputs</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Embed prevention + early intervention and empower the community</td>
<td>Teams use mental wellbeing coaching&lt;br&gt;Voluntary sector embedded within integrated teams&lt;br&gt;New interactive community directory is based on needs&lt;br&gt;People and staff have helped design the programme&lt;br&gt;Expansion of assistive technology in the community</td>
<td>4 locality based teams functioning 7 days a week&lt;br&gt;Productive case finding by risk stratification and care homes&lt;br&gt;Assessments are multidisciplinary and integrated&lt;br&gt;Care planning is person-centred and joined up.&lt;br&gt;People have an identified key worker&lt;br&gt;New roles established in the team e.g. pharmacist</td>
<td>▲ Mental wellbeing for people with LTCs&lt;br▲ More self-care, knowledge, independence&lt;br▲ People are more resilient and feel in control of their health&lt;br▼ Health inequalities</td>
</tr>
<tr>
<td>Integrate and expand community health, mental + social care teams</td>
<td>Rev up and expand response in the community</td>
<td>Increased skill mix to GP practices&lt;br&gt;10 extra step up / step down beds in the community.&lt;br&gt;Urgent care services are coordinated with integrated teams.&lt;br&gt;Response and overnight team expands and functions 24 / 7.</td>
<td>▲ Quality of life for people with LTC&lt;br▲ GP/community staff satisfaction&lt;br▲ Person/patient/carer satisfaction&lt;br▼ Growth of permanent long term care</td>
</tr>
<tr>
<td>Develop systems and infrastructure</td>
<td>Shared IT records and interoperability&lt;br&gt;Shared use of estate across the area&lt;br&gt;Development of new commissioning framework&lt;br&gt;New provider arrangements&lt;br&gt;Shared business intelligence</td>
<td>Enablers: Quality&lt;brTransitional funding&lt;brCo-production&lt;brTechnology&lt;brWorkforce&lt;brSystem Leadership</td>
<td>▲ Reliance on non-elective hospital beds&lt;br▲ GP time freed up&lt;brNo ‘wrong door’&lt;brEasier access to rapid response&lt;br▼ ED attendance&lt;br▼ Acute hospital use at end of life</td>
</tr>
<tr>
<td>Clinical outcomes</td>
<td>Patient experience</td>
<td>Safety and quality</td>
<td>Transformation</td>
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**Rationale:** Care is not joined up; 1 in 5 acute admissions could be managed in less acute setting; 2 in 3 acute beds occupied by people whose needs could be met in a less acute environment; lack of capacity in community and primary care settings resulting in not enough ‘time to care’; avoidable admissions to long term social care; duplication between teams; gaps between services; lack of continuity of care; high demand for admission; uneven care home provision; system sustainability; people tell us they want to tell their story once and have a truly seamless services; need for parity of esteem between mental health and rest.
3.2 Our Priorities – Prevention is Better Than Cure

The purpose of this work stream is to develop an integrated approach to prevention as part of the new model of care. Prevention, as a theme, flows through the whole model: we are interested in preventing inappropriate use of services, avoidable growth in demand and unnecessary dependence on services. Our new care model aims to deliver the right care in the right part of an integrated system, as close to home as possible, with admission to hospital only when it is really necessary. Our Local Integrated Teams are developing their approach to proactive case management to prevent avoidable escalation of people’s long-term conditions and our Response and Overnight Service and community step-up beds will have a direct impact on preventing avoidable unplanned admissions.

This work stream, however, is concerned specifically with earlier interventions that support people and communities to stay healthy, well and independent, intervening before more intensive interventions from statutory health and care services are required. The intention is to reduce or delay this, and in some scenarios, prevent it altogether. The work stream will also develop the local approach to supporting people to become more active participants in keeping well and in managing their own health, particularly when they have long-term conditions.

Our approach and key current activity is as follows:

- A shared ethos to the NYCC Stronger Communities approach of:
  Understanding the needs of our communities, helping residents remain healthy and independent, having honest engagement and investing where communities evidence that they are working together to improve resilience
- Investing through Public Heath in a range of evidence based lifestyle prevention services such as weight management and smoking cessation

- Through the NYCC Living Well programme offer individuals personalised support to meet their goals and enable them to self care using motivational interviewing and other evidenced methods.
- We recognise the value of voluntary and community sector services and will develop a clear set of commissioning priorities and joint commission prevention services based on evidence of what works.
- Harrogate and Ripon Council for Voluntary Services has developed an online community directory as part of the New Models of Care to provide easier access for the public and professional staff to prevention activities.

We recognise that the wider determinants of health, such as housing, access to activity and avoiding social isolation are key to the health and wellbeing of our local population. One of our priorities is targeting falls: instead of taking a medical model approach to this. For example; Harrogate Borough Council services including their Independent Living Service (sheltered housing support) and sport and leisure, as well as NYCC Falls Coordinator and a wide range of voluntary and community sector organisations and therapy services, will be working together to develop a coordinated and proportionate response to falls as well as focusing on keeping people fit and mobile.

We are also linking Living Well and voluntary and community services to our Locality Integrated Teams - to support the development of priority areas such as:

- Frailty.
- Loneliness and social isolation.
- Supporting self-care and patient activation.
3.2 Our Priorities – Prevention is Better Than Cure

**Rationale:** NHS, local government and the third sector have a role to play in building confident and connected communities, where everyone, but especially those at highest health risk, can tap into social support and social networks, have a voice in shaping services and are able to play an active part in community life. We want to use community-centred approaches as a tool to consider potential options for commissioning health improvement and preventive services.

