Integrated Operational Plan 2014-19

The best health and
wellbeing for everyone.

Foreword

Dr Mark Hayes, Chief Clinical Officer

What will healthcare look like in five years from now? Will it be better and how would we know if it was?

In this plan we will try to answer these questions and to set out a clear vision for the future. We will draw upon the shared values of both patients and care givers, rallying them to the common purpose of creating a high quality and sustainable health and social care system.

We have spent the last 6 months in conversation with our community and we have learned about their priorities, wants and needs for a health and social care system. A number of interlocking themes emerged; such as services being involved and engaged with the patient at all times, ensuring care is coordinated across all community based services, continuity of care (including seven day working) and improvement in the provision of mental health services. There was also a desire to see the GP practice find a role at the centre of the health system of the future.

We have taken this knowledge and have used it to produce a plan that can deliver services to meet the aspirations of the community from within the available resources.

We have been actively researching various models of care provision both within this country and internationally. We have come up with a vision which we are describing as the “Care Hub Model”. We believe that with the support of our partner organisations we could develop this in a staged approach.

Whilst the model of ownership has yet to be finalized there are a number of possibilities under consideration including social enterprise, federated GP partnerships or hospital / GP partnership. However, the model is provided we believe that the most important task is to determine the nature of the services that will be offered. Once this is known we can think about the structures required to support the identified services.

The Care Hub (s) will serve a population of between 100,000 – 350,000, initially a virtual network based in existing premises, providing a comprehensive range of services including both health and social care. This will include an extended range of primary care services over a longer working day, seven days a week. Hubs may eventually provide the out of hours services, ensuring that continuity of care is maintained through a shared care record thereby reducing any unnecessary hospital admissions.

With the addition of community services and some out-patient services, the Care Hub will move towards merging primary care, secondary care,

community care and mental health and learning disability services into a single, integrated system of “care”.

Our partner organisations have given the CCG the role of system leader and working closely with them we have gained wide ownership of this plan. Conversations with partners have been important in laying out the scope of change that will be required across the system. From secondary care to primary care, community care to urgent care and from mental health to social care our partners are signed up to bring about this profound shift in the way that care will be delivered in the future.

There are a number of enablers that will support this change process in the future, including the potential to co-commission primary care with NHS England, the Better Care Fund across health and social care, and the promise of new and innovative funding mechanisms from NHS England.

There is a clear alignment of our plans with national requirements, more so than ever with the vision that Simon Stevens, Chief Executive Officer of the NHS England, has recently mapped out for local health systems. The levers and local flexibilities he advocates will provide additional momentum and focus on driving our plans for transforming integrated community and primary care.

As such we are currently bidding to be one of four national NHS Accelerate sites which would provide us with significant additional capacity and expertise to drive our integration pilots as well as trial some of increasingly innovative and sophisticated commissioning and contracting approaches.

The future offers us a range of possibilities and it is up to us to choose wisely. We believe that the plan we are presenting here is cohesive, deliverable and most importantly supported across our entire system.

I am pleased to present our Five Year Strategic Plan and associated Integrated Operational Plans which map out how we are delivering the changes required to achieve a sustainable healthcare system for the future.

Our team, and our relationships with our key stakeholders, has never been stronger and our successes in 2013-14 provide us with a strong foundation for our challenging programme of work for the next five years.

Dr Mark Hayes
Chief Clinical Officer
NHS Vale of York Clinical Commissioning Group

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Who we are

NHS Vale of York Clinical Commissioning Group (the CCG) brings together all GP practices in the Vale of York area to enable patients and primary care clinicians to have a greater say in how health services are delivered locally.

On 1st April 2013, we officially became the statutory body responsible for commissioning the vast majority of healthcare services for patients across the Vale of York. This includes hospital care, mental health and community services.

Led by a number of local GPs and other health professionals, we work with the community and our local partners to understand the needs of our patients. We are dedicated to working with local people to ensure they have access to the right services, in the right place, at the right time.

Remit

Our main areas of responsibility are:

- Planned hospital care
- Urgent and emergency care
- Community health services
- Mental health and learning disability services
- Tackling inequality including children's health and wellbeing

CCG Structures

We are a membership organisation overseen by the **Council of Representatives**, comprising a member from each GP practice in the Vale of York. The work of the CCG is led by the **Governing Body**, which consists of:

- Chair (lay member)
- Chief Clinical Officer,
- 8 GPs, (6 Clinical leads and 2 representatives from the Council of Representatives)
- Chief Financial Officer
- Chief Operating Officer
- Additional lay member representation
- Practice Manager representative
- Secondary care doctor
- Chief Nurse
- 2 Directors from relevant local authorities

The Governing Body monitors and challenges the delivery of work across the CCG, quality and health performance outcomes for the residents of the Vale of York, financial and risk management.

To find out more about the CCG go to http://www.valeofyorkccg.nhs.uk/about-us/

What We Do

In order to deliver our five year vision of **"Achieving the best health and wellbeing for everyone in our community"** our teams are working daily to drive four main activities:

1. Quality assurance and improvement	▪ Ensuring patient safety first and foremost ▪ Delivering the NHS Constitution ▪ Performance improvement ▪ Patient experience and dignity ▪ Safeguarding ▪ Quality Premium ▪ CQUINs ▪ Seven day services ▪ Response to Francis, Berwick and Winterbourne Review ▪ Compassion in practice ▪ Staff satisfaction
2. Financial sustainability	▪ Ensuring value for money ▪ Delivering productivity improvements and savings which contribute to our financial target Quality, Improvement, Productivity and Performance plans (QIPP) ▪ Prioritisation of funding and cost pressures ▪ Investment

3. Improving outcomes (Our five year ambitions)	Meeting our local trajectories and targets (health and quality outcomes) Meeting our local priorities Meeting our Better Care Fund Measures Tackling health inequalities Addressing unwarranted variation
4. Transforming services (Our five year strategic initiatives)	1. Integration of Care 2. Person-centred care 3. Primary care reform 4. Urgent Care reform 5. Planned Care (Productive Secondary Care including specialised services) 6. Transforming Mental Health and Learning Disability Services (and achieving Parity of Esteem) 7. Children's and Maternity **8.** Cancer and End of Life Care

Laying the Foundation: Key Successes in 2013/14

The first year of the CCG's existence has seen the foundations for future success being laid down with the achievement of some fundamental objectives, including:

- CCG received full authorisation
- Achieving financial turnaround
- Provision of a Section 136 Suite to provide a place of safety for people with mental health needs
- Investment in autism assessment services
- Work with Neurological Commissioning support to improve services to patients
- Development of a new community model of Diabetes Care in partnership with patients and Hospital clinicians
- Development of a Referral Support Service to support primary care in the way they refer patients for on-going treatment and to standardise referral guidelines
- Development of collaborative working across primary care to improve links between practices and opportunities to develop services
- Improvement in relationships between the commissioner and partner organisations, in particular providers and Local Authorities (as evidenced through the 360 Stakeholder Survey)
- Excellent engagement strategy and programmes embedded within every piece of work undertaken
- Development of a great CCG team that has innovation and improvement embedded as core values
- Strengthening of assurance gained from internal and external audit
- Clinical engagement and support for the Care Hub future model of care
- Strong aligned and jointly agreed goals for Integration across health and social care via the Better Care Fund and establishment of a number of integration pilots to test the vision
- Collaboration and common purpose across both our local Unit of Planning and wider planning footprint, which are driving our improvement interventions, QIPP initiatives, the Better Care Fund and specialised services commissioning
- Clear patient navigation and access to range of interventions with patients empowered and engaged across all their needs and the system
- Working collaboratively with primary care to improve services and redesign pathways
- Review of neurology pathways and development of community based pathways to support care closer to home
- Establishment of an Urgent care working group with representation from all key partners to implement system-wide solutions to managing demand in urgent care services

Already in early 2014-15 we are building further on this foundation with:

- All our contracts agreed with our providers, including Service Development Improvement Plans which map out the programmes of review and transformation
- Recommencing IVF treatment
- £290,000 of additional funding for delivering IAPT services
- Additional CCG experts to scope and drive transformation and address core areas such as ensuring safeguarding and focusing on patient experience
- Commencement of the redevelopment of mental health inpatient unit at Bootham Hospital (interim solution) by Leeds and York Partnership Foundation Trust
- Further engagement with voluntary sector as a critical enabler for delivering our transformation programmes
- Development of a CCG prioritisation framework to support challenging decision-making
- Ensuring all our service developments and transformation work can demonstrate VFM and clear impact of on improving health outcomes and/or addressing health inequalities and parity of esteem
- Roll out of improvement training and support for primary care to develop services

Vision, Mission and Values

Our Vision

"Achieving the best health and wellbeing for everyone in our community"

Our Mission

- Commission excellent healthcare on behalf of and in partnership with everyone in our community.
- Involve the wider clinical community in the development and implementation of services.
- Enable individuals to make the best decisions concerning their own health and wellbeing.
- Build and maintain excellent partnerships between all agencies in Health and Social Care.
- Lead the local Health and Social Care system in adopting best practice from around the world.
- Ensure that all this is achieved within the available resources.

Our Values

- **Communication** – Open and clear communication at all times, inside and outside the organisation, is essential for us to succeed. We recognise that the messages we send out need to be clear to everyone who receives them.
- **Courage** – We have the courage to believe that our community has the capacity to understand complex health issues and that it can be trusted to participate in making decisions on the allocation of health resources.
- **Empathy** – We understand that not all ills can be cured. We understand the suffering this causes and we work to reduce it.
- **Equality** – We believe that health outcomes should be the same for everyone. We will reduce unnecessary inequality.
- **Innovation** – We believe in continuous improvement and we will use the creativity of our stakeholders and staff.
- **Integrity** – We will be truthful, open and honest; we will maintain consistency in our actions, values and principles.
- **Measurement** – Successful measurement is a cornerstone of successful improvement.
- **Prioritisation** – We will use an open and transparent process to arrive at value driven choices.
- **Quality** – We strive to be the best that we can be and to deliver excellence in everything we do.
- **Respect** – We have respect for individuals, whether they are patients or staff colleagues; we respect the culture and customs of our partner organisations.

Our Health and Wellbeing Principles

The CGG also forms part of our three local **Health and Wellbeing Boards** and as such we are committed to delivering our plans in line with their main principles. Our City of York Council principles are outlined below:

1. Making York a great place for older people to live
2. Reducing health inequalities
3. Improving mental health and intervening early
4. Enabling all children and young people to have the best start in life
5. Creating a financially sustainable local health and wellbeing system
   This last principle is the over-arching aim of this five year strategic plan.

Our Objectives

People will be supported to stay healthy through promoting healthy lifestyles improving access to early help and helping children have a healthy start to life.
People will have more opportunities to influence and choose the healthcare they receive and shape future services.
People will continue to have good access to safe and high quality healthcare services.
When people become ill, they are treated in a timely manner with access to expert medical support as locally as possible.
Where people have long-term conditions they are supported to manage those conditions to give them the best possible quality of life.
When people are terminally ill, the individual and their families and/or carers are supported to give them the best possible quality of life and choice in their end of life care.
A move to 'Care Hubs', providing increased access to health promotion, care and support services, including GPs, pharmacies, diagnostics (e.g. scans/ blood tests), community services, mental health support and social care and community and voluntary services.
High quality mental health services for the Vale of York, with increased awareness of mental health conditions, improved diagnosis and access to complex care within the local area.
A sustainable and high quality local hospital providing a centre for urgent and emergency care and planned care for a wide range of conditions and elective operations, maternity and other specialisms within the Vale of York.
Access to world class highly complex and specialist care provided through specialist centres across the country.
Opportunities for accessing and leading research to improve healthcare systems for all.

Equality

Equality is a core principle of the NHS Constitution and embedded into the Health and Social Care Act 2010. What is more, as a public sector organisation we have a duty under the Equality Act 2010 to promote equality, eliminate discrimination and foster good relations.

For more information please see our Equality, diversity and Human Rights strategy and implementation Plan 2013-2017, which is available on our website at http://www.valeofyorkccg.nhs.uk/about-us/equality/

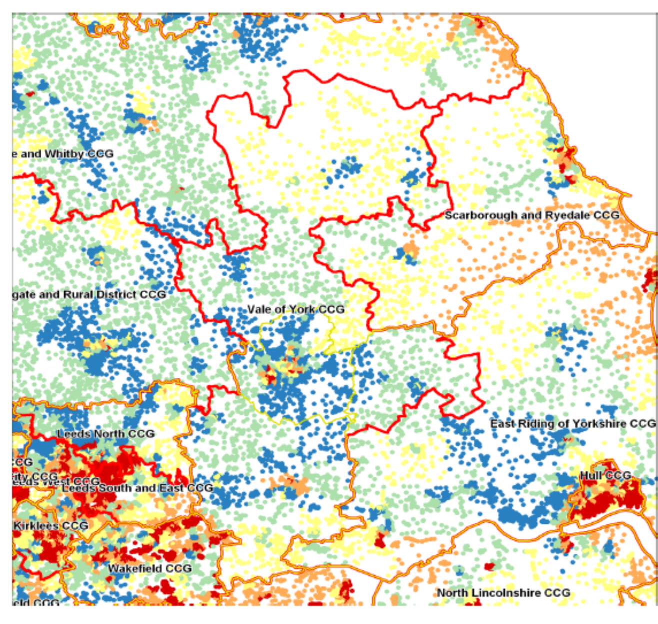
Our equality objectives are:

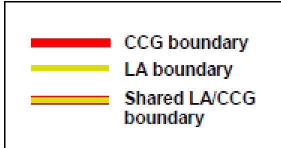
1. To provide accessible and appropriate information to meet a wide range of communication styles and needs
2. To improve the reporting and use of equality data to inform equality analyses
3. To strengthen stakeholder engagement and partnership working
4. To be a great employer with a diverse, engaged and well supported workforce
5. Ensure our leadership is inclusive and effective at promoting equality

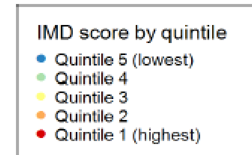
The Vale of York

Our Geography

We represent patients registered with 32 GP Practices located in places such York, Selby, Tadcaster, Easingwold, Pocklington and parts of Ryedale. Through these GP practices we represent a population of 336,330 residents.







The population is comparatively affluent; however, there are pockets of significant deprivation in parts of York and Selby and surrounding Sherburn-in-Elmet. We cover the urban city centre and rural surrounding areas, the complexity of working across different partner agency boundaries and geographic areas requiring a flexible approach to the provision of services across the area.

Our partners

We span 3 local councils, North Yorkshire County Council, City of York Council and East Riding of Yorkshire Council and work to three Health and Wellbeing Boards for each of these local authority areas. We work closely with NHS England Direct Commissioning (covering GPs, Pharmacies and Dentists), Public Health England , NHS England Specialist Commissioning, our neighbouring CCGs as well as our local Partnership Commissioning Unit (PCU) who commission mental health, learning disability services and children's services for our population.

Collaborative Improvement Board

To achieve the degree of change necessary all key partners and stakeholders need to work together in a 'whole system' approach to meeting the needs of the population within the resources available across the whole local health and social care system.

We have successfully initiated a high level Collaborative Improvement Board consisting of the Executive Directors of the York Hospitals Foundation Trust, East Riding CCG, Scarborough and Ryedale CCG and

Vale of York CCG to ensure alignment of commissioning for the majority of patients attending the shared acute provider, York Hospitals Foundation Trust.

The Collaborative Improvement Board has an agreed set of shared objectives and commits the partner organisations to close collaborative working to transform services across the health and social care system to deliver sustainable change to achieve maximum benefit for its populations.

Strategic Collaborative Commissioning Groups

We work closely with the other three 'North Yorkshire' Clinical Commissioning Groups and all the CCGs across North Yorkshire and Humber through two strategic collaborative commissioning groups. Through these arrangements we set out lead commissioners and risk-share arrangements to commission services for our local populations.

Urgent Care Working Group

We work in partnership through the Urgent Care Working Group to manage demand and capacity within the urgent care system. The group comprises representation from Vale of York, Scarborough and Ryedale and East Riding CCG's; Yorkshire Ambulance Service; City of York Council and North Yorkshire County Council; Mental Health Trusts from Tees, Esk and Wear Valley and Leeds and York Partnership Foundation Trust; Healthwatch and NHS England. This group leads on the implementation of the Urgent Care Strategy and the improvements set out in the Improvement and Intervention section.

Providers

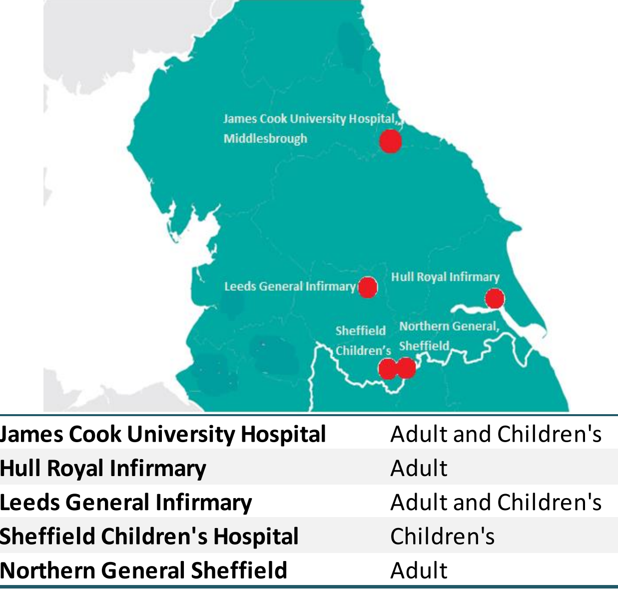
There is one main provider of hospital and community care (York Teaching Hospitals Foundation Trust) and one main provider of mental health services (Leeds and York Partnership Foundation Trust). Specialist healthcare services are primarily provided by Leeds Teaching Hospital for our area. The population is also served by the Yorkshire Ambulance Service and a range of other public, private, voluntary and independent health care providers across the range of services.

Specialist Services

National thinking around hospital based care has been influenced through high profile reviews such as the Keogh review of Mid-Staffs, and the Berwick and Cavendish Reviews. In his review of hospital services Sir Bruce Keogh recommended that serious or life threatening care should be delivered from centres of excellence, with the best expertise and facilities to maximise chances of survival and recovery. This has led to national recommendations moving towards commissioning of serious, life-threatening emergency care and rare services from centralised locations to ensure clinical and cost efficiencies are maximised.

Examples in the North Yorkshire and Humber region of centralised services include major trauma, procedures relating to Primary Percutaneous Coronary Intervention and vascular interventions already commissioned through specialist commissioned services.

Major Trauma Centres in the area are shown below:



James Cook University Hospital	Adult and Children's
Hull Royal Infirmary	Adult
Leeds General Infirmary	Adult and Children's
Sheffield Children's Hospital	Children's
Northern General Sheffield	Adult

Locally the Specialised Commissioning Team is undertaking consultation to establish their five year plan which is due to be published by the end of spring. Within the priorities being consulted on there is focus on the following:

- Complex Cardiology Services, with the view to full scale reconfiguration
- Morbid obesity surgery where there is a need for CCGs to commissioning Tier 3 weight management services to support this priority and in line with the national requirements Vascular Surgery

Commissioning Support

We are supported by the North Yorkshire and Humber Commissioning Support Unit, who provide a range of 'back office' functions and clinical policy support for the CCG. We also work in collaboration with our neighbouring North Yorkshire CCG's on areas, including Continuing Health Care, Mental Health and Learning Disability, Children's services and both children's and adults safeguarding through the Partnership Commissioning Unit (PCU). We work closely with these partners to meet the health needs of our population.

Demographics

Our population is comprised of 51.3% women and 48.7% men, with a higher proportion of people over age 50 than the national average and a significant transient student population (30,000 swell). Over the next five years we anticipate that our population will grow by 3.9% to 356,360 people; within this we expect that the percentage of people over 65 will increase by 10% and the percentage of people over 85 will increase by 18%. As we celebrate people living longer, we need to ensure that we have planned to meet their more complex needs and support quality of life in the later years.

In the 2011 census, 9% of our population reported that their day to day activities are a little bit limited by their health and 6.8% of people report that their day to day activities are limited a lot by their health. This shows that

for many residents (approx. 53,000) managing health conditions can be an issue.

The population is majority white British (95%) and report their religious beliefs as Christian (64%) or of no religion (26%). The Vale of York has a number of other significant ethnic groups including, Asian (2.2%), mixed race (1%), black (0.4%) and travellers and Roma Gypsy communities. There is also a diverse range of religious beliefs, including Muslim (0.7%), Buddist (0.4%), Sikh (0.1%) and Jewish (0.1%). We need to plan effectively for the different cultural, social and health needs of our community to everyone to achieve the best health and well-being.

The Case for Change

NHS Call to Action

The national 'Call to Action' identified that the current investment levels and growing population may lead to a £30billion funding gap nationally. This is being driven across all CCGs by:

- the challenge of an aging population – we now look after more pensioners than children
- the growing challenge of obesity, dementia and multi-morbidity (the co-occurrence of two or more chronic medical conditions in one person)
- more expansive and more expensive treatments

To ensure the sustainability of the NHS we need to work across our community and local partners to do things differently and to transform the current system. The transformation of services will include the 6 characteristics of a high quality and sustainable system outlined by NHS England in its planning framework 'Everyone Counts: Planning for Patients 2014-15 to 2018-19'.

This five year plan clearly identifies how we will address each of these areas:

- Citizen inclusion and empowerment
- Wider primary care, provided at scale
- A modern model of integrated care
- Access to the highest quality urgent and emergency care
- A step-change in the productivity of elective care
- Specialised services concentrated in centres of excellence

The CCG's delivery against these areas will be monitored and assured by NHS England quarterly and the assurance reports are available on the CCG website.

Our Local Population Needs

Joint Strategic Needs Assessments (JSNAs) outline a range of performance information, quality outcomes, financial data and feedback from the local population.

We use these http://www.healthyork.org/lifestyles-in-york/alcohol.aspx and http://www.nypartnerships.org.uk/index.aspx?articleid=26753 to understand the health needs and issues for the Vale of York. These are compared to other similar areas in the UK to help prioritise work and drive improvements in health across the local area.

The four key points that emerged from the JSNA 2014 were:

- Our population is ageing and will place increasing demands on health and social care services
- Health and wellbeing inequalities exist in the city and must be tackled
- We need to know more about the mental health needs of our population
- The importance of intervening early and give children and young people the best possible start in life

Successes and things working well

The CCG and local providers performs better than the national average on a range of services and outcomes. Compared to the average for England, our population reports:

- Greater patient satisfaction with their GPs
- A higher quality of life for people with Long Term Conditions (LTCs)
- More people feel supported to manage their condition
- The health and wellbeing of children and young people is better than the England average

Overall the population is comparatively healthy, the CCG area scores significantly better than the England average on 18 out of the 32 national health indicators. None of the areas commissioned by the CCG perform significantly worse than the England average. Particular areas of success for Vale of York CCG compared to the England average are:

- Fewer emergency admissions for alcohol related liver disease;
- Fewer unplanned admissions for asthma, diabetes and epilepsy in under 19s;
- Fewer emergency re-admissions within 30 days.

Overall the performance is robust against the commitments in the NHS Constitution, which includes the national timescales for access to treatment and appropriate care.

We have also seen significant organisational improvements in our first year of operation. We have had our conditions and directives from CCG authorisation removed and achieved a balanced budget after years of historical deficit in the local area. We are leading a collaborative approach to service improvement and have strong clinical engagement in all areas of our work. We have grown our staffing capacity, including apprenticeships and development opportunities for clinical trainees.

Areas for improvement

Despite the successes, there are some areas where we have lower outcomes than comparator and the national average. These areas are:

- Higher mortality rate for those with cancer under 7five years of age;
- Higher emergency admission for children with lower respiratory tract infections;
- The Selby area scores significantly worse than the England average for adult obesity;
- Higher than average spend on emergency admissions than comparators and national average;
- Higher than average growth in the number of emergency admissions than comparators and national average;
- Faster than average growth in the number of GP referrals to services than comparators and national average;
- Higher than average disease prevalence on Depression, Atrial Fibrillation, Dementia, Cancer, Hyperthyroidism, Stroke and Coronary Heart Failure;

- Top 20% of 55 ONS comparators for spend on Circulation, Neurology;
- Number of bed days for mental health problem significantly higher than average (England value: **4686**, Vale of York: **4976** per 100,000 population);
- People in contact with mental health services Significantly Higher than average (England value: **2176**, Vale of York: **2345** per 100,000 population);
- Carers of mental health clients receiving of assessments Significantly Lower than average, England value: **69**, Vale of York: **31%).**

We recognise that there are areas where current performance against the NHS Constitution commitments could be improved and strengthened, including:

- The prevalence of healthcare acquired infections (e.g. MRSA, C.difficile);
- Ambulance response and turnaround times;
- Accident and Emergency waiting times;
- Access to psychological therapies (IAPT);
- Cancer waiting times;
- Delayed transfers of care;

The CCG and its providers work closely to address any pressures on capacity in different care areas during each year and new System Resilience Groups are currently being established to ensure there is sufficient capacity for our population throughout the year in order to meet all NHS Constitution targets.

The services we have, as well as investment required for new treatments and services, also create financial pressures. The cost of healthcare activity in-year can exceed the planned budget and we are working hard to change this situation to make our services sustainable in the future.

Engagement and Collaboration

Listening to our Community and Citizens

Patients, carers and the public are at the heart of health services and we are committed to the philosophy of 'no decision about me - without me'. Delivering a sustainable and successful NHS in the local area is a collective challenge, and we will work with the public to put them at the centre of their care.

Engagement is at the root of everything we plan and do and our stakeholders have reported that our engagement is 'excellent'. We are committed to working in partnership with patients and the public to co-design changes in the health and social care system, and have a wide ranging engagement programme.

The CCG has a now well-established a platform to engage with the Vale of York community called **'Let's talk health'** which allows everyone to contribute to the conversation and be heard. Details of forthcoming engagement events are available at http://www.valeofyorkccg.nhs.uk/get-involved/ .

Our improvement interventions and comprehensive engagement with public, patients and stakeholders including clinical leadership from both our GPs and provider. We recognise that partnership working in all our interventions will be critical to success.

We work closely with Healthwatch organisations in our local area, and have held a number of joint engagement events on a wide range of health issues. A lay member for the CCG Governing Body is currently being co-opted from Healthwatch to further strengthen our focus on empowering our citizens in all our delivery and governance.

Our work with Healthwatch is supported by a more formal engagement structure through the Patient and Public Engagement Steering Group (PPE), Patient and Public Groups (PPGs) in primary care with LAY representation. The Chairman of the Governing Body provides the lead for engagement on the Governing Body. During our first year we have taken different approaches to engagement, including forum events, world café sessions, open space events and online consultations on service improvements including diabetes, mental health and out of hours.

In 2014-15 we also want our local citizens to undertake a greater role in making challenging decisions alongside us and we are currently considering how our new prioritisation framework can be used by citizens with the CCG to support decisions around investment and commissioning.

Throughout the development of this plan we have reviewed consultation information, held workshops on specific conditions and held local engagement events.

The Vale of York community has told us:

'We only want to tell our story once'

'Care needs to be individualised to match our needs'

'To improve support for patients, services need to communicate better'

'We need more open access GP appointments'

'It would be better if regular services could be provided in the community'

'We want more time with consultants'

'We want to wait less time for our hospital treatment'

'We need to be provided with reliable, relevant information to allow us to make informed decisions, particularly about our medications'

'Carers need to be considered and included'

'Mental health needs to be a main focus'

The full detail is available in the Annex 3 'You Said, We Did' including a summary of key stakeholder engagement activity the CCG has undertaken to date and some patient feedback from specific care areas which is guiding the improvement and transformation work we are now delivering and gives a clear vision of where we need to be in five years time.

We are currently undertaking a significant engagement programme to support the review of mental health services that is underway and which will inform the future procurement of our mental health and learning disability services.

DISCOVER!

28th April 2014 saw the launch of the DISCOVER! engagement programme. DISCOVER! is designed to support and complement existing engagement processes, bringing together stakeholder views from all sources to inform commissioning decisions – initially around mental health. The intention is to work with existing communications colleagues, service users, carers and relevant stakeholders to establish a new approach to engagement around mental health, ensuring that the people we serve have a real voice at all stages of the commissioning cycle.

The need to understand better the mental health needs of our population is critical. The launch event was attended by representatives from the CCG, Leeds and York Partnership FT, the local authority and voluntary sector organisations, MIND and Converge.

The intentions were to:

- Build a shared approach and shared sense of purpose for engagement across the 4 CCG localities.
- Develop the skills, capabilities and behaviours which will support a relational approach to engagement.
- Learn about how to lead this kind of engagement in our CCG Localities and use learning to develop a sustainable future approach.
- Generate immediate feedback about what matters to patients, carers,

service users and communities about mental health to help shape 2014 commissioning decisions.
- Generate feedback about mental health and about maternity services.

Using an Appreciative Inquiry approach, DISCOVER! is focusing upon the question **“What is your best experience of mental health services and what is your dream for how we can do more of that?”**

During June themed café-style events have taken place, one focusing on dementia and the other on general mental health. In between events, work has continued with the DISCOVER! network to gather further intelligence from as many places as possible. This will be developed into themes and fed back to the community and everyone involved in the DISCOVER! programme.

The CCG has also recently:

1. Recruited a **Patient Experience Lead** who will monitor the results of the Friends and Family test and Patient Experience information, and work with Health Watch, the CCG communications and engagement team and CCG clinicians to roll out the test in other areas (e.g. primary care) using digital technology
2. Started to develop clinical soft intelligence to further triangulate patient concerns within the economy.

Planning in collaboration with our commissioning partners

This Five Year Plan is based around a geographical footprint now commonly known as the CCG ‘Unit of Planning’ which includes all our providers, our commissioning partners in Leeds, East Riding, Scarborough and Ryedale and Hull; our three local authorities in City of York Council, East Riding County Council and North Yorkshire County Council, as well as the NHS England (NHSE) Direct Commissioning team in relation to the commissioning of specialised services, primary care and veterans care.

There is joint system-wide leadership across this Unit of Planning through a variety of collaborative groups supporting our programmes and all local CCGs in the North Yorkshire and Humber region including:

- Health and Wellbeing Boards of City of York, North Yorkshire and East Riding of Yorkshire
- Mental Health and Learning Disabilities Partnership Board
- North Yorkshire Collaborative Transformation Board
- City of York Collaborative Transformation Board
- Collaborative Improvement Boards for York, East Riding and Scarborough and Ryedale CCGs (CIB)
- Integrated commissioning group (NYCC)
- Collaborative Transformation Group (CYC)
- Strategic Collaborative Commissioning Group (all local CCGs)
- Urgent Care Working Group (alongside the emerging Systems Resilience Group)

- Safeguarding Children Boards for City of York, North Yorkshire and East Riding of Yorkshire
- Safeguarding Adults Boards for City of York, North Yorkshire and East Riding of Yorkshire
- PPE Steering Group
- Healthwatch Assembly – York
- Local Dental Committee
- Local Opthalmic Committee
- Police and Crime Commissioner

These represent highly effective and inclusive membership and the result has been increasingly aligned plans and joint work programmes. We welcome more and more collaborative work being led across more than one CCG where there are benefits to planning and redesigning models across this wider footprint, and to achieve economies of scale and deliver change at pace.

We work closely with the NHS England Area Team in relation to assurance as well as improvement planning when focusing on managing issues in the system or misalignment in planning between CCGs and providers. There is a high level of transparency and mutual support in addressing areas of significant challenge and mitigation.

There is also continuous engagement and planning with NHSE around services which they direct commission:

Primary care: the CCG is working closely with Area Team to deliver the transformational programme for primary care reform. The CCG has clearly indicated its interest in co-commissioning primary care with NHS England from 2014-15, including opportunities around community dentistry, community pharmacy and ophthalmic services which would support the delivery of the Care Hub Approach. This would include workforce planning and estates infrastructure required to deliver primary care at a greater scale in the future.

Public Health (with Public Health England [PHE] and our local authorities): delivering national immunisation and screening programmes; children's services years 0-5 and the healthy child programme (family nurse partnerships, health visiting, school nursing); there is also currently an on-going re-procurement of the 5 to 19 year old service across two of our local authorities.

Military health: the CCG is working with the Area Team to improve care co-ordination for military staff upon discharge, particularly access to specialist mental health services (IAPT, crisis services, post-traumatic disorder services) and ensure a Care Programme Approach is adopted between services and clear sign-posting to appropriate services. This will enable us to deliver our Armed Forces Community Covenant for York and to ensure equitable access for our military and veterans.

Offender Health: all services for offenders in custody including public health programmes.

Specialised services: the CCG is working closely with NHSE, York Teaching Hospitals NHS Foundation Trust and the Academic Health and Science Networks to understand and embed the implications and requirements from the Specialised Services Commissioning Operational Plan for 2014-16.

The national Planning Framework outlines a drive to deliver specialist services from a smaller number of centres of excellence in order to ensure high quality and more cost effective services. The aim of all partners is to ensure that there is no destabilisation of any service or provider and that the CCG can respond to the requirements of the commissioning plans rapidly this year to ensure all our transformation work captures the key issues.

There are a number of specific issues (including consistency in standards of care, clinical sustainability, financial sustainability, derogations from national service specifications) across a range of specialist services identified for our providers in York, Leeds, Sheffield and Hull which we are currently discussing:

- Hyper-acute stroke
- Neuro surgery
- ENT
- Children's surgery
- Children's centres and neonates
- Cancer (sarcoma)
- Major trauma
- Complex disability equipment
- CAMHS Tier 4

Planning and transforming services in collaboration with our providers

We recognise that partnership working in all our interventions will be critical to success and every improvement intervention includes dedicated clinical leadership for each intervention from both our GPs and provider. The CCG works closely with its providers to agree changes, plan and transform services as required, whether that is short-term action planning, identification of cost improvement plans, or undertaking fundamental service review and redesign work, including the retendering of services.

The CCG is committed to working with our current providers to strengthen their organisational health and sustainability, recognising their own specific organisational challenges and ensuring alignment in both current and future transformational plans. To this end there are regular discussions with providers through Board-to-Board sessions, Executive team meetings and at Contract Management Boards, as well as the many joint working groups established across the area driving specific improvements.

The **Urgent Care Working Group** has been highly effective in driving the national urgent care agenda locally. The new emerging Systems Resilience Group will build on this established group to plan and commission the appropriate volumes of activity required in both unplanned and planned care services throughout the year.

The contracts with our main providers have now been agreed and there is on-going discussion to agree the set of service developments and improvements which impact on our providers over the period of the

contracts and beyond, and which will require joint working and delivery. These will be captured in a Service Development Improvement Plan (SDIP).

Joint working is already well-established between the CCG and **York Teaching Hospitals Foundation Trust** with the Trust leading one of the integration pilots as part of the Care Hubs approach. There is also joint work on-going to address delivery of a joint medical and surgical assessment pathway.

Likewise, the CCG is actively supporting the redevelopment programme for Bootham Park Hospital inpatient accommodation and the review of mental health and learning disability services with **Leeds and York Partnership Foundation Trust** and our **Partnership Commissioning Unit.**

Voluntary Sector partners: we recognise the huge contribution that the voluntary sector plays in supporting the community and services to optimise outcomes for patients and their families. The role of the voluntary sector will become increasingly important as we move towards more integrated care pathways and service provision. The CCG is committed to continuing and developing our partnerships with the voluntary sector and further exploring how the services they offer may complement and enhance provision in line with our strategic plans.

We will work closely with providers in the voluntary sector to ensure all our initiatives consider the opportunities for voluntary sector to support and deliver change and future services. Indeed these organisations are sometimes critical to delivering the capacity required in the system, for example we are exploring how the voluntary sector can help us improve access to IAPT services and transport home from hospital. Nationally some of the voluntary organisations are driving some of the most innovative approaches to care and access, something which the CCG wants to enable and embed within its improvement interventions.

Carers: there are around 7 million Carers in the UK, saving the state approximately £119bn – this equates to one in ten of the population. Supporting Carers' wellbeing is in everyone's interests and can benefit the people being cared for, reduce overall spending in the NHS and help commissioners meet required outcomes. It is therefore important for the CCG to continue to recognise and support Carer's through actively engaging with them and by ensuring health professionals know how to identify a Carer and signpost them to appropriate services. Consideration of the role of carers and embedding a carer strategy will be considered by every improvement intervention.

Planning and transforming services in collaboration with our practices

Almost every Strategic Initiative and improvement intervention we are working on has an impact for primary care or requires our GPs and practices to refer or deliver care in a different way in the future. This will require practices to consider extending and expanding the scope of their general and enhanced services, and potentially partnering with a range of other stakeholder organisations in order to respond to new service tenders and opportunities such as Care Hub(s).

The CCG is working very closely with primary care to ensure practices understand and can contribute to all transformational initiatives, and is working to support any development needs which will help practices to use or deliver future services. Improvement and transformation support is being aligned to groups of practices through the establishment of Improvement Hubs which will support practices with understanding activity and data, highlight any variation in practice and allow practices to test and implement new pathways of care.

The development of providers and potential future partners to ensure there is sufficient capacity for market readiness is a significant enabler for delivering our integration programme. Ownership of new service models by our community of general practices is critical to the success of our transformation.

Our ambitions for the next five years

NHS Outcomes

We are committed to delivering the NHS Outcomes Framework, which sets out five areas of focus for all NHS commissioners:

- Preventing premature death (mortality) [Potential Years of Life Lost or PYLL];
- Improving quality of life for people with long term conditions;
- Supporting quick recovery from ill health;
- Ensuring a great experience of care;
- Ensuring safe care.

Over the past year we have worked closely with our partners to in the three Health and Wellbeing Boards on which we sit to address the key health issues we face. We have utilised the abundance of information in the Joint Strategic Needs Assessment documents to help prioritise potential programmes of work and will continue to do so. Understanding the determinants of ill health and monitoring the relevant indicators which measure our population's health and well-being are now captured in all our programmes of work and monitoring and reporting frameworks.

Reducing health Inequalities

Preventing ill health and targeting health inequalities is a priority for the Vale of York. We know that across the Vale of York there are significant differences in life expectancy for men (and women to a lesser extent) depending on where they live, and that for certain groups, access to services can be more challenging[1]. As a result outcomes are lower than the comparators in some areas, for example children's emergency admissions for lower respiratory tract infections and tooth decay in the under 3's.

We also work closely with the Health and Wellbeing Boards to address the wider determinants of health and target interventions for greatest impact on health inequalities. These include promoting mental health, economic well-being and housing reforms to reduce the health impact of poor quality housing.

Some examples of our current improvement interventions which are addressing key local health inequalities include reducing emergency admissions (urgent care – Emergency Care Practitioners, liaison psychiatry), frail elderly (integration/ Care Hubs) and neurology (Planned Care).

