Wakefield Health and Wellbeing Plan
Wakefield District Health and Social Care

Wakefield District

40 Practices;
367,370 registered population (1.10.16);
332,000 resident population;
3 Integrated hubs;
coterminous boundaries with the LA

There are 76,388 children and young people aged 0-19 living in Wakefield - 23.2% of the total population. There are 488 children and young people in care.

As of January 2015 there were 50 registered Care Homes within the Wakefield District which cater for people aged 65 and over. A further 17 Care Homes support individuals under the age of 65 with physical disabilities, LD and mental health issues. This provides 2435 active beds.

Police officers: 481
Police staff: 181
PCSOs: 59
Special constables: 128
Police Volunteers: 9

Multi agency safeguarding hub with X police and health staff working together to safeguard the district

2 hospices
43 Domiciliary care providers

1500 Voluntary and Community Sector organisations
154 operational firefighters plus retained firefighters carrying out preventative home visits

NHS Wakefield - New Network Configuration

Contains Ordnance Survey Data © Crown copyright and database rights 2016
Contains Royal Mail data © Crown copyright and database rights 2016
Layers of Transformation

In Wakefield there are four different layers on which we carry out our planning and we are clear about the layers on which we commission and transform services and where it is most appropriate to do so. It is acknowledged that most transformation will happen at a local level however, there will be priorities which are better commissioned and transformed on a larger footprint. Whilst distinct priorities have been identified for each of the transformation layers, it is also important to understand the golden thread which runs through all layers (for example with cancer services) and the alignment across all the local plans in West Yorkshire.

- **Y&H Place, YAS, Specialised Commissioning**
  - Some elements of transformation can only take place on much larger footprints and need to be on a wider Yorkshire and Humber level. In particular Yorkshire Ambulance Services (of which NHS Wakefield CCG are the contract lead) and some elements of specialised commissioning.

- **West Yorkshire Place, Healthy Futures programme and links to Working Together programme**
  - The Healthy Futures Commissioning Collaborative has identified Urgent and Emergency Care, Mental Health, Cancer, Specialised Commissioning, Workforce and Prevention at Scale as the key priorities for the West Yorkshire STP. There is a ‘golden thread’ through all layers of planning which identifies the interdependencies of delivery within local plans and at scale via the Healthy Futures STP.

- **MidYorkshire Place, Planned care transformation, clinical threshold management, system leadership, interdependencies with primary care**
  - Meeting the Challenge continues to be a focus in 16/17 with the hospital reconfiguration and system redesign programme being in year three of implementation A Joint Clinical Leaders Forum across Wakefield, North Kirklees and Mid Yorkshire Hospital Trust provides the foundations upon which planned care transformation and clinical threshold management programmes will be delivered. Across the Mid Yorkshire footprint the interdependencies with primary care are critical to ensure success.

- **Wakefield Place, Addressing local health need, integration (joint commissioning and planning), primary care (primary care networks and commissioning hubs), prevention, vanguards, primary care variation.**
  - Commissioning and transformation plans are centred on the ‘Wakefield place’ based on the Joint Strategic Needs Assessment and taking in to account national drivers within the Five Year Forward View. There are three priorities in this layer: Integration, Primary Care variation and Prevention. The development of New Models of Care through developing an Accountable Care system will be a key priority in 16/17, 17/18.
Local Governance – Delivering the Wakefield Health and Wellbeing Plan

Wakefield Health and Wellbeing Board
Overseeing six workstreams of the plan each led by a Health and Wellbeing Board Member

- Radical reduction in hospital admissions where appropriate leading to reinvesting in prevention
- New Accountable Care Systems to deliver new models of care
- Collective prevention resource across the health and social care sector and wider social determinant partners
- Expanded Health and Wellbeing Board membership to represent wider determinants
- A strong ambitious co-owned strategy for ensuring safe and healthy futures for children
- A shift towards allocation of resources based upon primary and secondary prevention and social determinants of ill health

Supported by task and finish groups, and existing groups including:
- Connecting Care Executive
- Connecting Care Joint Health and Social Care Partnership
- Joint Transformation Programmes across Children’s and Adults
- MYHT System Oversight and Assurance Executive
- A&E Improvement Group
- Planned Care Improvement Group
- In addition links to Children and Young People’s Partnership and Wakefield Safeguarding Boards
Wakefield as part of the West Yorkshire STP

This approach brings together local and collaborative West Yorkshire plans to deliver the required cumulative impact at a population level to meet our gaps.

Our local plans retain primacy. Much of the transformation will be delivered at local level.

Particularly, wellness, prevention and primary & community services

Supported by enabling workstreams: digital, workforce, leadership & OD, communications & engagement, best practice and strategic commissioning

Nine priority areas:
- Urgent & Emergency Care
- Specialised Commissioning
- Mental Health
- Prevention
- Stroke
- Cancer
- Primary & Community Care
- Acute Sustainability
- Standardisation and Variation
Principles by which we will deliver the plan

- Person Centred Approach
- Commitment to increasing digital literacy
- Brave challenging ownership culture
- Commitment to a ‘prevention comes first’ approach to finance
- Bringing communities with us
- Acknowledge the political element to our conversations
- Embed what we know already works
Working in Partnership

Reducing the Health and Wellbeing, Care and Quality and Finance and Efficiency gaps and as a result, our vision and outcomes will need us to work together across not just the health and social care sector but across the public and private sector in Wakefield.

Public

Through the Health and Wellbeing Board and existing programmes of work such as Connecting Care our integration programme, we have over the years developed strong mature relationships across our public sector, particularly in terms of health and social care. Over recent years however, this has extended beyond traditional health boundaries through understanding the role that other public sector organisations can bring in tackling some of the wider determinants of health. We know have strong relationships with Wakefield and District Housing in both integrated care and mental health and also West Yorkshire Police in developing street triage for the district. We are also exploring new links to how we can work with other organisations such as Fire and Rescue to deliver sustainability and transformation in our district.

Voluntary and Community Sector

We have a long history in Wakefield of working with our local Voluntary and Community Sector and they are a strong strategic and operational partner across our health and social care sector who:

• Works with and is part of communities with the greatest health inequalities creating trust, reach, culturally sensitive services, intelligence about gaps, people engagement;
• Works with people in an asset-based, person centred way, designed to empower and support people to recovery, to self-management, to staying in the community;
• Provides interventions that holistically address and understand the wider determinants of health and wellbeing, employment, housing, debt, education;
• Operates in a flexible way, both to meet the person’s needs but in addition able to organise flexibly to address unmet needs
• Delivers evidence-based cost effective health and care interventions.

Private Sector

We recognise that the private sector has a key role to play in our plan, particularly in terms of the prevention agenda. As a district situated in an area of significant logistical importance, Wakefield has the fastest growing economy in the Leeds City Region and has a flexible workforce with 2.7m people living within 20 miles of the city. This brings the opportunity for us to work more closely with our local businesses through ‘Wakefield First’ to encourage their workforces to self care, have healthier lifestyles and to access healthcare in the appropriate way at the appropriate time.
The Wakefield Health and Wellbeing Gap

Despite many years of work, Wakefield continues to have significant health issues. The Wakefield Health and Social Care economy is clear that our plan should focus on a shift towards prevention, which we aim to achieve through our Wakefield approach. Our JSNA reaffirms to us that our Health and Wellbeing Board priorities of early years (with a focus on childhood obesity, breastfeeding and maternal smoking at delivery), long term conditions (including diabetes, respiratory and circulatory diseases), Mental Health (including dementia and self harm) and older people (including reducing social isolation) will address the health and wellbeing gap for Wakefield. In addition these priorities will inform the review of the Wakefield District Outcomes Framework which is owned by public and private sector organisations in the Wakefield District.

Our population is changing, with both an increasing ageing population and an increase in the population in our children and young people. It is important that we plan for these changes to ensure safe and healthy futures.

Our plan has a focus on self-care as an element of prevention, with a common narrative and approach across the health and social care system through the Health and Wellbeing Board. This will allow some of our wider partners such as housing and the police to be able to help promote self care and it will be an important element of our STP. Through tackling our prevention and self care agenda we will reduce avoidable admissions over the next five years.
The Wakefield Health and Wellbeing Gap – Prevention at Scale

Our aspiration for 2020/21 is that we want people in Wakefield to have healthier, happier and longer lives with less inequality and to deliver this we will need to move to prevention at scale. We know that focussing on improving the first 1000 days of a child’s life will bring about significantly increased health and well being in future life. Focussing not solely on health and social care but also on the wider social determinants of health will support this prevention approach, particularly when looking at employment, housing, social isolation, the built environment and education.

Wakefield has one of the lowest breastfeeding rates in the region.

Older children have higher levels of decayed teeth than regional and national levels.

Alcohol consumption continues to be an issue, with harmful/hazardous drinking being greater than the national average which is reflected in increasing levels of liver disease in the district.

Significant challenges in terms of tackling long term conditions, particular in relation to respiratory and circulatory problems alongside the 16 cancers related to smoking and rising levels of diabetes

19.8% of older people living in poverty.

