

Neighbourhood Management in the Harrogate district - 'My Neighbourhood'

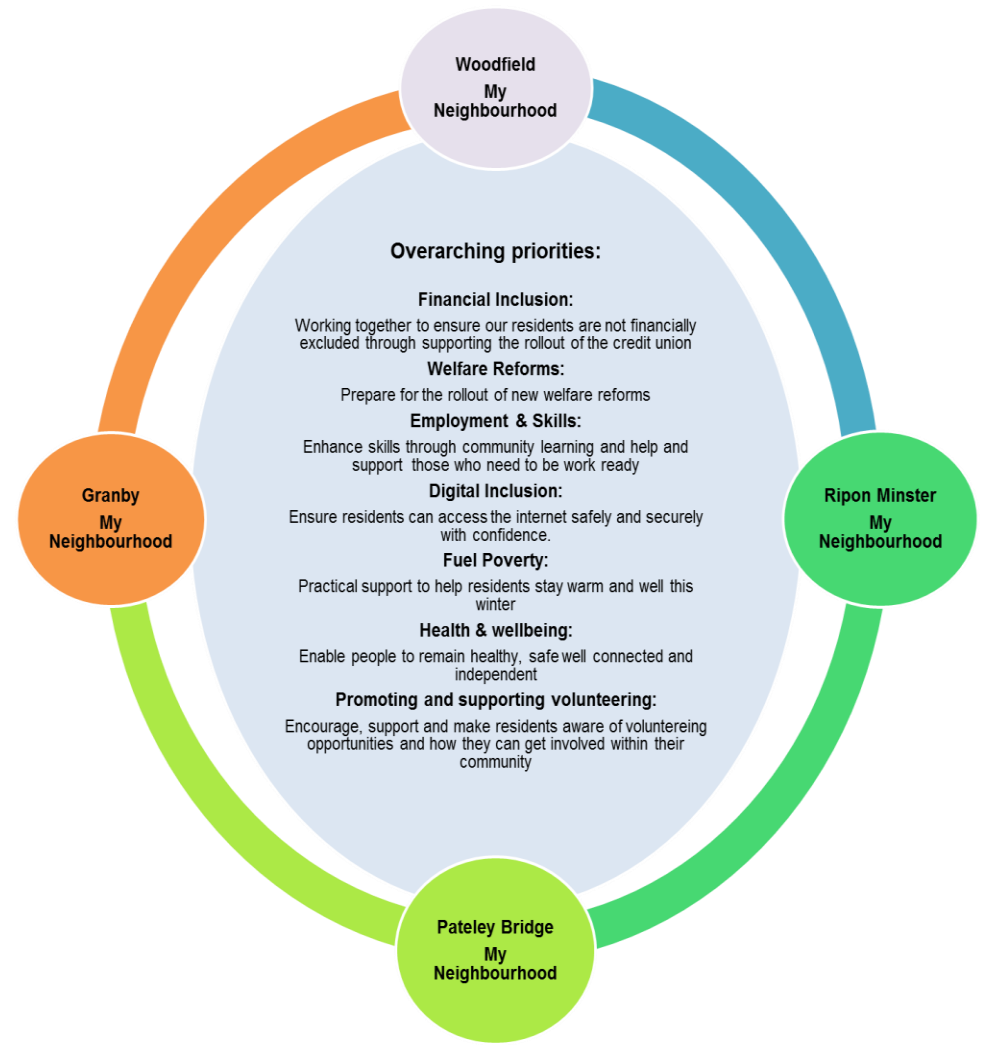
The Harrogate District Public Service Leadership board is the overarching partnership responsible for neighbourhood management in the Harrogate district. In 2010 a multi-agency partnership came together and agreed to support a neighbourhood management framework known as 'My Neighbourhood' within the 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.



3.3 Our Priorities – Primary Care Transformation

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...

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

1. Active Signposting

- Online portal
- Reception navigation
- Community directory

2. New Consultation types

- Telephone
- E-consultations
- Text message
- Group consultations

3. Reduce DNAs

- Integrated Texting Solution
- Reminders
- Report attendances
- Reduce 'just in case'

4. Develop the Team

- Practice / Community Nurse
- Physician Associates
- Pharmacists

5. Productive Workflows

- Matching capacity and demand
- Productive environment
- Efficient / collaborative practices e.g. procurement

6. Personal Productivity

- Well designed environment
- IT infrastructure including effective mobile working

7. Partnership Working

- Productive Federation
- Generalists and specialists
- Health and Care / Statutory and CVS

8. Social Prescribing

- Developed at hub or Federation level
- Practice based navigators
- Delivered by community and voluntary services