Our Care Hub model is a key enabler to reduce health inequalities, bringing together health and social care colleagues to assess and support an individual's needs holistically and provide a consistent single point of access for care.

[1] The CCG is also responding to the recommendation from the JSNA to work with local service providers to ensure that they record information on protected characteristics about their staff and clients / patients such as age, disability, gender re-assignment, marriage and civil partnership, pregnancy / maternity, race, religion and belief, gender and sexual orientation, in order to inform service provision to reduce health inequalities. Link: http://www.healthyork.org/the-population-of-york/specific-population-profiles/lesbian,-gay,-bisexual-and-transgender-(lgbt)-population.aspx

Each of our improvement interventions outlined in the next section clearly indicate which local ambition or priority they are driving.

Parity of Esteem

A mental health problem increases the risk of physical ill health -currently, men with a severe mental illness die on average 20 years earlier than other people; women 1five years earlier. Patients with a mental illness have higher rates of cancer, heart disease, respiratory disease and diabetes. Additionally, they have higher levels of alcohol misuse and obesity than the population as a whole, and do less physical activity. Some 42% of all tobacco smoked is by people with mental health problems. The outcome indicator for parity of esteem is reduction in premature mortality.

The development of mental health services and addressing local inequalities is a significant priority for the CCG. As such, consideration of all opportunities to develop the access and quality of mental health services provision, as well as improving the physical health of patients with mental health conditions when developing other care pathways is embedded within the operational plans and improvement interventions of the CCG.

Commissioning for Prevention

Led by colleagues in Public Health, both within Public Health England and in our three local authorities, the CCG supports a range of screening and vaccination programmes and targeted work to tackle the particular health issues for our population, these include programmes to support weight management, promote breastfeeding, reduce teenage pregnancy and smoking cessation, for example through the 'Stop before your Op' campaign and delivering the new local Alcohol Strategy.

We will also support national and local campaigns to improve health awareness, and through the Care Hub approach seek to provide and embed increased access to advice and support within communities on health promotion.

During 2014-15 the CCG will work with local partners through the Health and Well-Being partnership groups and Children's Trusts to implement targeted programmes in key areas:

- reduce smoking prevalence;
- excessive alcohol consumption (including binge drinking);
- reduce obesity levels(with a particular focus in Selby), and
- a review asthma prevalence using the five steps recommended in the national 'Call to Action Commissioning for Prevention' report[2].

I. Analyse key health problems
II. Prioritise and set common goals
III. Identify high impact programmes
IV. Plan resource
V. Measure and experiment

Work with the Yorkshire Police, Lord Majors Office and in conjunction with business partners across York has seen the CCG join the 2014 Challenge Campaign to provide children across York with the knowledge to manage their health through promoting weight management, mental health and exercise. This will commence in the Summer 2014 and we will work with the Police and the children involved.

Cancer prevention, diagnosis and treatment is also a focus for this CCG with a dedicated work programme currently being established that can respond to some of the key requirements and improvement recommendations from the York Cancer Network. Cancer prevention will be supported through the promotion of smoking cessation and healthy eating, and during the initial plan period we will undertake a review of our cancer pathways, in conjunction with primary care and specialist commissioning to ensure we have timely and effective routes to support diagnosis and treatment.

This will be supported by the following key screening campaigns commissioned by Public Health England which will have local implications for the CCG and local authority, including significantly:

- Bowel screening Sigmoidoscopy at 5five years;
- Additional new-born screening;
- The transfer of Health Visitors commissioning responsibilities to Local Authority;
- Maximising the immunisations programmes delivered by school nursing;

Delivering for the Vale of York – setting trajectories for improvement

We want to ensure that the current services are not only sustainable, but are enhanced and have a positive impact on people's lives.

In order to drive these improvements and know that we are making a difference the CCG has there set challenging local targets for improvement against key health and quality outcomes and address health inequalities. These **Trajectories (or Ambitions)** are mapped out through to 2018-19 and we are working hard to drive these improvements through all our programmes of work.

These trajectories include:

- Reducing the potential years of life lost (PYLL) from causes amenable to healthcare by 15%;
- Improving the health-related quality of life for people with long-term conditions by 1.9% per annum;
- Reducing avoidable emergency admissions by 14%;
- Increasing the proportion of people having a positive experience of hospital care;
- Increase the proportion of people having a positive experience of care outside of hospital, in general practice and the community.

Each Ambition is outlined below with a clear indication of which strategic initiatives are driving potential improvements.

The **Quality Premium** (a national CCG incentive scheme which includes a composite of indicators) includes the falls metric as a local priority, as well as PYLL and reducing avoidable emergency admissions.

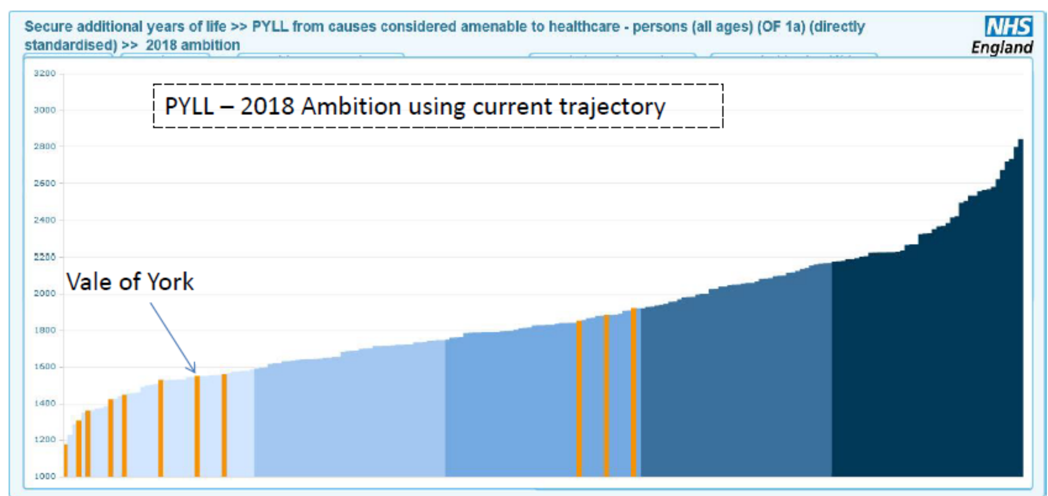
The national **Better Care Fund metrics** (a programme established to drive integration initiatives that would reduce hospital admissions and release funding to be targeted at joint health and social care services in 2014-15 and 2015-16) have also meant the CCG is reporting on the following metrics:

- **Reducing avoidable emergency admissions;**
- **Reducing inappropriate admissions of older people (65+) in to residential care;**
- **Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement / rehabilitation services;**
- **Delayed transfers of care from hospital per 100,000 population;**
- **Improving patient experience;**
- **Injuries due to falls in people aged 65 and over.**

AMBITION 1:

Reduce the potential years of life lost (PYLL) from causes considered amenable to healthcare by 15%.

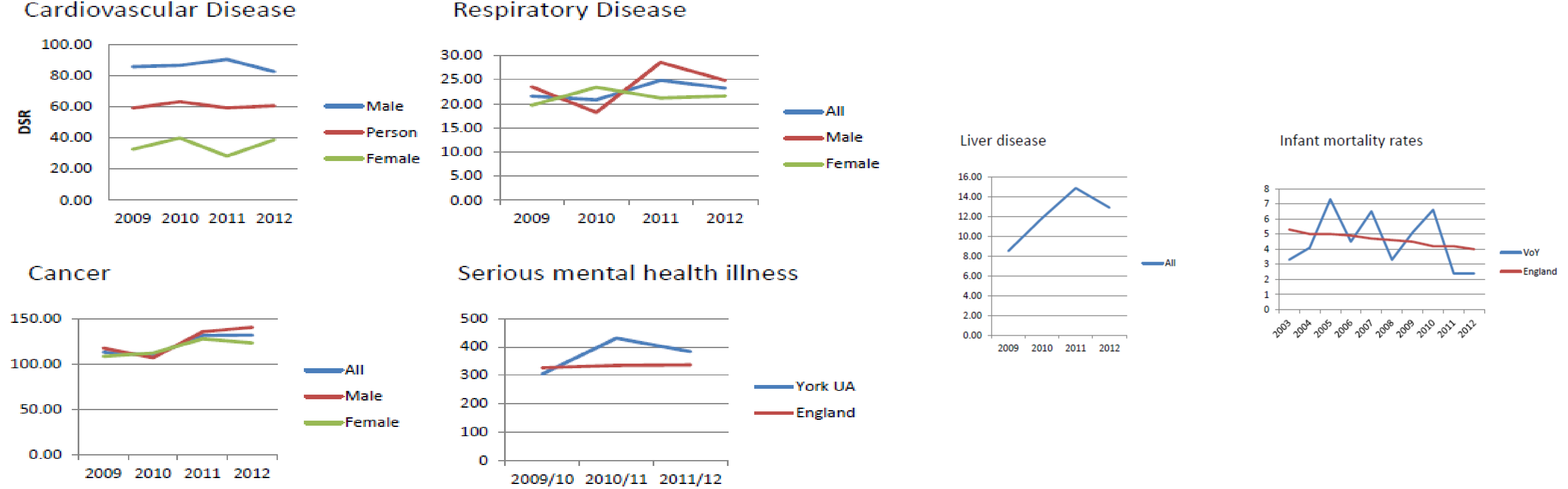
An annual improvement of 3.2% would move the CCG into the top quintile and be 10th out of its comparator group of CCGs. This would also meet the requirements of the Quality Premium.



PYLL All	At 3.2% reduction (straight line)
Baseline	1951
2014-15	1888
2015-16	1828
2016-17	1769
2017-18	1713
2018-19	1658
Overall change	15%

Main supporting indicators:

Respiratory disease shows the gap between male and female coming together. For Cancer the gap between men and women is getting wider. There is still a significant gap between men and women in CVD though this gap is closing. Premature deaths in under 75s due to serious mental health issues are above England figure but appears to have short term convergence. Position to be monitored. Therefore, possible opportunities exist in actions to improve outcomes in male CVD and Cancer.



CCG Strategic Initiatives driving trajectory:

- ✓ Planned Care:; diabetes; neurology; asthma pathway improvements; CVD hypertension and prevention initiatives;
- ✓ Mental health services review and re-procurement; psychiatric liaison;
- ✓ Primary care: GP care planning; risk stratification; neurology GP training;
- ✓ Prevention: binge drinking;
- ✓ Cancer;
- ✓ Children: Challenge Campaign and health promotion / self-care.

Metrics used for indicators:

PYLL from causes considered amenable to healthcare – persons (all ages) (OF1a) directly standardised.

Units: years lost per 100,000 population

Numerator: total years of life lost from amenable causes

Denominator: total registered patients (CCG-level) or ONS population estimates (LA-level)

Standardisation: directly age standardised to England population (CCG-level) or European Standard Population (LA-level)

Source: HSCIC Indicator Portal

Indicators used to measure improvement:

CCGOIS 1.2: Under 75 mortality rates from CVD

CCGOIS 1.6: Under 75 mortality rates from Respiratory Disease

CCGOIS 1.9: Under 75 mortality rates from cancer

CCGOIS 1.5: Reducing premature deaths in adults with serious mental health illness.

NHSOF1.3: Under 75 mortality rates from liver disease

NHSOF1.6i: Infant mortality rates

Dataset:

Levels of Ambition Atlas (CCG)

Time series from Levels of Ambition for England and City of York Council (2001-2012).

The baseline year for ambitions is 2012.

Baseline year with Comparator Group is 2012.

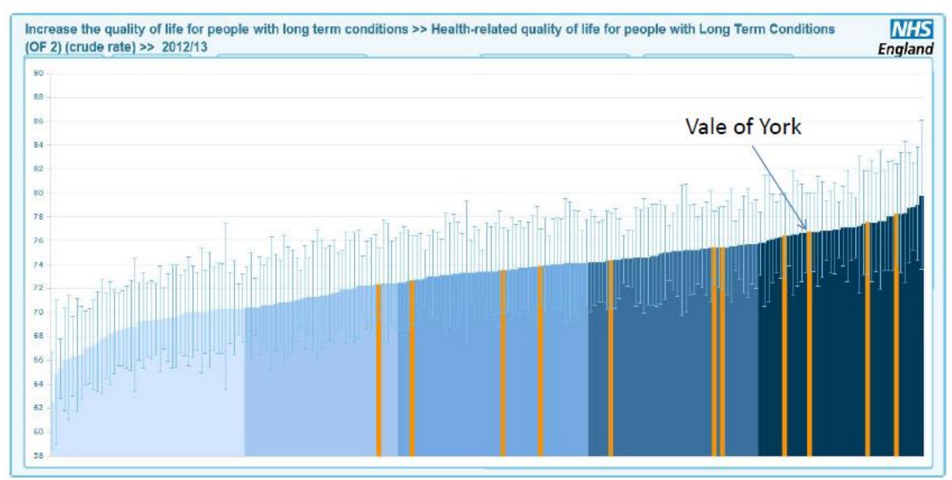
Ambition year with Comparator Group is 2018.

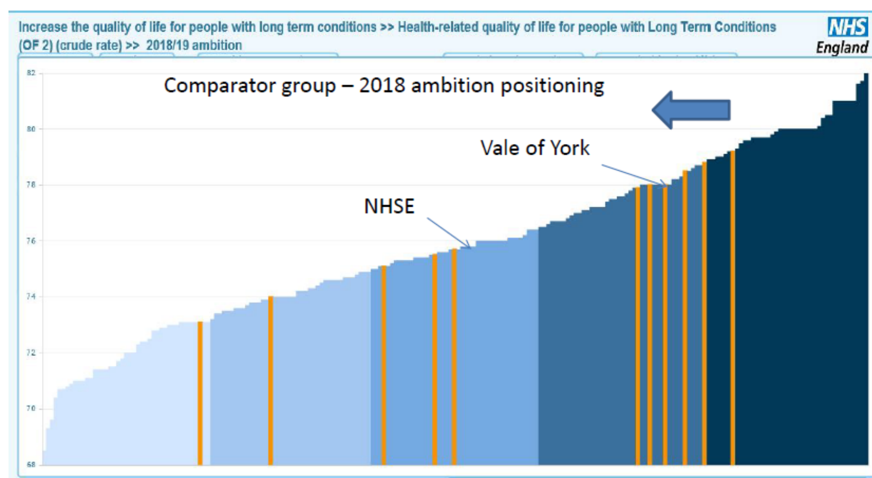
Conditions amendable to healthcare:

Tuberculosis Conditions Amenable to Healthcare
Selected invasive bacterial and protozoal infections
Hepatitis C
HIV/AIDS
Malignant neoplasm of colon and rectum
Malignant melanoma of skin
Malignant neoplasm of breast
Malignant neoplasm of cervix uteri
Malignant neoplasm of bladder
Malignant neoplasm of thyroid gland
Hodgkin's disease
Leukaemia
Benign neoplasms
Diabetes mellitus
Epilepsy and status epilepticus
Rheumatic and other valvular heart disease
Hypertensive diseases
Ischaemic heart disease
Cerebrovascular diseases
Influenza (including swine flu)
Pneumonia
Asthma
Gastric and duodenal ulcer
Acute abdomen, appendicitis, intestinal obstruction, cholecystitis / lithiasis, pancreatitis, hernia
Nephritis and nephrosis
Obstructive uropathy and prostatic hyperplasia
Complications of perinatal period
Congenital malformations, deformations and chromosomal anomalies
Misadventures to patients during surgical and medical care

AMBITION 2:

Ambition for improving the health-related quality of life for people with long-term conditions by 1.9% per annum

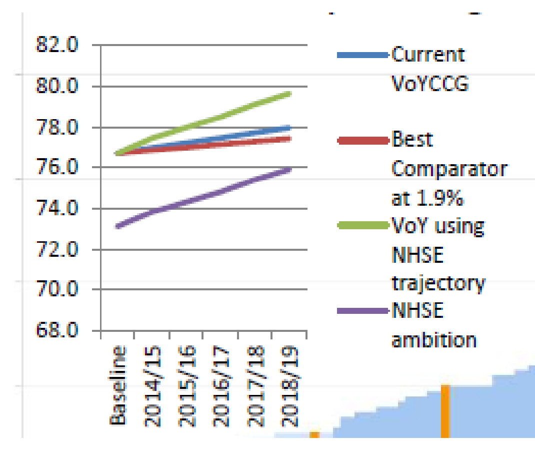




The CCG is towards the high end of performance (3rd best in its comparator group and comfortably in the top quintile) and there is limited headroom for improvement to the best levels currently measured nationally.

General improvement is required but no specific national target. Aiming for the current best comparator is a 1.9% increase per annum.

	Current NHS Vale of York CCG	Best Comparator at 1.9%
Baseline	76.7	76.7
2014/15	77.0	76.8
2015/16	77.2	77.0
2016/17	77.5	77.1
2017/18	77.7	77.3
2018/19	78.0	77.4



Strategic Initiatives driving trajectory:

- ✓ Integrated care: integration pilots (Care Hub approach) for LTCs and End of Life care
- ✓ Urgent care: ECPs and crisis management reducing admissions avoidance; out of hours procurement;
- ✓ Planned care: Neurology carers strategy
- ✓ Primary Care: Referral Support Service; Risk stratification;
- ✓ Prevention: self-care; assistive technology

Indicators used to measure improvement:

NHSOF2.1: People feeling supported to manage their condition

NHSOF1.4: Health-related quality of life for carers, aged 18 and above

Dataset:

Levels of Ambition Atlas (CCG)

Metrics used for indicators:

Units: total EQ-5D per 100 people with LTCs

Numerator: sum of the weighted EQ-5D values for all responses from people identified as having a long term condition

Denominator: The weighted count of all responses from people identified as having a long term condition

Standardisation: none

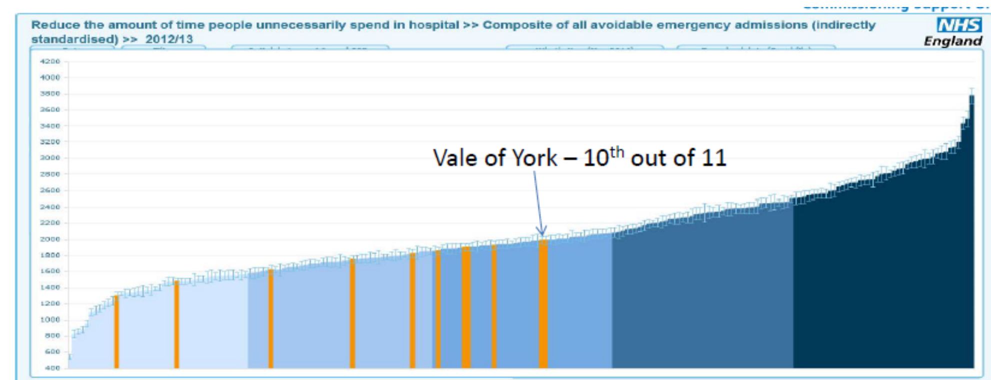
Source: GPPS HSCIC Indicator Portal

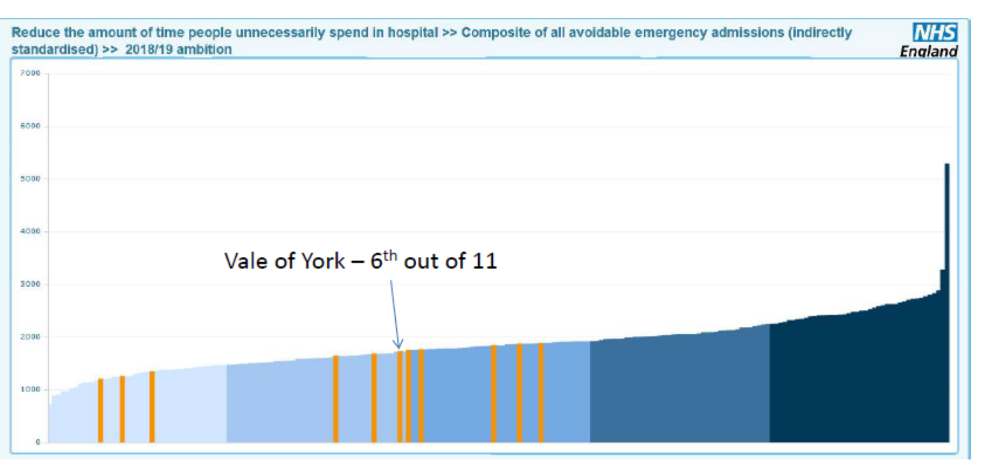
AMBITION 3: [This indicator is used to measure both the Quality Premium and the Better Care Fund metrics]

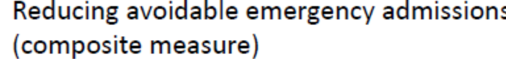
Ambition for reducing avoidable emergency admissions by 14%

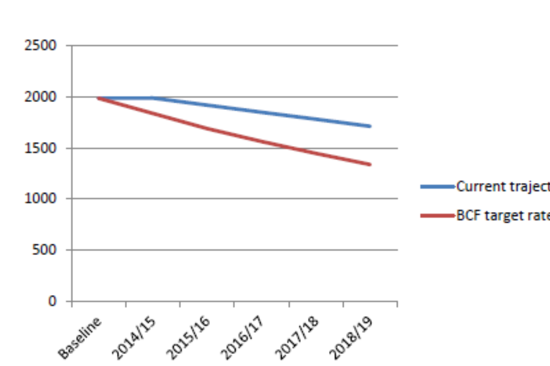
Emergency admissions for any of the conditions considered avoidable per 100,000 population, based on composite of following 4 areas:

- Unplanned hospitalisation for chronic ambulatory care sensitive (ACS) conditions;
- Unplanned hospitalisation for asthma, diabetes and epilepsy (under 19s);
- Emergency admissions for acute conditions that should not usually require hospital admission;
- Emergency admissions for children with lower respiratory tract infections (LRTIs);









	Current trajectory	BCF target rate
Baseline	1989	1989
2014/15	1990	1839.8
2015/16	1920.7	1690.7
2016/17	1851.4	1563.9
2017/18	1782.2	1446.6
2018/19	1712.9	1338.1

The current level for the CCG is in the middle quintile, but worse than most of its comparators (10th of 11, middle quintile).

Trajectory would improve comparator positioning to 6Th out of 11 and second quintile. The trajectory to end 2015-16 is in line with the plans in BCF for the same indicator.

After 2015/16 there are no “target” levels to achieve, but the CCG should look to move closer to the comparator group, and the current end point achieves this.

Strategic Initiatives driving this trajectory:

- ✓ Urgent care: ECPs and 'see and treat' (impact on falls); Out of Hours Procurement with KPIs for the management of emergency demand; psychiatric liaison; street triage
- ✓ Integrated care: hospice at home; Cellulitis, Bronchiectasis and Community IV
- ✓ Planned Care: Diabetes: October 2014 onwards 10% reduction in admissions where Diabetes is secondary diagnosis and a primary diagnosis of: (i.) UTI with LOS 2+ days; (ii.) Syncope and Collapse; (iii.) Patients 70 years+ with a Mental Health primary diagnosis
- ✓ Planned Care: Neurology - new Integrated Care Pathways developed for Parkinson's Disease /Epilepsy/ Multiple Sclerosis / Motor Neurone Disease
- ✓ Planned Care: asthma
- ✓ Children: lower respiratory tract infections

Metrics used for indicators:

Units: admissions per 100,000 population
Numerator: total emergency admission for the any of the conditions considered avoidable

Denominator: total registered patients
Standardisation: indirectly age-sex standardised to the England rates
HSCIC Indicator Portal

Source: HES
Data for 2012/13 has been updated and is now based on HES rather than SUS data.

Indicators used to measure improvement:

NHSOF2.3i: Unplanned hospitalisation for chronic ambulatory care sensitive conditions
NHSOF2.3ii: Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s
NHSOF3a: Emergency admissions for acute conditions that should not usually require hospital admission
NHSOF3b: Emergency admissions for children with lower respiratory tract infections

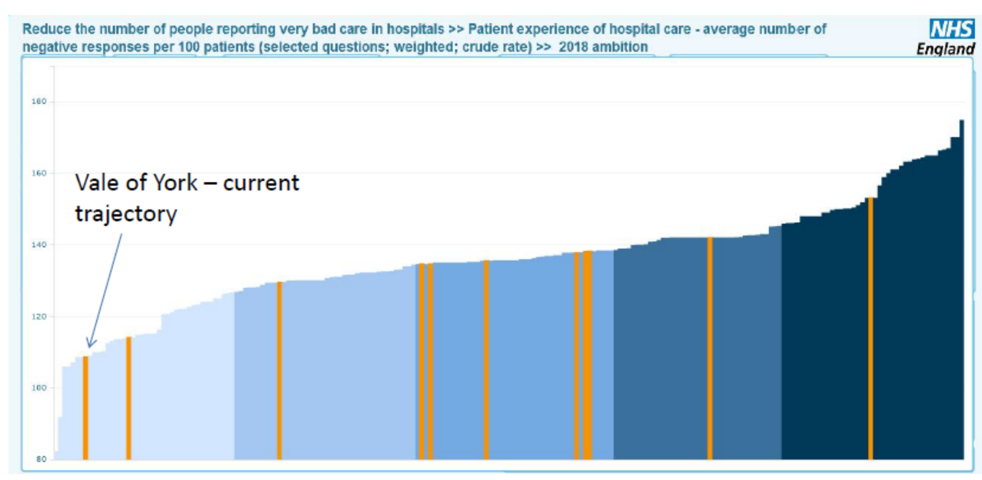
Dataset:

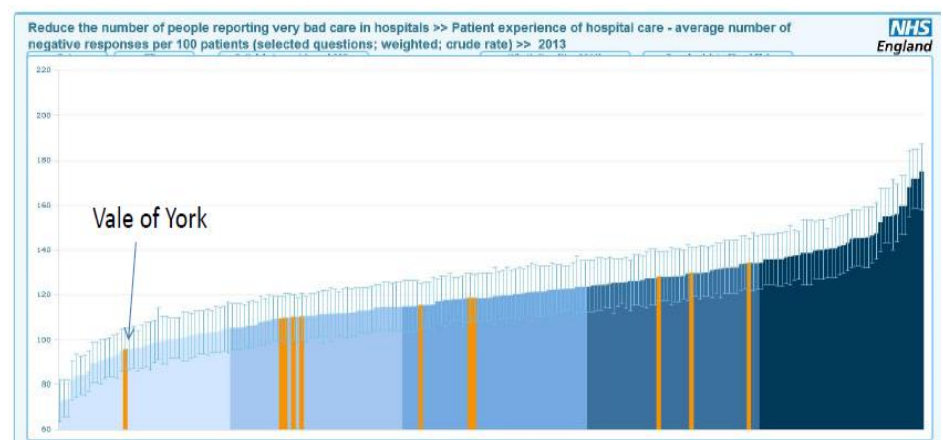
Levels of Ambition Atlas (CCG)
Baseline year with Comparator Group
2018 Ambition year with Comparator Group.

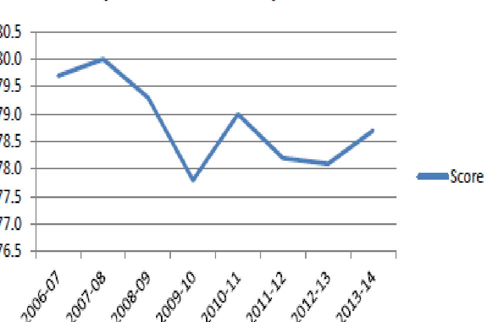
AMBITION 5:
Ambition for increasing the proportion of people having a positive experience of hospital care

The proportion of people reporting 'poor' experience of inpatient care in the 2012 Inpatient Survey.

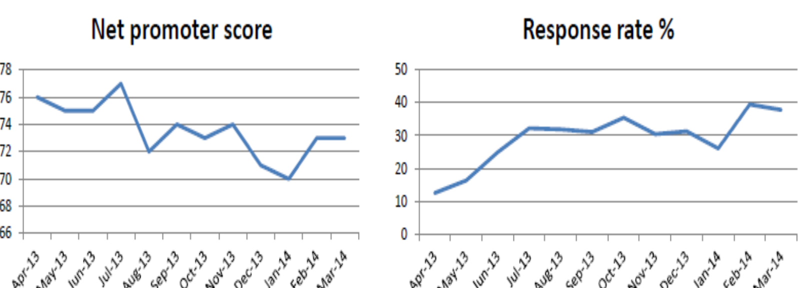
An *improvement* in the indicator is required, but no specific target set. The CCG performs very well on this indicator (1st in comparator group). There is little headroom for improvement against the current national best scores however the CCG will work hard to ensure that this high level of performance is maintained.



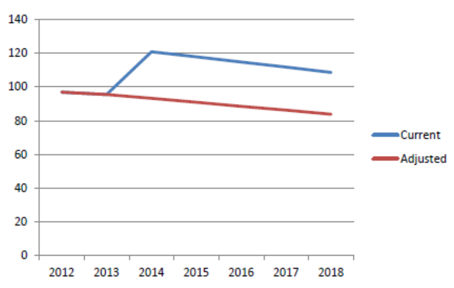




Friends and Family Test - Inpatient



	Current	Revised
2012	96.9	96.9
2013	95.5	95.5
2014	120.8	93.2
2015	117.8	90.9
2016	114.7	88.5
2017	111.7	86.2
2018	108.6	83.8



Strategic Initiatives driving trajectory:

- ✓ Planned care: Diabetes; Neurology
- ✓ Primary Care: Referral Support Service
- ✓ Quality improvement programmes – Patient Experience lead and soft intelligence analysis

Metrics used for indicators:

Units: negative responses per 100 patients
Numerator: Total number of 'poor' responses
Denominator: total number of respondents to the survey questions
Standardisation: none
Source: inpatient survey
NHSE Statistics
HSCIC Indicator Portal

Indicators used to measure improvement:

NHSOF4b: Patient experience of hospital care
Friends and Family Test -inpatient
Net Promoter Score and Response Rate

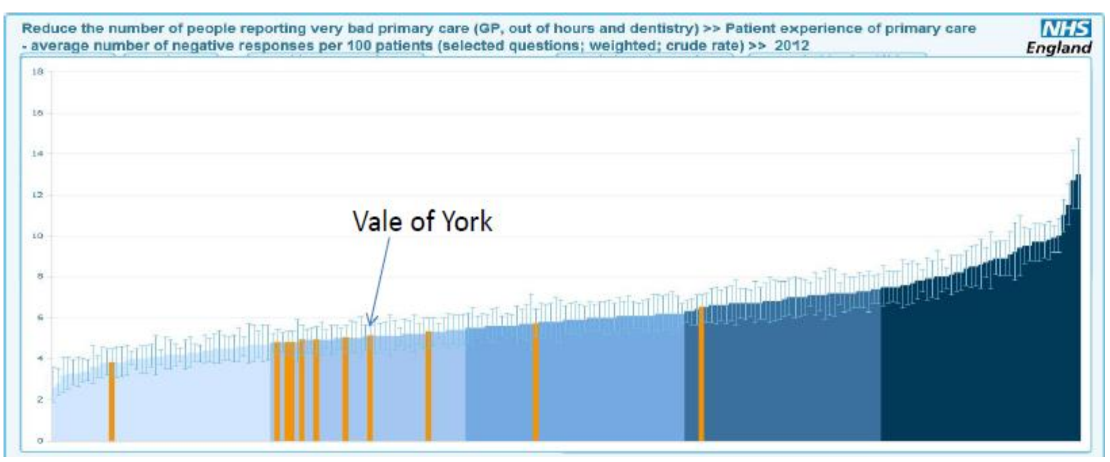
Dataset:

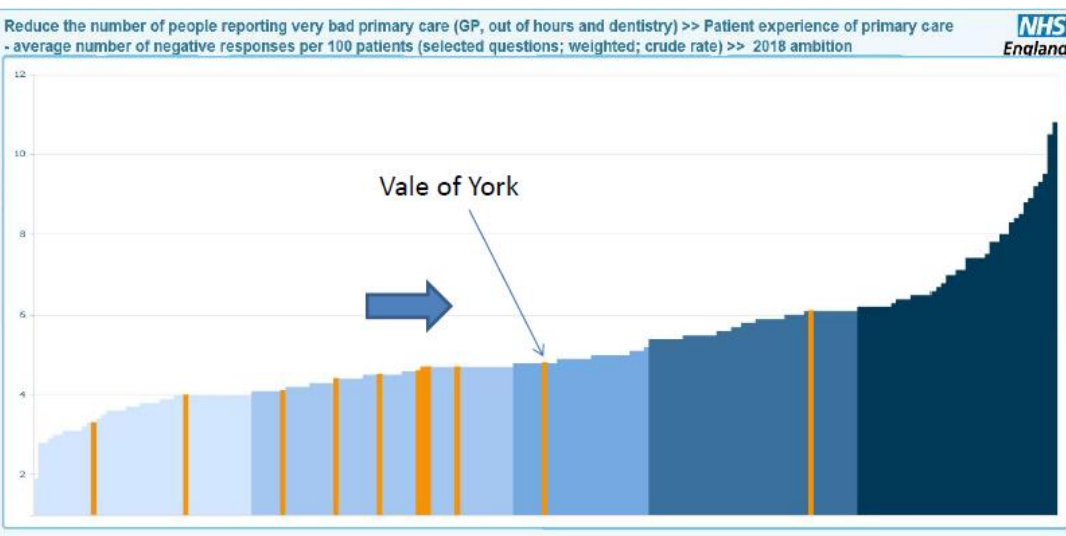
Levels of Ambition Atlas (CCG)
Baseline year with Comparator Group
2018 Ambition year with Comparator Group.

AMBITION 6:

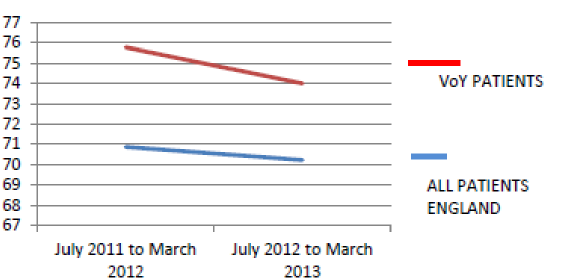
Ambition for increasing the proportion of people having a positive experience of care outside hospital, in general practice and the community

This indicator measures the average number of responses of a 'fairly poor' or 'very poor' experience across General Practice (GP), Out-of-hours services and Dentistry per 100 patients. The CCG is 8th out of 11 in its comparator group and falls in the middle of the second quintile. The recommended trajectory is to follow the NHS England trajectory giving a revised trajectory score of 4.3 in 2018 – upper part (good) of second quintile.



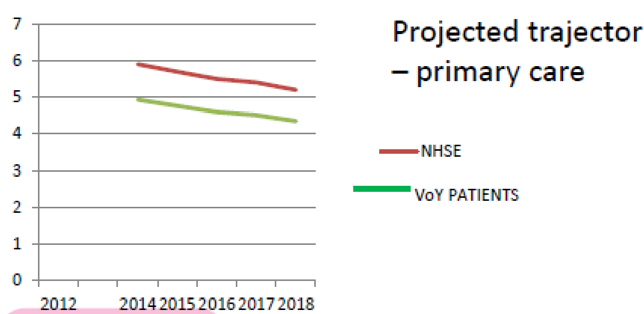


Current performance- OOH Services



	July 2011 to March 2012	July 2012 to March 2013
ALL PATIENTS ENGLAND	70.86	70.21
NHS VALE OF YORK CCG	75.78	74

Projected trajectories – primary care



	NHSE	VoY
2012	6.1	5.1
2014	5.9	4.9
2015	5.7	4.8
2016	5.5	4.6
2017	5.4	4.5
2018	5.2	4.3

Strategic Initiatives driving trajectory:

- ✓ Urgent care: out of hours re-procurement
- ✓ Integrated Care: Community IVs
- ✓ Planned Care: diabetes; neurology
- ✓ Primary Care: Referral Support Service; primary care web tool; GP care planning; GP education and training
- ✓ Quality improvement programmes – Patient Experience lead and soft intelligence analysis

Metrics used for indicators:

Units: negative responses per 100 patients

Numerator: Total number of 'poor' responses

Denominator: total number of respondents to the survey questions

Standardisation: none

Source: GPPS

Indicators used to measure improvement:

CCGOIS 4.1 Patient experience of GP out of hours services

Projection of ambitions

Dataset:
Levels of Ambition Atlas (CCG)
Baseline year with Comparator Group
2018 Ambition year with Comparator Group.

2014-15 QUALITY PREMIUM MEASURES

Domain of NHS Outcomes Framework	Quality Premium Measure	Strategic Initiatives driving these indicators
National Measures **1. Preventing people from dying prematurely**	▪ Potential years of life lost from causes amenable to health care (all ages)	✓ Planned Care: CVD hypertension and prevention initiatives; diabetes; neurology; asthma ✓ Mental health services review and re-procurement; psychiatric liaison ✓ Primary care: GP care planning; risk stratification; neurology GP training
2. Enhancing quality of life for people with long term conditions	▪ Improving access to psychological therapies (IAPT)	✓ Mental health review and increasing IAPT capacity to meet 15% target by 2015/16
3. Enhancing quality of life for people with long term conditions; helping people to receiver from episodes of ill health or following injury	▪ Reducing avoidable emergency admissions (composite measure) ▪ Unplanned hospitalisation for chronic ambulatory care sensitive conditions ▪ Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s ▪ Emergency admissions for acute conditions that should not usually require hospital admission ▪ Emergency admissions for children lower respiratory tract infections	✓ Urgent care: Out of Hours Procurement with KPIs for the management of emergency demand; psychiatric liaison; street triage ✓ Integrated care: hospice at home; Cellulitis, Bronchiectasis and Community IV ✓ Planned Care: Diabetes; Neurology; Asthma ✓ New Integrated Care Pathways developed for Parkinson's Disease / Epilepsy / Multiple Sclerosis / Motor Neurone Disease
4. Ensuring that people have a positive experience of care	▪ Addressing issues identified in 2013/14 Friends and Family Test ▪ Supporting rollout of FFT in local health economy in 2014/15 ▪ Addressing Friends and Family Test roll out in out of hours	✓ Urgent care: out of hours re-procurement ✓ Integrated Care: Community IVs ✓ Planned Care: diabetes; neurology ✓ Primary Care: Referral Support Service; primary care web tool; GP care planning; GP education and training
5. Treating and caring for people in a safe environment and protecting them from avoidable harm	▪ Improved reporting of medication-related safety incidents	✓ Quality improvement programmes
Local Measure **1. Local measure agreed by CCG with the local Health and Wellbeing Board**	▪ A reduction in the number of fall related injuries for residents over the age of 65	✓ Urgent care: ECPs and 'see and treat'

Our five year Strategic Initiatives

The CCG has 8 main strategic initiatives which will transform services and deliver the five year strategic vision **'My Life, My Health, My Way'** and its associated ambitions for improving the health and well-being of the Vale of York Community.