<table>
<thead>
<tr>
<th>Core Principles</th>
<th>Priorities</th>
<th>Outputs</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prevention: Universal and Targeted</strong></td>
<td>Making Every Contact Count</td>
<td>Reduce obesity – particularly amongst children</td>
<td></td>
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<tr>
<td></td>
<td>Living Well and Benefits Maximisation services</td>
<td>Reduce smoking. Increase physical activity</td>
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<td></td>
<td>Healthy living programmes</td>
<td>Reduce the harms of alcohol consumption</td>
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<tr>
<td></td>
<td>Delivery of tier 2 weight management services</td>
<td>Ensure every child has a healthy start in life</td>
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<td></td>
<td>Roll out of newly commissioned services in the area (e.g. stop smoking, oral health and 0-19 HCP)</td>
<td>Promote healthy aging</td>
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<td></td>
<td>Winter Health Strategy</td>
<td>Reduce excess winter deaths and fuel poverty</td>
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<td></td>
<td>Carers: identification, assessment, support</td>
<td>Reduce variations in health outcomes</td>
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<td></td>
<td>Suicide and self-harm reduction. Mental Health First Aid</td>
<td>Reduce loneliness and isolation. Reduce falls</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Healthy Weight, Active Lives 2009 – 20 re-write</td>
<td>Low level support to enable people to remain living in their own homes and communities</td>
<td></td>
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</tbody>
</table>

**Early Intervention**

- Future in Mind programme for children and young people.
- Early Intervention in Psychosis Service
- Crisis Care Concordat action plan.
- Community Safety Hubs
- ‘Street Triage’ – joint MH and police teams.
- Rehabilitation programmes: stroke, cardiac, pulmonary.
- NHS & community based ‘Health Checks’.
- Workforce Wellbeing Programmes.
- Continued commitment to improve access and early intervention though adults IAPT

**Self Care**

- New interactive Community Directory.
- 40+ condition specific self-help groups.
- Care planning is person-centred and joined up.
- Shared goal setting and decision making.
- Develop assistive technology strategy including exploration of roll out of telemedicine.
- My neighbourhood community learning programme.
- Health Champions

**Enablers:**

- System Leadership
- Engagement
- Technology
- Workforce
- Estate

- Empowered individuals - higher levels of activation. Increasing use of personal health budgets. Personalised packages of information for people with LTC - more self-care, knowledge and independence. People are more resilient and feel in control of their health. Improved mental and emotional wellbeing for people with LTCs. Champions involved in community informal support. Increased social prescribing.
Neighbourhood Management in the Harrogate district - 'My Neighbourhood'

The Harrogate District Public Service Leadership board is the overarching partnership responsible for neighbourhood management in the Harrogate district. In 2010 a multi-agency partnership came together and agreed to support a neighbourhood management framework known as 'My Neighbourhood' within the Harrogate district. This was a partnership agreement and approach developed to engage and work within communities, addressing local need with a focus on targeting priority areas and issues across the Harrogate district.

The aim of the 'My Neighbourhood' community engagement framework is to target resources and action within the chosen priority areas. The framework supports and contributes to the Localism and Big Society agendas.

'My Neighbourhood' partners are committed to raising the economic, social and environmental well-being within the Harrogate district through a partnership approach. An overview report and partner evaluation is carried out on an annual basis to demonstrate the outcomes achieved against the objectives.

'My Neighbourhood' projects are currently working in four areas across the Harrogate district and the overarching priorities and key action areas are reflected in the plan on a page.

The approach was Highly Commended in the HSJ Awards 2015.

3.2 Our Priorities – Prevention is Better Than Cure: A Case Study
### Primary Care: The Current Picture

There are 17 GP practices, covering 161,000 people - a mix of urban practices and rural practices, with some covering both. All practices are members of the Yorkshire Health Network GP Federation.

10 practices are dispensing practices.

- There are 152 GPs in the area (129 full time equivalent)
  - 38% are male (compared to 48% in England)
  - 15% are over the age of 55 years (compared to 22% in England)
  - The headcount and number of full time equivalents of all GP practitioners per 100,000 population is high compared to our 10 closest CCGs
  - The proportion of all GP practitioners who are Full Time Equivalent is 57% compared to 73% for England

The number of all practice staff per 100,000 population is similar to England but less than most of the other 10 most similar CCGs.

- Practice Nurse full time equivalent numbers per 100,000 population is high compared to our 10 closest CCGs.
- The proportion of advanced nurses or extended nurse roles is low.
- The number of admin and clerical staff full time equivalents per 100,000 population is low compared to our 10 closest CCGs.

Most practices are under the GMS contract but 3 practices are PMS. 13 practices use the SystmOne and 4 practices use the EMIS web clinical computer systems.

The current system is not sustainable...

### In 2020 Primary Care Will Not Look the Same.

- It will be able to work at scale making best use of new technologies.
- There will be development and expansion of the workforce and better premises.
- There will be improved signposting of patients to the most appropriate service for them or where appropriate supporting them to self-care.
- GPs will work as part of a more joined up primary care workforce and will be able devote the greatest amount of time to quality and health improvement for patients and local communities.
- There will be GP led primary care teams with the appropriate skill mix for the service, with Practice Pharmacists, Physicians Assistants, Advanced Care Practitioners and Advanced Medical Administrators to redistribute clinical and administrative tasks away from GPs.
- More care will be at home or close to home with an extended team of GPs and specialists offering better access to a wider range of health and care.
- Improve access to primary care in hours and deliver extended and seven day care in a model that fits with local need.
- Create better continuity of care and more time to see complex patients.
- Reduce variation in practice & duplication across the system.