In Wakefield we experience higher levels of child poverty than the national average. In 2012 the national rate was 19.2% compared to 20.6% in Wakefield.
**The Care and Quality Gap**

We know that we need to tackle variation in care and to reduce health inequalities across the district. In addition some challenges which have existed for some time now around our constitutional indicators such as Referral to Treatment and A&E waiting times will need to have significant focus over the next five years to ensure we provide the best quality of care to our patients.

Our Acute Trust has significant long term issues with sickness and retention, in 2015/16 sickness was at 5% and leavers within the Trust at 6%, both above the national average. This is a key focus area to ensure we have safe staffing levels for all our patients.

26 of our GP practices were inspected in 2015/16 with 3 rated outstanding and 23 rated as good. Patients having a good experience of GPs in Wakefield is currently 73.3% which is above the regional average.

<table>
<thead>
<tr>
<th>Care Quality Commission</th>
</tr>
</thead>
<tbody>
<tr>
<td>54.1% people with a learning disability received an annual health check</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Check Number</th>
<th>Target</th>
<th>Yorkshire Ambulance Service</th>
<th>Mid Yorkshire Hospitals NHS Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance wait</td>
<td>75%</td>
<td>Red 1: 68.5% Red 2: 69.5%</td>
<td>n/a</td>
</tr>
<tr>
<td>(as at March 2016)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A&amp;E (Type 1): wait</td>
<td>95%</td>
<td>n/a</td>
<td>79.7%</td>
</tr>
<tr>
<td>within 4 hours</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(as at March 2016)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 week RTT (March</td>
<td>92%</td>
<td>n/a</td>
<td>83.9%</td>
</tr>
<tr>
<td>2016)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Test</td>
<td>&lt; 1%</td>
<td>n/a</td>
<td>4.3%</td>
</tr>
<tr>
<td>Waiting times:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>longer than 6 weeks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(as at March 2016)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer: 1st</td>
<td>93%</td>
<td>n/a</td>
<td>96.63%</td>
</tr>
<tr>
<td>consultant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>appointment &lt; 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>weeks (as at March</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2016)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer: decision</td>
<td>96%</td>
<td>n/a</td>
<td>98.97%</td>
</tr>
<tr>
<td>to treat &lt; 31</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>days (as at March</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2016)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer: treated</td>
<td>85%</td>
<td>n/a</td>
<td>90.23%</td>
</tr>
<tr>
<td>within 62 days</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of urgent GP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>referral (as at</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>March 2016)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Womens expressing that they have had a good experience of maternity services is at 81%**

**Wakefield CCG (q2 16/17) 38 out of 40 practices surveyed**

<table>
<thead>
<tr>
<th>Total no</th>
<th>Total no</th>
<th>% of GPs</th>
<th>% of Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>of GPs</td>
<td>of Nurses</td>
<td>over 55</td>
<td>over 55</td>
</tr>
<tr>
<td>(FTE)</td>
<td>(FTE)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>245.41</td>
<td>137.90</td>
<td>11%</td>
<td>33%</td>
</tr>
</tbody>
</table>

**NHS Wakefield Clinical Commissioning Group**

**Locally Valued**
Developing the Wakefield Health and Wellbeing Plan with our Communities

Engaging with our patients and communities is always at the heart of all our work and alongside working with our patient reference groups and primary and secondary care workforce, we carried out a series of engagement events to help us develop our plans. These events allowed us to hear first-hand from the public, what their concerns are and what they value about services and how this fits with reducing the health and wellbeing, care and quality, and finance and efficiency gaps. These are some of their comments:

- Where safe and appropriate cheaper medicines should be prescribed
- Investing in health education is an effective way to increase health and wellbeing
- Where prescribed goods are readily available in shops or cheaper in shops they shouldn’t be prescribed
- The NHS should invest more and use digital technology to improve care
- Focus on early and quick diagnosis particularly in the case of cancer
- There should be investment in to developing resilient communities to reduce social isolation
- Extended access in primary care is needed to reduce A&E wait times
- People should take more responsibility for their own health
- Money for community services and public health should be ringfenced
- Investing in health education is an effective way to increase health and wellbeing

*NHS Wakefield Clinical Commissioning Group*
Wakefield Challenges to Outcomes – Reducing the Three Gaps

Radical reduction in hospital admissions where appropriate leading to reinvesting in prevention

New Accountable Care Systems to deliver new models of care

Collective prevention resource across the health and social care sector and wider social determinant partners

Expanded Health and Wellbeing Board membership to represent wider determinants

A strong ambitious co-owned strategy for ensuring safe and healthy futures for children

A shift towards allocation of resources based upon primary and secondary prevention and social determinants of ill health

Models of Care

Enablers

5 Year Outcomes

Priorities

Healthy living & Quality of life

Early years

Mental health

Long term conditions

Older people

Prevention & Early Intervention

Partnership

Evidence & Innovation

Personalisation

Inequalities

Enablers

NHS Wakefield Clinical Commissioning Group

Locally Valued
Wakefield outcomes 2020/21

Radical reduction in hospital admissions where appropriate leading to reinvesting in prevention

Building on the current integrated care models and learning from vanguards to design services to reduce hospital admissions where appropriate further and faster. Exploring using some of the savings where possible to reinvest directly in more preventative workstreams.

New Accountable Care Systems to deliver new models of care

Building on Connecting Care, designing a new accountable care system through removing traditional organisational boundaries. It will need to be primary care and community focussed, caring for the whole person seamlessly.

Collective prevention resource across the health and social care sector and wider social determinant partners

This allows us to move away from a traditional approach of prevention being the responsibility of Public Health to it being the responsibility of everyone. Working towards collective resources across the health and social care system and businesses beginning to take accountability for the health and wellbeing of their workforce.
Wakefield outcomes 2020/21

Expanded Health and Wellbeing Board membership to represent wider determinants

Expanding the membership of the strategic leadership of the Health and Wellbeing Board to include organisations outside of traditional health and social care sector. This will lead to work programmes also focusing on things which contribute to health and wellbeing such as skills, safety and poverty amongst others.

A strong ambitious co-owned strategy for ensuring safe and healthy futures for children

To have a strategy across all partners which has a true preventative approach to ensuring safe and healthy futures for children. This will include how we tackle issues such as:

- Child Poverty
- Skills for life
- Parenting Skills
- Worklessness
- Safeguarding
- Prevention
- Self Harm

A shift towards allocation of resources based upon primary and secondary prevention and social determinants of ill health

Through achieving the previous outcomes as a system we should begin to see a shift towards allocation of resources in different areas where appropriate, moving from a high percentage of costs in unplanned hospital admissions to more investment in prevention and wider determinants of health.
### Impacting on the Three Gaps

<table>
<thead>
<tr>
<th>Theme</th>
<th>17/18</th>
<th>18/19</th>
<th>19/20</th>
<th>20/21</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Smoking:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Development of Employer Health and Wellbeing workplace wellbeing charter encompassing smoking cessation. Smoking alliance to deliver smokefree play parks.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Measures:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Percentage of adults (16+) who are smokers</td>
<td>21%</td>
<td>20.5%</td>
<td>20%</td>
<td>19.5%</td>
</tr>
<tr>
<td>- Reduction in the percentage of lung cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• <strong>Health and Wellbeing Gap</strong> – reducing the level of smoking prevalence in the district will ensure increased health and wellbeing contributing to lower levels of respiratory disease and lung cancer. In particular reducing the number of women smoking at time of delivery will lead to more of our children and young people having better health in their first 1000 days and having healthier lives.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• <strong>Care and Quality Gap</strong> – through a joined up approach to commissioning across our health and social care system our patients will receive clear advice and access to smoking cessation services in the right place and at the right time.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• <strong>Finance and Efficiency Gap</strong> - a 2% reduction in smoking prevalence would result in a 2% reduction in attributable admissions, this would potentially give recurrent savings of £100,000 per annum.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme</th>
<th>17/18</th>
<th>18/19</th>
<th>19/20</th>
<th>20/21</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Obesity:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Development of a shared self care narrative. Working with employers across the private sector on healthy lifestyles. Tier 1-4 care pathway for managing obesity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Measures:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Percentage of adults (16+) with a self-reported BMI or 25 or higher</td>
<td>68%</td>
<td>67%</td>
<td>66%</td>
<td>65%</td>
</tr>
<tr>
<td>- Reduction in the number of patients newly diagnosed with diabetes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• <strong>Health and Wellbeing Gap</strong> – reducing the percentage of our adults in the district with a BMI of 25 and over will have a significant impact on health, reducing the risk of serious diseases such as diabetes, heart disease and cancers. In turn with a reduction in obesity in adults and a shared narrative across all partners there should also be an impact on the level of child obesity which would lead to better health outcomes for our children and young people.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• <strong>Care and Quality Gap</strong> – Through a shared self care narrative supported by a range of commissioned services including a specialist weight management service we intend to get Wakefield moving and to ensure that patients get the support and care they need.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• <strong>Finance and Efficiency Gap</strong> - estimated cost to the NHS in Wakefield of excess weight and obesity is £109 million p.a. in 2013, and increasing by £1m each year. Potential cost savings of £8m if target is achieved ie 5% more adults in Wakefield have a normal BMI.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Impacting on the Three Gaps