At the core of our five year strategic vision is the **Care Hub Approach** which involves whole system change in order to get the right model of care for the future.

A new approach – Care Hub Implementation

Following discussions with our community, local clinicians and partners, a number of themes emerged around patient centered care, more community based services, continuity of care (including seven day working) and improvement in the provision of mental health services. There was also a desire to see the GP practice find a role at the centre of the health system of the future.

To respond to the outcomes the public have asked for, we have been actively researching various models of care provision across both this country, and internationally, including polysystem models in Redbridge through to fully integrated community models in Canterbury, New Zealand and 'Extensivist' models in the USA. We have, and will continue to facilitate the local clinical community to look at options for local delivery to implement a model of care that we are describing as the "Care Hub Model".

Care Hubs' responsibility will be to assess, diagnose and deliver care to enable individuals to remain at home, or return there at the earliest opportunity following a period of ill-health or crisis. The initial focus will be on the frail elderly and those individuals with long term conditions, with a view to expanding this across a range of health needs and population groups.

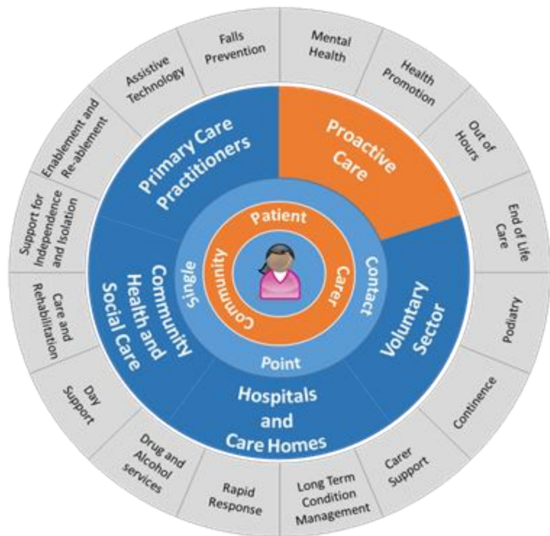
The hubs will be staffed by a multi-disciplinary, multi-agency team who will act as care co-ordinators to ensure care and support packages are put in place as quickly as possible and in the best interests of the individual and their carers. New funding models to incentivise providers to deliver this approach will be explored to ensure that providers truly deliver transformed models of care as alternatives to admissions to hospital or care homes.

People tell us they "only want to tell their story once". We fully support this and see this as fundamental to delivery of joined up care. Integrated information systems and sharing of data to support patient care also provides us with one of the greatest challenges we face. We need to join up our different information systems so we can work with partners and the wider business community to look at how we can do this. It will mean new ways managing data and working across organisations, to share relevant information and we will use the NHS number across both health and social care as the single way in which we identify those we are supporting and providing services to.

Through Care Hubs, patients will have one care record, and move to having their care co-ordinated through a single contact point. This could be a GP, a care manager, a district nurse, a community matron, an OT or specialist MH worker or any other health and social care practitioner with whom the person has regular contact. This person will retain accountability for their patient and will act as the facilitator to all other services and interventions. When an individual is admitted to a hospital setting, clinical responsibility will transfer to the relevant hospital clinician but the single contact point will still have an accountable role for in-reach and discharge planning and co-ordinating the overall pathway of care.

The journey to develop a fully integrated care hub will take time and so the initial focus is on establishing a small number of integrated care pilots involving primary, secondary care, the voluntary sector and social care. These pilots are currently testing different models of delivery to inform best practice for the evolving care hub approach.

Care Hub Model



In order to ensure we gain maximum learning and innovation from this approach, we do not intend to be too prescriptive on how Care Hubs and Proactive Care should be delivered. The integrated care pilots will help us to learn which model delivers the best outcomes for patients and their families.

“Every system is perfectly designed to get the results it gets.”

Professor Paul Batalden
Dartmouth University.

We want to move away from traditional definitions of primary, secondary, community and social care to a model of 'care'. This exciting new opportunity requires new organisational structures to deliver it, drawing on the strengths of the different sectors.

We have set the outcomes we want to achieve and the impact we expect their respective models to have. Specifically we expect to see rapid and measurable evidence that the following ambitions and impacts have been delivered:

- **Reduce the amount of time people spend avoidably in hospital by 14% through better and more integrated care in the community, outside of hospital.**
- **Increase the proportion of older people living independently at home following discharge from hospital from a baseline of 76.7**
- **Improve the health related quality of life of people with one or more long-term condition, including mental health conditions to equal the best amongst our peers**
- A reduction in the proportion of residents being admitted to care homes from both acute and community settings
- A decrease in the proportion of delayed transfers of care and excess bed days from acute settings for those patients medically fit for discharge
- A reduction in the requirement for emergency placements
- A reduction in length of stay for individuals where emergency placements are necessary
- A reduction in the proportion of attendances at emergency departments for individuals presenting with mental health problems
- A reduction in the number of patients known to the Community Mental Health Team attending emergency departments
- A reduction in the number of falls related injuries for residents over the age of 65
- A shared care record for each individual accessing the Care Hub
- A named single contact point for each individual accessing the Care Hub
- A move towards 24 hours / seven day working

We will support the development of improvement initiatives this through evidence based improvement programmes, for example 'Virginia Mason Total Production System' (VMPS). The Care Hub approach will be continuously evaluated to ensure it delivers the required impact and outcomes.

We are aligning improvement support to groups of practices to ensure that the integration pilots (Care Hubs approach) use every opportunity to address and improve access to and delivery of mental health interventions as well as improve the physical health of patients with mental health illnesses. These approaches will be embedded within the final Care Hub model.

The five year roadmap to creating a financially sustainable local health and wellbeing system

Each of our eight strategic initiatives is being delivered through a set of **Improvement Interventions** which reflect the six characteristics of a modern and sustainable health care system as defined by the NHS 'Call To Action' and are embodied within the overarching strategic plan ''My Life, My Health, My Way' and underpinned by the whole system move to the 'Care Hub' approach. The strategic initiatives and improvement interventions are outlined in detail in this section.

'My Life, My Health, My Way' will be officially launched on 3 August 2014 when the Vale of York CCG and its partners will run the ASDA Foundation York 10k (Jane Tomlinson Run For All). This will be an opportunity to highlight the overarching strategic plan for achieving the highest quality, sustainable service delivery by 2018-19 and to celebrate the significant work to date in establishing the integration pilots which will enable the delivery of transformed out of hospital services.

This will also focus on the person-centred care programme of work and what this means for local people in terms of well-being, self-care and prevention. The Roadmap to 2018-19 encompassed within **'My Life, My Health, My Way'** is summarised in the following Plan on a Page.

Laying the foundations		Embedding and extending	Financially sustainable system
2014/15	2015/16	2016/17 · 2017/18	2018/19

Laying the foundations (2014/15 – 2015/16)

Prevention, Self Care and Wellbeing
- Weight Management
- Smoking Cessation
- Alcohol Strategy

Integrated Care
- Integration Pilots
- Community Services Review
- Patient Transport Services Review

Community Services Procurement

Primary Care Reform
- Empowerment and Market Readiness
- Co-Commissioning with NHSE
- Referral Support Service
- Risk Stratification

Out of Hours Procurement

Urgent Care Reform
- Liaison Psychiatry; Street Triage
- Emergency Care practitioners
- Front Door Geriatrician

System Resilience Groups

Planned Care
- Pathway Review and Redesign
- Neurology Planned Care
- Diabetes
- **MSK Procurement**
- **Elective Orthopaedic Procurement**
- EOL Pathway Review
- Specialised Services and Co-commissioning

Children's and Maternity
- SEN and Care Bill
- CAMHS
- Autism Review
- Asthma

Cancer and End of Life
- Cancer Pathway Review
- Palliative Care Review
- Survivorship Agenda

Mental Health
- IAPT
- Mental Health Service Review
- Bootham Inpatient Redevelopment
- Prescribing Review

Mental Health Procurement

Urgent care pathways embedded throughout system

Embedding and extending (2016/17 – 2017/18)

Care Hub(s) established
- End of Life Care pathway embedded
- Self care and prevention embedded
- Mental Health pathways (including Physical Health checks) embedded

New Models of Primary Care
- Expanded capacity
- Seven day working
- New partnerships

Resilient System of Secondary Care and Hospital
- Sufficient capacity
- Productive services
- Value for Money
- Specialised services in fewer centres of excellence

Modernised Mental Health Services
- Sufficient IAPT Access
- Fit for purpose estate
- Parity of Esteem

Financially sustainable system (2018/19)

New System of Fully Integrated Care
- Seven day working
- New organisational forms
- Lead contractor arrangements
- Total dedicated accountable budget

NHS
Vale of York
Clinical Commissioning Group

My Life, My Health, My Way: High quality care, in the most appropriate setting, to meet the needs of our population.

Our work will deliver a sustainable and high quality health service available to all to improve health and wellbeing across the Vale of York. Targeting Health inequalities, increasing parity of esteem between physical and mental health and providing local access to care. The CCG will provide system leadership.

NHS Vale of York Clinical Commissioning Group

You said, we did

- Help people to stay healthy
- Provide people with the opportunity to influence and change healthcare
- Ensure access to good, safe, high quality services closer to home
- Support people with long term conditions to improve quality of life
- Improve health-related quality of life and end of life care
- Implement local 'Care Hubs' across the Vale of York
- High quality mental health services for the Vale of York, with increased awareness of mental health conditions
- Ensure local healthcare services are sustainable
- Ensure people have access to world-class complex and specialist care
- Support health research in the local area

Our strategic initiatives

Prevention, Self Care and Wellbeing: help people stay healthy through informed lifestyle choices, support people to self-manage long term conditions where possible

Integrated Care: coordinate health and social care services around the needs of patients to create a fully integrated out of hospital system of care

Primary Care Reform: improve the continuity of care and delivering services seven days a week through GP practices working together to support larger populations; enabling the Care Hub Model

Urgent Care Reform: improve and coordinate of all aspects of urgent care provision that ensure that patients are treated at home wherever possible

Planned Care: enhance the referral support service to ensure the right care is delivered for patients first time. Improve productivity of elective care

Transformed Mental Health: improve the management of people with mental health needs and improve their physical health through all new models of care across system

Children's and Maternity: give children the best start in life possible, promote healthy lifestyles and supporting self-management of their conditions

Cancer and End of Life: prevention, diagnosis and treatment; carers pathway

Enabling work

- Co-commissioning of primary care with NHSE
- Primary care improvement hubs
- Workforce planning
- IT connectivity across the system
- Shared care record and individual care plans
- Sophisticated Commissioning and Contracting
- Procurement choice and market readiness
- Estates and infrastructure
- Clinical data review and analysis
- Assistive technology (referral support; community equipment)
- Research and innovation
- Prescribing
- Carers and voluntary sector

Our improvement interventions

- Drinking interventions and joint delivery of Alcohol Strategy and Wellbeing Business Plan with local authorities
- Weight Management (Selby)
- Smoking Cessation

- Piloting of four Care Hub Models
- Community services review and procurement
- Embedding urgent care, self-care and End of Life pathways in Care Hub Model
- Patient transport services

- Referral support service and care plans for frail old people and complex needs
- Out of Hours review and procurement
- Doctor First; Risk stratification
- Extended role of community pharmacy
- Dentistry in residential homes

- Street triage and emergency care practitioners
- Psychiatric liaison in A&E
- Paediatric zero length of stay
- Front door geriatrician

- Systematic service review and pathway redesign – ophthalmology, critical care review
- New pathways of care in diabetes and neurology; System resilience: planning capacity
- MSK and elective orthopaedic procurements

- Mental health service review and procurement
- Autism review; dementia service development; IAPT expansion; prescribing
- Bootham inpatient redevelopment

- Children and Families Act: Special educational needs
- Regional work programme 2014-16
- Asthma, CAMHS and health reviews for looked after young people

- Palliative Care Review
- Cancer Pathway Review and Survivorship

Outcomes

Quality outcomes:
- Delivering on the NHS Constitution
- Enhanced **quality** and **safety** of care
- Improved patient experience of care outside of hospital (12%)
- Increase in number of people having positive experience of hospital care

Health outcomes:
- Reduce the potential years of life lost (15%)
- Reduced emergency hospital admissions (by 14%)
- Increase in proportion of older people living independently at home following discharge
- Improve the health-related quality of life of people with LTCs
- Improving physical health of those with mental illness (parity of esteem)
- Reducing Falls
- Improve dementia diagnosis

Impact on activity 2014/15:

Elective	**-£ 27,757**
First appointments	-£ 335,863
Follow-up appointments	-£ 816,443
A&E	-£ 782,357
Non-elective	-£ 1,489,179
Total	**-£ 3,451,600**

Impact on finances:
- Delivering on the NHS Constitution
- Financial sustainability of the Vale of York health economy.
- Increase productivity of secondary elective care (target 20% by 2018/19)
- Ensuring **Value for Money** for every £ spent.
- Contribution of QIPP schemes of £5m to financial gap of £9.4m

Our values will underpin everything we do: Quality • Governance • Engagement and co-design • Prioritisation • Equality • Sustainability • Empathy; Integrity • Respect • Courage

2014/15 - 2015/16	2016/17 - 2017/18	2018/19
Laying the foundations	Embedding and extending	Financially sustainable system

2014-15 and 2015-16 (Years 1 and 2)

The improvement interventions currently being delivered are mostly aligned to the Better Care Fund (the national programme for driving integration across health and social care) and delivering the national Urgent Care programme and associated Out of Hours procurement. They represent a robust and comprehensive programme of improvements addressing the fundamental transformation required in the local health and social care system. They focus on increasing productivity wherever possible and where there is an opportunity to release savings they are being accelerated in 2014-15 in order to support the CCG managing the existing financial gap. Together they form a strong foundation for developing our other Strategic Initiatives and the basis for whole system change.

Moving forward these improvement schemes will be delivered alongside a dedicated programme for transforming primary care that will be enabled through the CCG co-commissioning primary care services with NHS England. This will support the provision of sufficient capacity in primary care, community and social care to deliver the activity changes and transfers anticipated from acute hospital settings into community through the Better Care Fund in 2016-17.

Two large whole service reviews are currently underway for community services and mental health services, culminating with the anticipated procurements for each with contracts awarded for mental health provision in October 2015, and community services in April 2016.

Alongside the transformational programmes there will be a systematic review of key services and care pathway commencing with our acute providers (involving baseline assessment, service mapping and benchmarking) and running throughout the next 2 year period to 2016-17. This will enable us to ensure we are continuously driving up efficiency and identify areas where we should target for transformation jointly with our providers in the following ways:

- ✓ Services are being delivered in the right place for our patients and have considered models of delivery which represent best practice, lean, innovative and technology-enabled ways of working which avoid unnecessary attendances and admissions;
- ✓ Services are productive, cost effective and represent VFM for every pound we spend in order ensure the sustainable use of our finite resources;
- ✓ Services are improved and performance managed against a range of increasingly sophisticated contractual targets, incentives and outcomes-based commissioning mechanisms which encourage transformation and integration;
- ✓ The CCG is assured it is commissioning the right amount of capacity to deliver the NHS Constitution targets for Referral to Treatment (RTT) in every specialty and in A&E;
- ✓ Services are paid for under the most appropriate tariff and price;
- ✓ Referrals into services are always appropriate and at the right point of access.

The additional resource generated by this process will be used to fund:

- new investment requirements for new treatments and service developments we are agreeing with our providers
- pump priming of new models of care or invest to save schemes (e.g. integration pilots)
- programme management and development costs of large transformation programmes of work,
- enabling work programmes
- the parallel running of services as models and pathways transform and procurement and re-commissioning is rolled out, and ensure there is no destabilisation of current providers who are committed to working with us to transform pathways of care
- and to ensure that the CCG continues to commission services within the resources available

We have established some key principles for our programmes and investments from 2014-15 as follows:

- ✓ Our aim is to invest a proportion of productivity gains back into services to support the delivery of the transformed services our population require and thus to enable providers to securely plan for a healthy and financially sustainable future delivering the services we require locally
- ✓ Transfers of activity and associated funding across the health and care system will be undertaken in a planned and collaborative way based on joint delivery of our transformational work – we will avoid destabilisation of any current provider and support future providers in readiness for all tendering of new or re-commissioned services
- ✓ Investment in schemes which enable transformation and result in savings in the longer-term will be prioritised
- ✓ Given the significant financial challenge facing the CCG a prioritisation framework has also been developed against which to consider any new initiatives/ developments as well as the review existing services for continued funding to ensure that the services we currently commission represent VFM

The current financial efficiency target for the CCG remains high and challenging, and the CCG is working hard to identify all opportunities available at this point to develop QIPP schemes which can contribute towards meeting our target:

- Current programmes of redesign are being accelerated wherever appropriate
- Review and revisit all outlier areas in terms of benefits gained for investment made (Commissioning For Value indications) and unwarranted variations which can be addressed
- Reflection on other CCG's improvement and productivity plans showing evidence of productivity gains
- Utilising national tools such as the portfolio of NHS England Call to Action reports identifying opportunities for transformation

Systematic pathway review will also support the continued drive to deliver productivity savings (QIPP) each year and ensure that we address QIPP in a systematic, rigorous and coherent manner which aligns with our providers CIP programmes and supports our transformation.

During 2014-15 the full impact of the specialised services commissioning plan for the area will also be considered and addressed collaboratively with our providers, NHS England and our fellow area commissioners on our wider Unit of Planning footprint.

It is anticipated that newly restructured funding and reimbursement models will emerge for 2015-16 that enable us to focus on commissioning for outcomes and explore the potential for using population-based virtual commissioning budgets and to work closely with local authorities on effective ways of targeting joint budgets.

Key in 2014-15 will also be the establishment of **System Resilience Groups** which CCGs will co-ordinate across the unit of planning to ensure that sufficient capacity is commissioned throughout the year in both urgent care and planned care to meet the access and performance required in the NHS Constitution. All the CCGs transformational and productivity work with its providers and social care will support planning and delivering this resilience, and this group will be a significant enabler for unit of planning-wide collaboration and co-ordination.

2016-17 to 2018-19 (Years 3 to 5)

The main focus of transformation in Years 3 to 5 will be the continued evolution, embedding and extension of the future Care Hub approach based on the outcomes of the 4 integration pilots. The hubs will incorporate the emerging pathway changes in out of hospital care from other care areas such as self-care and prevention, and mental health.

Our other Strategic Initiatives will all be delivered with the Care Hub approach as the central framework for delivery. Opportunities for improving the physical health of patients with mental illness will be also be considered in every improvement intervention.

Further development of primary care and out of hours community services will be enabled by the CCG co-commissioning primary care with NHS England. Our systematic review of all care processes which will ensure all in-hospital care is highly productive and cost-efficient, being delivered in the right setting and with a service specification and contract that is fit for purpose.

Further development of our modelling will allow us to understand the scale of the changes in practice and behaviour required from our GPs, providers and public to deliver significant transfers of activity from different settings.

We envisage there will be a potential need for estate review and development in line with the future model of out of hospital care, and most critically a more flexible and mobile workforce with new roles and responsibilities working across hospital and community settings.

Additionally the CCG recognises its responsibilities to make ready the market and our potential future providers so they are empowered and fully functional to bid for new contracts and tenders alongside new partners and in a complex business environment.

These transformations will require significant capacity and capability in terms of programme management, modelling, engagement and investment. Our existing programme plans for each strategic initiative are already developing workstreams to capture these requirements and enable delivery of the whole system change through to 2018-19.

The CCG has submitted several bids for the Regional Innovation Fund and every improvement manager is actively seeking through individual and collaborative efforts with providers to access the best innovative new ideas and developments related to their work programmes.

However, dedicating sufficient capacity and energy now will lay the foundation for a transformed and sustainable healthcare system in 2018-19 where there is truly potential to deliver:

- Integrated health and social care services delivered from Care Hub (s) in the community, seven days a week by multi-specialty provider groups, with lead contractor arrangements and dedicated joint multi-year budgets from primary and secondary care;
- Strong, healthy secondary care services providing the planned diagnostic, treatment and care and specialised services required in hospital settings seven days a week;
- Enhanced and extended primary care services and GP networks with responsibility for co-ordinating the care of the elderly and most vulnerable through care hub(s) and local hospitals and delivering out of hours services consistently seven days a week;
- Transformed mental health and learning disability services which ensure that all patients have access to the right services in the best environment seven days a week in order to optimise both their mental and physical health;
- An urgent care model that meets unplanned care needs *across* primary care, secondary care, community services and mental health and is embedded appropriately within Care Hub(s) and the future hospitals.

Strategic Initiative 1: Integration of Care

Objectives

- **When people become ill, they are treated in a timely manner with access to expert medical support as locally as possible;**
- **Where people have long-term conditions they are supported to manage those conditions to give them the best possible quality of life;**
- **A move to 'Care Hubs', providing increased access to health promotion, care and support services, including GPs, pharmacies, diagnostics (e.g. scans/ blood tests), community services, mental health support and social care and community and voluntary services;**
- **Integrated care co-ordinated through a strong community system of Care Hubs with seven day working, full out of hours services in place and accountable GPs caring for our frail elderly and patients with moderate LTCs in the community;**
- **When people are terminally ill, the individual and their families and/or carers are supported to give them the best possible quality of life and choice in their end of life care.**

The integration of care will be led through the implementation of the Care Hub approach. During 2014/15 and 2015/16 this is supported by the 'Better Care Fund' programme which plans and co-ordinates the transfers of activity from emergency admissions to hospital into community and the associated transfers of funding to a pooled budget to fund joint health and social care projects. The integration pilots are initially focusing on frail elderly individuals and those with Long Term Conditions, and then will expand to incorporate a wide range of care needs, including community mental health and end of life.

This strategic initiative is complex but critical to delivering the foundation for whole system change required for the five year vision.

A detailed planning model has now been developed which enables the CCG to clearly describe and cost our vision of future in-hospital care versus out-of-hospital care, and to understand implications of our programmes of work on both our GPs/ practices and providers in terms of impact on activity delivered to patients in hospitals and the associated number of beds required.

Our **Improvement Interventions** which will support delivery of this strategic initiative include:

- Implementation and Evaluation of Care Hubs has commenced with 3 **Integration Pilots** established and 1 further pilot in development
- **Mental Health Street Triage**, creating a team of skilled mental health professionals to be deployed by the police to provide initial assessment and advice for individuals with mental health needs to help avoid unnecessary detentions
- **Hospice at Home** to focus on clients who are approaching the end of their life and wish to die at home or their usual place of care
- A dedicated **Acute Liaison Psychiatry Service** to the Emergency Department at York Teaching Hospital 24 hours a day, seven days a week to support patients with mental health issues.
- **Single point of contact** to enable patients to have one care record and a single point to contact health services. There will be a named care coordinator who will retain accountability for the individual and act as facilitator to access other services and interventions
- **Enhanced rapid assessment team and domiciliary support service** to provide clinical management of patients who have urgent care needs as close to home as possible
- **Full Community Services review** to ensure our services are commissioned in line with the new approach and deliver high quality local services
- **Community equipment review** to ensure that people have timely access to high quality and safe equipment to support independence and care at home
- Implementation of new community pathways of care in **diabetes and neurology**
- **Community IV:** Delivery of intravenous therapy at home and in the community as an alternative to hospital stays

Enabling work:

- **Co-commissioning of primary care** between the CCG and NHS England (community pharmacy, ophthalmic services, community dentistry, self-care opportunities are all currently being considered)
- **Training:** implementing a consistent approach to lean improvement methodology (Virginia Mason Production System methodology) including some of our partners are now also adopting this approach – City of York Council are to train their team in same methodology to support partnership working and system change.
- Development of **Improvement Hubs** focussed round groups of GP practices to support development and innovation in readiness for market development
- Recruitment of GP ST4 posts to provide backfill capacity to practices to free up clinicians to develop hubs and pathways of care
- **Risk stratification tool** is now commissioned to target patients who would benefit from early interventions
- **Supporting IT infrastructure**
- Development of a **Carer strategy**
- The CCG has also submitted a bid to **NHS Accelerate** to have the Care Hub supported as one of 5 national pilot sites

Future interventions which are currently being explored include:

- Revised pathways for the management of asthma in children
- Extended roles for community pharmacy
- Community dentistry into residential homes
- Direct access diagnostic services for primary care

IMPACT:

On our Ambitions and Trajectories:

- Reduce the amount of time people spend avoidably in hospital by 14% through better and more integrated care in the community, outside of hospital ;
- Increase the proportion of older people living independently at home following discharge from hospital from a baseline of 76.7;
- Improve the health related quality of life of people with one or more long-term condition, including mental health conditions to equal the best amongst our peers;
- A reduction in the number of falls related injuries for residents over the age of 65;
- Reduce avoidable hospital admissions;
- Increasing the proportion of people having a positive experience of care outside hospital, in general practice and the community.

On addressing health inequalities:

- Focus on frail elderly
- Focus on parity of esteem for people with mental illness and improving both their mental and physical health

Expected Outcomes:

- ✓ Increase in the proportion of older people living independently at home following discharge from hospital
- ✓ Reduction in the number of people admitted to hospital who can be supported in other settings (community or home)
- ✓ Improve the health related quality of life for people with long term conditions to equal the best among our peers
- ✓ Reduced bed occupancy
- ✓ Reduced length of stay
- ✓ Reduction in delayed transfers of care
- ✓ Single point of access for clinicians
- ✓ End of life care plans

On meeting what patients need and want:

More co-ordinated care, with a single point of contact for managing and supporting the whole care pathway regardless of number of agencies involved.

'it would be better if regular services could be provided in the community'

'carers need to be considered and included'

On our providers:

- York Hospitals NHS Foundation Trust: Community services review
- Leeds and York Partnership Foundation Trust: mental health services review
- Voluntary sector

Milestones:

Future re-procurement of community services following evaluation of integration pilots

- Tender July 2015
- Award contract October 2015
- Start delivery April 2016

Savings/ Productivity:

QIPP savings have been identified from a number of these interventions based on reductions in A&E attendances, reduction in emergency admissions and reductions in length of stay.

CCG Clinical Lead:

Dr Mark Hayes

CCG Improvement Managers:

Ryan Irwin
Paul Howatson
Shaun Macey

Local Authority Leads:

- Dr Paul Edmondson-Jones, City of York Council (CYC)
- Richard Tassell, Group Manager, Adults Social Care/ACE - CYC
- Richard Webb, Corporate Director of Health and Adult Services, North Yorkshire County Council (NYCC)
- Rosy Pope - Head of Adult Services, East Riding County Council (ERCC)

Provider Leads:

- Mike Proctor, Deputy Chief Executive, York Teaching Hospitals NHS Foundation Trust

Other Partners:

GPs, emerging Federations and practice collaborations

Reports to:

Health and Well-Being Boards for

- City of York Council,
- North Yorkshire County Council and
- East Riding County Council

Supporting Working Groups:

- Integrated Commissioning Board (NYCC)
- Collaborative Transformation Board (CYC)
- Healthcare and Wellbeing Action Board (ERoYCC)
- Joint Delivery Group (all 3 Boards)

Strategic Initiative 2: Person Centred Care

Objectives:

- **People will have more opportunities to influence and choose the healthcare they receive and shape future services.**
- **People will be supported to stay healthy through promoting healthy lifestyles improving access to early help and helping children have a healthy start to life**

Patients, carers and the public are at the heart of health services and we are committed to the philosophy of ‘no decision about me - without me’. Delivering a sustainable and successful NHS in the local area is a collective challenge, and we will work with the public to put them at the centre of their care, help people stay healthy through informed lifestyle choices, support people to manage long term conditions and offer people choice through a range of providers. This also includes the move towards more personalised health care services and the roll-out of personal health budgets for people with complex needs and disabilities.

Our vision of the way services will look and feel like for patients

- ✓ Local people will be supported to achieve their optimal well-being and independence through early intervention and support to change in choices, lifestyle and behaviour.
- ✓ For those with long-term conditions will be fully empowered in their own care through the equipment, support, education, development of their personal resilience.
- ✓ Specific local social challenges such as alcohol abuse, binge drinking and weight management will be addressed through targeted interventions
- ✓ Improving peoples’ knowledge and understanding of access points, services available and signposting.

Our **Improvement Interventions** which will support delivery of this strategic initiative include:

- Implementation of the local Public Health Strategies in collaboration with providers, public health and Public Health England (see below);
- Encourage GPs and other health care workers to promote healthy lifestyle and provide access to support to stop smoking, increase physical activity levels and eat a balanced diet;
- Implementation of personal health budgets for people with complex health needs to extend their choice and influence over the care that they receive;
- Explore options of a health ‘service directory’ to increase public knowledge of services and promote choice;
- Healthy eating and weight management (focus on Selby population);
- Brief drinking interventions for over drinking and binge drinking;
- Review of asthma prevalence.

Enabling work:

- Refresh and implement our **Communication, Engagement and Involvement Strategy** to ensure that all stakeholders and members of the public can influence the shape of local health services.
- **Carers Support Strategy**. As we support people to manage their conditions and live at home for longer, we recognise this can place different demands on the people who care for them.
- **Technology**: we recognise the positive impact advances in technology can have in health care, both in improving efficiency and outcomes in planned care and to support self-management of conditions. The opportunity to make greater use of technology is considered in our approach to service improvement, with investments in:
    - Referral Support Service
    - The expansion of Choose and Book
    - Exploring opportunities for advanced technology through Care Hubs (exploration of e-consultations, integrated care records and risk profiling systems)
    - The introduction of Doctor first project to improve triage of calls and appointments, prioritise patient visits and use technology to support a reduction in unneeded contacts – freeing up clinician time for patient care

Public Health Commissioning Plans

The local authority Public health team currently commission sexual health services, stop smoking, school nurses and alcohol treatment.
There are a number of key recommendations identified from the JSNA 2014 which the CCG will be working with the Public Health Directorate to address key actions from their Well-Being Business Plan 2014-16, including:

- Review the effectiveness of smoking cessation services for specific population groups; particularly stop smoking support offers for pregnant women, and for manual workers.
- Development of a holistic strategy to address childhood obesity which includes consideration of; Breastfeeding Support Programmes; UNICEF accreditation initiative; targeted sport and active leisure programmes; access to active sport and leisure options; dietary advice and support.
- Development of an in-depth multi-agency local needs assessment and alcohol strategy to include consideration of; licensing; harm prevention; interventions and brief advice; crime and disorder; hospital based and specialist treatment services; parental alcohol misuse; risky behaviours in young people; older people and alcohol.
- To develop a more detailed understanding of the local needs and service provision around Stroke, Transient Ischemic Attacks (TIA) and vascular diseases which can contribute to Stroke. To include within this a review of Stroke pathways, opportunities for prevention and how local Health Checks can contribute to identification of risk factors for Stroke.
- To explore options for early supported discharge and re-ablement.
- To maximise the effectiveness of any health checks that are locally commissioned or provided by working with practices to analyse the take up of health checks by factors such as gender and deprivation. To use this information to target the offer of health checks to those groups less likely to attend and to increase the number of health checks that are completed, specifically for people with learning disabilities.

IMPACT:

On our Ambitions and Trajectories:

- **Reduce the Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare by 14% by 2018-19.**
- **Improve the health related quality of life of people with one or more long-term condition, including mental health conditions to equal the best amongst our peers.**
- **Reduce avoidable hospital admissions.**
- **Reduce the amount of time people spend avoidably in hospital by 14% through better and more integrated care in the community, outside of hospital.**
- **Increase the number of people with mental and physical health conditions having a positive experience of hospital care by and care outside hospital in general practice and the community by 12%.**

Expected Outcomes:

- Reduction in smoking prevalence;
- Take up of vaccination and immunisation and screening programmes;
- Increased take up of the friends and family test;
- Increased opportunities for engagement across the Vale of York;
- Increased access to personal health budgets;
- Use of technology in healthcare to deliver improved services for patients which are more flexible and convenient – increasing time for clinicians to spend with patients who require their support.

On meeting what Patients need and want:

- Seeing the right person, at the right time, as quickly as possible;
- Telling their story once;
- 'We need to be provided with reliable, relevant information to allow us to make informed decisions, particularly about our medications'.

On our providers:
Acute provider - York Teaching Hospital Foundation Trust.

Procurement:
None immediately but self-care and prevention will form part of any community services procurement in relation to delivering the Care Hub approach.

Savings/ Productivity:
Services which support people to stay well, and to remain well after recovery from illness. Reduction in number of people requiring clinical support for preventable conditions.

CCG Clinical Lead:
Tim Maycock/Emma Broughton.

CCG Improvement Manager:
Shaun Macey.

Local Authority Lead:
Paul Edmondson-Jones, Director of Public Health, City of York Council
Julie Hotchkiss, Consultant in Public Health, City of York Council.

Other Partners:
Healthwatch, Public Health England.

Reports to:
Health and Wellbeing Boards.

Supporting Working Groups:
Collaborative Transformation Board, CYC
Joint Delivery Group (all three local authorities).

Strategic Initiative 3: Primary Care Reform

Objective:

When people become ill, they are treated in a timely manner with consistent access to expert medical support as locally as possible seven days a week

National Context as of June 2014

The national Primary Care Strategy proposes significant reforms to Primary Care, taking account of national proposals for the Accountable GP, the 14/15 GP Enhanced Service around 'admission avoidance and proactive case management', seven day working and transforming GP practice.

Reasons for supporting changes in general practice:

- ✓ more proactive, coordinated care will be of real benefit for frail older people and other people with complex needs;
- ✓ more person-centred care for people with long term health conditions and people with mental health problems;
- ✓ responsive care for the general population, including same-day access to services for people with urgent care needs; but also different ways of accessing services may benefit other groups such as young people;
- ✓ preventative care, advice and interventions that will support communities and individuals to better manage their own health to avoid becoming ill, and prevent unnecessary interventions.

- **Ambition one:** proactive, coordinated care: anticipating rather than reacting to need and being accountable for overseeing your care, particularly if you have a long-term condition.
- **Ambition two:** holistic, person-centred care: addressing your physical health, mental health and social care needs in the round and making shared decisions with patients and carers.
- **Ambition three:** fast, responsive access to care: giving you the confidence that you will get the right support at the right time, including much greater use of telephone, email and video consultations.
- **Ambition four:** health-promoting care: intervening early to keep you healthy and ensure timely diagnosis of illness - engaging differently with communities to improve health outcomes and reduce inequalities.
- **Ambition five:** consistently high-quality care: removing unwarranted variation in effectiveness, patient experience and safety in order to reduce inequalities and achieve faster uptake of the latest knowledge about best practice.

Our vision of how services will look and feel like for patients

General Practices will be working together, through the Care Hub approach, across populations of at least 100,000 to provide an enhanced and integrated care service. We want to move away from traditional definitions of primary, secondary, community and social care to a model of community based integrated 'care'. This requires working closely with pharmacy, dental services and community based services, and workforce reform to enable a seven day service within the community.

Patient Experience Now	Patient Experience in five years
Primary Care	
GP managed Personalised Care Plans starting to be developed for 2% of patients through Enhanced Service.	Care Plans in place for all patients with a LTC by end April 2015 (NHS Constitution).
Patients don't routinely have access to their Personalised Care Plans.	Patients will be able to access and contribute to their own Care Plans online.
Patient Care can be fragmented with patients telling their story/details many times.	Community based care will be co-ordinated by General Practice - the delivery of care for patients will be integrated across supporting Community Nursing, Mental Health and Social Care teams.
Provision of care can be reactive for patients.	Through Risk Profiling and access to real-time admissions/discharge information, patients will be identified for proactive case management and post-discharge support.
Patients may have avoidable admissions and avoidable long stays in Hospital.	General Practice co-ordinated care teams will help to prevent emergency admissions and work with Hospitals on proactive discharge planning.

Patient Experience Now	Patient Experience in five years
GP Out of Hours Services	
Three potential OOH providers for different areas within Vale of York CCG; variable quality/type of service available.	Single provider giving integrated, high quality service, supporting all Care Hubs.
Clear distinction between in-hours and out of hours services with disconnect in communication.	Integration between in-hours and out of hours services as Care Hubs progress and GP hours change in line with national policy. Communication systems with GP's that automatically flag patient changes in OOH period.
Limited and variable support for EOL patients.	Integrated support with Hospice, Pharmacies and acute Trust involvement.
Call process via NHS111 still requires improvement.	Additional staffing expertise around specialist services available.
Limited access to Mental Health Services OOH.	Psychiatric Liaison Services will be improved in 2014-15 and part of on-going Mental Health contracting from 2015-16 to provide much more robust access to services.

Our **Improvement Interventions** which will support delivery of this strategic initiative include:

- Integration of Care
- Engagement strategy with practices through regular GP Forums and education and learning events to ensure that GP's are up to date with the latest clinical developments and aware of best practice and opportunities for improvement that have been tested elsewhere.
- Procurement and provision of risk profiling tools to assist in the systematic identification of 'high risk' patients who would benefit from proactive case management.
- Investigate the use of electronic consultations to improve access to GP appointments
- Implement Doctor First appointment triage
- Community Pharmacy
- **Community Dentistry in Residential Homes:** the CCG will commission a dedicated dental service for care and nursing home residents that builds on international evidence with local support from the Local Dental Network. This initiative is in response to the currently unmet need of this group of patients. The evidence suggests that poor oral hygiene leads to malnutrition which in turn leads to weight loss and decline in physical wellbeing. This can push an already compromised elderly person into an irreversible decline. The proactive management of oral health can ensure that patients maintain their optimum level of health. There are sufficient numbers of patients in these homes within the CCG to make the provision of a mobile dental unit a viable proposition. This development also forms part of the portfolio of schemes within our "Co-commissioning Primary care" submission.

Enabling work:

Co-commissioning of Primary Care

The CCG is currently exploring opportunities for the co-commissioning of Primary Care services in partnership with NHS England in order to support the shift of hospital activity into a more community based setting, through the development and collaboration of GP Practices enhanced services with community pharmacy, dental and optometry services. The CCG will pilot different models of general practice and extended primary care alongside the integration pilots, including consideration of how all current enhanced funding can be best utilised in order to tackle local priorities across the whole system change requirements. Potential opportunities identified include:

- ✓ **Community pharmacy;**
- ✓ **Ophthalmic services;**
- ✓ **Community dentistry;**
- ✓ **Self-care, prevention;**
- ✓ **Primary care variation in disease management;**
- ✓ **Estates strategy;**
- ✓ **Whole system funding and budgets.**

The Improvement Hubs

These will support General Practice in developing common approaches to both clinical and operational issues - addresses workforce planning, identification and proactive management of high intensity users, workplace efficiencies and the development of standards and operating procedures

Risk Stratification

In order to promote a more standardised approach to the proactive identification and management of patients who are at risk of unplanned admission across Practices, the CCG is making a Risk Profiling system (RAIDR) available to Practices to support the Enhanced Service on Admissions Avoidance.

