www.everyoneactive.com

Ryedale District Council Active Community Plan 2018 - 2023

To be reviewed annually




Ryedale District Council

everyone ACTIVE

Section 1: Introduction

SLM Mission Statement:

To promote activity, health & wellbeing within Ryedale District Council in line with the Everyone Active mission statement

'***To create the best value experience that makes members feel better being active for 30 minutes 5 days a week – at least 2 activities supported within our centres'***.

Ryedale District Council Mission Statement

Ryedale District Council have several key strategies which work collaboratively in delivery of activity outcomes. Two strategic documents that underpin the work of the council are;

1. The Ryedale District Council Business Plan 2017 – 2022 Vision: ***"The vision for Ryedale District Council is to continue doing what matters for Ryedale."***

2. Ryedale District Council Leisure Strategy 2013 - 2023 Vision: **"To improve the quality of sport and active recreation opportunities for people in the area."**

This Active Community Plan will continue to build on strong partnerships in the Ryedale district which align Everyone Active and Ryedale district Council strategic priorities set within localised strategies such as; The Business Plan, Leisure Strategy, and County Health and Wellbeing Strategies.

This Active Community Plan has been produced in line with research on the localised need for physical activity ensuring all partners work together to deliver the expectations. The integration of the Public Health and Primary Care sector is hugely important to build upon previous and current work that has been undertaken, and provide support and resources to compliment future development of delivering community based outcomes.

Greater collaboration and use of resources will be fundamental to the success of this plan. All organisations involved in the development of this document have an important role to play in achieving the outcomes that are needed for the improved health and wellbeing of the District and will be very much a part of the success of the improved wellbeing of its communities.

Section 2: The Bigger Picture

National Influencers

There are several key policies and national campaigns that influence the development of the Ryedale District Active Community Plan. Below outlines those strategies, the visions, and the key outcomes derived from the action;

Strategy Document	Who	Vision / Mission / Principle	Priorities / Outcomes / Themes
Sporting Futures	Department of Culture, Media, & Sport	*"Develop a more 'Active Nation'"*	• Physical wellbeing • Mental wellbeing • Individual development • Social & community development • Economic development
Towards an Active Nation	Sport England	*"We want everyone in England regardless of age, background or level of ability to feel able to engage in sport and physical activity. Some will be young, fit and talented, but most will not. We need a sport sector that welcomes everyone – meets their needs, treats them as individuals and value them as customers."*	• Tackling inactivity • Children and young people • Volunteering • Mass markets • Sustaining the core market • Working locally • Facilities
Physical Activity Standard Evaluation Framework	National Health Service	*"The SEF for physical activity aims to describe and explain the information that should be collected in any evaluation of an intervention that aims to increase participation in physical activity.* *It is aimed at interventions that work at individual or group level, not at population level."*	• How to identify appropriate physical activity outcomes for evaluating different types of intervention. • How to define suitable measures for different types of physical activity outcome. • How to approach the challenges of assessing and measuring physical activity and energy • Expenditure
Health Matters; getting every adult active every day	Public Health England	*"Increasing physical activity has the potential to improve the physical and mental health and wellbeing of individuals, families, communities and the nation as a whole. Public Health England (PHE) wants to see more people being physically active."*	• Active Society • Moving professionals • Active environments • Moving at scale

Start active, stay active	Department of Health	*"Bringing all of the aspects of the report together creates a number of key features on the influence of regular physical activity:* • *A life course approach* • *A stronger recognition of the role of vigorous intensity activity* • *The flexibility to combine moderate and vigorous intensity activity* • *An emphasis upon daily activity* • *New guidelines on sedentary behaviour"*	Chief Medical Officer Guidelines; • Under 5 Active 3 hours a day • Young people 1 hour a day • Adults 30 minutes 5 times a week • Older adults 30 minutes 5 times a week
Change 4 Life Campaign	NHS Choices	*"To inspire a broad coalition of people, including the NHS, local authorities, businesses, charities, schools, families, community leaders"*	To play a part in improving the nation's health and well-being by encouraging everyone to eat well, move more and live longer implementing national campaigns and initiatives such as; • Food4Life • Walk4Life • Play4Life
Everyone Active Sports Development Strategy 2014 - 2018	Sports & Leisure Management	*"To be the community's premium sports and activity provider for both adults and children for all abilities, genders, and ethnicity"*	• Sports and Activity Programming • Coaching and Colleague Development & Skills • Volunteering • Community Health, Inclusion, and Behaviour Change • Facility Development & Supporting Excellence

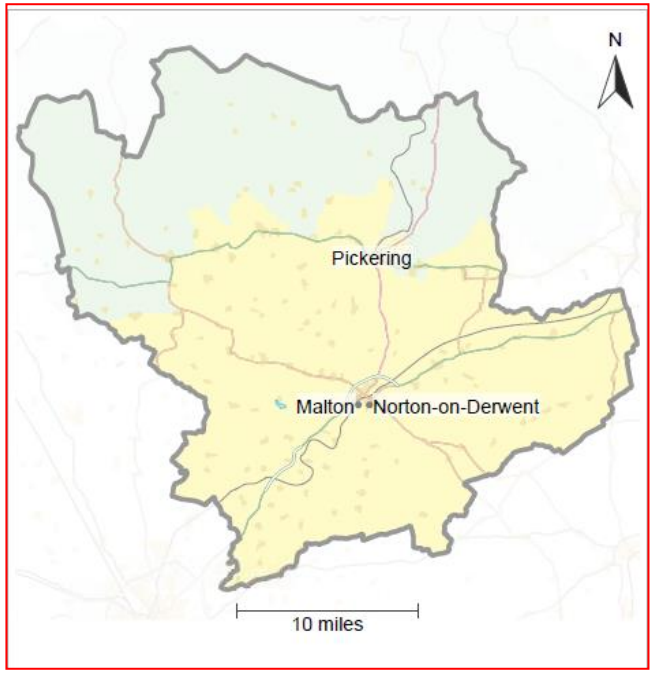
Section 3: Local Influencers & Strategy

There are several key policies and strategies that influence the development of the Ryedale District Physical Activity, Health and Community Plan. Below outlines those strategies, the visions, and the key outcomes derived from the action at a local level;

Strategy Document	Who	Vision / Mission	Relevant Priorities / Outcomes / Themes
The Ryedale District Council Business Plan 2017 – 2022	Ryedale District Council	*The vision for Ryedale District Council is to continue doing what matters for Ryedale...framed around five values: Passion, Respect, Openness, Unity and Decisive.*	• Capitalising on our culture, leisure and tourism opportunities • Designing all of our services with the customer at the heart of everything we do • Helping our partners to keep our communities safe and healthy • Utilising assets in supporting the delivery of priorities
Ryedale District Council Leisure Strategy 2013 - 2023	Ryedale District Council	*Our Vision is for everyone in Ryedale to enjoy an active, adventurous, and healthy lifestyle as an integral part of everyday life, encouraging More People, to become More Active, More Often.*	• More people aspiring to take part in sport and active recreation • More people actually taking part in sport and active recreation • More people becoming involved as volunteers in sport and active recreation • Increased participation amongst people already taking part in sport and active recreation • Increased satisfaction with facilities and opportunities for sport and active recreation in the Ryedale area • Increased usage across all Ryedale owned leisure facilities
Humber Coast & Vale Sustainability and Transformation Plan	Humber Coast and Vale Partnership Board	*Our vision for 2021 is a system that:* • *Supports everyone to manage their own care better* • *Reduces dependence on hospitals* • *Uses our resources more efficiently*	• Give people advice and resources to look after themselves. • Implement prevention activities that we know work well across all localities – such as those that tackle obesity, alcohol misuse and falls.
Ambition for Health	Statutory agency partnership, council	*Healthy lifestyles – An ambition to help people lead healthy lifestyles, supporting them to take control of their own health to prevent illness*	• Prevention, self-care and helping people of all ages to lead healthy and active lifestyles – with a particular emphasis on encouraging a smoke free generation

Scarborough & Ryedale Clinical Commissioning Group Strategy		*To improve the health and wellbeing of our communities*	Our population is: • Physically and mentally healthy • Take responsibility for staying healthy and active

2.3: Local Demographics



Health Profile 2017

Health in summary
The health of people in Ryedale is varied compared with the England average. About 12% (1,000) of children live in low income families. Life expectancy for both men and women is similar to the England average.

Health inequalities
Life expectancy is not significantly different for people in the most deprived areas of Ryedale than in the least deprived areas.

Child health
In Year 6, 15.6% (70) of children are classified as obese, better than the average for England. The rate of alcohol specific hospital stays among those under 18 is 27*. This represents 3 stays per year. Levels of smoking at time of delivery are worse than the England average. Levels of teenage pregnancy are better than the England average.

Adult health
The rate of alcohol-related harm hospital stays is 541*, better than the average for England. This represents 310 stays per year. The rate of self-harm hospital stays is 121*, better than the average for England. This represents 59 stays per year. Estimated levels of adult physical activity are better than the England average. The rate of people killed and seriously injured on roads is worse than average. Rates of sexually transmitted infections and TB are better than average. Rates of violent crime, long term unemployment and early deaths from cardiovascular diseases are better than average.

Local priorities
Priorities in Ryedale include starting well (improving school readiness, reducing childhood obesity, reducing injuries), and living well (reducing alcohol and substance misuse, reducing obesity, and reducing smoking), ageing well (reducing excess winter deaths, loneliness and isolation) and End of life care.

Physical activity and Sporting Participation for Ryedale

An analysis of the data collected through the active lives survey reveals that participation in physical activity in Ryedale is slightly better than national average levels, with 23.4% inactive, 10.9% insufficiently active and 65.7% active (Table 1).. 79.9% of respondents also reported being active at least twice in 28 days (Data retrieved via the Active Lives on line analysis tool).

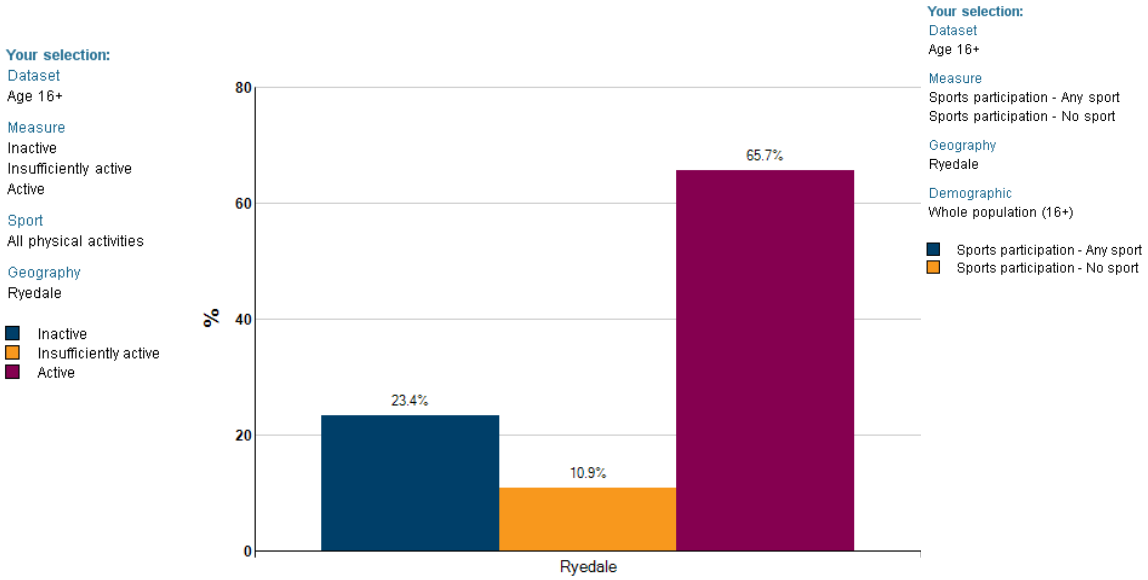


Table 1.

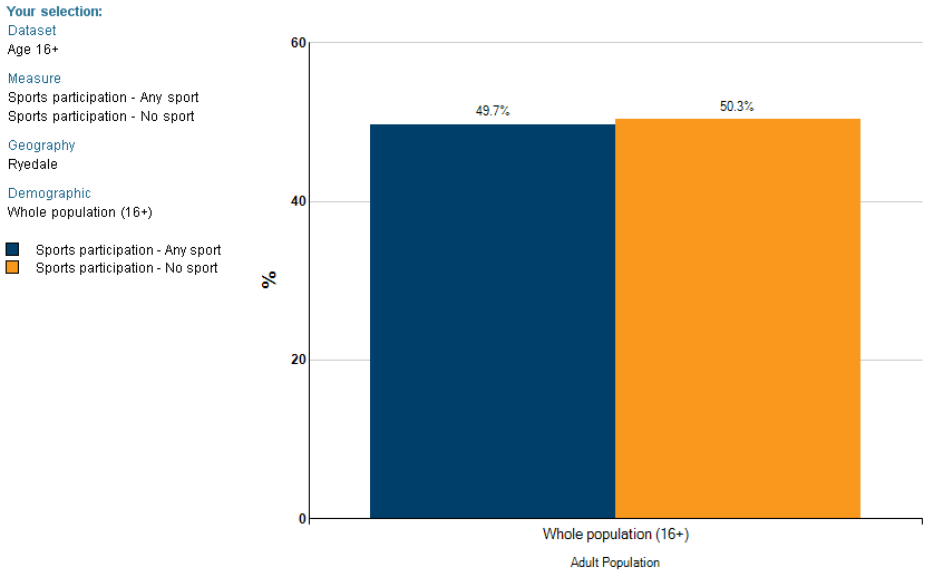


Table 2.

In relation to actual participation in sporting activities, there is currently a relatively even split of residents taking part and not taking part in sporting activities: 49.7% against 50.3% (Table 2)

The chart below outlines the frequency of participation in sporting activities; highlighting that 39.0% take part at least once a week, 17.7% three (or more) times a week and some, but less than three times a week (Table 3).

Your selection:

Dataset
Age 16+

Measure
Sports participation - At least once a week
Sports participation - Three (or more) times a week
Sports participation - Some, but less than three times a week

Geography
Ryedale

Demographic
Whole population (16+)

- Sports participation - At least once a week
- Sports participation - Three (or more) times a week
- Sports participation - Some, but less than three times a week

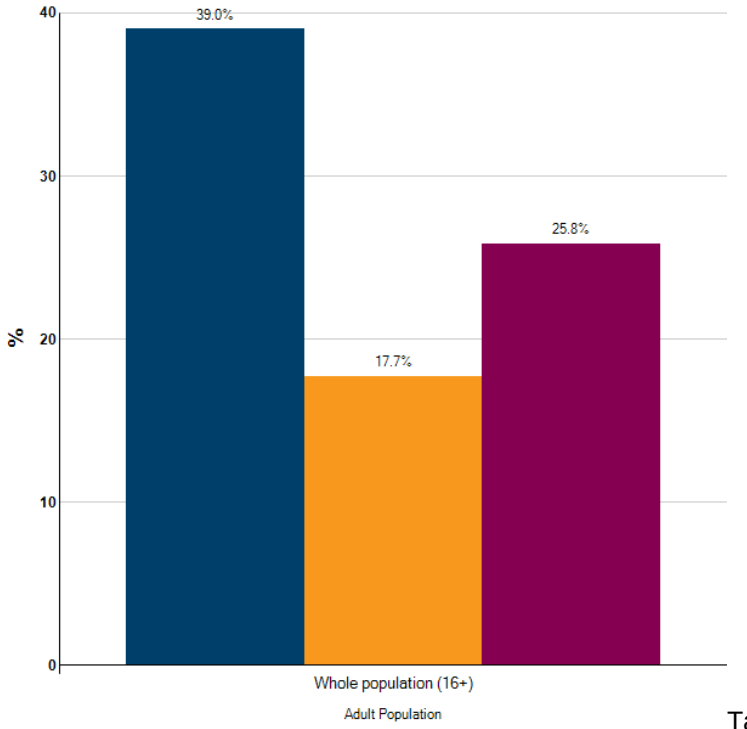


Table 3.

Whilst the participation levels are slightly above national averages, which is positive; 23.4% are inactive and 10.9% are insufficiently active, meaning there are some local challenges to address in relation to physical activity and sport.

Section 3 – Active Community Plan - Framework for Actions

The Active Community Plan actions in section two are grouped into 6 areas outlined below. These areas are based on the evaluation of key Local, County and National strategies.

By delivering the actions outlined in the below categories this will lead to the positive outcomes that are overriding all of the elements below which are healthier lifestyles and reduced obesity.

- Management, Infrastructure, & Resourcing
- Children, young people and adult programmes
- Health Interventions
- Club & Workforce Development
- Partnership in Raising the Profile of Activity Partnership Working in the Community
- Equality and Access Provision

The framework is further influenced by the demographic and health research information in section 4

Key Outcome Indicators

Local Authority Outcomes

Outcome Key	Outcome Description
R1	More people aspiring to take part in sport and active recreation
R2	More people actually taking part in sport and active recreation
R3	More people becoming involved as volunteers in sport and active recreation
R4	Increased participation amongst people already taking part in sport and active recreation
R5	Increased satisfaction with facilities and opportunities for sport and active recreation in the Ryedale area
R6	Increased usage across all Ryedale owned leisure facilities

Sport England Framework

Outcome Key	Outcome Description
S1	Physical Wellbeing
S2	Mental Wellbeing
S3	Individual Development
S4	Social & Community Development
S5	Economic Development

Ryedale District Active Community Plan - Framework for Action

Management Infrastructure, and Resourcing

What (Activity Need / Gap / Development)	When (Timescale)	Where (Location)	Who (Target Group & Partners)	How (Outputs)	Outcomes
Review Resourcing, Recruit, and Induct / Training	Annual review of workforce skill levels and variety Recruitment drive 6 monthly Additional training as and when required on when funding is available	Access to other Everyone active centres locally in the north east where training is held including Scarborough, Middlesbrough, Redcar & Cleveland as well as Ryedale itself where training is possible Other Partner Training Locations	• Existing workforce • New colleagues at point of recruitment • Potential partners with tangible outputs on usage and viability i.e. Rye special families and swim clubs. • Volunteers • Regular members from existing base who wish to become employed or as mentors	1. Conduct coaching and coordinator gap analysis 2. Complete training and corporate induction 3. Provide PRD's and KPI's 4. Recruit appropriate colleagues 5. Sports Leader Tutor Training 6. Activity Apprenticeships / Traineeships CPD's and Online Training 7. Safeguarding Modular 8. RQF L1 / L2 Sports Leadership Qualifications	All colleagues fully inducted, roles and responsibilities agreed, outcomes of the service agreed. Induction packages for colleagues ongoing as and when recruited this is now online as well as in centre Gap Analysis Spreadsheet visible and accessible to senior management All Management & Activity Management have a PRD in file reviewed within the last 6 months All colleagues under taken safeguarding training online through corporate induction modular 6 All Activity Camp Leaders are L1 Sports Leader or UKCC L1 or 2 Qualified
Installing deliver infrastructure and understand / utilisation of partner resources	Ongoing	Ryedale Leisure Facilities Community Partners and Sport Club Hubs	Internal colleagues Ryedale District Council North Yorkshire Sports Partnership Local Sports Clubs	Analyse each partner's outcomes and consider EA potential contribution with support of site Activity Coordinators. . Assess how everyone active can support the delivery of those outcomes by using the facilities, activities, and resources we have available.	Agreed resources available to deliver aspects of the integrated physical activity and health aspiration. Proposal of a working plan utilising current services to meet shared partner goals/priorities. Commitment Statements / SLA's on how clubs and Everyone Active will work together on increasing participation.

				Work with established NGB contacts to analyse the current provision and implement an improvement plan for the activities across the sites	
Club Development Networks and Deployment	6 monthly once data base is created	Locally in centre and at suitable locations locally within Ryedale	All clubs/partners and groups who use the facilities and also a wider network for all other local clubs and groups who do not use the centres	The Contract Manager and Site General Managers will meet with all clubs associated with the leisure and community facilities on a six monthly basis to review club development plans and service level agreements with the leisure facilities. Agreed frameworks for coaching opportunity, and also identify programme pathways for customers from entry level to competitive sport.	Agree and implement six monthly review meetings with key clubs that support the participation outcomes. Club SLA's in place with agreement on responsibilities for delivering service and participation outcomes Dates / calendar for club meetings or forums Standard agenda drafted for meetings

Children, young people, and adult programmes

What (Activity Need / Gap / Development)	**When (Timescale)**	**Where (Location)**	**Who (Target Group & Partners)**	**How (Outputs)**	**Outcomes (throughput)**	
Early Years Physical Activity Development	Sept 18 – Dec 18	In centre and if possible in community facilities groups and schools	0-5 years and parents Central Ryedale children's centre Pickering Community Infant and Nursery School Potter Hill Playgroup Ryedale District Council	Everyone Active will work in partnership with local schools, early year's providers and local voluntary & community groups to identify appropriate opportunities to provide physical activity sessions to under 5's. Sessions will take place at both community facilities were feasible and the local leisure centres.	Engage local providers to establish appropriate plan for under 5 PA sessions. Explore and secure funding/resources to support programme delivery. Deliver 1 x Under 5 session either in centre or within local community	S1, S2, S3, S4 R1,R2, R3,R4,R5,R6
Children's Sport and Physical Activity Programmes	October 18 – February 19	Primary and Secondary Education Establishments	Thornton Dale C Of E Primary School Pickering Community Junior School Ryedale School	Everyone Active will work with its NGB, delivery partners and local associations to implement high end activities and quality assurance. We will also work with governing body and training providers to adequately train current work workforce. Additional activities that will be included from the current provision are;	Classes operating at 80% occupancy with colleague cost v income ratio at maximum 55% 14 children enrolled onto each of the sports	S1, S2, S3, S4 R1, R2,R3,R4,R5,R6

			St Joseph's R C Primary School Ryedale & Whitby School Sport Partnership North Yorkshire Sports Partnership	• Roller Skating • Holiday Activity Camps • Birthday Parties • Inclusive Programmes • General Physical activity sessions Everyone Active will work with specified secondary schools, academies to explore opportunities to implement activities and programmes at the leisure and school facilities working with volunteers and club coaching networks to deliver activities. • Fitness Classes/Gym Sessions • Group Cycling • Tennis Variants • Multi-Sports sessions • Badminton Variants	programmes operating each week Holiday Camp daily KPI of 90% occupancy 6 Birthday Parties held each across the contract School Survey conducted with parents, kids, and teachers at selected schools every 6 months – results to formulate decisions and actions to implement	
Adults Activities 16+ years	August – January 2019	Ryedale Sports Centre Ryedale Swimming Pool Derwent Swimming Pool Sport Club Locations and Recreation Grounds where volunteers deliver	Adults 16 – 25 yrs Women 16+ BME 25 – 55 yrs North Yorkshire Sports Partnership Local Sports Clubs	Understand club activities and provision which would take place within centre and community programme, including accessible activity opportunities. Develop and deploy resources to promote and educate local residents on the range of benefits in relation to physical activity and raise awareness of these opportunities available across the district. Other activities that may be included within the Adult Activities Programme are; • No Strings Badminton • Back to Netball • Dodgeball • Frisbee Golf • Health Walk Groups • Couch 2 5k/Running Groups • Group Exercise Classes • Fitness Workshops and Small Group Training • Personal Training	All internal activities listed on the EA Ryedale websites under ‘discover activities’ Create a ‘Whats on guide’ which includes activities taking place at the centres and at community locations Internal activities 80% viability with 55% coach cost to income ratio 70% of adult enquires successfully referred into club environments of choice.	R1, R2, R4, R6 S1, S2, S3, S4, S5

Active Seniors Programme	August – March 2019	Ryedale Sports Centre Ryedale Swimming Pool Derwent Swimming Pool Sport Club Locations and Recreation Grounds where volunteers deliver Pickering Memorial Hall	Older people 55+ Ryedale Walking Group Ryedale Friendship Group Ryedale Forum for older people North Yorkshire Sports Partnership	EA will continue to deliver senior activities but will re-brand and promote the wider activities within an 'Active Seniors programme'. This will include additional activities more appealing to the over 50's age group based on extensive feedback from our over 50's database. This may include lighter exercise classes, swim clinics and gym workshops, tea dancing and line dancing. Everyone Active will work in partnership with key groups and agencies to identify opportunities and funding to deliver activities in local communities. We will work with clubs and the voluntary sector to set up senior activities that can be sustained within community settings.	Stronger programme with additional activities. New 'Active Seniors' branding to attract the Over 50's market Activities to be operating at 70% class viability with minimum of 10 participants per class.	R1, R2, R4, R6 S1, S2, S3, S4

Club & Workforce Development

What (Activity Need / Gap / Development)	**When (Timescale)**	**Where (Location)**	**Who (Target Group & Partners / Resourcing)**	**How (Outputs)**	**Outcomes**	
Club Development	Sept 18 – Dec 18	Ryedale Sports Centre Ryedale Swimming Pool Derwent Swimming Pool Sport Club Locations and Recreation Grounds	Local Sports Clubs currently delivering from the Everyone Active Centres Community Clubs that require support and new clubs to the centre North Yorkshire Sports Partnership	Everyone Active value the clubs that are both associated with the leisure facilities and the local community. Duty Managers and Site Activity Coordinators will receive training and resources to best support clubs and development. This will include the following; • Review club time and space within facilities • Service Level Agreement between Everyone Active and Club Responsibilities • Supporting, Writing, and Developing individual club development plans • Working with talented Athletes	All clubs associated with each of the centres have a signed SLA agreement Each club has a draft one page Club development plan with priorities Talented athletes on EA Sporting Champions Programme or as agreed by EA and Ryedale District Council will be supported by free membership	R1, R2, R3, R4, R6 S1, S2, S4, S5
Club Recognition	Sept 18 – Dec 18	Ryedale Sports Centre Ryedale Swimming Pool	Ryedale Sports Club Directory	Everyone Active recognise the importance of creating consistency in sport club delivery on leisure and community facilities. It will support	60% of Clubs has undertaken a self-assessment against the	R1, R2, R3, R4, R6

		Derwent Swimming Pool Sport Club Locations and Recreation Grounds	Relevant NGBs and representatives Sport England Regional Representatives North Yorkshire Sports Partnership	clubs to develop infrastructure and ability to develop talent at grass roots level. It will also create opportunities for entry level initiatives for target groups. As part of the Regional Activities Manager Role will be to support Centre Management working with local clubs on the following; • Assistance with Club Mark • Club Development Plans and Pathways • Financial support through the 'Everyone Active Sporting Champions' Programme	current Club Mark Criteria in year one – EA to retain this self-assessment for reference Identify individuals to be put forward for the Everyone Active Sporting Champions Programme in Ryedale EA to develop a 1 page club development strategy	S3, S4, S5

Working in Partnership to raise the profile of Physical Activity

What (Activity Need / Gap / Development)	**When (Timescale)**	**Where (Location)**	**Who (Target Group & Partners / Resourcing)**	**How (Outputs)**	**Outcomes**	
Youth Initiatives across Ryedale	April 19 – Aug 19	Ryedale Sports Centre Ryedale Swimming Pool Derwent Swimming Pool Sport Club Locations and Recreation Grounds Lady Lumley School Primary & Secondary Education	5 – 11 years 12 – 15 years Street Games North Yorkshire Sports Partnership Ryedale and Whitby School Sports Partnership	The Leisure Contract Manager and Regional Activities Manager will work closely with community partners to support and promote existing activities across Ryedale as well as exploring potential funding opportunities to deliver new initiatives within the Leisure Facilities; • Enrol new students onto the Aqua Passport / Sport Passport which provides parents access to education on skills, programmes, and pathways to children's development • Open sessions and events to promote new activities and launches	500 participants taking part in free programmed activities across the Ryedale District council Facilities over the 3 years 10 schools delivering the Fitter Schools Challenge by the end of year one Deliver free taster sessions on national play day at Ryedale Sports Centre	R1, R2, R3, R4, R6 S1 – S5
Adult Initiatives in the Ryedale	July 18 -	Ryedale Sports Centre Ryedale Swimming Pool Derwent Swimming Pool	North Yorkshire Sports Partnership North Yorkshire Public Health – Health and Social Care NHS Scarborough and Ryedale CCG	Everyone Active will work with the business sector, primary care partners, and sports clubs to find ways to champion physical activity across the district by promoting the following; • Active Seniors Programme • Workplace Health	Offering of 3 specific Over 50's activities across the Ryedale district – 100 – 120 participants per week	R1, R2, R3, R4, R6 S1 – S5

		Sport Club Locations and Recreation Grounds	Age UK Scarborough & District	• Provide Opportunities on the Everyone Active Sporting Champions Programme linking into the talent coaching programme with Health Campaigns across the year such as stop smoking • Keep active • Healthy living	10 business's involved in Workplace Badminton Scheme	
Partner Engagement & Working Together	June 2018	Ryedale Sports Centre Ryedale Swimming Pool Derwent Swimming Pool	Community Groups ASA Badminton England Street Games Business Creative North Yorkshire Sports Partnership North Yorkshire Public Health – Health and Social Care NHS Scarborough and Ryedale CCG Age UK Scarborough & District Ryedale & Whitby School Sport Partnership	Everyone Active will work with the following key strategic partnerships. It will be important to engage in local partnerships at linking them to centre based activity and solutions. Below are a range of partners we will engage with; • Sport England • Living Sport • National Governing Bodies of Sport • Everyone Health • Scarborough & Whitby Public Health • Ryedale District Council • NHS/CCGs • Uniformed Services • Local Housing Associations • Primary, Secondary and Special Schools • Voluntary Organisations for children, young people and families	Formalised commitment statement / SLA which Everyone Active will agree its responsibilities to each partnership. Meeting / Communications plan – which may include phone conferences, 1:1 meetings, forums, partner conferences	R1, R2, R3, R4, R6 S1 – S5

Equality & Access Provision

What (Activity Need / Gap / Development)	**When (Timescale)**	**Where (Location)**	**Who (Target Group & Partners / Resourcing)**	**How (Outputs)**	**Outcomes**	
Quality Assurance	June 2018 -	Ryedale Sports Centre Ryedale Swimming Pool Derwent Swimming Pool	Right Directions Sport England Representatives Regional Activities Manager Contract Manager	Everyone Active will enhance its quality assurance programme by fulfilling its requirements for national, regional and localised quality assurance frameworks. This will mean the centres undertaking the following QA assessments; • Quest	Receive 'Good' score for completion of the Quest Junior Activities Module 90% on internal activities Gold Standard Assessment	R5 S1 – S5

			Duty Managers Site Activity Managers	• Club Mark Accreditation • Gold Standard Assessment for Activities and other sport related modules		
Improving Access	June 2018 -	Ryedale Sports Centre Ryedale Swimming Pool Derwent Swimming Pool	EA Customers and Members NGBs / Schools Contract Manager / General Managers Duty Managers Site Activity Managers	Everyone Active will work with agencies, NGB's, schools, and contractors to review access provision for all groups of people. This will be done by completing consultation and feedback of communities and hard to reach groups. This will be done by; • Physical Activity Access Survey • Attending meetings with clubs and council meetings • Visiting sites with improved outcomes from similar projects • Consulting with the English Federation of Disability Sport and its Inclusive Fitness Initiative (IFI) • Single Customer View Feedback System	200 responses across the contract per 6 months on Physical Activity Access Survey Attend all relevant council meetings which presents an opportunity to discuss improving access to sites	R5 S1 – S5
Customer Satisfaction	June 2018 -	On site and through external media possible external meetings and working groups	EA Customers and Members Contract Manager / General Managers Duty Managers Site Activity Managers	Everyone Active recognise the importance of acknowledging customer feedback and using it to contribute to the long term improvement of its facilities and activity programming. To ensure we continually receive this feedback we will set up the following interventions; • Single Customer View Feedback System • 6 monthly Club and Customer Forums • Focus Meetings for Vulnerable Groups and Charities • Manager Clinics • Surveys for Parties, Holiday Camps, After School Sports Clubs, Adult Activities, Health programmes and sport courses This as well as quality assurance will be considered and recorded for action as part of its centre service improvement plan	Planned feedback and consultation schedule Respond to customer feedback within 48 hours – records kept as evidence to provide to the client School surveys with school head teachers each term across minimum of 6 schools – records kept as evidence to provide to the client	R5 S1 – S5

Section 6 – Measurement and Review

Measurements of success will be varied and comprehensive. Dependant on the action they relate to there will be many different forms including:

- Numbers of courses / activities delivered – both activity and coaching
- Participation rates for activities delivered including GP referrals, courses for coaching,
- Participation of those programmes both Throughput and 'Unique' visits'
- Participation rates of clubs, schools and other organisations in dialogue, the formulation of action plans and the 'signed up' commitment of these organisations in spirit and in practice
- Retention of participants in activity programmes
- Conversions from exercise referral into mainstream fitness/ activity
- Number of successful funding applications and amount of money accessed
- Number of events held and participation
- User & non user feedback – both qualitative and quantitative
- The achievement of coaching qualifications
- Sustainability of programmes

Section 7 – Appendices

- Clubs Directory
- Ryedale district council Plan 2017
- Ambition for Health vision
- Active lives adult survey
- Ryedale district council sport and active lives strategy to 2023
- NHS Scarborough and Ryedale clinical commissioning group strategic plan to 2019
- Start well, live well, age well HC&V sustainability & Transformation plan

Appendix 1

Clubs Directory

everyone ACTIVE

Angling Malton and Norton Angling Club Mr Fox Tel: 01653 600338	**Angling** Ryedale Junior Angling Club Mr Craft Tel: 01653 696785
Athletics Pickering Athletics Ms Lawal Tel: 01751 472877	**Badminton** Coneysthorpe Badminton Club Pauline Foxton
Badminton Pickering Badminton Club Sheila Blenkinsop Tel: 01751 476678	**Badminton** Slingby Badminton Club Mrs Clark Tel: 01653 628625
Basketball Pickering Basketball Club Stuart Cleary Tel: 01751 472846	**Bowls** Harome Bowling Club Mr Hewlett Tel: 01439 770026
Bowls Helmsley Bowling Club Mr Whitham Tel: 01439 771817	**Bowls** Hotton-Le-Hole Bowling Club William Campbell-Trotter Tel: 01751 417657
Bowls Kirbymooreside Bowling Club Mrs Horne Tel: 01751 432618	**Bowls** Kirbymooreside Short Mat Bowling Club Mr Hewlett Tel: 01439 770026
Bowls Malton Outdoor Bowls Club Mr Smith	**Bowls** Pickering Bowling Club Mr Lloyd Tel: 01751 472566
Bowls Malton and District Short Mat Bowls Club Brian Tel: 01751 432688	**Bowls** Ryedale Indoor Bowls Club Bowling Lane, Scarborough Road Norton Malton YO17 7EG Tel: 01653 600010
Bowls Settrington Bowling Club Mr Croser Tel: 01653 692522	**Bowls** Swinton Indoor Short Mat Bowls Club Matt Fenwick Tel: 01653 694640
Bowls Thornton-Le-Dale Bowling Club Mr Knapton Tel: 01751 477495	**Bowls** Welham Bowling Club Michael Pole Tel: 01653 699624
Canoeing Malton and Norton Canoe club Mr S Scott	**Cricket** Ebberston Cricket Club Mr Winspear Tel: 01723 507978
Cricket Heslerton Cricket Club Mr Nutt Tel: 01723 859616	**Cricket** Hoveringham Cricket Club Mr Mosey Tel: 01439 788300
Cricket Kirbymooreside Cricket Club Andre & Debbie Bayes Tel: 01904 479823	**Cricket** Malton and Old Malton Cricket Club Mrs Hudson Tel: 01653 692223
Cricket	**Cricket**

Nawton Grange Cricket Club Mr Collier Tel: 01439 771212	Pickering Cricket Club Mr Mansfield Tel: 01751 475442
Cricket Sheriff Hutton Bridge Cricket Club Barrie Speake Tel: 01904 760096	**Cricket** Snainton Cricket Club Karen Maw Tel: 01723 859530
Cricket Thornton-Le-Dale Cricket Club Mr Calvert Tel: 01751 472533	**Cricket** Thixendale Cricket Club Ms England Tel:
Cricket Westow Cricket Club Ms Price Tel: 01653 658338	**Croquet** David Wilson Tel: 01653 692207
Cycling Malton Wheeler Road Club Matther Enticknap Tel: 01653 694571	**Fencing** Welburn Fencing Club Donald Walker Tel: 01653 648026
Football Amotherby and Swinton Football Club Mr Audsley Tel: 01653 658208	**Football** Brooklyn Junior Football Club Mr C Lloyd Tel: 01653 693682
Football Heslerton Football Club Mr Driver Tel: 01653 693598	**Football** Kirbymoorside Junior Football Club Mr Alexander Tel: 01751 431162
Football Norton United Football Club Tel: 01653 693241	**Football** Pickering Town Community Football Club Keith Usher Tel: 01944 711410
Football Pickering Town Junior Community Football Club Gary Dawson Tel: 01751 432576	**Football** Thornton-Le-Dale Football Club Mr Barnes Tel: 01751 475134
Football Malton and Norton Football Club Mike Snowden Tel: 01653 699874	**Golf** Ganton Golf Club Mr Ware Tel: 01944 710329
Golf Kirbymoorside Golf Club Ms Rivis Tel: 01751 431525	**Golf** Malton and Norton Golf Club Mrs Gurnell Tel: 01653 697912
Golf Snainton Golf Centre Ltd Mr Hinchliffe Tel: 01753 859914	**Hockey** Malton Ladies Hockey Team Mrs Julie Pease Tel: 07763 009885
Hockey Pickering All Blacks Mrs Todd Tel: 07966 536289	**Hockey** Pickering Junior Girls Hockey Club Mrs Taylor-Olsson Tel: 07738 227586
Hockey Pickering Ladies Hockey Club Mrs Williams Tel: 01751 476741	**Martial Arts** Ryedale Judo Club Mr Seller Tel: 01751 431744

Martial Arts Lee Family Arts Tai Chi Mr P Abbott Tel: 01759 305221	**Martial Arts** Malton Karate Club Mr S Flint Tel: 07814 54013
Martial Arts Ryedale Dragons School of Kung Fu	**Motoring** Malton Motoring Club Mr Harper Tel: 01904 760050
Motoring Pickering and District Motor Club Mr Brown Tel: 01904 622274	**Mountain Biking** Purple Mountain Biking Tel: 01751 460011
Netball Pickering Netball Club Mr Grady Tel: 01751 470041	**Orienteering** Eborienteers Orienteering Club Mr Speake Tel: 01904 760096
Outdoor Adventure Peat Rigg Outdoor Training Centre Mr Thorpe Tel: 01751 417112	**Outdoor Adventure** Ryedale Forum for over 50's Mr wray Tel: 01653 693635
Petangue Westow Petangue Club Mr Ainley Tel: 01653 693107	**Rugby** Malton and Norton R.U.F.C Mr Laidler Tel: 01751 472228
Squash Malton Squash Club Mr Gillbank Tel: 01653 699388	**Squash** Kirbymoorside Squash Club Mr Goodyear Tel: 01751 432217
Squash Thornton-Le-Dale Squash Club Mr P Turner Tel: 01751 477129	**Scuba** Ryedale Sub Aqua Club Mrs Grantham Tel: 07949 017434
Swimming Derwent Valley Amateur Swimming Club Mr Mark Wheatley Tel: 01653 693572	**Swimming** Ryedale Swimming Club
Table Tennis Malton and Norton Table Tennis Coaching Club Mr Stansfield Tel: 01944 738714	**Table Tennis** Ryedale Sports Club Table Tennis Club Mr Gascoyne Tel: 01751 474954
Table Tennis Amotherby Table Tennis Club Mr Seed Tel: 01653 696704	**Table Tennis** Helmsley Table Tennis Club Ms R Purseglove Tel: 01439 771095
Table Tennis Hovingham Table Tennis Club Mr Ellis Tel: 01653 628699	**Table Tennis** Ryedale Table Tennis League Mr Seed Tel: 01653 696704
Tennis Ryedale Sports Club – Tennis Club Peter or Karen Hill	**Tennis** Pickering Tennis Club Mr Grady Tel: 01751 470041
Tennis Sheriff Hutton Tennis Club Mrs Johnson Tel: 01347 878626	**Tennis** Kirbymoorside Tennis Club Mrs Clements Tel: 01751 431787

Tennis Malton Tennis Club Ms L Dwyer Tel: 01439 770881	**Walking** Ryedale Walking Group Mr Catterall Tel: 01751 476380

Appendix 2

Ryedale District Council Plan 2017

everyone ACTIVE

Vision:

The vision for Ryedale District Council is to continue doing what matters for Ryedale...