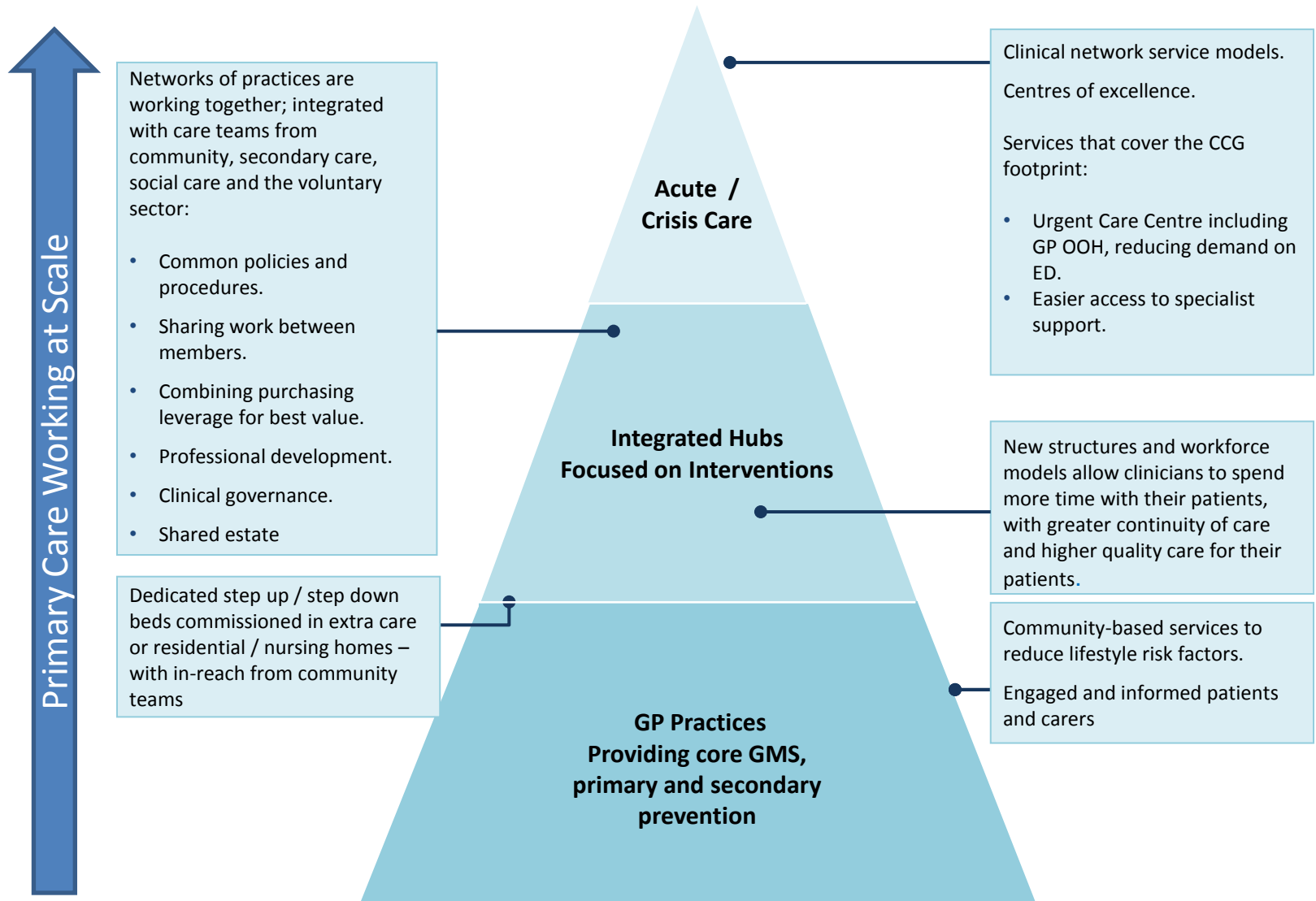
9. Support Self Care

- Prevention
- Long term conditions
- Acute episodes

10. Develop QI expertise

- Leadership of change
- Process improvement
- Rapid cycle change

3.3 Our Priorities – Redesigning Out-of-Hospital Care



Right Care Opportunities

	Top Opportunities			Other Opportunities									
HaRD CCG	Endocrine	Neurological	Total	Musculoskeletal	Gastro-intestinal	Maternity	Trauma & Injury	Cancer	Circulation	Genito-urinary	Respiratory	Total other	Grand Total
Value (£k)	363	1036	1399	1421	1388	75	879	710	609	329	520	5931	7330

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

3.4 Our Priorities RightCare - Reducing Demand and Unwarranted Variation in Planned Care Utilisation

The Harrogate Clinical Board (CCG and HDFT) 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

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

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 work-place.
- 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

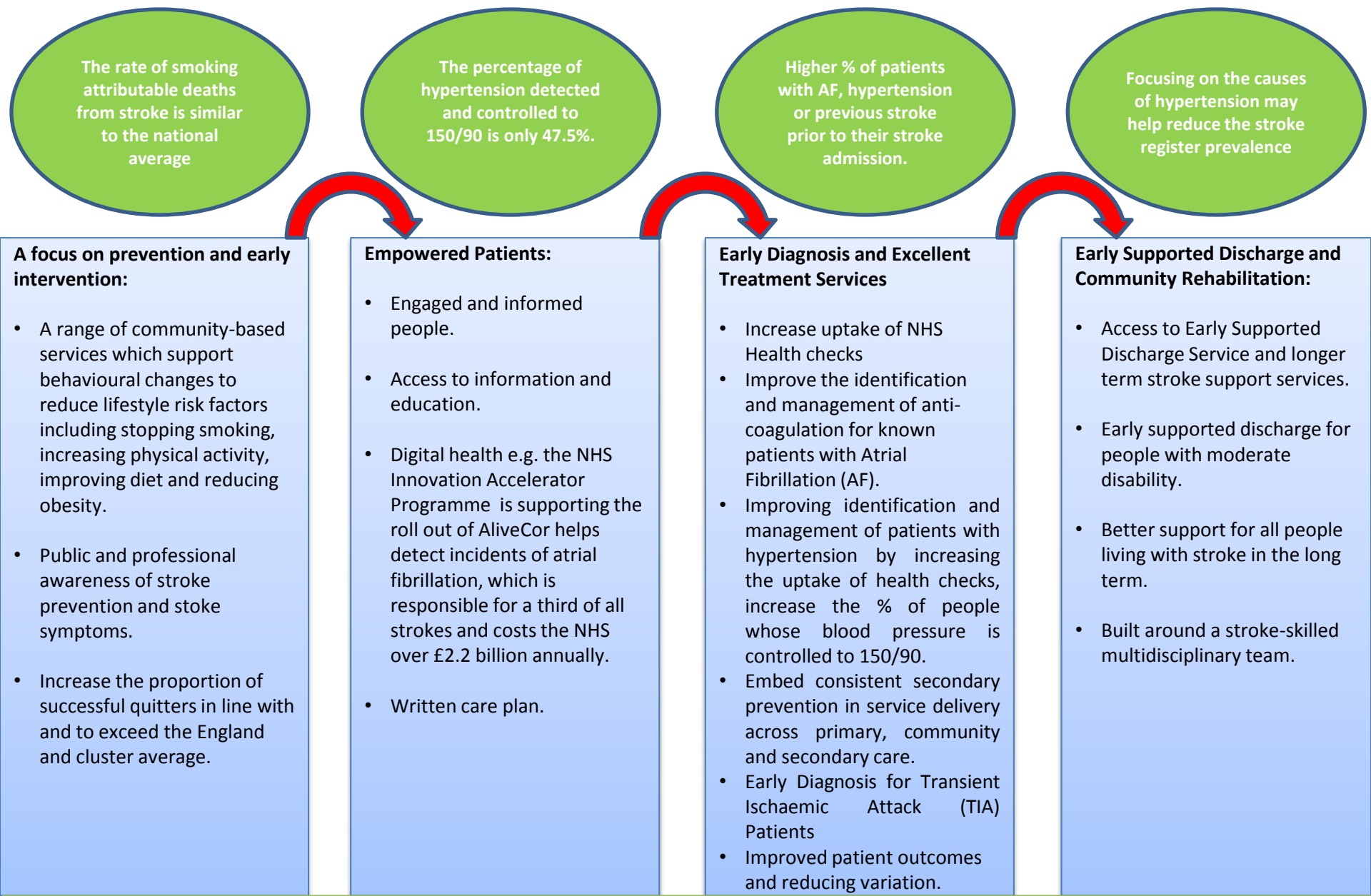
- Work in new ways to take into account the full range of people’s needs, including physical health.
- We will review the impact of new technology so that it can be put to best use for people with mental health issues, but also so that we are aware of any possible negative impacts on young or vulnerable 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.