One of our main strategic aims for this year is to support Primary Care in starting to do more to help reduce unplanned hospital admissions, and to develop services that help patients to better manage their conditions closer to home.

A key enabler for this work is the 2014-15 GP Enhanced Service on "Avoiding unplanned admissions: proactive case review and care planning for vulnerable people", which the CCG is actively supporting through the provision of the NECS RAIDR Primary Care Dashboard to its Practices.

The NECS RAIDR Primary Care Dashboard is a web based system (accessible from all Practices) that links both GP and Hospital data (using the Combined Predictive Model algorithm) to give Practices monthly data sets that allow them to easily and systematically identify their patients who are at most risk of an unplanned hospital admission. Through the Enhanced Service (which we understand 31 of our 32 of our Practices have signed up to) we are keen for Vale of York Practices to develop Personalised Care Plans for patients who are identified as 'at risk' through Risk Profiling – in order to proactively manage their care and prevent hospital admissions.

This proactive approach to Care Planning, co-ordinated from within General Practice, but with support from a range of 'wraparound' community based services firmly underpins the CCG's plans and aspirations around Care Hub Models (initially through Integration Pilots), and puts the patient at the centre of an integrated health, mental health, voluntary sector and social care system. As Personalised Care Plans for the most at risk patients become more established, our aspiration is that Practices should then also be able to adopt a more preventative approach to managing long term and complex conditions for a wider cohort of their patients.

The NECS RAIDR system also provides Practices with risk algorithms to predict AF/stroke, fracture, and COPD – we already have our first data extract from GP systems, and the planned go-live date for RAIDR is 24th June 2014. We believe that 31 of our 32 Practices will use RAIDR to support their work for the Enhanced Service.

Closely linked to this, and another enabler for Practices to work more proactively with elderly/complex patients is the '£5 per head' funding for General Practice that was referenced in 'Everyone Counts' - to support GP's in improving the quality of care for elderly patients. The CCG is committed to making this funding available to Practices to help them to quickly get up to speed with the development of Personalised Care Plans for the 2% of patients required through the Enhanced Service.

The GP Education and Engagement Programme involves subsidising GP attendance at the RCGP accredited 'GP Update' programme which is delivered by HYMS and updates clinicians on best practice and recent clinical developments. It is hoped that over a 2 year cycle, all Vale of York GP's will attend this update course in order to promote best practice.

Understanding and managing unwarranted variation in primary care

Using tools such as the Primary Care Web Tool the CCG is supporting practices to understand and work through the variations in referrals and non-elective and A&E attendances for Practices when adjusted for Age and Population.

The CCG will provide support to address unwarranted variation including utilising the further roll-out and expansion of the Referrals Support Service (RSS) which was launched last year.

Use of technology

Optimising the use of technology at various stages of the pathway can have a significant impact on releasing time to care for patients. The CCG will scope and implement services which use technology to increase the value added time for patient care and reduce unnecessary steps and waiting. Schemes to be explored include Doctor First, telemedicine solutions and the use of electronic consultations where appropriate.

IT Strategy

Strategically, the interoperability agenda is a key enabler to deliver 'whole system' efficiencies and cost-savings through more effective communication and sharing of information - and to support the CCG's aspirations to further develop GP co-ordinated care planning across multidisciplinary teams. This will require collective engagement and agreement to delivering a preferred IT option for delivering across all sectors of health and social care. A critical component of this is engagement and cooperation from individual providers in making their data available to systems that support the wider sharing of information.

The CCG has commissioned a recent review to start understanding the aspirations and requirements of all relevant stakeholders and this will form the foundation of a dedicated programme of work around IT systems which will need to be co-ordinated with NHS England, all our providers, local authorities and other CCGs in the wider unit of planning.

The CCG is currently talking to two major integration suppliers: Cerner, who would like to bring their Population Health Management system from the US to the UK; and Orion, who have already integrated Health and Social Care records in Northern Ireland.

The overall recommendation is that we proceed with a number of small projects across the area to test integration/interoperability engines that sit over existing health and social care information systems (i.e. no rip and replace) and enable relevant information to be surfaced from those systems via a portal for sharing (with patient consent) across care professionals. The interoperability layer should also enable the development of electronic shared care plans that are accessible by multidisciplinary teams of care professionals, and patients and their carers.

IMPACT:

On our Ambitions and Trajectories:

- **Reduce the Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare by 14% by 2018-19.**
- **Improve the health related quality of life of people with one or more long-term condition, including mental health conditions to equal the best amongst our peers.**
- **Increase the number of people with mental and physical health conditions having a positive experience of hospital care by and care outside hospital in general practice and the community by 12%.**
- **Reduce the amount of time people spend avoidably in hospital by 14% through better and more integrated care in the community, outside of hospital.**

On addressing health inequalities:

- Identifying those patients who will most benefit from early interventions and care planning.

On Parity of Esteem:

- Taking into account the mental health needs of vulnerable patients and those of high risk of disease at the same time as supporting physical health needs.

Expected Outcomes:

- Better identification of at risk patients to enable proactive care
- Seven day working patterns across the Vale of York;
- Delivery of out of hours service (new procurement);
- More patients being cared for and supported to live independently at home by community based services;
- Targeted care for elderly, end of life and complex patients (using Risk Profiling tools to assist with case finding of appropriate patients) – with shared care plans for these patients and named care leads;
- More complex services accessible in a Primary/Community care setting;
- More flexible access to Primary Care services;
- Closer working between Primary Care and Acute elderly/LTC specialties.

On meeting what patients need and want:

Co-ordinated care planning which take account of all the physical and mental health needs of an individual, with the patient at the centre of care planning regardless of the range of providers and services involved.

"We need more open access GP appointments."

On our providers:
Primary care teams
Voluntary sector

Procurement:
Out of hours procurement could have impact
Future community service procurement

Milestones:
OOH Contract start April 2015

CCG Clinical Leads:
Dr Tim Maycock, Dr Emma Broughton, Dr Andrew Phillips

Reports to:
Primary Care Strategy Group, Quality and Finance Committee

CCG Improvement Manager:
Shaun Macey and Becky Case

Local Authority Lead:
Dr Paul Edmondson Jones

Other Partners:
Social Care teams, Primary Care and GP practices

Strategic Initiative 4: Urgent Care Reform

Objectives:

- **When people become ill, they are treated in a timely manner with access to expert medical support as locally as possible.**
- **Only the highest acuity patients are seen in A&E and alternative models of urgent care delivery will be developed in home, ambulatory care and within the community** (via Care hubs and extended primary care).

We will implement revised delivery models and pathways to reduce avoidable attendances and admissions. This will be supported by the Integration of Care transformation detailed above, as well as specific funding from winter pressures support which allows testing of new services and pathway change. This programme of work is led through the Urgent Care Working Group.

Our vision of how services will look and feel like for patients

Patient Experience Now	Patient Experience in five years
Emergency Care Practitioner Expansion	
Limited ECP service available; only 4 for Vale of York area.	Expanded service with predicted 9 ECP's plus admin support to filter calls.
Level of training and hence competencies can vary depending on where ECP trained.	Standardised job role and description for all ECP's.
Not all appropriate calls are picked up by ECPs so patients can be conveyed to hospital unnecessarily.	Admin support and increased public face of team will increase usage.
Psychiatric Liaison Provision	
Patients presenting to ED have a hugely variable wait time depending on the time of day they present, available staffing and day of the week.	Patients will get a consistent service whatever day or time they present, and will not breach 4 hour waiting times.
A subsequent wait for assessment means that patients are further delayed in getting the help that they need.	Assessment capacity will be better matched against demand and assessments will not be seriously delayed.
Currently the MHALT team can provide some assistance to 65 and overs but not working age adults.	Service will have capacity for all adults and provide different pathways for different life circumstances and presentations.
Social care teams are not currently involved in patient care and decision making.	Social care teams will be part of the MDT and available for support/advice.
Other vulnerable patients and children, and potentially those with alcohol issues may have to wait in ED alongside people with mental health problems.	Separate and appropriate waiting areas will be provided and wait times cut so there will be a reduction in mixing between patient groups.

Our **Improvement Interventions** which will support delivery of this strategic initiative include:

- Demand and Capacity planning for system – wide resilience planning;
- Increased Emergency Care Practitioners across the area. These will help to respond quickly to crisis and urgent need, seeing and treating at the scene to reduce transfer to Emergency Departments, working with our Yorkshire Ambulance Service;
- Under 5's admissions review, to reduce the numbers of children experiencing a 'zero length of stay' in hospital and ensuring children have swift access to high quality diagnosis in emergency departments;
- Patient Transport Services review to improve access to healthcare services;
- Out of hours services review, to enhance out of hours services aligned to the Care Hub approach and supporting the transition to 24hr/ seven day working across the health system;
- Provision of a geriatrician at the front door of ED to ensure the frail elderly have swift access to high quality diagnosis in emergency departments;
- A revised Deep Vein Thrombosis Pathway to ensure people have timely access to diagnosis and treatment.

Enabling work:

- NHS 111 as part of care co-ordination;
- In hours GP service and primary care reform initiatives.

IMPACT:

On our Ambitions and Trajectories:

- **Reduce the Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare by 14% by 2018-19;**
- **Improve the health related quality of life of people with one or more long-term condition, including mental health conditions to equal the best amongst our peers;**
- **Reduce avoidable hospital admissions;**
- **Increase the number of people with mental and physical health conditions having a positive experience of hospital care by and care outside hospital in general practice and the community by 12%.**

Expected Outcomes:

- Reduce unplanned emergency hospital admissions by 14%;
- Compliance with NHS Constitution targets for urgent care services;
- A more flexible and integrated service between OOH and GP provision;
- Better provision for paediatric urgent care in the community as well as through hospital;
- Better integrated support for frail elderly/care home urgent care;
- 24 hour, seven day working patterns across the Vale of York.

On meeting what Patients need and want:

Timely and responsive care in the right setting.

On our providers:

Yorkshire Ambulance Service NHS Trust
York Teaching Hospitals Foundation Trust
NHS 111

Procurement:

Out of hours (OOH) procurement
Re-procurement of mental health services will also impact

Milestones:

Tender OOH procurement July 2014
Contract award OOH procurement October 2014
OOH Contract start April 2015

Savings/ Productivity:

From reductions in emergency admissions

CCG Clinical Lead:
Dr Andrew Phillips

CCG Improvement Manager:
Becky Case

Local Authority Lead:
Richard Tassell - CYC
Richard Webb – NYCC
Rosie Pope - East Riding CC

Provider Leads:
David Whiting, Yorkshire Ambulance Services Trust
Liz Booth, York Teaching Hospitals NHS Foundation Trust
Mathew Walker, OOH lead Harrogate and District Hospital

Other Partners:
Primary Care

Reports to:

Urgent Care Working Group

Strategic Initiative 5: Planned Care

Objectives:

- **A sustainable and high quality local hospital providing a centre for urgent and emergency care and planned care for a wide range of conditions and elective operations, maternity and other specialisms within the Vale of York.**
- **Highly productive elective care delivery based on a jointly transformed acute pathway.**

Our vision of how services will look and feel like for patients

We propose to deliver efficiencies in Planned Care through reducing variations and enhancing outcomes and productivity of elective care. We support developing the hospital as a centre for elective excellence and will review of clinical pathways targeted at areas of lower performance or inefficiency and prescribing approaches. There will be a streamlining of all processes for referral.

Theme	Patient Experience Now	Patient Experience in five years
Diabetes	Access to provision only available via a hospital centric service. Lack of information and therefore confidence in patients to self-manage.	Service provision to be shared between primary, community and acute services, allowing patients to be seen at the right place and at the right time. Extend current education programmes i.e. Good2Go second stage/advance education to include insulin courses, as well have developed stronger links to eating well and correct dietary advice for people with diabetes. Easy access to advice, via website, should improve confidence to self-manage.
Neurology	*"I was given no information at diagnosis about my condition or what to expect in the future. When I got home I did my own research on the internet."* (Person with Parkinson's) *"Some years ago there was a specialist neurology ward which worked very well and understood patients' needs. It was abruptly closed in the interests of efficiency. Result: disaster. Other wards*	Referral guidelines to ensure admission of neurology patients is appropriate. An alert system when a neurology patient is admitted to a non-neurology ward. Introduce 'medication on time' initiatives into hospitals for Parkinson's patient. Address out-of-hours support for neurology. A general practice monitoring system for people with epilepsy who are not collecting prescriptions due to the higher risk of seizure.

	are having to deal with those cases and can't." (Person with Motor Neurone Disease)	Training GP staff to handle neurological queries Develop a one-stop-shop advice line for managing acute problems.
Elective Care Procurement	Current contracts for Elective Orthopaedics and MSK are due for renewal – procurements to ensure that current high level of service provision based within the community is maintained.	Develop innovative, creative, workable and robust evidence based clinical pathways placing the patient at the centre of the process and further developing working relationships with both primary and secondary care providers. Have embedded a continuing development programme of further clinical pathways which not only meet 18 week target but also relieve the pressure on the wider district health economy and meet the local needs of the populations. Provide patients with a seamless pathway of care from outpatients through to diagnostics/ procedures and on to discharge. Develop care pathways reflecting local needs and demands in partnership with patient users and clinical referrers. Maintain a high quality of health care that will be reflected in patients' continuous reporting of high satisfaction and further patient selection of the service through choose and book.

Referral Support Service	*"Good, really quick definitely seems more efficient, easy and quick extremely impressed, less than 24 hours from seeing doctor to hospital booking."* (Patient Feedback) *"How simple it is to get an appointment when and where you need it, all sorted with just one phone call amazing service."* (Patient Feedback)	Look to maintain standards and to improve where possible through acting on feedback that is continually sought.
Cellulitis, Bronchiectasis and Community IV	Patients requiring IV antibiotics for Cellulitis or similar problems are required to attend a ward and stay as an in-patient for days or weeks on occasion to receive treatment. Patients defer treatment because they know they'll be in hospital for some time and hence may deteriorate. Beds can be difficult to access at busy times and again elective admissions for treatment may be delayed.	Patients will be able to have a homecare company provide the necessary equipment, drugs and monitoring to be able to receive treatment at home. This would be supported by YTHFT community staff. Same as above.

	Other patients requiring IV antibiotics may attend as an outpatient but may need to attend a local hospital once or twice daily; limiting their quality of life.	
Prescribing	Branded medicines prescribed in large numbers. Some practices prescribing non-commissioned drugs; which may have been taken off formulary for clinical or financial reasons. Patients prescribed dressings in large volumes that are difficult to store and may be wasted if not used. Gluten free products are not prescribed equitably across the region. Stoma care products are not prescribed equitably across the	Generic medicines prescribed more where appropriate, freeing up spend for other specialist drugs to be commissioned. All patients only prescribed commissioned drugs; safety improved and freeing up spend for other specialist drugs to be commissioned. Dressings all prescribed from dedicated software, enabling split packs to be issued and hence a reduction in storage, more appropriate dressings used, and less waste across system. There will be a standard testing and diagnosis regimen which will ensure equity and management of gluten free products for patients requiring them. Stoma care products will be prescribed as required, with less wastage and appropriate products
	region and patients may be prescribed products in large volumes that are difficult to store and may be wasted if not used. Sip feeds are often prescribed to patients inappropriately or in unsuitable volumes creating storage difficulties and wastage for patients.	for patient complaints. Patients will be prescribed products appropriately and they will be issued to reduce wastage and improve adherence to feeding regimens.

IMPACT:

On our Ambitions and Trajectories:

- **Reduce the Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare by 14% by 2018-19**
- **Improve the health related quality of life of people with one or more long-term condition, including mental health conditions to equal the best amongst our peers**
- **Reduce avoidable hospital admissions**
- **Increase the number of people having a positive experience of hospital care by 12%**

Expected Outcomes:

- Improved patient access to care with a reduction in referral to treatment time for key conditions
- Roll out of the Referral Support Service across targeted disciplines
- Reduction in procedures of limited clinical value
- Reduction in zero length of stays
- Effective care as specified by NICE guidelines – building on the success of the diabetes model
- Improved sharing of information across service providers
- More electronic referrals, less paper in the system
- review delivery of all planned admissions for less complex treatments and maximisation of day case activity
- Pathway and VFM review (benchmarking and new prioritisation framework)
- Reductions in LOS (QIPP)
- Improvement of new: follow-up ratios (productivity)

Our **Improvement Interventions** which will support delivery of this strategic initiative include:

The following areas will be reviewed to ensure that the pathway from diagnosis to treatment and long term management, where appropriate, is timely and as efficient as possible and delivers high quality and safe care.

- Clinically appropriate management of outpatient follow-ups
- Diabetes pathway review
- Neurology pathway review
- Dressings Management
- Ophthalmology service review
- Cellulitis, Bronchiectasis and Community IV

On meeting what Patients need and want:

Telling my story only once
Co-ordinated care across providers and settings
'We want more time with Consultants'
'We want to wait less time for our hospital treatment'

On our providers:

York Teaching Hospitals Foundation Trust, Leeds Teaching Hospitals NHS Trust, Hull and East Yorkshire Hospitals NHS Trust

Procurement:

Elective orthopaedics procurement, Musculoskeletal service procurement

CCG Clinical Lead:
Dr Shaun O'Connell

Reports to:
Collaborative Improvement Board

CCG Improvement Manager:
Andrew Bucklee

Provider Lead:
Mike Proctor, YTHFT

Strategic Initiative 6: Transforming mental health and learning disability services

Objectives:

- **Reduction in premature mortality**
- **High quality mental health services for the Vale of York, with increased awareness of mental health conditions, improved diagnosis and access to complex care within the local area.**
- **Services delivered from modernised and fit-for-purpose infrastructure**
- **Delivering the required system capacity to target local need, address inequalities and meet our challenging access and diagnosis targets**

Development of mental health and learning disabilities (LD) services and addressing the current inequalities in access and outcomes is a key priority for the CCG.

Our IAPT psychological therapies services currently have long waiting times and the inpatient estate at Bootham Park Hospital requires redevelopment.

We plan to transform our mental health and LD services in the local area to enable a greater parity of esteem between mental and physical health and ensure that timely, safe and quality care is equally as accessible as care for physical illness or injury.

This will be an area for investment for the CCG in the next five years, with a complete review of the model of provision and the supporting estate to ensure that it is fit for purpose.

This will include a focus on dementia, access to psychological therapies (IAPT) and the physical health of people with mental health issues. The challenge of meeting IAPT and dementia targets will require innovative approaches to developing capacity and pathways and we are working with Leeds & York Partnership Foundation Trust (LYPFT), the voluntary sector providers locally and NHS England to plan further capacity development.

Our vision of what services will look and feel like for patients

A new model of mental health provision for the local area, which will:

- Increase dementia diagnosis rates;
- Reduce out of contract placements;
- Improved access to psychological therapies;
- Support people with dementia who move from acute to community care to live independently;
- Improve the standards of physical health care within mental health in-patient facilities to support earlier diagnosis and treatment of common illnesses. This is vital to our on-going goal of reducing premature mortality;
- Encourage people with mental health problems to access existing health and dental checks, and to understand the effects of medication and the need for screening and immunisation;
- Reduce waiting times across mental health provision;
- A clear and appropriate autism strategy and pathway;
- Estate that is fit for purpose;
- Reduce delayed transfers of care.

Our **Improvement Interventions** which will support delivery of this strategic initiative include:

- **Full review of Mental Health services** including all provision, quality performance and contract monitoring – this will be in support of tendering the current contract in November 2014 and service commencement October 2015;
- Review and development of an **estate development plan** to ensure all estate is fit for purpose; currently there is work on-going to provide an interim facility while the Bootham Park Hospital estate is redeveloped;
- Commission a comprehensive **liaison psychiatry service** that is responsive to those within A&E and complex cases on wards for those with mental ill health (Leeds and York Partnership Trust working in partnership with York Teaching Hospitals NHS Foundation Trust). This should also support an increase in the diagnosis rates of those with dementia;
- Active review of placements to **reduce out of contract placements**
- Investment in the psychological therapies service **(IAPT)** to provide a range of therapies from low level interventions to high intensity treatments within primary and community settings with an expected achievement of 8% by the end of 2014/15;

- Dementia pathway review including:
  - Work in partnership to develop **Dementia Friendly Communities** to reduce stigma and improve early diagnosis and provide support to people to live independently for as long as possible
  - Dementia work with primary care to increase the knowledge and skills of practice staff, increase efficiency of screening, coding and links to memory clinics
  - **Dementia Care Navigator** tender currently being developed with NYCC in order to (i.) reduce stigma and encourage people to seek support, (ii.) maintain and develop social networks and support mechanisms to live well with dementia, and (iii.) maintain independence for as long as it is safe to do so

Enabling work:

- The **DISCOVER! engagement programme** to inform the service specification for the future mental health tender;
- Hospital staff training programme for Dementia for clinical staff and all staff with general public contact;
- Implementation of the Lester Tool by clinicians to support the assessment and diagnosis of physical health needs in patients with mental illness (cardiac and metabolic health);
- Work with Primary Care to increase the knowledge and skills of practice staff, increase efficiency of screening, coding and links to memory clinics and care navigator.

Parity of Esteem

Transforming mental health services also provides an opportunity for the CCG and its providers to focus on tackling wider health inequalities. We recognise that reforming mental health services are integral to the transformation of the whole health and care system to meet the needs of our population.

Access to primary and community care for physical and mental health issues should be comparable. Therefore, our vision of Care Hub Models will be to integrate the mental and physical health services helping improve the recognition and diagnosis of mental health conditions, including dementia. We will also work in partnership with health promotion and local authorities to help remove the stigma surrounding mental health conditions.

The CCG will consider all opportunities to:

- develop the access and quality of mental health services provision
- consider how to improve the physical health of patients with mental health conditions developing other care pathways

The mental health and learning disability services review and procurement will focus on identifying all opportunities for improving health promotion work (smoking cessation, weight management, routine health checks; screening; oral health and screening/ immunizations) and early diagnosis of physical health issues in all mental health service settings.

IMPACT:

On our Ambitions and Trajectories:

- **Reduce the Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare by 14% by 2018-19;**
- **Improve the health related quality of life of the people with one or more long-term condition, including mental health conditions to equal the best amongst our peers;**
- **Increase the number of people with mental and physical health conditions having a positive experience of hospital care by and care outside hospital in general practice and the community by 12%;**
- **Quality Premium;**
- **Improving access to psychological therapies (IAPT).**

Expected Outcomes:

- 'a new model of mental health services' (see above)

On meeting what patients need and want:

Patients will:

- Be able to make sense of their change of behaviour;
- Get an earlier diagnosis;
- Be able to make informed choices about their future – how they want to live and how they want to die;
- Be able to learn coping mechanisms – for the person with dementia and their family and friends;
- Be able to arrange for support to help them maintain their independence for as long as possible;
- Receive parity of care which takes account of mental health and physical health needs – focussing on the whole individual and not just disease pathways;
- Have an improved quality of life.

On our providers:

Leeds and York Partnership Foundation Trust

Milestones:

Mental health procurement – tendering the current contract in November 2014 and commencement of new service October 2015

CCG Clinical Lead:

Dr Louise Barker

CCG Improvement Manager:

Paul Howatson

Partnership Commissioning Unit:

John Clare

Reports to:

Mental Health Partnership group

Health and Well Being Board

Supporting Working Groups:

Procurement Project Group

Bootham Park Hospital

Programme Board

Local Authority Leads:

Paul Edmondson Jones, CYC

Richard Webb, NYCC

Rosy Pope East Riding CC

Other Partners:

East Riding CCG

Strategic Initiative 7: Children and Maternity

Objective:

- **People will be supported to stay healthy through promoting healthy lifestyles, improving access to early help and helping children have a healthy start to life**

Our vision of what services will look and feel like for patients

We want to enable the best start in life though supporting children and families to achieve improved health outcomes. This incorporates safe and effective maternity services for the local area, and support to vulnerable children throughout their childhood and transition to adult life.

The major focus of transformation is the move to more personalised packages of care for children with special educational needs and disabilities, the review of child and adolescent mental health services, aligned to the Mental Health Transformation, and the reduction of health inequalities for children and families.

NHS England Public Health key priorities

We will work with NHS England and contribute to deliver the following key public health priorities, through co-commissioning:

- Additional elements to screening programme e.g. new born / antenatal x four additional test as part of Blood spot screening, plus additional new immunisation programmes;
- Health visitor trajectories;
- Childhood flu as 2014/15 plus increase in primary schools and secondary schools;
- Childhood flu as 2013/14 Age 0-4 Years plus School Years 7-8 years;
- Re-procurement of school nursing immunisation service in North Yorkshire with North Yorkshire Council;
- Maximise immunisation programme Coverage (16 immunisation programmes) screening coverage (cancer, non-cancer, new-born and antenatal);
- Adolescent vaccinations in schools

Yorkshire and Humber Children's and Maternity Work Programme 2014-16

A number of our improvement initiatives contribute to the wider regional improvement programme, for example:

- Developing systems to reduce the level of unplanned admissions to hospital for Long Term Conditions
- Developing systems to support the review of CAMHS provision and the transition between CAMHS and adult services

Children and Families Act

We are working with our partners, particularly local authorities to implement a number of changes required under the Children and Families Act, including: Special Educational Need reforms, Education, Health and Care plans and Personal Health Budgets.

We are also contributing to the three Health and Wellbeing Strategies across our area, for example York's Health and Wellbeing Strategy's priority 'Enabling all children and you people to have the best start in life'.

A number of our improvement projects link to other work programmes our partners are undertaking, for example:

- Improvements to Health Visiting before the transition from NHS to local authorities in October 2015
- Healthy Start Programme and Breastfeeding programmes
- Weight Management initiatives
- Food for Life Partnership, engaging with communities to promote healthy eating
- Reducing smoking during pregnancy and supporting young parents.

Our **Improvement Interventions** which will support delivery of this strategic initiative include:

- To revise the Maternity Commissioning Strategy working collaboratively with North Yorkshires CCGs to provide sustainable and safe maternity services;
- Develop a maternity dashboard to ensure we have the appropriate information to affectively monitor the quality and performance of the maternity services we commission;
- Enhance health reviews and health promotion service for Looked After Children (LAC). This includes ensuring that all LAC receive health assessments and developing health passports for care leavers;
- Review the emergency admissions for children with lower respiratory tract infections (part of our wider objective to reduce unplanned admissions and promote quality of life);
- Access to Personal Health Budgets for those with Continuing Health Care and Long Term Conditions;
- Access to person centred Education, Health and Care Plans, ensuring we meet the new duties under the Children and Families Act to give children and parents more flexibility in their health and care support;
- Establish a clear pathway to tiers 1 to 4 Children and Adolescent Mental Health Services (CAMHS) based on the review of CAMHS Strategy, working with local authorities to ensure we have a comprehensive services across the levels of need, delivered in a timely way;
- Autism pathway to improve diagnosis assessment timescales and support to children and families across the Vale of York;
- Weight management (particular focus on Selby population);
- Supporting the local 2014 Challenge Campaign to support children in managing their own health through weight management, mental health and exercise promotion and awareness
- Review of asthma prevalence

IMPACT:

On our Ambitions and Trajectories:

- **Reduce the Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare by 14% by 2018-19;**
- **Reduce avoidable hospital admissions.**

Expected Outcomes:

- Improved performance on the maternity dashboard
- Increased breastfeeding rates
- Timely health reviews for all Looked After Children
- Access to personal health budgets and education and Health and Care plans
- A clear pathway across tiers 1-4 for CAMHS
- Decrease waiting times for Autism diagnosis
- Ensure comprehensive and timely services across the varying levels of need

On meeting what Patients need and want:

- Safe and sustainable maternity services that promote increased choice.
- Timely health reviews for all Looked After Children
- Improved performance framework for maternity services leading to more effective commissioning aligned with population need.
- Increased collaborative working to ensure delivery of the Healthy Child Programme.
- Looked After Children will be more engaged in decisions about their own health and wellbeing with improved access to health services.
- Care in the right place at the right time and by the appropriate health professional.
- Personal Health Budgets will allow increased choice and control for children and families, supporting personalisation.
- Person centred, rather than service led, care and support for children and families integrating education, health and social care.
- Decrease waiting times for Autism, achieving higher quality diagnosis assessments and support in accordance with NICE guidance.
- Clearer pathways for tiers 1-4 mental health services.

On our providers:

York Teaching Hospitals Foundation Trust
Leeds and York Partnership Foundation Trust
Leeds Teaching Hospitals NHS Trust
Hull and East Yorkshire Hospitals NHS Trust

CCG Clinical Lead:

Lucy Botting (Chief Nurse and Safeguarding Lead)
Dr Emma Broughton – Maternity
Clinical Lead for Children to be appointed July 2014

Reports to:

YorOK (and report to Health and Well Being Board CYC)

CCG Improvement Manager:

Polly Masson

Partnership Commissioning Unit:

Jayne Hill

Local Authority Lead:

Directors of Children's Services for each of our Local Authorities

Provider Lead:

York Teaching Hospitals Foundation Trust

Strategic Initiative 8: Cancer, Palliative and End of Life Care

Objectives:

- **When people are terminally ill, the individual and their families and/or carers are supported to give them the best possible quality of life and choice in their end of life care.**
- **Reduce the amount of time people spend avoidably in hospital by 14% through better and more integrated care in the community, outside of hospital.**

Cancer prevention, diagnosis and treatment are a key focus for this CCG. This will be supported through promotion of smoking cessation and healthy eating initiatives. This will also be supported by the screening campaigns from Public Health England and the Well-Being plan which includes an alcohol strategy.

During the initial planning period we will undertake a review of our cancer pathways, in conjunction with primary care and specialist commissioning to ensure we have timely and effective routes to support diagnosis and treatment.

Concurrently, the CCG will also start a review of the local Palliative Care and End of Life care services and pathways. It is envisaged that future End of Life services will be embedded within the Care Hub (s).

Our vision of what services will look and feel like for patients

Patient Experience Now	Patient Experience in five years
Care and support for carers and palliative care patients and those facing the end of life is variable and disjointed.	Patients and carers will have their needs assessed and navigated to the right service, first time.
Currently, the only consistent providers of quality care are Marie Curie Overnight Nursing Service and the services provided by St Leonard's Hospice.	Patients and carers will experience joined up care between provider organisations.
It has been acknowledged that some health professionals across a variety of settings struggle to identify when someone may be facing the end of their life and lack the confidence to discuss this. Workforce planning.	VOICES surveys of patients/their carers will show a stepped change and more positive responses to questions raised.

Improvement Interventions that will deliver this strategy:

- Cancer pathway review and redesign working with Survivorship programme
- Palliative care review

Enabling work:

- Carers strategy
- Well-being plan implementation
- Work with GPs to deliver primary care Hospice at Home

IMPACT:

On our Ambitions & Trajectories:

- **Reduce the Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare by 14% by 2018-19**
- **Increase the number of people with mental and physical health conditions having a positive experience of hospital care by and care outside hospital in general practice and the community by 12%**
- **Reduce the amount of time people spend avoidably in hospital by 14% through better and more integrated care in the community, outside of hospital.**

Expected Outcomes:

- Improve screening uptake;
- More patients being cared for and supported to live/die at home by responsive community based services;
- Carers needs are assessed and addressed appropriately;
- Targeted care for elderly, end of life and complex patients (using Risk Profiling tools to assist with case finding of appropriate patients) – with shared care plans for these patients and named care leads;
- More complex services accessible in a Primary/Community care setting;
- More flexible access to Primary Care services;
- Individuals and carers' will be more engaged in decisions about their own health and wellbeing with improved access to health services;
- Work towards an accountable lead provider in future procurements, specifically for palliative/end of life care.

On meeting what patients need and want:

- Care in the right place at the right time and by the appropriate health professional.

On our providers:

- Increased collaborative working to ensure seamless care delivery

Procurement:

Development of the Palliative and end of life care specification for future procurements.

Savings/ Productivity:

Opportunity within future commissioning of community services to further improve quality and efficiency.

CCG Clinical Leads:

Dr Joan Meakins – Cancer
Dr Andrew Phillips – Palliative & End of Life care

CCG Improvement Manager:

Paul Howatson

Local Authority Leads:

Richard Tassell – CYC
Chris Jones- King – NYCC

Provider Leads:

YTHFT, LYPFT, HEYHT

Other Partners:

Marie Curie, Macmillan, St. Leonard's Hospice, Independent Care Group, St. Catherine's Hospice

Reports to:

Vale of York and Scarborough and Ryedale Palliative and End of Life Care Programme Board.

Supporting Working Groups:

Vale of York Palliative and End of Life Care Locality Group.

Quality Assurance and Improvement

Objectives:

- **Population Wide Quality Outcome Improvement**
- **Parity of access to safe, high quality healthcare services**
- **Improved quality outcomes for people with physical and mental health conditions**
- **Increase the number of people with physical and mental health conditions having a positive experience of health care**
- **Increase harm free, effective quality care across all areas of health and social care**
- **Increase the practice of continual quality improvement through learning from our past mistakes**

Achievements in 2013/14 - Laying the Foundations:

1. Development of robust quality governance arrangements internal and external to the CCG to support a focus on quality surveillance, assurance and a relentless focus on continuous quality improvement;
2. Development of close collaborative partnership working with providers to support continuous quality improvement. This included work during winter 2013 /14 to relieve the pressure on urgent care and work to support a reduction in health care acquired infections;
3. Collaborative working with providers to deliver the 2013/14 CQUIN schemes and put in place appropriate CQUIN measures for 2014-15;
4. Successful renegotiation of the 2014-15 quality schedules within our main provider contracts to include updated critical outcomes and reporting from lessons learnt from the Francis and Berwick Report(s), Winterbourne View, Munroe Report and Hard Truths;
5. Development of triangulated information systems (quality, performance, patient experience) to enable a proactive focus on quality surveillance and its improvement.

Achievements going forward in 2014-15:

6. Building a proactive collaborative quality surveillance, assurance and improvement system;
7. Continued development of robust quality governance arrangements extending to our members within primary care i.e. the development of a clinical commissioning network for health professionals in line with compassion in practice;
8. In line with HEE and the demographics around an aging workforce a relentless focus on workforce development for all professionals in line with the strategic plan;
9. Continued development of triangulated surveillance and intelligent systems extending to our members within primary care to include quality improvement support;
10. Soft Intelligence development – clinical and patient soft intelligence development to enhance the quality and richness of information

received to enable “you said, we listened, we did “in line with the Francis Report;

11. Development of a CCG Quality Strategy and Quality Assurance Framework in line with the CCG five year Strategic Plan;

12. Collaborative working with our providers to further reduce harm and promote a ‘lessons learnt’ approach to quality and safety improvement. This will include a further reduction in health care acquired infections and improvement in areas such as pressure ulcer care, falls and performance (RTT/Diagnostics/ Cancer Waits);

13. A focus on proactive safeguarding for children, young people and adults deemed as vulnerable.

Quality

Quality means different things to different people, however improving people’s lives (quality outcomes) and improving their experience of care is at the heart of what matters and helps drive the change we want to see to improve quality care within the Vale of York CCG.

As an overarching principle ‘quality care’ can be defined as:

- The improvement of patients’ lives (quality outcomes- life expectancy, health outcome)
- Patient experience of care
- The safety of the care and treatment provided.
- The clinical effectiveness of the care and treatment provided
- Parity of esteem.

To achieve this vision the CCG have put in place robust systems and processes to enable quality to become co-centric and embedded within the five year strategic plan. This includes a focus on:

- Quality Outcomes – the development of meaningful quality outcome measures that enable us to monitor the health of our population and focus resource on areas deemed critical to health improvement
- Quality Governance – the structure, process, values and behaviours internal and external to the CCG that enable us to provide the assurance and the control that care is safe and of high quality.
- Quality Surveillance and Assurance –the proactive monitoring, management and evaluation of services that we commission to ensure high quality, harm free care.
- Quality Improvement –continuously challenging quality assumptions, learning from past mistakes and adapting our approach to health care in order to achieve a better focus on improved quality outcomes.

Quality Outcomes

In line with the Quality Outcomes Framework and in conjunction with our demographic health profile the CCG has prioritised population need and developed meaningful commissioning intentions in line with the Strategic Plan for years 1-5 which aim to improve the quality of life for all our population (health outcomes and life expectancy): this includes those with a mental health illness, those vulnerable and frail elderly and children and young people starting out in life. Meaningful quality outcome measures will enable us to gauge how well we have achieved our ambition and enable us to refocus our intentions in the future on those with the greatest need.

Quality Governance

In line with Monitor's Quality Governance Framework the Vale of York CCG firmly believes that robust quality governance is essential to achieve our desired outcomes for success. We have ensured this through:

- Leadership for Quality at Executive and Governing Body levels (GP and Nurse Clinical leadership)
- A review of our quality governance processes (internal and external to the CCG) to include a clinical effectiveness group as a sub-committee of the Quality and Finance Committee to assure that health care planning is bound by best practice guidance. This includes research governance.
- A review of current intelligence systems, processes and reporting which has included a refresh of our quality and performance dashboard to ensure that intelligence is up to date, triangulated and includes patient experience. This provides richness and a more robust degree of accuracy to the information we source to enable intelligent commissioning in line with recommendations from the Francis Report.
- A Commissioning for Quality Network across the CCG to ensure all professionals, nurses and allied health professionals have a voice in the commissioning of healthcare
- The CCG Quality Strategy refreshed to form a strategic alignment with the five year plan
- Quality embedded in everything we do, everything we plan and in all our processes and systems

Quality Surveillance and Assurance

It is important when an organisation appears to be failing that we take immediate and effective notice of 'early warning triggers'. The CCG will work in partnership with providers, partners and stakeholders to collaborate and share soft and hard intelligence to ensure that triggers to failure are highlighted with immediate effect and the recipient organisation is supported in order to minimise risk and harm.

Lessons learnt from the recommendations from the Francis and Berwick Report(s), Winterbourne View and the Munroe Review have been applied to enhance and further develop quality within our organisation (the tools, systems and processes we use to plan, monitor, assure and evaluate quality) and within our commissioned services. These recommendations are routinely applied to the renegotiation of contracts and the setting of quality schedules and form part of the Key Performance Indicators that the provider will report on i.e. Hard Truths (workforce), Duty of Candour. These recommendations also form part of our Quality Assurance Checklist for existing or new services.

To provide a further degree of scrutiny and rigour to the surveillance and assurance of quality the CCG:

1. Monitor the performance and quality of commissioned services using the triangulation of quality, performance and patient experience. These indicators analyse baseline thresholds as well as performance trends and local and national benchmarked averages. This is reported to the Quality and Finance Committee on a monthly basis with escalation to the Governing Body. An escalation contingency plan enables the ad hoc escalation of risk should risk rise about a threshold.