<table>
<thead>
<tr>
<th>Theme</th>
<th>17/18</th>
<th>18/19</th>
<th>19/20</th>
<th>20/21</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cardiology:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A shift to early detection and identification of long term conditions, through a skilled primary care workforce</td>
<td>47 per 100,000</td>
<td>44.5 per 100,000</td>
<td>43 per 100,000</td>
<td>42 per 100,000</td>
</tr>
<tr>
<td><strong>Measures:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Directly standardised rate of deaths from coronary heart disease of people aged under 75, per 100,000 population (3 years pooled data)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• <strong>Health and Wellbeing Gap</strong> – our prevention at scale workstream brings a shared approach to encouraging healthier active lifestyles which will not only reduce the amount of people developing long term conditions such as this but also reduces the possibility of admission to hospital and premature mortality.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• <strong>Care and Quality Gap</strong> – our work to ensure a skilled primary care workforce and e-consultation will lead to improved detection and identification of cardiology conditions. Alongside our shared self care narrative to support those with long term conditions we will ultimately over the life of our plan lead to 22 fewer deaths.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• <strong>Finance and Efficiency Gap</strong> – Through early detection and improved self management of long term cardiology conditions there will be a contribution to reducing the finance and efficiency gap by reduced emergency admissions.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme</th>
<th>17/18</th>
<th>18/19</th>
<th>19/20</th>
<th>20/21</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Respiratory:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work with primary and secondary care to implement National recommendations of care for both Asthma and COPD</td>
<td>21 per 100,000</td>
<td>20.3 per 100,000</td>
<td>20 per 100,000</td>
<td>19.5 per 100,000</td>
</tr>
<tr>
<td><strong>Measures:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Directly standardised rate of deaths from COPD of people aged under 75, per 100,000 population (3 years pooled data)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• <strong>Health and Wellbeing Gap</strong> – our work on reducing smoking prevalence will have a direct impact on improving the health and wellbeing of our patients, reducing the risk of developing respiratory disease. This will lead to reductions in asthma in adults and children and young people, in addition reducing the level of premature mortality for those with chronic obstructive pulmonary disease.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• <strong>Care and Quality Gap</strong> – through a shared narrative around self care we will be able to ensure those with respiratory problems are supported to self care where appropriate, avoiding where possible admission to hospital.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• <strong>Finance and Efficiency Gap</strong> – our work on respiratory would contribute to a reduction in smoking prevalence. A 2% reduction in smoking prevalence would result in a 2% reduction in attributable admissions, this would potentially give recurrent savings of £100,000 per annum.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Impacting on the Three Gaps

<table>
<thead>
<tr>
<th>Theme</th>
<th>17/18</th>
<th>18/19</th>
<th>19/20</th>
<th>20/21</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Frail Elderly:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Embed the Wakefield District Prevention Principles across older peoples services</td>
<td>2089</td>
<td>2055</td>
<td>2021</td>
<td>2000</td>
</tr>
<tr>
<td>Measures:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- A reduction in the rate of injuries from falls in people aged 65 and over per 100,000 population</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jointly with the Local Authority we will review pathways and seek to identify innovative ways of working together. We have a joint aim with the Local Authority to reduce the stigma of mental health and improve population wellbeing.</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Measures:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- An achievement of the 50% Improving Access to Psychological Therapies (IAPT)recovery rate and access standards for early Intervention Psychosis service and IAPT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Health and Wellbeing Gap** – our Connecting Care programme aims to maximise the health and wellbeing of our older people and through identifying those most at risk of falls and supporting them we are able to increase health outcomes and minimise the possibility of admission to hospital.

**Care and Quality Gap** – our approach to multidisciplinary teams in our Connecting Care programme ensures that we are able to provide the best quality care to avoid incidences of falls and to provide services in the right place at the right time to support patients to stay in their home safely.

**Finance and Efficiency Gap** – through a planned approach to reduce the risk of repeat falls by identifying people at risk and referring them for appropriate medication and falls prevention services could lead to potential savings of £77 per person seen.
# Impacting on the Three Gaps

## Developing a New Care Model in Wakefield – Multi Speciality Community Provider

<table>
<thead>
<tr>
<th>Theme</th>
<th>17/18</th>
<th>18/19</th>
<th>19/20</th>
<th>20/21</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health and Wellbeing Gap</strong></td>
<td>Increased integration and managing condition / disease pathways</td>
<td>Migration of services into the MCP and increasing ability to accept risk</td>
<td>Commission the MCP as an ACO on through a capitated contract</td>
<td>Accountable Care Organisation created</td>
</tr>
<tr>
<td><strong>Care and Quality Gap</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Finance and Efficiency Gap</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Health and Wellbeing Gap
- through our new MCP people will be encouraged and supported to be healthy by having access to advice and information which is clear, up to date and consistent and being able to live in safe and positive communities. This will in turn improve the health and wellbeing of our patients and increase opportunities for their future health.

### Care and Quality Gap
- the Wakefield MCP will facilitate greater standardisation of care pathways; better access to specialist care; the strongest leadership development with innovation at the heart of improvement initiatives; and the capacity and competence of the workforce to be strengthened providing better care and quality for Wakefield patients.

### Finance and Efficiency Gap
- the Wakefield MCP provides the opportunity for efficiencies of £54.5m overall (with net savings of £10.2m in 2020/21).

## Integration of Wakefield support services

<table>
<thead>
<tr>
<th>Theme</th>
<th>17/18</th>
<th>18/19</th>
<th>19/20</th>
<th>20/21</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health and Wellbeing Gap</strong></td>
<td>Virtual shared management team</td>
<td>-</td>
<td>-</td>
<td>Fully integrated support services</td>
</tr>
<tr>
<td><strong>Care and Quality Gap</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Finance and Efficiency Gap</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Health and Wellbeing Gap
- through having an integrated support services across the Wakefield system we will be able to not just have shared commissioning policies, but also shared policies around our own workforce. It will enable a shared narrative around the health and wellbeing of all our patients and employees, fostering a culture of self care in the district.

### Care and Quality Gap
- a shared support service across the health and social care sector in Wakefield enables the use of shared data and insightful business analytics to provide whole place and whole person commissioning therefore ensuring better care and quality for our patients.

### Finance and Efficiency Gap
- Creating a partnership service that brings organisational expertise in areas such as estates, commissioning, contract management and procurement together can drive both efficiencies and improve quality and leads to the potential opportunity of £27.15m of efficiencies.
What we will do

- Develop and implement a strategy to ensure Wakefield children and young people are healthy and achieve their potential.
- Develop an action plan to address the recommendations in the national maternity review owned by all partners of the Health and Wellbeing Board.
- We will address the review of the regional recommendations on still birth & bereavement & develop a plan for any remedial action required.
- We will continue to drive the choice agenda. We have published a Local Offer which sets out our plans for expansion of Personal Health Budgets to mental health, Learning disabilities and Special Educational Needs and Disability (SEND) in the first instance.
- We will develop pathways for transition to adult services which ensure that young people are prepared for adult life.
- We will maintain a focus on children through our Children and Young Peoples IAPT programme and the Future in Mind programme, enhancing dedicated crisis, intensive support and liaison service for children, young people and their families.
- Baseline the new Children and Young People Eating Disorder access and waiting time standard and subsequently deliver the standard.

How will we enable change?

Technology
- Using and sharing information across teams in our Early Help Hubs to support professionals and families.
- Increase the use of mobile working.
- Introduce a digital version of the Redbook, through this provide digital signposting to advice and guidance.
- Recognising that the millennial generation expects “digital by default”, therefore ensure services are available across channels to support parents using platforms they choose to use.
- Extending Schools App Challenge

Estates
- Exploring more opportunities for co-location of childrens services within early intervention hubs.

Workforce
- We will use Facing the Future standards to develop the right acute workforce model across primary and secondary care’

The Scale of the Challenge

- In 2012, there were 14,015 children aged under 20 years who were living in poverty, this is almost 20% of children.
- On average there are around 4,000 births each year in Wakefield.
- The proportion of women smoking during pregnancy is significantly higher in Wakefield (18.6%) than the regional (16.2%) and national (10.7%) averages.
- Breast feeding rates in Wakefield are amongst the lowest in the country.
- Each five year old child in Wakefield has on average 1.66 teeth that are decayed, missing or filled.
- Data shows that Wakefield has high rates of hospital admissions caused by unintentional and deliberate injuries.
- The rate of hospital admissions as a result of self-harm is significantly higher in Wakefield compared to both the national and regional averages, and the rate is increasing.
- It is estimated that in Wakefield there are around 4,260 children with clinically diagnosable mental health disorders, 9.6% of children.
- In the 2015 Children’s Survey, 16% of Year 9 pupils stated that they had been offered drugs (of any kind).
- It is estimated that there may be around 1,310 children in Wakefield who are experiencing domestic abuse.
- There are X number of children in care.