Values:

Passion:
We are passionate about our communities and the services we deliver

Respect:
We value every individual, respecting people for who they are and for their unique knowledge, skills and experience

Openness:
We are open and honest in our relationships and in our communications

Unity:
We will work as one organisation

Decisive:
We are willing to make brave decisions, to take on big challenges and see them through

Priorities:

Sustainable Growth

- Promoting a strong economy with thriving businesses and supporting infrastructure for future generations
- Capitalising on our culture, leisure and tourism opportunities
- Managing the environment of Ryedale with partners
- Enabling the provision of housing that meets existing and anticipates future need
- Minimising homelessness, improving the standard and availability of rented accommodation and supporting people to live independently

Customers & Communities

- Designing all of our services with the customer at the heart of everything we do
- Making the best use of resources to ensure maximum benefit for all customers and communities across the district, particularly the most vulnerable
- Helping our partners to keep our communities safe and healthy
- Supporting Communities to identify their needs, plan and develop local solutions and resilience

One Ryedale

- Working together as One Ryedale, members and staff share the PROUD values and behaviours
- Utilising assets in supporting the delivery of priorities
- Developing business opportunities for the Council and optimise income
- Building capacity and influencing policy in partnership
- Enabling services through the innovative use of IT
- Delivering the Towards 2020 programme and anticipating further savings required to 2022

Performance:

RYEDALE DISTRICT COUNCIL

Sustainable Growth

- Economic growth
- Housing delivery
- Homelessness prevention

Customers & Communities

- Customer satisfaction
- Timely delivery of services
- Take up of services

One Ryedale

- Budget monitoring
- Income generated
- Salaries monitoring

Appendix 3

Ambition for Health Vision

everyone ACTIVE

Ambition for Health

Transforming health and social care services in Scarborough, Ryedale, Bridlington and Filey

Our vision

Contents

1.0 Introduction

The organisations responsible for health and social care in Scarborough, Ryedale, Bridlington, Filey and the surrounding area have united to create a shared ambition for the health of local communities.

This is an important time for health and social care services. We want you to be aware of our plans, why they are needed; and to know how all of us, as local residents, can keep ourselves healthy and independent and can help to influence the health and social care services we use.

This document sets out our ambition and explains why things need to change. Whilst it will take time for us to achieve our ambition, it is essential that we start taking action now. As you will read and may be aware, the NHS and social care, both nationally and locally, are facing some big challenges. Not only is our population changing and needs more care and support, we also have the added pressure of providing this care with less money and in a jobs market where fewer people are choosing to work in health and social care.

The only way, and we believe the best way, we can respond to these challenges is by working together to review and change the way we do things. By acting now we will ensure our communities have access to the best information and advice to keep well, and can access health and social care support – now and long into the future.

All partners – across the local NHS and Council organisations listed above – have committed to supporting the Ambition for Health Programme and to promote better health and the future sustainability of health and social care services in our communities.

2.0 Our ambition

Our ambition covers three main aspects of health and social care:

1. **Healthy lifestyles** – An ambition to help people lead healthy lifestyles, supporting them to take control of their own health to prevent illness

2. **Care at home** – An ambition to improve the care provided at home and in the community (sometimes called 'out of hospital care') so that health and social care services work more closely together with the aim of preventing people needing treatment in hospital

3. **Sustainable services** – An ambition to ensure that our hospitals and other major services are of a high quality, are financially sustainable and that we all have access to the right care, in the right place, at the right time.

These ambitions are informed by what local people tell us; and what local statistics show. They also respond to national and local strategies, including the NHS Five Year Forward View and the Joint Health and Wellbeing Strategies of North Yorkshire and the East Riding of Yorkshire.

3.0 Why we need to change

There are four main reasons why we must take action now:

Changing health needs of communities creating more demand for health and care services

Poor health outcomes for people living in deprived areas

Workforce pressures from an inability to recruit and retain staff

Financial pressures from a reduction in funding for health and care services

3.1 Changing health needs of our communities

Beyond the famous coastline and the beauty of the North York Moors National Park, our area has a significant and diverse population. It has a mix of deprived and affluent, urban and rural. The main urban centre of Scarborough is located approximately 40 miles away from the nearest city. It experiences significant seasonal fluctuations in population – the impact of which can be immense on health and care services.

Scarborough Hospital is a cornerstone of local health services and much valued by local people. However, our local health and social care systems experience financial and workforce pressures which are increased by current national financial and policy models. The small resident population of Scarborough and surrounding areas does not generate sufficient demand to provide enough income to build sustainable services, which is why we need to modernise services and change the way they are funded. It is anticipated that Bridlington Hospital would continue its role as an Elective Care Centre.

From a national perspective, England has an ageing population. By 2025, the number of people over 80 years old will have increased by 50% compared with 1995. We can expect the growth in our ageing population to lead to an increase in conditions such as dementia and an increase in unplanned hospital admissions. Much is made of the increasing age of the population and the pressure this will place on health and social care services. Whilst this pressure is real and cannot be ignored, we will also seize the opportunity of a generation who are staying healthy for longer into retirement, to drive community and voluntary involvement. Many older people are the glue of our communities, looking after younger generations and volunteering to help others.

We must also recognise that treating a person's physical condition only responds to part of their needs. We will establish equality between physical and mental health and will strive to understand the personal and social context that has led to a person needing support from health or social care. By managing purely medical or care needs as they appear at a moment in time, we miss an opportunity to understand the root cause of those issues and therefore limit the possibility of it happening again.

We therefore need to create a model of care that places an emphasis on prevention in the community, has less reliance on people having to access care at hospital by providing services in alternative settings, and maximises people's potential to be independent through intermediate care and re-enablement services.

EXAMPLE: A SNAPSHOT OF HEALTH IN OUR AREA

- **The gap in life expectancy between the least and most deprived communities in North Yorkshire is around 12.5 years for men and 5.6 years for women**
- **In North Yorkshire 52,790 people have common mental health problems**
- **The leading cause of premature death (people under 75 years of age) in Scarborough and Ryedale is cancer, accounting for 38% of all deaths**
- **The number of people over 65 years of age is set to increase from 12,300 to 15,800 in Ryedale and from 25,500 to 31,300 in Scarborough**
- **Public Health priorities in Scarborough include reducing health inequalities in cardiovascular disease, reducing the prevalence of smoking and harm caused by alcohol.**

3.2 Poor health outcomes for people living in deprived areas

Life expectancy for people living in our most deprived areas is reduced by as much as 12 years compared with those living in the least deprived areas. This shocking statistic is linked to people leading unhealthy lifestyles, such as eating unhealthy food and being overweight, smoking, and/or drinking too much alcohol. This can lead to early deaths from conditions such as heart disease or stroke. We need to continue to raise awareness of the risks of leading unhealthy lifestyles and support people to change their behaviours.

Unhealthy adults often start life as unhealthy children, so we need to work closely together to support people to make good lifestyle choices for themselves and their children in all avenues of life, be it diet or smoking.

We will adopt the Making Every Contact Count (MECC) approach that encourages health and social care staff to have conversations with people using our services based on behaviour change methodologies (ranging from brief advice, to more advanced behaviour change techniques), so that people are encouraged to make healthier lifestyle choices. We will also work together to see what we can do to address what are called the wider social determinants (for example, the economy and employment, housing, transport) that influence our health.

EXAMPLE: THE IMPACT OF DEALING WITH INCREASING DEMAND FOR CARE WITH LIMITED RESOURCES

- **The winter of 2014/15 is a good example of how high demand for health and social care services combined with workforce pressures pushed the health system to its limit.**
- **Scarborough Hospital experienced significant service pressures with a number of occasions where all inpatient beds were occupied. Patients experienced long waits for assessment and many emergency admissions had to be diverted to other hospitals.**
- **This 'winter pressure' came after a sustained period of time (approximately 18 months) where Scarborough's emergency department had been unable to achieve the standard four-hour waiting time. One of the consequences of high numbers of emergency admissions was a high level of cancellations for planned procedures (such as knee and hip replacement surgery) as emergency and planned patients 'competed' for a limited number of beds.**
- **These types of situation can also have a knock-on impact in the community, particularly for people who need 24 hour care in a residential or nursing home or who need help with personal care at home. A number of care homes have closed in the area in recent years and some that remain, alongside home care services, can find it difficult to recruit and retain staff.**

We also recognise that health and social care cannot be separated from the communities in which services operate, so we will work closely across statutory, business and voluntary partners to explore ways in which we can contribute to the wellbeing and sense of pride and belonging of local communities.

We also know that there are areas of Scarborough, Ryedale, Bridlington and Filey which suffer from poor housing stock and have high levels of private sector renting, with properties unsuitable for adaptation should a person's needs change. Across rural areas, there are also issues around housing such as fuel poverty and affordable warmth, although these tend to stem from people living in isolated, poorly insulated homes, which have become unsuitable as a person's age advances. Circumstances such as these increase the risk of people suffering either a physical injury such as a fall, or of becoming lonely and isolated with the subsequent deterioration of mental health and wellbeing. We will work closely with communities, housing providers and landlords to ensure that housing is suitable, safe and adaptable as people age with a view to ensuring people are able to remain independent and in their own homes for as long as possible.

EXAMPLE: THE IMPACT OF LEADING AN UNHEALTHY LIFESTYLE IN SCARBOROUGH

- **Levels of smoking are significantly worse than the national average at 21.8% and accounted for approximately 250 deaths in 2012. The smoking rate for mothers at the time of delivery was 17.7 per 100,000 – well above the nation average of 12 per 100,000.**
- **The rate of alcohol related harm hospital stays was 649 per 100,000, which represents 721 stays per year which is in line with the national average. In 2012 24.1% of people were classified as obese with rates of early death from heart disease and stroke trending above the England average at 92 deaths per 100,000. Despite this, levels of physical activity in adults are reported as above the England average.**

3.3 Workforce pressures

Recruitment and retention of both clinical and social care staff in our area is a huge problem. Not having enough specialist health staff to provide care can lead to services becoming unsafe, which then means alternative solutions must be found, usually at short notice. In social care a lack of social workers and occupational therapists can lead to delays in assessments and hospital discharges, whilst a lack of care workers can result in understaffing in care homes or the inability of the sector to meet demand especially at peak times, which again impacts on the health service. Where any part of the system is understaffed, this situation can result in cancellations to planned treatments or temporary arrangements being put in place, which cause disruption for everyone involved.

Workforce issues are not unique to our area; they are a national issue which will take time to address. We need to provide services in different ways which can be delivered by current levels of staff and which attract new people into the health and social care workforce. We will explore how to make the NHS and social care more attractive as employers and care as a career of choice.

The seasonal nature of employment in the area (linked with tourism) is not an issue that can be solved easily. We will look to develop ways of working with the current labour market to create a sustainable and predictable staffing base for all services.

EXAMPLE: THE IMPACT OF NOT HAVING ENOUGH SPECIALIST CLINICAL STAFF

In June 2015, the local NHS had no choice but to make changes to how patients received immediate care following a stroke.

Typically, a stroke patient would receive their immediate care (hyper acute) from a stroke consultant at Scarborough Hospital, and then be moved to a different part of the hospital or sent home for rehabilitation. Two stroke consultants working at Scarborough Hospital retired earlier this year and, despite numerous attempts over a long period of time, efforts to recruit replacement consultants had only limited success.

In order to maintain safety, measures were introduced which meant that any patient suffering a stroke in the Scarborough area would first be taken to Scarborough Hospital for initial assessment and thrombolysis (clot busting drugs) if appropriate, before being transferred to York Hospital to receive hyper acute consultant care (typically required for around three days).

The need to introduce this change was solely because of an inability to recruit the specialist staff required to provide a safe service in Scarborough Hospital.

There is also an opportunity to invest in workplace health and wellbeing for colleagues across the local health and social care system. This will contribute to their delivery of the best care possible to those they serve; and also help keep employee absence rates low.

3.4 Financial pressures

In 2012, York Teaching Hospital NHS Foundation Trust took over Scarborough and Bridlington Hospitals. This change included a significant amount of financial support provided by NHS England to help with the transfer of services. This financial support ends in 2017.

The way hospital services are currently provided is not sustainable without this funding.

The extent of the financial challenge should not be underestimated – by 2017 the budget for hospital care will be reduced by at least £17million compared with today. The Local Authority picture is no less challenging, with Councils having to make savings in social care of at least £6million locally by 2020.

We do not believe additional financial support will be made available to the NHS and other local health and social care services in our area. Therefore, to meet the challenges presented by this financial reality,, we must seek new and alternative ways to provide care which are just as effective in terms of health outcomes for local people. As an example, health and social care will need to work closely together to avoid duplication and deliver joined-up care.

It is worth remembering that even with spending reductions, the NHS and local government in our area invest over £200 million each year in health and social care services. In addition, significant numbers of people, who are not eligible for public funding, fund their own social care. Investment hasn't ceased during this period of financial pressure, and we will ensure that future investments are also made wisely and managed well.

4.0 A change for the better: our top priorities

The challenges detailed above are having a significant impact on our ability to deliver the quality of care that local people and services expect. For example, not having enough staff to provide care can often result in lengthy waiting times and cancelled appointments, all of which lead to a bad experience for people.

Although the way services are provided in the future may look quite different, they will continue to be provided to the best possible standard and, where possible, to a better standard than they are now. We will be active learners from good and poor practice.

EXAMPLE: PREVENTION IS BETTER THAN CURE

North Yorkshire County Council and NHS Scarborough and Ryedale Clinical Commissioning Group are funding a new team of Living Well Co-ordinators, to work with people who are on the cusp of needing care. This programme will focus on making the most of the support that exists in local communities and help individuals to maintain or re-gain their confidence. Alongside this, the Stronger Communities Programme is already supporting voluntary and community organisations to develop and maintain community transport schemes, improve youth services, maintain libraries and provide support to older and disabled people.

The County Council and Borough and District Councils are also working together to build more extra care and supported accommodation, so that more people can live independently, with help available if it's needed. The efficient use of Disabled Facilities Grants will also aid those in private-sector accommodation to make necessary home adaptations.

And there's support too for making healthier lifestyle choices. New Stop Smoking Services are being developed and the Public Health service is funding Scarborough Borough and Ryedale District Councils to pilot a weight management programme for individuals aged 18 who are obese. There's also some targeted work to increase take-up of NHS Health Checks amongst farming communities and in the most deprived wards in Scarborough: Castle, Central, Falsgrave Park, Northstead, Ramshill, and Stepney, as well as with homeless people.

In working towards achieving our ambitions, we will focus on ten major priorities:

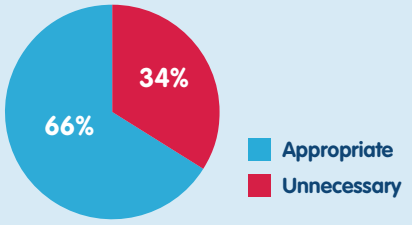
1. Prevention, self-care and helping people of all ages to lead healthy and active lifestyles – with a particular emphasis on encouraging a smoke free generation
2. Improving emotional health, through better mental health services and helping people to live well with dementia
3. Providing services that are of the expected quality and safety, within budget
4. Securing a sustainable future for Scarborough Hospital, in particular maintaining core services including the care of the emergency patient, obstetrics (pregnancy and childbirth) and paediatrics (services for babies, children and young people). Bridlington Hospital would continue as an Elective Care Centre.
5. When people do need to be admitted to hospital, ensuring they return home as soon as they are fit and ready to do so
6. Providing more services in the community wherever possible, including better support for carers and more choices for people to live in their own homes with support, leading to a consequent reduction in unnecessary admissions to hospital and to 24 hour care
7. Supporting people to have more choice about where they die
8. Working together to align services, reduce duplication and ensure a positive experience of health and social care for each individual
9. Listening to, and shifting power, to patients and the public, including through better information and advice send the creation of shared records
10. Developing our workforce and recruit and retain the right people for the right roles

EXAMPLE: DO PATIENTS REALLY NEED TO BE IN HOSPITAL?

In 2014 we undertook an audit of occupied beds on wards at Scarborough Hospital, Bridlington and Malton Community Hospitals and two residential/rehabilitation care homes. The aim of the audit was to see how many of the patients occupying beds were receiving the appropriate level of care for their needs, which ranges from level one to level five:

- **Level 1 – Intensive care**
- **Level 2 – Acute care**
- **Level 3 – Specialist rehabilitation**
- **Level 4 – Rehabilitation in own home or rehabilitation/care home**
- **Level 5 – Fit for hospital discharge**

The findings were very interesting. Out for the 371 patients included in the audit, 127 were deemed to be receiving a level of care that was unnecessary for their needs:



This was mainly patients receiving level 4 care (rehabilitation) or level 5 care (fit for hospital discharge).

In summary, this means that 34% of the patients included in the audit were either receiving a level of care above what they needed (level 4) or were still in hospital when they no longer need to be (level 5). If patients reside in an inappropriate part of the system relative to their needs, it wastes precious resources and does the patient a disservice.

5.0 Achieving our ambition

We are still very much at the start of our journey. However, we have set ourselves a clear direction of travel. Over the coming months we will begin to develop more detailed plans about the changes we need to make. We are committed to involving you in this process. We are still very much at the start of our journey. However, we have set ourselves a clear direction of travel. Over the coming months we will begin to develop more detailed plans about the changes we need to make. We are committed to involving you in this process.

Involving you through communications and engagement

It is important we raise awareness amongst local people about how we can work together to overcome the challenges presented in this document, for example how all of us who live locally can lead a healthier lifestyle or how the NHS and local government can use resources better.

Your opportunity to get involved in shaping our plans begins now.

As we use your feedback to help define our proposals and plans further, there will be additional opportunities to have your say. For example, we are committed to consulting on services that may look significantly different in the future, and acting on guidance and feedback from local Health Overview and Scrutiny Committees and independent bodies such as HealthWatch. These Committees/bodies also double-check that our plans and proposals meet our statutory obligations.

If you have any comments on the contents of this document, or would like to make suggestions for how you think we can achieve our ambition for health, we'd like to hear from you. Here's how you can get in touch:

By email: **ambitionforhealth@nhs.net**

By letter:

Ambition for Health
c/o NHS Scarborough & Ryedale CCG
Scarborough Town Hall – York House
St Nicholas Street
Scarborough
North Yorkshire
YO11 2HG

Ambition for Health

Transforming health and social care services in Scarborough, Ryedale, Bridlington and Filey

North Yorkshire County Council

Whitby Scarborough Filey Borough Council

Ryedale District Council

East Riding of Yorkshire Council

NHS

NHS Scarborough and Ryedale Clinical Commissioning Group
NHS East Riding of Yorkshire Clinical Commissioning Group
York Teaching Hospital NHS Foundation Trust
Tees, Esk and Wear Valley NHS Foundation Trust

Appendix 4

Active Lives Adult Survey

everyone ACTIVE

ACTIVE LIVES ADULT SURVEY

NOVEMBER 16/17 REPORT

Published March 2018

SPORT ENGLAND

WELCOME

Welcome to the third *Active Lives Adult Survey Report* summarising activity levels in England from November 2016 to November 2017.

With only two full years of data it is too early to meaningfully talk about trends over time, but based on these results, it is fair to say that the picture is one of stability.

Alongside presenting the latest national picture of engagement in sport and physical activity, we have included references to where there have been statistically significant changes in the last year, which you will see indicated with arrows. Where there is no change, or it is within the margin of error and therefore too small to be confident there is a genuine difference, it is recorded as 'no change'.

The intention of this report is to give the big picture in an easily digestible format. For those who want to explore the data further, there are links in this report to the data tables. If you would like to carry out your own analysis of the data, I would recommend you take a look at our Active Lives Analysis Tool, which can be found at activelives.sportengland.org. The tool will enable you to explore the data and focus on your own areas of interest.

Finally, the fourth Active Lives Adult Survey Report (May 2017 to 2018) will be released in October 2018, when two full years of volunteering data will enable us to draw comparisons and shed light on how levels of volunteering to support sport and physical activity are changing.

Lisa O'Keefe
Insight Director

SPORT ENGLAND

CONTENTS

KEY INFORMATION

This report presents data from the Active Lives Adult Survey for the period mid-November 2016 to mid-November 2017. Data is presented for adults aged 16+ in England.

RELEASE DATES

This release: 22 March 2018
Next release: 11 October 2018

FIND OUT MORE

For further information on the data presented in this report, please visit the Active Lives section of our website.

LEVELS OF ACTIVITY

THIS CHAPTER PRESENTS INFORMATION ON THREE LEVELS OF ACTIVITY:

- **INACTIVE** (LESS THAN 30 MINUTES A WEEK)
- **FAIRLY ACTIVE** (30-149 MINUTES A WEEK)
- **ACTIVE** (AT LEAST 150 MINUTES A WEEK)

LINK TO DATA TABLES

DEFINITION

SPORT ENGLAND

WHAT DO WE MEAN BY PHYSICAL ACTIVITY?

THE GRAPHICS BELOW SHOW THE ACTIVITIES WE INCLUDE – AND WHEN THEY COUNT (FOR ADULTS AGED 16+):

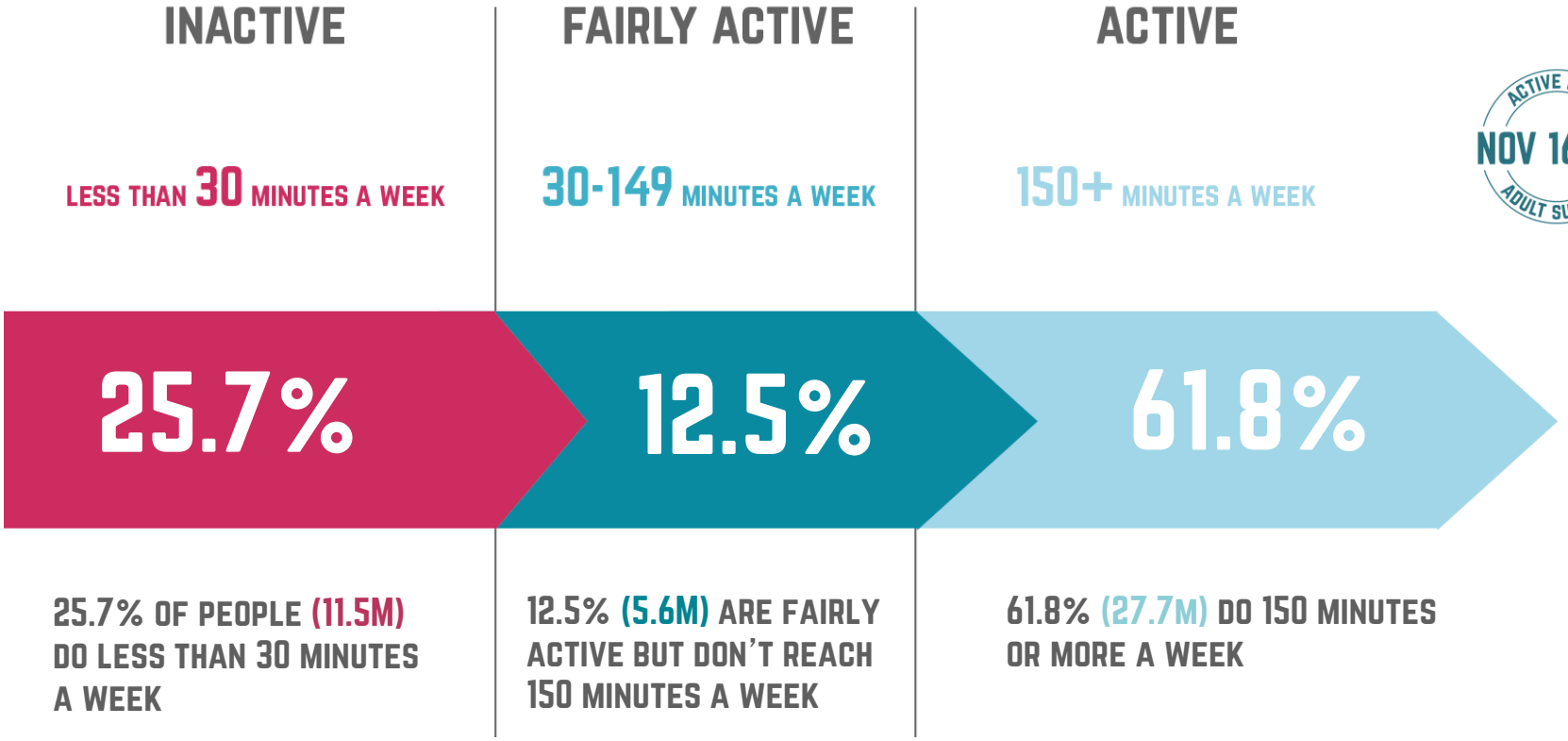
* VIGOROUS INTENSITY COUNTS AS DOUBLE

Note: We count most sport and physical activity, but exclude gardening. However, Public Health England does include gardening in its local level physical activity data. You can view the PHE data here. This will be updated in early April to include the November 2016/17 data.

LEVELS OF ACTIVITY

HEADLINES

Our data shows that 6 in 10 adults (27.7m) are getting the health benefits from achieving 150+ minutes of activity a week.



LINK TO DATA TABLES

LEVELS OF ACTIVITY

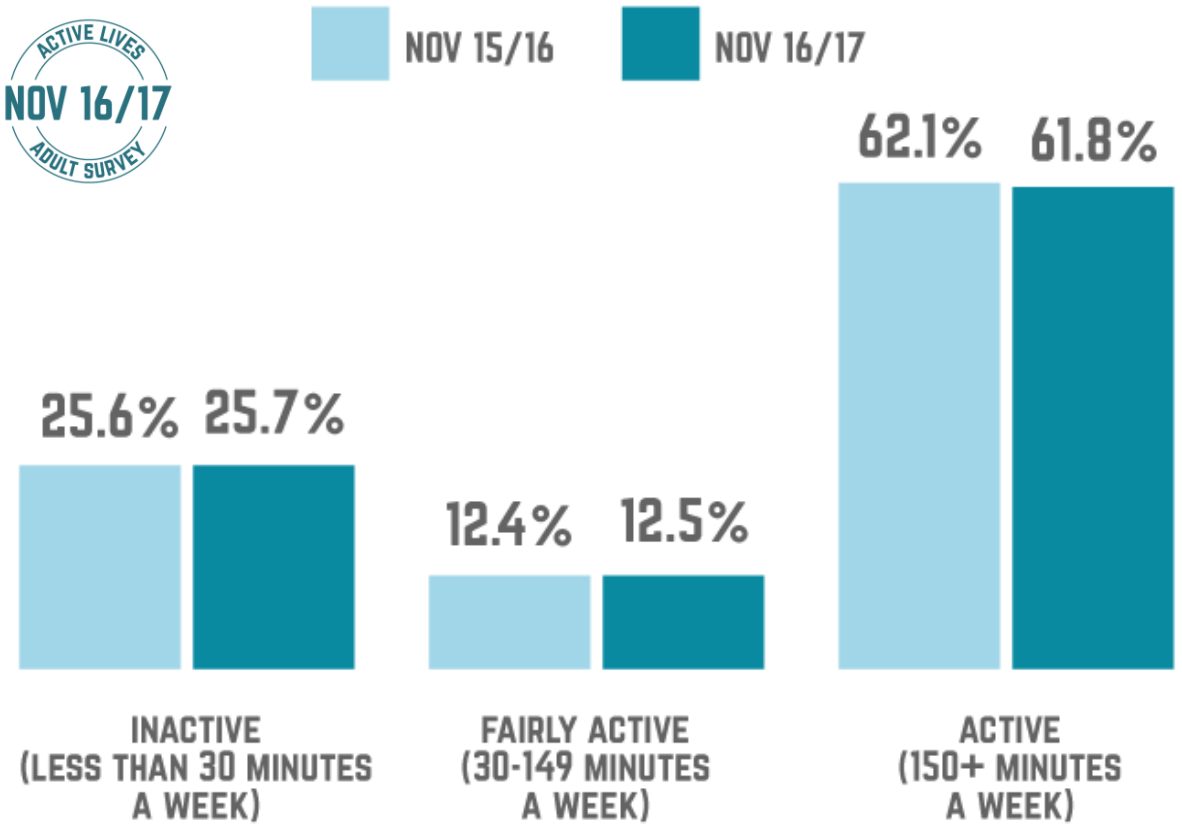
12-MONTH COMPARISON

Activity levels have not changed in the last 12 months.

HOW WE MEASURE CHANGE

Active Lives figures are based on the response of 200,000 adults, which we then scale up to provide an England-wide picture. That means there will naturally be small fluctuations when we compare the figures we have now with 12 months ago.

In accordance with Government Statistical Service good practice guidance, we highlight changes within the report where we are confident that there are genuine differences. If the data is showing only small differences which are within the margin of error, they are noted as “no change”.



LINK TO DATA TABLES

LEVELS OF ACTIVITY

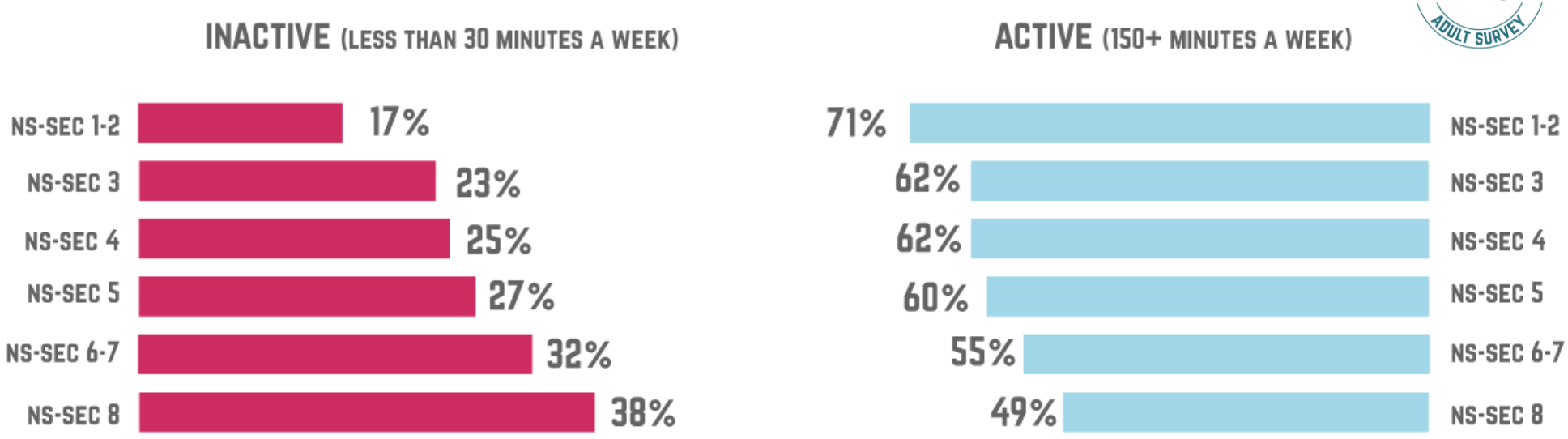
SOCIO-ECONOMIC GROUPS

Our data shows there are significant disparities between different socio-economic groups.

- People who are long term unemployed or have never worked (NS-SEC 8) are the most likely to be inactive (38%) and the least likely to be active (49%)
- People who are in managerial, administrative and professional occupations (NS-SEC 1-2) are the least likely to be inactive (17%) and the most likely to be active (71%).

There have been no changes compared to 12 months ago for any of these groups.

ACTIVE LIVES NOV 16/17 ADULT SURVEY



LINK TO DATA TABLES

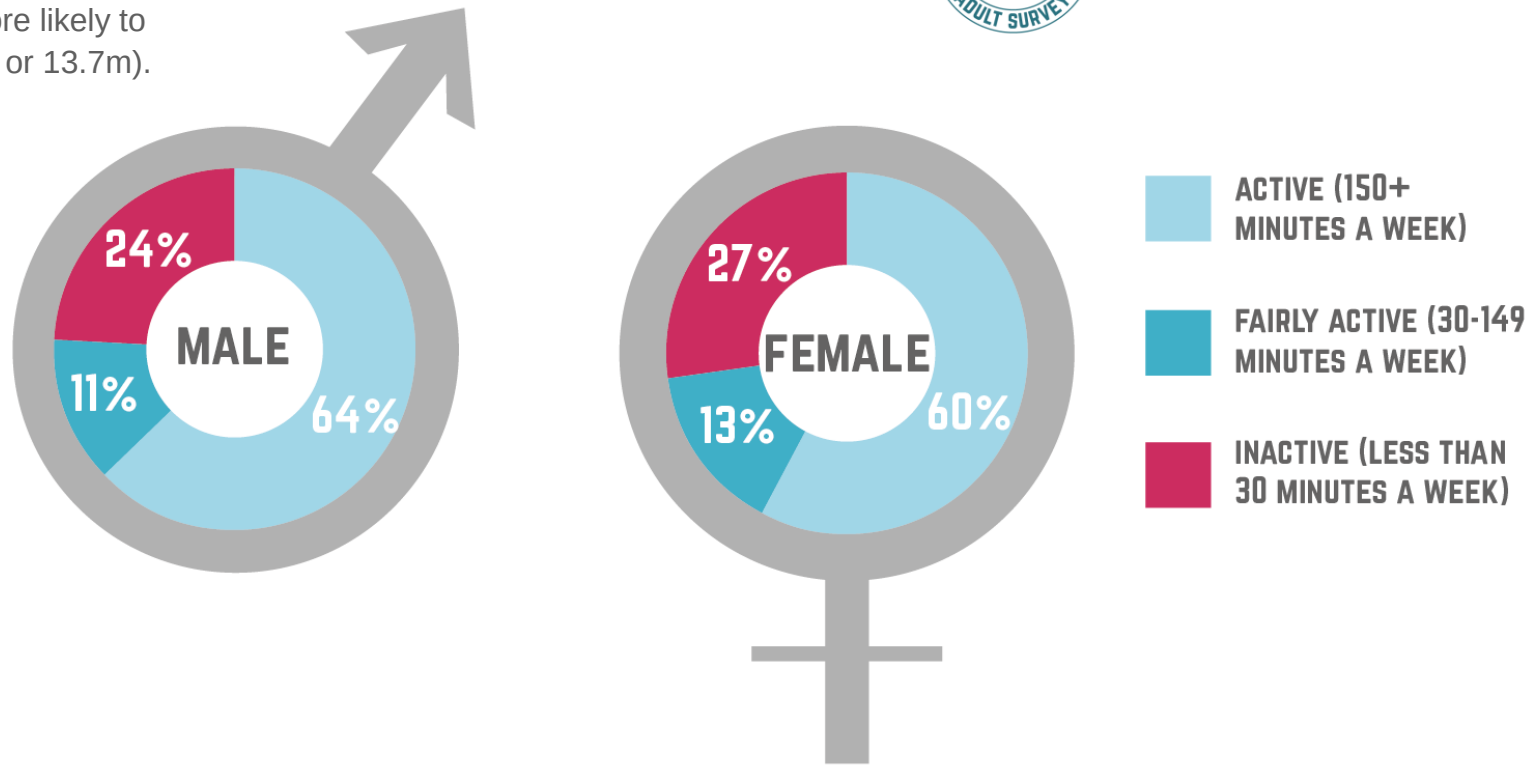
Note: Full details of what the NS-SEC categories mean can be found on the definitions page.

LEVELS OF ACTIVITY

GENDER

Activity levels have not changed compared to 12 months ago for either men or women, so we continue to observe the same gap between them. Men (64% or 14.0m) are more likely to be active than women (60% or 13.7m).

ACTIVE LIVES NOV 16/17 ADULT SURVEY



LINK TO DATA TABLES

LEVELS OF ACTIVITY

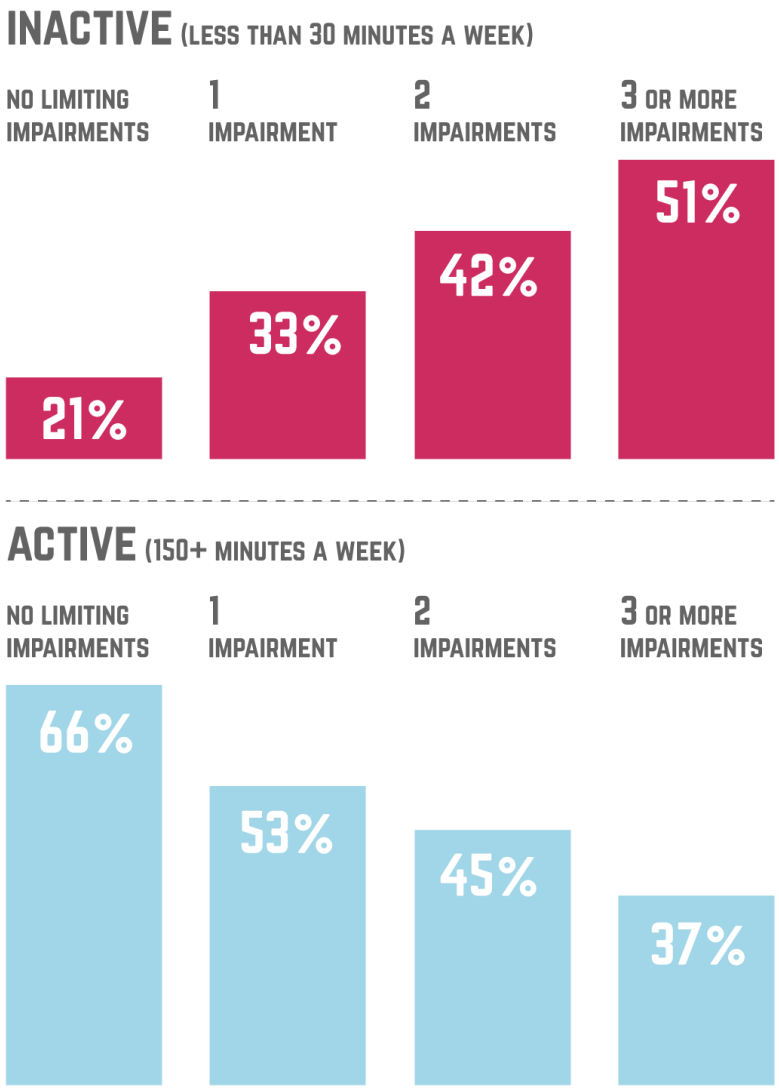
DISABILITY

There have been no changes in activity levels among people with a disability compared to 12 months ago

Inactivity is more common for those with a disability (43%) than those without (21%). Furthermore, it increases sharply as the number of impairments an individual has increases – 51% of those with three or more impairments are inactive.

This is important because over half of all disabled people (52%) have three or more impairments, while 21% have two impairments and 26% have just one impairment (of 14 impairment types), source *Life Opportunities Survey June 09/12*.

LINK TO DATA TABLES



ACTIVE LIVES NOV 16/17 ADULT SURVEY

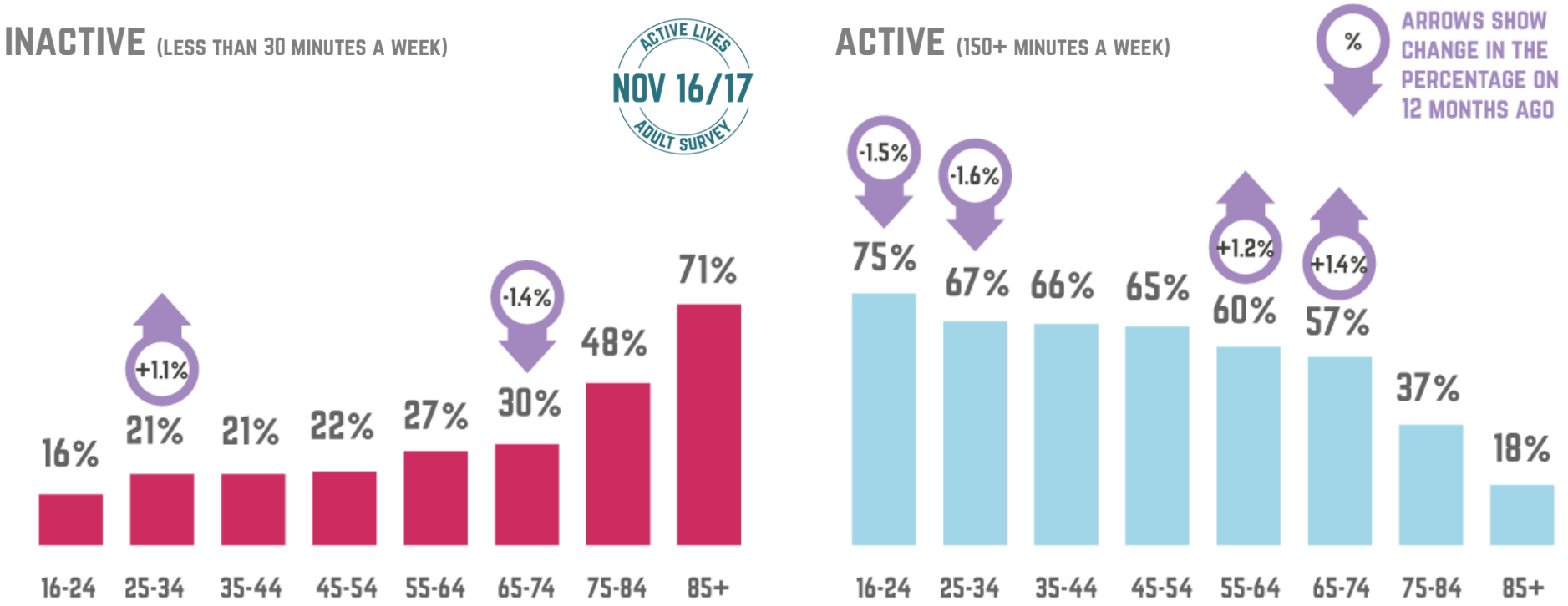
LEVELS OF ACTIVITY

AGE

Inactivity levels generally increase with age, but the sharpest increase comes between ages 75 and 84 (48%) and age 85+ (71%).