2. Higher level quality scrutiny occurs with partner organisations such as our neighbouring CCGs, NHS England, regulators i.e. CQC, TDA and Monitor and others such as Health Watch and the Local Safeguarding Children and Adults Boards. The CCG work with partnership with these organisations to communicate, monitor and asses the risks in relation to quality. Where harm is identified and / or care deemed unsafe the necessary processes, levers and enforcements are put in place to support and resolve mitigation. This includes the work of the Quality Surveillance Group whose remit it is to share quality concerns across Yorkshire and Humber.

3. Oversight of a provider's quality and performance targets are undertaken by each CCG, these may include serious incidents, complaints, and failures in performance. The lead and associate commissioners meet with the provider on a monthly basis at the respective quality and performance committee, a sub group of the contract management board to discuss any decreasing trends or quality concerns to challenge and improve practice. Where escalation is required these concerns are taking to the contract management board.

4. Formal Contract Management Boards take place each month with the respective providers to manage, challenge and resolve quality and performance concerns. This takes the format of informal to formal challenge, which may include holding the provider to account through improvement actions assuring each CCG that failures in quality are actionned and improved.

5. Where care has been deemed unsafe and at a degree of escalated concern that it puts patient safety at risk, with no immediate actions to resolve, the commissioner in conjunction with NHS England and / or the regulator may have no other option but to suspend the service. Full consideration of resolution will be considered in the first instance.

6. Quality Accounts. All providers are required to produce an annual quality account, which sets out the provider's standards and achievements in relation to the quality of care and patient experience provided in the previous year and ambitions going forward. It is our duty as commissioners in accordance with the Health and Social Care Act 2012 to ensure that these accounts are a true and accurate representation. These accounts are published on the provider's website.

7. In line with providers cost improvement plans it is the expectation that they will also produce quality impact assessments (QIAs). These assessments are undertaken to assess risk in relation to the quality and safety of care provided. As commissioners it is our duty to assess and assure these plans to ensure that no detriment to quality occurs. These plans are monitored and reviewed regularly at the quality and performance committees.

8. Other surveillance and assurance activities include walking the walk with patients and providers and other forms of soft intelligence such as networking events, forums and patient engagement events.

Quality Improvement

In accordance with the recommendations from the Frances and Berwick Reports and the government's response to these reports (Hard truths) quality improvement is the basis for which we continuously challenge assumptions on quality, striving to improve areas of quality and safety in line with clinical effectiveness.

We have ensured that quality improvement is embedded within everything we do and within the five year strategic plan. Actions related to this include:

1. Quality Governance: The clinical effectiveness group monitor commissioning plans in relation to area of quality effectiveness change in relation to National guidance and policy. This includes NICE Guidance i.e. changes to treatments such as IVF, Varicose Vein procedures. Recommendations are presented to the Governing Body.
2. Clinical Quality and Improvement Scheme (CQUIN). The CCG work with providers to agree local CQUINs. These are schemes and associated payment to improve the quality of care, based on areas of provider weakness or changes to national or local policies which indicate a higher degree of quality in a given area. Indicators are set at national and local levels. These are monitored throughout the year.
3. Quality Premium. Set at national level the quality premium is a retrospective payment made to the CCG to improve areas of quality, based on national quality and performance indicators of concern. Whilst most of the indicators are national i.e. Accident and Emergency 4 hour waits, ambulance response rates, there is also the opportunity for CCGs to set local indicators to oversee quality improvement. In 2014-15 the CCG have chosen falls and the family and friends test (Out of Hours) as markers of quality improvement. These indicators are managed by work streams within the CCG and reported to the Quality and Finance Committee.

Safeguarding

The failures at Mid Staffordshire NHS Foundation Trust and at the independent care home, Winterbourne View as well as child protection (Baby P), provide stark reminders that when the NHS falls short of their responsibilities in respect of quality, the consequences for patients, service users and their families can be catastrophic.

The Vale of York CCG have made safeguarding a priority and as such are increasing the capacity within both the children's and adults safeguarding teams to ensure there is the capacity to deliver a robust model of proactive assurance across the Vale of York.

Equally the CCG as the accountable health organisation for safeguarding must have:

- An Executive lead on the Governing Body for safeguarding
- A GP lead on the Governing Body for safeguarding adults and children
- Are permanent members of the Local Safeguarding Children and Adult Board

Safeguarding is also embedded within all the work of the CCG, staff training and a full list of relevant policies are in place.

The following table summarises some of the initiatives that we will reinforce over the next year to promote and enable service quality.

Quality: Our Priorities for 2014-15

Patient Experience	Increase the use of Friends and Family Test across all care delivery sectors. This includes providing support to Primary Care
	Promote real time data capture of patient/ carer and clinical experience to inform quality delivery.
	Monitor staff survey results and ensure that action is taken to resolve any significant concerns.
	Actively work with providers to ensure their duties in relation to the duty of candour are appropriately discharged.
	Work with the Looked after Children's team to ensure that Children have parity of access to health and have are happy, fulfilled and their wellbeing prioritised
	Promote the use of digital technology to reach professionals and the public.
Patient Safety	Work with YHFT to reduce hospital mortality rates.
	Work with all providers to reduce the incidence of Never Events and to ensure organisational learning from Serious Incidents
	Reduce Hospital Acquired Infections in line with or preferably below national thresholds
	Ensure robust arrangements are in place for safeguarding adults and children
Commissioning Clinically Effective Care	Work with YHFT to develop a service recovery plan where required to support improved compliance with nationally identified staffing ratios
	Commission services based on NICE clinical quality standards and ensure all providers are performance managed against the relevant standards
	Work with providers to meet the standards in service specific outcome strategies for mental health services, cancer, COPD, asthma and LTC associated with premature mortality.
	Continue to support clinical strategies aimed at reducing early mortality from CVD, Stroke, kidney disease, diabetes and for patients with mental illness.
	Promote the CCG approach to commissioning for outcomes ensuring a robust approach to using evidence to support commissioning decisions and the development of performance monitoring metrics to measure outcomes
Winterbourne	Work with the continuing healthcare team in line with the concordat for Winterbourne View to ensure vulnerable adults are placed appropriately including MCA/DOLs capacity assurance.

National CQUIN Indicators 2014-15

National CQUIN Scheme	Acute Services (York Hospital)	Community Services (York Hospital)	Ambulance Services (Yorkshire Ambulance Service)	Mental Health Services (Leeds and York Partnership Foundation Trust)
Friends and Family Test	√	√	√	√
NHS Safety Thermometer	√	√	N/A	√
Dementia and Delirium	√	N/A	N/A	N/A
Improving physical healthcare to reduce premature mortality in people with severe mental illness	N/A	N/A	N/A	√

Local CQUIN Indicators 2014-15 NHS Providers

Organisation	Local CQUIN Indicators
York Teaching Hospital NHS Foundation Trust	• Sepsis Care Bundle • Care of the Deteriorating Patient – 12 Hour Assessment by Consultants • Pressure Ulcers • Stroke – Early Supported Discharge • Medicines Management – prescribing and missed critical medicines
Leeds and York Partnership NHS Foundation Trust	• Care Planning – training to improve quality of care plans and audit to ensure CPA standards • Establish a culture of engagement and involvement with service users and carers – set up service user forums • Incident reporting – rollout Datix web system to York Services, train staff and encourage a culture of open and transparent reporting.
Yorkshire Ambulance Service Emergency Services	• Care Homes: Right Care, Right Place • Improving Red 1 and Red 2 performance in underperforming CCGs (including NHS Vale of York CCG) • Improving Patient Safety and Reducing Harm (reporting incidents on falls/medicine errors and harm whilst in YAS care)
Yorkshire Ambulance Service Patient Transport Services	• Improving the experience of patients with complex needs • Improving patient experience related to transfer times for patients attending outpatient clinics
Nuffield, York	• VTE • Electronic Discharge Letters • Falls Risk Assessment and Care Plan
Ramsay – Clifton Park Hospital	• VTE • Electronic Discharge Letters • Nutrition and Hydration Audit

Quality outlier : areas for further improvement (YHFT)	Specific Area of Improvement	Mitigation
Falls	Increase in the number of fractured neck of femur	Action plan in place.
Refer to Treatment Times	Capacity issues identified with:- • Cardiology • Dermatology • ENT • Gastroenterology • General Surgery • Gynaecology • Neurology • Rheumatology • Thoracic medicine • Urology	RTT external report outstanding. Discussions with YHFT: system and process issue including capacity. Not a growth demand assumption. Monitor and NHSE aware.
Diagnostics	Cystoscopy, Gastroscopy, Audiology Assessments and Non-obstetric Ultrasound	Systems, process and capacity issue. Awaiting RTT report.
Cancer Waits	Particular areas include Breast Screening.	Included within RTT external report. Possible systems, process and capacity issue. Report outstanding.
HCAI	C.Diff – 7 cases against plan of 59 (May 2014)	Operational Lead In place for Vale of YorkCCG. Action plan in place.
Safe Staffing (Hard Truths)	Report to be submitted to Trust Board in June 2014	Report outstanding. CCG monitoring in relation to areas of quality/ performance concern.
Audiology Assessments for Children	Scarborough	Managed and action plan In place by PCU
IAPT	Modelling and capacity issues	Business case submitted for 8% growth threshold. Modelling to drive – 15% by end of 2014-15.

Financial Sustainability

Financial Strategy 2014-15 to 2018-19

Introduction and 2013-14 Successes

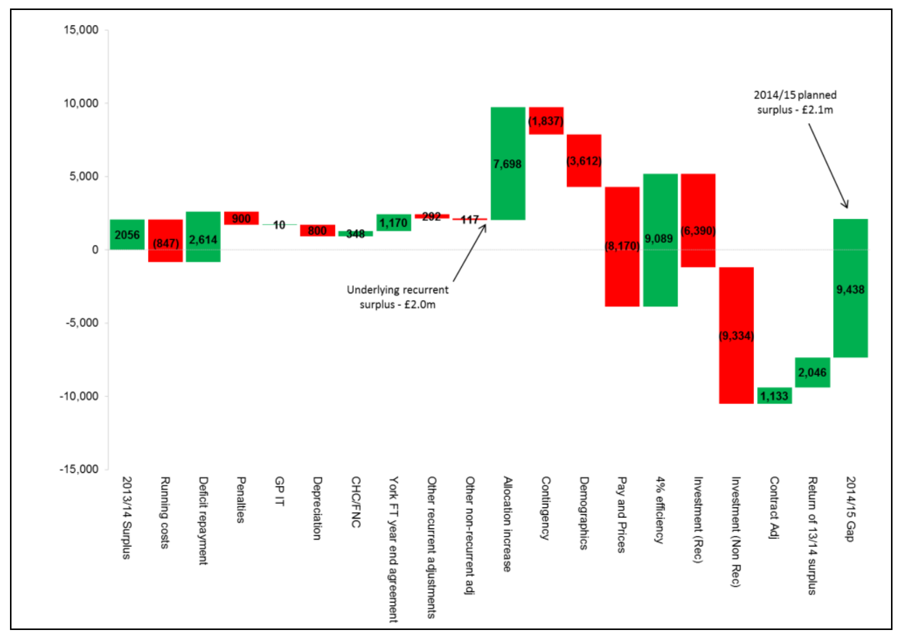
The financial strategy for the CCG provides a framework for supporting and driving the delivery of the five year Strategic Plan. It is aligned with the overarching timeline of the strategic plan of ensuring foundations are laid to enable a move to long term financial sustainability. It supports the integration programme, improvement interventions and delivery of better quality care for the Vale of York population.

2013/14 was the first year of operation for the CCG and financially, a challenging one. In the early part of the year, the legacy of the PCT was evident with a historic deficit to repay, a reduced finance and contracting team and gaps in financial governance processes. However, the CCG achieved some significant financial successes:

- Planned surplus of £2.05m delivered;
- Annual Accounts prepared and submitted with an excellent, unqualified audit report;
- Increased finance and contracting team resource recruited including Chief Finance Officer;
- Significantly improved accuracy of contracting data and influence in contract negotiations;
- Built good relationships with local providers and partners which led to 2013/14 agreement on financial positions and agreement of 2014-15 contract baselines.

2013-14 Outturn and Underlying Position

The outturn for 2013/14 was £2.05m surplus (0.57%). The impact of the changes to allocations, business rules and key financial assumptions on the CCG's underlying position that will be carried forward in to 2014-15 is shown below. This has also been communicated and discussed in detail with senior management in the CCG and the Governing Body.



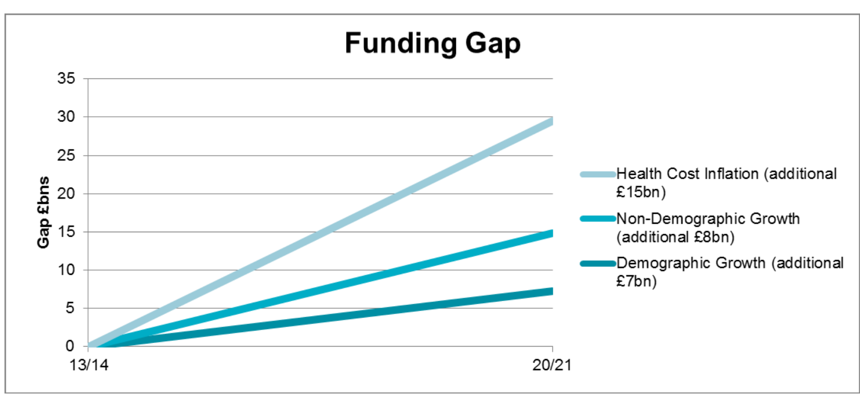
This shows that after the return of the £2.9m transfer from running costs, the one-off £3.5m repayment of the historic deficit and a series of other in-year adjustments, including the application of penalties on the YFT contract (£0.9m) and GP IT depreciation (£0.8m), the CCG will carry forward a recurrent surplus of £2.0m. It also highlights that the basis for the plans for

2014-15 creates a gap of £9.4m that will be bridged in order to generate the required surplus through a combination of QIPP, BCF and contract management and negotiation.

Financial Sustainability – A Call to Action and the Funding Gap

Spending on the NHS in the UK as a share of national income has more than doubled since its introduction in 1948, rising by an average of 4.8% in real terms. This period of rapid growth has now come to a halt but funding pressures on the NHS continue to rise. The NHS in England has been targeting efficiency savings of £20bn by 2014-15 to meet this challenge. Looking further ahead, in July 2013 NHS England published the 'Call to Action', which projected that the NHS may have to make a further £30bn of efficiency savings by 2020/21:

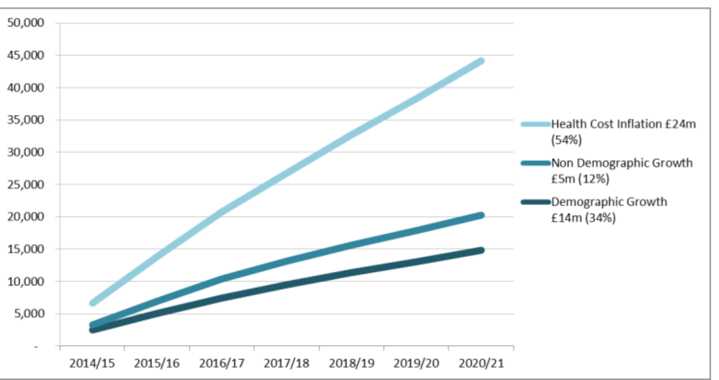
National



- Health Cost Inflation (pay and prices) – 50%
- Non-Demographic Growth (over and above demographic growth) - 27%
- Demographic Growth (change in population by age band) - 23%

Locally, for the Vale of York CCG, this translates to a funding gap of potentially £44m:

Funding Gap – NHS Vale of York CCG



The proportions that relate to inflation and growth are noticeably different locally than the national picture for demographic and non-demographic growth showing that the impact of projected population growth in Vale of York is considerably more than the average nationally.

Ensuring financial sustainability is about finding ways to raise the quality of care for all in the Vale of York communities to the best possible standards, while closing the funding gap at the same time. Fundamentally, this requires a significant shift in activity and resource from the acute hospital sector to the community.

Key **enablers** to deliver financial sustainability are:

- **Integration with social care**

  The funding and implementation of the Better Care Fund has the potential to improve sustainability and raise quality, particularly by reducing emergency admissions. Investment in and reconfiguration of existing community services will provide a robust alternative to hospital admission, reducing the volatility of non-elective acute activity and subsequent financial impact.

- **Improving productivity**

  There is a planning expectation for acute providers to aim to deliver a 20% productivity improvement in elective care within five years. Productivity is about having the opportunity and ability to treat more patients with better outcomes at the same or lower cost.

- **Increasing efficiency**

  This relates to delivering the same service for less cost, time or resource and is a key driver for financial sustainability. It is essential that all parts of the system are innovative, ambitious and transformational in their plans for delivering care in order to help ensure long term financial sustainability.

- **Effective funding mechanisms**

  NHS England and Monitor have joint responsibility for the payment system for NHS services and they have indicated their intention to review funding mechanisms to ensure they truly support improving outcomes. They will focus on twin themes of operational improvement and creating new patterns of care. The funding and payment system is critical to ensuring financial sustainability for the whole health system.

- **Excellence in performance**

  Commissioners are not in a position to be able to pay for quality and performance that does not deliver the best possible care for patients. Creating an environment and culture where all health, social care and third sector stakeholders can work together to deliver this is critical to helping ensure long term financial sustainability.

- **Co-commissioning and effective partnerships**

  Close alignment with primary care and specialist commissioners through co-commissioning and alliances with other partners such as public health and local authorities to ensure congruence of plans and services.

- **System Resilience Groups**

  Evolvement of Urgent Care Working Groups in to SRGs and the inclusion of planned care will align disparate systems of care and enable system wide discussion and whole pathway change.

- **Commissioning for Quality and Innovation (CQUIN)**

  Incentivising improvement in quality standards has had a significant effect since the introduction of CQUIN and effective use of targets in commissioning will see this key enabler continuing its critical role.

Financial sustainability will be achieved through a number of ***mechanisms***:

- **Financial governance**
  Excellence in financial governance and rigorous financial management in the CCG is key to ensuring financial systems and processes are robust. This will ensure that financial planning, reporting and management are well controlled and directed and that investments, disinvestments and QIPP schemes are subject to appropriate challenge and approval. Internal audit have an important role to play in this and the plan developed in conjunction with internal audit for the next 3 years reflects the CCG priorities and Governing Body views on gaps in assurance.

- **Procurement**
  Effective procurement of identified services drives significant improvement in the quality of services, innovation, efficiency and value for money. In particular, innovative procurement mechanisms focussed on outcomes and incentives will drive service and quality improvements that would not otherwise be realised through traditional contract extensions. The CCG has a number of complex and large scale procurements planned over the five year planning which will drive improvement in the quality of services provided on an unprecedented scale.

- **Contract management**
  Rigorous approach to contract management to ensure defined outcomes are achieved, activity paid for is coded and counted correctly, performance objectives are met and demand is managed to ensure value for money. Contracting levers and incentives must also be utilised effectively to ensure the best outcomes. The CCG has taken the approach of ensuring baselines agreed for 2014-15 are realistic and accurate, reflecting current and predicted future demand and agreed with providers. This provides a robust baseline position from which to make future decisions and allows modelling of improvement interventions to be done accurately.

- **Business intelligence and modelling**
  Real time and outcome focussed business intelligence and predictive modelling is critical to ensure the CCG has the tools it needs to respond quickly to emerging issues and flex contracts and resources accordingly.

- **Benchmarking**
  Considered use of key benchmarking data and participation in exercises to identify where the CCG is an outlier or performing well and where costs are currently incurred to enable informed decisions to be made about QIPP and investments.

- **Innovative commissioning and informed decommissioning**
  The CCG will use an outcomes based approach to commissioning to cultivate innovation and a consistent, fair, prioritisation framework to ensure services decommissioned are those that do not deliver the desired outcomes. The CCG will also conduct a full baseline assessment of services that are currently provided to ensure equity in consideration of where resources should be focussed.

- **Working with, and sustainability of, partners**
  Sustainability of provider organisations, particularly York Teaching Hospital NHS Foundation Trust, is critical to ensuring a sustainable local health economy for the Vale of York. Effective working with all partners and working in partnership, including co-commissioning and shared resources, is an important focus for the CCG as a whole pathway approach to the provision of healthcare in the area is critical. Local partners in delivery include providers, primary care and GPs, specialised commissioners, NHS England and Area Teams, the three local authorities, the Partnership Commissioning Unit (PCU), the Commissioning Support Unit (CSU) and the diverse voluntary sector.

NHS Vale of York CCG Strategy for Financial Sustainability

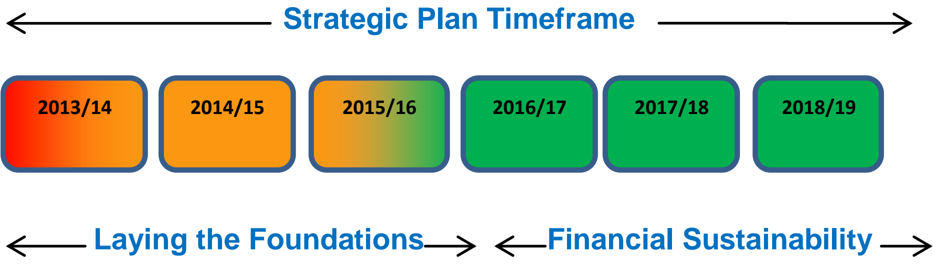
The CCG delivered a surplus of £2m (0.57%) in 2013/14 which, although not meeting the 1% recurrent surplus requirement, was a significant achievement given the debt inherited from the former PCT. Long term sustainability can be achieved and the CCG believes, through rigorous planning and consideration of risks, that a realistic timeframe for this is 3 years. 2014-15 is the second year of this important which lays the foundations for future financial sustainability.

The CCG has made the decision to plan for a surplus in 2014-15 in line with that achieved in 2013/14. This gives the CCG a planned surplus of £2.1m (0.57%) in 2014-15 and a move to the level required in the business rules of 1% from 2015-16 and thereafter.

The CCG has agreed a baseline contract for 2014-15 with York Teaching Hospital NHS FT at a level which both organisations believe is realistic and delivers the RTT constitutional targets. There has also been considerable work done across the North Yorkshire and Humber patch during 2013/14 and early 2014-15 to agree further baseline allocation adjustments for specialised commissioning.

These issues have created considerable additional pressure for the CCG in the early part of 2014-15 and, whilst a positive step for the organisation in recognising realistic activity levels and commissioning appropriately, are consistent with a phased approach to achieving longer term financial sustainability.

This is also consistent with the staged that the CCG has already taken to reinstating investments in the CCG's financial plan which have not previously been available. These include investment of readmissions and marginal rate rule funding and carer's breaks and reablement funding. Furthermore, the CCG's integration and care hub plans and implementation of the Better Care Fund in 2015-16 align with this move towards financial sustainability from 2016-17 onwards.



Financial Plan 2014-15 – 2018-19

Allocations

The NHS Vale of York CCG allocation for programme activity is £367,439,000 and £8,312,000 for running costs in 2014-15.

Following and extensive review and consultation, NHS England agreed a new funding formula for local health commissioning based on more accurate, detailed data and including a deprivation measure specifically aimed at tackling health inequalities. The new methodology has regard for population on a per capita basis and takes into account both inequalities and the impact of an ageing population on demand for healthcare.
The new 'fair shares' allocation formula sets the Vale of York CCG budget over the five years of the strategic plan as follows:

Year	Growth %	Allocation per Head £	Programme Allocation £'000	Running Cost Allocation £'000
2014-15	2.14%	1,062	367,439	8,312
2015-16	1.70%	1,072	373,685	7,476
2016-17	1.80%	1,100	380,411	7,471
2017-18	1.70%	1,111	386,878	7,465
2018-19	1.70%	1,122	393,455	7,460

Programme allocations have been published for 2014-15 and 2015-16 and indicative allocations published for 2016-17 – 2018-19 and the CCG's plans are based on these. An additional recurrent allocation of £5.94m will also be received in 2015-16 relating to the Better Care Fund (BCF) and corresponds to existing funding currently transferring from Health to Social Care.

Running cost allocations have been published for 2014-15 and indicative allocations published for 2015-16 – 2018-19 and the CCG's plans are based on these. The 10% reduction in running costs planned nationally for 2015-16 is also reflected.

Non-recurrently, the CCG is assuming return of the 2013/14 outturn surplus of £2.05m in 2014-15 and the 2014-15 planned surplus of £2.1m in 2015-16. From 2015-16 the planned surplus is the recurrent requirement of 1% and return of this in 2016-17 and thereafter is assumed in the CCG's plans.

Business rules

The business rules published in the planning guidance are included in the plan for 2014-15 and 2015-16 as follows:

Requirement 2014-15	Target 2014-15	Actual 2014-15	Target 2015-16	Actual 2015-16
Surplus	1.0% = £3.7m	0.57% = £2.1m	1.0% = £3.8m	1% = £3.8m
Contingency	0.5% = £1.8m	0.5% = £1.8m	0.5% = £1.9m	0.5% = £1.9m
NEL Threshold	£1.2m	£1.2m	£1.2m	£1.2m
Readmissions	£1.0m	£1.0m	£1.0m	£1.0m
Non-Recurrent	2.5% = £9.2m	1.9% = £6.9m	1% = £3.8m	1% = £8.3m
Better Care Fund			£19.4m	£19.4m

The 2.5% non-recurrent requirement in 2014-15 also includes the following requirements in the planning guidance:

Reablement and Carer's Breaks Funding	£2.3m	£0.7m
Primary Care Elderly Care Funding	£5/head = £1.7m	£1.2m

Both of these are provided non-recurrently in 2014-15 with the expectation that all plans will form part of the recurrent Better Care Fund from 2015-16 onwards.

The PCT historically and the CCG in 2013/14 were not able to create and fund the NEL threshold and readmissions funds due to underlying financial pressures. The CCG has committed to ensuring a transparent financial planning process by re-creating all required lines of expenditure and making active planning decisions. £0.5m has been identified for work to reduce readmissions and emergency admissions and will be governed by the multi-stakeholder Urgent Care Working Group. The CCG has been clear that a staged approach is required to attaining levels of investment in a number of areas and that these will not be funded in full in 2014-15. This will demonstrate planned partial funding through 2014-15 with full impact in 2015-16 for all areas, particularly those related to the Better Care Fund.

The CCG is also required to include £1.4m non-recurrently for payments relating to retrospective continuing care claims made during the period up to 2012/13. This is included in baseline allocations and will be transferred to a national central risk pool where payments will be made from. Initially, CCGs will be required to make these payments to ensure no cases are delayed while this process is established but this will not impact on the CCG's baseline allocation.

The business rules for 2015-16 and beyond are also included, notably the reduction in the non-recurrent requirement to 1% in 2015-16. The CCG is planning to deliver all of these in full by 2015-16 and, assuming there are no changes to the requirements, on an on-going basis for 2016-17 to 2018-19.

Running costs

Running costs are planned and anticipated to be within the allocations for each of the five years of the strategic plan. Pay and non-pay inflation have been factored into the planning assumptions and increased resource in Governing Body representation, quality, performance, medicines management, procurement and organisational development have been included. The 10% reduction in allocation in 2015-16 is included from 2014-15 in that recurrent expenditure is being kept below 90% with the remaining 10% being available for flexible use relating to project work and development.

Planning Assumptions

Published alongside the planning guidance is the Call to Action technical paper. This sets out the key financial and activity assumptions that underpin the £30bn challenge that was published in July 2013. This guidance, together with additional local work, has been reviewed to develop these assumptions further for the CCG's financial plan.

The core financial planning assumptions over the next five years are therefore as follows:

Area of Plan	Assumption	2014-15	2015-16	2016-17	2017-18	2018-19
Acute	Demographics	1.5%	1.5%	1.4%	1.4%	1.4%
	Pay and Prices	2.5%	2.9%	4.4%	3.4%	3.3%
	Efficiency	(4.0%)	(4.5%)	(4.0%)	(4.0%)	(4.0%)
Community	Demographics	1.5%	1.5%	1.4%	1.4%	1.4%
	Pay and Prices	2.5%	2.5%	2.5%	2.5%	2.5%
	Efficiency	(4.0%)	(4.0%)	(4.0%)	(4.0%)	(4.0%)
Community – YFT**	Demographics	0%	0%	0%	0%	0%
	Pay and Prices	0%	0%	0%	0%	0%
	Efficiency	0%	0%	0%	0%	0%
Mental Health**	Demographics	0%	0%	0%	0%	0%
	Pay and Prices	0%	0%	0%	0%	0%
	Efficiency	0%	0%	0%	0%	0%
Other Services*	Demographics	0%	0%	0%	0%	0%
	Pay and Prices	2.5%	2.5%	2.5%	2.5%	2.5%
	Efficiency	0%	0%	0%	0%	0%
Prescribing	Demographics	0%	0%	0%	0%	0%
	Pay and Prices	4%	4%	4%	4%	4%
	Efficiency	0%	0%	0%	0%	0%

**Includes Continuing Healthcare and Funded Nursing Care*

***The community and mental health position is based on agreement for 2014-15 and 2015-16 to maintain these block contracts at the 2013/14 level while the significant redesign and integration work is undertaken across these sectors.*

In 2014-15, an additional 0.3% pressure in the acute tariff relating to CNST in specific HRGs results in a net tariff adjustment of 1.2% for core acute services. Also included in planning assumptions is an assumed 0.7% pensions pressure for 2015-16 arising from the revaluation of public sector pension contributions and a further 1.4% pension pressure for 2016-17 arising from reforms to the state pension. These are predominately cost pressures for providers and assumed to be funded through tariff. The 1.4% in 2016-17 is however currently an estimate and in practice NHS England and Monitor will need to discuss with central government closer to the time the exact amount of funding pressure that will need to be met by the NHS and any funding arrangements to meet this pressure.

Areas such as prescribing and continuing healthcare, that are not subject to a percentage efficiency requirement, do have specific and targeted QIPP schemes applied in order to continue to deliver efficiency in these areas.

Financial Plan Summary – Programme Costs 2014-15 to 2018-19

The income and expenditure impact has been modelled on an individual provider basis, in line with the monthly financial dashboard headings presented to the Quality and Finance Committee and Governing Body. This is provided at summary programme line level in the table below for 2014-15 to 2018-19. The QIPP gap is shown here in total for transparency but in reality is profiled across the relevant programme lines and embedded in contracts.

	13/14	14/15	15/16	16/17	17/18	18/19
Acute	214,366	219,418	217,178	219,420	221,175	222,723
Mental Health	37,325	37,974	38,966	38,967	39,968	39,969
Community	28,905	30,729	30,660	29,772	29,763	29,753
Continuing Care	23,458	24,174	24,885	25,607	26,344	27,093
Primary Care	49,147	51,053	53,015	55,037	57,122	59,275
Other Programme	6,046	11,643	33,505	45,322	51,248	58,234
Contingency		1,838	1,868	1,932	1,964	1,997
Gap (QIPP / BCF / Other measures)		(9,438)	(22,156)	(29,775)	(34,833)	(39,717)
Total Programme Costs	**359,247**	**367,391**	**377,921**	**386,282**	**392,751**	**399,327**
In-year Gap (Non Cumulative)		(9,438)	(12,718)	(7,619)	(5,058)	(4,884)

		14/15	15/16	16/17	17/18	18/19
Allocation		367,439	373,685	380,411	386,878	393,455
BCF		-	5,938	5,938	5,938	5,938
Prior Year surplus		2,046	2,094	3,796	3,863	3,928
Total Resources		**369,485**	**381,717**	**390,145**	**396,679**	**403,321**
Total Expenditure		**367,391**	**377,921**	**386,282**	**392,751**	**399,327**
Surplus		2,094	3,796	3,863	3,928	3,994

QIPP

The QIPP gap/targets for each year of the strategic plan are shown in the table above. Of the £9.4m target in 2014-15, £5.0 has been identified and agreed with providers recurrently and there is an unidentified gap of £4.4m. However, there is a clear plan of additional opportunities to explore, scope and develop to provide additional contribution to the remaining financial gap. Until these plans are agreed and contracted, the CCG is being clear in identifying these separately to ensure an accurate picture of the QIPP and financial risk is presented.

There is also a future pipeline of potential improvement interventions which could drive further cost efficiency and support delivery of a financially sustainable local health system from 2015-16 and these are being worked on now in 2014-15. These are a mixture of transactional programmes of work which are currently being mobilised now that the activity and contractual baselines have been agreed with our main providers; and transformational programmes driven by intelligence, benchmarking and analysis which is identifying areas of unjustified variation and areas of care pathways which show significant potential to improve both efficiency and quality.

The detailed BCF modelling that we have undertaken indicates that significantly greater impact is likely than that included as 'identified' QIPP at this stage and this will be a major contributor to the remaining QIPP target. However, as this is not yet embedded in provider contracts as agreed QIPP is based on provider modelling at an earlier stage in the integration pilot planning process.

All transactional and transformational opportunities mobilised into programmes of work will be assessed and aligned against the Integration programme and will also adjust in line with the evolving national direction in order to ensure all opportunities for maximising sustainability and efficiency are realised.

Remaining risk in the unidentified proportion of QIPP will be met through transactional measures, delay in investments and other non-recurrent actions during 2014-15.

Local position and alignment

Expenditure on health services in Vale of York CCG covers acute, mental health and community services, primary care, prescribing, continuing care, ambulance and urgent care services and a number of independent and voluntary sector contracts. Our footprint also covers three local authority areas. Citizens in the Vale of York area have a wide choice of possible providers, particularly for hospital care and, for many of these contracts, the CCG is an associate to a lead contract held by another CCG.

We have close working and robust contract management arrangements in place with all providers and this is particularly important in working with acute, mental health, community, social care and primary care partners in agreeing plans to deliver the required outcomes of QIPP schemes and the Better Care Fund. Considerable work has been undertaken to ensure congruence of strategic plans and that the CCG vision is a joint and shared one. Financially, contracts are agreed with all providers and longer term trajectories are agreed in principle and are in line with the CCG's vision, integration planning and implementation of care hubs which will deliver the reduction in unplanned admissions.

We have agreed and approved extensions to key contracts in community and mental health services to ensure that there is stability operationally and financially over the period where services are undergoing transformation and new pooled budget contracts are being agreed.

We also ensure close working with Scarborough and Ryedale CCG through considerable alignment with QIPP plans and investments as we share our main provider. This ensures consistency in approach to Better Care Fund, Quality, Innovation, Productivity and Prevention (QIPP) and that investment plans and joint quality and performance management arrangements in place.

Contracting

The NHS standard contract remains the form of contract which commissioners must use for all contracts for clinical services, other than primary care. Commissioners are expected to enforce the standard terms of the contract, including the application of penalties.

One of the CCG's critical mechanisms for delivering financial sustainability is rigorous contract management. This will ensure defined outcomes are achieved, activity paid for is coded and counted correctly, performance objectives are met and demand is managed proactively. Contract levers and incentives will also be utilised effectively to ensure the best outcomes. The CCG has taken the approach of ensuring baselines agreed for 2014-15 are realistic and accurate, reflecting current and predicted future demand and agreed with providers. This provides a robust baseline position from which to make future decisions and allows modelling of improvement interventions to be done accurately.

We have fully assessed the impact of existing QIPP programmes on financial and activity baselines and these are embedded in provider contracts through detailed Service Development and Improvement Plans (SDIP). A Heads of Terms is also agreed with YTHFT which defines risk share arrangements, non-recurrent and recurrent investment, demand management and cap arrangements and areas of joint working and review through 2014-15 for impact in 2015-16 and beyond. It also clarifies agreement on areas of contract negotiation and the outcomes.

Identified QIPP schemes and Better Care Fund modelling has been done to specialty and POD level and included in contract level baselines.

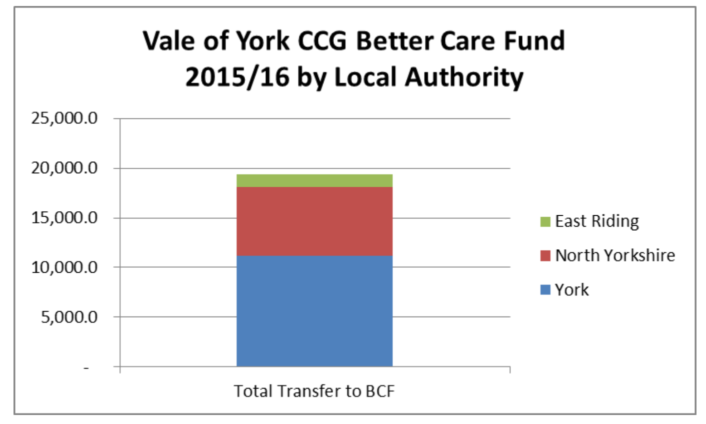
We have invested significantly in additional contracting team resource and will ensure detailed analysis of contract positions throughout the year in addition to conducting audits and reviews of a range of activity areas to ensure counting and coding rules are applied correctly. The CCG is also developing an enhanced Business Intelligence (BI) specification with the Commissioning Support Unit to ensure contracting support is fit for purpose and focussed on the CCG's vision and strategy. The CCG also has an embedded member of staff from the BI team who is critical to bringing together the QIPP modelling and BI contract work.

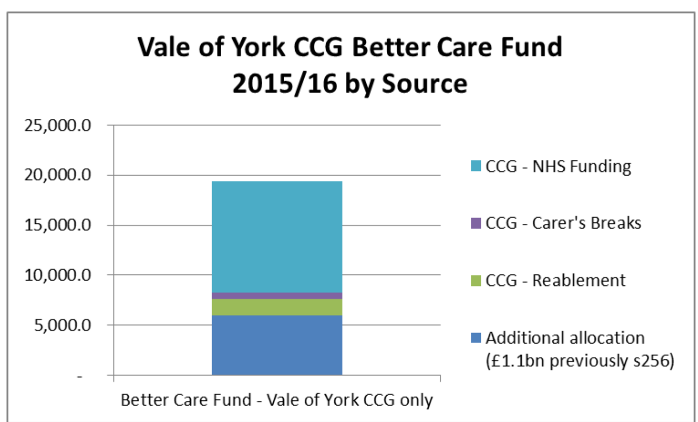
This is a considerably more robust approach to contracting than the CCG has had previously and establishes a baseline of good practice moving forward into years 2-5 of the strategic plan.

Better Care Fund

The £3.8 billion national Better Care Fund that comes into operation in 2015-16 is aimed at supporting the integration of health and social care. The fund is an opportunity for local services to transform and improve the lives of the people that need it most and is a key driver for long term financial sustainability. We have included in our plans the actions we will take in 2014-15 to create the funding required to make the Better Care Fund affordable when it is introduced in 2015-16. For the Vale of York, this takes the form of 3 separate BCF plans aligned with the 3 local authorities in the CCG boundary and are submitted as distinct plans in their own right, led by the respective Health and Wellbeing Boards.