3.6 Our Priorities – Stroke



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

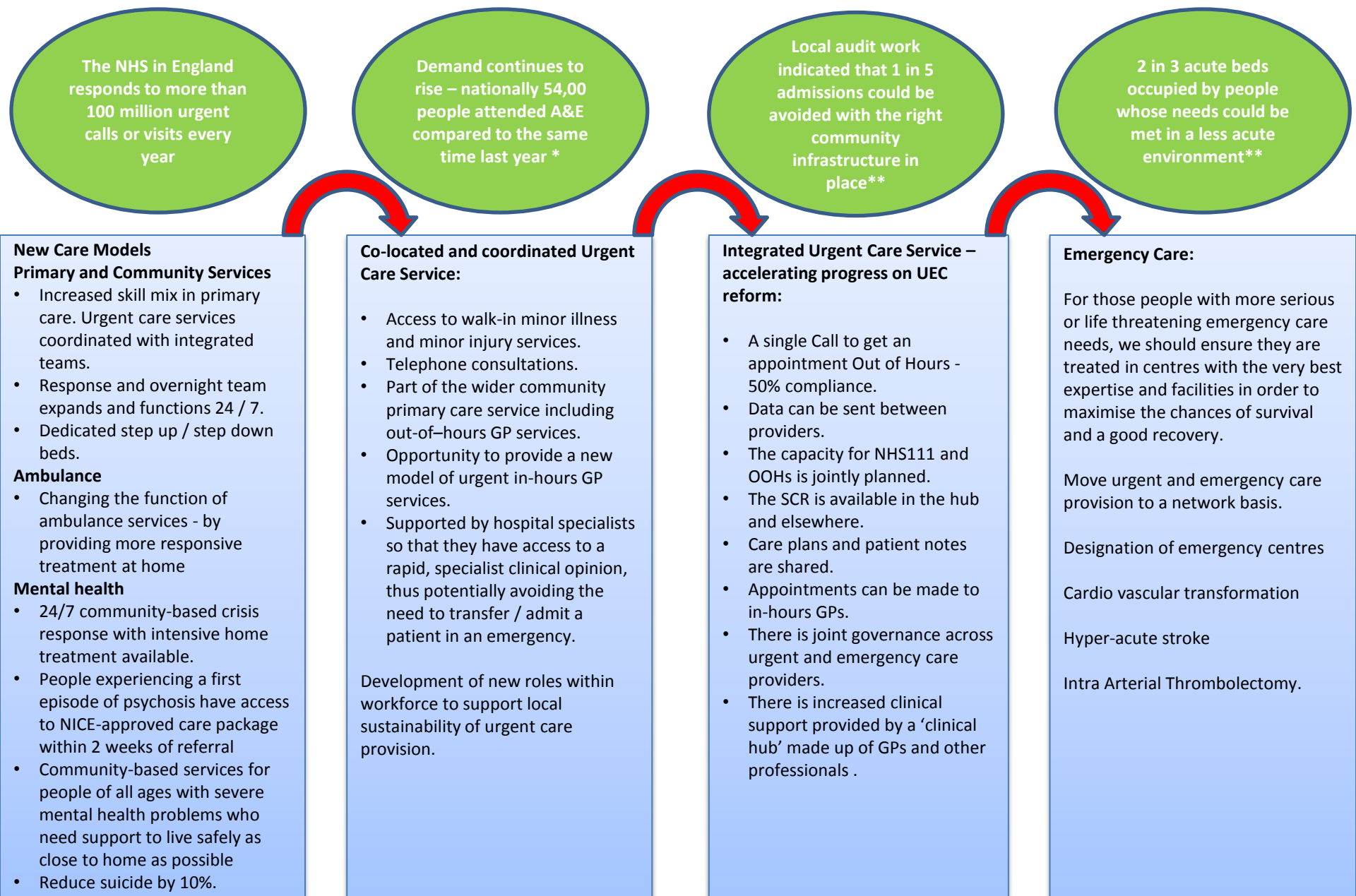
- Work with our local GPs and Cancer Research UK Facilitators to ensure timely referral for diagnostics and assessment and sustainable capacity within out-patient and diagnostics services to manage local need now and for the foreseeable future.
- Increase the percentage of cancers diagnosed at an early 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



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

3.9 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.

Harrogate and District Plans

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 by Q4 2016/17.
Pooled budget from 2017/18 focused on the achievement of joint outcomes.
Align with aims of the Public Service Leadership Board .

Impact & benefits

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 Harrogate Plan.

3.10 Finance and Efficiency: achieving financial balance, securing good value for patients and the public

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.

Do Nothing		2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
NHS Commissioner Surplus / (Deficit)	£000s	(0)	46	(9,770)	(14,125)	(18,174)	(20,402)
NHS Provider Surplus / (Deficit)	£000s	(509)	2,172	(6,418)	(10,173)	(15,631)	(21,849)
Footprint NHS Surplus / (Deficit)	£000s	(509)	2,218	(16,189)	(24,298)	(33,805)	(42,250)
Social Care & Other Surplus / (Deficit)	£000s	-	-	(1,528)	(2,440)	(2,869)	(3,405)
Total Do Nothing Surplus / Deficit	£000s	(509)	2,218	(17,717)	(26,738)	(36,674)	(45,655)