Whilst activity levels have fallen slightly among the two age groups covering 16-34 year olds, with fewer achieving 150+ minutes a week, 75% of young people reman active.

In contrast, activity levels have increased slightly among the 55-64 and 65-74 age groups.



LINK TO DATA TABLES

TYPES OF ACTIVITY

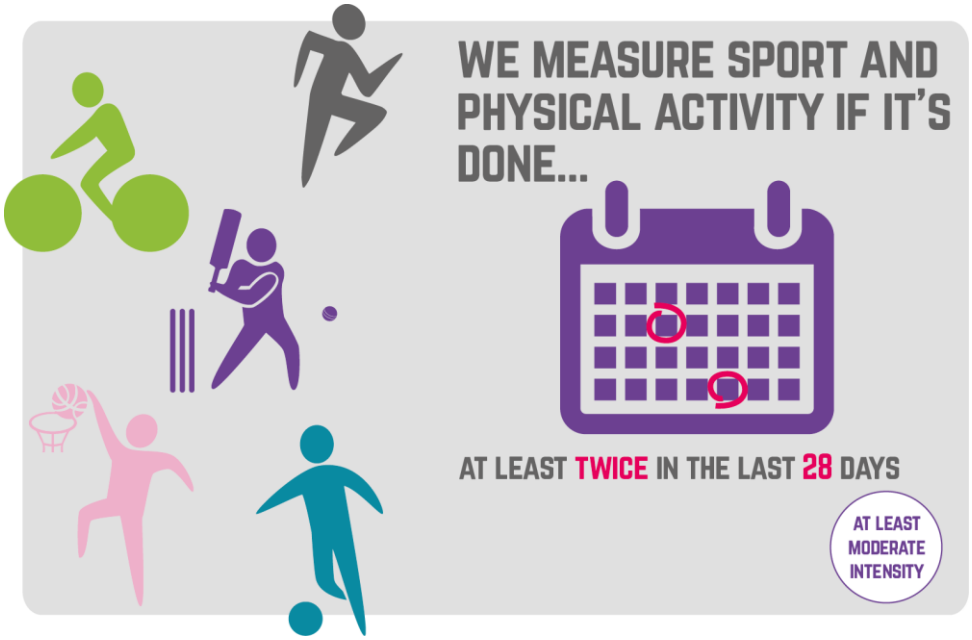
THIS CHAPTER PRESENTS DATA BROKEN DOWN BY ACTIVITY GROUP AND LOOKS AT THOSE WHO HAVE PARTICIPATED AT LEAST TWICE IN THE LAST 28 DAYS.

LINK TO DATA TABLES

PARTICIPATION – OUR DEFINITION

LOOKING AT PARTICIPATION AT LEAST TWICE IN THE LAST 28 DAYS PROVIDES:

- AN ENTRY LEVEL VIEW OF PARTICIPATION OVERALL
- A USEFUL MEASURE OF ENGAGEMENT IN DIFFERENT SPORTS AND PHYSICAL ACTIVITIES
- AN UNDERSTANDING OF THE CONTRIBUTION OF ACTIVITIES TO ACHIEVEMENT OF 150+ MINUTES A WEEK

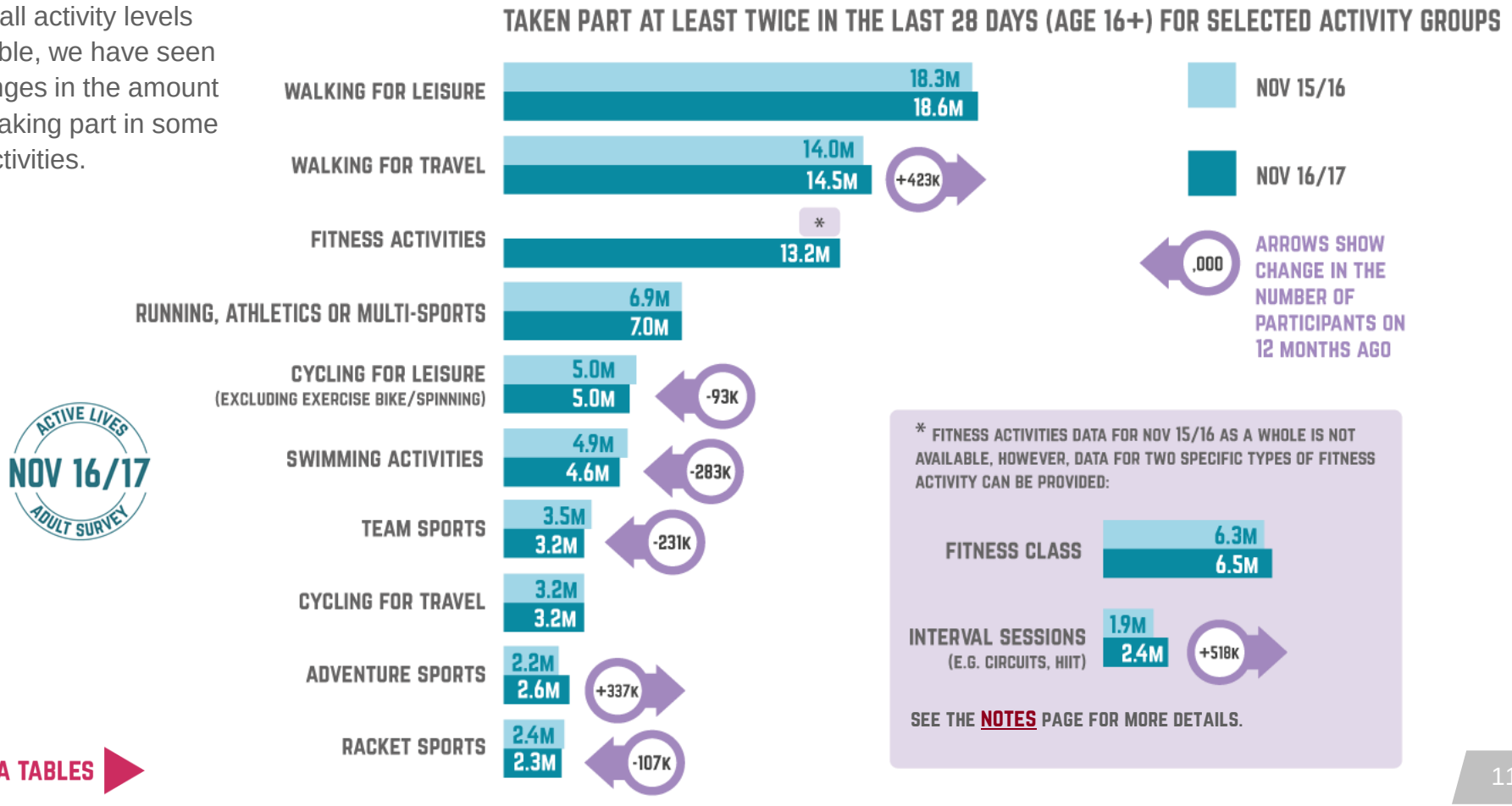


TYPES OF ACTIVITY

ADULTS ACHIEVING 150+ MINUTES OF ACTIVITY A WEEK DO SO THROUGH A BLEND OF ACTIVITIES

Analysis of numbers engaging in activities at least twice in the last 28 days helps us understand the contribution of different activities.

Whist overall activity levels remain stable, we have seen some changes in the amount of people taking part in some of these activities.



LINK TO DATA TABLES

VOLUNTEERING

AT LEAST TWICE IN THE LAST 12 MONTHS

A volunteer makes all the difference. And it benefits both the volunteer and the person receiving the support. Whether it's serving refreshments, coaching a player or assisting people with disabilities to take part, we need people to give their time.

LINK TO DATA TABLES

DEFINITION

SPORT ENGLAND

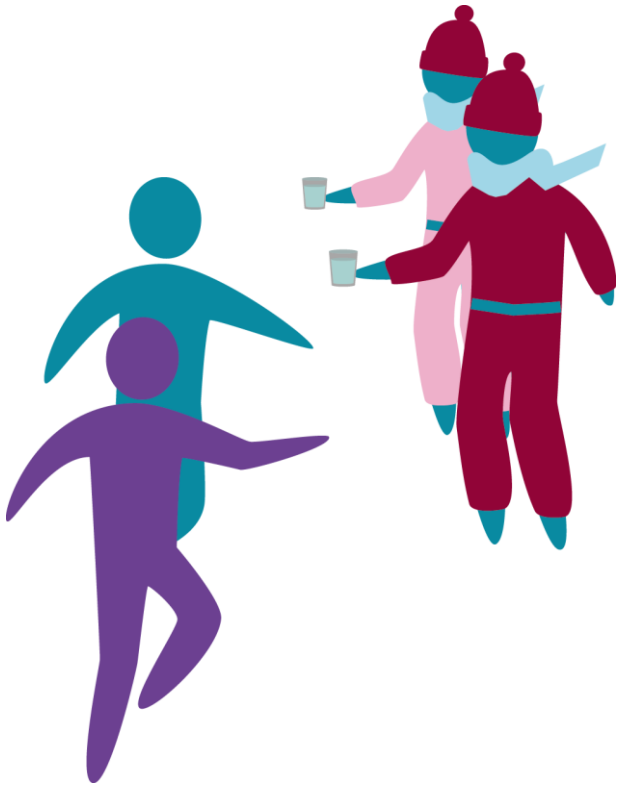
WE COUNT A PERSON AS HAVING VOLUNTEERED IF:

THEY HAVE TAKEN PART IN A VOLUNTEERING ROLE TO SUPPORT SPORT/PHYSICAL ACTIVITY

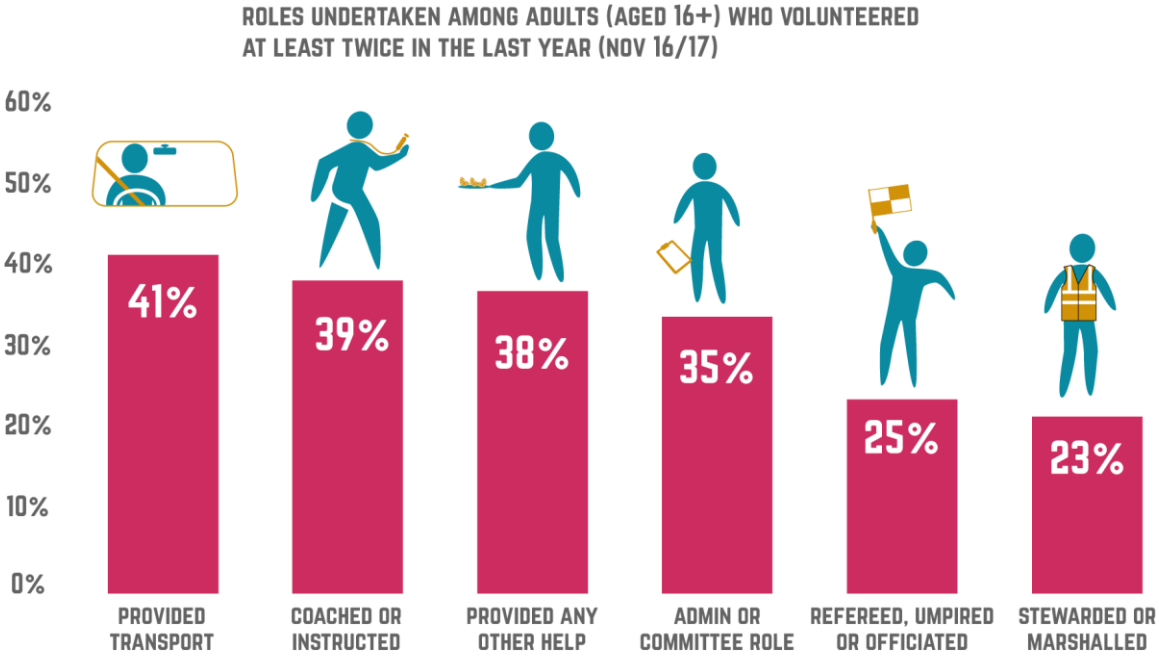
(A full list of roles can be found in our definitions at the end of this report on page 17).

+

A PERSON HAS VOLUNTEERED AT LEAST TWICE IN THE LAST 12 MONTHS



VOLUNTEERING



15%

6.6M ADULTS VOLUNTEERED

AT LEAST TWICE IN THE LAST YEAR TO SUPPORT SPORT AND PHYSICAL ACTIVITY

ACTIVE LIVES NOV 16/17 ADULT SURVEY

Further breakdowns on the profile of volunteers can be found in the data tables linked to this report

LINK TO DATA TABLES

WELLBEING, INDIVIDUAL AND COMMUNITY DEVELOPMENT

Data linked to the following metrics for different levels of engagement in sport and physical activity can be found in the data tables linked to this report:

- Mental wellbeing
- Individual development
- Social and community development

LINK TO DATA TABLES

DEFINITION

SPORT ENGLAND

MENTAL WELLBEING

IS PRESENTED AS AN AVERAGE LEVEL OF AGREEMENT TO THE FOLLOWING QUESTIONS (SCALE OF 0-10):

"Overall, how happy did you feel yesterday?"

"Overall, how satisfied are you with your life nowadays?"

"Overall, to what extent do you feel that the things you do in life are worthwhile?"

"Overall, how anxious did you feel yesterday?"

INDIVIDUAL DEVELOPMENT

IS PRESENTED AS AN AVERAGE LEVEL OF AGREEMENT TO THE FOLLOWING QUESTION:

"I can achieve most of the goals I set myself?"

SOCIAL AND COMMUNITY DEVELOPMENT

IS PRESENTED AS AN AVERAGE LEVEL OF AGREEMENT TO THE FOLLOWING QUESTION:

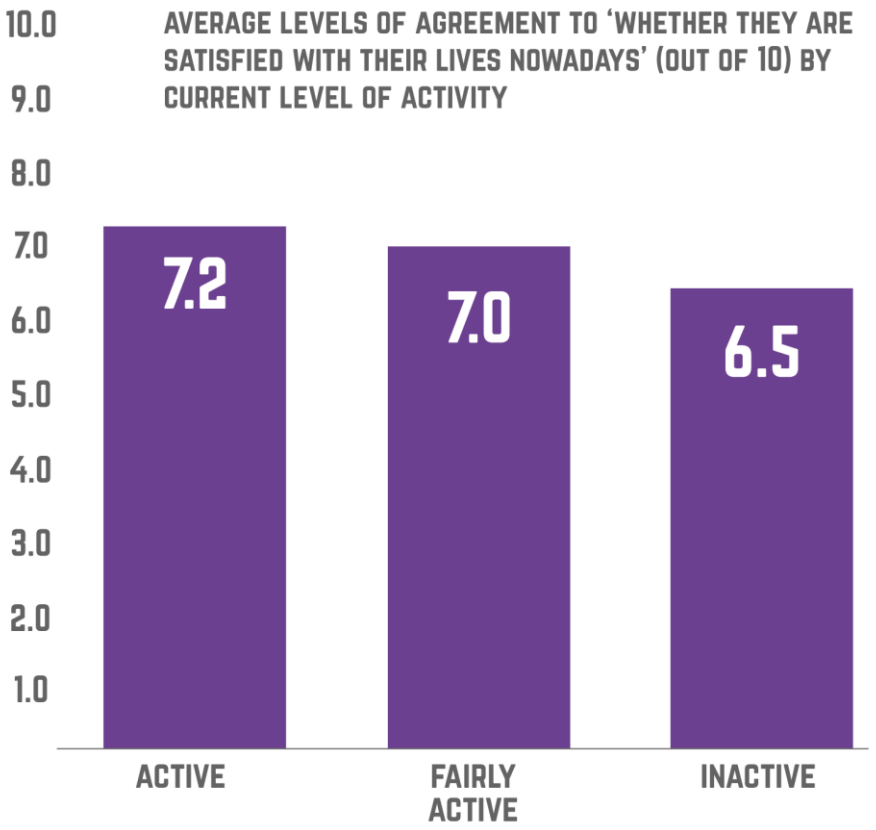
"Most people in our local area can be trusted?"

WELLBEING, INDIVIDUAL AND COMMUNITY DEVELOPMENT

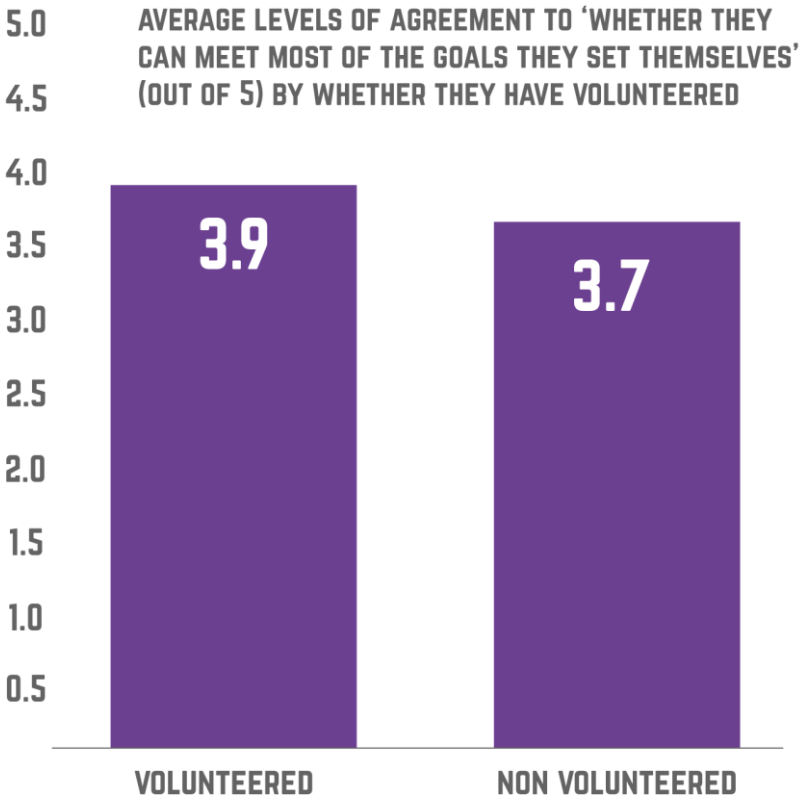
ACTIVE LIVES NOV 16/17 ADULT SURVEY

SPORT ENGLAND

SOME ACTIVITY IS GOOD, MORE IS BETTER IN TERMS OF MENTAL WELLBEING



VOLUNTEERING IS POSITIVELY ASSOCIATED WITH INDIVIDUAL DEVELOPMENT



Further breakdowns across all six metrics linked to both activity levels and volunteering can be found in the data tables linked to this report

LINK TO DATA TABLES

LOCAL LEVEL DATA

Data for local areas, including, nine regions, 44 County Sports Partnerships, and 353 local authorities are available for the following measures:

- **LEVELS OF ACTIVITY**

  LINK TO DATA TABLES

- **PARTICIPATING AT LEAST TWICE IN THE LAST 28 DAYS**

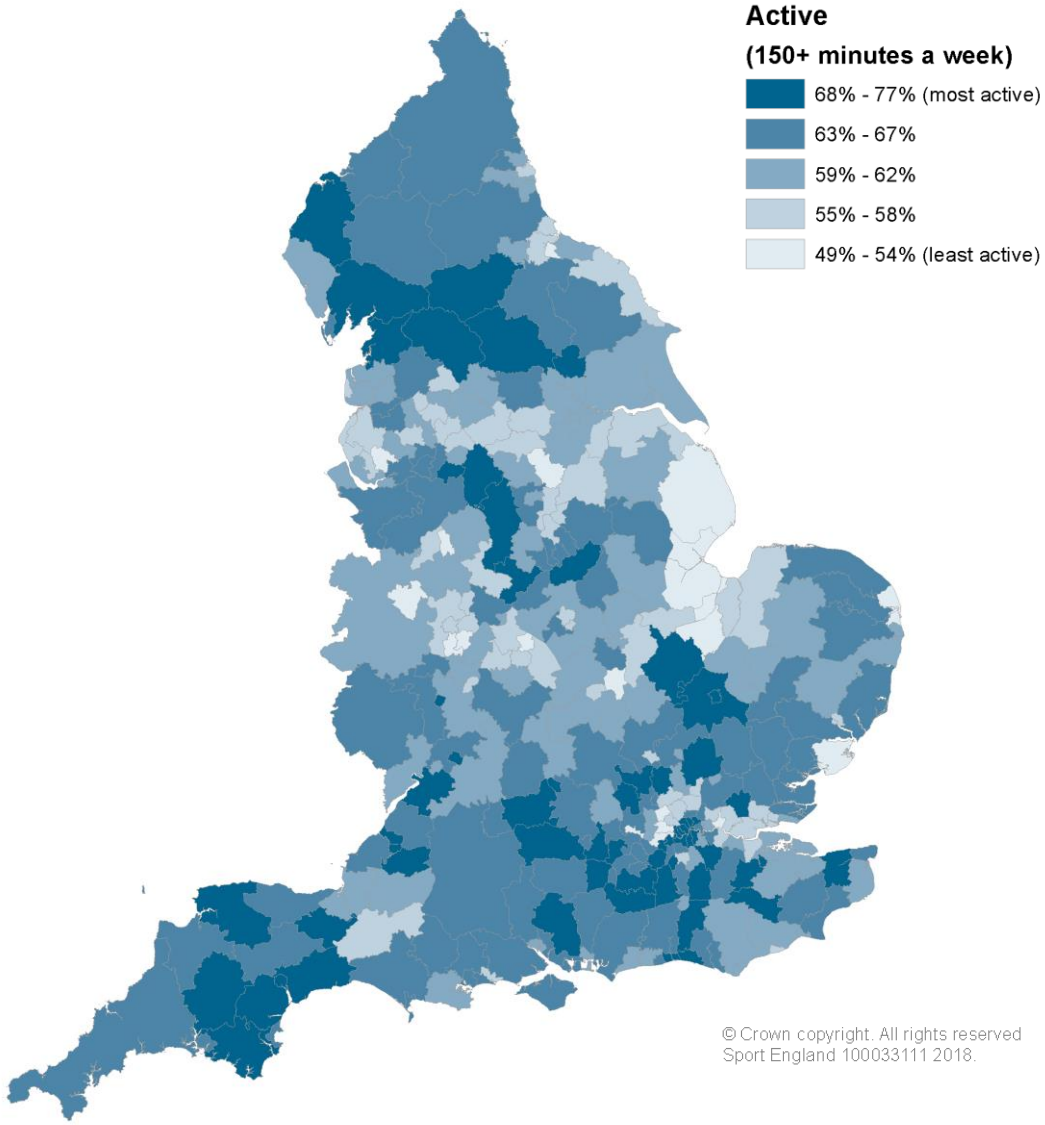
  LINK TO DATA TABLES

- **VOLUNTEERING AT LEAST TWICE IN THE LAST 12 MONTHS**

  LINK TO DATA TABLES

Details of change in the last 12 months can be found in the tables.

ACTIVITY ACROSS ENGLAND



DEFINITIONS

MODERATE ACTIVITY is defined as activity where you raise your heart rate.

VIGOROUS ACTIVITY is where you're out of breath or are sweating (you may not be able to say more than a few words without pausing for breath).

NS-SEC groups are defined as:

- NS-SEC 1-2: Managerial, administrative and professional occupations (e.g. chief executive, doctor, actor, journalist)
- NS-SEC 3: Intermediate occupations (e.g. auxiliary nurse, secretary)
- NS-SEC 4: Self employed and small employers
- NS-SEC 5: Lower supervisory and technical occupations (e.g. plumber, gardener, train driver)
- NS-SEC 6-7: Semi-routine and routine occupations (e.g. shop assistant, bus driver)
- NS-SEC 8: Long term unemployed or never worked
- NS-SEC 9: Students and other.

LIMITING DISABILITY is defined as an individual reporting they have a physical or mental health condition or illness that has lasted or is expected to last 12 months or more, and that this has a substantial effect on their ability to do normal daily activities.

VOLUNTEERING ROLES are defined as:

- Provided transport: To help people other than family members take part in sport
- Coached or instructed: For an individual or team(s) in a sport or recreational physical activity (other than solely for family members)
- Refereed, umpired, or officiated: At a sports match, competition or event
- Administrative or committee role: For a sports organisation, activity or event (e.g. chairman, treasurer, social secretary, first aider, welfare officer)
- Stewarded or marshalled: At a sports activity or event
- Provided any other help: For a sport or recreational physical activity (e.g. helping with refreshments, sports kit or equipment).

LINK TO MORE INFORMATION ON MEASURES AND DEMOGRAPHICS

NOTES

THE ACTIVE LIVES ADULT SURVEY IS A PUSH-TO-WEB SURVEY

Carried out by Ipsos MORI, it involves postal mailouts inviting participants to complete the survey online. The survey can be completed on mobile or desktop devices. A paper questionnaire is also sent out to maximise response rates. More information on the survey can be found here.

SPORT SPECTATING

While not covered in this report, data tables showing the number of people attending live sports events form part of this release.

LINK TO DATA TABLES

LINK TO MORE INFORMATION ON MEASURES AND DEMOGRAPHICS

THE ACHIEVED SAMPLE was 198,911 (16+).

DATA HAVE BEEN WEIGHTED to Office for National Statistics (ONS) population measures for geography and key demographics.

CONFIDENCE INTERVALS can be found in the linked tables. These indicate that if repeated samples were taken and confidence intervals computed for each sample, 95% of the intervals would contain the true value. Only significant differences are reported within the commentary. Where results are reported as being the same for two groups, any differences fall within the margin of error.

SIGNIFICANCE TESTS can be found in the linked tables. The tests indicate that if repeated samples were taken, 95% of the time we would get similar findings, i.e. we can be confident that the differences seen in our sampled respondents are reflective of the population. When sample sizes are smaller, confidence intervals are larger, meaning differences between estimates need to be greater to be considered statistically significant.

POPULATION TOTALS are estimated values and have been calculated using ONS mid-2016 estimates. Confidence intervals also apply to these. More detail can be found here.

FITNESS ACTIVITIES

During the first six months of surveying, a number of respondents were double counting a gym session and the individual activities that they did within the gym. We resolved this problem by re-wording the question, however, this means the first point at which we can report this data is May 16/17. We can however show 12 month change for fitness classes and interval sessions which were unaffected by this.

REVISIONS to the Nov 15/16 data relating to levels of activity are presented as part of this release with full breakdowns available in the tables. For more details please see our website.

Appendix 5

Ryedale District Council Sport and Active Lives Strategy to 2023

everyone ACTIVE

ANNEX A

RYEDALE DISTRICT COUNCIL

Ryedale District Council

Sport and Active Lives Strategy

2013 -2023

P Long
Head of Environment, Streetscene, Facilities, ICT

Forward

I am pleased to introduce and endorse this strategy 'More People, More Active, More Often'. This document is the result of many months of research, local consultation and deliberation involving organisations, members and community group's right across Ryedale. My thanks to all involved.

The challenge at the heart of the strategies aspiration is the pressure facing the District Council through reduced Local Authority funding. As such where direct service provision remains it will need to demonstrate optimised value for money with facilities and products that reflect customers service and quality expectations. The actions put forward in this plan represent a considered response to these issues.

Increasing the number of people who are active will have a significant impact on the health and well-being of the residents of our district. With the changes envisaged regarding our National Health Service this will become ever more pertinent regarding Local Authority responsibility. It is now beyond doubt that more activity will help both our physical health and our mental health, including reducing heart disease, diabetes, falls in the elderly, dementia, strokes and much else. There are also effects on social isolation which are especially important for older people. Increased activity has a part to play in reducing rising levels of obesity linked to unhealthy diet and an unhealthy and sedentary lifestyle. However the obesity pandemic has been a generation in the making; change will not happen overnight and will be a long term process.

As such the importance of emphasising 'active lives' rather than 'sports' or 'physical activity' is important in several ways. We must avoid turning away people who in the past have not been active because they thought it was all about team games or because they had too much pressure on their time. Through an increasingly promotional and enabling role we must help people to do whatever activity they are able to do and to incorporate this into their everyday life. The benefits of 'active lives' is not just all about health, secondary benefits of such activities as cycling and walking can save on transport costs, reduce congestion and pollution.

Active recreation is especially important for children and young people. This should include team sports and other competitive activity, and helping talented young people achieve the very best they can, it is important for them and for Ryedale, but it also means helping young people to develop active lifestyles which will be sustainable for the rest of their life and through example be passed on through future generations.

We need a plan to make sure we are all pulling in the same direction, working towards the same goals to give the current and future generation of people in Ryedale the best possible opportunity to reap the benefits of being active.

Cllr L Cowling
Leader - Ryedale District Council

Introduction

In producing this strategy Ryedale District Council (RDC) have not only worked with a host of partner organisations and many local residents, but also internally have drawn upon officers from across the Council whose work could potentially impact on the provision of sport and active living opportunities in Ryedale.

This strategy sets the agenda to improve the quality of sport and active recreation opportunities for people in the area. Ryedale District Council will focus their efforts on facilitating and enabling people to have a more active life, the aim being to improve opportunities and increase participation.

At the heart of the strategies aspiration is the pressure facing the District Council through reduced Local Authority funding. Where direct service provision remains it will need to demonstrate optimised value for money with facilities and products that reflect customers service and quality expectations. As such this is not an assets-focused strategy, but a strategy for developing and encouraging greater collaboration, partnership and more effective use of Ryedale's limited resources.

Within Ryedale, sport and active recreation is not focussed solely on participation within formal sports facilities. Ryedale is an area of outstanding natural beauty its natural assets provide a wealth of informal opportunities for local people and visitors to the area to take part in a variety of pursuits including rambling, walking, running, MBT duathlon, orienteering, climbing, canoeing, cycling etc. In particular Ryedale is recognised as a world class venue for mountain and road biking, hosting the British Mountain Bike Championship 2009 and UCI Mountain Bike World Cup at Dalby Forest and Pro Sprint eliminator (around the streets of Pickering) in 2010 and 2011, the Tour of Britain stage 2009, Ryedale Grand Prix & Ryedale Rumble 2009 and 2010 and the 2012 National Road Race Championships.

This Sport and Active Lives Strategy (hereafter the 'Strategy') has been developed to provide a clear vision and framework for the development of sports activities, facilities and services within Ryedale to 2023. The intention is for it to be realistic and deliverable regarding the practicalities of reduced Local Government funding and founded on a clear identification and understanding of the needs of the community, and the role and responsibilities of RDC and stakeholders, the ultimate aim being to improve satisfaction regarding sporting infrastructure and get *'More People, More Active, More Often'.*

Vision and Themes

Our Vision is for everyone in Ryedale to enjoy an active, adventurous, and healthy lifestyle as an integral part of everyday life, encouraging More People, to become More Active, More Often.

Aims:

By 2023 we want to see more people in Ryedale enjoying the benefits associated with a more active lifestyle. This means:

- More people aspiring to take part in sport and active recreation
- More people actually taking part in sport and active recreation
- More people becoming involved as volunteers in sport and active recreation
- Increased participation amongst people already taking part in sport and active recreation
- Increased satisfaction with facilities and opportunities for sport and active recreation in the Ryedale area
- Increased usage across all Ryedale owned leisure facilities

Objectives:

We particularly want to see:

- An increase year on year of participation in sport and active recreation in Ryedale (based on a baseline of the 2009/11 Active People Survey results)
- Increased capacity within the local community to enable the above through support of
- existing and creation of; new sports clubs, coaches and officials and improved facilities
- Engagement of young people, adult males and hard to reach groups such as people with a disability, and older people to encourage and facilitate opportunities for them to remain healthy by being active.
- To promote, maintain and develop quality indoor and outdoor leisure facilities and support the utilisation of village halls etc as small community sports facilities in the villages and small towns.
- To support the development of better levels of public transport, safer roads and walking and cycling infrastructure, encouraging sustainable travel and improved transport to facilities in the principal settlements

Overarching Themes

During the consultation processes three complementary themes emerged that will help us to achieve this overall vision of increasing participation and the wider benefits this brings as set against the current challenges of the reduced public sector funding. These are:

- Activating Change
- Active More Often
- Active Places and Spaces

Key actions are summarised below. Further and more comprehensive detail is listed in the Action Plan on page 8.

Activating Change

To raise the profile of sport and active recreation throughout Ryedale and increase the capacity and awareness of opportunities to participate by working in partnership with the public, private and voluntary sectors.

A clear and consistent message of the overall importance of sport and an active lifestyle is the intention of this strategy and its actions. Making sport and active recreation part of every day life is at the core of developing healthy lifestyles, however other elements such as healthy eating, sensible alcohol consumption and reduction in smoking make a big contribution. Regarding this aspect the intent is to support partners in the health sector to help raise awareness and promote the benefits of a holistic approach to health and wellbeing in the widest sense.

Ryedale is fortunate in already having a wide range of good quality private and voluntary sector sport and active recreation providers. The strategy seeks to support these identifying and promoting local clubs, supporting coach/volunteer education and helping them target external funding streams in order to enhance quality and long term sustainability.

Better communication regarding the range of activities provided should have positive impacts on people's engagement, awareness and participation. In this the role of North Yorkshire Sport is seen as fundamental to ensure better communication capture and co-ordination.

Key Actions:

- Through North Yorkshire Sport (NYS) maintain an up to date club and activity data base for Ryedale based activities on a dedicated section of NYS website for residents and visitors information.
- Promotion of North Yorkshire Sport (NYS) website to encourage awareness of Ryedale clubs and activities.
- With support from NYS review and reconfigure the role of Active Ryedale to facilitate co-ordination and monitoring regarding the encouragement and development of volunteers and coaches local to Ryedale.
- Through NYS offer guidance to clubs regarding funding programmes available to them.
- Promote benefits of sport and physical activity through support of and co-ordination with NYS and PCT Health and Wellbeing campaigns.
- Maintain the existing revenue funding for Active Ryedale and NYS to facilitate the above.

Active More Often

Engaging and motivating people to be more active and develop healthy lifestyles from birth through to later life to enhance their quality of life, health and to support independent living.

Taking account of Ryedale's below average participation rates in sport and active recreation; in addition to promotion of existing opportunities, development of new ones should be encouraged and promoted. These need to be varied in offer regarding a wider or more targeted appeal for differing age groups and gender. Activities need to be convenient, being capable of fitting into busy life schedules in order to encourage people to accommodate becoming more active generally as a lifestyle choice.

Following re-procurement of leisure delivery regarding Ryedale Council owned leisure facilities, the strategy will assist in encouraging new facility programmes and initiatives. Within this process the importance is recognised of setting challenging but realistic targets, monitoring progress and reviewing outcomes.

Through working with partners – the strategy encourages and supports NYS initiatives and the development of rural activity centres utilising village halls, play grounds, voluntary sector facilities etc to make activities local as possible and accessible to a wider population catchments. Funding is to be considered, as applicable, through Community Investment Fund (CIF), Community Infrastructure Levy (CIL) and section106 monies.

Finally the strategy will promote, support and encourage the development of open space type activities for those not wishing to participate in more formalised activity.

Key Actions:

- Support and promote NYS Sportivate programmes targeted at 20-25 range.
- Procure and provide financial assistance for new leisure arrangement changing from grant to contract in September 2014.
- Continue to provide and maintain financial assistance to ensure provision of a leisure service run through RDC facilities once new contract awarded.
- Following a procurement process consider initiatives to increase participation through council owned facilities and introduction of performance monitoring measures.
- Consider and cost – as part of procurement process of new leisure contract – introducing an 'Action Van' to rural areas, providing and co-ordinating targeted activities and exercise advice etc for the more elderly, utilising village halls, residential homes, open space etc.
- Encourage healthy workplace initiatives within RDC.
- Support and encourage the use of outdoor space and the development of outdoor/adventure play for adults and children including green gyms, trim trails etc.
- Support the development of walk/cycle to school travel plans.

Active Places & Spaces

Support and develop good quality indoor and outdoor leisure facilities and encourage the development of safer roads and sustainable travel infrastructure.

Quality of sports facilities is closely linked to participation and therefore it is vital in order to meet today's higher customer expectations that steps are taken to ensure we have the best available facilities in the District.

Existing Leisure facility infrastructure throughout Ryedale is generally good with the potential exception of swimming pool provision which at best could be described as about adequate. Ryedale DC currently runs two pools, Ryedale Pool and Derwent Pool and supports Helmsley Pool through provision of a small grant. For both Ryedale pools to be retained and maintained to a good quality further financial investment is required. This presents the District with a challenge regarding reduced Local Authority Funding.

Maintenance and refurbishment of both Ryedale Pools over the next ten years is considered to be the most efficient and cost effective strategy, however over this period an options appraisal will need to consider the cost implications of continuing funding Derwent Pool – the older pool of the two - beyond a further 10-12 years. Options will need to consider further funding or future investment into a new facility.

Finally the strategy supports improvement to road infrastructure, local transport arrangements and the development of and improvement to foot and cycle paths for transport, sport and recreational purposes.

Key Actions:

- Support maintenance funding for Ryedale Pool leisure facility to maintain quality of existing provision over the next 20 years.
- Support maintenance funding for Derwent Pool leisure facility to enhance quality of existing provision over the next 10-12 years.
- Support continuation of grant funding for Malton School and Helmsley Pool.
- Consider options regarding closure of Derwent Pool from 2023 onwards and new build.
- Consider investment into better signage for open spaces.
- Consider lease arrangements at Northern Ryedale Leisure Centre as part of procurement process.
- Support applications for improvement to village halls/voluntary clubs infrastructure, play areas through Section 106/CIL/CIF applications, as applicable, to enhance rural leisure service provision.
- Support improvements to road infrastructure and extension of cycle networks to encourage sustainable travel options.