What will the impact be?

- A reduction in the percentage of children aged 10-11 classified as overweight or obese.
- A decrease in the percentage of women who are smokers at time of delivery.
- An increase in women’s experience of good maternity services.
- A reduction in the percentage of children living in poverty.
- A reduction in the number of children living in care and on the edge of care.
- A reduction in the rate of stillbirths and deaths within 28 days of birth per 1,000 live births and stillbirths.

Our Outcomes:

- **A strong and co-owned strategy for ensuring safe and healthy futures for our children and young people**
The Scale of the Challenge

• The number of people living with two or more conditions is rising rapidly and multi-morbidity is a more important driver of costs in the health and social care system than other factors such as age
• between 12% and 18% of all NHS expenditure on long-term conditions is linked to poor mental health
• In financial terms, at least £11 billion of NHS expenditure can be linked to mental health co-morbidities
• People with mental health problems use significantly more unplanned hospital care for physical health needs than the general population, including 3.6 times the rate of potentially avoidable emergency admissions
• Diagnosis and treatment of medically unexplained symptoms costs at least £3bn every year in England. MUS adds to pressures in primary care with these symptoms accounting for up to 30% of all GP consultations
• life expectancy for people with bipolar disorder or schizophrenia is 15 to 20 years below that of the general population, largely as a result of raised rates of cardiovascular disease and other physical health conditions

What will the impact be?

• An achievement of the 50% Improving Access to Psychological Therapies (IAPT) recovery rate and access standards for early Intervention Psychosis service and IAPT
• An increase in the estimated diagnosis rate for people with dementia
• An increase in the percentage of patients diagnosed with dementia with a care plan who have received a face to face review in the preceding 12 months.
• An increase in the proportion of people with a learning disability on the GP register receiving an annual health check
• A reduction in the reliance on specialist inpatient care for people with a learning disability and/or autism
• An increase in the promotion of good mental wellbeing, increased prevention of future mental health problems, and support pre-crisis point and during recovery

What we will do

Mental Health Transformation Programme (adults and children)
• Jointly with the Local Authority we will review pathways and see to identify innovative ways of working together.
• We have a joint aim with the Local Authority to reduce the stigma of mental health and improve population wellbeing.
• We will maintain a focus on children through our Children and Young Peoples IAPT programme and the Future in Mind programme.
• Alongside our local priorities, we will also deliver against the Healthy Futures Mental Health Programme objectives of; reducing Mental Health in-patient admissions, eliminating all out-of-area mental health acute placements, reducing unnecessary attendance at A&E for crisis episodes, reducing all inappropriate emergency service responses, reducing Mental Health Act detention in Police Cells and reducing number of suicides.
• Baseline the new Children and Young People Eating Disorder access and waiting time standard and subsequently deliver the standard.

How will we enable change?

Technology
• Online resources have a larger part to play in engaging and supporting our young people eg Kooth.
• Providing access, for those who choose to use it, to online Mental Health services eg “Minddistrict” (Rightstep 24/7).
• Using a person held record to maintain a digital diary
• Our suicide prevention programme aims to reduce suicides by targeting mental health stigma in key risk groups and supporting early intervention.
• Understanding mental health needs through detailed local intelligence about mental health morbidity.

Estates
• Working with Turning Point to develop 3 talking shops across the district.
• Developing co-location of staff with WDH and Connecting Care and early intervention hubs.
• Collaboration between the CCG, West Yorkshire Police, YAS and the three mental health trusts has secured funding to improve health based places of safety for people in mental health crisis.
• Tackling social isolation and improving resilience through a new social well-being service and small grant VCS fund.
• Improving mental well-being via lifestyle interventions delivered by public health services

Workforce
• Re-design of Clinical Support Workforce will see the extension of clinical apprenticeships, through to the development of Associate Nurses providing clearer career progression into professionally qualified nursing roles.
• Medical agency spend will be reduced over the next 12 months with recruitment of Consultants into a new Mental Health Acute and Community model of service.
• Workplace Well-Being charter and the Local Authority Good Growth Strategy.

Our Outcomes:

New Accountable Care Systems to deliver new models of care
**The Scale of the Challenge**

**Long Term Conditions Care Management**
- In 2014/15 in Wakefield 66.7% of people with a long term condition felt supported to manage their own condition, we need to do better to support more people.
- In Wakefield in March 2016 we had 8.5 personal health budgets per 100,000 population, lower than the regional and national average.
- The quality of life of carers (health status score) in Wakefield in March 2015 was 0.78 which is below both the national and regional average.
- Currently there are 25,200 people diagnosed with asthma in Wakefield. This is 7% of the population, compared to 6% nationally.
- We have around 10,200 people with COPD. This is 2.8% of the population – much higher than the 1.9% nationally.
- Premature mortality from COPD is much higher in Wakefield (21.52 per 100,000) than in England (17.70 per 100,000).
- In addition premature mortality from stroke is 21.5 compared to a national average of 13.5 and premature mortality from coronary heart disease is 54.4 compared to 40 nationally.

**What we will do**

**Long Term Conditions Care Management**
- A shift to early detection and identification of long term conditions, through a skilled primary care workforce.
- Through development of a shared self care narrative we will ensure that people with LTC are supported to take responsibility for self-care.
- Review clinical care pathways to ensure appropriate management of patients with LTC.
- Continue to develop multi-disciplinary teams to underpin new care models in the right place at the right time by the right person (as outlined in our two Vanguards, the Care Home Vanguard and West Wakefield Health and Wellbeing Ltd MCP).
- Develop a new Multi Speciality Community Provider Contract for a new accountable care system in the district.
- Continue to work across primary and secondary care to ensure that diabetes patients achieve all three of the NICE recommended treatment targets.
- Work with primary and secondary care to implement National recommendations of care for both Asthma and COPD.
- Review respiratory care pathways to ensure appropriate management of patients at all stages of the disease and including those with acute presentation of respiratory disease.

**How will we enable change?**

**Technology**
- Person held records and self-care apps will support people with LTC to understand their conditions and take greater responsibility for self-care.
- Share information across multi-disciplinary teams to underpin new care models in the right place at the right time by the right person.
- Encourage use of virtual consultations to support people in their own home.

**Estate**
- Integration hubs

**Workforce**
- Workforce framework - *Shaping the future together the Wakefield Connecting Care Integrated Workforce Framework*.
- Competencies – report and recommendations completed using the Frailty pathway.
- Workforce profiling – Wakefield Adult social care workforce report and high level health workforce data collected.
- Workforce Transformation (HR) group established and operational.

**What will the impact be?**

- Reduction in the number of Emergency Admissions for urgent care sensitive conditions.
- An increase in percentage of people with a long term condition feeling supported to manage their condition.
- An increase in the number of people with diabetes diagnosed less than a year who attend a structured education course.
- An increase in the percentage of diabetes patients that have achieved all the NICE recommended treatment targets.
- Improved outcomes for those living with respiratory disease as diagnosis and management meets national and local standards.
- Appropriate use of resources through adoption of best practice guidance which includes pharmacological and non pharmacological management of respiratory disease.

**Our Outcomes:**

- **New Accountable Care Systems to deliver new models of care**
What we will do

Older People: Promoting independence and ambition
- Work towards an age friendly district through the development of dementia libraries and our work on frailty falls for example
- Embed the Wakefield District Prevention Principles across older peoples services
- Moving towards a focus on preventative/self care to older peoples health
- Continue to build on the Care Home Vanguard to expand learning across the district
- Review of the dementia pathway with a view to transforming services for patients and meeting the Prime Ministers challenge on Dementia 2020
- Jointly develop a public health Dementia Health Action Plan
- Ensure that care plans and patients notes are shared across care settings.
- Ensure that a greater number of calls result in a patient speaking to a clinician via a clinical hub.

How will we enable change?

Technology
- Moving towards a focus on preventative/self-care to older people’s health using digital signposting as an additional channel
- Continue to build on the Care Home Vanguard to expand use of NHSmail and SystmOne to better support older people
- Develop of virtual consultations to support people in their own home or in a care home
- Implement remote and assistive technologies to support people at home

Estates
- Development of the Waterton Integrated Hub to facilitate effective delivery of Connecting Care
- Development of the Castleford Integrated Hub in line with the wider provision of primary and secondary care.

Workforce
- Create and roll out a Wakefield Connecting Care customer care strategy and training programme – based on local best practice and offered to relevant frontline staff

Our Outcomes:

- A radical reduction in hospital admissions where appropriate leading to reinvestment in prevention
- New Accountable Care Systems to deliver new models of care

What will the impact be?