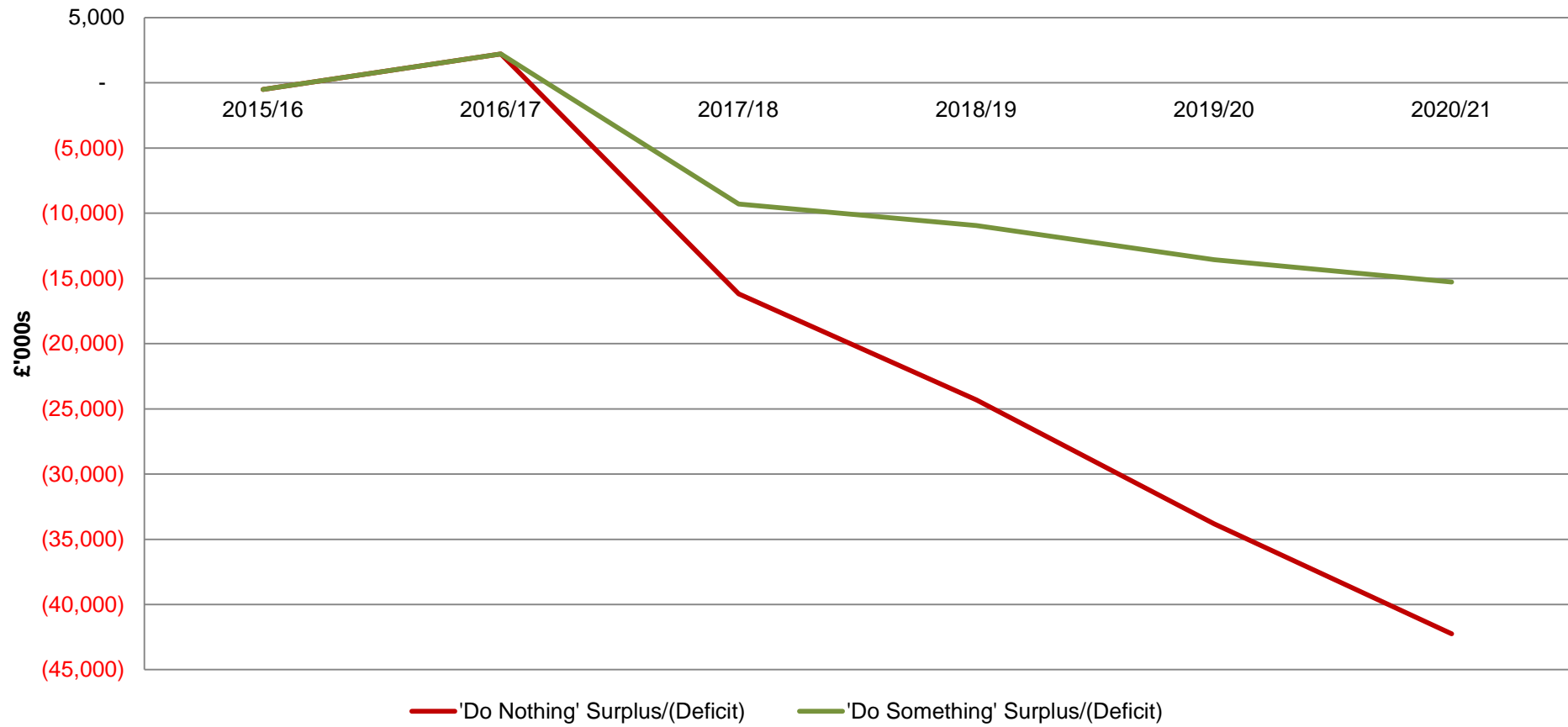
We have identified a number of solutions to close that gap.

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

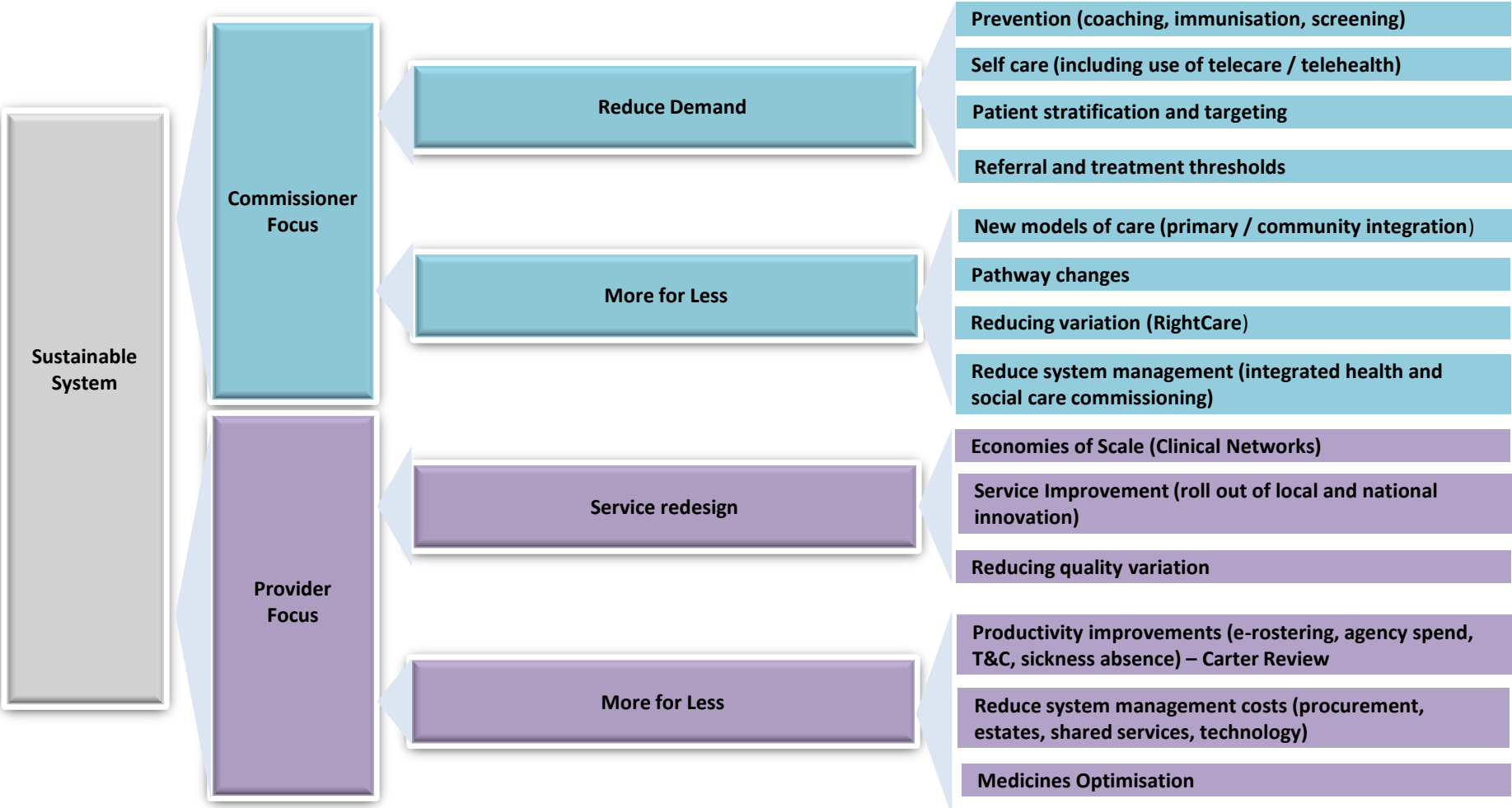
Solutions	2016/17 Impact £000s	2017/18 Impact £000s	2018/19 Impact £000s	2019/20 Impact £000s	2020/21 Impact £000s
1: Provider: Carter Programme (Workforce)	-	2,712	5,424	8,135	10,847
2: Provider: Carter Programme (Estate)	-	146	291	437	582
3: Provider: Carter Programme (Other)	-	1,015	2,031	3,046	4,062
4: Commissioner: New Care Model	-	308	308	708	908
5: Commissioner: Right Care and Dr Foster	-	874	1,574	2,274	2,974
6: Commissioner: Practice Based demand management; Prescribing efficiencies, QIPP	-	1,846	3,726	5,642	7,600
NHS Footprint Total	-	6,901	13,354	20,243	26,973
Social Care	-	1,528	2,440	2,869	3,405