ACTION PLAN

Activating Change

ACTION	HOW DELIVERED	LEAD	PARTNERS	POTENTIAL FUNDING	PRIORITY
Update and maintain a detailed club and activity database for Ryedale based activities ensuring key information including contacts is up to date	Undertaken by North Yorkshire Sport (NYS) by re-negotiation of existing agreement. NYS to mailshot clubs regarding any new initiatives etc.	RDC	North Yorkshire Sport	Utilises existing NYS £5K budget	2013
Update sports web site	Sign post from RDC site onto leisure service provider site and create new dedicated section of North Yorkshire Sport website create Ryedale club activity data base by re-negotiation of existing agreement	RDC ICT	North Yorkshire Sport	Utilises existing NYS £5K budget	2013
Link More People, More Active, More Often from RDC website to NYS site and from NYS site to other partners.	ICT to ensure links	RDC - ICT	North Yorkshire Sport	No implications	2013
Promote new NYS/Ryedale website and sporting opportunities and activities to public and walking and cycling routes eg AONB	Improved awareness of new website through internal and external promotion from RDC ie letters, e mail, notice boards, parish council mail shot etc Mail shot from NYS to all clubs on updated database and promote via annual club evening. Encourage promotion on site of local events, competitions, challenges, walking routes, cycling routes etc	RDC/NYS	North Yorkshire Sport	No RDC budgetary implications Existing NYS £5K budget in place already	2013
Review and reconfigure Active Ryedale into role of Strategic Executive – ensuring partners (NYS and Active Ryedale) work together to create range of initiatives and run a consistent and comprehensive programme of generic and specific education courses in the District	Support from NYS to co-ordinate and act as chair Proposed key aims of the Active Ryedale network: To promote sport and active recreation in Ryedale -To ensure that quality sport development occurs through the development of volunteers and coaches. -To include advice and direction and support/ fund attainment of voluntary coaching qualifications	NYS Active Ryedale	North Yorkshire Sport Active Ryedale	No RDC budgetary implications Existing £3K Active Ryedale budget	2013

	including coach education courses such as Emergency First Aid and Safeguarding & Protecting Children -To act as a representative body for Ryedale on regional sporting issues. -To share information and provide advice to sports organisations in Ryedale -Arrangement for board to be agreed but suggestions this should include : RDC champion for sport Director NYS Rep from schools – Malton, Pickering, Norton, Nawton /Beadlam Reps from major sport clubs Rep from schools sports partnership. Rep from PCT				
Provision of annual club evening to include discussion ie the range of funded programmes available to them from North Yorkshire Sport, local and national context issues etc including Safeguarding and workforce development.	Support from NYS to host evening and provide leisure expertise through re-negotiation with North Yorkshire Sport utilising existing £5K budget	NYS	NYS Active Ryedale	No RDC budgetary implications Utilises existing NYS £5K budget	2013
Promotion of health benefits of sport and physical activity	Support campaigns by NYS and PCT Utilise RDC notice boards Publicise in all RDC leisure facilities	NYS	CLL PCT	Utilising existing £5K budget	2013
Providing support and guidance for local voluntary clubs regarding funded programmes available to them and help and advice with bid submissions	To be facilitated by NYS through re-negotiation of existing agreement. Encouragement will be given to attain 'Clubmark' accreditation as appropriate	NYS	NYS Active Ryedale	Utilises existing NYS £5K budget	2013
Provide Taster days sessions to introduce residents to new sports	Could be facilitated by NYS and/or considered regarding procurement of Leisure Contract	NYS	NYS	No existing budget Need to consider use of New homes bonus	2013
Support NYS programme of Sport makers to increase the number of people taking part in sport and	Facilitated by NYS The Sport Makers programme uses the inspirational pull of London 2012 to recruit, train and deploy **NEW** volunteers to make sport happen	NYS	NYS	NA	2013

sport volunteering	across the county				
Support and promote NYS on line coaching system	NYS has an online coaching system that can support coaches by signposting them to courses, job/volunteer opportunities and information regarding bursary and funding. This will help identify the need for courses based around local demand.	NYS	NYS	NA	2013
A detailed audit of the major clubs in the Ryedale	NYS could provide audit to cover capacity, standards, workforce etc	NYS	NYS	No existing budget Need to consider use of New homes bonus	2013
Delivery of Tutored workshops to local clubs	NYS could facilitate tutored workshops with relevant experts as required	NYS	NYS	No existing budget Need to consider use of New homes bonus	2013
Work with PCT to help support health initiatives and promote health benefits of physical activity	Support/lobby for introduction of compulsory traffic light system for food labelling – red bad – green good. Promotion on NYS website with links from RDC Display leaflets in all leisure outlets and RDC facilities and promote current recommendations ie ->>under fives –three hours a day ->>5-18 year old – 60 minutes and up to several hrs a day of moderate to vigorous intense exercise. Three days a week should include vigorous intensity exercise that strengthen muscle and bone ->>adults and older people 19+ 150 mins each week of moderate to vigorous exercise. Muscle strengthening twice a week eg heavy gardening, swimming, group sports such as volleyball, basketball etc. intensity and type of physical activity will change to reflect age. Extend the availability of walks and cycle routes through promotion at GP surgeries. Make the most of future opportunities to influence GP commissioning groups to offer exercise on prescription and patient referral schemes to sports centres.	PCT	NYS PCT CLL	N/A	Ongoing

Active More Often

ACTION	HOW DELIVERED	LEAD	PARTNERS	BUDGET	PRIORITY
Support and promote NYS sportivate programme.	Sportivate delivered by NYS is a programme aimed at increasing participation amongst people aged 14-25. -Promotion by NYS and through RDC leisure facilities and notice boards -In particular targeted at 20-25 age range	NYS	NYS Schools	NA	Ongoing
Action Van/trainer to rural areas for elderly	Consider as part of new leisure contract. Would require costing separately from tender and trial to evaluate success. Target older people in rural areas, village hall activities, homes etc	RDC	New Leisure provider	New homes bonus/contract subsidy	2015
Work with and continue to support and fund council activities through councils existing leisure provider	Family friendly environment Varied activities Competitive pricing structure -consider subsidisation/concessions for talented sports people/ elite status	CLL	CLL	Grant provide to CLL	Ongoing
Support sporting based charitable events on the basis that it encourages people who might normally not take part in sport to do so	National and local charity organisations	RDC		N/A	Ongoing
Support for competitive events for cycling, running etc on an elite , amateur, participation basis	National and Local Organisations	External bodies		N/A	On going
Change existing leisure arrangement from grant to contract and procure new leisure contract for Sept 2014 - inc consideration lease arrangement at Northern Ryedale Leisure Centre.	-Engage consultants to undertake option appraisal, analysis of existing provision, consideration of service required, packaging of tender, detail specification, evaluation criteria etc - Invite expressions of interest -Bidders day -Shortlist -Invitation to tender -Award new tender	RDC	Consultant support. NYS	Potential £60K for the procurement process - to be determined and include: -Funding of consultants to support bid process -Fund additional support of NYSD as critical friend -Fund new leisure contract once awarded	2013/14
Consider initiatives to increase	-As part of a new contract initiate programmes that	RDC	Consultant	Annual subsidy funding of	2014

participation through Council owned facilities as part of new leisure Contract	compliment current programmes, plans and practices of NYS**: To consider:** -Develop health referral schemes across the facilities -Support/develop multi activity sports clubs aimed at children with weight problems Review pricing policy to encourage return to exercise. Encourage sessions targeted at and specific to elderly ie swim and gym etc combined with a social aspect. -Development of taster sessions free or discounted give it a try sessions. -Greater flexibility of opening hrs and scheduling of activities. - Schedule activities for children at same time as parents or carers. - Reinstate early bird sessions. -consider targeted male activity to increase participation. -promotion of competitive events and challenges -Ensure continuous high quality facility management through Independent verification of overall performance through the national benchmarking service across all facilities. -Work with sports clubs that use the facilities to increase the quality and participation rates against an annual sports development plan. -Ensure an appropriate and comprehensive range of activities to be made available to the community to ensure an ethos of 'Sport for All' encompassing the young through to later life. -Monitor Performance, measures to include: >>>Increase the number of new participants by % per annum against the baseline of users across all facilities >>>Increase individual participation rates by % per annum against the baseline of existing users who are participating in activity at least 3 times 30 minutes per week across all facilities		support. NYS	contract to be determined	

	>>>Increase the usage across all facilities by % against the baseline in the first year of operation, and 2% per annum thereafter. >>>Achieve overall customer satisfaction rating of 85% in the first year of operation and thereafter each year a % increase and thereafter maintained.				
Encourage workplace activity within RDC – Staff Health and Well Being Group	Initiatives to be linked to RDC health and wellbeing agenda eg reduced sitting /increased standing, use of lifts etc, shower facilities promotion of lunchtime exercise at RDH , RDC leisure facilities or through local providers such as Malton school, CLL, local gyms, walking routes from work etc. Promote lunchtime activity packs for the benefit of staff as supplied to local businesses.	RDC	Malton school CLL	N/A	2013
Encourage bids from Parish councils and playing field associations to fund outdoor green gym equipment for use by adults and children	Promote though Parish liaison group	RDC	Parish councils Playing Field associations	New homes bonus Section 106 monies CIL	2013
Encourage development of outdoor boot camp type training for adults and children	Consider as initiative in new leisure contract Utilise RDC and – promote adventure play and encourage less risk adverse attitude.	RDC		Consider and cost as part of contract	2015
Set up activities link from RDC and NYS website to Tourism Association North Yorkshire to promote adventure type activities for residents and encourage use of Ryedale's natural resources as an active playground ie walking, cycling, rock climbing, canoeing, horse riding etc	ICT to set up links and promote to residents	RDC	Tourism Association North Yorkshire	NA	2013
Ensure clubs are aware and promote events on Tourism association North Yorkshire 'what's on in Ryedale ' events calendar	Promote at club evening and mail shot through sports clubs data base.	RDC	Tourism Association North Yorkshire	NA	2013
Support schools regarding travel plans, walking to school, adventure play etc	Through NYS	NYS		N/A	2013

Active Places & Spaces

ACTION	HOW DELIVERED	LEAD	PARTNERS	BUDGET	PRIORITY
Maintain and Invest in Ryedale pool over next 10-20 years to maintain quality of existing service provision	Facilities Management Investment on the basis of supporting existing swimming pool facility	RDC		205K capital Investment	2013-2023
Maintain and Invest in Derwent pool over next 10-12 years to improve quality of service provision	Facilities Management	RDC		470K capital Investment	2013-2023
Consider provision of new leisure facility replacing Derwent pool from 2023 onwards	Facilities Management options include: -Investment on existing site – limited site potential -Closure and new build in or close to geographical location of existing ie Norton/Malton + maintain existing Pickering site. -Closure and one pool only @ Pickering- reduced capacity. -One pool option , larger facility and pool capacity at one site ie expand Pickering or close and build new. Reduced capacity and geographical reach.	RDC		CIL RDC capital programme	2023
Investment into better signing for open spaces	Better signing for RDC open spaces eg, Orchard Fields, Castle Gardens etc	RDC		New homes bonus	2013
Support Village halls , play area s etc undertaking improvement s to their facilities	Through reference to the LDF utilising; -Community Investment Fund -Community Investment Levy	RDC	Village hall associations etc	New Homes Bonus Section 106 monies CIL, CIF as appropriate	Ongoing
Support Voluntary clubs , play area providers undertaking improvement	Through reference to the LDF utilising; -Community Investment Fund	RDC	Voluntary Clubs	New Homes Bonus Section 106 monies	Ongoing

s to their facilities	-Community Investment Levy			CIL, CIF as appropriate	
Continue to maintain and invest in RDC owned facilities	Facilities Management	RDC		Maintain existing Budget provision	Ongoing
Consider lease arrangements at Northern Ryedale Leisure Centre	Consider as part of procurement process	RDC	NYCC Lady Lumley's School	Potential £60K for the procurement process - to be determined and include: -Funding of consultants to support bid process -Fund additional support of NYSD as critical friend -Fund new leisure contract once awarded	2013/14
Continue to support Helmsley pool and Malton School gym	Grants delivery mechanism	RDC		Maintain Existing Budget provision	Ongoing
Brambling Fields improvement of the A64 Junction to help reduce traffic around butchers corner, eliminate current Air Quality Management Area and encourage walking and cycling between Malton and Norton	Delivered in partnership by RDC , NYCC and Highways Agency	Highways Agency	RDC NYCC	Funded	Completed
Extend the cycle network in Ryedale, within and linking market towns , tourist attractions and public transport	Delivered in partnership with NYCC NB North Yorkshire Local Transport Plan 3- reference Tour de France legacy project	NYCC	NYCC	To be determined NYCC	2023
Improve access over County bridge /facilitate a footbridge/cycle bridge to Orchard fields	Delivered in partnership with NYCC NB North Yorkshire Local Transport Plan 3	NYCC	NYCC	To be determined N YCC	2023
Promotion of a road awareness campaign to slow down traffic and consider safety of cyclists and reduce young driver accident/fatality.	Delivered in partnership with NYCC NB North Yorkshire Local Transport Plan 3- reference Tour de France legacy project	NYCC	NYCC	To be determined NYCC	On going
Support development of Pickering to Malton cycle path – encouraging links to Dalby forest, Newbridge Woods etc and Helmsley to KMS cycle path.	Delivered in partnership with NYCC NB North Yorkshire Local Transport Plan and Sustrans	NYCC	NYCC	To be determined NYCC	On-going

Develop a policy of developer contributions to meet shortfalls in leisure provision through sect 106 monies and CIL	Development of CIL strategy	RDC		N/A	On-going

Appendix 6

NHS Scarborough and Ryedale Clinical Commissioning Group Strategic Plan to 2019

everyone ACTIVE

NHS
Scarborough and Ryedale
Clinical Commissioning Group

NHS SCARBOROUGH AND RYEDALE CLINICAL COMMISSIONING GROUP

STRATEGIC PLAN
2014/15-2018/19

Table of contents

Diagrams

Appendices

Forward

Welcome to NHS Scarborough and Ryedale's strategy document.

This document describes our strategic aims for the next five years and sets out the evidence on which they are based. It builds on the plan that we developed in 2012/13 with a clearer focus on community and mental health services. Our long term intention is to fundamentally change the way health and social care services are delivered for the population of Scarborough and Ryedale by:

- Developing integrated services around a community hub model of care to enable patients to be cared for as close to home as possible;
- Using innovative solutions to link primary, secondary and community services to encourage patient centred services;
- Developing integrated urgent and emergency care services to ensure patients access the right treatment at the right time;
- Ensuring mental health provision is increased to provide early support and diagnosis for adults and children
- Reducing the need for patients to attend and/or be admitted to secondary care by providing suitable alternative services in primary or community settings

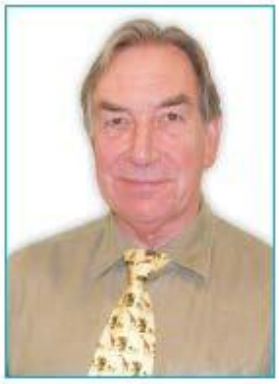
The Health and Social Care Act of 2012 that introduced Clinical Commissioning Groups has at its heart a desire to increase the involvement of both clinicians and the public in the design of the healthcare system. This intention is strengthened in the planning guidance issued by the Department of Health for 2014-19. NHS Scarborough and Ryedale has been keen, from the outset, to engage in a meaningful way with the public and patients. Our Patient Representative Group is up and running and patients are beginning the journey of true involvement and consultation such as with the Chronic Obstructive Pulmonary Disease (COPD) and Me Booklet consultation and the urgent and emergency care re-design engagement.

We should however be under no illusion that change will be easy; the historic financial challenges faced by our predecessor commissioning organisation will continue to be ever present. In order to operate effectively in this climate it is inevitable that we will need to make some difficult decisions, some of which may not sit comfortably with some people. However, we are committed to making sure that you, in whatever relationship you have with our CCG, have the opportunity to have your say over any changes we may propose.

Whilst the NHS Scarborough and Ryedale Governing Body will have overall responsibility for the healthcare of our communities, the challenges we face can only be achieved by this local team working in partnership with providers and stakeholders to ensure we deliver quality services for our local communities.

Although it is a time of unprecedented change for the NHS, I truly believe that bringing the responsibility for the commissioning of health services to a more local level and empowering clinicians to make decisions about local services for our populations can only be a positive move for patient care.
In five years' time the model of care will be less focused on hospital care and more focused on supporting patients to live healthy, active lives in the community supported by responsive services tailored to meet individual needs.

By 2018/19 we envisage a joint organisation providing health and social care, thus removing the existing barriers which historically have prevented effective and efficient working together, to provide patient centred care with seamless pathways and support when and where it is needed.



Dr Phil Garnett
Clinical Chair
Scarborough and
Ryedale CCG

1. Introduction

This document sets out the 5 year strategy and operational plan for NHS Scarborough and Ryedale Clinical Commissioning Group (SRCCG). It provides a statement of intent for the CCG to engage with its patients, public, and stakeholders: a statement on the direction, vision and major aims of the CCG. However, SRCCG recognises its success is critically dependent on the support, engagement and commitment of its stakeholders and the CCG vision has to be aligned with these stakeholders.

The plan integrates the major strategic principles of the CCG; its major commissioning targets; the organisational structures and development required to implement the plan; and a financial framework providing the CCG with a sustainable resource envelope from which to deliver high-quality patient care and improved patient outcomes.

The current integrated plan is the result of dialogue between the CCG, patient representative groups and our member practices and a wide range of other stakeholders. This has included focus groups with stakeholders such as Healthwatch, voluntary sector organisations, and the relevant Local Authorities. The CCG intends to continue with more widespread engagement and consultation, so that decisions that affect you, as patients and partners, are made with you.

The planning footprint used for this plan is SRCCG and our main secondary care provider, York Foundation Trust. The CCG believes the unit of planning is appropriate, however we recognise that there will be the need to extend the planning footprint for some aspects of our five year strategy, i.e. acute provider re-organisation, centres of excellence for services such as stroke care and emergency care. There may also be opportunities to jointly procure services with our neighbouring CCGs.

The CCG has made a deliberate decision to align itself more closely with East Riding CCG with regards to managing the contract with York Foundation Trust in 2014/15 – with the aim of focusing more attention on the Scarborough and Bridlington hospital sites.

Our Values

After debate within the CCG and with its stakeholders the CCG confirms its core values, summarising how it wants to conduct its activities:

- To commission high quality services
- To engage patients, carers and other organisations in our planning and decision process
- To ensure value for money
- To be open and honest in our transactions, and accountable to our communities
- To respect our staff and promote a learning environment
- To improve health outcomes

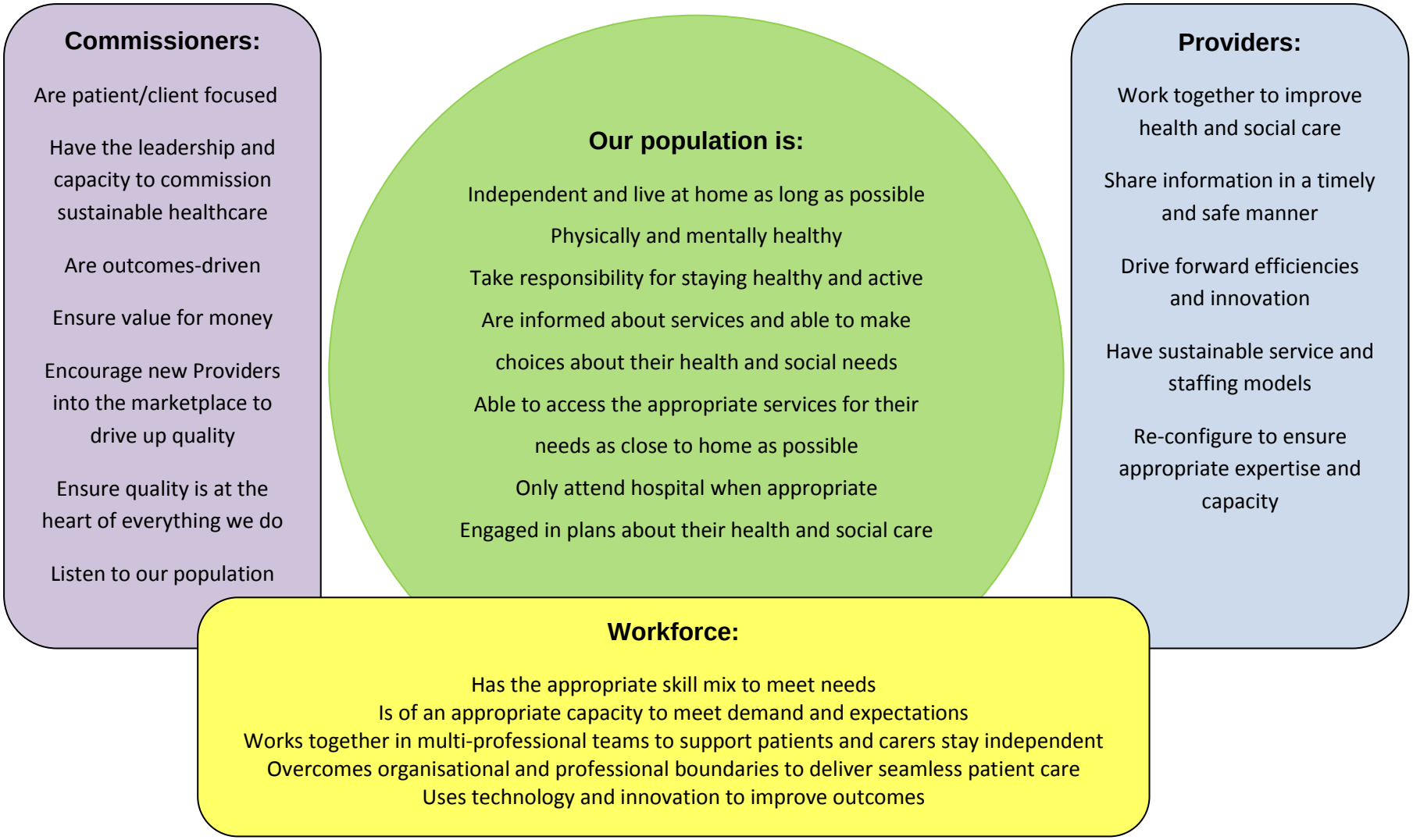
Our Vision:

The overarching vision for the CCG is:

"To Improve the health and well-being of our communities"

Diagram 1

The health and social care model for 2019



2. NHS Scarborough and Ryedale Clinical Commissioning Group

SRCCG is comprised of 16 practices across the areas of Scarborough and Ryedale, with a registered population of approximately 118,000

The CCG has a relatively elderly population with 21.9% of its population aged over 65 (see Appendix 1 for Joint Strategic Needs Assessment summary). Over 50% of the CCG population lives in the most deprived population quintile of North Yorkshire. The demographic profile of the CCG provides it with the combined challenge of an elderly population with high health resource usage; and significant areas of deprivation with associated poor health outcomes. As such this is a challenge unlike any other in North Yorkshire or York.

The 16 practices have a range of patient list sizes (see Appendix 2) and support approximately 100 GPs working in the CCG area. The commissioning budget of the CCG is over £150 million.

3. Strategic context

The election of the Coalition government in 2010 was followed by the announcement of radical changes to the NHS, summarised in the 2010 Health White Paper (Department of Health 2010).

“The NHS changes will emerge in the context of an ‘age of austerity’.” Commissioning will need to continue to respond to the challenge set by the former NHS Chief Executive Officer and deliver annual efficiency gains of 4%, totalling £20 billion over a five year period (House of Commons 2011).

In addition to the dynamic national context and the historic issues, the CCG has faced significant financial challenges from inception. The acquisition of Scarborough and North East Yorkshire Healthcare Trust by York Teaching Hospitals Foundation Trust (YFT) in 2012 provides a potential longer term solution to some of the challenges faced by a remotely positioned small district general hospital, however, YFT is faced with similar financial restraints as the CCG and will be working to provide

increasing levels of cost improvement in the York and Scarborough health economy. Consequently, the health economy faces a double challenge of limited funding for commissioning and the need to reduce costs within our main Provider.

The CCG faces a complex series of challenges, including not only responding to the economic environment, but at the same time actively promoting health improvement to bring the health and wellbeing of its communities closer to those of the majority of North Yorkshire.

In addition to significant areas of deprivation, the CCG locality also includes a relatively elderly population. This provides significant challenges to the provision of health and social care. In addition to the need to plan for services to support those who are able to live in their own homes, the locality has a significant population living in care homes. Furthermore, the locality is considered to have relatively low levels of alternative provision to care homes, such as extra-care housing, and this accentuates the challenges faced by a CCG wanting to support older people's independent living.

The closer working of health and social care over the next few years will bring its own challenges; different cultures, different management methodologies, the complexity of health services free at the point of delivery working alongside social care which is means tested will not be easy obstacles to overcome, although overcome them we must.

A Call to Action (NHS England 2013), is a recognition by the NHS Trust Development Authority (TDA), Monitor, Public Health England, National Institute for Health and Care Excellence (NICE), the Health and Social Care Information Centre, the Local Government Association, the NHS Commissioning Assembly, Health Education England, the Care Quality Commission (CQC) and NHS England that organisations can no longer stand alone and sets out a commitment to working collectively to improve services across a range of sectors.

"For years, pundits and practitioners alike have argued that prevention is better than cure. Clearly patients would prefer to avoid getting ill in the first place (primary prevention) or, if they do get ill, ensure that it is diagnosed at an early stage and that arrangements to manage the condition effectively are put in place as soon as possible to allow them to continue living autonomous and active lives (secondary prevention)" [NHS England 2013]

SRCCG is aware of the high prevalence of chronic disease such Chronic Obstructive Pulmonary Disease (COPD), Ischaemic heart disease, Cancer and Mental health in our population and is also aware of the connection between risk factors such as smoking,

alcohol, physical activity, diet and socio economic factor and these diseases. For these reasons our strategy focuses on the key priority disease areas of Cancer, Cardiovascular, Mental health and Elderly Care. Many of our projects over the next five years will not only be aimed at improving pathways of care for patients suffering from these diseases but also on preventative care (often in partnership with the Local Authority and Public Health England) such as reducing the prevalence of smoking and alcohol related conditions.

This joint ownership of the challenges faced by health and social care not only highlights the threat to financial stability and sustainability of services but a true desire to overcome these problems and a national vision that will deliver change locally led by clinical commissioning groups, Health and Wellbeing Boards, other partner organisations and patients and the public.

The CCG will adhere to the NHS mandate (which sets outs the Government's priorities for health and clear objectives and measurements for 2014-15) and will embrace the ethos of improving health and well-being. We will commission services that ensure our patients rights' under the NHS Constitution are met and performance against key standards is as or above expected levels. We will follow the planning guidance "Everyone Counts: Planning for Patients 2014/15-2018/19 and ensure our local priorities reflect the national priorities to deliver the NHS vision of High Quality Care for all, now and for future generations.

We are fully committed to the improvement in the quality of services including those that we commission, and those that we may not commission directly but which are provided to our resident population, for example, primary care services and care provided in care homes. We will build on the definition of quality as established in the 2008 Next Stage Review document also commonly referred to as the Darzi review (Darzi,2008) which includes care that is safe, clinically effective, and takes into account patient experience, a definition that was later enshrined in legislation (Department of Health, 2010).

We recognise that while Clinical Commissioning Groups are young organisations, we have been given a challenging mandate from the Government who has made clear that CCGs are central to their ambition to deliver high quality and patient centred outcomes for their populations, within the available allocated resources. The CCG has a statutory duty to commission and ensure high quality care for the local population including the scrutiny of all providers and also to assure the Governing Body that the continuous improvement in quality of care is being achieved.

We cannot do this in isolation. We will develop a quality assurance strategy that will set out our objectives and how we plan to meet them. We will be clear about who we will be working with, and we will set out how we will respond to the day to day

challenges as well as planning for the future. We want quality to be a tangible part commissioning health care, and where this is not the case, we want to learn and improve as an organisation in our own right, as well as supporting learning in the organisations from whom we commission care.

The breakdown in the quality of care for people with learning disabilities at Winterbourne View and other recent high profile cases, remind us all of the role in safeguarding the care of vulnerable people, both for adults and children including children looked after by the state or in care. The most recent planning guidance from NHS England also reinforces the need to ensure 'parity of esteem' for those with mental health and learning disability needs. This applies equally to the monitoring and assurance of services we commission directly from specialist providers of learning disability and mental health services, as well as to providers of more generic medical and surgical services, and also to care in the independent and private sector including the care home and domiciliary care market.

We recognise that safeguarding is integral to all aspects of patient safety linked to reducing harm and promoting well being, and we also recognise our statutory role as an employer as well as a commissioner of services.

The overall vision of the CCG is to improve the health and wellbeing of our communities: In order to achieve this within limited resources, the current configuration of health and social care needs to change and we need to plan sustainable, high quality services for our population. In the future fewer people will need to attend secondary care and more patients will be cared for either in their own homes or in primary/community settings.

Urgent Care /Out Of Hours(OOH) will change in line with our proposed service development to integrate urgent care into a single service offered from a Hub and spoke arrangement across Scarborough and Ryedale. Inevitably, this development will change the emergency care service in our local hospital and we will work with YFT to ensure the emergency department is appropriate for the needs of the population.

Elective/Acute hospital care in Scarborough will be separated between the Scarborough Hospital site and the Bridlington Hospital site, with Bridlington developing as the elective care facility.

Discussions are on-going with primary care colleagues and the Area Team to determine the future configuration and possible Federation of practices.

The CCG will work with Secondary Care Providers and Providers of tertiary/specialist services to rationalise acute and specialist care, recognising that all services cannot continue to be provided safely and efficiently in DGH settings and fewer centres of excellence will be developed.

Community Services will be managed around a community hub providing physical and mental health support, social and voluntary support and links to primary care neighbourhood care teams (NCT) to support patients to stay at home and avoid hospital admissions.

The local and national vision will be underpinned by six characteristics of high quality and sustainable service change as set out in the Everyone Counts guidance:

3.1 New approach to ensure citizens are fully included in all aspects of service change:

The CCG has adopted a Communication and Engagement Strategy and Equality and Diversity Plan which sets out how we have and will continue to communicate and engage with our population. These provide a framework on the activities we believe will help us to understand what the people of Scarborough and Ryedale say are important when it comes to healthcare in our community.

Throughout 2013-14 all our engagement activities focused on refining our 2014-2019 commissioning strategy and events held to-date have provided valuable feedback from stakeholders both on the overall plan but also on specific service developments. The overall plan is summarised by a “Plan on a Page” and further detail is available on our website in interactive form.

3.2. Wider primary care – provided at scale

We are embracing our role of re-designing primary care in Scarborough and Ryedale. We will need to increase access for patients, reduce variation and ensure quality of services provided. Recognising the demand already placed on primary care and the difficulty in recruiting, coupled with impending retirements among our practices, the new model may have fewer practices through reconfiguration, although services they deliver will continue to be of the high standard that patients in Scarborough and Ryedale currently enjoy.

Discussions are on-going with our member practices, NHS England and the Local Medical Committee (LMC) about the future configuration of primary care and a sustainable model to ensure adequate access and a range of services are delivered in primary care to reduce attendances at secondary care. This may result in practices forming federations or groups of practices working together to support one another and enable them to provide the additional capacity required to meet demand.

A list of possible services that can transfer from secondary care to primary care has been developed and we are currently working through this list with practices to develop these ideas into service provision. Through a programme of development, we will ensure that practice nurses and Health Care Assistants (HCAs) are utilised to their maximum potential to support GPs.

Resources will be made available in our financial plan to support the £5 per head investment and the 70% investment* from the application of marginal rate rule will support achievement of the non-elective QIPP.

As part of the 14/15 planning process, CCGs must be able to demonstrate how they intend to use the 70% "saving" to reduce emergency admissions. The local Urgent Care Working Group (of which the CCG is a member) is responsible for signing off these intentions.

** The marginal rate rule was introduced in 2010/11 in response to concerns about growth in the volume of patients being admitted to hospital as emergencies. The rule sets a baseline value for income from emergency admissions for each provider. For emergency admissions above this baseline, the provider receives 30% of the normal price. The rule is intended to give acute providers an incentive to collaborate with other parties in the local health economy to manage demand for avoidable emergency admissions and treat patients in the most appropriate setting.*

3.3. A modern model of integrated care

The community hub model will provide medical, mental health, social, therapy and nursing integrated care aimed at keeping patients in their own homes and minimising the need for acute admission to secondary care. Expertise will be focused in a community hub(s) and be able to outreach to patients when required. As well as the physical and mental needs of patients, involving our voluntary sector colleagues we will try and provide social and lifestyle support to reduce loneliness and isolation in the form of group activities.

Patients with long term conditions will be managed by a Neighbourhood Care Team which incorporates all the skills required to sustain patients at home and prevent unnecessary crisis intervention. These teams will have strong links to the community hubs.

We know that we have a lot of care homes including homes with nursing in our CCG. The care that our patients receive in these establishments is important to us and we will be working closely with our partners in the local authority and in primary care to develop plans for how we can support the improvement of quality on an ongoing basis in these settings.

3.4. Access to the highest quality urgent and emergency care

The CCG has developed a vision for urgent and emergency care and is currently engaging with stakeholders to transform this vision into a viable, sustainable model for integrated care with the aim of procuring this service in Spring 2015.

The service will be designed with the needs of patients at the heart, where patients receive, timely, accurate diagnosis and treatment without having to access multiple other services before receiving the care they need.

The model will reduce the current pressure on Accident and Emergency services in secondary care and simplify the structure of urgent care to reduce confusion amongst patients. (see diagrams 2a and 2b)

Our vision is for a single service providing urgent and OOHs care for patients who need to be seen quickly but who do not require emergency A&E care.

Our current OOHs and walk in centres are valued highly by our patients and we will ensure that this high quality patient experience is maintained and indeed improved in the new service and that patients in Scarborough and Ryedale have equal access to urgent care.

The CCG is committed to ensuring a high quality of service whether or not this service is delivered in or outside a hospital setting.

3.5. A step change in the productivity of elective care

The CCG is working with our main provider to understand demand for elective care and agree how and where capacity will be sourced in the most efficient way possible. Bridlington Hospital will develop as an elective centre.

The introduction of Expert Consulting will allow GPs to seek advice from secondary care clinicians without the patient always requiring a face to face consultation.

Our drive to reduce follow up attendances will continue, developing shared care pathways and avoid unnecessary visits to secondary care.

Efficiencies gained in out-patients will release valuable consultant time to help increase productivity in elective care.

We will optimise patients in primary care before referral to secondary care by introducing referral protocols and templates, facilitating access to Map of Medicine in primary care and to ensure that patients are only referred to secondary care once all appropriate investigations and interventions have taken place. Expert Consulting will support this approach.

3.6. Specialised services concentrated in centres of excellence

The CCG recognises there may be a need to centralise specialised services in order to ensure that patients receive the best possible quality clinical care. We will work with the clinical networks and tertiary care providers to secure services in line with national guidance:

- Pro-active engagement with networks to secure local pathways and interface with specialist services;
- Work with national commissioners to support clinical and business case for proposed changes;
- Analyse the impact on changes upon our local population and potential risk to local services;
- Work alongside specialist commissioners to develop and support a jointly agreed programme of work to deliver the economies of scale;
- Engage our communities in consultation processes to ensure full understanding of the need to change and the resulting impact.

Diagram 2a

Urgent Care – In 2014

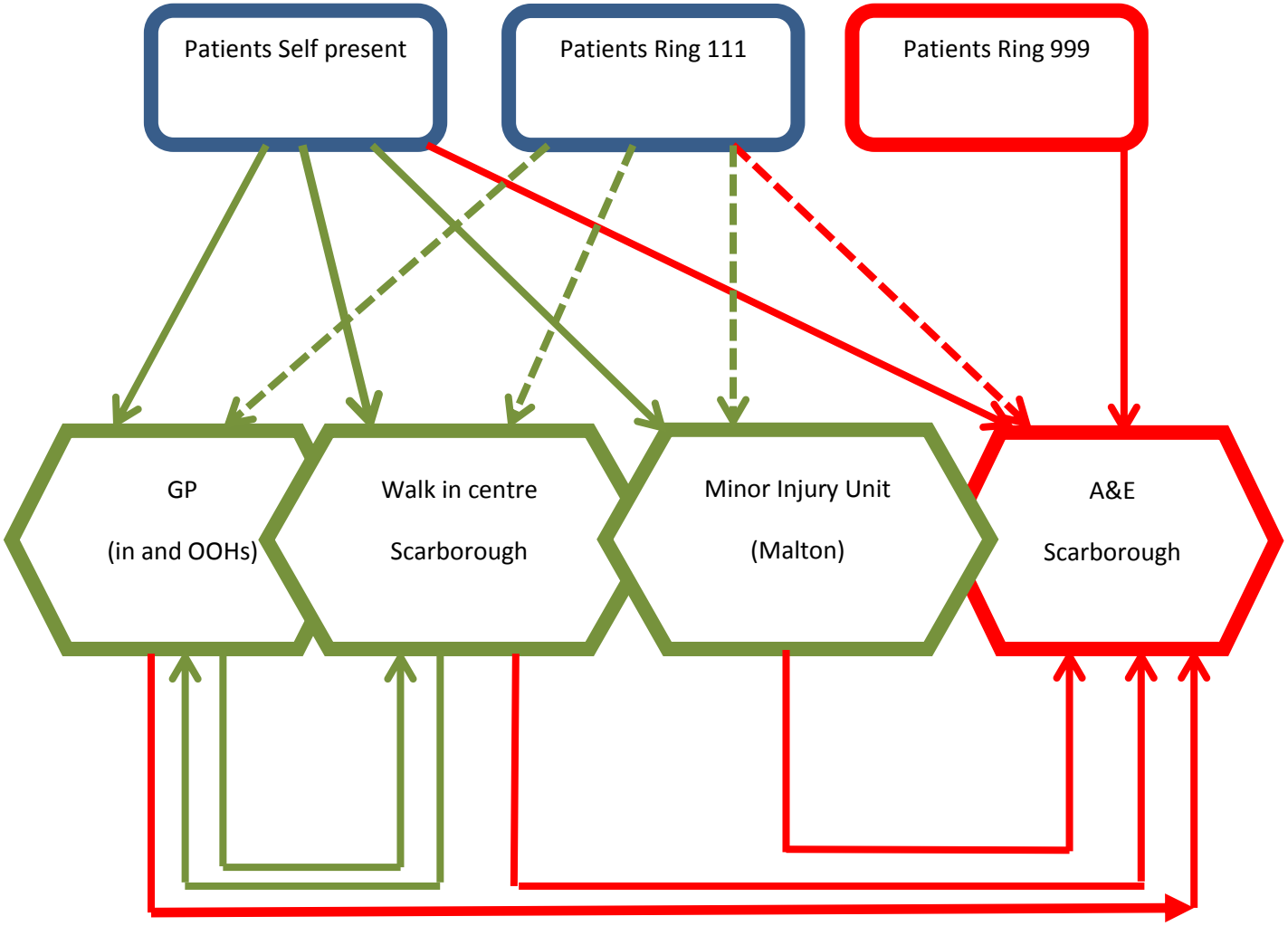
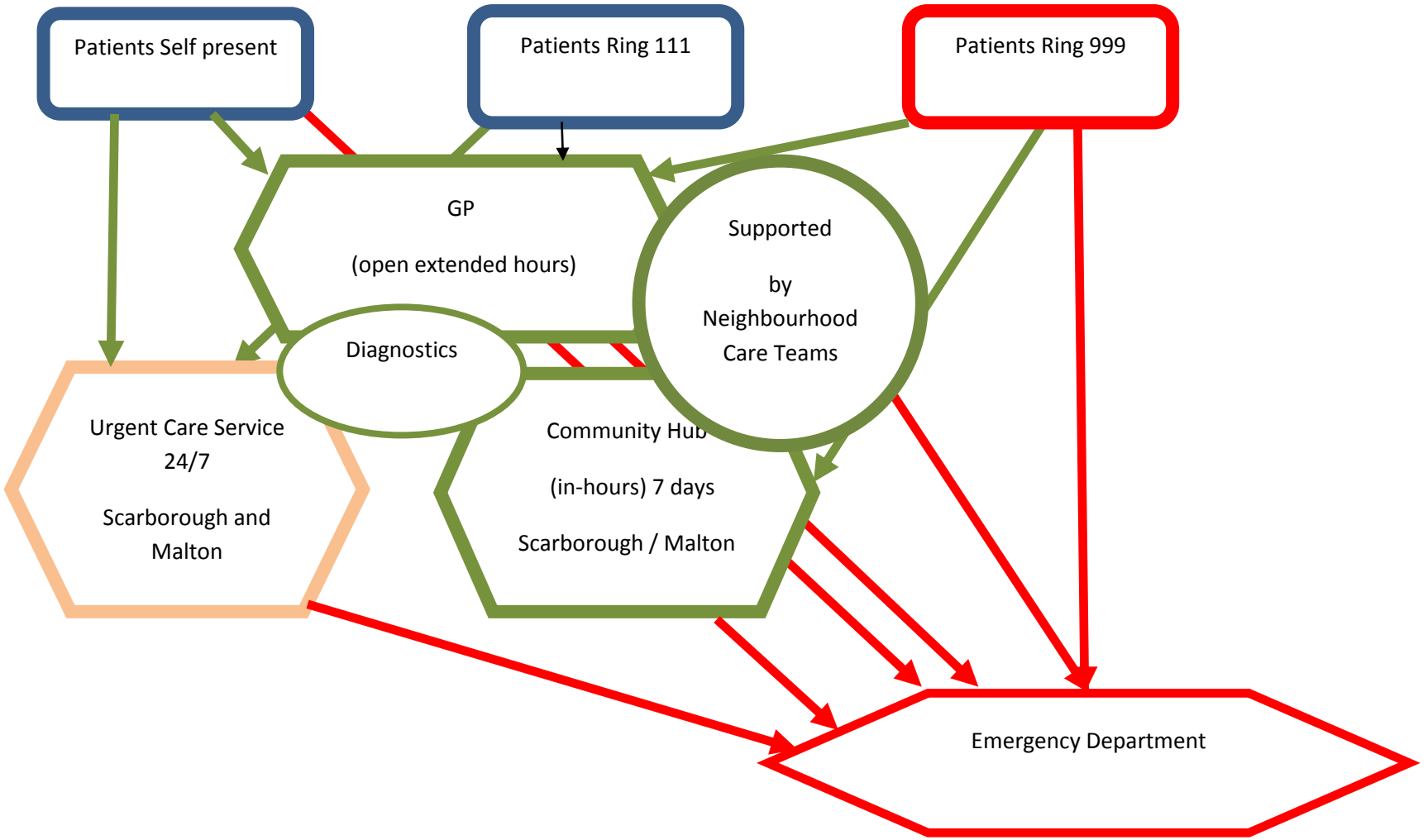


Diagram 2b

2015 onwards



3.7 Improving Quality and Outcomes

Based on public health evidence and local clinical knowledge about our local health problems, the CCG has established four health priority areas – cardiovascular, cancer, mental health and elderly care. We will focus efforts on these areas to improve the outcome ambitions identified in Everyone Counts:

3.7.1 Securing additional years of life

Much work has already been carried out to reduce premature mortality and we will continue and expand upon this. For example, working in collaboration with Public Health England and York Foundation Trust we are proactively aiming to reduce the numbers of pregnant women smoking at the time of delivery; we are exploring ways of providing smoking cessation advice to patients before undergoing elective surgery and supporting a no smoking in hospital campaign.

In 2013 Scarborough Hospital was awarded provisional accreditation for its Stroke Service and we will continue to work towards improving this status and the service for stroke patients.

Our cancer work will focus on early referral and detection of lung and breast cancer, working closely with the cancer network. and will include capacity planning across the whole pathway.

We will continue and expand work commenced in care homes and improve rehabilitation support for patients who are discharged from hospital settings.