The future system will be sustainable...
3.3 Our Priorities – Primary Care Transformation: Strategic Direction

**Joined up solutions for person-centred primary and community services**

**Growing the primary care workforce** – new roles to support GP consultations: physician associates, clinical pharmacist, Transforming Nursing for Community and Primary Care Workforce Programme.

**System Partnerships** – developing and supporting a shared identity and voice for primary care within the local health and care system

**Improving access** – collaborating at scale makes it possible to improve access through multi-service centres (or hubs).

**Releasing time to care** – practices collaborate on procurement and back office functions to drive transactional efficiencies, 10 High Impact Actions.

**Redesigning the way care is commissioned provided** – a new integrated clinical framework and clinical model to integrate and transform primary and community services.

**Technology** – maximising digital solutions: shared care records; new ways for patients to interact with services; healthcare Apps.

**Strategic Estates Plan** – primary and community estate development which will help the local health economy to meet changes in demography and demand for healthcare services.
3.3 Our Priorities – Primary Care Transformation: Implementation of the 10 High Impact Actions to Release time to Care

<table>
<thead>
<tr>
<th>1. Active Signposting</th>
<th>6. Personal Productivity</th>
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<td>• Reception navigation</td>
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<td>• Text message</td>
<td>• Health and Care / Statutory and CVS</td>
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<td>• Reminders</td>
<td>• Practice based navigators</td>
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<td>• Report attendances</td>
<td>• Delivered by community and voluntary services</td>
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<td>• Reduce ‘just in case’</td>
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<td>• Prevention</td>
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<tr>
<td>• Physician Associates</td>
<td>• Long term conditions</td>
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<td>• Pharmacists</td>
<td>• Acute episodes</td>
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<td>• Productive environment</td>
<td>• Process improvement</td>
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<td>• Efficient / collaborative practices e.g. procurement</td>
<td>• Rapid cycle change</td>
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Acute / Crisis Care

Integrated Hubs Focused on Interventions

GP Practices Providing core GMS, primary and secondary prevention

- Networks of practices are working together, integrated with care teams from community, secondary care, social care and the voluntary sector:
  - Common policies and procedures.
  - Sharing work between members.
  - Combining purchasing leverage for best value.
  - Professional development.
  - Clinical governance.
  - Shared estate

- Clinical network service models. Centres of excellence.
- Services that cover the CCG footprint:
  - Urgent Care Centre including GP OOH, reducing demand on ED.
  - Easier access to specialist support.

- New structures and workforce models allow clinicians to spend more time with their patients, with greater continuity of care and higher quality care for their patients.

- Community-based services to reduce lifestyle risk factors.
- Engaged and informed patients and carers
### Right Care Opportunities

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<tr>
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<tr>
<td><strong>Total other</strong></td>
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</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>7330</td>
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**Elective Specialties where greatest savings to be made**
- Musculoskeletal
- Gastro-intestinal

**Top Specialties for NEL savings**
- Neurological
- Respiratory

**Top Specialty for prescribing savings**
- Neurological
- Gastro-intestinal
The Harrogate Clinical Board (CCG and HDTFT) 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 Right Care to undertake benchmarking and identify opportunities for value and savings. These have included The Atlas for Variation in Healthcare, Commissioning for Value Programme, Spend and Outcome (SPOT) Tools and Public Health Profiles.

In addition we are undertaking an **Elective Care Rapid Testing Programme** during 2016 with the ambition to:

1. **To rethink referrals models** to break down barriers between clinicians in different care settings and raise the quality of referrals to ensure that patients are referred to the right place, first time.
2. **To explore the potential of shared decision making** to support patient choice of provider and preference of treatment.
3. **To transform outpatient appointments** to better manage and moderate demand.

**The six priorities are:**

**Consultant to consultant referrals (C2C):** Exploring ways to manage Consultant to Consultant referrals, to ensure that patients receive the care they need in the most efficient and effective way.

**Peer Review of Referrals:** Creating the processes and culture for peer review of referrals by GPs and feedback loops from consultants to regulate and improve quality of referrals. Review and feedback can be used as part of a triaging service to redirect referrals away from secondary care, when not needed, to the most appropriate care setting.

**GP/Consultant Advice and Guidance:** Breaking down barriers between clinicians in different care settings, providing the opportunity for specialists to provide advice and guidance on patient care before making a referral, avoiding unnecessary referrals and ensuring patients receive the right care, first time.

**Shared Decision-Making:** Embedding the process in which patients, when they reach a decision crossroads in their health care, can review all the treatment options available to them and participate actively with their healthcare professional in making that decision. No decision about me, without me.

**Transforming outpatient appointments:** Exploring alternative formats for outpatient appointment to reduce demand (e.g. virtual clinics and one-stop clinics) and embedding processes to allow patients to choose when and how they receive specialist input from consultants.

**Integrating technology:** Using new technologies better to: improve access to specialised expertise; increase patient engagement; and facilitate information sharing between care settings. Tech solutions may range from simple online tools to more specialized programmes and systems.
3.5 Our Priorities – Mental Health

**Resilience:** Individuals, families and communities supported to help themselves
- New programmes to help children and young people to stay strong.
- Work with North Yorkshire employers to promote good mental health in the workplace.
- Work with local groups, with support from the Stronger Communities programme, to introduce a range of local initiatives to sustain wellbeing.
- Campaigns to raise awareness, to tackle stigma and discrimination, and to celebrate the positive in mental health.