STP 'Do Nothing' vs 'Do Something' Outturn – current plans result in a **£15.2m** gap by 2020/21



3.10 Delivering System Efficiencies

How we will deliver against our financial and efficiency gap



4. OUR ENABLERS

4.1 Enabling Change – Digital transformation

Increasing efficiency in processes - administrative and medical - promoting positive health-related behaviour change, or increasing the effectiveness of therapeutic processes and procedures.
Apps that reward people for performing certain behaviours,
Web portals for patients to book appointments or order prescriptions,
Devices that track and monitor patients remotely.
All patient and care records will be digital, interoperable and real-time by 2020 (PF@PoC)

Harrogate and District Plans

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 innovate 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.

Impact & benefits

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.

Harrogate and District Plans

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.

Impact & benefits

- 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

4.3 Enabling Change – Estates and Assets

- To accelerate the development of infrastructure to enable the improvement and expansion of joined-up out of hospital care for patients.
- To increase flexibility to accommodate multi-disciplinary teams. This will add to the range of care they provide for patients, add more training facilities and greater use of technology.
- To facilitate primary care at scale and enable a wider range of services for patients.

Harrogate and District Plans

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.

Impact & benefits

- 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

5.1 Harrogate and District STP: Delivering transformation and financial sustainability (DRAFT)

Delivery Plan	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	
New Care Model : What Matters to Us		▶					
Right Care / Elective Care Rapid Testing		▶					
Primary Care: 10 High Impact Actions to release time to Care		▶					
Primary Care at Scale			▶				
Integrated Health and Social Care Commissioning			▶				
Integrated Health and Social Care Community Model			▶				
New Urgent Care Model			▶				
Digital Transformation		▶					
Commissioner Efficiencies: QIPP (prescribing, continuing healthcare)		▶					
Provider Efficiencies: (e-rostering, reducing use of Agency Staff, supplies,		▶					

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**

**Reduced reliance on
hospital care with
activity delivered at home
or in communities**

**Sustainable
Financial
Position**

**Prevention of ill-
health to reduce
inequalities and
demand on the system**

**Reduction in
duplication and
variation**

**Resilient and
sustainable
workforce**

**Integrated Teams
supporting people to
live longer, healthier
lives independently
at home**

**Reduce the health
gap between people
with **mental health**
problems and those
who do not**

**Shared clinical record
across the system**

5.3 Impact on the three gaps

Health and Wellbeing	Quality and Care	Finance and Efficiency
Health inequalities	Constitutional Standards	New Care Model
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.	Maintaining A&E, cancer waiting times and RTT standards.	<ul style="list-style-type: none"> Reduction in A&E attendances by 11% by 2018/19. (NCM) Reduction in emergency admissions by 16% by 2020/2021. (NCM)
Personalisation and choice	Mental Health	RightCare
<ul style="list-style-type: none"> ↑ Proportion of people using social care who receive self-directed support and those using direct payments. (HWB) ↑ Number of people using personal health budgets. (IAF/HWB) People with a long-term condition feeling supported to manage their condition. (Target 72.2 in 2016/17) (NCM) % of patients with a single care Plan (Target 95% of patients supported by integrated team in 16/17). (NCM) 	<p>At least 60% of people experiencing a first episode of psychosis should commence treatment with a NICE approved care package within two weeks of referral by 2021. (IAF)</p> <p>75% people referred to IAPT begin treatment within six weeks, and 95% within 18 weeks, with a 55% recovery rate from treatment.</p> <p>>76.7% diagnosis rate for people with dementia. (IAF)</p> <p>>79.5% of patients diagnosed with dementia whose care plan has had a face-to-face review in the past 12 months. (IAF)</p>	<ul style="list-style-type: none"> Reduction in elective care activity Reduction in variation
Diabetes	Maternity	Digital
<ul style="list-style-type: none"> ↑ > 40.2% of diabetes patients have achieved all of the NICE-recommended treatment targets (current median). (IAF) ↑ People with diabetes diagnosed less than a year who attend a structured course (national av. currently 5.7%) (IAF) Roll out of the Diabetes Prevention Programme in 2017. 	<p>Neonatal mortality and stillbirths (IAF)</p> <p>Maternal smoking (at time of delivery) (IAF)</p> <p>Choice in maternity services (IAF)</p> <p>Women's experience of maternity (IAF)</p>	<p>Local Digital Roadmap implemented</p> <ul style="list-style-type: none"> Shared care record Digital infrastructure Mobile working Innovative technologies <p>Paper free at the point of care by 2020.</p>
Child Obesity	Cancer	Carter Review
<ul style="list-style-type: none"> ↓ % of children aged 10 or 11 (Year 6) who have excess weight (HWB / IAF). 	<ul style="list-style-type: none"> ↑ % new cases of cancer diagnosed at stage 1 and 2 (IAF). 	<p>Delivery of efficiencies (workforce review, back office functions, estate)</p>
	Hypertension	
	<ul style="list-style-type: none"> ↑ % of people whose blood pressure is controlled to 150/90 	
	End of Life Care	
	<ul style="list-style-type: none"> % of deaths in hospital/at home/in hospice (HWB) 	