3.7.2. Improving the health related quality of life of people with one or more LTCs, including mental health:

- Introduce Liaison psychiatry model in A&E, adult and elderly care wards to support patients with mental health needs.
- Increase numbers of people accessing talking therapies
- Increase dementia diagnosis through dementia collaborative, pathway development
- Continue and enhance NCTs to monitor patients with LTC in primary care
- Continue alcohol work: Current project was developed in partnership with Scarborough Hospital, North Yorkshire Police, North Yorkshire County Council and the CCG. A full time alcohol worker has been placed in the A&E department with a remit

to identify and intervene with those patients with alcohol related presentations. The object is to provide immediate and follow up support with a view to reducing future A&E presentations and crisis interventions.
- Continue to work with the voluntary sector to support patients where appropriate
- Work with Yorkshire Ambulance Trust (YAS) and other emergency agencies to provide street support in the Scarborough town centre, particularly for patients with alcohol, drug and mental health issues.

3.7.3. Reduce amount of time people spend in avoidable hospital through better integrated care outside hospital:

- Roll out Neighbourhood Care Teams across the whole of Scarborough and Ryedale
- Integrated urgent and emergency care facility with prompt elderly assessment and diagnosis ambulatory care pathways
- Develop community hub, particularly aimed at supporting the frail elderly population
- Develop fast response team(s) model of support for improving quality of care in nursing and residential homes
- Continue work to decrease unplanned hospitalization for asthma, diabetes and epilepsy
    - community epilepsy nurse for children
    - diabetes pathways in primary care

3.7.4. Increasing proportion of older people living independently at home following discharge

- Increase rehabilitation for stroke patients
- Increase rehabilitation for all patients being discharged from hospital (over the age of 75)
- Day care project to provide social and holistic support
- Increase domiciliary care support to allow people to stay at home

3.7.5. Increase number of people having a positive experience of hospital care:

- Ensuring our Providers achieve the NHS constitutional standards
- Reducing Health-Care Acquired Infections (HCAI)
- Reducing Never Events
- Supporting the reporting of serious incidents and ensuring learning is shared

- Reducing cancelled Out Patient appointments and cancelled elective procedures
- Ensuring our patients are fully informed of “next steps” in their treatment
- Continue roll out of Compassion in Practice (Care, Compassion, Competence, Communication, Courage and Commitment) the 6 C’s.
- Reducing falls in secondary and primary care
- Encouraging providers to maximise the care of deteriorating patients

3.7.6. Increase number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and community settings.

- Develop integrated urgent and emergency care to include OOHs and in hours general practice.
- Increase access in primary care
- Develop community hub and NCT model
- Develop a more integrated approach to enable District Nursing service to work more closely with general practice
- Improve support to patients requiring mental health care by introducing a “street triage” mental health worker to work alongside the police in Scarborough Town Centre
- Improve support to patients in A&E requiring mental health support by using voluntary sector MIND workers in A&E

3.7.7. Make significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care:

- Improve reporting of medication errors
- Reduce HCAIs
- Robust mechanisms for investigating quality issues
- Triangulation of soft and hard intelligence
- Ensure adherence to quality standards
- Work in partnership with YFT

Based on national and local drivers the CCG has established three key strategic commissioning aims:

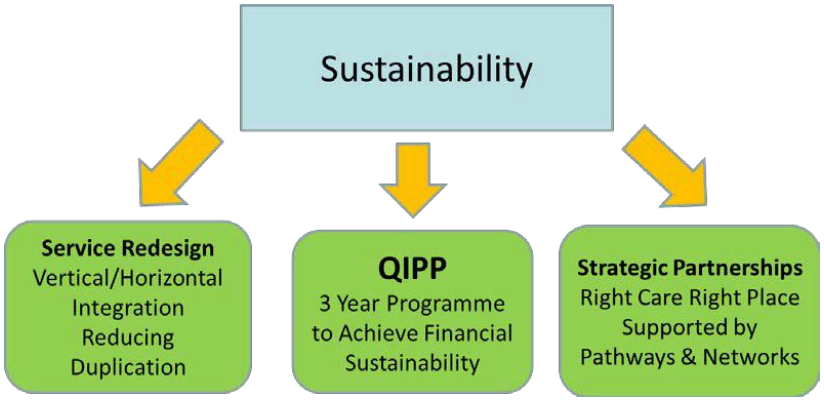
- Commissioning sustainable, high-quality services within the available resources (people, money, buildings)
- Delivered by a stronger community system, integrating care across the whole care economy.
- Securing improvement in priority areas of health need and reducing health inequalities.

4. Strategic Commissioning Aims

5. Sustainability

Sustainability will provide assurance and security to the CCG's population that its services are safe, consistent, and not vulnerable to threat. The health economy has experienced threats from an inability to secure the appropriate clinical staff; from constant financial pressure; and from varying restraints in physical capacity.

This principle that underpins our strategy reinforces that commissioning should seek to establish consistently high-quality, safe services, within a financially and clinically sustainable framework.



5.1. Service Re-design

In order to build a sustainable health economy, we recognise that some of the current configuration of services will need to change. A priority for 2014-15 will be to procure an integrated urgent and emergency care service. The first stage of this is to share our ideas and seek comments from a wide audience through an engagement strategy which commenced in January 2014. **'Right care, first time:** Developing a new, integrated model for urgent care services in Scarborough and Ryedale.

This period of engagement will enable the CCG to incorporate views and ideas into a detailed specification that will be used to tender for the new service during 2014, with the expectation that the new service will be ready to accept patients in April 2015.

Urgent care is for a sudden illnesses or injuries that need treating quickly, but are not considered to be a 999 emergency.

The current urgent care services that form part of the CCG review are:

- Castle Health walk-in centre in Scarborough (provided by Echo)
- Malton Community Hospital Minor Injuries Unit (provided by York Teaching Hospitals NHS Foundation Trust)
- GP out-of-hours service (provided by Prime-care)
- Minor ailments that are treated within A&E departments at York Teaching Hospitals NHS Foundation Trust and Scarborough Hospital.

The CCG believes there is an opportunity to improve patient experience and create better value for money by integrating these services into a single contract.

There are number of national and local drivers to create a more integrated urgent care system that will not only benefit patients, but that is also better value for money.

Nationally, there is a desire to:

- Develop a more integrated urgent care system that ensures patients are treated in the most appropriate setting for their needs;
- Simplify the structure of urgent care services to reduce confusion amongst patients and ensure they access the right service, first time;
- Reduce pressure on accident and emergency departments by treating patients with minor symptoms either in primary care or in the community;
- Improve patient experience of urgent care services such as reducing waiting times and the need for patients to be redirected to other services;
- Respond to the demands for health services from an ageing population.

At a local level, we know that:

- Pressure on A&E departments continues to increase and that up to 50 per cent of presentations are for minor symptoms that could have been treated elsewhere;
- There is confusion amongst some patients about what services are available and which service they should access for different health needs (for example a survey into the use of Malton MIU showed that many people did not understand what types of symptoms it was there to treat and thought that it could be used as an alternative to seeing their own GP);
- Based on a CCG survey about the current GP out of hours service, the most important aspects of accessing out of hours care were reported as:
    - The ability to see a clinician face-to-face
    - To be seen and treated in the same place
    - The service being located near other health services such as a pharmacy
    - Whilst a home visit is preferable to most (although people recognise this isn't always possible), the second preferred way to access treatment out of hours is a walk-in facility
- People rate the quality of the existing GP out-of-hours service as good or very good, so this level of patient experience needs to be maintained in any new system that is introduced. However, we know that patient experience of A&E is not as positive and this response is often a result of long waiting times;
- That MIU service in Malton is highly valued by local residents and they would expect to see minor injury provision maintained in the area.

Through our conversations so far, we have been able to create an outline of a model for urgent care that we believe will result in a better service for patients and that is more cost effective for the NHS. It is important to stress that this model will evolve based on feedback obtained during the engagement period.

With our proposed model, we would:

- Integrate the current urgent care services into two urgent care centres – one in Scarborough and one in Ryedale – that will operate on a 24/7 basis;
- The urgent care centre in Ryedale will provide a slightly smaller range of services than the centre in Scarborough; however, access to services will be better than at present (bearing in mind that MIU in Malton is only open during the daytime).
- These two centres will provide the same or improved level of services that are currently provided by urgent care services at Castle Health Centre, Malton MIU, A&E departments at York and Scarborough and also the GP out-of-hours service.

These integrated urgent care centres will aim to treat patients in one place and avoid them having to access additional services.

Currently the CCG is not able to specify a preferred location for the urgent care centres as this would potentially limit the number of providers who could tender for the service.

We are however committed to ensuring appropriate access to services across both Scarborough and Ryedale for all groups in our community.

Developing a more integrated urgent care system will mean:

- A simple process for patients to access the right urgent care service, first time
- A more cost effective, joined-up service that aims to treat patients in one place and avoid them having to access additional services - a ‘one-stop-shop’ for all urgent care needs
- 24 hour access to a range of urgent care services, not just between certain times
- Shorter waiting times than if you were to attend A&E
- Shorter waiting times for patients with emergency care needs at A&E

- Reduced pressure on A&E departments from less patients attending with minor injuries and illnesses – meaning that A&E doctors can dedicate their time to treating patients with more serious health needs

Alongside this major project, the CCG will continue to redesign and rationalise services in priority clinical specialities such as rheumatology, ophthalmology, chronic pain, cardiology and diabetes with a focus on providing more support for patients in primary and community care.

YFT is also planning to re-design acute services in Scarborough Hospital. Inevitably this is a consequence of the merging of two hospitals, but it is also necessary to deliver the 7 day a week services as prescribed in "Everyone Counts: Our contract with YFT will include an action plan to deliver clinical standards that all patients should expect to receive seven days a week when accessing urgent and emergency care. This process in YFT will be led by the Scarborough Acute Board Development and Delivery Group which has delegated authority to assess current plans and develop new plans unpinned by the following principles:

- A commitment to develop the safest, highest quality, efficient acute services possible for Scarborough Hospital
- Organisational and professional boundaries will not impede delivery of the vision
- Nothing should be assumed about the validity of current practice or proposed changes to practice
- Personal views are respected but must not prevent decisions being made about service configuration, which it is in the best interests of patients

York Teaching Hospital NHS Foundation Trust took over the running of the Scarborough and Bridlington Hospitals in 2012. YFT received additional financial support over a 5 year period to support them in taking over the hospital and addressing underlying issues with the estate and services on the east coast. That financial support ceases in March 2017, and the CCG in partnership with the Trust needs to have defined a service model for Scarborough and Bridlington Hospitals that is affordable for the CCG under national tariff, yet retains appropriate services in the local area. This will require consideration of those services which are retained locally within the current tariff structure, those where the CCG may pay a supplement to retain services locally, and also services which are not sustainable locally.

We will consult with our population on the options available to the CCG, and what service priorities should be considered as part of making these decisions.

It is essential that the CCG and Acute Provider work together to deliver changes within an open and honest environment. The end goal is for our local hospital to be financially and clinically stable for the future.

5.2 Direct Commissioning

The CCG is not responsible for commissioning all health care services: many services including primary care, dental and eye care are commissioned by the national NHS England and the NHS England Area Team. Relationships and clearer understanding of responsibilities between these two bodies is still developing, however the CCG already works closing with the Area Team on many aspects and will continue to do so. Sections 5.3 to 5.11 are compiled by our local Area Team and provide an overview of services, contracting mechanisms and aspirations for the future:

5.3 Access including the promotion of self-care

The Area Team will support CCGs to delivery primary care services across seven days a week by using a range of options appropriate to geographical and population need. A full and integrated range of services will be available requiring joined-up working across primary and secondary care. The transfer of care to out of hospital providers will impact on GP practices already struggling to meet demand for appointments and a radical shift is needed towards closer working relationships between practices and other healthcare providers. Practices are already moving towards closer working across a wider footprint through federations and sharing of resources will be necessary to meet this challenge.

Often patients are unable to see a doctor on the day they wish unless it is “urgent” and are left waiting for several days or over a weekend. Some end up at A & E and a range of options is needed to avoid this. There is a need to move away from GPs seeing all patients to free up their time for other more complex cases. A clinician-led triage service acting as the first point of contact for patients across a number of practices would reduce GP appointments and ensure patients are transferred to the appropriate service in health or social care. For minor ailments, patients could be directed to alternative healthcare providers, in particular pharmacies, to speed up access to healthcare and avoid an unnecessary doctor’s appointment. Practices can work in rotation to offer extended hours to cover evenings and weekends.

Access need not be face-to-face and web-based GP consultations and virtual clinics may be appropriate in some geographical areas to provide easier access to healthcare. This can only be done where safe and clinically appropriate, and will not be appropriate in all areas as there will be groups of patients who are unable, or unwilling to use this technology. It also depends on IT connectivity, especially in very remote areas.

Services need to be more mobile in order to target "hard-to-reach" groups and identify health risks, for example by visiting factories, agricultural shows and rural market days. Deeply rural areas need to be identified and assessed in terms of service need.

Access in care homes has traditionally been provided by visits from a patient's "own" GP. Bearing in mind patient choice, this could be streamlined by a GP-led team with a skill-mix of both health and social care taking responsibility for a group of care homes.

Community pharmacy is a key frontline health service that provides healthcare and advice as an effective alternative to a GP practices. By supporting the Health Living Pharmacy initiative this will enable community pharmacy staff to promote healthy living, provide well-being advice and services and support people to self-care and manage long-term conditions. The Pharmacy Call to Action will stimulate debate in local communities to find out the best way to develop an integral service, and the Local Professional Network will provide the clinical interface and expertise to support this.

Services which have historically been undertaken at GP practices (e.g. flu vaccinations, minor ailment schemes, monitoring of long-term conditions) could be carried out by pharmacies and create capacity to allow GPs to deal with more complex cases.

Access to dental care is maintained by ensuring the provision of high quality dental services through existing dental contracts and the out-of-hours service. The Dental Call to Action will stimulate ideas about the NHS dental service in order to improve oral health and increase access to the NHS dental services.

All contractor groups can promote self-care as part of their daily contact with patients and members of the public. The pharmacy framework already includes essential services that can be used more effectively to provide access to healthcare including promotion of self-care. As pharmacies are generally open longer hours, up to 100 hours per week including Sundays which will improve access for patients.

Support for self-care, in particular for long-term conditions, can also be provided by voluntary and not for profit organisations working with CCGs.

5.4 Continuity of care

In order to change the way primary care currently operates, skill mix will be essential to ensure that a variety of staff can provide primary care services for patients.

Workforce is central to continuity of care although this presents significant challenges due to the large percentage of GPs who are due to retire. These issues are discussed in the workforce section.

Funding will need to be made available for training nurses and other staff groups who will need to provide a greater array of primary care services in order to release GPs to concentrate on the more complex patient groups. However, GPs will need to be retained at the centre of care planning for patients. GPs will become the “care navigators” for their patient base.

General Practice will need to work in a collaborative manner to ensure sustainability. This will include health and social care providers such as community services, social services and local authorities. Pharmacies can also enhance the work that GPs undertake with a greater focus on self-care and minor ailments but also in carrying out more effective medicines uses reviews.

CCGs will need to consider providing services across a larger geographical footprint. A number of CCGs are forming federations which will allow the commissioning of services relevant for their population. Possibilities include “specialist practices” providing a service for a number of practices. These organisations can begin to develop training and education programmes to ensure that the appropriate workforce is in place.

CCGs will need to think about innovative ways of working in order to harness real change while also thinking about continuity of care. This may mean that two tier systems may operate; the old model stays in place while the new model of primary care is tested.

CCGs will need to ensure that there are excellent communication channels in place to engage with General Practices to ensure that they are able to support delivery of their strategic objectives.

5.5 Contracting

There are currently three main types of core GP contracts: General Medical Services (GMS), Personal Medical Services (PMS), and Alternative Provider Medical Services (APMS). The GMS contract is agreed nationally and essential services provided under this contract are set out in legislation. PMS is a locally negotiated contract and allows greater flexibility to respond to local needs. The APMS contract allows commissioners of primary care medical services to contract with a wide range of providers including those in the independent sector. It can be used to encourage innovative tailored services responsive to local needs. Like PMS the contract is more flexible than GMS. For GP contracts additional services are commissioned through enhanced services (formerly Directed Enhanced Services (DES) contracts) and Community-Based Services (formerly Local Enhanced Services (LES) Contracts). NHS England Commissions Enhanced Services Contracts, from April 2013 CCGs have delegated responsibility for managing community based services. Local Authorities are responsible for commissioning public health services such as screening and immunisation from April 2014. GPs are currently operating in a complex contracting and payment system.

5.6 Integrated Care Pathways

In order to deliver the new model of patient care integrated care pathways are essential. This model requires collaborative working across primary and secondary care, health and social care and voluntary services.

Work that can be undertaken in primary care should be commissioned in primary care. This will require a seed change as services will need to be shifted from Secondary Care. CCGs and NHS England will need to facilitate these discussions with the relevant providers in order to break down barriers and truly reform the current care model.

CCGs will need to have the courage to test new innovative ways of working whilst ensuring continuity of care for patients. The Area Team can assist with this change in methodology by looking at the contract mechanisms that can support this change.

There will also be an emphasis on self-care. Pharmacies can support this work through various enhanced services such as Minor Ailments and Medicines Use Reviews. Protocols such as this allow patients to be more independent and more involved with their healthcare which provides enhanced quality of life.

A communication campaign will be central to the above in order to inform patients of the new model and signpost them to the correct service provider.

Information Technology is also vital to support these changes. In order to establish integrated pathways service providers will need access to a contemporaneous patient record to ensure that they have a full patient history when providing care.

All sectors need to see this change as a positive paradigm shift which will mean the right people will be treating patients in the correct setting for their needs. There will be huge opportunities for both primary and secondary care to set up intermediate services for the benefit of patients in this shared leadership role. This change can be facilitated by the locality hub method which is being adopted by many CCGs and federated GP practices. This is no easy task as it will require a complete service redesign. However, this is what is required in order to create a quality driven sustainable NHS for the 21st century and beyond.

5.7 Workforce – ensuring resilience, developing planning and training

Ensuring a resilient, capable and reliable primary care workforce is vital to ensuring health services can be delivered effectively and efficiently across North Yorkshire and Humber. The national changes to Primary Care services identified by NHS England in the Call to Action publications can only be met locally if individuals and teams undertaking the services are trained, motivated and committed to providing excellent patient care. Providers must also be successful in effectively recruiting and retaining highly skilled and dedicated healthcare professionals.

The NHS England North Yorkshire and Humber Area Team (AT) will play an important role in facilitating change, instigating discussions and supporting CCGs and primary care providers to train, recruit and retain a skilled and flexible workforce that can service the health needs of the local population. Challenging CCGs to take a proactive approach in shaping the primary care workforce can be included in the assurance framework so the Area Team can be confident these issues are being addressed.

The AT will need to work collaboratively and communicate with a range of health and social care groups and stakeholders including but not limited to CCGs, primary care providers, Local Healthcare Committees, the NHS Leadership Academy and NHS England including other Area Teams and the Academic Health Science Networks to help shape development of the primary care workforce and access their resources where possible.

One of the key partners that the Area Team and CCGs must utilise is Health Education England (HEE). HEE provide training programmes nationally but operate at a local level. Through HEE methods for recruiting, retaining, training and developing staff can be accessed supporting the need to motivate and empower staff and create a successful skill mix within practices. Such resources include apprenticeships, e-learning packages, practice placements, skill development programmes, the Advanced Nurse

Practitioner scheme and the Advanced Training Practice Strategy. HEE North Yorkshire and Humber is also responsible for post-graduate training in medicine and dentistry across the region; they will be able to create training programmes more suited to local service needs which could improve the workforce skill mix and attract staff to the area.

The Local Professional Networks for dental, eye health and pharmaceutical services set up to promote a strategic, clinically informed approach to the planning, commissioning and delivery of services can be used to identify local training and development needs as well specifying the range of skills providers should be looking to recruit.

5.8 Medical

Across the North Yorkshire and Humber region approximately 50% of GP's are in a position where they could retire tomorrow. The AT must engage with CCG's to ensure they are producing and implementing effective plans to attract additional and where possible younger GPs into the area. This can be achieved by reviewing the career paths and development opportunities of current and prospective practitioners specifically identifying local resources and institutions such as Hull and York Medical School as potential places of recruitment. CCGs must identify what working conditions could entice GPs into the area and see how they could be provided.

To improve access for patients and reduce appointment time's practices will be tasked with introducing a range of access pathways and solutions for patients. CCG's must identify how the new ways of working could be used as an incentive for GPs. As some of these solutions would be IT based such as telephone, Skype, internet virtual surgeries and tele-health greater flexibility could be offered to GPs when provided these services for example working from home might appeal to doctors and help recruitment and retention. A shift to seven day working could also appeal to younger workers with families who would have the option to work evenings and weekends.

The removal of treatment in acute settings leading to a large increase in out-of-hospital care will impact on GP Practices. This means practices will be required to undertake a range of services in addition to the core services they already provide. Whilst this will be a challenge, CCGs and practices should see it as an opportunity to offer their GPs a more varied range of work and create specialised roles either within their own practice or across an alliance of practices. As this new way of working may not be constrained by the traditional contracting methods it will encourage innovation and forward thinking which will ultimately assist in the retention of staff by offering an interesting and stimulating working environment. The formation of Federations would allow for more specialisms across the patch.

The shift of work form secondary to primary care will also provide opportunities for staff, specifically nurses to be re-skilled. CCGs must identify what services nurses can provide and ensure they are trained accordingly. Similarly to GPs there is an ageing nursing workforce so the recruitment and retention of younger nurses must be considered.

CCGs must ensure that staff appraisals, peer reviews and Continuing Professional Development programmes are be used by practices to encourage innovation and identify opportunities within individuals to further develop their role resulting in greater job satisfaction.

5.9 Dental

For secondary care, the main inpatient dental admissions are for the treatment of dental caries (tooth decay). To reduce admissions to hospital for dental treatment support must be offered to providers to develop effective oral health campaigns. Oral health prevention can be managed through a workforce with a varied skill mix; therefore dental practices should be encouraged to employ dental therapists, dental hygienists, dental technicians and dental nurses as well as dental practitioners.

Dental providers can be encouraged and supported to become training practices offering places for Vocational Dental Practitioners in the region; this would attract dentists into the area. The design of the training courses could be discussed with HEE so that dentists are better placed to deal with more complex cases allowing for other staff within the practice to deal with more straightforward treatments such as fluoride varnish application.

A process to be put in place through the Local Dental Network to agree to Patient Group Directive's where appropriate, potentially allowing dental practices to better maximise the skill mix across their practice staff. This could be important when the new dental contract is introduced with more of a focus on improving oral health.

5.10 Pharmacy

To ensure GP Practices can cope with the increase in out of hospital care pharmacies will be required to play an important role in ensuring they provide services more traditionally provided by GP Practices, the NHS Call to Action identified a need for pharmacies to play a stronger role in the management of long term conditions. Pharmacists will need to be trained in order for these services to

be delivered at a high quality; as not all patients visiting a pharmacy will need to be seen by the pharmacist a greater staff skill mix will be required to effectively deal with the additional workload. For example dispensers could be identified to take on further responsibilities such as the promotion of health lifestyles.

Supporting the Health Living Pharmacy (HLP) initiative would allow further services to be commissioned best suited to the needs of the local population. As part of the initiative a Healthy Living Champion must be appointed to support the important health and wellbeing role of the HLP. This would be suitable for a Medicines Counter Assistant further supporting the skill mix of the pharmacy team as well as empowering and motivating individuals.

Pharmacies will be encouraged to provide advanced and locally commissioned services so that GP admissions can be reduced. CCGs must identify the services they want to commission so that pharmacies can ensure their staff are fully trained and accredited to provide these services.

5.11 Eye Health

The Local Eye Health Network was piloted in the Humber region and has been running since 2012. It has been successful in developing training programmes, expanding the skills of optometrists, improving local services and streamlining referrals resulting in fewer GP admissions.

Ophthalmic Practices will be encouraged to provide locally commissioned services so that GP admissions can be reduced. CCGs must identify the services they want to commission so that practices can ensure their staff are fully trained and accredited to provide these services.

6.Quality, Innovation, Productivity and Prevention (QIPP)

The QIPP programme is a large scale programme of work developed by the Department of Health to drive forward quality improvements in NHS care, at the same time making considerable efficiency savings. The premise being that improved efficiency will lead to improved quality of care.

All clinical commissioning groups must develop QIPP plans as part of their routine business planning. SRCCG has developed a five year plan, building on plans which began in 2012/13. The detailed phasing of the plan has been developed, reflected in the contract plan for 2014/15 and 2015/16 and will inform future contract negotiations with service providers.

6.1 SRCCG QIPP Programme

The CCG faces a significant challenge in its QIPP programme for the period of the strategic plan. In the first two years the CCG currently forecasts a requirement to achieve a 4% efficiency gain, reducing to 3% in years three to five. This is consistent with the national expectations surrounding QIPP and reflects the impact of demographic and technological changes that increases demand. Although the CCG QIPP forecast is not out of line with other health communities it represents a scale of financial efficiency not previously achieved. However, the QIPP plan enables the CCG not only to plan for savings, but also to plan for investment in support of service redesign. Thus, financial efficiency will be achieved through targeted actions to improve utilisation, reduce waste, and improve patient outcomes.

The QIPP programme focuses on a number of different areas of health spend:

6.1.1 Planned Care

- The CCG will continue its development of an Expert Consulting system as a means to reduce unnecessary attendances at secondary care.
- Where difficulty in meeting demand has already been highlighted, for example rheumatology and ophthalmology we will explore new and innovative solutions in primary care

6.1.2 Demand management

- The CCG will co-ordinate work with its GP practices to develop greater capacity in primary care to effectively manage some patients without onwards referral into secondary care, for assessment or diagnosis. The CCG is considering introducing a form of virtual fundholding, to encourage the strengthening of service provision in primary care.
- We will work with YFT and Primary care to ensure that patients' diagnostic phase is optimised before referral for specialist opinion.
- We will facilitate training in musculo-skeletal (MSK)conditions for all of our GPs

6.1.3 Emergency Care

- The CCG's strategic objective of strengthening community services will reduce the overall demand for emergency inpatient admission.
- The targeted investment linked to the Better Care Fund [ref 8] will improve efficiency through: reducing inpatient admissions; shifting elderly care admissions from long to short stay; and reducing the total number of emergency excess bed days.

6.1.4 Urgent Care

- The CCG's major urgent care procurement for a new Urgent Care service will see a new service established in April 2015. The reduction in duplication across a number of separate services and service providers will release significant efficiencies from 2014 onwards.

6.1.5 Prescribing

- The CCG and its member practices have a strong track record in delivering prescribing efficiencies. The prescribing efficiency plan is well developed and is forecast to achieve a 4% efficiency of the total primary care prescribing budget.

6.1.6. Community and Partnerships

The CCG spends a large proportion of its commissioning resource on areas such as Continuing Healthcare (CHC), often in care packages involving a number of partner agencies. As 2013-14 saw reduced spend in elements of CHC, the current QIPP plan includes actions to reduce cost, in areas such as creating greater local capacity to avoid unnecessary and expensive out of area placements.

The schedules contained within the financial plan provide a detailed description of the elements of the QIPP plan, the efficiency gains forecast, and the phased target achievement across the timescales of the plan.

The QIPP plan lays the basis for the achievement of recurrent in-year financial balance (so-called ‘run-rate balance’). The Financial Plan includes the summary of the 5 year QIPP plan.

The CCG believes the QIPP plan provides a credible plan to provide financial sustainability for Scarborough and Ryedale whilst driving through improved quality in clinical services.

6.2 Our approach to Medicines Management

Medicines expenditure in SRCCG was £19,057,866 in 2012-13. The national average number of prescription items dispensed per head of population is rising. (18.7 items in 2012). Prescribing accounts for the second largest area of spend in the NHS (second to staffing costs) and is considered to be the most frequent health care intervention.

Optimal use of medicines represents a significant opportunity to improve health outcomes but when used sub-optimally or inappropriately their use can impact on patient safety and wellbeing and furthermore may cause harm leading to hospital admissions: there is evidence that approximately 7% of hospital admissions are due to adverse drug reactions. It is considered that up to 50% of patients do not take their prescribed medicines as intended. Inappropriate use of antimicrobials can lead to development of healthcare associated infections such as Clostridium difficile and MRSA.

6.2.1 Key objectives of the medicines management strategy

The CCG is committed to ensuring that medicines are used safely, effectively and efficiently and will do this broadly by focusing on safety and quality, and financial and budgetary control. In more detail this strategy will cover:

- Engaging with key stakeholders – patients, the public and healthcare professionals in optimising use of medicines for individuals
- Establishing a culture of safety and quality with respect to medicines use including governance frameworks to underpin safe systems for medicines use from procurement through to administration
- Ensuring budgetary efficiency and management of financial risk associated with medicines and prescribing by effective decision making for medicines commissioning; utilisation of benchmarking tools and appropriate performance management. The CCG will aim to remain in the lower range of cost per ASTRO-Pu (Age/Sex/Temporary Resident/Originated Prescribing Unit) across the region.
- Ensuring compliance with NICE guidance and effective application of horizon scanning processes to safely manage the entry of new drugs.
- Development of systems and processes to enable patients to get optimal use from their medicines to ensure that the full benefit of care pathways can be realised.
- Making optimal use of IT tools to underpin the safe and efficient processes for prescribing and dispensing medicines and to enable ready selection of formulary choices of medicines.
- Ensuring that there is appropriate specialist pharmaceutical support to prescribers in the safe use of medicines, ranging from education to practical help and advice.
- Effective communication to ensure consistency in approach and consistent application of best practice.
- Development of innovative ways of managing medicines from review of procurement systems to imaginative ways of delivering medicines management support to patients and prescribers
- Ensure that all processes relating to medicines use and associated transactions are transparent and facilitate integrated care across all care settings.

- Prevention - preventing ill health and preventing premature death – ensuring the optimal use of prophylactic medicines for e.g. stroke, coronary heart disease and diabetes.
- Enhancing the quality of life for patients with long term conditions – enabling patients to get the best from their medicines: supporting patients to understand the benefits of effective medicines compliance and where to get support regarding their medicines use. Also to identify patients who might be at risk of medicines interactions or adverse effects.
- Enabling and supporting self-care and aiding recovering from ill health and injury through appropriate medicines use and signposting.
- Supporting the population in ageing well through effective use of medicines with regular review to reflect changes in patients' needs and physiological states.
- Promotion of self-care for patients from ill health prevention to minor illness and chronic disease.
- Support for medicines management systems and processes in all care settings including care homes and domiciliary care.
- Unplanned admissions – developing mechanisms to identify patients who may be at risk of harm from complex medicines regimes or whose condition may be poorly managed due to suboptimal medicines compliance e.g. COPD.
- Contribute to the achievement of wellbeing of the population by reducing medicines related adverse events and optimising the use of medicines to achieve the best possible outcomes within the context of achieving value for money.

Medicines optimisation services should be developed based on the core features as described above. In practical terms, this will include:

- Clinical engagement in local medicines commissioning decisions processes to ensure value for money. Further engagement with secondary care to ensure medicines commissioning and procurement processes are aligned and support the achievement of best value.
- A strategy for reducing medicines waste.
- Safe management of controlled drugs.
- Effective communication and engagement with all prescribers about all aspects of medicines management underpinned by a comprehensive web based information system.

- Efficient GP practice based plans and IT systems to manage medicines effectively by:
    - Effective use of medicines formularies supported by sophisticated IT solutions
    - Effective use of medicines information tools and personnel to manage medicines safety alerts and to enable responsiveness in changes to medicines pathways
    - Safe and effective use of antimicrobials underpinned by best practice guidance to minimise harm to patients
    - Effective communication between stakeholders to achieve seamless and safe care across all interfaces including admission and discharge.
    - Closer collaborative working with secondary care to enable patients at risk of harm from their medicines to be safely transferred back into domiciliary care. Schemes to support medicines reconciliation post discharge using pharmacists and technicians to work as integral part of the practice team
- Utilising every opportunity for patient contact with all healthcare professionals to deliver medicines optimisation– promote shared goals and collaboration amongst all healthcare professionals.
- Enabling medicines use to be optimised across all care settings including care homes, domiciliary settings and in the consultation room – developing schemes to identify the best use of available skills to make targeted interventions for medicines optimisation.
- Further development of systems to enable medicines optimisation outcomes to be quantified and translated into demonstrating tangible benefits to patients.

7.The Provider Landscape within which we must facilitate change

In order to preserve the fundamental values of the NHS, the NHS must change. If services stay as they are, continuing demand and an aging population combined with difficulty in securing staff and skills will make "the NHS become financial unsustainable and quality and safety will decline". The current configuration of providers of healthcare will change over the next five years. In some instances, change will need to be radical. In order to facilitate care closer to home, we will need to strengthen primary and community care. We have an excellent voluntary sector in Scarborough and Ryedale and we will maximise the use of these bodies to support patients and carers. We will need to enhance technology and implement innovative solutions. Our populations will need to take responsibility for changing lifestyles and work with agencies to prevent illness and improve public health.

Initial discussions are planned with our Council of Clinical Representatives in July 2014 regarding the future of secondary care services. This debate will help to form the basis of further discussions with our main providers.

The current vision for services in Scarborough Hospital continues to reflect the concept of the 'Health Village'. This sees a relatively focused District General Hospital providing a range of acute services that are those with sufficient volume of activity for quality and performance to be consistent with delivering good patient outcomes.

Some of the more specialised services may be delivered either in specialist centres (as is currently the case with certain types of heart attack treatment) or through clinical networks. The CCG is engaging with YFT in developing such networks in areas such as stroke care, and this may be extended to other specialised services, utilising networks involving clinicians from York and Hull.

Where care can be delivered closer to a patients' own home, it is anticipated the role of acute hospital care will be to facilitate assessment and diagnosis, but with a greater emphasis on outpatient and domiciliary care and less on management through inpatient admission.

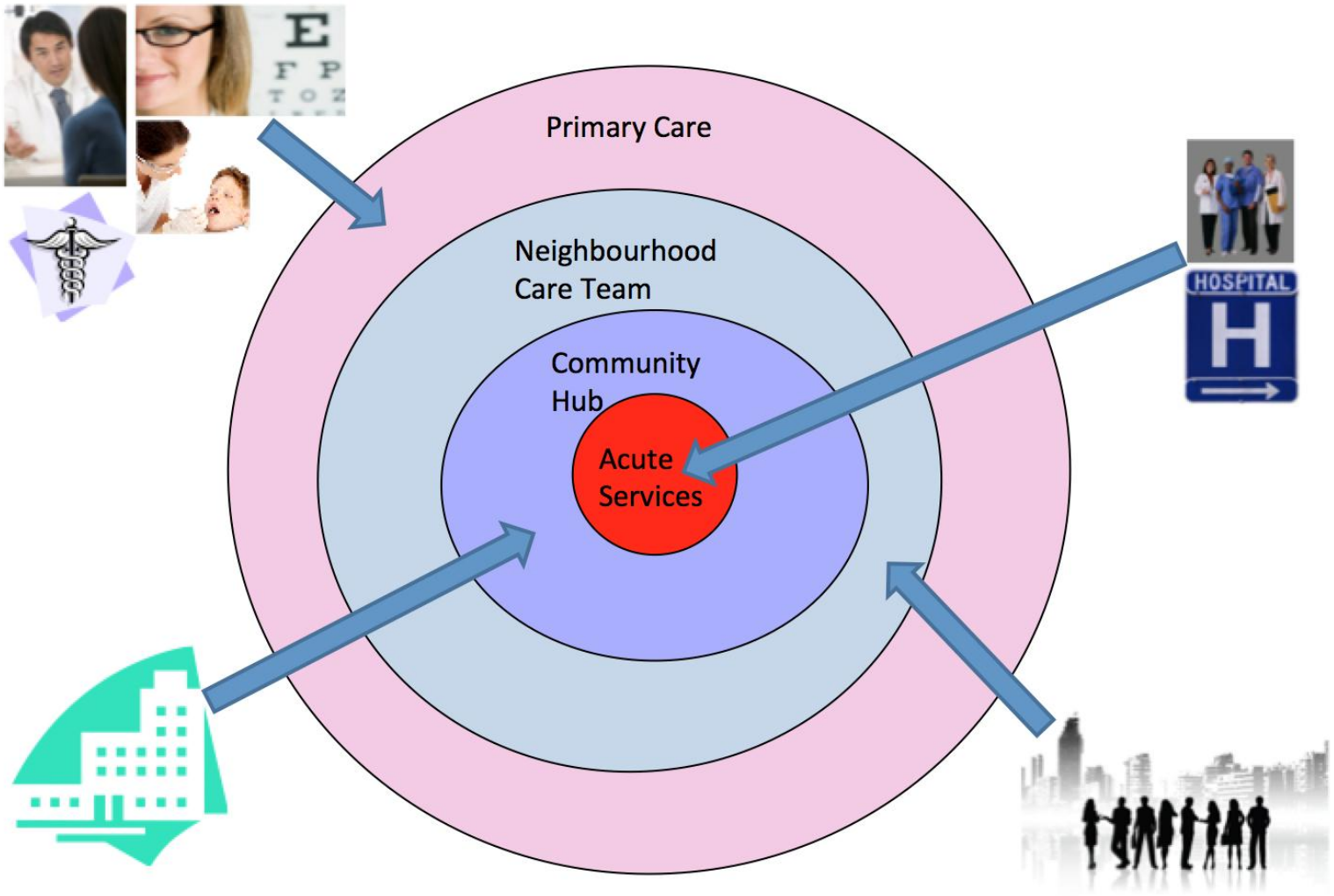
The acute hospital itself will continue to provide a core range of services, including Emergency Care, Maternity, Paediatrics, Diagnostic interventions, and a range of elective treatments. Elective care will primarily be minor and intermediate surgery, but where larger volume and high quality care can be provided, for example elective Orthopaedics, this may continue through the acute hospital system in the locality. It is anticipated more complex major surgery may be primarily delivered in larger specialist centres

(as is already the case in most instances).

The described community hub services will ‘wrap around’ the acute hospital: the hubs themselves wrapped around by the primary care led Neighbourhood Care Teams. As part of the service planning through the Better Care Fund, the CCG plans for a greater focus on self-care, and maximising the use of the already mentioned strong local voluntary sector.

The vision of tightly commissioned acute service, supported through clinical networks, wrapped by a series of community and primary care services is illustrated in diagram 3.

Diagram 3


Primary Care
Neighbourhood Care Team
Community Hub
Acute Services
HOSPITAL
H

York Teaching Hospital NHS Trust is our main secondary care provider of services for our population with flows into Hull and East Yorkshire NHS Trust (HEY) for general services in the southern and eastern parts of the patch and for certain tertiary services across the whole area.

7.1 York Teaching Hospital NHS Foundation Trust

York Teaching Hospital provides a comprehensive range of acute hospital, specialist healthcare services and community services for approximately 530,000 people living in and around York, North Yorkshire, North East Yorkshire and Ryedale. The trust employs approximately 8,000 staff working across the hospitals and community, with an annual turnover of over £400m.

York Hospital	The largest hospital site run by YTH. This is a 700 bed hospital, offering a range of inpatient and outpatient services. It has an Accident and Emergency department and provides acute medical and surgical services, including trauma, intensive care and cardiothoracic services to the population and visitors to York and North Yorkshire.
Scarborough Hospital	Scarborough Hospital is the Trust's second largest hospital. It has an Accident and Emergency department and provides acute medical and surgical services, including trauma and intensive care services to the population and visitors to the North East Yorkshire Coast.
Bridlington Hospital	Bridlington Hospital is a district hospital which provides surgical, rehabilitation, and outpatients services to the local Bridlington community. The hospital is being developed into an elective surgery centre to allow the separation of elective and acute care in Scarborough
Malton Community Hospital	Malton Hospital is an inpatient and outpatient unit providing hospital care to patients over the age of 18. The hospital provides inpatient rehabilitation, palliative care and outpatients services to the local Ryedale community in association with local GPs. The hospital also has a nurse-led minor injuries unit.

7.2 Hull & East Yorkshire NHS Trust (HEY)

HEY provides a comprehensive range of acute hospital, specialist and major trauma services for approximately 1.25 million people living in the Hull, Yorkshire, East Riding and Northern Lincolnshire area. The trust provides networked services with other providers in the area, including; major trauma, major vascular, neurosciences, cardiology, oral surgery urology, cancer services, and a range of screening services. The only major services not provided locally are transplant surgery, major burns and some specialist

paediatric and highly specialised cancer services. HEY employs approximately 8,664 staff working across the hospitals and community, with an annual turnover of £495m. HEY do not yet have Foundation Trust status.

Hull Royal Infirmary	Hull Royal Infirmary is based in the centre of Hull. With 709 beds, it is the emergency centre for the Trust. The A & E department sees 120,000 people each year, and is currently being upgraded. The site also consists of a dedicated Renal Dialysis unit, the Eye Hospital, and the Women's and Children's Hospital. The Clinical Skills facility is also based here.
Castle Hill Hospital	Castle Hill Hospital is based in the rural East Riding. It provides predominantly elective care, with 610 beds. This site includes the award-winning Queen's Centre for Oncology and Haematology, the Centre for Cardiology and Cardiothoracic Surgery (bringing diagnostic and treatment facilities in one state-of-the-art building on the site), and the Centenary Building (Breast Surgery and ENT).