**Responsiveness:** Better services designed in partnership with those who use them
- Building on the Crisis Care Concordat, ensure a faster and better response to anyone experiencing a mental health crisis, backed by comprehensive mental health first aid programmes.
- Greatly improve access to “talking therapies”.
- Personal health budgets for people who need support, alongside individual care plans.
- One Stop Shop’ for diagnosis of dementia to shorten the diagnostic process and a new follow-up pathway for people on medication for dementia, resulting in increased specialist resource that can be directed to people with dementia in Care Homes and people with complex problems.

**Reaching Out:** Recognising the full extent of people’s needs
- Work in new ways to take into account the full range of people’s needs, including physical health.
- We will review the impact of new technology so that it can be put to best use for people with mental health issues, but also so that we are aware of any possible negative impacts on young or vulnerable people.
- Work with partners to ensure that mental health and wellbeing is embedded in all strategies and plans.
- North Yorkshire Mental Health Champions brought together annually to share best practice and offer supportive challenge.

**Accelerate progress in implementing the mental health taskforce report.**
- Achieve access standards for Early Intervention Psychosis service and IAPT.
- Achieve 50% IAPT recovery rate standard by April 17.
- Baseline the new CYP eating disorder access and waiting time standard in 16/17, and prepare to deliver it from 17/18.
- Implementation of local transformation plans for CYP MH, including establishment or enhancement of dedicated crisis, intensive support and liaison service for children, young people and their families.

‘Building the Right Support’
Transforming Care Partnership for North Yorkshire reflects the low numbers/high value of these services and thus the need for an economies of scale approach to this transformation redesign, requiring a holistic model.

**Poor mental health has a direct impact on life expectancy- and is related to deprivation**

**People with more than one physical illness are much more likely to have poor mental health as well**

**The prevalence and incidence of depression is significantly higher locally than nationally**

**The overall prevalence of mental health problems is significantly lower than the national average**

**Poor mental health has a direct impact on life expectancy- and is related to deprivation**

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**The prevalence and incidence of depression is significantly higher locally than nationally**

**The overall prevalence of mental health problems is significantly lower than the national average**
3.6 Our Priorities – Stroke

A focus on prevention and early intervention:
- A range of community-based services which support behavioural changes to reduce lifestyle risk factors including stopping smoking, increasing physical activity, improving diet and reducing obesity.
- Public and professional awareness of stroke prevention and stroke symptoms.
- Increase the proportion of successful quitters in line with and to exceed the England and cluster average.

Empowered Patients:
- Engaged and informed people.
- Access to information and education.
- Digital health e.g. the NHS Innovation Accelerator Programme is supporting the roll out of AliveCor helps detect incidents of atrial fibrillation, which is responsible for a third of all strokes and costs the NHS over £2.2 billion annually.
- Written care plan.

Early Diagnosis and Excellent Treatment Services
- Increase uptake of NHS Health checks
- Improve the identification and management of anticoagulation for known patients with Atrial Fibrillation (AF).
- Improving identification and management of patients with hypertension by increasing the uptake of health checks, increase the % of people whose blood pressure is controlled to 150/90.
- Embed consistent secondary prevention in service delivery across primary, community and secondary care.
- Early Diagnosis for Transient Ischaemic Attack (TIA) Patients
- Improved patient outcomes and reducing variation.

Early Supported Discharge and Community Rehabilitation:
- Access to Early Supported Discharge Service and longer term stroke support services.
- Early supported discharge for people with moderate disability.
- Better support for all people living with stroke in the long term.
- Built around a stroke-skilled multidisciplinary team.

The rate of smoking attributable deaths from stroke is similar to the national average.

The percentage of hypertension detected and controlled to 150/90 is only 47.5%.

Higher % of patients with AF, hypertension or previous stroke prior to their stroke admission.

Focusing on the causes of hypertension may help reduce the stroke register prevalence.

Significant preventable risk factors in relation to stroke related to poor diet, lack of physical activity, alcohol, obesity and smoking with diabetes, high-cholesterol, atrial fibrillation (AF) and hypertension significantly increasing the risk of stroke.
3.7 Our Priorities – Cancer

Cancer is the biggest cause of death from illness in every age group in Harrogate and District and will affect 1 in 2 of the population born since 1960.

Up to 42% of cancers are potentially preventable. More than 1 in 4 cancers are attributable to smoking.

Alcohol is one of the main causes of cancer (mouth, throat and bowel).

Compared to England, overall Harrogate has a significantly higher incidence of melanoma, breast and urological cancers.

A focus on prevention and early intervention:
- Interventions to reduce lifestyle risk factors including stopping smoking, increasing physical activity, improving diet and reducing obesity.
- Public and professional awareness, focussing on risk factors for skin, breast and urological cancers and encouraging early awareness of signs and symptoms, and a focus on reaching people with learning disabilities.
- Increase rates of uptake across the screening programmes. - particularly rural and older populations and people with learning difficulties.

Empowered Patients:
- Engaged and informed people.
- Access to information and education.
- Digital health
- Written care plan.
- Monitor the development of innovative means of gathering real time feedback of patient experience with a view to implementing this as soon as is practicable. In the interim build on excellent patient experience using the data available from the Cancer Patient Experience Survey (CPES) and peer review process.
- Work with YCRN and local providers to ensure patients have access to research trials that may be of benefit to them.