- A reduction in the percentage of deaths which take place in hospital
- A reduction in the rate of injuries from falls in people aged 65 and over
The Scale of the Challenge

- In Wakefield in Q3 2015/16 86% of people with an urgent GP referral had a 1st definitive treatment for cancer within 62 days of referral, lower than the national average.
- In 2013 68.6% one year survival from all cancers, significantly lower than the national average, this is a particular challenge for lung cancers.
- In 2014 Cancer patient experience was rated as 0.87 which again is significantly lower than the national and regional average.
- We know that Lung cancer mortality in deprived parts of the District is three times higher than in affluent areas.
- In Wakefield District 42% of lung cancers are diagnosed via emergency presentation (37% at Stage 4).
- In Wakefield we achieve below minimum targets for bowel (56% compared to a 60% target and cervical (77% compared to an 80% target) screening.
- Smoking prevalence (linked at least 14 cancers) was 21.9 in 2014/15 which is higher than the national (18.4) and regional (20.5) average.

What we will do

- We will develop programmes of work under the six recommended work streams of the national cancer strategy as detailed on the next page and aligned to the West Yorkshire Cancer programme.
- We will have an initial focus on Lung, Breast, Prostate and Bowel cancers.
- We will work towards an increase in five and ten-year survival, with 57% of patients surviving ten years or more.
- We will work towards an increase in one-year survival to 75%.
- We will work towards a continuous improvement in patient experience.
- We will seek to deliver a continuous improvement in long-term quality of life.
- We will seek to reduce smoking prevalence to 13%.
- Drive a national ambition to achieve earlier diagnosis.
- Establish patient experience on par with clinical effectiveness and safety.
- Transform our approach to support people living with and beyond cancer.
- Explore investing in the Urgent Suspected Cancer pathway to improve take up from 3% to 8%.

How will we enable change?

Technology
- We will seek to extend the use of e-referrals beyond lung cancers, particularly bowel and prostate.
- Work through the Local Digital Roadmap to drive interoperability in relation to online results.

Estates
- Utilisation of more diverse estates to pilot prevention schemes.

Workforce
- Embedding an ‘every contact counts’ approach to and referral to prevention services within all cancer commissioning and service development.
- Developing a local community based approach to Clinical Nurse Specialists.
- Development of an Employer Health and Wellbeing workplace wellbeing charter including employer approach to tackling smoking for example.

Research
- The WY Research and development team continue to work on behalf of all CCGs contributing to several cancer research studies with the aim of increasing the efficiency of the cancer diagnosis process. In addition they have a strong collaborative relationship with the Academic Unit of Palliative Care at Leeds University.

What will the impact be?

- An increase in the percentages of new cancers diagnosed at stages 1&2 as a proportion of all new cases of cancer diagnosed.
- An increase in the percentage of people with an urgent GP referral who had a 1st definitive treatment for cancer within 62 days of referral.
- An increase in the percentage of one year survival from all cancers.
- An increase in the rate of cancer patient experience.
- A reduction in the percentage of lung cancers diagnosed via emergency presentation.
- An increase in rates of screening for bowel, breast and cervical cancers.
- A reduction in smoking prevalence.

Our Outcomes:

A radical reduction in hospital admissions where appropriate leading to reinvestment in prevention.
<table>
<thead>
<tr>
<th>Prevention and Public Health</th>
<th>Early Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Joint commitment to West Yorkshire Trading Standards</td>
<td></td>
</tr>
<tr>
<td>• Employer Health and Wellbeing workplace wellbeing charter</td>
<td></td>
</tr>
<tr>
<td>• Breathe 2025, Tobacco Alliance, Smokefree playparks. Aspirational target for reduction to 13% in line with WYSTP</td>
<td></td>
</tr>
<tr>
<td>• Development of the Oral Health service</td>
<td></td>
</tr>
<tr>
<td>• Community Pharmacy Cancer signs and symptoms &amp; Community Pharmacy alcohol scheme</td>
<td></td>
</tr>
<tr>
<td>• Development of joint working between Specialist smoking cessation services with Wakefield District Colleges and between Wakefield Libraries and secondary school curriculum.</td>
<td></td>
</tr>
<tr>
<td>• GP Target events tackling primary care variation in referrals</td>
<td></td>
</tr>
<tr>
<td>• NICE guidance vs diagnostic capacity</td>
<td></td>
</tr>
<tr>
<td>• Ensuring delivery of the Local Digital Roadmap and development of interoperability.</td>
<td></td>
</tr>
<tr>
<td>• Delivery of the WYSTP cancer programme and diagnostics and WYAAT radiology workstream</td>
<td></td>
</tr>
<tr>
<td>• Extending e-consultations from lung to further cancers</td>
<td></td>
</tr>
<tr>
<td>• Investing in the Urgent Suspected Cancer pathway to improve pick up to 8%</td>
<td></td>
</tr>
<tr>
<td>• Development through the Local Digital Roadmap of inter-operability &amp; Online results</td>
<td></td>
</tr>
<tr>
<td>• Delivery of the WYSTP cancer programme and diagnostics and WYAAT radiology workstream</td>
<td></td>
</tr>
<tr>
<td>• Shared care pathways for cancer as a long term condition</td>
<td></td>
</tr>
<tr>
<td>• National survey of patient experience – recommendations to be addressed in an action plan locally and linking to WYSTP &amp; PROMS</td>
<td></td>
</tr>
<tr>
<td>• Developing a local community based approach to Clinical Nurse Specialists</td>
<td></td>
</tr>
<tr>
<td>• Living with and beyond cancer phase 3 programme – holistic needs assessment, treatment summaries, cancer care review (PC), health and wellbeing events – breast, colorectal and prostrate</td>
<td></td>
</tr>
<tr>
<td>• Risk stratified pathways (already in place for prostate – exploring extending to breast and colorectal)</td>
<td></td>
</tr>
<tr>
<td>• Links to WYSTP cancer programme and diagnostics and WYAAT radiology workstream</td>
<td></td>
</tr>
<tr>
<td>• Palliative Care Review</td>
<td></td>
</tr>
<tr>
<td>• Shared care pathways for cancer as a long term condition</td>
<td></td>
</tr>
<tr>
<td>• Maintaining strategic leadership through the Cancer Locality Group.</td>
<td></td>
</tr>
<tr>
<td>• Utilising Rightcare</td>
<td></td>
</tr>
<tr>
<td>• Safetynetting/linked to Local Digital Roadmap (LDR)</td>
<td></td>
</tr>
<tr>
<td>• Development of an implementaion plan to deliver the local cancer strategy including measurement of patient outcomes</td>
<td></td>
</tr>
<tr>
<td>• Learning from cancer peer review workshops</td>
<td></td>
</tr>
<tr>
<td>• Oral Health promotion service (contract lever to refer to smoking cessation reducing oral cancers)</td>
<td></td>
</tr>
<tr>
<td>• Recommissioning of Breastfeeding service</td>
<td></td>
</tr>
<tr>
<td>• Recommissioned obesity service</td>
<td></td>
</tr>
<tr>
<td>• Embedding of ‘every contact counts’ approach and referral to prevention services within all cancer commissioning and service development</td>
<td></td>
</tr>
<tr>
<td>• Local Cancer Dashboard</td>
<td></td>
</tr>
</tbody>
</table>
The Scale of the Challenge

We know that demand for emergency and urgent care services is rising. We also know that when people are in crisis they need to be able to access services easily and quickly, so in the past many access points and different services have been put in place. But when people are in crisis it is difficult for them to make rapid decisions with complex service offers, so urgent and emergency care access needs to be intuitive. We also know that the demographics of our population is changing and we need to ensure that we plan for this change. Modernisation of urgent care outside of hospital to ensure it co-ordinates better and is more responsive to patients needs is also a key dimension. When engaging with our population improving access to urgent care out of hospital has been shown to be important. People have supported the idea of having a GP or primary care within the emergency departments and highlighted as we expected that they would like to be seen as soon as possible. Our approach locally is to use the feedback we have received and national evidence to design an urgent care system which works best for our local people.

What we will do – Our Local Approach

We know that demand for emergency and urgent care services is rising. We also know that when people are in crisis they need to be able to access services easily and quickly, so in the past many access points and different services have been put in place. But when people are in crisis it is difficult for them to make rapid decisions with complex service offers, so urgent and emergency care access needs to be intuitive. We also know that the demographics of our population is changing and we need to ensure that we plan for this change. Modernisation of urgent care outside of hospital to ensure it co-ordinates better and is more responsive to patients needs is also a key dimension. When engaging with our population improving access to urgent care out of hospital has been shown to be important. People have supported the idea of having a GP or primary care within the emergency departments and highlighted as we expected that they would like to be seen as soon as possible. Our approach locally is to use the feedback we have received and national evidence to design an urgent care system which works best for our local people.

What will the impact be?