7.3 Key Principles

There are some principles common to all CCGs across the North Yorkshire and Humber patch which underpin the way services will be commissioned from Providers over the next 5 years:

- Quality and safety must be the highest priority
- There will be an increasing requirement for focus on prevention and self-care / independent living rather than reliance on hospital based care
- A small number of hospital services will be commissioned from centralised locations if necessary to improve outcomes
- There is a need to reduce inappropriate admissions to inpatient beds in hospitals and care homes through better management of care in the community
- Organisational barriers need to be broken down where needs are complex and patient care crosses numerous boundaries to improve co-ordination and reduce fragmentation of care
- Providers will be expected to work within the financial constraints of each health community

7.4 Core enabling themes

In order to deliver this challenging agenda there are some specific enabling work that will need to be undertaken.

7 day working and 24/7 access to key services and information is required both in hospital services and primary care/community services (meeting the national standards)

- The workforce needs to be supported to work, and to have their training and professional development, in different ways to support the integration agenda
- IT infrastructure and access to health and social care records must be seamless and timely, and cross organisational barriers, using technology to ensure better outcomes and efficiencies. This needs to include partner organisations such as Local Authorities, to ensure that we overcome the challenges with sharing and transferring information.
- Single Point Access, and/or Single Point of Contact to support appropriate care navigation where individuals and their families/carers are directed to the most appropriate service at the most appropriate time
- Providers will need to work with health and social care commissioners (including Local Authorities) to change the way that acute services are provided to reduce face to face interventions and promote community based care
- Community services and Primary Care will be strengthened, for example; primary health care teams, community nursing, community based diabetic care, or management of long term conditions to ensure that hospital services are used appropriately.
- Communication channels between care homes and the wider health and social care community need to be strengthened and improved
- There is a need to increase access to hospice care for all patient groups (e.g. COPD and heart failure patients and other end of life care, not just cancer patients) and to ensure this is available in a timely manner, in order to reduce admission to hospitals (particularly out of hours)
- Transport and infrastructure will be a key concern for patients if current service locations are changed, and commissioners will work with transport companies to use resources as effectively as possible
- A range of different technologies will be harnessed to enable and promote self-care and home-care provision of services where safe and clinically appropriate
- Outcome based measurement of care services rather than process metrics to ensure that organisations focus on quality of care outcomes rather than timings and volumes.

7.5 Future direction of travel for commissioning of acute hospital services

Based on a mix of national recommendations and local needs assessments:

7.5.1 The national picture

National thinking around hospital based care has been influenced through high profile reviews such as the Keogh review of Mid-Staffordshire Hospital, and a selection of other hospitals around the country. Recommendations from these reviews have underpinned commissioners thinking locally. In his review of hospital services Sir Bruce Keogh recommended serious or life threatening care needs to be delivered in centres of excellence, with the best expertise and facilities to maximise chances of survival and recovery. As such, national recommendations are moving towards commissioning serious and life-threatening emergency care services from centralised locations. A lot of this has already happened in our area with major trauma, procedures relating to some heart attacks and vascular surgery already commissioned and delivered through clinical networks.

It is anticipated that a large number of very specialised providers will be commissioned to provide a few procedures at exceptional levels of quality and value. Hospitals will be expected to utilise generalist-led, multi-disciplinary teams to provide continuous care around each patient, so the patient doesn't need to move around wards. This could include in-reach/outreach services where one team covers the whole episode, for example; defining a care group/need and having one organisation lead or follow the whole pathway.

Most health consultations and diagnosis will be commissioned from local primary centres and the home, as specialists consult virtually from a small number of large specialist hospitals, and a greater understanding of genetic risks and how to combine personalised medicine with services will enable management of risks and disease prevention.

7.5.2 The local picture

This national thinking has informed past and on-going discussions between the CCG and hospitals within our local area. This has focussed on how services could be delivered jointly in the future in a sustainable way. Patients already travel within the NYH area and further afield for certain specialist integrated services, and benefit from high quality care through the commissioning of services from clinical networks between hospitals. YTH, HEY and North Lincolnshire and Goole have shared with commissioners that they feel the scale of the quality, workforce and financial challenges will not be achieved if they work in isolation, and as national thinking

moves more towards centralisation of specialist services, for quality and safety purposes, and it is anticipated that this principle will be applied to a small number of services where appropriate in the NYH area, subject to consultation processes.

Commissioners are clear that centralisation of health care services will not save money (as the same number of patients will need to be treated). In some cases it may even cost more to move services into one location, as there could be some building/relocation costs. Centralisation considerations are to improve quality and safety.

Whole-system changes to existing health and social care services will be required if commissioning intentions and national recommendations are to be implemented. This may include changes to organisational constructs, or reconfiguration of organisational boundaries.

The work led by the Chief Executives of NLaG, HEY and YTH is looking at the vision of health care services by 2030 and is based on the following assumptions:

- There will be fewer tax payers
- Not every health and care service will be free
- There will be a skill deficit
- HEY acute building site will have to be replaced
- There will be reduced operating costs
- People will travel for excellence
- There will need to be increased provision for the elderly
- There will need to be increased end of life provision
- The workforce will be older
- Employee contracts will look different

Commissioners have set out their expected service requirements, and it is up to providers to respond to those requests. It is expected that provider responses will involve a range of different options for delivery of services, including reconfiguration, collaboration, alliances and clinical networked approaches. The local acute hospital trusts are working proactively to establish closer clinical networks and support joint integrated working in preparation for any changes to organisational constructs that may be

required. Commissioners will not define the approach, but will expect to sign off on any changes to healthcare delivery for their populations.

Undoubtedly this will involve whole-scale change, and different ways of commissioning, providing and receiving care. Health and Social Care Commissioners and providers will have to work together to deliver the scale of change that will be required.

7.5.3 "Specialist Services concentrated in centres of excellence"

Specialist services are not commissioned by the CCG; these services are the responsibility of NHS England. However, as a minority of our patients will at some time in their lives need to access specialist services it is important that the CCG is involved where changes to pathways or service delivery is being considered. Predominantly our patients currently access specialist services from hospitals in York, Hull, Leeds, and South Tees. There is a national drive to develop centres of excellence across the country which may lead to changes in our current services and result in fewer hospitals providing certain services. With these changes in mind,

- We are committed to working with Strategic Clinical Networks and specialist commissioners to secure and couple local commissioning responsibilities with those of national commissioning responsibilities;

- We will proactively engage with Operational Development Networks (e.g.Vascular, Major Trauma, Cancer) regarding securing local pathways which interface with specialist services.

- Where changes to pathways and service delivery are being considered we will work in collaboration to support the development of new pathways and business case for proposed changes.

- We will proactively contribute to the evidence base and input into local consultation processes.

- We will ensure that there are effective links to specialist commissioners so that local GPs and other professionals are informed and able to support their patients accordingly

As mentioned in section 2, all Provider Trusts find themselves in similarly challenging financial situations as the CCG. Trusts are expected to deliver efficiencies whilst maintaining and improving quality of care and as such all have Cost Improvement Plans (CIP) in place.

The CCG has an on-going and established process for assuring itself around the:

(i.) robustness of Providers' Quality Impact Assessment (QIA) processes which are in place
(ii.) quality impact of Providers' Cost Improvement Plans

This includes the forward reporting of new emerging CIPs through the Contract Management Board as well as on-going QIA reporting for CIPs already in implementation. This is in line with all the appropriate national guidance and is embedded in the contracting and provider performance & compliance framework. There is regular reporting to and discussion with the CCGs' clinical leads through the appropriate Quality and Performance Committee, and in turn to Governing Body. The CCG assurance processes are co-ordinated by the Executive Nurse with support from contracting, planning & assurance and workforce teams as required.

8. A Strong Community System

If there is one area where the commissioning strategy intends the health and social care system to look radically different it is in the development of a much stronger, integrated community system. Thus, the redesigned system will provide:

- Capacity – through a transfer of resource into primary and community services, closer to patients.
- Efficiency – through streamlined pathways and less use of hospital resources by supporting patients in their own residences
- Effectiveness – through integrating services within healthcare (across primary, community, and secondary care boundaries) and through integrating across health and social care
- Responsiveness – through partnership working with a range of agencies, in particular the local voluntary sector.
- Workforce – a flexible streamlined workforce, reducing service duplication, with a transfer of resource from hospital based to community based services.

The work-streams in 2014/15 and 2015/16 are:

- Extending Neighbourhood Care Teams (NCTs) – bringing together community nurses, therapists, and social care staff, clustered around General Practice.
- Development of Community Hubs in Malton and Scarborough which will provide outreach to NCTs and rapid assessment and care planning for frail, elderly patients who all too often are admitted to secondary care beds because there is no other alternative service available.
- Developing a model to support patients in care homes
- A pilot scheme to consider a more integrated approach to district and practice nursing within a neighbourhood care team
- Roll out of the Neighbourhood Care Team (NCT) project across the locality
- A pilot, changing community hospitals from ‘small hospitals’ into non-hospital ‘community hubs’ including a frailty model of early assessment, diagnosis and support.

- Implementing specialist liaison mental health services into urgent care and acute hospital inpatient care.

In addition to national indicators, the CCG has decided to aim to achieve a local priority indicator “reduction in falls in the elderly”. To support this ambition, a falls service will be commissioned as part of the community hub.

Through discussion, debate and engagement with stakeholders across health and social care we have developed a strategic approach to commissioning care in the community.

The strategic context is informed by a number of major national and local factors, including:

- The current economic downturn. Despite the re-emergence of economic growth, the UK economy remains below its output level at the start of the financial crisis and the government has indicated a need to continue to restrain public spending.

- A desire for greater integration between health and social care. The divides between care sectors often appear nonsensical to patients, and provide discontinuity of care and duplication of resources. However, moving towards more integrated care across different organizations, with different financial and delivery challenges remains far from easy.

- “The demographic challenge has arguably been overstated in terms of the number of heavily dependent older people requiring care”. What may be clearer is the generally larger number of those requiring some form of care, and their expectation of when and how that care is delivered. There may not be an objective need for greater numbers of care home beds, but there may be a need for a greater range of services for the chronically ill, mostly accessible with short waiting times.

- “A desire to develop much greater integration as a means of addressing a demographic challenge should not obscure the relative lack of supporting evidence for community initiatives (including some technological ‘solutions’) in reducing the number of emergency admissions”. The evidence base will need to be considered when considering significant shifts of resource from one care sector to another.

- The ‘Scarborough complex’. The history of the Scarborough health community’s challenges over the last 10-15 years have been documented elsewhere. However, the recent acquisition of the Scarborough Hospital by York Teaching Hospitals NHS Foundation Trust (YFT) has not fundamentally resolved the challenges. Although the YFT acquisition has been welcomed, it requires major changes to make services in the locality sustainable for the longer-term.

The move to joint working at a corporate level indicates the significant pressures that face the NHS and Social Care as a growing elderly population, with a significant proportion of complex needs, and ever increasing public expectation threaten to overwhelm current services. We are fully aware of this national issue in Scarborough and Ryedale with large proportions of our health budget being attributed to elderly care, emergency presentations at A&E and long stay acute admissions. We recognise that this is not a sustainable position and seek to make radical changes over the forthcoming years. Specifically in 2014-15 and 2015-16 we will put in place the building blocks to allow patients to be treated as close to their home as possible by ensuring that primary care and community care has sufficient capacity and appropriate skills to avoid unnecessary visits and admissions to secondary care.

8.1 Developing the community strategy

Through a series of workshops and stakeholder engagement the CCG has developed the vision for community services.(see diagram 3)

To achieve a common approach to community system development we will seek to agree a series of overarching principles that all partner organizations can commit to and which guide subsequent actions. The initial proposed principles are:

- Promoting health
  A priority should be given to evidenced based initiatives that improve population health. Whilst the direct health benefits and cost reductions may be largely into the longer-term, the overall gains are likely to be large.

- The patient's own residence as the default place for care delivery
  Accepting that there may not necessarily be a significant evidence base that 'care closer to home' is more economically efficient; the principle should underpin the overall strategy. It is considered to be supported by the majority of the patient population, and may allow significant cost reduction in expensive specialist facility based care.

- No health without mental health. [DH 2011]
  Whilst many mainstream mental health services may be of high quality, there are significant gaps in 'interface' services, such as liaison psychiatry. The principle of no health without mental health should underpin the commissioning of all care services.

- Common procedures for individual care needs assessment
  Delays in care planning and management, with resulting inefficiency and duplication may be attributed to a lack of common, integrated care assessment. Partners commit to work to agree common assessment frameworks wherever possible.

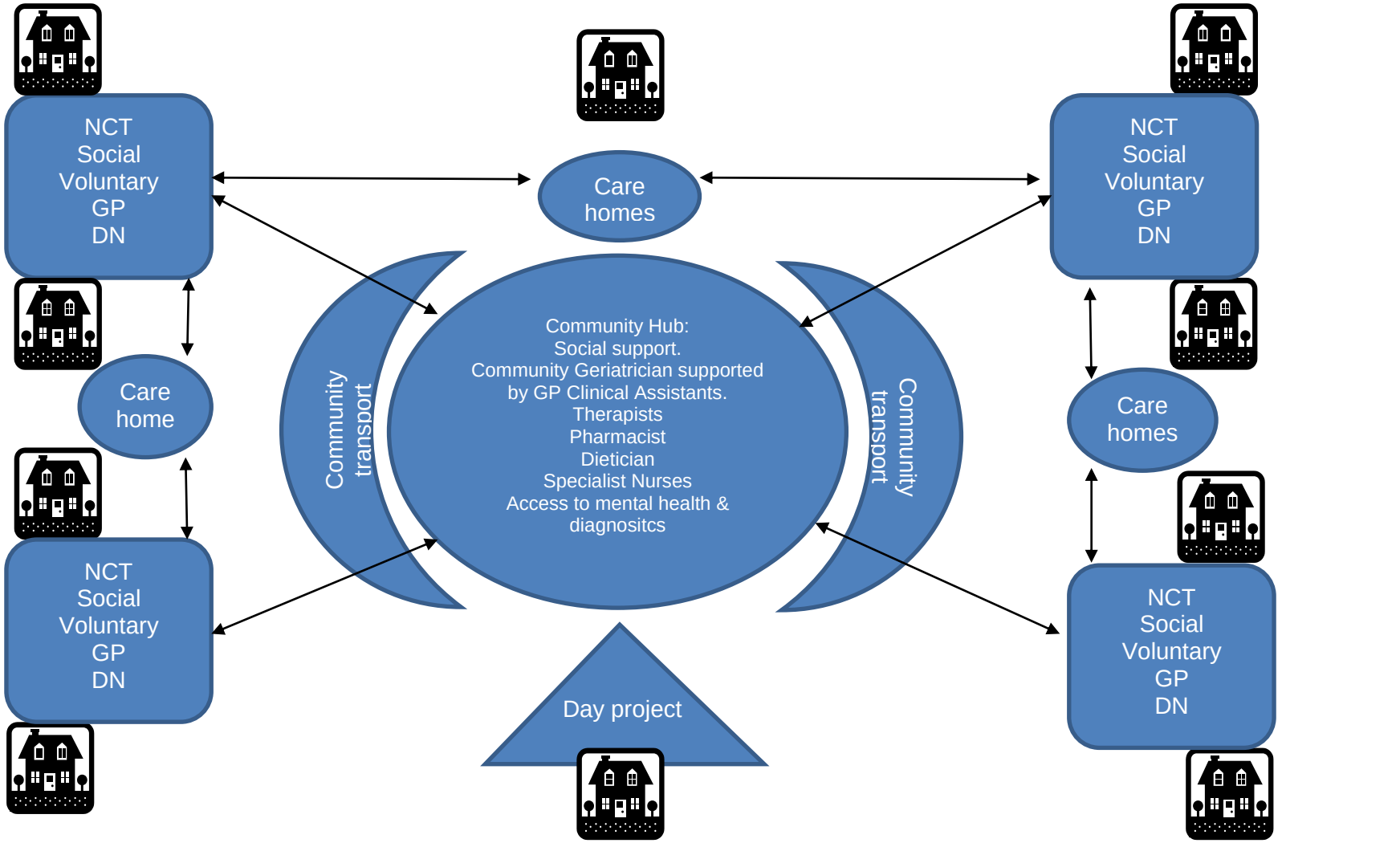
- Pooling of resources wherever possible to support joint care delivery
  The local experience of formal pooled budgets appears relatively limited and integration may benefit from much greater use of pooled budgets. The Better Care Fund should be seen as the minimum level of investment into integrated care, not the maximum.

- Financial mechanisms that obstruct integrated care development should be adjusted or abandoned
  Although the introduction of Payment by Results (PbR) by the NHS has had many benefits, in some cases it appears to provide perverse incentives and can obstruct service redesign. Partners should commit to move away from such financial flows where they appear problematic.

- Cost shunting is not efficiency
  Merely transferring a financial problem from one care sector or agency to another does not reduce the overall cost burden. The focus for efficiency gains is to reduce actual costs not to transfer financial pressures between sectors.

It is essential there is commitment to support implementing the areas of action. It is also important to recognise it is unlikely in any major area of improvement that a detailed agreed plan of action will necessarily be produced at the outset. A lack of a detailed 'blueprint' should not be seen as a weakness: in some cases it may be a strength. However, there will be a need to agree and support the overarching principle and objective. Partners may disagree as to precise implementation but such disagreement can be managed through a collective endorsement of service improvement as an approach and the need to act and reflect, through early actions and trials.

Diagram 3


NCT
Social
Voluntary
GP
DN
Care
homes
NCT
Social
Voluntary
GP
DN
Care
home
Community Hub:
Social support.
Community Geriatrician supported
by GP Clinical Assistants.
Therapists
Pharmacist
Dietician
Specialist Nurses
Access to mental health &
diagnositcs
Community
transport
Community
transport
Care
homes
NCT
Social
Voluntary
GP
DN
NCT
Social
Voluntary
GP
DN
Day project

9. Improving Health and Reducing Inequality

SRCCG will continue to work closely with North Yorkshire County Council to improve health and reduce health inequalities as identified in the JSNA and draft Health and Wellbeing Strategy. The relevant sections of the JSNA include those for North Yorkshire as a whole as well as specific issues identified for SRCCG and can be found at Appendix 1. Public health improvement programmes commissioned by North Yorkshire County Council will be supported and implemented locally, including smoking cessation, drug and alcohol treatment services as well as immunisation and screening programmes that will be commissioned by NHS Commissioning Board.

The stronger community system will support improved outcomes through clinically and cost-effective models of delivering sustainable, safe, patient focussed services. The aim of the services will be to improve the health outcomes of our communities, with particular focus on areas considered high priorities.

From analysis of the Joint Strategic Needs Assessment (JSNA) the CCG has identified four priority areas for improvement in health outcomes:-

- Cancer
- Cardiovascular care
- Mental Health
- Elderly care

9.1 Cancer.

Cancer remains the lead cause of premature death in SR area. The CCG will develop plans working with public health and other key stakeholders to reduce inequalities in outcomes between the most affluent and the most deprived communities in our population and to increase the 1 and 5 year survival rates to compare more favourably both national and internationally.

Although the quality of cancer treatment for the CCG population is considered good, there remain opportunities to improve outcomes through earlier diagnosis.

There are currently around 2,500 people living with cancer in the SR locality. The aim of the National Cancer Survivorship Initiative is to ensure those living with and beyond cancer get the care and support they need to lead as healthy and active a life as possible, for as long as possible. In March 2013, Living with and beyond cancer: Taking Action to Improve Outcomes was published to help inform the direction of survivorship work in England to 2015. The document identified a number of key interventions that could make an immediate difference, including the introduction of "The Recovery Package" which includes:

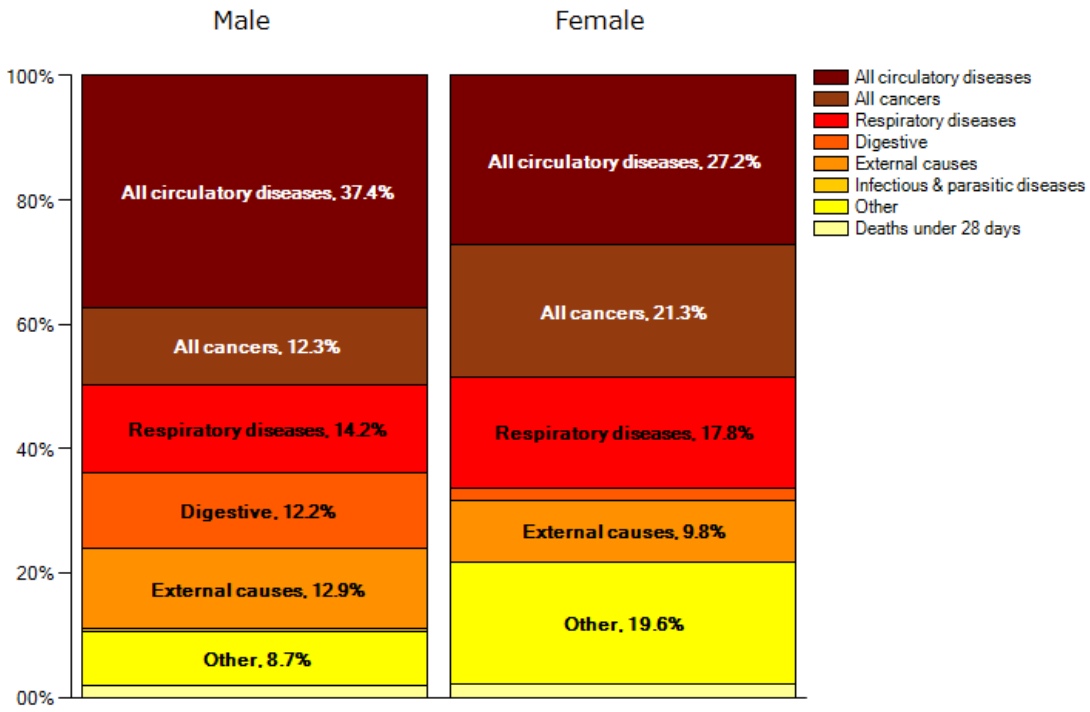
- Structured Holistic Needs Assessment and Care Planning
- Treatment Summaries and Cancer Care reviews
- Patient education and support events
- Advice about and access to schemes that support people to undertake physical activity and healthy weight management

The CCG is committed to working with providers and the Strategic Clinical Network to develop new models of care which will deliver these elements of care and reduce the need for continued follow up.

9.2 Cardiovascular care.

Cardiovascular outcomes are significantly worse for the CCG population than for the rest of North Yorkshire and contribute significantly to the health inequalities evident in the most deprived areas of the CCG. The most significant contribution to tackling the gap in life expectancy is therefore likely to come from the risk factors common to all these diseases, particularly smoking

cessation, as well as the detection and improved management of hypertension, raised cholesterol, coronary heart disease and diabetes. The graph below demonstrates the impact of cardiovascular disease on mortality.



In 2012-13 the CCG targeted improvements in stroke care, in line with current NICE guidance with the aim of: improving the time stroke patients spend in a dedicated stroke unit; improving access to TIA clinics; and instituting early supported discharge for appropriate stroke patients. The focus on improving outcomes for stroke patients will continue.

The CCG and partners will continue the implementation of the developed model pathway for Congestive Heart Failure (CHF). Further developing work will focus on managing hypertension and angina in primary care.

The CCG has committed to review diabetes care, particularly in relation to the relatively high rates of amputation in Scarborough and Ryedale.

9.3 Elderly care.

Alongside the work developing for LTCs the CCG is committed to improving the services for the elderly patients. The CCG intends to commission a rapid assessment service for elderly patients with complex needs and a falls service as part of the Community Hub. The aim is to provide rapid assessment and treatment planning for elderly patients (whether in or outside the hospital) seeking to avoid unnecessary hospital admission. Linkages to social care and the voluntary sector will support an approach of seeking to 'maintain normality' by ensuring adequate support is available.

9.4 Improving mental health and achieving parity of esteem

In line with No Health without Mental Health and the requirement in Everyone Counts to ensure parity of esteem, the CCG aims to improve the quality and access of mental health services

Parity of Esteem is a key theme in Everyone Counts and fits well with SRCCGs strategy to focus on mental health services. We are well aware that mental health services on the East Coast are not as robust or consistent as they should be. There are numerous factors that have contributed historically to this, not least the difficulty of providing care in a remote location, distant from Mental Health Providers. However, we are committed to improving the range of services and ensuring adequate access to diagnosis and therapy support:

9.5 Psychological Therapies

Improving Access to Psychological Therapies (IAPT) is a national programme which supports the implementation of NICE guidance for people suffering from depression and anxiety disorders. It was set up to offer patients a realistic and routine first-line treatment, combined where appropriate, with medication which traditionally had been the only treatment available.

In Scarborough and Ryedale the waiting times for IAPT is over 14 weeks for low intensity support and 14 months for high intensity support. This has led to a great deal of service user and referrer dissatisfaction and negative media attention. The current provision will not meet the operational target of 15% by the end of 2014/15 (The proportion of people who have depression and/or anxiety disorders who receive psychological therapies will be 15% by 2015). The National IAPT programme has identified SRCCG as having a projection of 3.7%.

SRCCG will commission a psychological therapies service that provides a range of therapies from low level interventions and support to high intensity treatment within primary and community settings that is responsive and accessible and meet the national target of 15% of the population accessing IAPT who meet the criteria.

The services will:

- Have one point of access
- Be responsive and accessible, with an aim of waiting times of no more than 2
- weeks
- Offers choice of therapies (1-1 / group-work / use of technology)
- Provide timely and informative feedback to primary care (GPs) on the outcomes of the treatment provided

With the provision of this service we would expect to see improved outcomes, in particular:

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

9.6 Dementia

Currently, only about one third of people with dementia receive a formal diagnosis.
When a diagnosis is made it is often too late for those suffering with the illness to make choices about their future care and is also often made at a time of crisis which could have been avoided if a diagnosis had been made earlier causing distress to patients and carers.

In 2012 there were 779 people on GP registers with a diagnosis of dementia. This equates to 0.67% of the population.

To overcome this problem SRCCG will:

- Support the development of Dementia Friendly Communities within SR CCG to reduce stigma, increase awareness of dementia, increase early diagnosis and provide support to people to live independently for as long as possible
- Work with Primary Care to increase the knowledge and skills of practice staff, increase efficiency of screening and links to memory clinics and care navigator.

As a result of these developments, patients will:

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

In addition to these services, the CCG will work in partnership with our Mental Health Provider, Acute Provider and local authority, to develop a dementia collaborative aimed at reviewing dementia care pathways across all sectors of care to ensure that support is available when needed and streamline care for patients with dementia. This programme of work will be underpinned by Lean Thinking methodology.

9.7 Liaison Psychiatry

People with a long term physical illness are three to four times more likely to have a mental illness and the prevalence of mental health conditions is particularly high (30-65%) among acute hospital patients. This co-morbidity is associated with a number of adverse consequences, including poorer quality of care for the physical condition, reduced adherence to treatment, increased costs and poorer health outcomes. Liaison Psychiatry services have been developed in response to this need and have shown to improve care and enable discharge earlier if patient's mental health needs are addressed, also reducing re-admission rates.

SRCCG will commission a comprehensive liaison service that is responsive to patients requiring mental health support in A&E and for complex cases on wards, in partnership with York Foundation Trust and Tees, Esk and Wear Valley Mental Health Trust. The service will bring appropriate detection of mental illness, signposting of specialist mental health services, working to avoid re-admissions and up skilling ward staff.

We anticipate the outcomes of this service to be:

- Increased diagnosis of mental health (including dementia)
- Decrease in bed occupancy
- Reduction in inappropriate investigations
- Reduction in discharge to care homes
- Improved service user and carer experience

9.8 Vulnerable People

9.8.1 Learning disabilities

On the 10th December 2012, the Government published its final report into the events at Winterbourne View Hospital and set out a programme of action to transform services so that vulnerable people will no longer live inappropriately in hospitals and are cared for in line with best practice.

The Partnership Commissioning Unit(PCU) on behalf of the CCG has put an action plan in place to ensure the requirements of the concordat are met.

The PCU has developed a register in line with the concordat that identifies where everyone is placed.
A programme of reviews is being undertaken. All those patients in in-patient settings have been reviewed. Those in residential and nursing homes who are placed out of area are being reviewed by the concordat deadline.
For those where it is appropriate to discharge them or move them into area plans are being put in place to support this.

A commissioning strategy will be developed to respond to the needs of those in hospital settings and out of area to provide services in the community as close to home as possible.

We would expect to see the following outcomes as a result of service changes:

- People will be getting the appropriate care that meets their individual needs
- People will be placed close to home if that is appropriate for them
- People will be in placements that are safe and of high quality and are value for money.
- People will be supported to reach their potential and live as independently as possible.

The CCG will implement the recommendations within Closing the Gap including:

To improve the physical health of those with mental health:

Having 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 die 15 years earlier. This group of patients have higher rates of cancer, heart disease, respiratory disease and diabetes.

People with mental health problems have higher levels of alcohol misuse and obesity than the population as a whole, and do less physical activity. Some 42% of all tobacco smoked is done so by people with mental health problems.

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

We will encourage 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.

To ensure that people living with mental health problems have the same levels of access to and outcomes from mainstream services as the general population, we will 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.

As a result we would expect the following outcomes:

- Reduction in the number of premature deaths in people with mental health problems.
- Improved physical health of those with mental ill health
- Increased use of screening and health checks by those with mental ill health.

Roll out of Psychological Therapies to ensure children, young people and those from minority or marginalised communities have access to support

Half of those with lifetime mental health problems first experience symptoms by the age of 14. Psychological therapies need to be delivered in a different way to children and young people compared to adults.

Improve support to carers of those with Mental ill health

Caring for someone with a mental health problem can be hugely draining both emotionally and financially. The CCG will work with partners in the Local Authority to provide better support and ensure carers are involved more closely with decisions about service provision.

Improve the support to those with mental ill health as they grow from young person to adulthood

It is recognised that young people who rely on mental health services are often 'lost' to the system when they reach adulthood. The CCG will utilise the national specification (currently being developed) for transition from Children's Mental Health Service to Adult Services to build on best practice and evidence from a range of service models to commission high quality measurable person centred services.

9.9 Children's services

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

By developing and commissioning modern models of integrated care we will ensure that children and young people with complex and additional health needs, including Special Education Needs, receive high quality services which support them and their families.

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

In 2014 York Foundation Trust will be undertaking an assessment of their paediatric surgery standards across both sites to ensure that there is compliance with national guidelines.

As part of the capital programme at Scarborough Hospital, changes are planned to the current layout of the children's facilities. The CCG is involved in these discussions and will work with YFT to implement change.

9.9.1 Safeguarding and Looked After Children (LAC)

The CCG has an established team of Designated Professionals for Safeguarding Children (i.e covering both the Child Protection and Looked After Children agendas) to work across the whole health economy in North Yorkshire and York as per the recommendations in the NHS England Accountability and Assurance Framework (2013) and in line with the 'Working Together' statutory guidance.

There are clear safeguarding governance and assurance pathways within the CCG and in relation to commissioned services including relevant polices and agreed arrangements for representation on multi-agency partnership bodies (the Local Safeguarding Children Board, the Safeguarding Adult Board, the LAC Strategic Partnership for North Yorkshire and the Health Partnerships Group).

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

The Designated Professionals Business Plan (set out in the Annual Report 2012-13) describes priorities for future working across the CCG area to strengthen and further embed safeguarding children and LAC arrangements. This includes:

- Improved data reporting through shared access to LCS
- Joint Initial Health Assessments action plan
- A more streamlined and effective specialist LAC team
- Complex needs pathway
- Work being undertaken regarding care leavers

10. Delivery and Performance Management

Describing the vision, values and direction for the health community does not inevitably mean the associated objectives are achieved. Effective means to execute the strategy and deliver its benefits are the main work of the CCG and its partner agencies. As such all delivery mechanisms, and corporate elements should reflect planning and implementation of the strategy. Assurance frameworks, including risk management, should take the strategy as their foundation: assurance of strategic delivery as their main concern

Delivery will be supported by:

- **Strong practice engagement**. As a membership organisation this will be critical to the CCG. This active membership will not merely support the CCG Governing Body: it will be its main method of delivering the strategy. This will include performance management of practice performance and facilitating innovation through tools such as practice grouped CCG learning sets.
- **Joint Commissioning.** The CCG will actively seek out arrangements with other commissioners to support effective, planning, procurement, and contracting. Current examples include the established joint commissioning committee with North Yorkshire County Council. Joint commissioning will support 'delivery at scale': those areas where commissioning or redesign at a larger geographical level may provide benefit. As such the CCG will continue to support certain elements of the work emerging from the North Yorkshire and York Review.
- **Joint health promotion initiatives.** Working with upper-tier and lower-tier Local Authorities and the Public Health team, the CCG is engaged in actions relating to reducing the incidence of smoking (particularly in pregnancy) and in alcohol and substance abuse (statistically the CCG has the most significant challenges in the county).
- **Programme management.** The CCG's officer team will manage the competing priorities and workload through a systematic use of project management methodology, linking with that used in other agencies to provide effective programme coordination. The overall strategy will be treated as a 5 year transformation programme. The integrated plan will be underpinned by a detailed project delivery plan, detailing specific actions, timescales, and project deliverables.

- **Service improvement.** The CCG does not believe that in every area it seeks improvement it can clearly describe a blueprint for success: rather it may need to use proven service improvement methodologies to facilitate bottom-up service redesign that is meaningful to a local context and has been designed by patients, public, and local clinicians.
- **Communication.** Integration in particular will be delivered more effectively by staff being empowered to communicate with each other and to redesign communication channels when they are seen to be ineffective. Appropriate points of communication and coordination will support better multi-agency working and smooth the patient journey.
- **Leadership.** The critical test for SRCCG is that it can provide clinical leadership to implement its strategy and improve its healthcare system. The CCG leaders will be the champions of the strategy and its vision for the future.
- **Patients and the public.** If the leadership needs to promote a sense of collective ownership to shared problems, it presupposes that the collective will support problem solving. The most important element of delivery is that of engaging patients and the wider public in decision-making, resource allocation, and service planning.
- **Organisational development.** Underpinning the delivery mechanisms of the CCG will be an organisational development plan that focuses on supporting strategic delivery and developing CCG corporate capacity.

To support programme delivery and to provide assurance as to the quality of existing commissioned services the CCG has established a strong performance management framework. It has reviewed the risks of performance delivery of existing services and developed a performance management plan to address high-risk areas and support effective delivery.

11. Access

The CCG is committed to improving access to patient led services, where:

- People have a range of choices and of information and help to make choices
- There are standards and safeguards to protect patients
- NHS organisations – Commissioners and Providers - understand the needs of their patients and actively engage with patients and carers to use feedback to improve services.

Improving access and designing new pathways of care for patients within our communities will play a major role in this strategy.

The CCG has a responsibility to ensure that patients are treated within national waiting times in line with the NHS Constitution. We are aware that this has not always been the case for our population and although the Provider may be meeting the standards at an aggregate level, often our patients attending Scarborough Hospital have not been treated within either the 18 week, A&E or cancer standards. This is not always the fault of commissioner or provider, but often because patients choose to wait longer to be treated locally. We will continue to work closely with YFT to improve waiting times and ensure that our patients do not wait longer than the national recommendations.

Whether it be to facilitate the transfer of activity from secondary care to primary and community care, the optimisation of patients in primary care, development of the community hub, development of the urgent care service and the streamlining of specialist services all will require patients to be able to access services at the appropriate time and place:

12. Quality & Performance Management

In exercising its functions the CCG will have a general duty to act with a view to securing continuous improvements in the quality of services for patients and in outcomes, with particular regard to clinical effectiveness, safety and patient experience. This means that the CCG has to put in place effective systems and processes to proactively identify early warning of failing services, monitoring and acting on patient feedback, identify quality including safety issues and secure continuous improvements in the quality of services provided.

SRCCG's Quality and Performance Committee is responsible for providing assurance to the Board that commissioned services are being delivered to a high quality and in a safe manner. A quality and Assurance Strategy will be developed to provide clarity about the CCGs role and ambition for improving quality in the services it commissions.

A range of data from many different sources will ensure that the CCG captures relevant information on the three domains of quality: effectiveness, safety and patient experience. Our sources of intelligence will include but will not be restricted to the following which are grouped for ease of reading but which cut across all three domains:

12.1 Quality

- Staff satisfaction and wellbeing evidenced through improved Staff Opinion Survey results
- External assurances via audit reports, peer reviews and inspection reports
- On-going compliance with CQC Essential Quality and Safety Standards
- Contract Performance Schedules/CQUINs/Quality Accounts
- Quality of care in care homes
- Quality of primary care provision
- Quality impact assessment of service redesigns
- Quality impact assessment of Provider Cost Improvement Programmes
- Priorities set out in the Operating Framework relevant to quality

12.2 Safety

- Safeguarding children and young people
- Safeguarding adults
- Safeguarding Looked After Children
- Serious Incidents, never events and homicide reports/unlawful killing
- CAS alerts closure rates and outstanding issues
- NRLS trends analysis
- Infection prevention and control
- Providing assurance on the clinical governance arrangements in commissioned services
- Compliance with NICE guidance (implementation and adherence)
- Analysis of mortality rates (HSMR, SHMI and crude rates)

12.3 Patient experience

- Patient experience reports including complaints reports
- National Patient Survey results and associated improvement plans
- Compliance with Eliminating Mixed Sex Accommodation guidance
- Patient engagement and communication activities including patient and carer forums

SRCCG will be relying on the services and expertise within the Commissioning Support Unit to convert the mass of data and information into intelligence that can be easily analysed and monitored pro-actively, across care pathways and all care settings, to assess risk and promote continuous quality improvement.

A web based performance dashboard providing up-to-date information relating to services we commission has been developed to facilitate this process.

12.4 Quality Assurance Framework

Our quality assurance framework will include but will not be limited to:

- SRCCG Governing Body
- SRCCG Quality and Performance Committee
- SRCCG Patient Engagement and Communication Committee
- Practice Patient forums
- Local Safeguarding Children's Board
- Local Adult Safeguarding Board
- Health and Well Being Board
- Joint Strategic Commissioning meetings
- Safeguarding Children's Framework
- Safeguarding Adults Framework
- Serious Incident Review Group
- Care Home Forum
- Data Group
- GP Member Consortia meeting
- Contract Management Boards
- Contract Management Quality and Performance Sub Groups

12.5 Contract Management

Quality schedules and CQUIN (Commissioning for Quality and Innovation) which form part of the contract between the CCG and providers contain a range of key performance indicators and stretch targets relating to patient experience, patient safety and clinical outcomes. The provider reports against the Quality Schedules and CQUINs on a monthly basis.

Contract Management Board meetings provide a forum for detailed oversight and scrutiny of provider performance against service quality, performance schedules and CQUINs frameworks. With smaller contracts, where a Quality and Performance sub group has not been established, a CCG Officer (or a CSU officer delegated to act on behalf of the CCG or a Host Commissioner) leads this dialogue through the main contract meeting.

Where performance issues arise, plans are put in place to achieve compliance as detailed in the Quality and Performance/CQUIN schedule, and unresolved issues are escalated to the overarching contract sub group.

The Quality and Performance Committee receives monthly reports on the performance of providers against their respective quality and performance schedules and CQUINs and monitors any plans put in place to resolve compliance issues as set out in the schedules or by agreement. The SRCCG Board receives a bi-monthly performance and quality exception report that currently covers underperformance and on- going risks.

12.6 Reporting of Patient Safety Incidents

Patient safety incident reporting is ultimately the responsibility of healthcare professionals in the first instance to flag up and report incidents when they happen. SRCCG will work with the providers to promote a culture of openness and transparency to ensure that expected levels of reporting continue. Incident reporting is a vital mechanism for identifying downward trends in the quality of care and facilitating learning.

All Serious Incidents (SIs) are reported through the Department of Health's central Strategic Executive Information System (StEIS). On behalf of the CCG the CSU will manage the process of receiving and reviewing completed investigation reports from the provider to ensure that comprehensive investigations have been undertaken which identify organisational learning and confirm assurance with regards to patient safety.

CCGs will remain accountable for the sign off and closure of SIs and as such needs to establish internal mechanisms for carrying out this duty including sharing any learning and picking up on trends to support improved quality and patient safety. It is proposed that in order to promote shared learning and to make best use of the CSU resource, that the CCG collaborates with other CCGs,

in partnership across North Yorkshire, in either case through a restructured and augmented SI review group (facilitated by the CSU).

The Quality and Performance Committee will receive a monthly report summarising the Serious Incidents (SI) and incidents that have occurred and identifying the number of incidents, emerging themes and actions taken to address concerns.

12.7 Feedback from the public, patients and staff

The CCG is utilising a variety of approaches and relevant sources of information on patient and public feedback to identify quality issues before they become serious failures including; complaints and Patient Advice and Liaison Service (PALS) data, national survey data. The CCG will take steps to look at better ways of obtaining real time data and more innovative ways to collect patient experience data.

It is important the CCG develops a system to ensure CCG is able to obtain intelligence from these and triangulate where possible. The CCG will take appropriate steps to engage with any new process or systems that the emerging NHSCB Local Area Teams establish in relation to incident reporting and complaints management in Primary Care.