Early Diagnosis and Excellent Treatment Services
- Work with our local GPs and Cancer Research UK Facilitators to ensure timely referral for diagnostics and assessment and sustainable capacity within out-patient and diagnostics services to manage local need now and for the foreseeable future.
- Increase the percentage of cancers diagnosed at an early stage (stage 1 and 2) either to 60% overall or an increase in 4% from the previous year.
- Maintain a focus on delivery of high quality treatment services with strong clinical engagement and leadership.
- Explore scope for configuration and efficiency gains e.g. chemotherapy, radiotherapy

Living With and Beyond Cancer:
- Increase delivery of the Recovery Package interventions: support for managing consequences of treatment; supporting earlier access to palliative care as a driver for improvement in both quality & length of life; implementation of cancer care reviews in primary care.
- 2 years funding from Macmillan to establish a program for LWBC initially focusing on breast and colorectal cancer. Program will reduce follow up, and enable patients to move on and self manage.
- Flexible use of palliative care services to support people at, or close to home.
- Risk stratified pathways to reduce follow ups and improve capacity.

Improving one year survival rates to 75% and reducing variation between areas
3.8 Our Priorities – Integrated Urgent Care

The NHS in England responds to more than 100 million urgent calls or visits every year.

Demand continues to rise – nationally 54,000 people attended A&E compared to the same time last year.*

Local audit work indicated that 1 in 5 admissions could be avoided with the right community infrastructure in place**

2 in 3 acute beds occupied by people whose needs could be met in a less acute environment**

**Kings Fund QMR ** Bed audit conducted by HaRD CCG, GPs, NYCC and HDFT (Nov 2014)

New Care Models
Primary and Community Services
- Increased skill mix in primary care. Urgent care services coordinated with integrated teams.
- Response and overnight team expands and functions 24 / 7.
- Dedicated step up / step down beds.

Ambulance
- Changing the function of ambulance services - by providing more responsive treatment at home

Mental Health
- 24/7 community-based crisis response with intensive home treatment available.
- People experiencing a first episode of psychosis have access to NICE-approved care package within 2 weeks of referral
- Community-based services for people of all ages with severe mental health problems who need support to live safely as close to home as possible
- Reduce suicide by 10%.

Co-located and coordinated Urgent Care Service:
- Access to walk-in minor illness and minor injury services.
- Telephone consultations.
- Part of the wider community primary care service including out-of-hours GP services.
- Opportunity to provide a new model of urgent in-hours GP services.
- Supported by hospital specialists so that they have access to a rapid, specialist clinical opinion, thus potentially avoiding the need to transfer / admit a patient in an emergency.

Development of new roles within workforce to support local sustainability of urgent care provision.

Integrated Urgent Care Service – accelerating progress on UEC reform:
- A single Call to get an appointment Out of Hours - 50% compliance.
- Data can be sent between providers.
- The capacity for NHS111 and OOHs is jointly planned.
- The SCR is available in the hub and elsewhere.
- Care plans and patient notes are shared.
- Appointments can be made to in-hours GPs.
- There is joint governance across urgent and emergency care providers.
- There is increased clinical support provided by a ‘clinical hub’ made up of GPs and other professionals.

Emergency Care:
For those people with more serious or life threatening emergency care needs, we should ensure they are treated in centres with the very best expertise and facilities in order to maximise the chances of survival and a good recovery.

Move urgent and emergency care provision to a network basis.

Designation of emergency centres
Cardio vascular transformation
Hyper-acute stroke
Intra Arterial Thromboleoctomy.
3.9 Our Priorities – Care Market: Availability and Quality

Commissioning intentions
- Continue to reduce the number of residential and nursing care placements by providing alternative models of care to support people in their communities.
- Where residential or nursing care is the most appropriate options, which will increasingly be for people with dementia, we will expect the homes to encourage contact and integration with their communities and help people to maintain their independence.
- Engage with providers to explore solutions for people with more complex needs for people currently in settings out of county and coming through transitions.

System Integration
- Local plans also include ensuring care homes are linked to the overall transformation agenda.
- Implementing the SystmOne Care Home module so that staff provide the appropriate care to their residents, setting the foundation for future innovation at these sites.
- Step up / step down facilities.
- Encouraging innovation and service development in line with personalisation.
- Taking into account the requirements of people who fund their own care, as self-funders, via Direct Payments or other means.

Market Development
- Measures to support people at home and reducing admissions to residential and Nursing Care.
- Supporting self funders with information on alternative choices to residential care e.g Extra Care.
- Developing Extra Care provision as a good quality alternative.
- Proposed Care Fee increases being consulted on.
- Free Nursing Care increases proposed.
- Quality assurance processes to support early identification of concerns to avoid provider failure where possible.
- Working through the New Care Models to find joint solutions for interim care to support hospital discharge.

Care sector is competing for staff with retail and hospitality

Availability of Personal Support at home is crucial to support our objectives.

Four home closures in 18 months and low vacancy rate of 2.6%

There is a fragile residential and nursing care market with issues of quality and affordability

Improvements in the availability and quality in residential and nursing care and a sustainable care market.
3.10 Our Priorities – Integrated Health and Social Care Commissioning

What’s wrong with the current system?
An individual’s care will be funded by a range of commissioners who fund many different providers responsible for hundreds of different services. 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.

Agree integrated and lead commissioning arrangements
Technical issues (e.g. governance, budget-setting, accounting and auditing, VAT, insurance, legal, HR, information sharing)
Establish shadow arrangements in 2017/18.
Pooled budget from 2017/18 focused on the achievement of joint outcomes.
Align with aims of the Public Service Leadership Board, Joint Health and Wellbeing Strategy and Health and Wellbeing Board.