For the Vale of York, the Better Care Fund in 2015-16 is £19.4m and is analysed as follows:





The total CCG contribution in 2015-16 is £13.4m, the difference being made up by an additional allocation of £6.0m relating to the funds previously transferred directly to social care from the NHS under s256 arrangements. The £13.4m also includes re-ablement and carer's breaks funding not previously funded by the CCG or the PCT historically.

The Better Care Fund in the Vale of York will be managed through 3 distinct pooled budgets for each local authority and will be governed by the Health and Wellbeing Boards. Formal agreements will enable the creation of the pooled budgets and transfer of funds from social care to health to contract for agreed services.

A proportion of the fund will be performance related with payments linked to progress against national metrics, such as delayed transfers of care and avoidable emergency admissions. Hospital emergency activity is expected to fall by around 15% to generate the savings required to resource for the Better Care Fund so CCG plans are focussed on this area of activity as described in the strategic plan.

Statement of Financial Position (Balance Sheet)

The financial plan templates include a detailed statement of financial position, previously known as the balance sheet. This includes details of assets, liabilities and taxpayers' equity and reconciles to the cash plan. We hold non-current assets, previously known as fixed assets, relating to medical equipment at the independent treatment centre and GP IT.

Cash

We are expected to manage its cash within the resource allocation available and financial plan demonstrates this. The cash profile takes in to account the phasing of QIPP and improvement interventions impact and specifically, a front-loaded cash profile has been agreed with YTHFT to ensure the CCG's main provider is not disadvantaged during the early part of the year.

Capital

We have submitted, and had approved, a capital planning return to NHS England Finance and Investment Committee, which approves the capital plan and indicative allocations for CCGs, subject to the approval of business plans. This includes investment in IT and community equipment.

In the medium term, the CCG is leading the development of a new, permanent mental health facility in York to re-provide the services currently delivered in Bootham Park Hospital. A high level feasibility study is being conducted initially to determine the best option and then a decision will be made in conjunction with stakeholders as to the proposed way forward.

Financial Risks

The CCG faces a number of specific financial challenges and risks through 2014-15, 2015-16 and in the latter years of the plan. The critical ones are descried below:

Area of Plan	Risk	Mitigation
Acute Services	**Specialised commissioning** Issues relating to the correct distribution of resource relating to specialised services have continued from 2013/14 in to 2014-15 and remain a material cost pressure for the CCG.	A complete re-base exercise has been undertaken for two principal local providers and provision has been made in the plan for the estimated impact of these. A further risk is also highlighted explicitly in the financial risk analysis until an agreement is made.
Acute Services	**Activity Variation, Demand Management and Achievement of RTT Targets** The CCG has made a number of growth and activity assumptions that it considers reasonable and have agreed	Monthly detailed analysis and contract reconciliations done by contracting team

Area of Plan	Risk	Mitigation
	these with providers, but there is a risk that activity exceeds this or issues arise in year that haven't been planned for and RTT targets cannot be met within contracted activity.	followed by monthly Contract Management Board meetings with relevant Trusts will ensure any issues are identified and mitigated early.
QIPP	**Under-delivery of QIPP schemes** QIPP schemes are at differing stages of development and while some are well advanced and the risk to delivery is low, others are still being developed and there remains an element of unidentified QIPP in the 2014-15 plan as schemes are transformational and delivery of activity impact starts during 2014-15 will full impact in to 2015-16 and beyond.	Further QIPP schemes are actively being developed alongside a number of contractual actions and levers to further reduce spend and drive efficiency.

Area of Plan	Risk	Mitigation
Mental Health	**Costs in 2015-16 and beyond** The current contract with the main provider of mental health services has currently been extended to September 2015 so there remains a degree of uncertainty as to the costs of the service after that point depending on the procurement route undertaken.	The plan assumes a flat position currently with no savings or investment other than specific investments already agreed. Any procurement process will ensure services are contracted within available resources. Decisions on additional further investment in services will be taken through the CCG process for approval.

Area of Plan	Risk	Mitigation
Integration Programme (and Better Care Fund)	**Savings and outcomes not delivered as planned** The CCG will contribute to three funds across three local authority areas. The vision is clearly articulated and stakeholders are agreed but there remains significant risk that the savings and outcomes required are not realised and activity does not shift from the acute sector to community and primary care as planned. Investment will have been made in BCF schemes but activity continues to flow to current providers creating significant financial risk.	Governance arrangements are in place for all three local authorities and CCG plans are consistent across all three. Risk share arrangements are being discussed to ensure no one stakeholder holds all the financial risk.

Finance Development

The CCG is a member of the Healthcare Financial Management Association Commissioning Finance Faculty which aims to provide a network for finance staff within commissioning organisations, offering support, education and advice that will help them to tackle the challenges they face. The Faculty offers opportunities to share experience and expertise and to influence thought and policy in the commissioning finance arena. It will also provide a forum for learning, technical development and networking. The HFMA also gives the CCG access to finance training and networking opportunities for other Governing Body members, including lay members.

The CCG is also signed up to 'Future-Focussed Finance'. In January 2014, the six heads of the finance profession in the NHS came together to initiate Future-Focused Finance which offers a vision for NHS finance to aspire to over the next five years. The three strategic themes, incorporating 6 action areas, align extremely well with the five year strategic plan and financial strategy of the CCG:

1. **Securing Excellence**
   - Best possible value
   - Efficient systems and processes
2. **Knowing the Business**
   - Close partnering
   - Skills and strengths
3. **Fulfilling our Potential**
   - Great place to work
   - Foundations for sustained improvement

The CCG CFO will ensure these principles are embedded in the Finance and Contracting function and throughout the organisation in terms of financial values and governance.

Workforce

The Current Situation: The Health and Social Care workforce across North Yorkshire and Humber

Current workforce data suggests that the number of people working in the Health and Social Care sector across North Yorkshire and Humber region is upwards of 160,000. This number comprises of approximately 27,710 people working within secondary care [1], 4,200 in primary care [2], and 120,000+ people working in social care settings [3]. Note that the estimate for the number of people working in social care are judged to be on the conservative side, owing to the challenge with collecting data from independent providers.

Within secondary care 52% of staff work in a large acute; 28% in a teaching acute; 10% in mental health/learning environment and 9% within a community provider. Of these staff 31% are deemed to be nursing/midwifery; 20% admin/clerical; 19% additional clinical services; 10% medical and dental; and 6% allied health professionals. The secondary care workforce is 78% female, 22% male with around half the workforce (45%) in AfC bands 1-4 and 41% in AfC bands 5-6. As of October 2013 17% of staff were aged 55 or over. In ten years' time 49% of the current secondary care workforce will be 55+. Unless radical intervention occurs this will have a direct impact on our ability to deliver high quality care and the ensuing achievement of health outcomes aligned with the strategic plan.

There are approximately 245 General Practices in North Yorkshire and Humber serving 1,747,077 registered patients. [4]. These practices comprise of 1,023 GPs, 526 practice nurses and 2037 admin/clerical workers. In 2012 a quarter of GPs in North Yorkshire and Humber were 55+. In 10 years' time approximately 61% of the current GP workforce will be 55+. With an ageing workforce it is therefore critical in line with our strategic vision that we explore how we retain, attract and recruit nurses and doctors to positions in primary care or explore very different future solutions to providing proactive, high quality care within this setting.

There are approximately 3,600 social care establishments in Yorkshire and Humber employing 120,000+ people within residential homes (42%), domiciliary homes (38%), community care (15%) and day care (4%). Two thirds of the care homes in the region are independent (67%), 13% local authority and 5% NHS. Of the 120,000+ workforce, 73% are care workers, 7% managerial/supervisory and 7% community and professional roles. The average pay rate for a care worker is £6.50/hour with NHS trained nurses receiving £24,000.

There is a high turnover in the social care workforce (29%, approximately 14,500 posts per year) even though 87% are permanent staff. It is estimated 40% of the social care workforce have no qualifications, 24% a level 2 and 11% a level 3 diploma. The workforce is primarily female (84%), a quarter are aged 50-59 and 9% 60+. In ten years' time 60% of the current workforce will be 55+.

Workforce trends: North Yorkshire and Humber (August 2009 to Oct 2013)

There has been an overall increase of 1,405 FTE across the main providers in North Yorkshire and Humber with 14,820 at August 2009 and 16,225 at August 2013, however it is worth noting that the nursing workforce has seen a decline. In summary from August 2008 to August 2013:

- Nursing/midwifery numbers decreased by 400fte;
- Administrative and clerical increased from 2,605 to 3,305 in August 2010 followed by a decline to 2,870 at Aug 2013;
- Additional clinical services have increased by 370fte;
- Medical and dental increased by 275fte;
- Additional professional and scientific roles increased by 140fte.

Workforce current gaps, risks, issues

In 2013 Providers highlighted a number of risks and issues around:

- An aging medical and nursing workforce with difficulties in recruitment;
- Training/recruitment difficulties in Psychiatry, A&E, GP, Anaesthetics and General Medicine (Consultant level); advanced nurse practitioners;
- Reduction in training numbers (Surgery Anaesthetics and Core Medicine);
- Gaps in nursing and medical recruitment / rotas (Acute and Emergency Medicine and medical specialities), leading to high locum, bank and agency spend;
- Implications of the North Yorkshire and Humber health and social care workforce.

The health and social care workforce in North Yorkshire and Humber is an aging workforce. As of Oct 2013 approximately 20% of the workforce were aged 55+, and hence close or eligible to retire. In ten years' times approximately 55% of the current health and social care workforce will be aged 55 and over. This will have implications for leadership and hence the development and coaching of newly qualified staff. Equally there is the potential for the loss of skills across the area.

All Clinical Commissioning Groups have voiced concerns about the aging GP workforce in North Yorkshire and Humber. Workforce planning trends indicate that there should be enough medical trainees to meet this demand, if they consider GP registrar training. However, there are additional factors (geography in particular) which may affect the ability for North Yorkshire and Humber to recruit GPs and it may be the case that Clinical Commissioning Groups will need to look at Innovative approaches to recruitment. Equally there may be opportunities to develop more advanced level nursing roles to fill this void.

It is noted that there is a large gap in the skills, training and education of social care staff in comparison to health staff. Approximately 40% of social care staff have no qualifications. If social care staff are to support the reduction in unnecessary admissions to hospitals there will be a need to educate/up skill this staff group.

The move towards an integrated health and social care system may benefit from the experiences and learning of current multi-agency (or multi-disciplinary) approaches to team working especially within the children's sector. In particular learning from the social pedagogical approaches, a team around the patient approach. A team led by a lead-professional (someone with advanced skills across a wide-range of disciplines). Such an approach would require a change of culture and language, new training and development approaches with rotational training programmes and the development of a common induction programme. This has already been seen with the development of virtual wards for those with complex long term conditions.

The move towards an approach to bring care closer to home, back into the community (which will also include specialist care) will have an impact on the professional staffing types trained and the staffing numbers required for 24/7 staffing and out of hours care. This may have an immediate adverse effect of increasing bank, agency and locum costs in order to meet safe/appropriate staffing levels. To mitigate this risk, innovative approaches may be needed i.e. joint, shared and rotational posts across community and secondary care settings.

The move towards a greater level of self-care, assisted by technology, will require staff to be appropriately trained to use, manage and support the technology. Such skills and abilities should be built into training and CPD programmes for new staff. Existing staff would need to undergo training as appropriate.

Staff Survey Results (2012) - North Yorkshire and Humber

N.B. The following data has been adapted from the Staff Survey Toolkit (2012).

Most Improved Key Findings since 2011

Since 2011 there has been:

(A) A 6.8% increase in equality and diversity training.

(B) A 6.4% increase in overall engagement score.

(C) A 6.1% increase in feeling able to contribute towards improvements at work.

TOP 10 MOST IMPROVED KEY FINDINGS FROM 2011 TO 2012

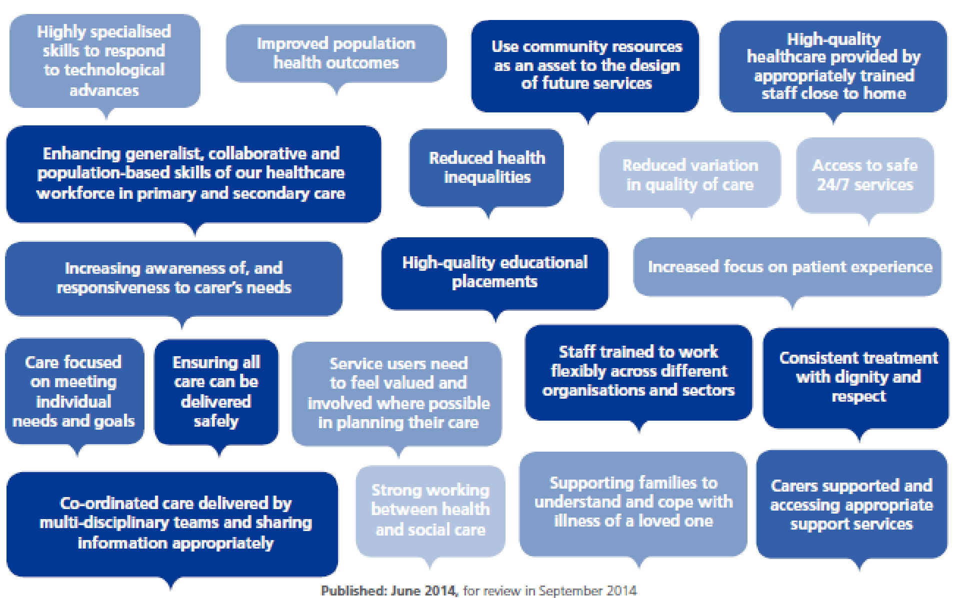
KEY FINDING	RELATIVE CHANGE FROM 2011	
KF26. % having equality and diversity training in last 12 mths	6.8%	Increase
Overall engagement score	6.4%	Increase
KF22. % able to contribute towards improvements at work	6.1%	Increase
KF1. % feeling satisfied with the quality of work and patient care they are able to deliver	3.3%	Increase
KF6. % receiving job-relevant training, learning or development in last 12 mths	3.0%	Increase
KF7. % appraised in last 12 mths	2.8%	Increase
KF23. Staff job satisfaction	1.9%	Increase
KF28. % experiencing discrimination at work in last 12 mths	1.7%	Decrease
KF24. Staff recommendation of the trust as a place to work or receive treatment	1.5%	Increase
KF8. % having well structured appraisals in last 12 mths	1.3%	Increase

Most Deteriorated Key Findings since 2011

- An increase in bullying / harassment from patients (1.4.8% increase) and staff (8.6% increase) across the region;
- An additional 8.1% have reported an increase in work-related stress;
- Health and safety training has decreased by 7% since 2011;
- A 7% increase in the experience of physical violence.

Workforce Development

Workforce development plays a significant role in the delivery of high quality healthcare. Stakeholder responses to the HEE workforce strategy development (2009-2014) highlighted some key areas of importance.



Equally futures modelling work by Health Education England highlighted that:

Area	Key messages/ future trend
Informal and formal care	There will be a need for a larger informal workforce; carers, volunteer's, families and even app-based self-care. This may take the form of formal support complemented by these informal networks etc. Alternative sources of health advice with less state dependence and more family dependency.
Co-production	Co-productive health models; Patient expertise; Users as assets; Shared power.
Whole person care	A generalist and adaptable workforce to complement specialist care; reduced specialists; greater flexibility of roles/careers; more flexibility and co-ordination around the individual.
Care Access	Increased consumerism, evidence and transparency will drive greater access to 24/7 care with a need for more access across settings. There will need to be an increase in more flexible working, with hours and patterns that respond to patient need (recognising work/life balance); Remote working with I.T support may also support this.
Knowledge, skills and compassion	Increased training in relation to technology; Information and intelligence as a currency; Healthcare workers as knowledge brokers.
Expectations	Patients will expect no waiting; Patients will expect seamless, high quality care, 24/7 in a range of settings; more "active consumers" than "grateful citizens"; value, care and compassion will be expected above all else; Staff want a better work/life balance; More part-time working; Staff want more "time to care".
Informed, engaged and active	More appetite for health information; Greater use of technology to inform decisions but some inequality in technology access and use; More engagement to self-care and be active; Greater disparity between those who can and those who can't.
Communities of health	Blurring of roles between patients and professionals; More co-productive care; "Community of health" will include more family, friends and fellow sufferers; Increased isolation for some groups; Less distinction between physical and mental wellbeing.

Key workforce issues for NHS Vale of York CCG:

Alongside the Strategic Plan our workforce will need to be:

- Responsive and flexible, meeting the holistic needs of patients 24 hours a day, seven days a week;
- Multi skilled and multi trained for instance, joint roles between health and social care health, practice and community staff, practice, community and hospital.

To enable this we need to ensure that we are clear about the:

- Capacity modelling plan for our workforce for the next 1-five years;
- Development of models for recruitment, retention and succession planning;
- Develop, market and support local initiatives around training and learning i.e. GP registrars, advanced nurse practitioners and post registration practice nurses;
- Work with Health Education England (HEE) and our local university providers and colleges to deliver and support educational requirements.

Equally:

- Our care should be driven by evidence and research and supported by the latest technology i.e. tough books, single system entry into all care records no matter what system;
- With a greater role for the informal support role i.e. carers, families and communities, in line with localism.
- With a greater role for preventative self-care and management i.e. public health champions, volunteer public health champions and digital technology i.e. self-care apps.

NHS Vale of York CCG - our starting point:

Through our strategic planning and vision and by undertaking detailed work on capacity modelling we will ensure that the future model of care supports the health care workforce and its capacity plan for the future, so that we have a flexible, response, 24/7, fit for purpose workforce: the right skills, at the right time, in the right location.

In order to align 7-day working across primary, community and secondary care there will be the requirement to develop multi-disciplinary, multi-agency teams embedded with the care hubs, led by the most appropriate clinician who are equipped with the right skills to support assessment, diagnosis and treatment along the patient pathways which will include urgent, emergency and routine care.

Education will need to accommodate the delivery of the skills and competencies required to deliver a 7-day service across the sectors.
Modelling will also see a shift from increased numbers of staff working in an acute setting to the transfer of numbers and skill base into the community. This will have implications for education, training and development as well as culture and language change.

There is much work to be done to better understand and define the required roles, skills and knowledge required to deliver the integrated health and social care workforce for the future. There will also be opportunities to explore different ways of working i.e. opportunities for advanced nurse practitioners (assuming appropriate supply) to undertake tasks traditionally allocated to junior doctors and General Practitioners, hence enabling the reallocation of time/resources amongst junior doctors in secondary care and General Practitioners in Primary Care. The Vale of York CCG will need to work with HEE England to ensure the requisite vision and demand for staff for the future meets the supply. This in itself will also have implications for mentorship and coaching among the existing workforce.

In summary the Vale of York CCG's future workforce needs to be:

- Flexible (both in terms of roles/duties performed and location of service);
- Adaptable (to undertake new/alternative roles across different settings);
- Informed (to either make the right decisions or refer for appropriate advice);
- Multi Skilled (to undertake a variety of tasks and skills across different sectors);
- Resilient (to deal with both the change to working conditions but also culture).

And supported with appropriate education, training and governance structures that enable new ways of working across health and social care without compromising the quality of care and patient safety
The Vale of York will work closely with the HEE to look to model the workforce for the future. This includes:

- Workforce capacity and remodelling planning;
- Supporting the recruitment locally of workforce programmes;
- Influencing the commissioning of education and training for healthcare students.

What will success look like?

When a person turns to the NHS for help, their needs are met by professionals of the right numbers, skills, values and behaviours to provide high quality care:

- Patients able to self-care and treated in ways that recognise their needs
- Communities empowered to co- deliver care
- Better patient/provider relationships
- Reduced inequalities and greater high-quality care provision
- Improved technology and research whilst maintaining care and compassion

Building on the work of W. Edwards Demming, we are committed to the idea of the 'joy of work' and implementing this through our Care Hub model. This new approach will enhance the working environment and encourage key staff to defer retirement plans, increase retention and so bridge the potential staffing gap over the next few years.

Through workforce remodelling, working with the Local Education Training Board, universities and providers we will ensure that we have the right skill mix to deliver our ambitions.

Programmes such as the Advanced Training Practice in primary care and the new student nursing programme inclusive of internships in primary care at the University of York have helped pave the way and the CCG will continue to work with provider and CCG members to build a future workforce, fit for purpose in line with our vision for success.

Governance

NHS Vale of York CCG works within a national framework for NHS bodies, and is governed through the Constitution, supporting policies and scheme of delegation. These are available on our website at the following links: http://www.valeofyorkccg.nhs.uk/data/uploads/constitution-version-2_15-08-13.pdf

http://www.valeofyorkccg.nhs.uk/publications/policies/

http://www.valeofyorkccg.nhs.uk/data/uploads/publications/policies/new/detailed-scheme-of-delegation.pdf

Council of Representatives
Health and Wellbeing Boards
Governing Body
Local Safeguarding Boards
Partnership Boards
Children's Trust
Learning Disabilities and Mental Health
PPE Forum and Steering Group
GP Forum
Remuneration Committee
Audit Committee
CCG Senior Management Team
Quality and Finance Committee (previously known as Performance and Finance Committee)
Collaborative Transformation Board
Information Governance Steering Group
Medicines Commissioning Group
Clinical Quality Group
Partnership Commissioning Unit (PCU)
Contract Management Boards and sub-groups
Programme Delivery Steering Group
Urgent Care Working Group
Project Groups

The Health and Wellbeing Boards drive the implementation of the strategy across the whole health economy. The partnership structures underpinning the Health and Wellbeing Boards play a key role on monitoring the delivery of commitments within the plan.

Within the health infrastructure, the commitments will be translated into the contract management processes, and monitored monthly through contract management boards and quality and performance contract monitoring meetings. For areas of improvement across North Yorkshire or North Yorkshire and Humber CCGs, these are also monitored through the Strategic Collaborative Improvement Group and Collaborative Improvement Board.

The delivery of the Better Care Fund will be led through partnership groups, for example the Joint Delivery Group (City of York) and the Integrated Commissioning Board (North Yorkshire), which will report both to the CCG's Improvement and Innovation Steering Group and through to partners' boards as appropriate. This Board will lead on the transformation activity through the Better Care Fund and the development of Care Hubs.

Programme Delivery

The CCG has rigorous programme delivery framework in place in order to drive action and change in order to meet all the associated indicators, targets and priorities for improving the health and experience of our Vale of York population when accessing services they need.

Within the CCG, the Governing Body holds overall responsibility for the delivery of the strategic plan, with oversight of the plan through the Quality and Finance Committee.

The Programme Delivery Steering Group provides programme management of the improvement interventions and associated QIPP schemes within the operational plan, driven by all teams within the CCG. Each scheme of work within the Strategic and Operational Plans has associated impact measures and will have a named CCG lead that will hold accountability for the progress of the work, financial and quality impact. The Programme Delivery Steering Group reports directly to the Quality and Finance Committee.

The programmes of work set out in this plan, and the enabling projects will be overseen by the CCG Programme Office within the corporate team. Each scheme of work will follow a formal process including:

- An initial viability assessment;
- Business Case development and approval at the appropriate committee;
- Project plan and support project documentation, including a risk register, issues log and tolerances for timescales and resource;
- Monthly reporting on progress through the Innovation and Improvement Steering Group and monitored through the programme office;
- Highlight and exception reporting to Committee to monitor progress and manage changes to projects or programmes of work.

There are detailed plans for each programme of work which include the following:

Programme Delivery:	Supporting documentation:
▪ Description of the specific improvement interventions and purpose	Initial viability assessment Business Case Project plan
▪ The activity impact – what changes to volumes of activity delivered, where that activity delivered, by which provider and with what performance targets for on-going efficiency	QIPP Monitoring report Contract Monitoring report
▪ The finance impact – any investment required, contribution to financial gap and productivity	QIPP Monitoring template
Expected Outcomes: ▪ The impact on health outcomes – the trajectories (targets over five years) and indicators which give an indication or measure of improvement in health and social care outcomes ▪ The impact on specific health inequalities in the local population or within specific population groups ▪ The impact on patient experience of service ▪ The impact on quality and safety improvements ▪ The contribution towards delivering parity of esteem	Reporting on the specific metrics and indicators within each programme of work which can demonstrate progress in each of these areas.

Programme Delivery:	Supporting documentation:
▪ The impact on our local service providers and our contracts with them	Service Development and Improvement Plan in contracts Service Specifications Contract Variations
▪ The implications for procurement tendering for new, existing and re-commissioned services)	Procurement plans
▪ The timelines and phasing for each work-stream ▪ The significant milestones in that programme of change ▪ The enabling pieces of work which will drive and facilitate delivery and change by stakeholders (patients and providers) in order to transform	Project plan Flash reports (monthly) Workforce plans Estates plans
▪ The engagement and patient needs which drive each programme and which define what services need to look and feel like in the future	Engagement plan and events Collaborative partnerships and working groups
▪ Risks (barriers to success)	Risk assessment and mitigation plans

We are combining process improvements in the way we identify, plan and deliver improvement projects with a programme of training to embed a culture of delivery and assurance across the CCG which will help us to deliver measureable quality improvements with our partners. We are doing this through:

- Training the Innovation and Improvement team and clinical leads in lean methodology to support delivery of improvement events, and enhance planning and service delivery skills
- Identifying a Programme Management structure for key work themes and improvement projects
- Standardising the project management approach to service improvement to ensure accurate planning, reporting and evaluation of improvement projects
- Delivering projects through a team approach which includes a dedicated finance and governance lead to support the transformation and efficiency agenda.

We are investing in tools to enable systematic modelling of activity, finance and workforce impact, and an integrated programme and risk management tool (Covalent) to ensure consistent and systematic project management and risk reporting. This is supported by the CCG's 'lean' service improvement methodology and programme approach.

All Improvement Interventions will be managed in line with this systematic approach, with dedicated governance support to ensure all work is compliant with relevant governance processes, including risk, equalities, information management and procurement assessments.

Financial Governance

We are committed to a robust process for financial governance. This is underpinned in the Financial Policies and Procedures. The financial plan is an integral element of the strategic plan, and all planning assumptions are worked collectively between finance and innovation teams. All Improvement plans will have a direct finance support to ensure effective impact modelling and monitoring of spend. The Senior Management Team monitors the financial plan on a weekly basis to manage and mitigate operational risks.

The Quality and Finance Committee maintains oversight of the financial plan; receives and acts upon monthly reports on the financial positions and issues arising from the Contract Management Boards. The Audit Committee meets quarterly and scrutinises the financial plan assumptions and decisions. The Quality and Finance Committee and the Audit Committee report into the Governing Body and escalate key risks. The Chief Financial Officer provides a standing financial report to the Governing Body to provide update and assurance.

These processes embed the focus on good financial governance across the organisation. Assurance on these processes and their effectiveness is provided through our internal and external audit functions.

Annual Plan Reporting

The strategic and associated operational plan will be monitored monthly to assess the delivery against committed actions, performance and financial position to ensure that any emerging risks are addressed in a timely manner and to avoid slippage. This process will be led by the Quality and Finance Committee and reported to the Governing Body.

The Plan will be formally reviewed annually using both the financial and performance perspective, but also the ‘you said, we did’ framework and the results published to increase transparency for the public.

Procurement

Our five year strategy involves significant transformation including service review and potential procurement or re-procurement. We are already planning five major procurements from 2014-15, including the Out of hours services; mental health services and community services in order to establish the Care Hub Approach for fully integrated care in 2016-17.

Choice and competition

As a CCG we need to make a decision on where choice and competition for services is in the best interest of the patients and to do so the following factors would need to be considered:

- Needs assessment and the priorities of patients and communities
- The quality of existing services
- Feedback from service users
- Scope for quality and/or efficiency improvement
- Sustainability of existing service configurations
- The levels of clinical risk
- The need to maintain continuity of service
- The potential benefits of integration
- The availability and capacity of providers
- The scope for patient choice and control

The future aim is to enable health care services to be provided in an integrated way and the provision of health care services to be integrated with the provision of health-related or social care services where it considers this would:

- Improve the quality of services and outcomes
- Reduce inequalities between persons with respect to their ability to access services
- Reduce inequalities between persons with respect to outcomes achieved for them

Although the vast majority of procurements will fall within Part B of Schedule 3 of Part 10 of the Public Contract Regulations 2006 (the "Regulations") (and therefore not subject to the full scope of the Regulations), it is recommended, throughout the whole of any procurement process, to apply best procurement practice.

Healthcare Services are not subject to all competition law but must comply with competition obligations in S75 regulations and not engage in anti-competitive behaviour unless to do so is in the interests of people who use healthcare services

The NHS recognises that Procurement provides a transparent mechanism for securing new contracts for services which reflect patient and population needs. Done well, procurement can be a powerful tool for stimulating innovation and enabling improvements in quality and value. Procurement can stimulate or enable providers to develop new service models and/or

redesign care pathways to improve quality of care to patients (e.g. greater personalisation) and make better use of the available healthcare resources in responding to the diverse needs of patients and communities.

It is important to ensure that an appropriate procurement approach is followed to allow compliance and reduce the risk of legal challenge and has a system to facilitate efficient and effective communication with the provider market.

Innovation and Research

Supported by our member practices and partners, we are leading a range of system wide transformational programmes to improve health and social care outcomes for our population.

- Working in partnership with key stakeholders to identify and implement system change which benefits our communities across the health and social care system;
- Identifying examples of good practice nationally, undertaking benchmarking and other comparative data and utilising patient feedback information to identify areas for improvement;
- Working in partnership with organisations such as the University of York to establish robust evaluation mechanisms for key areas of work such as Community Hubs;
- Exploring opportunities to bid for any funding which will support testing new approaches to care delivery, and innovation across the health and social care system.

We are combining process improvements in the way we identify, plan and deliver improvement projects with a programme of training to embed a culture of delivery and assurance across the CCG which will help us to deliver measureable quality improvements with our partners.

We are doing this through:

- Training the Innovation and Improvement team and clinical leads in lean methodology to support delivery of improvement events, and enhance planning and service delivery skills;
- Rolling out this approach with partners such as City of York Council and acute providers to give a consistent approach to service improvement;
- Providing senior improvement support to clusters of primary care providers to explore innovation at scale and partnership working across the Vale of York locality;
- Identifying a programme management structure for key work themes and improvement projects;
- Standardising the project management approach to service improvement to ensure accurate planning, reporting and evaluation of improvement projects;
- Delivering projects through a team approach which includes a dedicated finance and governance lead to support the transformation and efficiency agenda.

Research

Objective: Opportunities for accessing and leading research to improve healthcare systems for all

Research is essential to support continuous improvements in quality, efficiency and patient outcomes across healthcare.

As a member of the Academic Health and Science Network our aim is to increase participation in research studies and clinical trials by our GP practices and local providers, contributing to Excessive Treatment Costs.

We are committed to using evidence-based research in our service developments and improvement interventions, drawing on experience and best practice internationally and within the UK. We work with the Academic Health Science Network to support this approach and develop our knowledge base.

All research and clinical trial work is overseen by the Clinical Quality Group within the CCG.

The CCG also has a Clinical Effectiveness and Research Group established which co-ordinates with the local CSU Horizon-Scanning and Impact Assessment Groups to identify new guidance, best practice, innovation and research relevant to the CCG's strategic initiatives.

The CSU also host the Northern and Yorkshire Primary Care Research Network and works with our GP practices to mobilise research studies.

Sustainability

We have committed to a Sustainable Development Management Plan (http://www.valeofyorkccg.nhs.uk/about-us/delivering-sustainability/) which addresses the financial, environmental and social sustainability of health care services the CCG commissions.

We ensure that every policy and service improvement initiative is reviewed from a sustainability perspective at both committee and Governing Body level.

Sustainability Objectives:

Domain	Actions:
Governance	• Embed sustainability within the CCG's policies and procedures and reinforcement of Board level commitment and responsibility. Raise awareness of sustainability across the workforce through organisation development. • Work with strategic partnerships (e.g. Health and Wellbeing Boards) to support sustainable development and better prepare and adapt to the predicted effects of a future changing climate. • Complete the Good Corporate Citizenship Self-Assessment Tool to set a baseline and identify opportunities for improvement. • Review the plan on an annual basis and report on sustainability in the CCG Annual Report
Travel	• Identify opportunities to reduce car usage by staff and patients: encouraging active travel; promoting low carbon models of care; encouraging the use of remote communication in place of face to face meetings and encouraging home working.
Procurement	• Commission health services which are environmentally, socially and economically sustainable. • Through the contracting processes ensure that the providers of services commissioned by the CCG are complying with national and local requirements on sustainability, including carbon reduction
Facilities Management	• Minimising impacts on the environment (reduce energy and water demand, minimise waste) and supporting the local community and economy.
Workforce	• Respond to local employment conditions and needs and proactively building a skilled local workforce, promoting the health and wellbeing of employees through our HR policies.
Community Engagement	• Understanding the local community and involving its members in decision making and scrutiny, the planning and delivery of healthcare and supporting a strong and sustainable local economy. • Identify innovative solutions from engagement.
Buildings	• Consider all relevant sustainability issues in the design and operation of new or refurbished buildings to reduce waste, energy and resource use e.g. promoting active travel, expanding green and natural spaces.
Adaptation	• Contribute to the development of strategic multi-agency plans for responding to emergencies in partnership with the Local Health Resilience Partnership (LHRP).
Models of Care	• Collaborate with cross sector partners to prevent illness, promote health and develop sustainable joint service plans. • Tailor healthcare so it is closer to home. • Work with cross sector partners and individuals to reduce inequalities.

The Climate Change Act 2008 is a long term legally binding framework to reduce carbon emissions, mitigate and adapt to climate change. Organisations are required to meet the following UK Climate Change Act Targets - reduction in CO2e2 by 2050 (1990 baseline):

- **34% by 2020**
- **50% by 2025**
- **80% by 2050.**

In addition the NHS has a separate short-term NHS target of 10% reduction by 2015 based on a 2007 baseline.

We are making some progress towards reducing our carbon emissions as an organisation, for example, we are now located in West Offices, a building with excellent sustainable design, construction and operation in a central location, which promotes active travel and public transport use. We also have a Sustainability Impact Assessment in place for staff to use when developing policy, Governing Body reports, services or projects, to consider positive and negative effects on financial, environmental and social sustainability.

As the major health commissioner, we have a role to play in promoting sustainability across the whole local health system, for example, through our membership of Health and Wellbeing Boards. Sustainability is aligned with a number of our and our partners' strategic objectives, specifically, integrating care and support and reducing health inequalities.

Equality and Diversity

Equality is a core principle of the NHS Constitution and embedded into the Health and Social Care Act 2010. What is more, as a public sector organisation we have a duty under the Equality Act 2010 to promote equality and eliminate discrimination and foster good relations. For more information please see our Equality, diversity and Human Rights strategy and implementation Plan 2013-2017, which is available on our website (http://www.valeofyorkccg.nhs.uk/about-us/equality/).

Our equality objectives are:

- To provide accessible and appropriate information to meet a wide range of communication styles and needs
- To improve the reporting and use of equality data to inform equality analyses
- To strengthen stakeholder engagement and partnership working
- To be a great employer with a diverse, engaged and well supported workforce
- Ensure our leadership is inclusive and effective at promoting equality

These objectives have been informed by evidence gathered from previous engagement activity, review of a wide range of documents and internal self-assessment using the Equality Delivery System.

We are also committed to a wider set of ambitions to embed equality within the organisation and our commissioning activity. This includes:

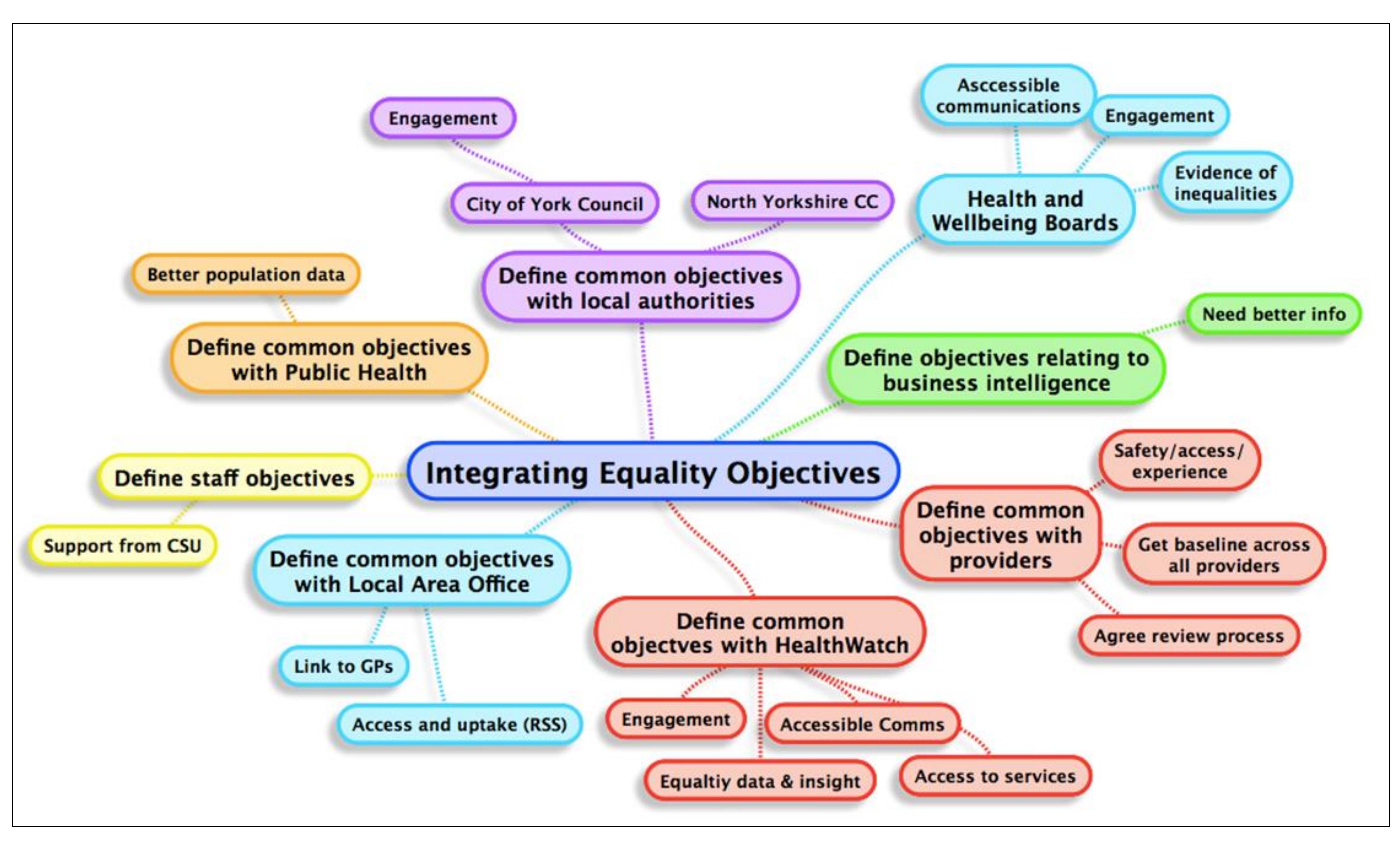
- Reducing health inequalities – a strategic ambition for us and the Health and Wellbeing Boards across our area.
- Committing to exploring the implementation of the living wage within our organisation and procurement.
- Developing the Joint Strategic Needs Assessments with local authorities to improve our understanding of our population.
- Further embedding equalities within our organisation development programme

We measure the equality impact of our decisions, through Equality Impact Assessments, to carefully consider the impact of the decisions we make on the population or on our staff, particularly for people who share protected characteristics.