The CCG working with the CSU ensures that a comprehensive Complaints process is in place and will agree the relevant route within the CCG governance framework in order to review themes and trends and identify patterns for recommending change in practice. The CCG will receive at least quarterly summaries including the complaints and PALS activities, to identify emerging themes and trends and details of actions/recommendations made to improve services through the experience of and learning from complaints, and other contact with our patients and the public.

12.8 Quality Accounts

Publication of an annual Quality Account is a Department of Health requirement to encourage provider and commissioning organisations to assess quality across the entire range of their healthcare services, with a focus on continuous quality improvement. Quality Accounts are a key mechanism to demonstrate that a focus on improving service quality is being maintained. The CCG will need to contribute in the planning and development stage of the providers quality account and will be

responsible for providing scrutiny and a supporting statement which will be included within the account, which are publicly available documents.

12.9 Continuous Quality Improvement

The CCG is committed to putting quality at the heart of everything we do. Using a continuous quality improvement (CQI) methodology, it will strive to commission high quality services for its patients. Core Concepts of CQI are:

- Quality is defined as meeting and/or exceeding the expectations of our customers.
- Success is achieved through meeting the needs of those served.
- Most problems are found in processes, not in people. CQI does not seek to blame, but rather to improve processes.
- Unintended variation in processes can lead to unwanted variation in outcomes, and therefore CQI seeks to reduce or eliminate unwanted variation.
- It is possible to achieve continual improvement through small, incremental changes.
- Continuous improvement is most effective when it becomes a natural part of the way every day work is done.

CQI is an approach to quality management that builds upon traditional quality assurance methods by emphasizing the organisation and systems: it focuses on "process" rather than the individual; it recognizes both internal and external "customers"; it promotes the need for objective data to analyse and improve processes.

CQI is a management philosophy which contends that most things can be improved. The CCG will endeavour to develop a culture where CQI is applied to everyday work to meet the needs of the population served and the services commissioned.

12.10 Ambitions for improving quality and outcomes

Analysis of the JNSA identifies four priority areas for improvement in health outcomes for the population of Scarborough and Ryedale: Cancer, Cardiovascular, Mental Health and Elderly Care.

Initiatives related to these disease areas include:

- Continue to work closely with YFT to reduce avoidable mortality
- Continue and develop smoking cessation plans with regards to elective surgery, smoking in pregnancy and no smoking in hospital in conjunction with Public Health
- Improve early diagnosis for cancer patients
- Improve acute and rehabilitation stroke care
- Review of current cardiology services
- Review of diabetes service
- Development of Psychiatric liaison service,
- Improved diagnosis and support for dementia and improved low level support for patients with mental health problems
- Acute assessment for frail, elderly patients with complex needs
- Partnership working with LA on alcohol and drug treatment services
- Review of rheumatology service
- Review of children's services and development of children's strategy
- Continue work to reduce emergency admissions with asthma, diabetes and epilepsy

13. Innovation

The CCG acknowledges the critical role innovation will make as a catalyst in delivering the scale, pace and challenges of transformation and levels of ambition required in patient outcomes, quality & safety, performance and efficiency of services.

Innovation is the most significant enabler which commissioners and providers can use to plan sustainable and fully integrated health and social care services into the future and ensure the improvements in clinical and patient experience outcomes outlined in their trajectories.

To this end the CCG along with its partners will look to cultivate and embed innovation throughout every stage of the commissioning cycle and planning processes. It will ensure every willing stakeholder is enabled to contribute to the development of new ideas and adoption of existing relevant innovations.

The aim will be to maximise the positive impact of innovation across:

- Commissioning practices and approach - develop the highest quality commissioning, decision-making and resource allocation underpinned by patient-centred research-based evidence and innovation
- Engagement and empowerment – sharing and accessing information with patients, public, staff & providers to enable 24/7 integrated working & care planning; and collaboration with all key partners (including other CCGs and industry) in order to drive key research themes
- Clinical practice – using technologies, devices, medications, therapies, equipment & treatment strategies
- Models of care and systems of service delivery - including pathway redesign, configuration of services, estates and assistive technology

This will require the CCG to address innovation in the following three ways when looking at every programme of transformation, service development or action plan to drive meeting their ambitions:

- Revisit all areas of identified variation and outliers in outcomes (e.g. through QOF and Commissioning for Value analysis) and assess progress with implementing **best practice** and innovations which are known to have a demonstrable improvement on outcomes (e.g. enhanced recovery programmes; NICE guidelines and quality standards, and TAGs (Comply or Explain regime); WHO Safer Surgery Checklist; Productive services; NHS Quality Improvement programmes)

- Assessment of progress with providers adopting the evidenced, **high impact innovations** and emerging/ early adoption exemplars (e.g. Innovation, Health & Wealth 6 High Impact Innovations & 108 potential high impact innovations; Yorkshire & Humber Area Health & Science Network Improvement Academy high impact innovations in stroke prevention in AF patients & mortality review programme; Anytown Tool

- Identification of key new and emerging innovations through horizon scanning for adaption and adoption, alongside key research priorities to focus on which could structure and drive the local R&D strategy

This focus and commitment will require dedicating significant time, leadership and resources in order to make innovation a reality and drive meaningful adoption and diffusion in practice.

The CCG is working closely with its key partners in the national Innovation, Health & Wealth team, the regional Innovation Hub (Medipex), the Academic Health & Science Network (AHSN), the Area Team, the NYHCSU, PHE and the National Institute for Health Research & Development (NIHR).

14. Value for Money

Since the NHS was established in 1948, its spending has increased by an average of 4% in real terms each year.

As A Call to Action points out, this position is not sustainable in the present economic climate and all public sector organisations are tasked with continuing to provide a high standard of care/services within limited financial resources.

One of the CCGs core values is to ensure Value for Money and we will strive to spend our public budget of £150 million in the most effective and efficient way by:

- Improving productivity across all sectors by:
    - Clinical pathway re-design and process improvements
    - Using continuous improvement methodologies such as Lean Thinking to reduce waste
    - Making better use of estate and facilities
    - Finding new ways to generate income
    - Right care/right place/right professional
    - Reducing waste in medicine and appliances
    - Maximising potential of our most expensive resources – people

- Allocating spend rationally:
    - Historically NHS contracts have “rolled” forward with little objective assessment of whether or not the services being provided were value for money. We will review our contract arrangements and make changes where appropriate.

- Innovation:

    - Reducing face to face consultations by adopting technology
    - Shared care across sectors
    - Sharing data across health and social care to reduce duplication

- Encouraging patients to manage their own care:
    - Raising public awareness of health issues
    - Advocating early screening and diagnosis
    - Reducing elective procedures/interventions where outcomes are deemed to be ineffective or solely cosmetic

- Only using hospital services where no other option is appropriate:
    - Developing the community hub
    - Procuring new urgent care service
    - Improving access in primary care
    - Developing support mechanisms in community

15. Organisational Structure and Development

SRCCG does not underestimate the challenge of building a new organisation. In order for the CCG to be fit for purpose a structured organisational development plan has been developed to help shape the interventions required to help the new organisation evolve into a responsive, collaborative and effective team that is known to “make a difference through clinical leadership.

SRCCG is committed to supporting developing individuals as well as the team in which they work and we recognise the importance of working in partnership with the Commissioning Support Unit (CSU) and other CCGs to deliver efficient and cost effective commissioning for the local healthcare economy.

The Organisational Development plan sets out the interventions that are needed to demonstrate to member practices, the NHS CB and patients and public that SRCCG is fit for purpose and recognises the areas that need to be strengthened. Organisational development is “the practice of planned intervention to bring about significant improvements in organisational effectiveness” and the plan sets out how SRCCG intends to continue to develop. The CCG and has developed an organisational structure that reflects the need to promote clinical leadership and effectively utilises staffing resources. The principles behind the structure are:

- Clear leadership roles for clinical leaders within the CCG
- A core team of highly skilled officers and support staff to facilitate clinical commissioning
- Strong joint commissioning relationships with other local CCGs and Local Authorities
- Strong support from the Commissioning Support Unit (CSU) across a broad range of areas

The organisation will ensure the strategic plan is delivered through a robust governance and programme management system with overarching clinical leadership.

- Joint system-wide leadership / board arrangements across all partners to the Strategic Plan:
    - Health and Well Being and joint Integrated Care Board
    - Contract Management and Quality Sub Groups with main Providers
    - Council of Clinical Representatives
    - CCG Governing Body

- Clear project documentation and milestones:
    - The CCG has commissioned a Programme Management Tool from CSU which will be used by Project managers and relevant management groups/Board to input and track performance against milestones.
- Rigorous governance and PMO arrangements:
    - Regular programme management and project updates to CCG Business Committee and Governing Body.
    - Fortnightly QIPP steering group with regular updates to Business Committee and Governing Body

15.1 Strategic Alliances with CCGs

SRCCG is engaged in collaborative commissioning arrangements with 4 other North Yorkshire and York CCGs. The arrangements between the 5 former North Yorkshire and York CCGs are covered within the terms of the Strategic Collaborative Commissioning Board (SCCB). As part of the joint contract arrangements for 2014/15 we will also be liaising closely with the East Riding of Yorkshire CCG.

15.2 Joint Commissioning with Local Authorities

The CCG has established a Joint Commissioning Committee with representation from:

- the lead Clinical Commissioning Group (CCG) (Scarborough and Ryedale CCG to act as host liaising with other CCGs as associate commissioners)
- North Yorkshire County Council (NYCC) Adult and Community Services Directorate
- The North Yorkshire Public Health Directorate (currently under the auspices of the PCT, but later under the auspices of NYCC.

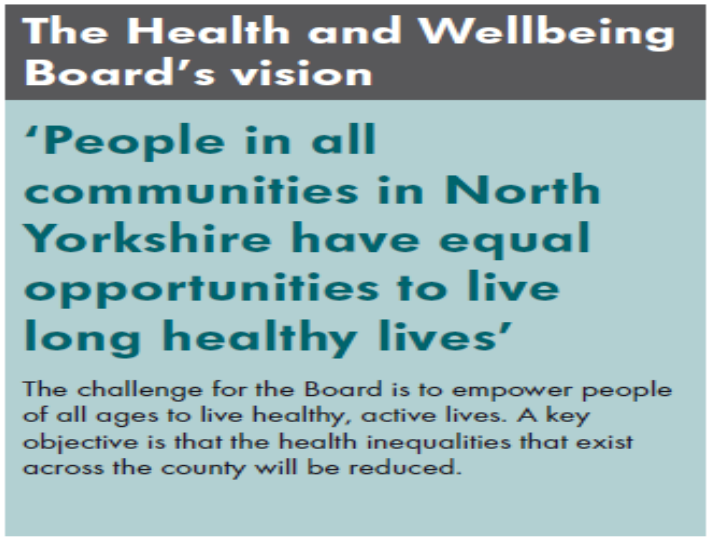
The Board will function as joint forum of the SRCCG Board and of NYCC Adult and Community services, with delegated responsibility from both bodies.

The JCB will initially take responsibility for the management of:

- The current intermediate care pooled budget (circa £200k)
- The resources used to commission care related voluntary sector provision (currently jointly commissioned but not through a pool)
- The locality reablement resource, feeding into the county wide joint board

15.3 Health and Wellbeing Board

The CCG has been a lead partner in the shadow North Yorkshire Health and Wellbeing Board (HWB) from its inception. It is a contributor to the developing HWB strategy, of which the current CCG strategy aligns very closely. The CCG will be an active player in the further development of this strategy and its on-going implementation.



15.4 Local Strategic Partnerships (LSP)

The CCG has been actively involved in the LSPs of Scarborough and Ryedale lower-tier authorities. This has included work targeting support to the vulnerable elderly and on childhood obesity.

Support for improving the wider determinants of health is being delivered through the CCG's engagement in support of the wider economic regeneration initiates in the locality.

16. Governance and Assurance

SRCCG has developed a strong assurance framework, supported and delivered by its organisational structures and corporate leadership. The Seven Principles of Public Life (often referred to as the 'Nolan Principles') underpin the objectives and behaviour of the CCG. They are:

- **Selflessness** Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.
- **Integrity** Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.
- **Objectivity** In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.
- **Accountability** Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office
- **Openness** Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands it.
- **Honesty** Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.
- **Leadership** Holders of public office should promote and support these principles by leadership and example.

The CCG has established appropriate policies to support its good governance including producing and publishing a conflicts of interest register as part of a corporate conflicts of interest policy.

The Board Assurance Framework has been developed to provide assurance to the Governing Body that the CCG strategic objectives are being delivered and corporate risks managed. The outline assurance framework is provided as a supporting document, along with the latest version of the corporate risk register.

17. Stakeholder engagement

The CCG has developed a strong process for engagement of all major stakeholders. This has been led by the Governing Body's Communication and Engagement Committee (CEC), which has produced an ambitious Communications and Engagement Strategy. This strategy sets out plans for enhancing the way the CCG communicates and engages with patients, the public and wider stakeholders, describing the methods that will be used and the evaluation of its relative success.

We take very seriously the comments that we receive from patients, carers and various stakeholders and value them in helping us to commission services. For example

What you said	What we did
Reduce unnecessary follow up appointments	Agreed with providers the most clinically appropriate place for FU and transferred routine FU to GPs.
Difficult to know who and how to raise concerns and complaints with since changes to NHS commissioning structure.	Improved SRCCG website and supporting policies and processes to sign post patients
Duplicated services and /or disjointed provided to vulnerable patients	Piloting neighbourhood care teams with care coordinators
Lack of information and appropriate systems to allow patients to choose provider and consultant	Working with provider to accelerate programme of work to ensure patients have choice
The process and timeliness of Continuing Health Care assessments needs to improve	Recruited additional resources to address the back log of outstanding assessments and improved processes and

	communications with patients.
Patients have difficulty deciding where to go with minor injuries and urgent care needs.	Improved patient information leaflets whilst carrying out a complete review of urgent care services with planned procurement.
Gap in services for newly diagnosed diabetics	Commenced work on reviewing education programmes for diabetics.
Higher levels of than national average of amputation rates	Commissioned work to understand reasons for variations in outcomes.
Patients with COPD had difficulty accessing pulmonary rehabilitation	Venue for rehabilitation sessions changed to one that is more accessible and number of sessions increased.
Inequity of access to IVF services	Commitment to commission IVF services with details of level of service and start date being assessed.
Unacceptable waiting times for assessments for autism	Identified funds to provide additional assessment to clear back log.
People with mental health problems do not have access to talking therapies	Worked with current mental health providers to increase access

18. Financial Plan

18.1 Financial Framework

Over the last year, the CCG has worked to establish itself, with appropriate management of services for the population in Scarborough and Ryedale, whilst paying back an inherited deficit position from North Yorkshire PCT and working towards achieving a balanced financial position.

The transformation the CCG aims to achieve will require a shift of resources across the health system, and overlapping the health and care boundaries; the challenge will be to do this at scale, within available timescales. The overarching vision of the CCG is to take a whole system approach with significant partnership working with all Local authorities within its boundaries and a collaborative approach with its main acute and community provider York Teaching Hospitals NHS Foundation Trust.

The CCG has a running cost allowance, which is reducing over time, within which to manage the changes across the system. To make best use of this limited resource, we will be working with our partners to deliver service transformation effectively across the wider North Yorkshire and East Coast area.

18.2 Medium term financial plan 2014/15 – 2017/18

SRCCG has developed its medium term financial plan based on this Strategy, taking into consideration the predicted population changes over the period, underlying growth in activity and prices, as well as efficiency assumptions in providers and our own investment and service transformation agenda. A summary of the plan is shown in Table 1, with further detail about how the plan was built up provided below.

18.3 Financial Planning Assumptions

The financial information included within this document is based on the principles set out in the document Everyone Counts: Planning For Patients 2014/15 To 2018/19, and supporting documents such as Payment by Results guidance.

The following assumptions have been made

- Resource allocation and Running Cost allowance in line with the notified allocations for 2014/15 and 2015/16, and uplifted by indicative rates based on demographic and allocation growth of 3% for year 3, and just under 2% for years 4 and 5.

- Achievement of a 1% surplus in 2013/14, and maintenance of this surplus level thereafter

- A creation of recurrent headroom (ring fenced funds that can only be used non recurrently) at a level of 2.5% in 2014/15, dropping to 1% from 2015/16. This helps the CCG in managing the transfer of funds to the Better Care Fund.

- Transfer of £0.9m resource into an enablement fund pooled with North Yorkshire Council in 2014/15, and transfer to the Better Care Funds from 2015/16 of £5.5 million per annum.

- Inflation on acute providers is 2.6% in 2014/15, rising to 4.4% by 2016/17 before falling again to 3.3% in 2018/19. All other inflation is assumed at 2.2% for the duration of the plan.

- Efficiency is assumed at -4.0% per annum for the duration of the plan.

- The assumptions on tariff inflation and efficiency will be reset annually upon publication of the national tariff guidance.

- Payments for non-elective activity will continue at 30% marginal tariff rate for the duration of the plan, similarly any QIPP reductions related to non-elective activity would also be at 30% marginal rate unless activity returns to a level below the 2008/09 threshold.

- The financial impact of non-payment for readmissions has been built into the plan although the clinical audit to review the baseline is underway

- The CCG has made allowance, in line with guidance, for ringfencing of the contract reductions for the non-elective threshold and readmissions penalties, and plans to spend the money on schemes to reduce non-elective admissions, and readmissions.

- Payment of CQUINS (Commissioning for Quality and Innovation) payments at the national level of 2.5%.

- Demographic growth of 0.9% is included in most areas of commissioning. The exception is Prescribing budgets, where growth of 5% is assumed, based on historical trends.

- The required QIPP (Quality, Innovation Productivity and Prevention schemes) cost savings requirement for the CCG is then calculated to bring the organisations plan back within its financial allocation.

No recurrent investments over and above the current expected costs are assumed. The CCG has some non-recurrent reserves to allow for trials, pump priming and support to QIPP schemes and service transformation projects, but the expectation is that new models of care when up and running will be affordable with in the current available funding.

(£ 000)	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Revenue Resource Limit	**149,147**	**154,372**	**158,718**	**161,556**	**164,193**	**166,990**
Programme Activity	144,843	149,206	153,744	156,537	159,064	161,895
Running Costs	2,850	2,820	2,521	2,505	2,490	2,476
Contingency	-	800	800	850	850	850
Total Costs	**147,693**	**147,693**	**147,693**	**147,693**	**147,693**	**147,693**
Surplus	**1,454**	**1,546**	**1,653**	**1,664**	**1,789**	**1,769**
QIPP requirement		**6,000**	**6,000**	**4,500**	**4,500**	**4,500**

Table1: 5 year financial plan

18.4 Financial collaboration and risk sharing

There is a strong commitment across the four former North Yorkshire CCG's, (Scarborough and Ryedale CCG, Vale of York CCG, Harrogate and District CCG and Hambleton, Richmond and Whitby CCG) to maintain historic collaboration. There are three key strands to this:

• Functions run at a North Yorkshire Level where there is an intention to continue through commissioning support services, for example continuing care, commissioning for vulnerable people, non-contract activity.

• There will be North Yorkshire "host" contract arrangements where one CCG will lead on negotiation, in year performance and contract management.

• Financial risk sharing is proposed to cover three areas: continuing health care, funded nursing care, high cost patients. All four North Yorkshire CCGs will pool resources to share the risks and benefits of these areas, liaising with the associated CCG of NHS Airedale, Wharfedale and Craven.

The collaborative approach and risk sharing will allow us to maximise the use of our administrative resource, as well as mitigate some of the financial variation that might be seen in a smaller organisation due to random variation.

18.5 Where does the money go?

The table below: details where the CCG expends its resources. The majority of resource is expended with York Teaching Hospitals NHS Foundation Trust, following the acquisition of Scarborough and North East Yorkshire, accounting for 51% of expenditure.

Contract/ Spend area	£ million	% of spend
York Teaching Hospitals NHS FT	73.9	51.0%
Tees Esk and Wear Valley NHS FT	12.7	8.8%
York Ambulance Service NHST	5.5	3.8%
Hull and East Yorkshire NHST	4.3	3.0%
Harrogate and district NHS FT	1.7	1.2%
Leeds Teaching Hospitals NHST	1.1	0.8%
Other Acute, Community and Mental Health Commissioning	6.9	4.8%
Continuing Care	13.1	9.0%
Primary Care	22.9	15.8%
Other commissioning and services	2.8	1.9%

Table 2 where does the money go (2013/14 estimated outturn figures)

18.6 Running costs

The NHS Commissioning Board has set a running cost allowance for each CGG based on registered population adjusted to Office of National Statistics (ONS) clusters. For Scarborough and Ryedale CCG this is £2.82m for 2014/15, which equates to £23.90 per head of population (unadjusted). A significant number of support functions will be provided by the North Yorkshire and Humber Commissioning Support Unit (CSU). The financial resource framework required to support CSU functions has been developed and

provides the required functions within an affordable financial envelope. Additionally, the North Yorkshire CCG's collectively support a Partnership Commissioning Unit (PCU) which administers Continuing Health Care, Mental Health Contracts and some of the risk shares on behalf of all organisations. The PCU is hosted by Scarborough and Ryedale CCG.

18.7 Practice Level information

Up to 2010/11 the PCT utilised the DH fair shares toolkit to calculate practice level budgets as part of the practice based commissioning initiative. Once the CCG is established as a statutory NHS body it will be provided with an allocation, PCT level data collection exercises have been conducted in September 2011 and July 2012 to ensure the DH has sufficient information to map expenditure from the current NHS architecture to the new system which incorporates CCGs. In addition a revised allocation formula will be put in place. This will notify the CCG of its Actual allocation and an assessment will be made of its distance from a fair shares allocation. It is also anticipated that a policy on how CCGs may move to a fair shares allocation will be published. In a period of flat growth where uplifts to the overall NHS allocation are only intended to cover inflationary increases any movement towards fair shares will be small, as such the CCG should not anticipate any significant movement from the overall PCT allocation for 12/13, once it has been disaggregated.

Once the overall CCG allocation is known the intention will be to refresh practice level budgets and ensure there is a consistent process for continuing the movement towards fair share practice level budgets**.**

18.8 Financial governance

As part of its establishment the CCG has established robust financial and corporate governance arrangements. There are several key policy and procedure documents, being:

Standing Orders and Standing Financial instructions

Prime financial procedure documents

Scheme of Delegation

In addition the CCG will be using the Shared Business Services ledger system to ensure its obligations for accounting for public funding can be met.

Committees of the board are be in place to seek assurance that the organisational governance is sound and assurance can be placed on the mechanisms in place. This is done predominantly through the Audit committee and the Finance and Contracting committee.

18.9 QIPP

The CCG QIPP target for 14/15 is £6m, or nearly 4% of expenditure. A summary of the schemes are provided below, there will be a mix of new schemes and full year effect of schemes that commenced in 2013/14. The Financial plan for future years (above) is predicted on the basis that QIPP requirements in each year are delivered.

	2014-15	2015-16	2016-17	2017-18	2018-19
Community service transformation	0.0	1,350.0	1,350.0	1,350.0	0.0
Continuing Care management and provision	500.0	600.0	100.0	100.0	100.0
Direct access and procedures of low clinical value reductions	1,949.9	864.0	450.0	250.0	150.0
medicines management	950.0	950.0	975.0	1,025.0	1,025.0
mental health out of area transfers	200.0	100.0	50.0	50.0	25.0
Inappropriate admissions/ Community support	375.0	675.0	1,025.0	1,325.0	2,850.0
Review of non-tariff services	113.8	112.6	0.0	0.0	0.0
Outpatient Follow Up reductions	1,211.9	650.0	550.0	400.0	350.0
Urgent Care / A&E reconfiguration	700.0	698.9	0.0	0.0	0.0
Grand Total	6,000.6	6,000.5	4,500.0	4,500.0	4,500.0

Table 3 Strategic QIPP plan

QIPP schemes for the CCG are in addition to any national provider efficiency requirements set in the operating framework and PBR tariff guidance. The medium term QIPP schemes are tabled above. There is still some required but unidentified QIPP at this point.

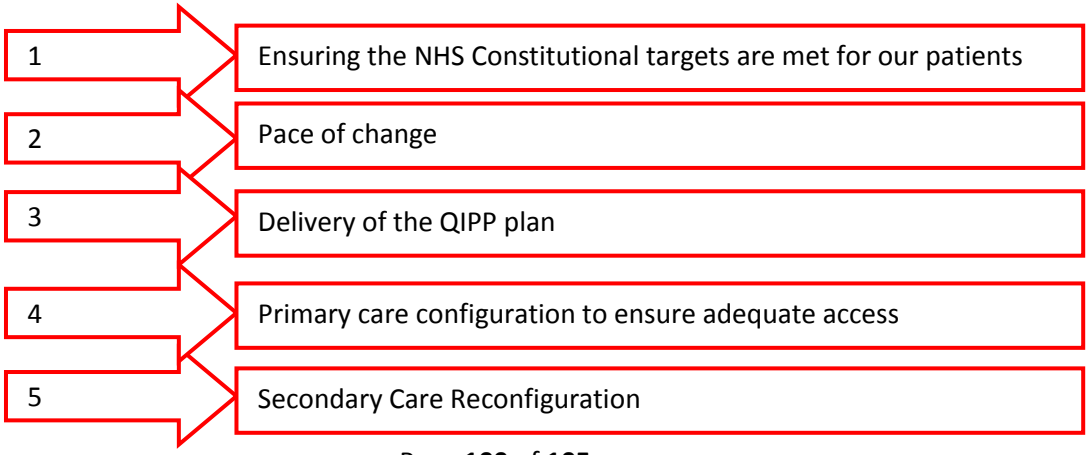
19. Equality & Diversity

The CCG has undertaken a baseline assessment against the national Equality Delivery System for the NHS. This has helped demonstrate initial progress on equality and diversity and will help us achieve compliance with the Public Sector Equality Duty/Equality Impact Analysis.

In support of this the CCG has developed an Equality Assessment Toolkit and as part of its wider programme of engagement and consultation will perform a full equality impact assessment on the strategy and its major objectives and actions. Equality Impact Assessment will be undertaken to ensure proposals are considered and developed appropriately as part of the implementation process.

20. Risks

As mentioned throughout this document, the challenges facing the NHS as a whole and this CCG are immense. At the time of writing, we estimate the following to be our key risks with regard to delivering this strategy:



21. Timetable to success

	2014-15	2015-16	2016-19
Self Help	Introduce Expert Programme for diabetes Smoking cessation campaigns	Continue education	
Primary Care	Develop Federation Extend opening hours Develop basket of locally enhanced services Pilot District Nursing aligned to practices Develop Neighbourhood Care Teams Health Care Assistant competency pilot Optimize patients before referral Reduce variation Optimize Medicines management Develop care plans for over 75s	Primary care has capacity to accept transfer from secondary care Practices work closer together and share workload Pharmacies/Allied health professionals extended roles to reduce GP workload	Review pathways for children with lower respiratory infections Continue to transform and transfer hospital activity Sustainable model of care
Community Care	Develop Community Hub in Malton Develop Nurse Practitioner in care homes	Develop Community Hub in Scarborough Review pathways for Chronic Ambulatory Care conditions Improve rehabilitation	Continue to transform and transfer hospital activity Sustainable model of care
Planned Care	Develop Expert Consulting Develop new enablement service Review pathways in cardiology/rheumatology/diabetes/ophthalmology Reduce 1st and follow up Out Patient attendances Develop primary care orthopaedic triage Improve efficiency Shift appropriate activity into primary and community	Review Stroke Model Develop children's strategy Implement changes from service reviews Review sleep apnoea service Continue to improve efficiency and shift activity	Implement Children's Strategyand develop Children's centre Review pathways for children with lower respiratory infections Sustainable Providers
Urgent Care	Engage, design and procure new OOH/Urgent care service Work with Urgent Care Working Group to ensure streamlined urgent care	New urgent care service commences April 2015 Utilise technology to link urgent/emergency and hub	24/7 working
Emergency Care	Service Improvement Event "Perfect Week" to inform system changes Develop new ambulance pathways	Refine emergency care model and align to urgent care and hub model Introduce short stay assessment	24/7 working
Tertiary Care	Commence discussions with CCGs, Networks and Providers to agree future configuration of services	Work with secondary care and tertiary providers to configure services	Centres of Excellence providing specialist care
Mental Health	Develop Liaison Psychiatry Improve Talking Therapies Improve Autism service Improve ADHD service Improve CAMHS	Continue to increase resource and expand services to achieve parity of esteem	Sustainable model of mental health care for East Coast

22. Improving Quality and Outcomes: How we will measure success

What we measure	How we measure	Where we were in 2012	Our aim	How we will do it	By when
Reducing Emergency admissions	Unplanned hospital admissions for chronic ambulatory care sensitive conditions Unplanned hospital admissions for asthma, diabetes and epilepsy in under 19s Emergency admissions for acute conditions that should not normally require admission Emergency admissions for children with lower respiratory tract infections Rate per 100,000 of population registered with CCG	2031	1722	Develop Community Hub & NCTs Develop care home support Service Improvement Event "The Perfect Week" Improve pathways for children with asthma, diabetes, epilepsy and lower respiratory tract infections Develop Children's Centre in Scarborough bring all agencies together to support children and families Introduce new Ambulance pathways Improve pathways for End of Life care	March 2019
Securing additional years of life (Potential years of life lost [PYLL]	PYLL rate per 100,000 population based on annual Office National Statistics avoidable mortality for England	2768	2580	Improve stroke care Smoking cessation campaigns Improve cancer diagnosis rates Cardiovascular work Improve rehabilitation	March 2019
Improving health related quality of life for people with one or more long term conditions	Average health status score for individuals who identify themselves as having a long term condition	72.4	73.4	Diabetes pathways Asthma, epilepsy, Liaison psychiatry, dementia work NCTs Community Hub/NCTs to support patients Alcohol worker in A&E	March 2019
Proportion of people reporting a positive experience of care in hospital	Rate of "poor" responses of inpatient care when answering the Inpatient survey per 100 patients (each patient being asked 15 questions)	95.5	94.9	Meet NHS constitutional standards Reduce HCAIs Reduce Never Events Reduce cancelled appointments Roll out Compassion in Practice Support Serious Incident process and sharing learning Maximising care of deteriorating patients	March 2019
Proportion of people reporting a positive experience of care outside hospital	Rate of "fairly poor" and "very poor" experience across general practice and Out of Hours services per 100 patients	5.1	3.6	Develop integrated OOH/urgent care service Increase primary care capacity Align district nurses to NCTs Develop community hub	March 2019

23. Summary

This document provides an outline of the CCG ambitions over the next five years.

Inevitably, some of the plan may change over this period of time due to national and local pressures, however our key strategic aim to commission high quality services that are sustainable and provided as close to home as clinically and practically possible will remain.

Patients accessing health and social care in 2019 will do so in a completely different way to now. More emphasis will be on care at home or as close to home as is practical and clinically safe. Fewer patients will attend hospital either for out -patient or in-patient stays. Patients requiring major or specialist support may have to travel to centres of excellence but day to day support will be provided by teams of multi-professionals dedicated to managing individual patients and supported them to avoid crisis intervention.

Organisations that currently work in silos will work collaboratively to ensure the patient receives the most appropriate care package, regardless of the organisation delivering it, in the most appropriate setting.

In order to bring about these essential changes, there will be difficult conversations and difficult decisions to make especially around services at our local hospital. However, we are committed to sustaining a local hospital although the services it provides may be different from those it provides today.

References

Department of Health (2005) Creating a Patient-led NHS

Department of Health (2010) NHS White Paper, Equity and excellence: Liberating the NHS

Department of Health (2011) No Health Without Mental Health

Department of Health (2012) Transforming Care: A national response to Winterbourne View Hospital

Department of Health (2014) Closing the Gap: Priorities for essential change in mental health.

Department of Health (2012) Compassion in Practice: Nursing, Midwifery and Care Staff, Our Vision and Strategy

D'Souza, S and Gupta, S (2013) Preventing admission of older people to hospital, British Medical Journal;346;f3186

Francis, R (Chair) (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. The Stationary Office, London; Accessed at: http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf

Keogh, B (2013) Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report, accessed at: http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf

Living With and Beyond Cancer: Taking Action to improve Outcomes (NCIS 2013)

Monitor, (October 2103) Closing the NHS funding gap: how to get better value health care for patients

NHS England (2013) NHS Services, Seven Days a Week Forum: Clinical Standards

NHS England (2013a) Everyone Counts: Planning for Patients 2014/15 - 2018/19

NHS England (2013b) A call to Action

NHS England (2013c) Accountability and Assurance Framework Safeguarding Vulnerable People in the Reformed NHS

NHS England (2013) Better procurement, Better value Care: A Procurement Development.

NHS England (2013) New Ways of Working, Broad Commissioning Principles. Programme for the NHS

NHS England ((2013/14) CCG Assurance Framework

North Yorkshire Health and Well Being Board (2013) North Yorkshire Health and Wellbeing Strategy 2013-2018

Nuffield Trust, A decade of Austerity? December 2012

Public Health England (2013) Commissioning for Value Insight Pack

Public Health England (2014) Sustainable, Resilient, Healthy People and Places, A sustainable development strategy for the NHS.

Scarborough and Ryedale CCG (2013) Communications and stakeholder engagement strategy

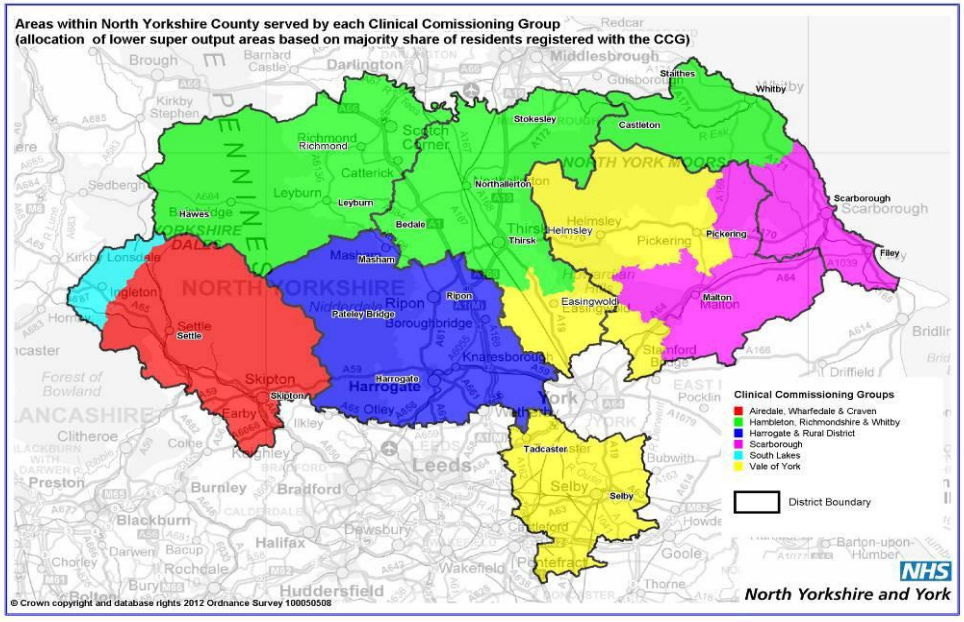
Spiker, J and McInnes, J (2013) Population Ageing: the time-bomb that isn't, British Medical Journal; 347:f6598

Scarborough and Ryedale CCG Joint Strategic Needs Assessment

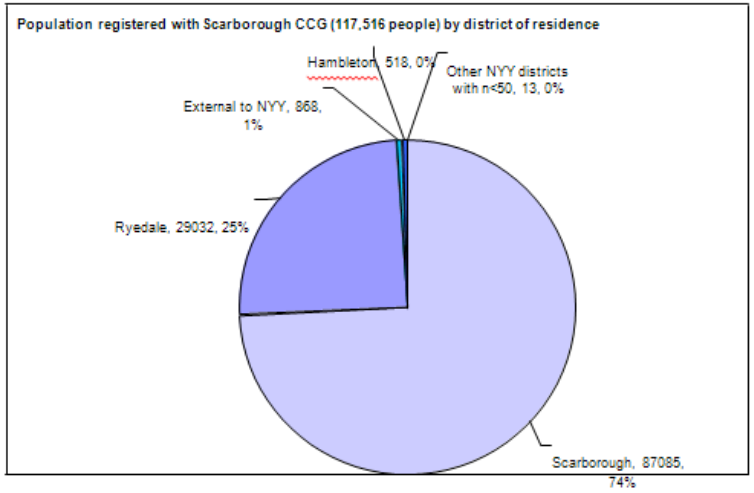
This geographical summary should be read in conjunction with the North Yorkshire summary as needs identified in the North Yorkshire section are applicable to all districts and CCGs.

Population

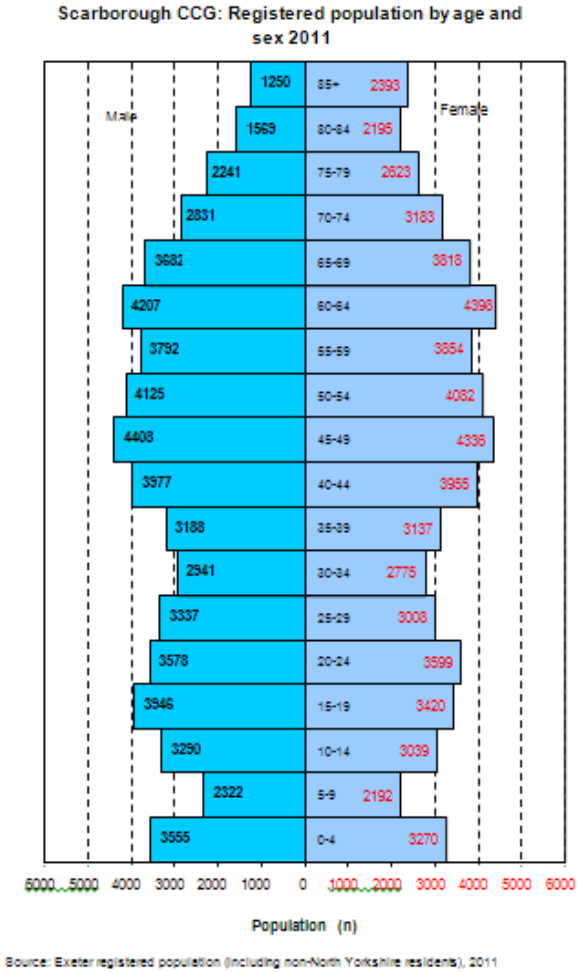
The map below shows the geographical boundaries (constrained to North Yorkshire County boundaries) for the Clinical Commissioning Groups.



Scarborough and Ryedale CCG comprises 17 General Practices with a combined registered population of 117,516, the vast majority of whom (74%) live in Scarborough district with a significant amount also living in Ryedale (25%).



Source: Exceter September 1

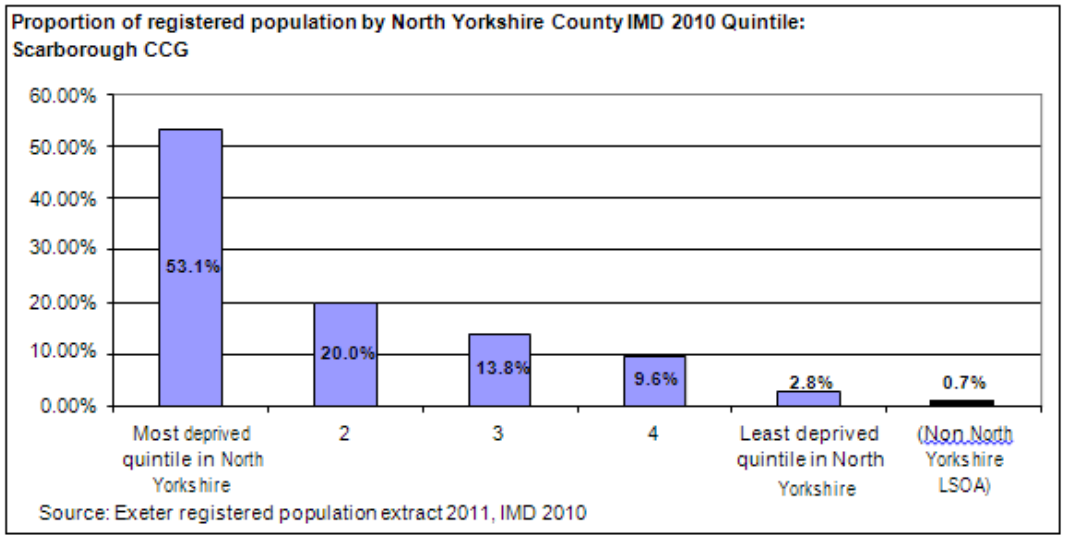


Source: Exeter registered population (including non-North Yorkshire residents), 2011

21.3% of the population are aged 0-19, 56.8% of the population are aged 20-64 and the remaining 21.9% are aged 65+.

Deprivation

Scarborough and Ryedale CCG has a large proportion (53.1%) of its registered population resident in the most deprived areas of North Yorkshire County.