Some of the benefits of joint commissioning
• Promote integration of health and social care as a key component of public sector reform.
• Improve health and wellbeing, with a focus on prevention and public health, and providing care closer to home.
• Reduction in emergency admissions and fewer people in residential and nursing homes.
• Delivering system-wide efficiencies.
• Basing decision making on better outcomes for citizens.
• Co-production between services users and their carers, commissioners and providers.
• Progress Personal Health Budgets in a wider range of service areas.
• Underpins delivery of the Public Service Leadership Board, Joint Health and Wellbeing Strategy and Health and Wellbeing Board.
Without transformational and transactional changes costs are predicted to outstrip allocations on the local health and social care economy by £45.6m by 2020/21.

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We have identified a number of solutions to close that gap.

Work is progressing during September and October across West Yorkshire to understand and review the amount being delivered:

- At an organisational level
- Within each local STP footprint
- Across Healthy Futures programmes
STP ‘Do Nothing’ vs ‘Do Something’ Outturn – current plans result in a £15.2m gap by 2020/21
3.11 Delivering System Efficiencies

How we will deliver against our financial and efficiency gap

**Commissioner Focus**
- Reduce Demand
  - Prevention (coaching, immunisation, screening)
  - Self care (including use of telecare / telehealth)
  - Patient stratification and targeting
  - Referral and treatment thresholds

- More for Less
  - New models of care (primary / community integration)
  - Pathway changes
  - Reducing variation (RightCare)
  - Reduce system management (integrated health and social care commissioning)

**Provider Focus**
- Service redesign
  - Economies of Scale (Clinical Networks)
  - Service Improvement (roll out of local and national innovation)
  - Reducing quality variation

- More for Less
  - Productivity improvements (e-rostering, agency spend, T&C, sickness absence) – Carter Review
  - Reduce system management costs (procurement, estates, shared services, technology)
  - Medicines Optimisation
4. OUR ENABLERS
After discussion with the Local Digital Roadmap (LDR) partners our initial focus is the following four areas:

- **Shared Care Record** – Fundamental to all health, social and public sector (i.e. Police) professionals is the provision of a shared care record. The LDR will indicate how working toward the first stage of integration (maximising the sharing capability of existing and emerging systems) will set the foundation for making a future decision on a single interoperable shared care record system. It will also indicate the work to be undertaken with regional colleagues i.e. West Yorkshire Urgent and Emergency Care Vanguard to enhance the patient record viewing and interaction capability for community and urgent care staff.

- **Digital Infrastructure** – Ensuring clinical and integrated care environments can support present and future technology by providing high bandwidth secure connections (fixed and wireless). This includes an initiative to provide local care homes with equal high quality connections, setting the foundation for future innovation at these sites.

- **Mobile Working** – Partners throughout the footprint have laid the foundation for further innovation in mobile working. As well as continuing to provide a consistent platform, previous work has enabled the providers to consider innovative use of the technology such as video consultation and specialist clinicians advising on patient treatment, leading to better patient outcomes.

- **Innovative Technologies** – Telehealth/Telecare has moved on with the development of ‘wearable’ technology. The LDR points toward consideration of these technologies and how they could help primary and acute care manage long term conditions.

More proactive and targeted care, reducing costs and improving outcomes.
Better integrated and coordinate care, supporting providers in collaborating more effectively.
Telehealth to reduce referrals, avoid unnecessary appointments and admissions, and provide access to specialist expertise and advice easily and in real time.
Rewrite the relationship with patients and carers by providing tools for patient engagement and self-management that allow more meaningful participation in care and more opportunities for self-service.
4.2 Enabling Change - Workforce

Upskilling of staff to embed an asset based approach to the relationship between professionals and service users
Ensuring the workforce is the right size and has the right skills and knowledge to meet the future demographic challenges.

WY STP Local Workforce Action Board will support a revised workforce strategy that is owned by all parties and drives retention, resilience and new models of care.

North Yorkshire Health and Wellbeing Board Integrated Workforce Development Programme established to identify needs, key issues and outcomes; changes required and workforce development requirements.

Shift activity and workforce from acute to community setting
- Focus on staff health and wellbeing
- Supporting cultural shifts – patient expectations of which staff they will see, risk aversion and barriers between health and social care
- Supporting patients to be seen as partners and supporting the role of unpaid carers as a key part of the workforce.

Primary and Community
Widening the workforce in the community through role development and collaboration and integration across primary, community, mental health, VCS and social care services, including residential and nursing care workforce. Discussions with HEE on the primary care workforce.

Calderdale Framework
Our team of specialists have used the framework to analysis services and tasks as a whole integrated system covering services across mental health, community health services, primary care general practice services and social care. We understand that this is the first time it has been deployed at this scale to build the skill mix from the bottom up. This is evidence based and highly replicable.

Prevention
Maximising the role of the workforce in prevention of ill-health for themselves and the populations they serve: Schwartz Rounds; Mental Health First Aid Champions; development of a rapid access MSK service.

Voluntary and Community Services and its role in growing social capital and impact on wellbeing.

- Sustainable workforce to support future configuration of services through new roles
- More integrated workforce across health and social care
- Mobile workforce to support resilience and retention

Productivity improvements in 2016/17 include:
- Implementation and roll out of Mentally Healthy workplace training, developed by NHS Employers.
- Pilot programme of staff health and wellbeing assessments, developed by Sheffield Hallam University.
- Review of skill mix.
- Compliance in e-rostering and reduce reliance on Agency staffing
The long-term strategy is for the public sector in the District to develop a cross-sector strategy to utilise the collective estate more efficiently and to support an integrated approach to the delivery of health and care services specifically and public services more generally.

**Mental Health**  
Inpatient new build: business case approved, outline plans submitted.

**Urgent Care Centre**  
Incorporating GP Out of Hours, to enable delivery of new service model which will improve quality of service.