- Delivery of 90% single care record (or equivalent) viewing in all Urgent and Emergency Care settings.
- Delivery of 90% eDischarge from Acute and Mental Health providers to GPs
- Joint governance across local urgent and emergency care providers
- Clinical hub containing (physically or virtually) GPs and other health care professionals

Glossary:

- HST - Hear, see and treat service, as delivered through the West Yorkshire Urgent and emergency care vanguard
- ED – Emergency department
Why specialised commissioning?
• Mortality in West Yorkshire (causes of deaths all ages, SMR 2008-2012) is significantly worse than England and specialised services impact on all of our biggest killers
• In West Yorkshire the increase in children & young people, coupled with >65 will be key demographic drivers with impact on neonatal specialist services, CAMHS & place based priorities linked to long term conditions e.g. cardiovascular disease & cancer
• The region is more deprived than England with important sub-geography differences & impact on patient flows & sustainability
• The ethnically diverse population of West Yorkshire will also impact on specialised services e.g. genetics, cystic fibrosis
• Population health risk factors are worse than England average with scope to look at whole pathway approaches where the greatest benefit can be gained
• Variation exists in costs, quality and outcomes across the region
• Workforce sustainability challenges
• National growth assumption expenditure will increase on average by 4.7% for each year until 2020/21 and six services account for 50% of this projected growth (chemotherapy, Secure Mental Health, Neurology, Neonatal Intensive Care & Neurosurgery)

Why prioritise on a WY footprint?
• Specialised commissioning has the single largest contract value in West Yorkshire (£500m) this is lower than the average per capita expenditure for the North of England
• Opportunity to improve alignment between NHSE and West Yorkshire developments to maximise the opportunities to address the key gaps and strengthen the focus on earlier intervention and prevention strategies
• Opportunity to created a shared understanding across all stakeholders (population, workforce, commissioners and providers) of the ‘tiering’ and ‘care bundle’ concepts and processes which will inform which specialised services should and could be provided across a bigger geography
• In order to maintain sustainability of services due to financial or workforce challenges, there must be a West Yorkshire or Yorkshire and Humber approach to the delivery of specialised services

Delivering Transformational Change
A number of delivery programmes will drive the specialised commissioning ambitions, with direction from a steering group of stakeholders drawn from wide range of organisations and roles, also comprising business support functions such as communications, BI and finance.

This board will have interconnections and support from;
• Patient engagement and participation groups
• Other priority workstreams where there is an interdependency (mental health and cancer)
• Relevant networks, bodies and organisations to the specific programme
What we will do

- Where we have concerns about quality of care in any setting we will share with the West Yorkshire Quality Surveillance Group and with the CQC. We will continue to work with MYHT to implement the findings from the CQC inspections and act as a critical friend to ‘test’ the impact of the improvements for local patients through our programme of patient safety walkabouts to the ward and service areas.
- As lead commissioner for Yorkshire Ambulance Service, we will continue to seek assurance and work with the trust on the implementation of its actions following their requires improvement rating in 2015.
- We will finalise a Local Offer during 2016 which will set out which areas for expansion of PHB we will focus on first and outline a plan for future growth. The Local Offer will include plans for people with Learning disability, mental health needs and for children with EHC plans.
- We will continue to drive forward improvement through our Quality Premium measures and our constitutional targets

How will we enable change?

- Technology
  - We will continue to work regionally to develop a PACS programme.
  - We aim to develop a digital patient record (Shared Care Record) with key data shared and accessible across settings and providers.
  - We will continue to ensure where appropriate that E-referrals are the primary route to referring in to secondary care.
  - We will continue to expand the number of specialities where e-consultation is available to ensure the best advice at the right time in the right place.

- Estates
  - Using ETTF to ensure safe and high quality premises in a primary care setting

- Workforce
  - Recruitment and retention programmes in MYHT

Our Outcomes:

- A strong and co-owned strategy for ensuring safe and healthy futures for our children and young people
- A radical reduction in hospital admissions where appropriate leading to reinvestment in prevention
- New Accountable Care Systems to deliver new models of care
The Scale of the Challenge

NHS England has published seven ‘RightCare Packs’ the information contained within each is designed to support local discussions and inform a more in-depth analysis around common conditions and pathways. These packs covering cancer; the CVD family of conditions, including diabetes; maternity and early years; mental health and dementia; MSK; neurology; and respiratory aim to help CCGs and their wider health economies identify the best opportunities for improving value for their populations in these high level programme areas. They then explore the variation within each programme to show which specific areas along a pathway the CCG might want to prioritise. In Wakefield the scale of opportunity to explore here is c£9m. In addition locally in our acute trust there is an ambition and a need to reduce unwarranted variation in areas such as pathology, procurement, medicines optimisation, non-specialist acute hospital costs, on the ward, in estates, in sickness and absence and in orthopaedics as set out in the Carter recommendations.

What we will do

The CCG has now set out new ways of working which will ensure that we can demonstrate a clear process through which transformation can happen, with consistent clinical engagement, cross organisation input with prevention at the heart of all transformation. In particular through the introduction of a ‘plan, review, deliver’ model which by using RightCare packs as a starting point for exploration, we are able to drive transformation through a Joint Better Value Group, Joint Modelling / Analytics / Intelligence Group and Clinical Cabinet Approvals Group. Our Acute Trust is fully engaged with the Carter programme and will continue to proactively explore opportunities regarding efficiency. As part of developing the Trusts future five year strategy the board is identifying key partnerships that will support sustainability and efficiency. Mid Yorkshire is an active part of the West Yorkshire Association of Acute Trusts and the South Yorkshire Working Together Partnership. These programmes have specific workstreams looking at collaborative working, service sustainability and estates.

How will we enable change?

Technology
- Development and procurement of Programme management systems to monitor major transformation programmes.

Estates
- Explore through the Local Estates Strategy and Local Estates Forum working towards One Public Estate and to identify opportunities for sharing elements of facilities management.

Workforce
- Introduction of a Joint planned care Transformation programme across the Mid Yorkshire Hospital footprint
- Introduction of a Joint Clinical Leaders Forum
- As part of the response to the Carter recommendations for the Acute Trust to develop plans to reduce agency spend and develop, retrain and retain a workforce with the right skills and values
- Development of Integrated multidisciplinary teams to underpin new care models

Our Outcomes:
- A radical reduction in hospital admissions where appropriate leading to reinvestment in prevention
- A shift towards allocation of resources based upon primary and secondary prevention and social determinants of ill health

What will the impact be?
- Improved provider efficiency of at least 2% p.a. including through delivery of Carter Recommendations, leading to reductions in the finance and efficiency gap.
- Efficiencies in the Wakefield Health and Social Care System through the exploration of RightCare opportunities, leading to reductions in the finance and efficiency gap.
Working across the Mid Yorkshire Hospital Trust footprint

Our local Trust, through the implementation of the ‘Striving for Excellence’ Strategy aims to be an integrated care organisation, delivering comprehensive and seamless services across community and hospital pathways. Working closely with the wider health and social care economy, the overarching aim is to develop care pathways that provide services to patients in the right place, at the right time by the right people.

The Mid Yorkshire Hospital Trust (MYHT) is continuing to progress the Acute Hospital Reconfiguration as part of the Meeting the Challenge (MTC) programme. The Reconfiguration is rooted in the need to provide services differently across the Trust’s three sites to ensure quality and safety are maintained. The programme enters a critical phase of implementation in 2016/17 and 2017/18. The key system changes which underpin this are:

• The re-profiling of A&E services provided from the three hospital sites;
• An integrated approach between acute, primary care and community services;
• Delivering services 7 days per week;
• Centralising some services to improve quality and safety; and
• Greater reliance on delivery of urgent services outside of hospital and providing elective services, outpatient, day case and inpatient surgery, at the closest hospital to where a patient lives.

Implementation of clinical threshold management.
As a programme of work this involves:

• Providing consistent clinical information, including care pathway information, to primary care clinicians at the point of potential referral;
• Adoption of technology approaches, including e-consultation, and similar approaches for primary care clinicians to share information and opinion quickly and securely with secondary care;
• Training opportunities for clinicians on “shared decision-making”, how patients can make informed decisions, in conjunction with their clinician, on what subsequent care they require.

Planned Care Transformation
We have an agreed framework for transformation of planned care built upon effective clinical threshold management and robust pathways of care as a key theme of the Five Year Forward View and an essential enabler of the Meeting the Challenge reconfiguration of hospitals. In 16/17 we will accelerate the work already underway with a clinical leaders forum of primary and secondary care clinicians to transform planned care across the Mid Yorkshire footprint.

The CCG is seeking to build on the positive working relationships they have developed with North Kirklees and the Mid-Yorkshire Hospitals NHS Trust and In partnership there will be a focus on:

• Managing growth for non-urgent, non-cancer referrals from primary care;
• Understanding and tackling any unexplained variation in non-urgent, non-cancer referrals from primary care;
• Promoting the use of e-consultation to minimise the need for primary care referrals for face-to-face outpatient appointments;
• Supporting secondary care clinicians to initiate e-consultations with primary care, as an appropriate alternative to an outpatient referral;
• Re-looking at services which require provision in a hospital environment and those that do not;
• The potential to minimise hospital face-to-face outpatient follow-ups by primary and secondary care clinicians adopting shared-care protocols and revised care pathways.
Working across the Mid Yorkshire Hospital Trust footprint

7 days services
The MYHT continues to seek to make progress towards the delivery of the 10 Keogh Clinical Standards for seven day working. During 2016/17, the Trust was invited to join the national drive towards seven day services as a phase 1 early implementer. As such there is a focus on the delivery of the four priority standards most likely to have an impact on the mortality risk associated with weekend admission to hospital.