We provide a range of health information on our website to promote equality, rights and diversity for our population and staff, for example:

- Health advice during Ramadan
- Health commissioning and race equality
- Lesbian, Gay, Bisexual and Trans Public Health Outcomes
- Women's voices on health and barriers to Primary Care

The diagram below shows the partners we will work with to embed our equalities objectives across all our work programmes.


Integrating Equality Objectives
Define common objectives with local authorities
City of York Council
Engagement
North Yorkshire CC
Health and Wellbeing Boards
Asccessible communications
Engagement
Evidence of inequalities
Define objectives relating to business intelligence
Need better info
Define common objectives with providers
Safety/access/ experience
Get baseline across all providers
Agree review process
Define common objectves with HealthWatch
Engagement
Accessible Comms
Access to services
Equaltiy data & insight
Define common objectives with Local Area Office
Link to GPs
Access and uptake (RSS)
Define staff objectives
Support from CSU
Define common objectives with Public Health
Better population data

Equality Impact Assessment

1.	Title of policy/ programme/ service being analysed
	My Health, My Life, My Way NHS Vale of York Clinical Commissioning Group Integrated Operational Plan 2014-2019
2.	**Please state the aims and objectives of this work.**
	The Integrated Operational Plan includes the following **Strategic Initiatives**: 1. Integration of Care 2. Person Centred Care 3. Primary Care Reform 4. Urgent Care Reform 5. Planned Care 6. Transforming mental health services 7. Children and Maternity 8. Cancer and End of Life And the following **objectives**: ▪ People will be supported to stay healthy through promoting healthy lifestyles improving access to early help and helping children have a healthy start to life ▪ People will have more opportunities to influence and choose the healthcare they receive and shape future services. ▪ People will continue to have good access to safe and high quality healthcare services ▪ When people become ill, they are treated in a timely manner with access to expert medical support as locally as possible ▪ Where people have long-term conditions they are supported to manage those conditions to give them the best possible quality of life ▪ When people are terminally ill, the individual and their families and/or carers are supported to give them the best possible quality of life and choice in their end of life care. ▪ A move to 'Care Hubs', providing increased access to health promotion, care and support services, including GPs, pharmacies, diagnostics (e.g. scans/ blood tests), community services, mental health support and social care and community and voluntary services.

	▪ High quality mental health services for the Vale of York, with increased awareness of mental health conditions, improved diagnosis and access to complex care within the local area. ▪ A sustainable and high quality local hospital providing a centre for urgent and emergency care and planned care for a wide range of conditions and elective operations, maternity and other specialisms within the Vale of York. ▪ Access to world class highly complex and specialist care provided through specialist centres across the country. ▪ Opportunities for accessing and leading research to improve healthcare systems for all
3.	**Who is likely to be affected? (e.g. staff, patients, service users)**
	The CCG represents patients registered with 32 GP Practices across the Vale of York area, equating to a population of 336, 330 residents. Equality is a key theme running through all the CCG's policies, strategies and plans and where possible we aim to improve access for our population, for example, increasing access to IAPT for all patients. The Integrated Operational Plan is wide ranging and encompasses the totality of the CCG's work and future ambitions to improve care and support over the next five years. There are a number of programmes of work and specific projects that will deliver this strategic plan. As part of the CCG's project management framework an Equalities Impact Assessment (EIA) is completed for all our projects. For the projects that are already being initiated, an EIA is in place. For those projects or interventions that have not yet evolved, an EIA will completed for each one during the Business Case development stage to assess how people or groups might be affected by any proposed changes to the health services we commission.
4.	**What sources of equality information have you used to inform your piece of work?**
	By being involved in the three Joint Strategic Needs Assessments across the Vale of York area, the CCG can gain a thorough understanding of its population – deprived communities, protected groups, and health and wellbeing need. This is particularly relevant to our ambition to reduce health inequalities. The CCG has a duty under the Equality Act 2010 to promote equality and eliminate discrimination and foster good relations. Our Equality, Diversity and Human Rights Strategy & Implementation Plan 2013-2017 includes the following objectives: 1. To provide accessible and appropriate information to meet a wide range of communication styles and needs 2. To improve the reporting and use of equality data to inform equality analyses 3. To strengthen stakeholder engagement and partnership working 4. To be a great employer with a diverse, engaged and well supported workforce 5. Ensure our leadership is inclusive and effective at promoting equality

	These objectives have been informed by evidence gathered from previous engagement activity, review of a wide range of documents and internal self-assessment using the Equality Delivery System.
5.	**What steps have been taken ensure that the organisation has paid due regard to the need to eliminate discrimination, advance equal opportunities and foster good relations between people with protected characteristics**
	The analysis of equalities is embedded within the CCG's project management framework. Every project must have a business case, with a completed EIA attached, for approval by the Quality and Finance Committee before they can be initiated. We are keen that equality impact assessment becomes embedded in the planning of our improvement work programme. This process will ensure that the CCG has paid due regard to the need to eliminate discrimination, advance equal opportunities and foster good relations between people with protected characteristics. Engagement and consultation with our stakeholders, especially patients and the public is also fundamental to our planning and project management. This enables us to fully explore the impacts of any proposed changes for our population, with those who will be affected.
6.	**Who have you involved in the development of this piece of work?**
	Stakeholder involvement: Our Integrated Operational Plan is based on extensive engagement with a range of stakeholders: staff, service users, patients and voluntary sector representatives. We have a well-established programme of engagement, 'Let's talk health' and we work closely with the three Healthwatch organisations across our area and more formally through our Patient and Public Engagement Steering Group (PPE), Patient and Public Groups (PPGs) in primary care with lay representation. To date we have engaged with our stakeholders on the following themes to plan improvements to services: ▪ Community Services ▪ Diabetes ▪ GP Out of Hours Service ▪ Long Term Conditions ▪ Mental health ▪ Neurology ▪ Palliative and End of Life Care ▪ The Better Care Fund (health and social care services) ▪ The CCG's Integrated Operational Plan for 2014-19.

	Please refer to the Annex 'You Said We Did' document within our Integrated Operational Plan for a summary of engagement activity. The Integrated Operational Plan is a strategic plan which sets out the CCG's vision for the next five years. This EIA is focused on the strategic aims and objectives within this plan. Those projects that are already underway have an EIA in place and will be for any future projects or interventions to explore any positive or negative impacts in more depth.
7.	**What evidence do you have of any potential adverse or positive impact on groups with protected characteristics? Do you have any gaps in information?** **Include any supporting evidence e.g. research, data or feedback from engagement activities** **(Refer to** Error! Reference source not found. if your piece of work relates to commissioning activity to gather the evidence during all stages of the commissioning cycle)

Disability People who are learning disabled, physically disabled, people with mental illness, sensory loss and long term chronic conditions such as diabetes, HIV)	Consider building access, communication requirements, making reasonable adjustments for individuals etc

The delivery of our strategic initiative **'Transforming mental health services'** within our Integrated Operational Plan will have a positive impact for people with mental illness.

- IAPT psychological therapies services currently have long waiting times and the inpatient estate at Bootham Park Hospital requires redevelopment. We plan to transform our mental health services in the local area to enable a greater parity of esteem between mental and physical health and ensure that timely, safe and quality care is equally as accessible as care for physical illness or injury.

This will be an area for investment for the CCG in the next five years, with a complete review of the model of provision and the supporting estate to ensure that it is fit for purpose.

We are currently working with City of York Council to carry out a 'deep dive' into mental health need across York. This information will inform our transformation of mental health services.

Sex Men and Women	Consider gender preference in key worker, single sex accommodation etc

The Integrated Operational Plan highlights the following findings relevant to men's health and women's health:

- Respiratory disease shows the gap between male and female coming together.
- Cancer - the gap between men and women is getting wider.
- A significant gap between men and women in CVD though this gap is closing.

We have an ambition to reduce the potential years of life lost (PYLL) from causes considered amenable to healthcare by 15%, which will be driven by our strategic initiatives set out earlier in this document.

Across the Vale of York there are significant differences in life expectancy for men (and women to a lesser extent) depending on where they live. The CCG is committed to working with partners, including Health and Wellbeing Boards to reduce health inequalities, not only between men and women, but between the most and least deprived populations.

Some examples of our current improvement interventions which are addressing key local health inequalities include reducing emergency admissions (urgent care – Emergency Care Practitioners, liaison psychiatry), frail elderly (integration / Care Hubs) and neurology (Planned Care).

Race or nationality People of different ethnic backgrounds, including Roma Gypsies and Travelers	Consider cultural traditions, food requirements, communication styles, language needs etc

The Vale of York population is majority white British (95%) and report their religious beliefs as Christian (64%) or of no religion (26%). There is a number of other significant ethnic groups including, Asian (2.2%), mixed race (1%), black (0.4%) and travellers & Roma Gypsy communities. There is also a diverse range of religious beliefs, including Muslim (0.7%), Buddist (0.4%), Sikh (0.1%) and Jewish (0.1%). We need to plan effectively for the different cultural, social and health needs of our community to everyone to achieve the best health and well-being.

Age This applies to all age groups. This can include safeguarding, consent and child welfare	Consider access to services or employment based on need/merit not age, effective communication strategies etc

Our Quality Assurance and Improvement function includes a focus on proactive safeguarding for both children, young people and adults deemed as vulnerable.

The CCG is increasing the capacity within both the children's and adults safeguarding teams to ensure there is the capacity to deliver a robust model of proactive assurance across the Vale of York. The CCG as the accountable health organisation for safeguarding have:

- An Executive lead on the Governing Body for safeguarding
- A GP lead on the Governing Body for safeguarding adults and children

- Are permanent members of the Local Safeguarding Children and Adult Board

Safeguarding is also embedded within all the work of the CCG, staff training and a full list of relevant policies are in place.

Children and Maternity is one of the CCG's strategic initiatives, supporting people to stay healthy through promoting healthy lifestyles, improving access to early help and helping children have a healthy start to life. Following the appointment of a Clinical Lead for Children and Maternity, we will start to scope this initiative over the next year.

It is also evident that we have an ageing population, which will have an impact on the care and support we will need to commission in the future. Our strategic initiative to integrate care is particularly relevant here to ensure that the local health and social care system is fit for purpose and sustainable to provide the right care to the right people at the right time.

The Workforce profile across the Vale of York suggests an aging workforce, especially in relation to General Practitioners and Practice Nurses. Building on the work of W. Edwards Demming we are committed to the idea of the 'joy of work' and implementing this across our Care Hub model. This new approach will enhance the working environment and encourage key staff to defer retirement plans, new staff to join and bridge the potential staffing gap over the next few years.

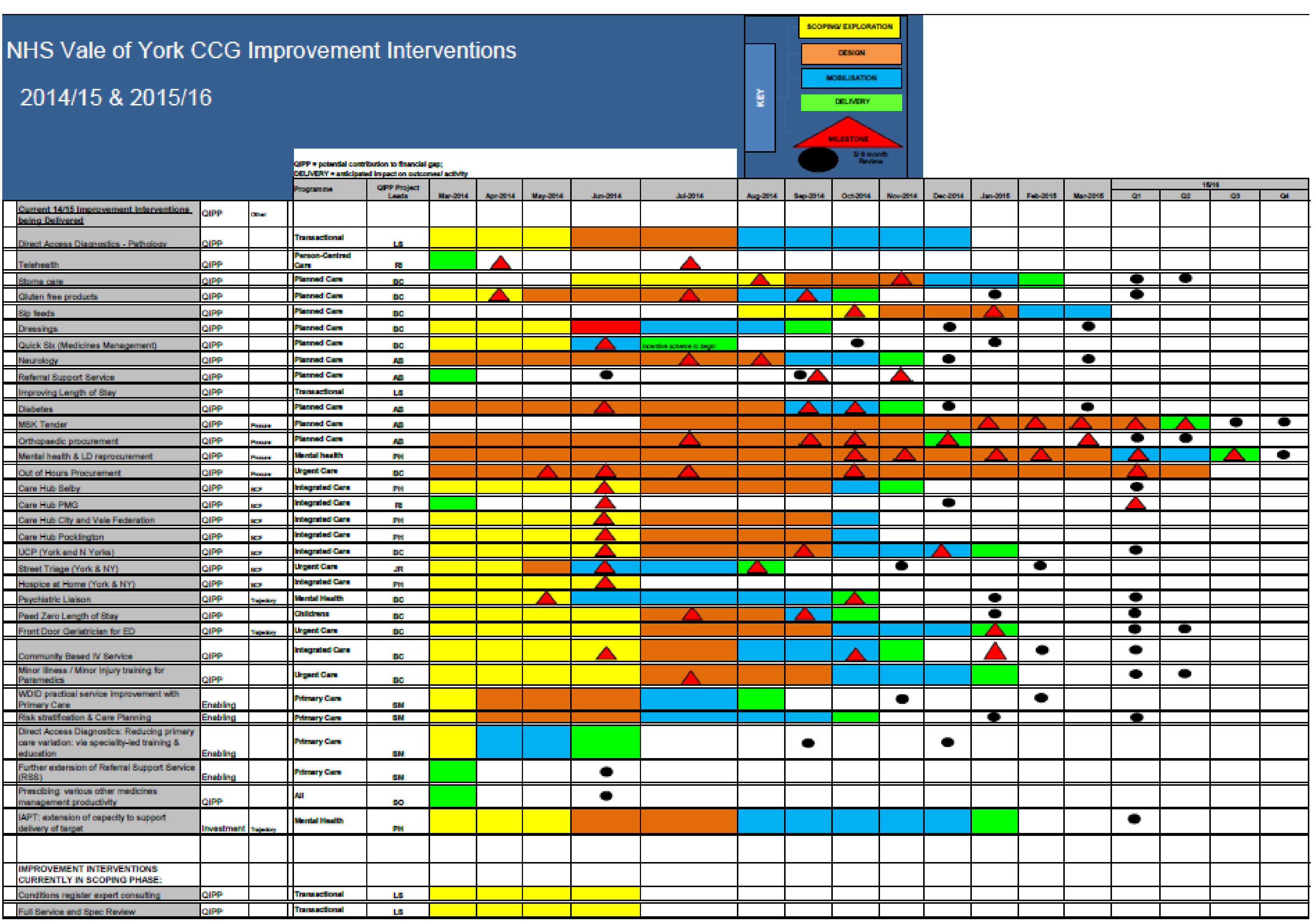
Trans People who have undergone gender reassignment (sex change) and those who identify as trans	Consider privacy of data, harassment, access to unisex toilets & bathing areas etc
None.	
Sexual orientation This will include lesbian, gay and bi-sexual people as well as heterosexual people.	Consider whether the service acknowledges same sex partners as next of kin, harassment, inclusive language etc
None.	
Religion or belief Includes religions, beliefs or no religion or belief	Consider holiday scheduling, appointment timing, dietary considerations, prayer space etc
None.	
Marriage and Civil Partnership Refers to legally recognised partnerships	Consider whether civil partners are included in benefit and leave policies etc.

(employment policies only)	
None	
Pregnancy and maternity Refers to the pregnancy period and the first year after birth.	Consider impact on working arrangements, part-time working, infant caring responsibilities etc.
None.	
Carers This relates to general caring responsibilities for someone of any age.	Consider impact on part-time working, shift-patterns, options for flexi working etc.
Supporting carers is a key theme throughout the Integrated Operational Plan, for example we want to improve the quality of life carers and young carers and ensure they are involved in the planning and delivery of care and support. This is particularly relevant to two of our strategic initiatives; Integrated Care and Person-centred Care.	
Other disadvantaged groups This relates to groups experiencing health inequalities such as people living in deprived areas, new migrants, people who are homeless, ex-offenders, people with HIV.	Consider ease of access, location of service, historic take-up of service etc.
To reduce health inequalities, the CCG is also responding to the recommendation from the JSNAs to work with local service providers to ensure that they record information on protected characteristics about their staff and clients / patients such as age, disability, gender re-assignment, marriage and civil partnership, pregnancy / maternity, race, religion and belief, gender and sexual orientation, in order to inform service provision to reduce health inequalities. http://www.healthyork.org/the-population-of-york/specific-population-profiles/lesbian,-gay,-bisexual-and-transgender-(lgbt)-population.aspx	

8.	**Action planning for improvement** The Integrated Operational Plan aims to improve services and access to them for patients, carers and the public, therefore having a positive impact across our population. The integrated Operational Plan is a strategic document setting out the five year vision for the CCG. Some projects are already underway to achieve this vision, which already have an EIA in place, including actions for improvement and any future projects or interventions will include an EIA as part of their business case before they can be initiated.

Sign off
Name and signature of person / team who carried out this analysis **Helen Sikora**
Date analysis completed **24 June 2014**
Name and signature of responsible Director **Rachel Potts, Chief Operating Officer**
Date analysis was approved by responsible Director

Annex 1: High level summary of all Improvement Interventions



Intervention			Programme	QIPP Project Leads
Current 14/15 Improvement Interventions being Delivered	QIPP	Other		
Direct Access Diagnostics - Pathology	QIPP		Transactional	LS
Telehealth	QIPP		Person-Centred Care	RI
Stoma care	QIPP		Planned Care	DC
Gluten free products	QIPP		Planned Care	DC
Sip feeds	QIPP		Planned Care	DC
Dressings	QIPP		Planned Care	DC
Quick Six (Medicines Management)	QIPP		Planned Care	DC
Neurology	QIPP		Planned Care	AB
Referral Support Service	QIPP		Planned Care	AB
Improving Length of Stay	QIPP		Transactional	LS
Diabetes	QIPP		Planned Care	AB
MSK Tender	QIPP	Procure	Planned Care	AB
Orthopaedic procurement	QIPP	Procure	Planned Care	AB
Mental health & LD reprocurement	QIPP	Procure	Mental health	PH
Out of Hours Procurement	QIPP	Procure	Urgent Care	DC
Care Hub Selby	QIPP	BCF	Integrated Care	PH
Care Hub PMG	QIPP	BCF	Integrated Care	RI
Care Hub City and Vale Federation	QIPP	BCF	Integrated Care	PH
Care Hub Pocklington	QIPP	BCF	Integrated Care	PH
UCP (York and N Yorks)	QIPP	BCF	Integrated Care	DC
Street Triage (York & NY)	QIPP	BCF	Urgent Care	JR
Hospice at Home (York & NY)	QIPP	BCF	Integrated Care	PH
Psychiatric Liaison	QIPP	Trajectory	Mental Health	DC
Paed Zero Length of Stay	QIPP		Childrens	DC
Front Door Geriatrician for ED	QIPP	Trajectory	Urgent Care	DC
Community Based IV Service	QIPP		Integrated Care	DC
Minor Illness / Minor Injury training for Paramedics	QIPP		Urgent Care	DC
WDID practical service improvement with Primary Care	Enabling		Primary Care	SM
Risk stratification & Care Planning	Enabling		Primary Care	SM
Direct Access Diagnostics: Reducing primary care variation: via speciality-led training & education	Enabling		Primary Care	SM
Further extension of Referral Support Service (RSS)	Enabling		Primary Care	SM
Prescibing: various other medicines management productivity	QIPP		All	SO
IAPT: extension of capacity to support delivery of target	Investment	Trajectory	Mental Health	PH
IMPROVEMENT INTERVENTIONS CURRENTLY IN SCOPING PHASE:				
Conditions register expert consulting	QIPP		Transactional	LS
Full Service and Spec Review	QIPP		Transactional	LS

Current 14/15 Improvement Interventions being Delivered	QIPP	Other		
High Cost Drugs / PbR excluded drugs	QIPP		Transactional	LS
Application of contract principles	QIPP		Transactional	LS
Full data quality review	QIPP		Transactional	LS
Readmissions review / audit refresh	QIPP		Transactional	LS
Management of internally generated demand (Consultant: Consultant referrals)	QIPP		Transactional	LS
Benchmarking practices and incentives	QIPP		Transactional	LS
Direct Access Diagnostics - Radiology	QIPP		Transactional	LS
Palliative Care Price & Contract Review	QIPP		Transactional	LS
Critical Care Review	QIPP		Transactional	LS
Data validation and Audits	QIPP		Transactional	LS
Community Transport	QIPP		Integrated Care	BC
Children's Asthma	QIPP		Childrens	PH
Gastro: explore outliers & constipation/continence	QIPP		Primary Care	SM
CVD (hypertension & prevention)	QIPP		Planned Care	SR
Community Pharmacy: initially minor ailments/treatments	QIPP		Integrated Care	JR/ RI
Ophthalmology Service Review	QIPP		Planned Care	AB
Cancer / EoL Pathway Review	QIPP		Cancer / EOL	PH
Dementia: increase diagnosis rates (increase knowledge and skills of practice staff, increase efficiency of screening, coding and links to memory clinics and care navigator)	QIPP		Mental Health	PH / LB
Doctor First - Avoiding unnecessary face to face contact	QIPP		Person-centred Care	SM
Low backpain pathway	QIPP		Primary Care	HW
Diagnostic Trailers, Mobile units	QIPP		Integrated Care	AB
Equipment Services to support discharge	Enabling		Integrated Care	JH
Nutrition and Care Homes	QIPP		Integrated Care	CD
Spinal Injuries	QIPP		Planned Care	AB
Near Patient Testing	QIPP		Primary Care / Integrated Care	SR
Mobile Dentistry Service to Residential Homes	QIPP		Primary Care	RI
Prescribing - repeat medications	QIPP		Planned Care	BC
Breast Disease / Pain	QIPP		Primary Care	SR
Emergency Health Care Plans (EHCP) Children's and Family Act Implementation: Implications of Care Bill		Mandatory	Children's & Maternity	PCU
Child and Adolescent Mental Health Services Strategy Review			Children's & Maternity	PCU
Maternity Commissioning Strategy			Children's & Maternity	PCU
Looked After Children Services			Children's & Maternity	PCU
Children with Lower Respiratory Tract Infections Review	QIPP		Children's & Maternity	PCU
CHC Price Re-negotiation for care packages (Pilot)	QIPP		Children's & Maternity	PCU
Review of dementia prescribing	QIPP		Mental Health	PCU
Review of high cost mental health prescribing	QIPP		Mental Health	PCU
Autism Pathway review			Mental Health	PCU
PCU Management Cost Reduction	QIPP		Mental Health	PCU
MH OOC Placements	QIPP		Mental Health	PCU
Addictions: brief interventions for over-drinking and binge drinking	QIPP		Person-Centred Care	PCU
Joint assessments of young people with CHC/ SEN/ Personal budgets before 18 years to manage enduring needs more jointly between health and social care	QIPP		Mental Health	PCU

Current 14/15 Improvement Interventions being Delivered	QIPP	Other																			
Survivorship Work			Cancer / EOL	CCG / CSU																	
Recovery Package and enhanced patient education			Cancer / EOL	CCG / CSU																	
End of Life Pathway Review	QIPP		Cancer / EOL	PH																	
Cancer pathway review and service redesign			Cancer / EOL	CCG / CSU																	
Cancer Diagnostics Review (link to West Yorkshire review)			Cancer / EOL	CCG / CSU																	
Review of Asthma prevalence in under 5 years (health inequality)			Children's & Maternity	PCU																	
Autism Assessment: pathway review to increase capacity			Children's & Maternity	PCU																	
Weight Management (focus on Selby population)			Person-Centred Care	CCG / CSU																	

Annex 2: Summary of all Improvement Interventions 2014-15 to 2015-16

The detail outlined below covers the first 2 years of the Strategic Plan and the programmes of work which have been prioritised and agreed for taking forward – these are either in delivery or currently being scoped to understand potential impact. Many of these are already well developed and progressing against their project plans. Many of the programmes will run for 3-five years (e.g. integration) and whole system change will be driven through them.

Strategic Initiative 1: Integration of Care

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
IN DELIVERY										
Emergency (Urgent) Care Practitioners (York & N Yorks) (BCF)	ECP's will clinically manage patients who have Urgent Care needs as close to home as appropriate, rather than conveying to hospital. The scheme will focus on 'Assess and Treat'; 'Assess and Refer'; and 'Assess and Convey' to alternative sites where appropriate.	1,343.9	Reduce A&E attendances and unplanned admissions at YTHFT. Reduce ambulance transfers to A&E and admissions at YTHFT.	Service specification completed and signed off – June 2014. Recruit and train ECP's. New pathway put in place – Sept 2014. 3 month service review – Dec 2014.	Successful recruitment and sustained employment of ECP's.	Agreement of risk share with YAS. Support from providers is not received.	390.7	AP	BC	YAS
Care Hub Selby (BCF)	The "community hub" model provides proactive and community-centred care for populations of around 50,000-	Year 1: 572.1 (FYE: 1,682.9)	Delivered in parallel with nationally-defined outcomes through the better care fund and local plan submitted, in addition to local	Formal approval of MoU and agreement to collaborate from Selby District GPs – June 2014.	CCG five year Strategic Plan. National integration strategy and	Significant and complex change programme.	Year 1: 280.8 (FYE: 591.9)	AP	PH	YTHFT

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
	100,000. The community hub model combines all resources of public sector, independent sector and community assets to deliver joined-up care and improved outcomes for the population it serves. YTHFT are working with 7 GP practices to lead this integration pilot in Selby for their population of c. 73,000 patients.		quality and performance metrics across a broad spectrum of care activities.	Develop workforce plan and initiate recruitment. Case managers in post - August 2014. Development of the community hub implementation plan. Launch community hub model – Oct 2014. Community Services procurement 2015/16	policy – Better Care Fund. Stakeholder and partner support. Financial and operational support. Provider programme lead. NHS Accelerate potential programme.					
Care Hub PMG (BCF)	Priory Medical Group is the provider lead for this integration pilot in York for their population of c. 55,000 patients.	Year 1: 150.0-450.0.	As above.	Programme plan and case submitted - Mar 14. Model initiated - April 14. Model implemented - June 14. Model evaluated and refined - June 14 onwards.	As above.	As above.	Year 1: 261.4	AP	RI	Priory Medical Group

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
Care Hub City and Vale Federation (BCF)	Possibility to introduce a 3rd Care Hub as a 2nd phase to the Priory integration pilot. Currently in discussions with the local providers, and scoping is being carried out.	TBC	Delivered in parallel with nationally-defined outcomes through the better care fund and local plan submitted, in addition to local quality and performance metrics across a broad spectrum of care activities.	Currently in scoping stage. Further milestones to be agreed.	As above.	Would be assessed and managed throughout development.	TBC	AP	PH	TBA
Care Hub Pocklington (BCF)	Possibility to introduce a 4th Care Hub. Currently in discussions with the local providers, and scoping is being carried out.	TBC	As above.	As above.	As above.	As above.	TBC	AP	PH	TBA.
Hospice at Home (BCF)	An expansion of the current Hospice at Home scheme to give more capacity to the team to cover weekend support for patients and carers on the EOL pathway.	810.0	Reduction in acute activity for patients on the EOL pathway. Increase of patients on the EOL pathway being cared for at home. Increase in number of patients who die in their place of choice.	If is invested in, 4 month trial to see if expected outcomes are delivered – Oct 2014. If desired outcomes are achieved will move from trial to full implementation – Nov 2014.		Concerns regarding capacity to deliver; costs of service and return on investment.	270.0	AP	PH	

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
			Increase in patient and carer experience.							
Community Service Review (Procurement)	On-going review of all community services in preparation for evaluation of integration pilots and future reprocurement.	TBC		Evaluation of Care Hubs and tender – 2015/16. Service start – 2016/17.						YTHFT
SCOPING										
Equipment Services to support Discharge	Improving efficiency of the Equipment Services to improve the delays of discharge.	Enabling & some potential savings	Discharge delays reduced. Patient Experience, due to better running of the equipment service.	Meeting to be held with the local commissioners to establish a working group to improve the efficiency of the equipment service – June 2014.	Integration pilots.		0.0	TBA	JH	YTHFT and other TBC
Diagnostic Mobile Units (CATS)	Procure a mobile care unit to provide a seven	TBC; but potential	Supports delivery of one of the five year strategic	TBC when Business Case presented.	Collaboration with local CCG's	Requires change to traditional in-	0.0	TBA	AB	TBA

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
	day (8am – 8pm) mobile outpatient care service which is easily accessible to GP's and patients. Ability to deliver provision where the demand is, and there is also flexibility to deliver services tailored to the commissioners requirements.	large savings.	aims: Reduce elective activity by 20% by 2018/19.		making any potential procurement more attractive to providers. Integration pilots. Community Service Review & Procurement.	hospital outpatient care model.				
Community Pharmacy	58% of those over 60 suffer from at least one long-term condition (LTC). LTCs risk being unmanageable without a significant change to the way care is provided - pharmacists can be integral to this change. Community pharmacists could provide an alternative triage point for many of the common ailments currently	TBC	Reduction in A&E attendances. Increased capacity and expertise in the system. Patient experience, patients being treated more locally.	Currently in scoping stage.	Included in EOI for co-commissioning of Primary Care (CCG & NHSE). Aligns with Care Hub approach. Community Services Review. LMC support strong.		TBC: Investment needed for training.	S'OC & Hazel Marsden	JR	TBA

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
	dealt with by out-of-hours services and Accident and Emergency departments.									
Community Based IV Service	Review the pathway for Bronchiectasis patients to assess suitability for home IV antibiotics. Patient assessment will be undertaken as well as the relevant diagnostic testing. This assessment (including physiotherapy assessment) should be undertaken by the specialist advanced nurse practitioner and take no more than 2 days (48hours) to complete. As part of the assessment, the specialist nurse has discussions with the patient to check their suitability for home IV	TBC	- Enables early discharge and frees up acute hospital beds - Prevents hospital admissions - Patients recover more quickly in their own home environment and can return to home life, work and school more quickly - Reduced risk to patients of developing nosocomial infections - Encourages patient choice						BC	TBA

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
	antibiotics. The plan is to discharge home these suitable patients within 48hours.									
Nutrition and Care Homes									CD	
Community Transport									BC	

Strategic Initiative 2: Person-Centred Care (Self Care, Wellbeing and Prevention)

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
IN DELIVERY										
Telehealth	Service decommissioned secondary to a full service evaluation.	180.0	Service reviewed with GP Practices and public in line with quality and outcome considerations.	Service decommissioned; Cost Savings Realised (£168k); Project close-down – April 2014. Remaining unit locations defined-July14.		Existing users of Telehealth equipment managed in line with assessment of on-going needs.	0.0	CCG	RI	Tunstall
Doctor First	Reduce unnecessary face-to-face contact between patients and healthcare professionals by incorporating technology into these interactions.	TBC	- Reduced face to face interactions - Faster & more convenient services - Improving choice and patient satisfaction.	Establish a working group with Trust & CCG representatives to agree implementation plan and milestones – June 2014.	Provider engagement.	System connectivity.	TBC	TBA	SM	TBA
SCOPING										
Weight Management	Introduce a weight management programme with the key components highlighted from NICE guidance to be included, to tackle obesity. Specific focus on targeting obesity levels in Selby.	TBC	- To be compliant with NICE guidelines. - Improve the health of overweight and obese people. - Effective services available to support people in the long term.		Work with local authority to deliver well-being plan (includes reducing obesity prevalence).		TBC	TBA	TBA	TBA

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
Addictions: Binge Drinking and Over Drinking.	Interventions to be implemented for binge drinking and over drinking.	TBC					TBC	TBA	PCU	TBA

Strategic Initiative 3: Primary Care Reform

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
IN DELIVERY										
Low Back Pain Pathway	To implement a pathway for the small cohort of patients who could potentially suffer with motor loss as a result of low back pain.	0.0	- To standardise a pathway in primary care for patients who suffer from low back pain, with associated motor loss. - To improve the quality of care received for those suffering from low back pain and prevent potential long term damage by the early detection and treatment of motor loss.	Pathway launch event - July 2014.	Partnership working with the MSK, Pain, Radiology and ED teams at York Teaching Hospitals Foundation Trust.	Small cohort of patients to target for launch event.	0.0	SO'C	HW	PH
WDID Service Improvement	Project being carried out at 4 GP Practices using Lean methodology to create efficiencies within the practices, to enable GP's to free up some of their time to work on additional activities.	0.0	- Better use of resources at GP Practices.	4 GP practices to be reviewed – July 2014. Roll out Lean methodology across more practices – September 2014 onwards.	GP engagement.	GP take up and adoption.	30.0	TM	SM	TBA
Risk Stratification &	System tool used by GP's to identify	0.0	- Better management of	System to go live June 2014.	GP engagement.	GP take up and	0.0	TM	SM	TBA

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
Care Planning	patients at high risk of hospital admission.		high risk patients. - Supports care plans for patients. - Reduce hospital admissions.		Successful implementation of the system tool.	adoption.				
Diagnostics Direct Access	Undertake GP practice diagnostics demand benchmarking triangulated with outpatients demand to identify best practice and outliers. Provide training to primary care clinicians to eliminate waste and ensure appropriate diagnostics are carried out. Conduct a joint demand efficiency review to eliminate waste and duplication of tests.	TBC	- Improve knowledge of Primary Care clinicians to maximise value from the service. - Provision of a sustainable and affordable service.	Establish a working group with Trust and CCG representatives to agree implementation plan and milestones – June 2014.			0.0	TM	SM / LS	TBA
SCOPING										
Mobile Dentistry Service to Residential	The CCG will commission a dedicated dental service for care	TBC	Ensure that patients maintain their optimum level of health.	Currently in scoping stage.	Sufficient numbers of patients in these homes		TBC	TM	RI	TBA

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
Homes	and nursing home residents that builds on international evidence with local support from the Local Dental Network. This initiative is in response to the currently unmet need of this group of patients. Evidence suggests that poor oral hygiene leads to malnutrition which in turn leads to weight loss and decline in physical wellbeing. This can push an already compromised older person into an irreversible decline.				to make the provision of a mobile dental unit a viable proposition. Forms part of the portfolio of schemes within our "Co-commissioning Primary Care" with NHSE submission.					
Breast Disease / Pain	Local criteria for breast pain referrals to be updated to enable a shift from these patients being managed in secondary care to	TBC: Greater than 50.0	- Reduction in new breast pain referrals, outpatient attendances and mammogram activity.	Currently in the scoping stage.			0.0	TM	SR	TBA

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
	be predominantly managed in primary care.		- Patient's anxiety to be better managed.							
Near Patient Testing / Anticoagulation	Introduce near patient testing to be based in the Community / Pharmacists / GP Practices.	TBC: Potential for large savings to be made	- Patient experience: closer to home. - Release capacity at YTHFT.	Currently in the scoping stage.	LES agreements for anti-coagulation monitoring with 32 GP Practices.		TBC	TM	SR	TBA
Gastroenterology	Exploring what areas of Gastro activity can be managed better in primary care. Initially the focus will be on the management of constipation.	0.0	Improve knowledge of Primary Care clinicians to maximise value from the service.	Data analysis to start being carried out to identify high activity areas – July 2014.	GP engagement.	Lack of GP engagement.	0.0	TM	SM	TBA

Strategic Initiative 4: Urgent Care Reform

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
IN DELIVERY										
Street Triage (York & N Yorks) (BCF)	This scheme sees Mental Health professionals working with NY Police to provide timely and appropriate interventions to individuals at their contact point with the police. The scheme will operate at 14:00 to 23:59 seven days per week.	450.0	- Reduction in A&E attendances - Reduction in S136 detentions - Improved outcomes for mental health patients in crisis	- Recruitment, interviews and training – June 2014. - Operations commence – August 2014. - 3 month review – Nov 2014.		Unable to recruit staff to posts. Inability to agree operational model between LYPFT and NYP.	198.8	AP	JR	NY Police LYPFT CYC
Out of Hours Procurement	On-going re-procurement of the GP Out of Hours service.	0.0	More effective, efficient service, meeting NQR's to improve patient service.	- Provider engagement May 2014. - Development of service specification – May 2014. - Tender period and evaluation June/July 2014. - Contract Awarded Oct 2014. - Contract start date April 2015.		Lack of interest in contract from providers.	0.0	AP	BC	YTHFT ED and Capital Plannin g Dept.
SCOPING										
Emergency Department Geriatrician	A significant number of patients enter ED	TBC	Improve patient experience.	Currently being scoped.	Care Hub approach	Unsuccessful recruitment to the	TBC	AP	BC	TBA

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
	every day who are frail elderly with a number of significant medical and care needs. Patients would be 'greeted' at the front door by experienced geriatricians who can recognise specific frailty markers. Patients would have fast-track access to therapy teams, outpatient clinics and to other holistic support.		Reduce admissions, and bed days post admission.	Milestones to be agreed.		Geriatrician post.				
Minor Illness / Injury training for Paramedics	Providing training for YAS paramedics so they are able to treat a number of conditions (minor injury or illness) at the scene, reducing the need for transportation and ED attendance.	Potential for 153.00 TBC	Reduction in A&E attendances. Increased capacity and expertise within the system.	Training packages and competency frameworks set up to pilot this scheme. Dates TBC.			TBC	AP	BC	YAS

Strategic Initiative 5: Planned Care

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
IN DELIVERY										
Stoma Care	£1.5M budget currently directly attributed to Stoma Appliances across 25,000 items. Potential interventions with Trust/Stoma Nurse/associated companies and Hospice for joint working.	150.0	- Increase in patient experience / satisfaction. - Reduction in wastage. - Appropriate prescribing undertaken.	Implementation plan to be developed – commence Nov 2014.	Prior work on gluten free products and dressings as example reviews and formulary updates.	Joint working with YTHFT and private suppliers. Patient choice.	0.0	SO'C	BC	YTHFT
Gluten Free Products	Review and update prescribing list initially followed by review of prescribing/supply route. Review with gastroenterology consultants to discuss criteria and to work with biopsy tests.	62.0	Provide clear pathway for future patients. Clear criteria around future prescribing.	Key recommendations from options paper agreed – April 2014. Implementation plan developed to include communications plan – July 2014. GP awareness complete and changes made – Sept 2014.	Patient satisfaction around clear tests and fair prescribing Public satisfaction around fair usage of NHS funds Evidence of other areas doing similar work.	Patient choice; dissatisfactio n around tests required and limitation of products GP availability for tests Costs of testing	0.0	SO'C	BC	YTHFT Dr. Gerry Robbins
Sip Feeds	£1.2M budget currently directly attributed to Sip Feeds; potential to work up scheme with	120.0	Clear pathways for patients to be assessed for treatment to support GP's and secondary	Implementation plan to be developed – Jan 2015.	Prior work on gluten free products and dressings as example reviews and	Joint working with YTHFT and private providers. Patient	TBC: 15.0 (for potential investment in a Dietician)	SO'C	BC	YTHFT Private Provider s