**Ripon Community Hospital**  
Subject to development of Business Case (CCG and NHS Property Services) to improve quality and physical environment and deliver new models of care. The project comprises three distinct commissioning elements:
- Ambulatory care commissioning.
- Extra-care housing (residential) enabling.
- Leisure and public health commissioning.

**Development of primary care estate**  
Improving existing premises, particularly premises which showed poor results in the 2008 6 facets surveys  
A clear strategy to develop general practice linked community hubs. The hubs are fundamentally linked to delivery of the changes required in care delivery and are part of the New Care Model developments.  
The development proposed for Ripon includes several surgeries, and is linked to the New Care Model community hub programme

**Extra Care Programme**  
It is a priority to continue the development of Extra Care schemes in Harrogate District where needs are identified.

- Enabling access to wider range of services out of hospital to reduce unplanned admissions to hospital.
- Reduction in running costs in line with Carter Report.
- More resource resilient through reducing energy costs.
- Enhanced utilisation of general practice estate through community hub models.
- Integrated community solution for Ripon.
- Identify opportunities to re-use, dispose or sublet as properties become vacant.
- 24/7 urgent care available.
- Community hub solutions identified and plans in place.
- Improved inpatient and community facilities for mental health.
5. DELIVERY
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<td>New Care Model: What Matters to Us</td>
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<td>Right Care / Elective Care Rapid Testing</td>
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<td>Primary Care: 10 High Impact Actions to release time to Care</td>
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<td>Primary Care at Scale</td>
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<td>Integrated Health and Social Care Commissioning</td>
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<td>Integrated Health and Social Care Community Model</td>
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<td>New Urgent Care Model</td>
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<td>Digital Transformation</td>
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<td>Commissioner Efficiencies: QIPP (prescribing, continuing healthcare)</td>
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<tr>
<td>Provider Efficiencies: (e-rostering, reducing use of Agency Staff, supplies,</td>
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5.2 Achieving the triple aim: How will we know if we have been successful?

- Healthy places / healthy communities with people more engaged in their own health
- Prevention of ill-health to reduce inequalities and demand on the system
- Integrated Teams supporting people to live longer, healthier lives independently at home
- Reduced reliance on hospital care with activity delivered at home or in communities
- Reduction in duplication and variation
- Resilient and sustainable workforce
- Sustainable Financial Position
- Shared clinical record across the system
- Reduce the health gap between people with mental health problems and those who do not
### 5.3 Impact on the three gaps

<table>
<thead>
<tr>
<th>Health and Wellbeing</th>
<th>Quality and Care</th>
<th>Finance and Efficiency</th>
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<tbody>
<tr>
<td><strong>Health inequalities</strong></td>
<td><strong>Constitutional Standards</strong></td>
<td><strong>New Care Model</strong></td>
</tr>
<tr>
<td>Fewer hospital admissions and lower premature death rates from heart disease, stroke and cancer, with the biggest improvements in the most deprived areas by 2020.</td>
<td>Maintaining A&amp;E, cancer waiting times and RTT standards.</td>
<td>• Reduction in A&amp;E attendances by 11% by 2018/19. (NCM)</td>
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<td><strong>Personalisation and choice</strong></td>
<td><strong>Mental Health</strong></td>
<td>• Reduction in emergency admissions by 16% by 2020/2021. (NCM)</td>
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<tr>
<td>✩ Proportion of people using social care who receive self-directed support and those using direct payments. (HWB)</td>
<td>60% of 1st episode of psychosis commence treatment with a NICE approved care package within two weeks of referral by 2021. (IAF)</td>
<td><strong>RightCare / Reducing Variation</strong></td>
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<td>✩ Number of people using personal health budgets. (IAF/HWB)</td>
<td>75% people referred to IAPT begin treatment within six weeks, and 95% within 18 weeks, with a 55% recovery rate from treatment.</td>
<td>• Reduction in elective care activity</td>
</tr>
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<td>People with a long-term condition feeling supported to manage their condition. (Target 72.2 in 2016/17) (NCM)</td>
<td>&gt;76.7% diagnosis rate for people with dementia.</td>
<td>• Reduction in variation</td>
</tr>
<tr>
<td>% of patients with a single care Plan (Target 95% of patients supported by integrated team in 16/17). (NCM)</td>
<td>&gt;79.5% of patients diagnosed with dementia whose care plan has had a face-to-face review in the past 12 months. (IAF)</td>
<td><strong>Digital</strong></td>
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<td><strong>Diabetes</strong></td>
<td><strong>Maternity</strong></td>
<td>Local Digital Roadmap implemented</td>
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<tr>
<td>✩ &gt; 40.2% of diabetes patients have achieved all of the NICE-recommended treatment targets (current median). (IAF)</td>
<td>Neonatal mortality and stillbirths (IAF)</td>
<td>• Shared care record</td>
</tr>
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<td>✩ People with diabetes diagnosed less than a year who attend a structured course (national av. currently 5.7%) (IAF)</td>
<td>Maternal smoking (at time of delivery) (IAF)</td>
<td>• Digital infrastructure</td>
</tr>
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<td>Roll out of the Diabetes Prevention Programme in 2017.</td>
<td>Choice in maternity services (IAF)</td>
<td>• Mobile working</td>
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<tr>
<td><strong>Child Obesity</strong></td>
<td>Women’s experience of maternity (IAF)</td>
<td>• Innovative technologies</td>
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<tr>
<td>✩ % of children aged 10 or 11 (Year 6) who have excess weight (HWB / IAF).</td>
<td><strong>Cancer</strong></td>
<td>Paper free at the point of care by 2020.</td>
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<tr>
<td><strong>Cancer</strong></td>
<td>% new cases of cancer diagnosed at stage 1 &amp; 2 (IAF).</td>
<td><strong>Carter Review</strong></td>
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<td>% of people whose blood pressure is controlled to 150/90</td>
<td><strong>Hypertension</strong></td>
<td>Delivery of efficiencies (workforce review, back office functions, estate)</td>
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<td><strong>End of Life Care</strong></td>
<td><strong>Long term care admissions</strong></td>
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<td>% of deaths in hospital/at home/in hospice (HWB)</td>
<td>✩ use of residential &amp; nursing accommodation.</td>
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## Appendix 1: Existing plans, priorities and transformation programmes