APPENDICES

Appendix 1: Existing plans, priorities and transformation programmes

Local Level Strategic Plans and Priorities	Existing Transformation Programmes
<p>North Yorkshire http://www.northyorks.gov.uk/article/23982/Our-key-strategies-plans-and-policies Joint Health and Wellbeing Strategy 2015 – 2020 Joint Strategic Needs Assessment (JSNA) Pharmaceutical Needs Assessment 2015-2018 Better Care Fund North Yorkshire’s Mental Health and Wellbeing Strategy 2015-18 North Yorkshire and York Mental Health Crisis Care Concordat Children and Young People’s Emotional and Mental Health Strategy 2014 - 17 Young and Yorkshire The plan for all children, young people and their families living in North Yorkshire 2014 – 17 ‘Live Well, Live Longer’ Learning Disabilities: Joint Strategy for North Yorkshire 2015 – 2020 (Draft) North Yorkshire Autism Strategy 2015 – 2020 North Yorkshire Carers Strategy 2012-2015 North Yorkshire Winter Health Strategy 2015 – 2020 North Yorkshire Tobacco Control Strategy 2015-2025 Smoke-Free North Yorkshire North Yorkshire Community Plan North Yorkshire Alcohol Strategy 2014 – 2019 2020 North Yorkshire: Care and Support Where I Live http://www.northyorks.gov.uk/article/30736/Our-care-and-support-where-i-live-strategy West Yorkshire: Healthy Futures: Cancer, Mental Health, Specialised Commissioning, Urgent/emergency care Yorkshire & Humber: Ambulance / NHS 111 Harrogate District Public Services Leadership Board Plan on a Page Joint strategic commissioning and grant funding principles Harrogate District My Neighbourhood Plan on a page Harrogate Health Transformation Board Local and Personal: our priorities for working together for better health in Harrogate and rural area. Harrogate and Rural District CCG Operational Plan 2016 – 17 Primary Care Strategy (Draft) Business cases e.g. Ripon Community Hub</p>	<p>New Care Model: What Matters to Us</p> <p>Systems Leadership Local Vision Programme</p> <p>West Yorkshire Urgent and Emergency Care Vanguard</p> <p>NHS England Rapid Testing 100 Day Challenge 100 (NESTA)</p>

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:

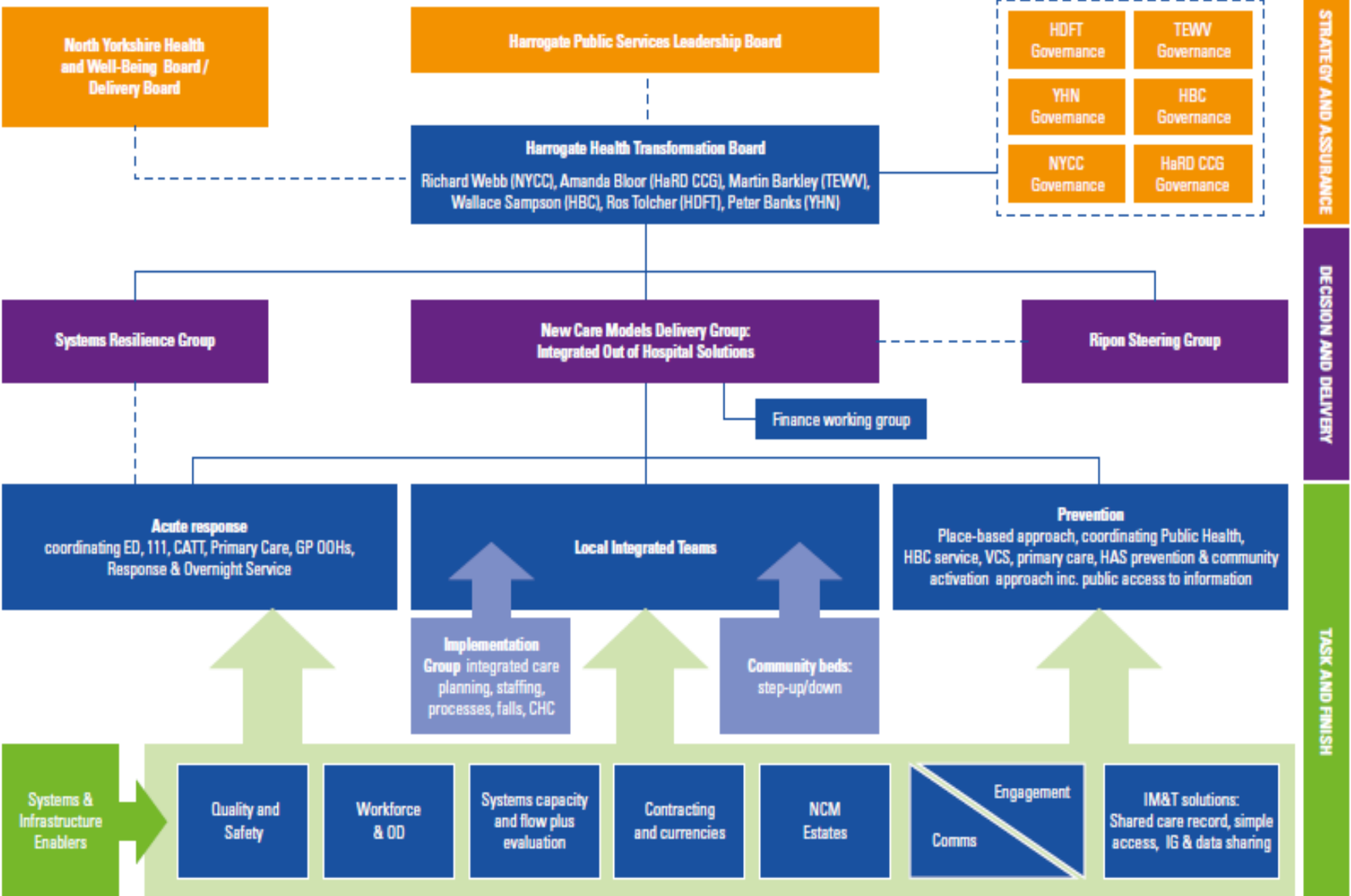
- Harrogate Borough Council.
- North Yorkshire County Council.
- NHS Harrogate and Rural District Clinical Commissioning Group.
- Harrogate & District NHS Foundation Trust.
- Harrogate College.
- North Yorkshire Police.
- North Yorkshire Fire & Rescue Service.
- Office of Police and Crime Commissioner North Yorkshire.
- 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:

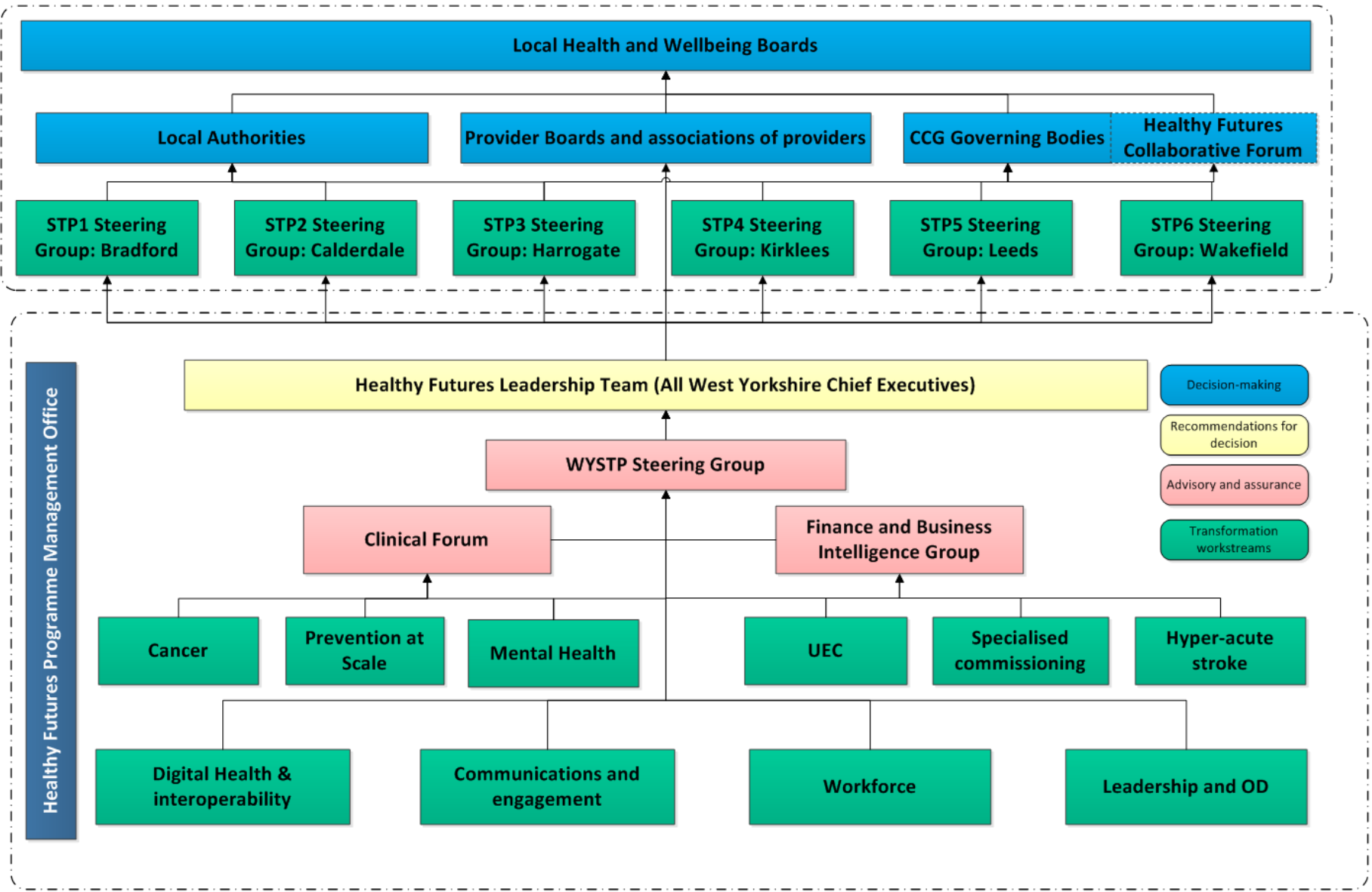
- A great patient experience and making services easier for patients to understand and use.
- The best clinical outcomes and reduce variation through single service models.
- More care closer to home.
- Integrated services across health and social care.
- Highly developed voluntary, third and community 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



Appendix 3 West Yorkshire Governance Structure Chart



Harrogate Health Transformation Board

Date: 22 September 2016	Agenda item no. 11	
Paper title: Sustainability and Transformation Plan	Information	X
	Discussion	X
	Decision	X
HHTB lead: Amanda Bloor	Paper author: Robyn Carter	

1. West Yorkshire STP Developments

Organisations across the NHS and Local Government in West Yorkshire have been planning together to develop the five year West Yorkshire STP (WYSTP) for five months now. The WYSTP is formed from local place-based plans and a set of supporting West Yorkshire programmes as follows:

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

Enabling workstreams:

- Workforce
- Digital
- Leadership and Organisational Development
- Communications and engagement
- Finance & Business intelligence
- Innovation and best practice
- Commissioning

As the WYSTP (both the local plans and the WY level programmes) develop, updated versions have been submitted to a group of national bodies including NHS England, NHS Improvement and the Local Government Association. There have been two such checkpoint submissions so far, the most recent was on 30 June 2016.

Harrogate Health Transformation Board

NHS England and NHS Improvement have provided feedback on the common themes, common enablers, common issues and requests that have been made by the 44 STP footprints across England. The common themes included urgent and emergency care, mental health and elective care. Common issues include delivering at scale and pace, cross boundary issues, fostering a collaborative culture, implementing good practice at scale, and the issue of being transparent and engaging stakeholders in exploring solutions. Work on developing the WYSTP has progressed during July and August, building on the feedback from the checkpoint submissions.