The Trust currently have a number of specialties where a consultant presence seven days a week already exists and these include Elderly Medicine, Emergency Medicine, Acute Medicine, and Obstetrics & Gynaecology.

As part of the early implementer programme the Trust has identified a high level action plan and submitted this to NHS England. This plan identifies the broad actions and timescales.

West Yorkshire association of acute trusts
Is an innovative collaborative which brings together NHS trusts delivering acute hospital services from across West Yorkshire and Harrogate to drive forward the best possible care for our patients. Their vision is to create a region-wide efficient and sustainable healthcare system that embraces the latest thinking and best practice so they can consistently deliver the highest quality of care and outcomes for our patients.

WYATT has specific work streams looking at collaborative working, service sustainability and estates. It is expected that over the next five years these collaborations will support the more efficient provision of services across wider geographies. As part of developing the Trust’s future five year strategy, the Board is identifying key partnerships that will support sustainability and efficiency.

The MYHT System Oversight and Assurance Executive
The MYSOA proposes a change to the way in which strategic leaders come together across the Mid Yorkshire health and social care system to take ownership and drive the development of resilience planning and transformational change in the delivery of healthcare across the local Mid Yorkshire system, aligning organisational priorities and plans to deliver the best possible outcomes for patients.

This framework recognises the need to continue to transform local hospital and community services underpinned by integrated health and social care and sustainable primary care services, building upon the transformation work already being undertaken, whilst maintaining resilience. The system blueprint for Mid Yorkshire will cover all areas of NHS England and CCG-commissioned activity as well as local authority commissioned services and will continue the journey of integration with local authority services and other partners as necessary.

The MYSOA will oversee a number of different specific delivery plans, some of which will necessarily be on different geographical footprints. For a number of services and pathways within Wakefield and North Kirklees these footprints may extend across West and into South Yorkshire.
New models of Care – Primary Care Transformation and Delivering the GP Forward View

The Scale of the Challenge

General practice faces the twin challenges of rising demand (rising population and population needs, increasing demand for service and increasing complexity of the problems presented due to age and co-morbidity) and constrained resources (inadequate funding, increasing workforce shortages and underdeveloped alternatives to traditional models of care).

How will we enable change?

General practice must become more integrated into wider health and social care provision:

**Workforce**
- Revising the skillmix and increasing the training capacity for the new workforce which these changes will require across organisations to provide integrated care
- Pooling resources, including estates and staff, with other care providers in order to maximise efficiency and resilience

**Technology**
- Using digital technology to provide information, advice and care navigation in order to improve access to appropriate care.
- Ensuring the availability of the single care record in the integrated hubs.
- Establishing sharing of care plans and patient notes.

**Estates**
- Pooling resources, including estates and staff, with other care providers in order to maximise efficiency and resilience
- Supporting the Local Estates Forum to ensure forward thinking planning around estates and primary and community care access.

What we will do

General practice must work differently in future:
- Support prevention and navigate patients to non-medicalised support
- Improve and streamline access for more straightforward episodic healthcare
- Reach out to groups who find it hard to access primary care and would benefit
- Provide more time to contribute optimum clinical management to the care plans of chronically ill, frail, vulnerable and medically complex people
- Work more closely with specialists to increase the scope of out of hospital clinical care
- Work with commissioners to develop the new MCP contract

What will the impact be?

These changes will keep more people from needing care, match those who need care with the right service and reduce duplication and confusion within the care system to improve the experience of people who need care, improve the working lives of those who provide care and reduce costs to help fund service improvement. There will be delivery of 80% e-referral service utilisation in primary care and 25% of patient utilisation in 16/17 and 50% in 17/18.

Our Outcomes:

- **New Accountable Care Systems to deliver new models of care**
- **A radical reduction in hospital admissions where appropriate leading to reinvestment in prevention**
New models of care

The Wakefield MCP Vanguard’s - Vision is to reconfigure both the provision of services and the culture of care delivery, to enable the identified Wakefield population to live safe, happy and healthy lives at home for as long as possible. Health and social care organisations working together wrapped around GP practices, statutory & voluntary organisations, commissioners and providers.

West Wakefield Health & Wellbeing Ltd is made up of a network of six neighbouring GP practices in Wakefield. These practices work together to provide the best possible healthcare for the local community. In total they are responsible for around 65,000 patients.

They are already delivering and developing services that include:

- Extended access to evening and weekend appointments with doctors, nurses and other health professionals
- Pharmacists working alongside health workers to make sure people get the right medication.
- Better joined-up working between health, social and community workers for older, vulnerable people.
- Innovative use of digital technology to help people look after themselves better at home and find the right services for them.

Enhanced Care Homes Project - The model of care is designed to break the mold for older people in care homes, providing proactive healthcare support, tackling social isolation and shifting from fragmented to connected care. We have developed a comprehensive approach to proactive assessment and care planning based around the wider determinants of health ‘somewhere to live; someone to love; something to do’ to optimise residents’ health and life experience. The year 2 approach is to continue with the phase one implementation throughout 16/17, initial 13 homes, and two extra care schemes plus an additional three homes, approximately 1005 residents.

The benefits feed into the Connecting Care Integrated Services Targets and include:

- Reduction in ambulance call-outs;
- Reduction in A&E attendances;
- Reduction in emergency admissions;
- Improved outcomes for individuals;
- Improved experience for individuals;
- Improved skills for care home staff;
- Reduction in social isolation.
New models of care – Wakefield MCP

“Creating person centred co-ordinated care” is the agreed Wakefield Vision and lies at the core of everything we strive to achieve working with our partners in Connecting Care Health and the Social Care Partnership. The Multi-specialty Community Provider (MCP) model is about integration and removing historical barriers that have prevented joined-up preventative patient care across primary, community, mental health, social care and acute services. The MCP provides a core platform from which radical change and improvement in the ways in which communities interact with health and social care services can be developed and sustained.

Wakefield CCG is one of six CCGs in the country chosen by NHS England to develop an MCP model. The MCP model is an opportunity that can help Wakefield address its health, quality and financial gaps by continuing its system transformation and ensuring we tackle the big issues relating to the role and scale of the hospital services in our health economy.

This model means developing and embedding innovative patterns of engagement throughout a system that currently exists in separate parts. The promotion of public health, effective deployment of multi-disciplinary teams, ease of access for the public to services, and the best use of technology are all elements which cannot operate in isolation and must be utilised and delivered in collaboration in order to fulfil the aims and opportunities available.

A successful MCP will see care delivered closer to home, fewer trips to hospital, improved co-ordination of support, better access to specialist care in the community, and a promotion of public health and wellbeing and the tools for greater self-care. This embodies an approach to improve person centred care for the people of Wakefield by ensuring communities achieve the best possible outcomes for themselves and their families, facilitated by coordinated services, provided as close to home as possible.

What is an MCP?

- More investment in primary and community care
- Social care needs considered holistically with physical health and care needs
- Less spending on hospital-based care
- Pilot Mental Health offer into Hubs (phase 2)

Care co-ordinated around the individual

- Care in the most appropriate setting
- Funding flows to where it is needed

What is an MCP?

- Joined up health and social care
- Organised around people’s needs not historic organisational structures
- One set of records shared across organisations

- Multidisciplinary home care teams
- Fewer people treated in hospital: those that are leave sooner
- More specialist support for people in the community
The Wakefield Finance and Efficiency Gap

As a Health and Social Care Sector we commissioned PWC to carry out some analysis of our finance plans in order to identify the emerging gap. This scenario is the gross five year view of sustainability based on the aligned assumptions. The impact of transformation and efficiency programmes (including Connecting Care, QUIPP, CIP etc.) programmes are not included in this scenario. In summary the analysis told us that the Wakefield care economy is facing an in year deficit of £229m in FY 20/21, which is equivalent to 13.9% of gross system revenue. The cumulative total of in year system deficits is c. £714m.

As a result of this analysis, the following graph illustrates the growth of the gross deficit over 5 years:

**Scenario 4 - Wakefield Health and Social Care economy – five year financial gap projection FY15/16 to FY20/21**

- **£63.826m** – Year-on-year deficit in FY 15/16
- **£86.114m** – Year-on-year deficit in FY 16/17
- **£121.065m** – Year-on-year deficit in FY 17/18
- **£156.217m** – Year-on-year deficit in FY 18/19
- **£181.678m** – The in year deficit in FY 20/21

This is equivalent to 15% of gross system revenue.

However, following the publication of ‘Strengthening Financial Performance and Accountability’ and new allocations, this situation altered in light of the new assumptions contained within it. The Wakefield Health and Social Care system is now facing an in year deficit of **£229m in FY 20/21**, which is equivalent to 13.9% of gross system revenue. The cumulative total of in year system deficits is c. **£714m**.
The Wakefield Finance and Efficiency Gap

Transforming to become a sustainable economy

Meeting the challenge

We assess that there is significant risk attached to Wakefield’s ability to deliver transformation and efficiency. Addressing Wakefield’s sustainability challenge requires a new approach in which existing transformation programmes are reinforced with more wide ranging and innovative change across both the commercial and operational elements of the business model. Future system transformation will need to expand beyond service re design and front line coordination to include new approaches to commissioning; the delivery of critical system enablers (estates, workforce and digital) and options for delivering key support functions (HR, procurement, back office etc).