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<thead>
<tr>
<th>Local Level Strategic Plans and Priorities</th>
<th>Existing Transformation Programmes</th>
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<tbody>
<tr>
<td><strong>North Yorkshire</strong></td>
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<tr>
<td>Joint Strategic Needs Assessment (JSNA)</td>
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<td>Pharmaceutical Needs Assessment 2015-2018</td>
<td>West Yorkshire Urgent and Emergency Care Vanguard</td>
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<tr>
<td>Better Care Fund</td>
<td>NHS England Rapid Testing 100 Day Challenge 100 (NESTA)</td>
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<tr>
<td>North Yorkshire’s Mental Health and Wellbeing Strategy 2015-18</td>
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<tr>
<td>North Yorkshire and York Mental Health Crisis Care Concordat</td>
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<tr>
<td>Children and Young People’s Emotional and Mental Health Strategy 2014 - 17</td>
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<tr>
<td>Young and Yorkshire The plan for all children, young people and their families living in North Yorkshire 2014 – 17</td>
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<td>North Yorkshire Autism Strategy 2015 – 2020</td>
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<td>North Yorkshire Carers Strategy 2012-2015</td>
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<td>North Yorkshire Winter Health Strategy 2015 – 2020</td>
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<td>North Yorkshire Tobacco Control Strategy 2015-2025 Smoke-Free North Yorkshire</td>
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<td>North Yorkshire Community Plan</td>
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<td>North Yorkshire Alcohol Strategy 2014 – 2019</td>
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<td>2020 North Yorkshire: Care and Support Where I Live</td>
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<td><strong>West Yorkshire: Healthy Futures</strong>: Cancer, Mental Health, Specialised Commissioning, Urgent/emergency care</td>
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<td><strong>Yorkshire &amp; Humber</strong>: Ambulance / NHS 111</td>
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<td><strong>Harrogate District Public Services Leadership Board</strong></td>
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<td>Plan on a Page</td>
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<td>Joint strategic commissioning and grant funding principles</td>
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<td>Harrogate District My Neighbourhood Plan on a page</td>
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<td><strong>Harrogate Health Transformation Board</strong></td>
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<tr>
<td>Local and Personal: our priorities for working together for better health in Harrogate and rural area.</td>
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<td><strong>Harrogate and Rural District CCG</strong></td>
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<td>Operational Plan 2016 – 17</td>
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<tr>
<td>Primary Care Strategy (Draft)</td>
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<td>Business cases e.g. Ripon Community Hub</td>
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Appendix 2 Harrogate and District Leadership, Governance and Engagement

The **Harrogate Health Transformation Board** has been established to design, develop and deliver an integrated, holistic and high quality out-of-hospital model of care that is clinically and financially sustainable to support the local community in their health and care needs. It comprises the Accountable Officers from the following organisations:

- NHS Harrogate and Rural District Clinical Commissioning Group,
- North Yorkshire County Council,
- Harrogate Borough Council,
- Harrogate and District NHS Foundation Trust,
- Tees, Esk and Wear Valleys Foundation Trust
- Yorkshire Health Network.

**Local government and wider public sector involvement**

The Harrogate Health Transformation Board operates within the governance arrangements of each participating organisation and the wider partnership system North Yorkshire Health and Well-being Board and Delivery Board and Harrogate District Public Services Leadership Board which comprises:

- Harrogate Borough Council.
- North Yorkshire County Council.
- NHS Harrogate and Rural District Clinical Commissioning Group.
- Harrogate & District NHS Foundation Trust.
- Harrogate College.
- North Yorkshire Police.
- North Yorkshire Fire & Rescue Service.
- Department of Work and Pensions.
- Tees, Esk and Wear Valleys NHS Foundation Trust.

Under the leadership of the **North Yorkshire Health and Wellbeing Board** in recent years there has been significant progress on integrating all aspects of care across the county. We intend to continue the work already underway locally, based on the core characteristics of our STP, in order to ensure:

- A great patient experience and making services easier for patients to understand and use.
- The best clinical outcomes and reduce variation through single service models.
- More care closer to home.
- Integrated services across health and social care.
- Highly developed voluntary, third and community sector.
- Harrogate and District as a great place to work, attracting and retaining a high quality workforce.
- Value for money for the taxpayer.
- Based on systems not structures.
- Maintaining focus on Reducing Health Inequalities to improve longevity and quality of life.
- Continuing to progress Mental Health and Learning Disability transformation.
- Implementation of Primary Care ‘at scale’

This has been an inclusive process with patients, the community, clinicians and staff. Established mechanisms for communicating with and involving stakeholders are in place. Engagement with patients, the public, clinicians and staff already underway in priority areas e.g. New Care Model, mental health strategy.
Appendix 2 Harrogate and District Governance Structure Chart