By 16th September 2016 STP footprints have to submit a set of financial returns. By the end of October these financial plans will need to include a clear narrative that sets out how the triple aims will be addressed, with a coherent story that includes provision and commissioning. The STPs need to show a joined up view of where the system needs to get to by 2020/21. The STP will set out the journey from sustainability to transformation year on year over its lifetime. The detail of years one and two are expected to be reflected in the CCG and NHS Provider Operational Plans required by December from organisations.

Governance and Engagement

Success will depend on *collectively understanding* the WY system and *making decisions jointly* as a system and *at all levels* – local CCGs and Health and Well-Being Boards, across provider Boards, across Local Authorities, and as a West Yorkshire Leadership Team, which has representation from all partner organisations.

A significant amount of effort has been spent on establishing the relationships and governance required by all health partner organisations to augment their current statutory authority and allow them to come together collectively to make recommendations and decisions. This has included developing new ways of working with regulatory bodies and exploring how the system can assure itself collectively that it is working towards reducing the current gaps, and manages risks to sustainability.

The Leadership Team, supported by the Clinical Forum, are now coming together for Leadership Days every month to progress planning and discuss the challenges and possible solutions as a system.

Engagement around the emerging WYSTP will start with our local communities and workforce as priorities and plans are agreed collectively by Health & Well Being Boards, CCG Governing Bodies and provider Trust Boards in September/October 2016.

Work to date

Planning to date as a system has focused on jointly understanding gaps and variations in outcomes, the pressures on services which are making them unsustainable and the contribution that collaborative programmes and local place-based plans can make to close these gaps and improve outcomes. This will provide an agreed foundation from which we can effectively plan and prioritise the transformation required over five years to address these gaps.

Harrogate Health Transformation Board

To date the West Yorkshire programmes of work have identified some return on investment but have yet to complete the STP Finance template for consolidation with the local plans.

2. Harrogate and District STP Development

The attached working document has been updated to reflect new guidance issued on 23 August. The new guidance adds significant risk to the overall position. The 1% cumulative surplus requirement for CCGs together with several new developments deemed to be within CCG allocations or Sustainability and Transformation Funds, alongside the pressures in social care, require a step change in approach to closing the WYSTP financial gap is required.

It includes two additional information requests, one on capital and one which requires footprints to map solutions against the national efficiency programmes. The guidance also clarified the general approach as follows:

For the CCG – achievement of 2016/17 business rules throughout the STP:

- 1% non-recurrent expenditure should be uncommitted at the start of every year of the STP and therefore cannot be used to fund routine pressures.
- 0.5% contingency the delivery of STP plans cannot be dependent on this.
- 1% cumulative surpluses each year, in line with the 2016/17 business rules.

For the Provider:

- 2% efficiency savings at a minimum for each year of the STP
- For 2015/16 the outturn should reconcile to the outturn position for each organisation.
- For 2016/17 the 'do nothing' forecast should reconcile to the plan, with no entries in the 'do something' section for 2016/17 on the basis that these are already reflected in operational plans and monitored through normal operational channels.
- All commissioner expenditure which is commissioned under tariff (or by proxy to tariff) should be modelled using net tariff (i.e. the price pressure growth assumption should be the net of tariff inflator and tariff efficiency factor, e.g. 0.3% in 2017/18).
- Solutions are mapped to national efficiency programmes

Financial Position

Financial analysis to date indicates the scale of the health and social care financial gap in the 'do nothing' scenario as **£45.6m** by 2020/21. Transformation programmes and provider efficiencies have been identified and mapped to the National Efficiency Programmes:

Harrogate Health Transformation Board

Solutions	2016/17 Impact £000s	2017/18 Impact £000s	2018/19 Impact £000s	2019/20 Impact £000s	2020/21 Impact £000s
1: Provider: Carter Programme (Workforce)	-	2,712	5,424	8,135	10,847
2: Provider: Carter Programme (Estate)	-	146	291	437	582
3: Provider: Carter Programme (Other)	-	1,015	2,031	3,046	4,062
4: Commissioner: New Care Model	-	308	308	708	908
5: Commissioner: Right Care and Dr Foster	-	874	1,574	2,274	2,974
6: Commissioner: Practice Based demand management; Prescribing efficiencies, QIPP	-	1,846	3,726	5,642	7,600
NHS Footprint Total	-	6,901	13,354	20,243	26,973
Social Care	-	1,528	2,440	2,869	3,405

This results in a financial gap of **£15.2m** by 2020/21.

CCG 2016/17 in year pressures

The CCG currently has QIPP plans across the following clinically led programme areas:

- Urgent Care
- Elective care
- Prescribing
- Continuing Healthcare and Mental Health

It was identified that an in-year recovery plan was required following the reported risk-adjusted forecast position at month 4. The CCG recognised within its monthly reporting cycle a high level of risk and as a result the CCG is reviewing and re-prioritising the transformational and QIPP schemes and identifying additional efficiencies relating to QIPP and demand moderation. These are listed in Appendix 4 of the STP and this section could be expanded to include individual organisational QIPP and CIP initiatives to reflect activities that we already have in place or are implementing in 2016/17 to help us to address the gap.

Harrogate Health Transformation Board

3. Next Steps and Key Dates

Confirm and challenge of the local STP plans by Healthy Futures, to re-appraise work to date, during September.

West Yorkshire STP meeting with Health and Wellbeing Board Chairs and Council Leaders on 15 September 2016.

National submission of financial information on 16 September 2016.

Final submission of draft West Yorkshire STP on 21 October 2016.

Publication of planning guidance for 2017/18 and 2018/19 by 20 September 2016.

Draft submission of two-year operational plans 2017/18 and 2018/19 by end November 2016.

CCGs and providers to finalise two-year operational plans with signed contracts by 23 December 2016

4. Recommendations and decisions required:

Harrogate Health Transformation Board is asked to:

- Agree the governance and sign-off process.
- Note the scale of the financial gap at £15.2m by 2020/21 and agree the approach to closing it.
- Agree what other opportunities should be included within the local plan.
- Identify the key interventions that will have the greatest impact on our population.
- Note the Healthy Futures requirement to undertake a peer review of local plans to understand the reasons for the different sub STP contributions and the West Yorkshire potential contributions.
- Note that the plan is a working document subject to review in response to national, regional or local developments or feedback.

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