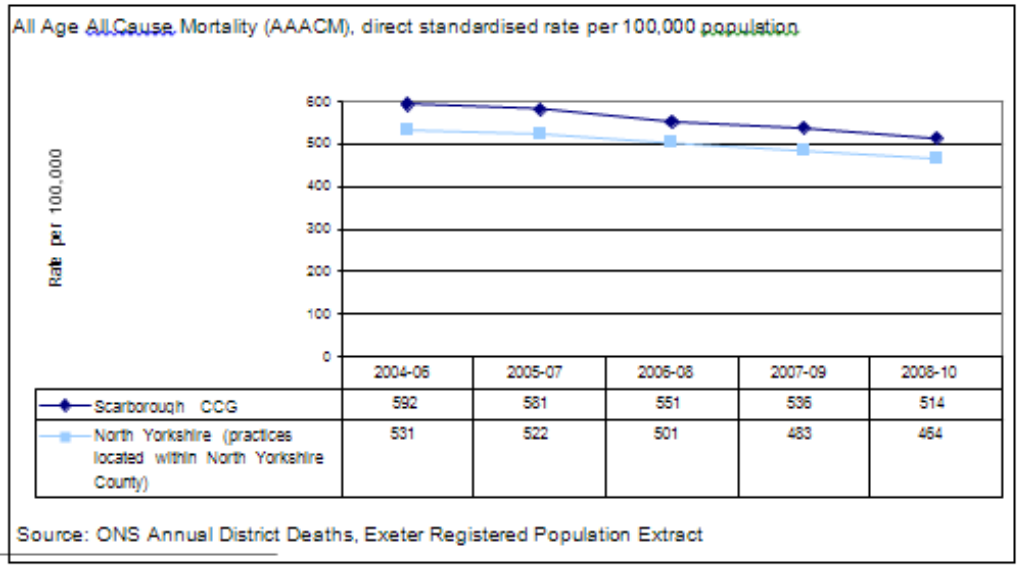


Based on the overall IMD score, the map below shows the most and least deprived areas within Scarborough and Ryedale CCG (i.e. the most deprived fifth of the population within the CCG, through to the least deprived)

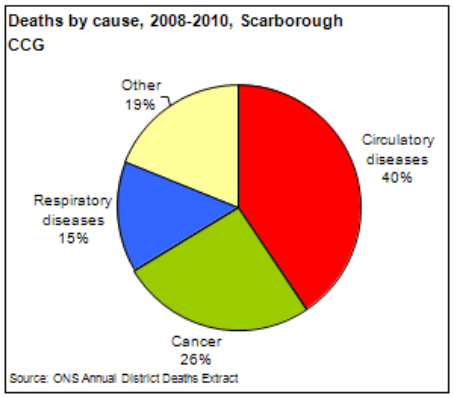
Outcomes

Also see Scarborough and Ryedale District summaries for further detail on outcomes

All age, all cause mortality (AAACM) is a measure of the overall health of a population over a given period. Between 2004-06 and 2008-10 the AAACM rate fell from 592 per 100,000 to 514 per 100,000 in practices in Scarborough CCG, statistically significantly higher than the North Yorkshire average of 464



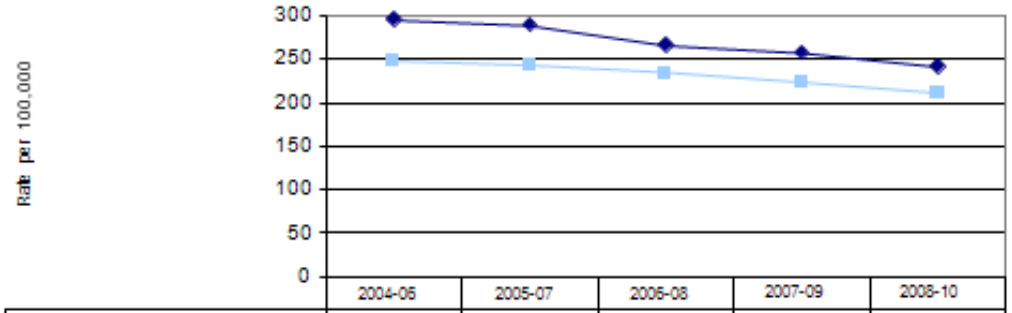
[123] ONS Annual District Deaths, Exeter Registered Population Extract



Circulatory diseases are the leading cause of death amongst those registered with Scarborough CCG accounting for 40% of all deaths.

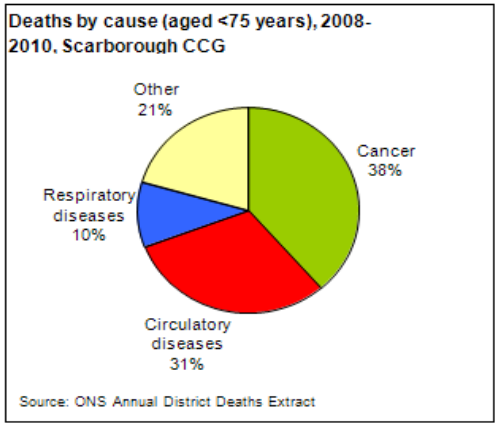
Between 2004-06 and 2008-10 the premature death rate (aged <75 years) fell from 296 per 100,000 to 243 per 100,000 in Scarborough and Ryedale CCG, statistically significantly higher than the North Yorkshire average of 210124

All cause mortality, age <75 years, direct standardised rate per 100,000 population



	2004-06	2005-07	2006-08	2007-09	2008-10
Scarborough CCG	296	290	267	259	243
North Yorkshire (practices located within North Yorkshire County)	248	243	235	223	210

Source: ONS Annual District Deaths, Exeter Registered Population Extract



The leading cause of death for those dying prematurely (<75 years) in Scarborough and Ryedale CCG is Cancer, accounting for 38% of all deaths.

When comparing the life expectancy of the most deprived members of the community to the least deprived there is a clear inequality. Men who live in Scarborough CCG's most deprived communities will die, on average 8.0 years earlier than their least deprived counterparts. Similarly, women in the most deprived communities in Scarborough CCG will die, on average 6.2 years earlier than those in the least deprived communities. Between
2001-05 and 2006-10, the Slope Index of Inequalities (SII) for males decreased from 9.7 years to 8.0 years. For females, the SII increased from 6.0 years to 6.2 years. However, these figures should be interpreted bearing in mind the wide confidence intervals around the SII.

Community Health Profiles

The Department of Health commissioned the Network of Public Health Observatories to publish Community Health Profiles on an annual basis for each local authority in England. Although they are not published at CCG level, the district level health summaries that appeared in the 2011 profiles can be found in the district summaries, outlining how the health of people in the districts compares with the rest of England. The 2012 profiles will be published in summer 2012 at http://www.apho.org.uk/default.aspx?RID=49802.

Scarborough and Ryedale CCG Big Issues

The issues received from people and organisations based in the Scarborough CCG area were overall similar to those received from other areas of the county. Issues from the Ryedale district part of the CCG area tended to have slightly more emphasis around transport, access to local services and other issues connected with rurality than from the less rural part laying within Scarborough district.

Issues that were mentioned during the JSNA events held in the Ryedale and Scarborough districts during December 2011 were fairly typical of other areas. All the issues raised during the Ryedale event covered topics also mentioned at one or more of the events held in other districts across the county. Although some of the issues that were mentioned during the JSNA Scarborough district event were typical of other areas, the total number of issues raised was higher than at most of the other events and several issues were uniquely raised that were not mentioned at any of the other events across the county.

Issues mentioned during discussion at the Ryedale and Scarborough district JSNA events	
Issues	**Event**
Access to services – transport, availability, location	Ryedale
Access to information, and in appropriate format	Ryedale
Care v reablement	Ryedale
Drugs & alcohol – culture change	Ryedale
Education about nutrition and other healthy lifestyle issues	Ryedale
Implications of an ageing population	Ryedale
Joined-up working	Ryedale
Social Isolation - cannot all be done by the community, Integrated solutions	Ryedale
What is already available locally?	Ryedale
Accommodation and housing – link to mental health, (Avoiding ghettos)	Only mentioned at the Scarborough event
Advocacy	Only mentioned at the Scarborough event
Affordable childcare	Only mentioned at the Scarborough event
Alcohol – availability, changing attitudes and behaviour	Scarborough district
Avoid duplication of services	Only mentioned at the Scarborough event
Education – information – lifetime investment	Scarborough district
Effective support for family carers	Scarborough district
Equal access to services (especially interpreters in health services)	Only mentioned at the Scarborough event
Family support isn't always there	Scarborough district
Isolation (particularly older population)	Scarborough district
Mental wellbeing – responding earlier	Scarborough district
Need doors opening to access community assets	Only mentioned at the Scarborough event
No short term funding – look to the future	Only mentioned at the Scarborough event
Obesogenic environment	Only mentioned at the Scarborough event
Simplification of assessment process (especially social care)	Scarborough district
Stop Consultancy	Only mentioned at the Scarborough event
Supporting communities to be more supportive	Scarborough district

Issues identified for Scarborough and Ryedale CCG

In addition to the needs identified across North Yorkshire, the following issues have been highlighted specifically in this locality. They have been described by Marmot Domain:

A Give every child the best start in life

Scarborough District has almost double the percentage of children in poverty as the rest of North Yorkshire (21%)

B Enable all children, young people and adults to maximise their capabilities and have control over their lives

- Lower educational attainment on most indicators compared to the rest of North Yorkshire and England.
- Falsgrave Park, Ramshill, Castle, Central and North Bay wards had a significantly higher rate of teenage pregnancy than the national average.

C Create fair employment and good work for all

- Higher unemployment rate in Scarborough compared to North Yorkshire and England.

D Ensure a healthy standard of living for all

- Higher rate of households in fuel poverty in Scarborough (26.3%) and Ryedale (28.2%) compared to England (18.4%).

E Create and develop healthy and sustainable places and communities

- Scarborough District has the highest and Ryedale District the lowest crime levels in North Yorkshire.
- Ryedale has a house price to earnings ratio in the worst quartile for affordability compared to England.
- Scarborough had the highest incidence of overcrowded housing at 4.95% of households, substantially higher than any other North Yorkshire district but lower than the national average of 7.13% for England.

F Strengthen the role of ill-health prevention

- Recorded crime attributable to alcohol in Scarborough District is the highest (7.1 per 1000 population) in North Yorkshire.
- There is a need to develop a Falls Service in Scarborough/Whitby /Ryedale.
- For reception children, obesity prevalence was second highest in Scarborough (8.0%).
- For year 6 children, obesity prevalence was highest in Scarborough (17.8%) and Ryedale (17.7%).
- Eastfield and Seamer fall into the bottom national quartile for expected levels of participation in at least 3 days x 30 minutes, moderate intensity adult physical activity.
- Children's participation in sport and physical activity is significantly lower than the England average in Ryedale District.
- Higher levels of Chlamydia screening in Scarborough District compared to North Yorkshire.
- Scarborough has the highest rates of smoking in North Yorkshire.
- Over the last five years, the percentage of mothers who were smokers giving birth at Scarborough was consistently significantly higher than the national average. During 2010/11 at Scarborough, 19.5% (almost 2 in every 10 mothers) were recorded as being a smoker at the time of delivery.
- During 2009/10, all districts within North Yorkshire had smoking attributable hospital admission rates per 100,000 population that were significantly lower than the national average, with the exception of Scarborough, which was significantly higher.

G Maximise the effectiveness of condition or treatment pathways (additional domain)

- Scarborough and Ryedale Districts had Coronary Heart Disease mortality rates significantly higher than the national average.
- The % of people with diabetes who have an Hb_{A1c} <7 was 2nd lowest in Scarborough and Ryedale CCG across North Yorkshire.
- Scarborough is in the 2nd bottom quintile nationally for dying in place or usual residence (i.e. below average).

- 24/7 community nursing service in Scarborough Area needs developing for end of life care.
- Blood pressure control for people with hypertension is lower in Scarborough and Ryedale CCG than other areas in North Yorkshire.
- Scarborough District had rates significantly higher mortality rates from stroke than the national average.

Population Groups

Carers

- Scarborough District has the highest rate of claimants for carer's allowance in North Yorkshire at 1.00% of the population, higher than the England average.

Homeless

- The number of homelessness acceptances per 1000 households in North Yorkshire is 2nd highest in Scarborough (3.00 per 1000).

Older People

- The number of people in Ryedale District aged 65 and over is set to increase from 12,300 to around 15,800 by 2021.
- The number of people in Scarborough District aged 65 and over is set to increase from 25,500 to around 31,300 by 2021.

Appendix 2

Practice sizes

PRACTICE CODE	PRACTICE NAME	Clinical Commissioning Group	1 Jan Raw List	1 Jan Weighted List	
GMS					
B82001	Dr D A Oldroyd & Partners	Scarborough	10360	11003.22	
B82011	Dr D R Carrie & Partners	Scarborough	4954	5402.99	
B82024	Eastfield Medical Centre	Scarborough	7480	8520.82	
B82037	Filey Surgery	Scarborough	8768	10793.46	
B82038	Prospect Road Surgery	Scarborough	7677	7518.22	
B82054	Scarborough Medical Group	Scarborough	12331	13956.11	
B82056	Claremont Surgery	Scarborough			**Closed as at 01/01/2014**
B82058	Norwood House Surgery	Scarborough	6278	6509.51	
B82063	Dr P J Robinson & Partners	Scarborough	7959	9488.62	
B82088	Trafalgar Medical Practice	Scarborough	5438	5561.69	
B82092	Belgrave Surgery	Scarborough	4643	4915.92	
B82106	Hackness Road Surgery	Scarborough	3250	3503.94	
B82609	Ampleforth Surgery	Scarborough	3892	3997.16	
B82628	Dr J Penfold & Partners	Scarborough	4067	5081.93	
PMS					
B82025	Derwent Practice	Scarborough	19677	19879.99	
B82611	Peasholm Surgery	Scarborough	8746	8959.22	
APMS					
Y02669	Castle Health Centre	Scarborough	2492	2374.03	

The Office Of National Statistics (ONS) population forecasts for the CCG areas (Sub-national Population Projections, 2010-based projections)

	Data								
AGE GROUP	**2011**	**2012 %**	**2012**	**2013 %**	**2013**	**2014 %**	**2014**	**2015 %**	**2015**
0-4	5.5	0.0%	5.5	0.0%	5.5	0.0%	5.5	3.6%	5.7
5-9	5.2	1.9%	5.3	0.0%	5.3	1.9%	5.4	1.9%	5.5
10-14	5.5	-1.8%	5.4	-3.7%	5.2	1.9%	5.3	0.0%	5.3
15-19	6.4	-3.1%	6.2	-1.6%	6.1	-4.9%	5.8	0.0%	5.8
20-24	6.6	0.0%	6.6	-1.5%	6.5	-1.5%	6.4	-3.1%	6.2
25-29	5.2	3.8%	5.4	3.7%	5.6	1.8%	5.7	0.0%	5.7
30-34	4.4	2.3%	4.5	0.0%	4.5	4.4%	4.7	4.3%	4.9
35-39	5.4	-7.4%	5.0	-6.0%	4.7	0.0%	4.7	-2.1%	4.6
40-44	6.7	-1.5%	6.6	-4.5%	6.3	-3.2%	6.1	-3.3%	5.9
45-49	7.9	-1.3%	7.8	-2.6%	7.6	-2.6%	7.4	-4.1%	7.1
50-54	7.7	2.6%	7.9	1.3%	8.0	0.0%	8.0	0.0%	8.0
55-59	7.3	-1.4%	7.2	2.8%	7.4	2.7%	7.6	2.6%	7.8
60-64	8.7	-6.9%	8.1	-3.7%	7.8	-2.6%	7.6	-2.6%	7.4
65-69	7.4	9.5%	8.1	3.7%	8.4	2.4%	8.6	0.0%	8.6
70-74	6.0	0.0%	6.0	1.7%	6.1	3.3%	6.3	3.2%	6.5
75-79	4.8	0.0%	4.8	4.2%	5.0	4.0%	5.2	0.0%	5.2
80-84	3.7	-2.7%	3.6	0.0%	3.6	0.0%	3.6	2.8%	3.7
85-89	2.3	0.0%	2.3	4.3%	2.4	0.0%	2.4	0.0%	2.4
90+	1.4	0.0%	1.4	0.0%	1.4	7.1%	1.5	6.7%	1.6
Grand Total	**108.1**	**-0.4%**	**107.7**	**-0.3%**	**107.4**	**0.4%**	**107.8**	**0.1%**	**107.9**

	Data								
AGE GROUP	**2011**	**2012 %**	**2012**	**2013 %**	**2013**	**2014 %**	**2014**	**2015 %**	**2015**
0-4	2.4	0.0%	2.4	4.2%	2.5	0.0%	2.5	0.0%	2.5
5-9	2.5	4.0%	2.6	0.0%	2.6	0.0%	2.6	0.0%	2.6
10-14	3.0	-3.3%	2.9	0.0%	2.9	-6.9%	2.7	3.7%	2.8
15-19	3.7	-2.7%	3.6	-5.6%	3.4	-2.9%	3.3	-6.1%	3.1
20-24	2.2	0.0%	2.2	0.0%	2.2	0.0%	2.2	0.0%	2.2
25-29	2.0	0.0%	2.0	10.0%	2.2	0.0%	2.2	9.1%	2.4
30-34	2.2	0.0%	2.2	-4.5%	2.1	4.8%	2.2	0.0%	2.2
35-39	2.8	-7.1%	2.6	-3.8%	2.5	-4.0%	2.4	0.0%	2.4
40-44	3.7	-2.7%	3.6	-2.8%	3.5	-2.9%	3.4	-5.9%	3.2
45-49	4.1	2.4%	4.2	-2.4%	4.1	-2.4%	4.0	-2.5%	3.9
50-54	3.9	2.6%	4.0	5.0%	4.2	0.0%	4.2	2.4%	4.3
55-59	3.9	0.0%	3.9	0.0%	3.9	0.0%	3.9	2.6%	4.0
60-64	4.4	-4.5%	4.2	-4.8%	4.0	0.0%	4.0	0.0%	4.0
65-69	3.8	5.3%	4.0	5.0%	4.2	2.4%	4.3	0.0%	4.3
70-74	2.9	0.0%	2.9	6.9%	3.1	3.2%	3.2	3.1%	3.3
75-79	2.2	9.1%	2.4	0.0%	2.4	0.0%	2.4	0.0%	2.4
80-84	1.8	0.0%	1.8	0.0%	1.8	0.0%	1.8	0.0%	1.8
85-89	1.0	0.0%	1.0	0.0%	1.0	10.0%	1.1	9.1%	1.2
90+	0.6	0.0%	0.6	16.7%	0.7	0.0%	0.7	0.0%	0.7
Grand Total	**53.1**	**0.0%**	**53.1**	**0.4%**	**53.3**	**-0.4%**	**53.1**	**0.4%**	**53.3**

		Data				
Speciality	Point of Delivery	2011-12	2012-13	2013-14	2014-15	2015-16
130 - OPHTHALMOLOGY	First Outpatients	3,350	3,355	3,386	3,421	3,451
	Follow-up Outpatients	9,981	10,008	10,154	10,297	10,411
	Outpatient Procedures	2,827	2,835	2,888	2,940	2,975
130 - OPHTHALMOLOGY Total		16,158	16,197	16,428	16,658	16,837
110 - TRAUMA & ORTHOPAEDIC	First Outpatients	4,895	4,873	4,868	4,879	4,886
	Follow-up Outpatients	9,836	9,827	9,868	9,919	9,948
	Outpatient Procedures	203	201	202	203	203
110 - TRAUMA & ORTHOPAEDICS Total		14,934	14,902	14,937	15,001	15,037
330 - DERMATOLOGY	First Outpatients	1,453	1,450	1,453	1,459	1,462
	Follow-up Outpatients	2,629	2,626	2,639	2,651	2,663
	Outpatient Procedures	5,149	5,152	5,161	5,189	5,188
330 - DERMATOLOGY Total		9,231	9,228	9,253	9,299	9,314
100 - GENERAL SURGERY	First Outpatients	1,959	1,959	1,969	1,982	1,986
	Follow-up Outpatients	4,065	4,071	4,108	4,143	4,167
	Outpatient Procedures	907	908	916	925	929
100 - GENERAL SURGERY Total		6,931	6,939	6,993	7,049	7,082
120 - ENT	First Outpatients	1,758	1,759	1,763	1,770	1,776
	Follow-up Outpatients	2,593	2,596	2,598	2,615	2,625
	Outpatient Procedures	1,640	1,642	1,652	1,668	1,677
120 - ENT Total		5,991	5,996	6,013	6,052	6,077
502 - GYNAECOLOGY	First Outpatients	1,102	1,095	1,091	1,086	1,083
	Follow-up Outpatients	1,822	1,815	1,806	1,802	1,796
	Outpatient Procedures	2,596	2,585	2,573	2,572	2,562
502 - GYNAECOLOGY Total		5,520	5,495	5,470	5,460	5,441
320 - CARDIOLOGY	First Outpatients	1,485	1,486	1,497	1,507	1,514
	Follow-up Outpatients	3,553	3,571	3,624	3,676	3,720
	Outpatient Procedures	327	329	333	337	338
320 - CARDIOLOGY Total		5,365	5,385	5,454	5,521	5,572
191 - PAIN MANAGEMENT	First Outpatients	455	453	452	454	453
	Follow-up Outpatients	3,137	3,134	3,145	3,165	3,170
	Outpatient Procedures	1,251	1,244	1,242	1,250	1,250
191 - PAIN MANAGEMENT Total		4,843	4,831	4,839	4,868	4,873
501 - OBSTETRICS	First Outpatients	807	803	796	796	796
	Follow-up Outpatients	2,639	2,623	2,606	2,606	2,609
	Outpatient Procedures	1,284	1,273	1,262	1,263	1,264
501 - OBSTETRICS Total		4,730	4,699	4,664	4,666	4,669
420 - PAEDIATRICS	First Outpatients	983	984	983	985	1,005
	Follow-up Outpatients	3,057	3,052	3,028	3,028	3,071
	Outpatient Procedures	2	2	2	2	2
420 - PAEDIATRICS Total		4,042	4,038	4,013	4,015	4,077
Grand Total		77,745	77,710	78,065	78,589	78,980

From the ONS data the CCG has calculated based on recent historic activity the estimated activity by speciality and by major admission type. These tables show the top 10 specialties for out-patient activity and the top 15 for in-patient activity.

		Data				
Point of Delivery	Speciality	**2011-12**	**2012-13**	**2013-14**	**2014-15**	**2015-16**
Elective	301 - GASTROENTEROLOGY	2,721	2,728	2,750	2,772	2,779
	101 - UROLOGY	1,932	1,944	1,969	1,996	2,019
	370 - MEDICAL ONCOLOGY	1,731	1,740	1,768	1,789	1,800
	110 - TRAUMA & ORTHOPAEDICS	1,677	1,679	1,689	1,698	1,702
	130 - OPHTHALMOLOGY	1,305	1,308	1,331	1,354	1,370
	100 - GENERAL SURGERY	1,254	1,257	1,263	1,272	1,277
	303 - CLINICAL HAEMATOLOGY	1,022	1,016	1,017	1,022	1,026
	502 - GYNAECOLOGY	713	709	703	699	695
	300 - GENERAL MEDICINE	592	598	607	615	618
	191 - PAIN MANAGEMENT	528	527	529	532	534
	120 - ENT	397	396	396	397	399
	144 - MAXILLO-FACIAL SURGERY	346	345	348	351	352
	320 - CARDIOLOGY	322	324	327	331	333
	410 - RHEUMATOLOGY	265	266	268	272	272
	104 - COLORECTAL SURGERY	235	236	238	239	242
Elective Total		15,040	15,074	15,202	15,339	15,419
Non-elective	300 - GENERAL MEDICINE	3,981	3,995	4,043	4,090	4,119
	420 - PAEDIATRICS	1,749	1,751	1,753	1,756	1,795
	501 - OBSTETRICS	1,693	1,686	1,673	1,666	1,662
	100 - GENERAL SURGERY	1,577	1,576	1,583	1,594	1,604
	430 - GERIATRIC MEDICINE	1,297	1,294	1,323	1,351	1,397
	560 - MIDWIFE EPISODE	628	628	628	627	628
	110 - TRAUMA & ORTHOPAEDICS	605	605	613	620	623
	320 - CARDIOLOGY	444	447	454	461	466
	502 - GYNAECOLOGY	430	429	427	426	425
	180 - ACCIDENT & EMERGENCY	259	258	260	262	263
	340 - RESPIRATORY MEDICINE	206	208	212	214	216
	101 - UROLOGY	188	188	190	192	194
	120 - ENT	106	106	107	108	109
	303 - CLINICAL HAEMATOLOGY	93	92	92	92	92
	160 - PLASTIC SURGERY	83	83	83	83	83
	301 - GASTROENTEROLOGY	83	83	83	84	85
Non-elective Total		13,422	13,428	13,524	13,624	13,760
Grand Total		28,462	28,501	28,726	28,963	29,179

Plan on a Page 2014-16

Vision

Improving the health and well-being of our communities

Values

To commission high quality services: To engage patients, carers and other organisations in our planning and decision process: To ensure value for money: To be open and honest in our transactions, and accountable to our communities

Commitment

Ensuring NHS Constitution standards are met: Delivering the NHS Mandate: Engaging and Empowering Citizens: Delivering the NHS Outcomes Framework: Facilitating Change in health and Social Care

Strategic Priorities

Improving Health and Reducing Inequality				Sustainable, high quality services			Building Strong Community Systems
Cancer	Cardio-vascular	Mental Health	Elderly care	Re-design	QIPP	Provider Landscape	Health and Social Care Transformation

Aims

Early diagnosis	Stroke	Liaison Psychiatry	Chronic pain	Urgent Care	Elective productivity	Evening Response	Community Hub	Day support
Smoking cessation	Cardiology	Dementia	Cardiology	Emergency Care	Specialised services	Support to Care Homes		Neighbourhood Care Teams
		Acute Assessment	Integrated OOH/Urgent Care	Planned Care	Primary care configuration			
		Talking Therapy	Ophthalmology	Prescribing	Voluntary			
		Autism ADHD CAMHS	Diagnostics	Community	Transfer activity/resource from secondary care	Health Trainers		Self Help
		Falls	Sleep apnoea pathway	Demand Management				

Local Priority

Falls

Access	Quality	Innovation	Value

Plan on a Page 2014-19

Vision	Improving the health and well-being of our communities
Values	To commission high quality services: To engage patients, carers and other organisations in our planning and decision process: To ensure value for money: To be open and honest in our transactions, and accountable to our communities
Commitment	Ensuring NHS Constitution standards are met: Delivering the NHS Mandate: Engaging and Empowering Citizens: Delivering the NHS Outcomes Framework: Facilitating Change in health and Social Care

Strategic Priorities	Improving Health and Reducing Inequality	Sustainable, high quality services	Building Strong Community Systems

2014/15

- Re-design OOH/urgent care service and proceed to tender
- Review diabetes, rheumatology, ophthalmology, chronic pain, cardiology services
- Introduce liaison psychiatry, increase access to IAPT, review CAMHS, ADHD and Autism pathways
- Develop Community Hub in Malton and roll out to Scarborough
- Continue implementation of Neighbourhood Care Teams
- Primary care reconfiguration and federation discussions
- Undertake capacity planning to ensure system resilience
- Service improvement event "The Perfect Week"
- Lay foundation for whole scale health and social care changes

2015/16

- Implement delegated responsibility for co-commissioning primary care
- Fully integrated community hubs linking with neighbourhood care teams to provide wrap around support for patients with long term conditions and the frail elderly
- Care home support
- Integrated OOH/Urgent care service
- Review sleep apnoea service
- Implement service review changes/procurement identified in 2014/15
- Continue to transfer activity/resources from secondary care to community and primary care
- Continue to develop mental health services
- Maximise utilisation of voluntary sector
- Review provision of diagnostics

2016/19

- 7 day a week NHS services
- Develop and implement children's centre in Scarborough
- Complete transformation of community and primary care to allow transfer of activity/resource from secondary care
- Modern model of integrated care – virtual or organisational – delivering care around individual patients, supporting patients to remain at home
- Sustainable local hospital and wider secondary care and tertiary services to create step change in elective productivity and centres of excellence
- Review pathway for children with lower respiratory infections
- Develop improved access to preventative services
- Parity of esteem becomes part of everyday commissioning of services
- Maximise use of technology and innovation

Appendix 6

The Vision and Strategy for Nurses, Midwives and Care Staff

6 Areas of Action

1. Helping people to stay independent, maximise well-being and improving health outcomes.
2. Working with people to provide a positive experience of care.
3. Delivering high quality care and measuring the impact.
4. Building and strengthening leadership.
5. Ensuring we have the right staff, with the right skills in the right place.
6. Supporting positive staff experience.

Our Culture of Compassionate Care - The 6 Cs

Care

Compassion

Competence

Communication

Courage

Commitment

Appendix 7

Start Well, Live Well, Age Well, HC&V Sustainability & Transformation Plan

everyone ACTIVE

Start well, live well, age well

HUMBER COAST AND VALE SUSTAINABILITY AND TRANSFORMATION PLAN SUMMARY

November 2016

Foreword

Our vision for the Humber Coast and Vale Sustainability & Transformation Plan (STP) is to be seen as a health and care system that has the will and the ability to help its population start well, live well and age well.

We are proud of our local health and social care services and the thousands of staff who provide them today, but there is much more to be done. 23% of our 1.4m population live in the most deprived areas of England and we are seeing significant variations in health outcomes seen in the diverse rural, urban and coastal communities. Adults in some areas are leading less healthy lifestyles and as a result are at greater risk of developing long term conditions that seriously impair their lives and future prospects.

Our ideas are not just about medical solutions. We are facing unprecedented demand for services, a long-term shortage of the skilled people we need to provide them and a looming funding gap of more than £420m by 2020/21. This means that we must make changes that can support our people to be healthier, that improve the quality of care they receive and that balance our books financially. Making changes now is integral to drive improvements for the future.

The STP is an opportunity for the public services and our vibrant voluntary sector to work effectively together in a partnership that can deliver huge benefits. The plan focusses on the wider determinants of health in our footprint, with all public services working together to support people to take more responsibility for their own health. Our proposals are designed to give everyone access to the right care in the right place at the right time. National standards are minimum standards, and we think people in Humber Coast and Vale deserve more.

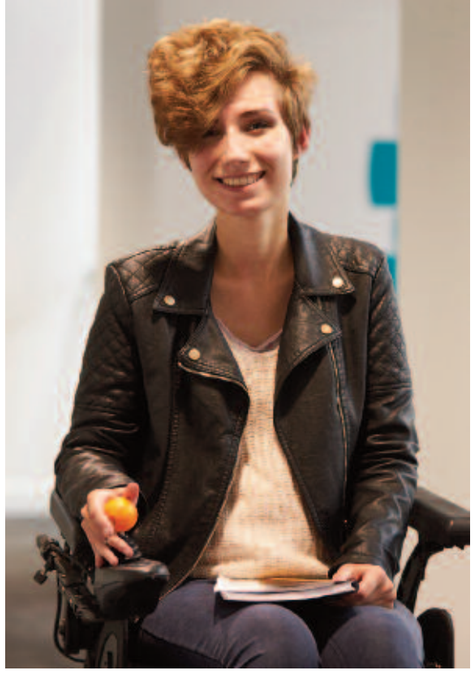
We believe that the ideas set out in this document are the right approach for the Humber Coast and Vale footprint, but they are not the easiest. We will not make any decisions without consulting our population and our staff on the changes we believe we should make. Indeed, much of what we propose is based on easing the concerns that people have already told us about.

We are now ready to work collectively to deliver the best care possible for the people of Humber Coast and Vale. We will be as efficient as possible with the resources we have to meet our population health and care needs in the best way.

Emma Latimer
Humber Coast and Vale STP Lead and Chief Officer NHS Hull CCG

What's happening?

Since April 2016, people from health and care organisations across the region, together with our vibrant voluntary sector, have been working together. We have developed proposals that we believe will change the way you manage your own health and how you receive health and social care when you need it, in the place where you live.



Why do we need these proposals in our region?

Mortality is much worse than the national average

14% of people aged 16-74 have mental health disorders

Smoking, alcohol abuse and obesity rates are higher than the national average

40% of A&E patients require no treatment.

If we do nothing we will have a budget deficit of £420 million by 2020/2021

People are having to wait more than four weeks to access some mental health services

25-50% of hospital beds are used by people who don't need them

36.5% of patients who went to A&E went there because their GP practice was unavailable or closed

27% of people seen by GPs could have had their issue resolved another way

51% of patients said they couldn't have an appointment at their GP on the day they wanted to

Cancer is the leading cause of death in under 75s. Cancer kills more than 4,000 people a year in Humber Coast and Vale, with lung cancer being the biggest killer

Our annual turnover in the Humber Coast and Vale healthcare system is £3bn

We will work at scale and locally

The Humber Coast and Vale area covers six NHS Clinical Commissioning Groups and six local authority boundaries representing communities in Hull, East Riding, York, Scarborough and Ryedale, North Lincolnshire and North East Lincolnshire - we call this our planning footprint. This scale creates opportunities to share resource in areas where we are currently stretched, providing a better service to patients and a better experience for the staff who work within those services.

Support services such as finance can also be shared to reduce costs and improve efficiency. Most of the things we do, however, will aim to deliver the best care we can locally, shaped around local need.

Who is involved?

Health services, local authorities, providers and voluntary sector colleagues across our footprint are working together to develop the Humber Coast and Vale STP.

The organisations that make up the Humber Coast and Vale Partnership Board are:

What can we do?

The Sustainability and Transformation Plan (STP) for Humber Coast and Vale is the blueprint for an ambitious approach to prevention and public health that puts your needs at the centre of service redesign.

The plan describes how we will move towards place-based provision of care and services. It focuses on the wider determinants of health in our footprint and how public services will work together to support everyone to take more responsibility for their own health.

Our proposals aim to design a healthcare system that by 2021 helps people to start well, live well and age well, that improves the quality of care and services that you receive and ensures that the system is financially sustainable for the long-term so that we can continue to deliver the services that you need.

We must meet three challenges - our "triple aims"

We will deliver our ideas by concentrating on three things in our footprint. These are our "triple aims":

- **Achieving our desired outcomes – "will the service be good?"**
- **Maintaining quality services – "will the service be safe and operationally sustainable?"**
- **Closing our financial gap – "will the service be financially sustainable?"**

> **"I know how to look after myself to reduce my chances of falling ill."**

> **"I know how to get help at an early stage to avoid a crisis."**

Our vision for 2021 is a system that:

Supports everyone to manage their own care better

Reduces dependence on hospitals

Uses our resources more efficiently

> **"I only go to hospital when it is planned and necessary and I am in hospital for the minimum amount of time needed."**

Six priorities

We have put six priorities that at the heart of the change we want to achieve. These are:

- **Helping people stay well**
- **Place-based care**
- **Creating the best hospital care**
- **Supporting people with mental health problems**
- **Helping people through cancer**
- **Strategic commissioning**

Our priorities

Helping people stay well

We want to focus on prevention – in other words **help people to help themselves to stay well.**

Our big ideas are:

- Offer high quality smoking cessation services based on what we know works
- Give people advice and resources to look after themselves.
- Take steps to identify and act early on cardiovascular disease and diabetes
- Implement prevention activities that we know work well across all localities – such as those that tackle obesity, alcohol misuse and falls.

Place based care

People want to receive **excellent care, close to their home, at times that work with their lifestyle**. They are frustrated that they need to give the same information to different professionals often on the same day.

Our big ideas are:

- Invest in General Practice in order to improve access to GPs.
- Allow practices to modernise and transform the way they work and, over time, increase the number of GPs in our footprint.
- Join up local services so that the health system works for everyone. Local teams will coordinate and deliver as much care as possible in the community. These teams will include GPs, social care, some services currently found in a hospital and services from our vibrant local community and voluntary sector.
- Transform urgent and emergency care services to ensure that people are able to access the level of service that is appropriate to their need on a seven day basis and reduce the need for them to go to hospital.

Creating the best hospital care

People who work in our hospitals tell us that they want to **collaborate, innovate and challenge the way services are currently delivered.** We know that we have a population that is getting older and this is leading to an increase in demand for hospital services.

Our big ideas are:

- Improve the quality of hospital services through working together to redesign clinical and operational processes.
- Develop high quality specialised services. We propose to review complex rehabilitation services, paediatrics, neonatal intensive care and specialised orthopaedics over the next five years.
- Share support services to become more efficient where there will be little direct impact on the quality of patient care. We are considering doing this for pathology, pharmacy, procurement and imaging.
- Develop a consistent Humber Coast and Vale level of maternity care.

Supporting people with mental health problems

We know that we have a lot to do to improve mental health services. More services need to be provided close to home rather than in hospital and **children, young people and adults need better access to mental health support services.**

Our big ideas are:

- We will make treatment in the community our default option, addressing existing gaps in onward placements and services, and making better use of beds across the patch.
- Invest in best start and prevention strategies for the under-fives focussed on bonding and attachment. These will be delivered through health visitors, schools and parenting support.
- Create new services to avoid unnecessary hospital stays. We will do this in collaboration with the new integrated multi-disciplinary teams.
- Provide services that maintain independence. The style of the care provided in hospital or other care settings can mean that people, especially those with dementia, can start to lose their independence. We will work with hospital and community based services to identify how to help people to continue with their activities of daily living and be supported to make informed decisions about their care.

Helping people through cancer

A focus on improving cancer services is important as **Humber Coast and Vale has higher than national average incidence and mortality rates for all cancers.**

The number of people living with and beyond cancer is predicted to increase by 28% by 2030, which means we need to change the way we treat cancer.

We want to simplify the way that cancer treatment is accessed, reduce the levels of variation and increase our focus on the prevention of cancer.

Our big ideas are:

- By managing cancer diagnostics across the patch they should become more efficient, which means patients will be able to access them when they need to.
- Provide a consistent cancer recovery service for all patients across Humber Coast and Vale.
- Take steps to identify and act early on cancer.

Strategic commissioning

Currently, patients may receive a different type of treatment or a different level of care depending on where they access services. Similarly, too many organisations are commissioning services. We aim to strike a balance between planning some services at scale so that we can get the best value from them and planning other services on a local level so that they can be **built around the needs of individual communities.**

Our big ideas are:

- Implement a strategic commissioning model that has a real focus on prevention, wellbeing, self-care and delivering outcomes that matter for patients.
- Plan hospital services to reduce variation, measure the success of services against the things that are important to the population and make best use of the staff, particularly for services where it is hard to recruit people.
- Plan services at 'place' level that will be developed locally on a smaller scale, for example our new integrated multi-disciplinary locality teams. This means that the services offered through these teams should meet the needs of the people who live there rather than a "one size fits all" approach.

How will we make the change happen?

Improving our health and care system in the way we describe will not happen overnight. We are trying to resolve challenges that our communities and public and voluntary sector organisations have been dealing with for a long time. It will also require a significant change in the way we work as organisations. We are putting in place some processes to help us make this happen.

Finance

We have developed a plan that will support us in closing the 'do nothing' £420m funding gap by 2021. Big changes in the way we will work involve us delivering a system control total. This will involve planning and monitoring our services based on what people in our communities think is important, rather than the number of times we see patients.

Governance

Our Strategic Partnership Board and our Strategic Executive Group support us in making the right decisions. Our Clinical Advisory Group will make sure clinical views are at the heart of what we do, but we know we have to do more to support clinicians in this role. We have begun to recruit into our programme team and our governance and resource model will continue to strengthen as we move into implementation.

Workforce

Our Local Workforce Action Board (LWAB) has planned two initiatives to help us to make sure we have the skills we need to deliver our strategy. These initiatives involve developing both support staff and advanced practice staff at scale. Both of these initiatives will significantly help us to fill the gaps we have in our workforce.

Our estate

Implementing this plan means we will have different estate needs across Humber Coast and Vale public sector partners. As demand changes we will need to use our estate flexibly to support delivery of our strategy.

Communication and engagement

We have challenging proposals for Humber Coast and Vale and are working on a comprehensive communications and engagement plan that has citizens and patients, staff and partners at its heart. We will not make any decisions without consulting our population and our staff on the changes we believe are needed.

Technology

We have a single plan across Humber Coast and Vale for using technology to transform our health and care services. This includes developing a single electronic care record that can be shared and accessed by health and care professionals, meaning that people will tell their story only once.

How will these proposals affect our communities and staff?

We want to make Humber Coast and Vale a better place to live. We want to develop health and care services that people want to use and work in. Over the next five years, we want people to be able to say:

Tell us what you think

Citizen voice is at the heart of everything we do. The ideas in this plan are based on what many of you have told us you want and need. Over the coming months we will build on the engagement we have carried out over the past two years, talking to our staff and local people about the plan so that many more of you have the opportunity to contribute as the plan develops.

We will be working with Healthwatch and other voluntary sector partners to make sure that we have sought and heard views from a wide range of communities and the ideas from those groups will be built into our plans.

You can contact us now with your views in a number of ways:

Email: HULLCCG.contactus@nhs.net

Freepost:
RTGL-RGEB-JABG
2nd Floor
Wilberforce Court
Alfred Gelder St
Hull
HU1 1UY

Telephone: 01482 344700