Taking such a comprehensive approach will amplify the benefits from existing front line service integration. Typical areas of transformation are summarised below.

Closing the gap in Wakefield

Our work with care economies across the North and with STP footprints nationally have identified three key transformation opportunities going forward:

1. **A fully integrated model of accountable care.** Integrating front line services and transforming contracting and payment mechanisms to enable an accountable care organisation to proactively manage demand.

2. **An optimised back office for Wakefield.** Developing a new business model for the provision corporate functions and corporate services across Wakefield, including estates, workforce and digital.

3. **Collaboration between acute care providers.** Transforming the provision of acute care at the regional or sub regional level.

---

**Strategy**

- Establishing the financial case for change and developing and agreeing the outcome framework

**Design**

- Agreeing the population and scope of services; developing the organisational design and implementing service transition

**Governance**

- Agree governance structure and arrangements; develop corporate processes and adopt new governance model

**Finance**

- Agree financial baseline; due diligence of commercial contracting; transition to new payment

**Contracting**

- Identify key contracting processes; secure legal and tax advise; develop payment mechanisms and negotiate contracts

**Capability**

- Assess capability; engage with new partners and key stakeholders; negotiate contracts; implement capability building
Building on success

Wakefield has received national recognition for the Connecting Care Programme that is bringing a more integrated model of community, adult social care, mental health and primary care to Wakefield. Since 2014 Connecting Care has been driving improvements in patient quality and experience including:

- Care is co-ordinated and seamless.
- Nobody is admitted to or kept in hospital or residential care unnecessarily.
- People are supported and in control of their condition and care, enjoying independence for longer.
- Care is cost-effective and within available budgets.
- All staff understand the system and work in it effectively.
- Unpaid carers are prepared and supported to care for longer.

Realising the full potential of existing transformation plans

The Connecting Care Programme is already delivering qualitative benefits, in a survey of 500 service users:

- 59% shared that the services helped them stay at home rather than go into a nursing home or hospital.
- 70% shared that the services helped them stay more independent.
- 84.5% felt more involved in making decisions about their care.
- 81% now understand more about their medication.

Maturing the MCP

Developing a future model of integrated, accountable care for Wakefield in which demand is proactively managed could take a number of organisational forms (PAC, MCP & Alliance etc) but the most likely route in Wakefield is through a systematic maturing of the MCP Vanguard model.

Our assessment indicates that a full model of integrated, accountable care could be commissioned in Q1 of FY 19/20. The foundations for achieving the ambition must be prepared in FY 16/17 in order to allow for the complexity of contract design and commercial development in FYs 17/18 and 18/19.

Our recommended approach to developing a fully integrated accountable model of care is summarised on page 46.
The Wakefield Finance and Efficiency Gap

Wider benefits of a fully integrated model of accountable care

Transformation offers system wide benefits across health and social care services.

- Ability to introduce a range of financial incentives to steer the ACO to work on key pressures in the system, for example moving people out of hospitals and into a more appropriate care setting.
- Slow the rate of increase in healthcare spend.

- Become part of a provider group for a locality with influence over how services are delivered beyond primary care. Better for patients
- Potential for new business model for GPs – earn a share of profits as part of JV rather than try to make it work as a small business
- More control over workload

- Community healthcare could have a key role to play alongside as care-coordinators and accountable clinicians.
- Mental health on equal footing with rest of the system, with sustainable models for community mental health

- Can reduce pressures on key parts of the hospital due to better collaboration, for example A&E admissions
- More control of demand flows into the hospital and rehabilitation after discharge
- Profit share arrangements alleviate reduced income from investment in prevention

- New model for social care which is under massive pressure
- More influence over NHS providers
- Better care for citizens
- Key plank of devolution settlements

- Key plank of devolution settlements

- More influence over NHS providers

- Better care for citizens

- Key plank of devolution settlements
The Wakefield Finance and Efficiency Gap

Impact on the deficit

Assimilating experience from elsewhere

Achieving sustainability will require innovation from all partners. We have reviewed our work with other care economies to consider the potential impact of implementing the three opportunities summarised on pages 13 – 16. With the exception of Greater Manchester (GM) our experience suggests that few systems have considered the full impact of all interventions. This presents system leaders in Wakefield with the opportunity to build on its reputation for innovations and adopt a market leading position.

In each case we have used identified opportunities as a percentage of the forecasted “do nothing” deficit for FY 20/21 to give an indicative scale of the savings opportunity that maybe available in Wakefield. The sum impact of the proposed opportunities is £99.5m which equates to 55% of the gross five year deficit.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Integrated model of accountable care</td>
<td>27%</td>
<td>-</td>
<td>8%</td>
<td>40%</td>
<td>30% £54.3m</td>
</tr>
<tr>
<td>2. Integration of Wakefield support services (Estates / Workforce etc)</td>
<td>5%</td>
<td>23%</td>
<td>5%</td>
<td>-</td>
<td>15% £27.15m</td>
</tr>
<tr>
<td>3. Hospital chains &amp; acute care reconfiguration</td>
<td>8%</td>
<td>12%</td>
<td>9%</td>
<td>-</td>
<td>10% £18.1m</td>
</tr>
</tbody>
</table>
**The Wakefield Finance and Efficiency Gap**

**Closing the gap**

**Opportunity 2 – optimising critical enablers and support services**

**Future vision**

Existing corporate functions and services that are duplicated across multiple public sector organisations are brought into a single Wakefield support service. Creating a partnership service that brings organisational expertise in areas such as estates, commissioning, contract management and procurement together can drive both efficiencies and improve quality. These benefits can be further enhanced through the use of shared data and insightful business analytics to provide whole place and whole person commissioning. We see this as being a wholly owned partnership service delivering key enablers and support services rather than an outsourcing approach.

**Innovate to increase revenue**

Adopting a commercial approach towards the management of corporate services and critical enablers can create new revenue opportunities. Growing and developing a shared service relationships to a level where they can provide services to a new client base outside of Wakefield will amplify the impact of adopting this model.

Working with Cheshire West and Chester Council PwC identified that £5.5m of potential benefit for Adult and Children's Social services could be released through innovative approaches to commissioning and contract management.

- **Investing in People**
  - Sharing best practice solutions from across the sector, creating growth for Wakefield people

- **Insightful Decisions**
  - Harnessing the power of your data with a BI & Analytics hub to drive Insightful Decisions

- **Commernationally Thriving**
  - To deliver efficiency, growth and innovation on a sustainable basis

- **New Relationships**
  - To foster new relationships based on shared insight to whole place and whole person needs

- **Market Leading**
  - A leading edge solution designed to reinforce Wakefield's positions as innovative and proactive
The Wakefield Finance and Efficiency Gap

Closing the gap

Opportunity 3 – acute provider collaboration in West Yorkshire

Transforming across West Yorkshire

Many systems across the UK are looking to restructure the organisational and operational models of acute care. Greater Manchester has established a vision for a single provider of acute care across the city region and in South East London providers are integrating back office and clinical support services. Many organisations are looking internationally at the US and in Europe at different models of collaboration between providers or at the growth of hospital chains. The recent letter (28 June 2016) from the Chief Executive and Chair of NHS Improvement is further evidence of this trend.

If the Wakefield care economy is to achieve a sustainable position in five years it must look to the West Yorkshire STP for support in transforming the model of acute care. There are models that could apply at both the regional level through the WYAAT group or on a smaller scale with neighbouring providers. In South East London and elsewhere potential savings equivalent to 2% of expenditure have been identified.

Six opportunity areas

- Capitalise on collective buying power
- Standardise and consolidate business support services
- Capitalise on the collective estate
- Consolidate clinical support services
- Optimise the workforce
- Capitalise on digital opportunities

Networked clinical support services

Integrated at the front line

Shared back office

Retained sovereignty
## Risks to the Wakefield Health and Wellbeing Economy

### Health and Wellbeing Gap
- Risk of a lack of understanding of how to access appropriate health and social care services at the appropriate time
- Risk of reduction of public health grant
- Risk of not successfully implementing new MCP contract
- Lack of delivery of the Local Digital Roadmap
- Risk of not delivering workplace health programmes

### Care and Quality Gap
- Risks of reduction of care home provision across the district
- Risk of issues around recruitment and retention in provision of all health and social care
- Risk of adequate support to deliver ambitious plans for technology, workforce and estates to transform services
- Risk of not successfully implementing new MCP contract
- Lack of delivery of the Local Digital Roadmap

### Finance and Efficiency Gap
- Risk of unmitigated growth and demand in the existing system
- Risk of efficiency challenge being greater than deliverable through existing approaches including Carter and Rightcare
- Risk of funding for policy impact affecting system resources eg GP Forward View, Care Act, Public Health
- Risk of new investment requirements not being affordable in the current environment
- Risk that current planning assumptions change due to current pace of development