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
	dietician involvement, with a review of prescribing recommendations.		care staff. Greater patient management and integrated working.		formulary updates. Patient satisfaction around clear pathways. GP satisfaction around wastage of items.	choice; dissatisfaction around limitation of products.				
Dressings	Introduction of an Online Non Prescription Ordering System (ONPOS). Combined with increased formulary compliance through raising awareness of the existing Tissue Viability Handbook and Formulary, through running awareness sessions.	At least 125.0	- Reduction / prevention of re-admissions to secondary care. - Improved patient care, and patient experience. - Increased adherence to wound care formulary and a reduction in wastage.	Scheme approval at SMT – end June 2014 Implementation phase – July/Aug 2014. Begin rollout - Sept 2014.	SMT approval. Buy in from Community Services and General Practices. Support from private provider to implement.	Lack of engagement from staff. Difficulties in using technology. Lack of support from private provider to implement.	0.0	SO'C	BC	

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
Quick Six (Medicines Management)	Changed to a 'Quick Switch' scheme; a number of items have been identified which are either non-formulary or non-commissioned, or where cheaper generic alternatives have been identified. There is also a list of quality improvements to be adhered to with a financial incentive attached. The CSU prescribing team supports practices to do this.	160.0	- Management of drugs that are unsafe or no longer supported. - Switch to generic equivalents where required. - Requirement for practices to engage with process promotes engagement.	Incentive scheme to begin – June 2014.	Previous work on incentive scheme during 2013-14. Prescribing website and newsletters. Payment for success. CSU Medicines Management team to support as well as new CCG pharmacy post.	Needs whole group sign up. Reluctance to change prescribing for long term patients. CSU support limited. Patient choice.	0.0	SO'C	BC	Practices
Neurology	Implementation of an integrated care pathway as agreed to address outcomes from NCS service redesign work. Implementing four pathways: Epilepsy, Motor Neuron Disease, Parkinson's Disease, and Multiple Sclerosis	182.7	Reduction in elective and unplanned admissions.	- Completion of 4 condition integrated pathways- July 2014. - GP training of Neurology awareness – Aug 2014. - 3 month review / evaluation of the service – Dec 2014.			TBC	S'OC	AB / JH	AH (Neurology Consultant YTHFT

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
Referral Support Service	Introducing a Referral Support Service to supports patient referrals from primary care into secondary care in a more timely and efficient manner. GP reviewers are also introduced to triage referrals prior to being booked into secondary care.	249.0	- Increased access for patients to the Choose and Book service – Patient Experience. - Improved efficiency and speed of the referral process. - Highest quality of safe care. - Eliminating any waste of resource. - Greater job satisfaction. - Reduction in referrals into secondary care.	Service evaluation completed – Nov 2014.			TBC	S'OC	AB	
Further extension of Referral Support Service (RSS)	An expansion of the current RSS project looking at several new areas including: Gastroenterology, Cardiology and Neurology.	TBC	Increased access for patients to the Choose and Book service. Improved efficiency and speed of the referral process.	Reviewers for Gastro, Cardiology, and Neurology recruited – Sept 2014.			TBC; will be investment required to recruit to new posts.	S'OC	AB	
Diabetes	Provide a community based diabetes service based on an integrated care	152.7	Supports the delivery of an improved first to follow up outpatient ratio.	- Finance/ Contracting agreement with YTH – June 2014.			0.0	S'OC	AB / JH	VJ (Consultant), JM (Directorate

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
	approach and closely link to development of NCTs.		Patient care is provided in a more convenient, community based setting for the patient.	- Launch CDT plus GP enhanced service launch event – Sept 2014. - GP sign up for enhanced services – Oct 2014. - Service Implementation – Dec 2014. - Formal service review – Mar 2015.						Manage r)
Musculoskelet al (MSK) Tender	On-going re-procurement of the MSK service. The future service should provide a fully integrated MSK service, delivered through a hub and spoke model, with strong links to current and future orthopaedic pathways. Maximum use should be made of the interface with the Referral Support Service (RSS) to make sure patients	0.0	Patient experience. Efficiencies due to patients accessing the correct pathway first time.	- Publish advert and PQQ – Jan 2015. - PQQ evaluation, Finalise specification and ITT documentation – Feb 2015. - Tender evaluation – Mar 2015. - Tender awarded – Q1 2015/16. - Mobilisation and service start – Q2 2015/16.	Support from the RSS.	Lack of market engagement in the provision of the procured service.	0.0	S'OC	AB	YTHFT

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
	access the new service on the most appropriate pathway from the start.									
Elective Orthopaedic Tender	Procurement of the elective orthopaedic service currently provided at Clifton Park Hospital.	0.0	To be delivered from a community based setting to maintain accessibility for patients and carers.	Publish advert and PQQ – Jul 2014. PQQ evaluation, Finalise specification and ITT documentation – Sept 2014. Tender evaluation – Oct 2014. Tender awarded – Dec 2014. Mobilisation and service start – Mar 2015.		Lack of market engagement in the provision of the procured service.	0.0	S'OC	AB	Clifton Park Hospital
Ophthalmology Service Review								S'OC	AB	
Cardiovascular Disease (CVD) Hyper tension (prevention focus)	The Commissioning for Value pack identified CVD as an area with high potential to improve outcomes, quality and efficiency. The prevalence is significantly higher for stroke,	TBC: Potentia l for up to 157.0	Reduction in LoS for CVD admissions. Early identification of atrial fibrillation. Improved commissioning and quality of hypertension	Currently in scoping stage. Milestones to be agreed.			TBC	S'OC	SR	TBA

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
	hypertension, AF and CHD. The focus will primarily be on Hypertension. Provide more care and treatment in primary care and the community.		services.							
Prescribing – Repeat Medications		TBC					TBC	S'OC	BC	
SCOPING										
Spinal Cord Injuries (SCI)	Develop a proactive and preventative approach to enable people with SCI to live healthy, active lives. Develop an integrated care pathway that will integrate health and social services, specialised and CCG commissioning services.	TBC: Possible saving of up to 109.0 (based on £0.32 saving per head of populati on)	Reduce hospital admissions and length of stay when patients with SCI are admitted. Improvement in care will reduce avoidable harm.	Data analysis: identifying health and social care spend and activity – July 2014. Review of existing services completed & recommendations for implementation – Jan 2015.			9.0	S'OC	AB	TBA

Strategic Initiative 6: Transforming Mental Health and Learning Disability Services

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
IN DELIVERY										
Improving Access to Psychological Therapies (IAPT)	Enable the CCG to strive towards achievement of the NHS England mandated target where a minimum of 15% per annum of those in need will be able to access psychological therapy services. Potential to involve voluntary sector in accessing additional capacity to achieve 15%.	TBC	Fewer people will be in contact with secondary mental health services. NHS England targets will be achieved.	Request to seek additional provision from the voluntary sector to enable us to achieve the national 15% target. Agreed to achieve local target of 8% with LYPFT - March 2015.	Additional funding £290k to LYPFT	Approval of funding request £291-£500k subject to agreement of process and capacity modelling.	Up to 500.0 to seek additional provision to achieve national target of 15%. 290.0 to achieve the 8% with LYPFT.	LB	Partnership Commissioning Unit (PCU)	LYPFT
Psychiatric Liaison	Provision of an integrated liaison service to meet service gap around working-age adult urgent mental health care.	TBC	Service gap filled to provide urgent / crisis care for adults not currently supported by the existing MHALT.	Trust to work alongside mental health partners to ensure service is well integrated and benefits realised – Sept 2014.	Link to Urgent Care agenda and Integration initiatives.		TBC	LB	BC (PCU)	WQ, SR (YTHFT)
Dementia **Diagnosis Rates Improvement**	Pilot review of dementia coding in Primary Care to work towards the national target. Increase knowledge and	0.0	Achieve national target of 2/3 of people with dementia identified and given appropriate support.	Run a GP education session to other practices – March 2014.			0.0	LB	PH (PCU)	LYPFT

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
	skills of practice staff, increase efficiency of screening, coding and links to memory clinics and care navigator.									
Mental Health & Learning Disabilities Service Review and Procurement	On-going review and re-procurement of the Mental Health and Learning Disabilities service.	All opportunities for efficiency/ productivity gains to be explored.	More effective, efficient service, to improve patient service.	- Start of procurement process Oct/ Nov 2014. - Tender evaluation Jan 2015. - Tender awarded and state of mobilisation Q1 2015. - Service start date Q3 2015.	CCG Priority for Transformation- Care Hub Approach.	Lack of interest in contract from providers, and thus not a competitive tender.	0.0	LB	PH (PCU)	LYPFT
SCOPING										
Review of Dementia Prescribing								LB	PCU	
Review of High Cost Mental Health Prescribing								LB	PCU	
Autism Pathway Review								LB	PCU	
PCU Management Cost Reduction								LB	PCU	
Mental health Out of County Placements								LB	PCU	

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
Joint assessments of young people with Continuing Healthcare / SEN								LB	PCU	

Strategic Initiative 7: Children's and Maternity

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
IN DELIVERY										
Personal Health Budgets (PHB)	Offer of personal budgets to continuing healthcare (CHC) patients. Patients with Long Term Conditions (LTC) offered a personal budget by CCG.	0.0	Better use of existing funding in line with patient choice and control.	Offer from - April 2014. Patient right by – Oct 2014. CCG need to offer LTC patients a personal budget - April 2015.		Unclear processes.	0.0	EB	PCU	NYCC CYC YTHFT
Paediatric Urgent Care - Zero Length of Stay	Reduce unnecessary unplanned admissions with a zero length of stay for paediatrics under the age of five.	TBC	- Fewer attendances at A&E. - Fewer admissions once attended A&E. - Increased reassurance for parents about the correct pathway.	Review, scoping and project plan – June 2015 Individual projects identified – Sept 2015 Testing and audit. Strategic overview.			0.0	AP	BC	TBA
Autism Pathway Review and Assessment	Increase children's autism diagnostic assessment capacity and reduce waiting times.	TBC	Quality clinical assessments which meet NICE guidance recommendations. NICE KPI 13 weeks from referral to first appointment achieved.	All new referrals will be seen within 13 weeks and meet national KPI – Sept 2014.	Increase funding into autism diagnostic assessment service from April 2014.	Recruitment of staff with appropriate level of skills and experience.	TBC	EB	PCU	LYPFT

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
SCOPING										
Emergency Health Care Plans (EHCP) (Children and Families Act 2014)	Health professionals must participate in the development of person centred EHCPs, according to the Children & Families Act Code of Practice statutory guidance for all health organisations.	TBC	Process of EHCP within 20 week timescale. Agreed outcomes across Education, Health and Social care. Person centred planning. Single process for families.	Outcome focused framework formed and agreed across all partners; including parent/children/YP – From Sept 2014.	Pathfinder and regional champion for NYCC and CYC. Project Steering Groups which report to Children's Trust Board.	Health professionals adapting to change of process. Health profession have a reduced timescale from 26 to 20 weeks for EHCP process.	TBC	EB	PCU	NYCC CYC YTHFT
CAMHS Clear Pathway: Tiers 1 to 4 CAMHS	Review of Child and Adolescent Mental Health Service (CAMHS) Strategy and provision to ensure we have a comprehensive service in place.	TBC	Increasing preventative offer across schools CYC. Address patients' level of need more accurately, and deliver treatment in a more timely way.	Action plan to be implemented following sign off by CAMHS executive – TBC.			TBC	EB	PCU	NYCC CYC LYPFT
Children's Asthma	Review of Asthma prevalence in under five years (health inequality).	TBC					TBC	AP	BC	PCU
Looked After Children's Services	Enhanced health review/ assessments and health promotion service.	TBC					0.0	TBC	JH (PCU)	CYC NYCC ERYC

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
Revised Maternity Commissioning Strategy	Includes development of a maternity dashboard.	TBC			Yorkshire and Humber Children's and Maternity Work Programme		0.0	TBC	JH (PCU)	S&R CCG ERY CCG HARD CCG
Continuing Healthcare Price Re-negotiation for care packages (Pilot)		TBC					TBC	EB	PCU	
Emergency Admissions for Children with Lower Respiratory Tract Infections	Commissioning for value packs for the CCG identified. Further exploration when children's packs from PHE are released.	TBC			Children's Packs PHE		0.0	TBC	JH (PCU)	CYC NYCC ERYC PHE

Strategic Initiative 8: Cancer, Palliative & End of Life Care

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
IN DELIVERY										
Palliative Care Review	Joint review of Palliative Care services provided across Acute, Community and voluntary sectors to ensure the provision of current care packages are the most appropriate for the local population. Potential future procurement.	TBC	High quality care in the most appropriate setting for patients. Increased understanding of services available.	Establish a working group with Trust and CCG representatives to agree implementation plan and milestones – June 2014.	Price and contract review and exercise to be completed by CCG contracting team.		TBC	JM	PH	TBA
Cancer and End of Life Pathway Review	Review and redesign of cancer pathway. Potential future procurement.				Survivorship work and network plans.					
SCOPING										
Survivorship Work	Re-launch of national Survivorship Work including further risk stratification pathways and build upon research completed on breast / head and neck /colorectal / prostate cancer.	TBC (small potential for cost savings) Mostly quality improve ments.		Currently at scoping stage.			TBC; but will require a level of investment.	JM	CCG / CSU	TBA

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
Recovery Package	Introduction of a recovery package and enhanced patient education.	TBC: Up to 50% reduction in follow up costs.	10% reduction in unplanned admissions to offset increases in new activity.	Currently at scoping stage.			TBC; but will require a level of investment.	JM	CCG / CSU	TBA
Service Redesign	Service redesign to be carried out in areas of high activity (e.g. Urology Service Redesign).	TBC		Currently at scoping stage.			TBC	JM	CCG / CSU	TBA
Cancer Diagnostics Review	A diagnostics review to be carried out with West Yorkshire.	TBC		Currently at scoping stage.			TBC	JM	CCG / CSU	TBA

Transactional Initiatives

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
Diagnostics Direct Access - Radiology	Price benchmarking work being undertaken to benchmark our local provider against other organisations.	375.0					0.0		LS	YTHFT
Direct Access Diagnostics – Pathology	YTHFT to support and work collaboratively with the CCG to review and manage diagnostics direct access demand to ensure service remains sustainable Undertake GP practice diagnostics demand benchmarking triangulated with outpatients demand to identify best practice and outliers (will require data to be provided by the Trust)		Improve knowledge of Primary Care clinicians to maximise value from the service. Provision of a sustainable and affordable service.	Establish a working group with Trust and CCG representatives to agree implementation plan and milestones – June 2014. Further milestones to be agreed.				TBA	SM	TBA

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
	Provide training to primary care clinicians to eliminate waste and ensure appropriate diagnostics are carried out Conduct a joint demand efficiency review to eliminate waste and duplication of tests [this is in addition to the Pathology price based QIPP separately discussed relating to price benchmarking]									
Improving Length of Stay	Undertake an efficiency review to identify and implement innovations to reduce length of stay for admitted patients. This is linked to the Discharge planning scheme recently undertaken.	375.0	- Patients benefit by spending less time in hospital with less risk of cross infection. - Trust benefits through greater efficiency. - CCG benefits through	Establish a working group with Trust and CCG representatives to agree implementation plan and milestones - June 2014. Further milestones to be agreed			0.0		LS	YTHFT

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
			reduced excess bed day expenditure.							
Critical Care Review	YTHFT and CCG to work collaboratively to review all aspects of the Critical Care Service and pathways to ensure the best quality and value for money services are provided to patients i.e. reviewing skills mix, bed numbers, researching best practice, review costings	TBC	Identification and implementation of best practice to benefit patient care.	Establish a working group with Trust and CCG representatives to agree implementation plan and milestones – June 2014.			TBC		LS	YTHFT
Application of Contract Principles	Rigorous application of all principles.	TBC	Optimisation of all contractual levers.	July 2014-March 2015					LS	YTHFT LYPFT
High Cost Drugs / PbR excluded drugs	High cost drugs information must be collected and provided at patient level including an indication of the condition drugs are prescribed for in order to enable commissioners to	TBC	Failure to provide patient and indication data will result in non-payment of high cost drugs given a reasonable period of time	Establish a working group with Trust and CCG representatives to agree implementation plan and milestones – June 2014.		Provider not implementing appropriate recording systems in a timely manner. This will result in non-payment of	0.0		LS	TBA

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
	validate payment.		to implement appropriate recording systems (timescale to be agreed)			high cost drugs.				
Full Data Quality Review	Part of Data Quality Improvement Plan	TBC							LS	YTHFT
Outpatient Service Review	To undertake a joint process of clinically driven consultation to review and reshape the outpatient service. Consultants and GP's will be supported to engage and work collaboratively towards developing innovative solutions to managing demand and transforming current services		Improved quality and convenient provision of health services to patients Demand management and service sustainability.	Establish a working group with Trust and CCG representatives to agree implementation plan and milestones – June 2014				TBA	TBA	TBA
Local Price Review	To undertake a joint process of consultation to review pricing and methodology applied		Transparency of costings. Enabling consideration of potential efficiencies and benchmarking exercises.	Establish a working group with Trust and CCG representatives to agree implementation plan and milestones – June 2014				TBA	TBA	TBA

Annex 3

Summary of Patient Engagement Themes: 'You Said, We Did'

Strategic Initiative	You Said	Your Suggestions	We Did / Plan To
Palliative and End of Life Care	Discharge planning needs to be more co-ordinated – should include carer support and education.	Healthcare professionals should be able to signpost to appropriate voluntary services. Carers included in the care plan for their friends/relatives. 24 hour support telephone line for support and signpost patients to services.	Working together to develop a "patient passport" to support hospital discharge planning with care homes/end of life forum. The CCG supports Carer Awareness Sessions with GP practices to help them identify carers and their needs and this will be continued. Telephone support services are not currently available 24/7 however information is available online through various websites.
Emergency Care Practitioner Expansion	Care is still considered to be disjointed and disparate and ultimately it feels that there are some gaps in the system. The concept of a total care/one stop shop (or at the very least a seamless transition of care) fits in with the lifestyles/ expectations of patients with accessibility being a key driver of its success.	Care should be provided 'closer to home' wherever possible to prevent unnecessary attendances, ED waits and admissions. Yorkshire Ambulance Service currently employs a number of skilled practitioners who could be put to better use.	Pro-active case management and admission avoidance are going to be part of the 2014-15 GP contracts set out by NHS England. Ensuring everyone over the age of 75 and also people with complex conditions will have a named GP responsible for co-ordinating their care implies this process will involve care planning across services. ECP's will support the principle of joined up care as well as maintaining people in their homes where possible. They have access to referral pathways for other services. The establishment of a universal training package for ECP's across the UK will mean that there will be consistent skills and a clear career path for paramedics to progress.
Psychiatric Liaison Provision	Mental Health should be a key area of strategy and focus for the CCG. Access to services needs to be improved. Current age limitations restrict patients from receiving the appropriate treatment needed.	Should introduce seven day services not 9-5 services, as current. Remove age limitation on services.	We are working with the Partnership Commissioning Unit (PCU) to develop our Mental Health strategy. The feedback received to date will continue to influence the development of future services. We plan to hold further engagement events specifically for Mental Health services as part of this process. Work is on-going around Psychiatric liaison with the Acute Trust to ensure that people with mental health problems are managed by people with appropriate skills in the best

			environment for them. As part of the community services engagement we are asking the public their views on extending services and the best options for doing this, this will inform future service delivery. In line with the local joint strategic needs assessments, we will be reviewing the demands of different age groups on services to determine how we might tailor services appropriately to age groups.
Diabetes	There is lack of a holistic approach. No mention of prevention and education to try and prevent patients getting on the diabetes ladder. There is no clear way of getting hold of general information or to ask questions.	Level 2 should have equivalent access to services as those under hospital care.	Developed the redesigned model within a strong partnership of commissioner, provider, service user, voluntary sector/charity. Equality of access to appropriate services a central tenet of the service redesign. Prevention is within the auspices of the primary care element of the new model, supported by the new Community Diabetes Team and the development of a service user specific education programme. Development of 'Your Diabetes' website provides information for the public and professionals. Intrinsic will be a forum platform that allows questions to be raised and answered.
Neurology	From the 2013 Quality Audit: 130 service users and professionals' opinions were obtained regarding current service provision. Issues and suggestions raised included:	Clear navigation required for advice and information about services and care. Clear care pathways, roles, and responsibilities, and referral routes are needed for professionals to work efficiently and improve patient pathways. Specialist and community rehabilitation needed that promotes self-management, independence,	Commissioned Neurological Commissioning Support (NCS) to facilitate a partnership approach (involving CCG, providers, service users and cares) to developing Integrated Care Pathways for: - Epilepsy - Parkinson's Disease - Multiple Sclerosis - Motor Neurone Disease

	The CCG was made aware that a local uncommissioned MND charity provider was about to fold, leaving a case load of patients at risk of losing on-going care. The Big Conversation (April 2014) included eighty service users, carers' health and social care professionals and representatives from the voluntary sector debating and discussing what the four condition pathways should look like in the future specifics included:	and personal support at the earliest stage possible. Services for the future to be delivered in a different way that is proactive not reactive and does not replicate what has gone before. Closer to home, encourage more self- management, innovation and embrace IT solutions.	CCG agreed to commission local community provider to continue care of existing caseload, maintaining continuity by transferring nursing staff from MND charity. Specific identified priorities included: **Within 3 months:** Communication – creating a list of key contacts of professionals. Working with the ambulance service, meet with 111 and paramedics to get emergency care plans flagged on patient address. Reinstate newly diagnosed course for Parkinson's and MS (MSS locally would support cost). **6 months:** Flag neurology patients when they are admitted to hospital. Develop mandatory neurology training for GP's. Provide more information for carers and a carer pathway. Pilot the Epilepsy Action self-management course. Set up neurology training for Practice nurses. **12 months:** Key worker assigned as first point of contact for patients. NICE guidelines should be leveraged to include reviews by Neurologist/ Care of the elderly physician and nurse specialists. Specialist nurses trained to undertake blood monitoring and attend nurse prescribing course.
Elective Care Procurement	Elective Orthopaedics procurement - patients have recorded very high satisfaction rates in on-going surveys, 99% reporting "excellent" or "very good".		Aim to maintain this level of service for newly procured service.
Referral Support Service	Only want to go to hospital if it's absolutely necessary.		Patients are treated in the best possible ways by their GPs before referral (and this can prevent the need to go to outpatients). Patients get all the right tests done before they see a

	Don't want to make unnecessary trips to the hospital. Getting an outpatient appointment is not a smooth process.	Improve the appointment process for outpatient appointments.	specialist. Booking appointments are done at a time and place convenient for the patient (Patients are contacted by telephone within two days of the RSS receiving their referral to book a hospital appointment).
Cellulitis, Bronchiectasis and Community IV	From what we are to believe care in the community was the way health care was going with benefits to patients to be seen at home and not in hospital which was supposed to be beneficial for their recovery? If primary and secondary care are expected to reduce hospital admissions and enable early hospital discharge, surely more resources are needed in the community to make process sustainable. Is a lack of co-ordination of care. Access to services needs to be improved.	Should have a single point of contact for co-ordination of care. Introduce seven day services, not just a 9-5 service like at current.	We are working to expand the range of services in the community to benefit patients and increase their independence and benefit their recovery. Same as above. The CCG are working with York Teaching Hospital and the Yorkshire Ambulance 111 service to set up a Single Point of Access (SPA) for GP"s so that communication between community services and GP's is improved; this will run for 6 months and then we envisage this will be expanded to include the hospital and possible social care to join up all the different pieces of work that currently go on to support these patients. As part of the community services engagement we are asking the public their views on extending services and the best options for doing this, this will inform future service delivery.
GP Out of Hours Service	Out of hours service particularly from students' point of view is not a priority until it's required.		A single telephone number for out of hours services where you would be put through to the appropriate service.

	Students also need easy access to sexual health services and dental services. There is confusion about what's available in terms of out of hours services, and about how to make contact with the appropriate service. One person described waiting up to three hours for a GP to ring back only to be told to go to hospital. How best to get the message across? Students don't want leaflets - social media is a better option.		More/clearer information about what services are available out of hours. 'Get in early with comms and engagement – when I have required out of hours service in the past I've gone straight to A&E when other existing services could have helped but I wasn't aware of them.' Information needs to be delivered clearly to students, particularly about changes to or new services – could be via Student Union. The SU offered to hyperlink from their welfare web page.

Annex 4 Summary of Patient Engagement Approaches

Patient surveys	The CCG has provided the opportunity for all stakeholders to take part in surveys about the re-design of services and to understand their opinions on a range of topics
Patient representation in project delivery	Through the design and delivery of projects, the CCG encourages a member of the local community to act as patient representative and give views that are representative of the wider population. Recent work includes the delivery of the Referral Support Service which is due to be launched mid-September.
Patient and public forums	As for surveys, the CCG has provided the opportunity for all stakeholders to take part in events and forums that discuss services and to understand their opinions on a range of topics
Engagement events	These are an important element in our two-way conversations with stakeholders to understand their views about services and their experiences of them. The CCG is using a range of approaches to optimise engagement with our communities and is working hard to develop new ways to listen to members of the community not usually represented or heard through traditional methods. Approaches include forums, meetings, world cafes, open space events and training with members of the community to support them hosting conversations with different stakeholder groups and individuals. Topics discussed at recent stakeholder engagements include: ▪ GP Out of hours service ▪ Dermatology services ▪ Diabetes service re-design ▪ Mental health and learning disability Discover! programme ▪
Patient and public newsletter	Providing updates on the CCG's progress and to announce future plans, the newsletter is distributed to current members of the CCG and to stakeholder organisations.
Communicating with stakeholders	Staying in touch and providing information to our partners, staff, provider organisation, local community organisations, practices etc
Engaging through social media	Providing opportunities give views and engage with the CCG, Twitter and re-tweets by partners helps to raise awareness of ways to get involved
Engaging through the CCG's website	As for social media – our website provides the full detail behind our work and ways to get involved. (The website is under review and will undergo improvement in Q3.)

Annex 5 - Glossary of terms

NHS Vale of York Clinical Commissioning Group (CCG)

NHS Vale of York CCG is an NHS organisation that commissions (plans and buys) healthcare services for the residents of the Vale of York. CCGs were established under the government's Health and Social Care Act 2012 and replaced Primary Care Trusts (PCTs). NHS Vale of York CCG is made up of all the GP practices in the local area and is led by a Governing Body.

Accident and Emergency (A&E) or Emergency Departments (ED)

A&E or ED departments assess and treat patients with serious injuries or illnesses.

Acute Liaison Psychiatric Service (ALPS)

ALPS is a critical service integral to all acute hospitals. Services comprise multidisciplinary teams skilled to integrate mental and physical healthcare in people whose mental health problems arise in, or have an impact on management of, physical illness and symptoms.

Acute services

Medical and surgical treatment provided mainly in hospitals.

Better Care Fund

In June 2013, as part of the Government's Spending Round, a £3.8 billion pooled fund was announced to promote joint working between the health service, and social care in 2015/16. The Better Care Fund includes existing NHS and social care funding, which will be jointly invested as the biggest ever financial incentive for health and social care to work together and improve outcomes for people.

Care Hub

A Care Hub is a team of health and social care practitioners working together from different organisations and disciplines. The Care Hub team could include a nurse, social care worker, GP, occupational therapist, pharmacist, and a Counsellor from a local provider. Care Hubs will be based in a community setting, such as a local GP surgery.

Care pathway/patient pathway

A care pathway (also sometimes called a patient pathway) is a diagram, drawn by healthcare professionals, of a patient's journey through care for a particular health condition. The pathway is developed so that, at each stage, the patient is getting the appropriate care. If that care does not work, the patient will continue on the care pathway to the next stage. Care pathways are designed to get the patient to the appropriate care smoothly.

Children and Adolescent Mental Health Services (CAMHS)

CAMHS stands for Child and Adolescent Mental Health Services. CAMHS are specialist NHS services. They offer assessment and treatment when children and young people have emotional, behavioural or mental health difficulties.

Children's Trust

Children's Trusts bring together all organisations responsible for delivering children's services in order to improve the lives of children and young people in the local area They aim to deliver better services and strengthen responsibility and accountability amongst a range of partners through the development of an agreed local strategy.

Choose and Book

Choose and Book is a service that lets you choose your hospital or clinic and book your first appointment. When you and your GP agree that you need an appointment, you can choose which hospital or clinic you go to. You will also be able to choose the date and time of your appointment.

Commissioning

Commissioning in the NHS is the process of ensuring that the health and care services provided effectively meet the needs of the population. It is a cycle of work from understanding the needs of a population and identifying gaps or weaknesses in current provision, to procuring services to meet those needs.

Commissioning intentions

Commissioning intentions are developed every year. They describe the changes and improvements to healthcare that the CCG wants to make for the year ahead and what we expect to commission (or ‘buy’) to achieve these changes. The CCG’s commissioning intentions are shared widely with providers and stakeholders and are then developed into a commissioning strategy plan for the year ahead.

Commissioning Support Unit (CSU)

A Commissioning Support Unit (CSU) is an organisation that provides services to CCGs. CCGs can decide on the services they wish to obtain through CSUs e.g. commissioning, IT services, medicines management, information analysis. The CSU providing services to the CCG is North Yorkshire and Humber Commissioning Support Unit.

Community health services

Community health services are NHS services provided outside a hospital. Community health staff include district nurses, health visitors, community midwives, district dieticians, chiropodists and community psychiatric nurses.

CQUIN

CQUIN stands for Commissioning for Quality and Innovation. CQUIN is a payment framework which allows commissioners like the CCG to link a proportion of providers' income to the achievement of locally agreed quality improvement goals.

Delayed transfers of care

A Delayed Transfer of Care is experienced by an inpatient in a hospital, who is ready to move on to the next stage of care but is prevented from doing so for one or more reasons. Timely transfer and discharge arrangements are important in ensuring that the NHS effectively manages emergency pressures. The arrangements for transfer to a more appropriate care setting (either within the NHS or in discharge from NHS care) will vary according to the needs of each patient but can be complex and sometimes lead to delays.

Elective care

Elective care is pre-arranged, non-emergency care, including scheduled operations. It is provided by medical specialists in a hospital or another care setting. You will usually be referred by your GP.

Emergency placements

An Emergency Placement is the placement of a Looked After child in foster care or residential care (including Secure Accommodation) made without the usual planning and/or thorough assessment process having taken place because of the need to ensure the safety and the welfare of the child immediately.

Health and Wellbeing Board (HWB)

The Health and Social Care Act 2012 established Health and Wellbeing Boards as forums where leaders from the NHS and local government can work together to improve the health and wellbeing of their local population and reduce health inequalities.

There are three Health and Wellbeing Boards in the Vale of York area. These are based in York, East Riding of Yorkshire and North Yorkshire and are made up of elected members of the local council, Directors of Public Health, Adult Services, Social Care Services, Children's and Young People Services, members of the CCG and a representative of Healthwatch.

Board members work together to understand the health and social care needs for the respective areas, they agree priorities and help to ensure that council and CCG plans and buy services in a more joined up way.

Health and Wellbeing Boards are responsible for carrying out the Joint Strategic Needs Assessment (JSNA) and developing a joint strategy (the Health and Wellbeing Strategy) for how these needs can be best addressed.

Health and Wellbeing Strategy

Health and Wellbeing Strategies for York, East Riding of Yorkshire and North Yorkshire have been developed by the respective Health and Wellbeing Board (HWB). The strategy is an overarching plan to improve the health and wellbeing of children and adults and reduce health inequalities.

Health inequalities

Health inequalities can be defined as unfair differences in health status or in the distribution of health determinants between different population groups. For example, differences in mortality rates between people from different social classes. In The Vale of York there are health inequalities between people who live in different parts of the area and improving health where there is an inequality is a priority issue for the local Health and Wellbeing Boards.

Healthwatch

Established by the Health and Social Care Act 2012, Healthwatch is an independent consumer champion for people who use health and social care services. It works to ensure that views of the local community are heard and used to improve the experience and outcomes of health and social care services.

The Vale of York CCG works with three Healthwatch organisations. These are Healthwatch York, Healthwatch North Yorkshire and Healthwatch East Riding of Yorkshire.

Hospice at home

Hospice at home is an integral component of community end of life care bringing the skills, ethos and practical care associated with the Hospice movement into the home environment; putting the patient and those who matter to them at the centre of the care. Hospice at home services aim to enable patients with advanced illness to be cared for at home and to die at home, if that is their preference.

IAPT

The Improving Access to Psychological Therapies (IAPT) is an NHS programme of talking therapy treatments recommended by the National Institute for Health and Clinical Excellence (NICE) which support frontline mental health services in treating depression and anxiety disorders.

Integration of care

Promoting joint working between the health service, and social care and support to improve experiences and outcomes for people.

Joint Strategic Needs Assessment (JSNA)

A JSNA describes the future health, care and wellbeing needs of local populations and the strategic direction of service delivery to meet those needs. JSNAs are developed jointly between the Council and the CCG – providing a framework for health and social care to work in partnership to identify the needs of the population they serve and to work together in commissioning services to meet those needs. The JSNA is a key part of the commissioning cycle and informs the CCG’s commissioning intentions. There is a JSNA for each local authority area.

KPIs

Key Performance Indicators. These are set out in contracts with our providers and help us to monitor their performance. Examples of KPIs include length of stay in hospital for a particular treatment or how satisfied patients are with the care they receive.

Long term condition

A long term condition is something that is controlled by medication and/or other therapies, including self-care and changes to lifestyle. This definition covers lots of different conditions such as diabetes, asthma, multiple sclerosis and pain.

NICE guidance

NICE stands for National Institute for Health and Care Excellence. NICE sets standards for quality healthcare and produces guidance on medicines, treatments and procedures.

NHS Constitution

The Constitution sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve.

NHS England

NHS England is an executive non-departmental public body of the Department of Health. NHS England oversees the budget, planning, delivery and day-to-day operation of the NHS in England as set out in the Health and Social Care Act 2012

Non-elective care

Non elective care is admitted patient care activity which takes place in a hospital setting where the admission was as an emergency/non-elective.

Out of hours

This term usually relates to access to Primary Care, for example a GP, in the evening, during the night or on a weekend.

Parity of esteem

Valuing mental health equally with physical health. Having access to Services which enable both mental and physical wellbeing to be maintained and ensuring that services assess and treat mental health disorders or conditions on a par with physical health illnesses.

Patient Participation Group (PPG)

A PPG is a group of patients who are interested in health and healthcare issues, and who want to get involved with and support the running of their local GP practice. Most PPGs include members of practice staff that and meet regularly to discuss services and facilities offered by the practice to its patients.

Person-centred care

Person-centred care is about ensuring the patient/client is at the centre of care and support services. This means that individual wishes and needs, life circumstances and health choices will be taken into account when planning care.

Personal health budgets

Personal health budgets are the allocation of NHS funding which patients/service users, after an assessment, are able to personally control and use for the services they choose to support their health needs.

Planned care

Planned care means services where you have a pre-arranged appointment. This includes things like being referred by your GP to see a physiotherapist or consultant or being sent for diagnostic tests such as an X-Ray.

Procurement

The process of specifying and buying goods or services. Procurement involves the evaluation of bids, and negotiation of contracts with health and social care service providers.

Providers/Service Providers

A provider or service provider includes anyone who is commissioned to supply a health or social care service. GPs are primary care providers. Social care providers include social workers and home support workers. Hospitals are classed as Acute care providers or Secondary care providers.

Primary care

Primary care includes services provided by GP practices, dental practices, community pharmacies and high street optometrists (opticians). Most primary care services are commissioned by NHS England. The CCG is not involved in the commissioning of these services.

Quality premium

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

QIPP

QIPP stands for Quality, Innovation, Productivity and Prevention. It is a national, regional and local level programme designed to support clinical teams and NHS organisations to improve the quality of care they deliver while making efficiency savings that can be reinvested into the NHS. QIPP is often used to indicate a contribution towards achieving a financial gap (i.e. a saving or efficiency/ productivity gain)

Referral support service (RSS)

The Referral Support Service (RSS) is a local service managed by NHS North Yorkshire and Humber Commissioning Support Unit on behalf of NHS Vale of York Clinical Commissioning Group. The aim of the RSS is to get patient's to see the right person, at the right time, in the right place.

Secondary care

Secondary care is the service provided by medical specialists, either in a community health centre or a hospital. These services are provided by specialists for example, cardiologists, urologists and dermatologists and patients are referred to these specialists by their GP.

Self care / management

Self care means looking after yourself in a healthy way, whether it's brushing your teeth, taking medicine when you have a cold, or doing some exercise.

If you have a long-term condition, there are extra things you may need to consider, such as making changes to your diet, different types of exercise, different types of medication you may need to take, managing pain or fatigue.

Shared / Summary Care Record

Records are kept in all the places that care is received. Usually information you're your records can only be shared by letter, email, fax or phone. At times, this can slow down treatment and sometimes make it hard to access information.

Shared/ Summary Care Records are being introduced to improve the safety and quality of patient care. Because the Summary Care Record is an electronic record, it will give healthcare staff faster, easier shared access to essential information about you, and help to give you safe treatment during an emergency or when your GP surgery is closed.

System Resilience Group (SRG)

These are groups which are currently being established in June 2014 to plan the capacity (amount of care and treatment) required to be delivered for the local population by the local acute hospital throughout the year. These groups will plan capacity in both unplanned (emergency or non-elective) care and planned (elective) care. The SRG will have membership from local CCGs who commission services from the local acute hospital as well as the local acute hospital itself. These groups will report back to both Monitor and NHS England, the monitoring bodes for Foundation Trusts (the acute hospital) and the CCGs.

Abbreviations

CSU – Commissioning Support Unit
CYC – City of York Council
ED – Emergency Department
ERY CCG – East Riding of Yorkshire CCG
ERYC – East Riding of Yorkshire Council
HARD CCG – Harrogate and Rural District CCG
LYPFT – Leeds and York Partnership Foundation Trust
NHSE – NHS England
NYCC – North Yorkshire County Council
PCU – Partnership Commissioning Unit
PHE – Public Health England
S&R CCG – Scarborough and Ryedale CCG
YAS – Yorkshire Ambulance Service Trust
YTHFT – York Teaching Hospitals Foundation Trust