West Yorkshire and Harrogate
Health and Care Partnership

Developing the long term plan for the NHS – Questions

West Yorkshire and Harrogate Health and Care Partnership Response

Please return your response to joanne.rothery@wakefieldccg.nhs.uk by Tuesday 18 September 2018.

Section 1: Life stage programmes		
Life stage programmes: Early life		
1.1	**What must the NHS do to meet its ambition to reduce still-births and infant mortality?**	The starting point is to recognise the link between socio-economic status/levels of community deprivation and perinatal mortality – we should have an explicit aim to reduce levels of health inequality in the areas with the highest levels of deprivation. We should focus on supporting healthy lifestyles primarily in deprived communities. This requires co-ordinated work with LA and Third sector to focus on long term improvement of health in young women and teenagers. We should support the prevention agenda via a nationally led, co-ordinated, approach to the sharing of relevant public health messages to raise awareness of the importance of good pre-conceptual care, in forms that are accessible to all communities, to improve maternal and child health outcomes. Appropriate resourcing of sexual health services to support women to avoid unwanted pregnancies. Resourcing of local public health services to support this. We should continue to build on the plans outlined in Better Births to develop Local Maternity Systems to improve access and support shared learning to reduce variation in outcomes. This should include pre and post-natal mental health support for mothers, and link these services to the wider neighbourhood teams at 30-50,000 population.
1.2	**How can we improve how we tackle conditions that affect children and young people?**	This requires the development of system-wide, partnership working to address health inequalities, to include areas such as access to early help and support and acknowledging the impact of poor housing and environment on a child's health. We also need to tackle rising obesity in children and young people, and joint working between the NHS Council and Third sector should provide greater opportunity for active travel, increased safer spaces and improved access to healthy food. We should work to develop local pathways that are appropriately resourced to allow children and young people to be cared for as close to home as possible, with access to support and provision from specialist centres as required.

		Improve access out of hospital care through the development of hospital out-reach and community based provision. Ensure we have access to appropriately qualified clinicians to meet the needs of children and young people and during transition to adult services and ensure adult services take ownership of the transition pathways. We should also develop the health economics evidence base around the benefits of meeting the care needs of children and young people as early as possible and model future funding streams to reflect this.
1.3	**How should the NHS and other bodies build on existing measures to tackle the rising issues of childhood obesity and young people's mental health?**	**Childhood obesity:** See responses above. This could also include: • Ensuring health care/NHS facilities are healthy places to work and be cared for and represent those values solidly at every level. • Ensuring community led activities available at no cost to increase physical activity in inactive groups using behavioural insights approach. • Offering free schools based holiday childcare based solely around food, nutrition and cooking. • Making nutrition and childhood obesity conversations a standard part of antenatal care conversations with learning based support • Providing free out of school childcare, including healthy meals, for those in receipt of free school meals during terms time. **Young People's MH**: Ensure young people are supported earlier through CAMHS and national CYP IAPT roll-out, development of self-care apps and further anti-stigma promotion. Continued focus on early intervention services. Further development of partnerships with schools and other young person's services. Development of accredited high quality digital content to engage young people. Development of trauma informed care to ensure the impact of early years traumas are picked up. National campaigns and local investment to promote improving self-esteem and wellbeing services for young people.
1.4	**How can we ensure children living with complex needs aren't disadvantaged or excluded?**	Good consistent support for the whole family – underpinned by a more robust understanding of the child's needs. The NHS needs to work with social care in the development of communities and ensure parents and young children are part of this. Specialist health visiting and school nursing services must be protected as vital link to these families. Improved access to diagnostic services such as autism assessment or health assessment for Education Health Care Plan to unlock support services for these CYP. Also timely access to services that are often required for these children.

		Build on the good practice identified through the implementation of the 2014 SEND Code of Practice. Expand existing statutory guidance and good practice recommendations around early identification to include on-going support for children with complex needs, including appropriate support during transition in to adulthood. Develop and resource specialist nursing provision to provide one to one care and provide training to carers, educators and the voluntary sector to support children with complex needs to access specialist or mainstream education, respite care and leisure services/opportunities.
Life stage programmes: Staying healthy		

1.5	**What is the top prevention activity that should be prioritised for further support over the next five and ten years?**	Difficult to identify the 'top' prevention activity to be prioritised. Important issues identified include:
		• Tackling obesity;
		  ○ Make healthy food accessible to all, cutting reliance on cheap processed high carb food.
		  ○ Promoting exercise that isn't based on competitive. Create opportunities so that exercise is easier and safer.
		  ○ Actively address the high sugar, highly processed food diet of many people: at a national level through legislation and taxation
		• Drug and alcohol use is at epidemic levels and the impact on services is huge. Measures should be taken to improve addiction services. A recovery model is appropriate (as most services are currently based on) but they should be properly funded and held to account (contract management by public health is poor).
		• Promoting good mental health
		• Smoking
		
		We also need to tackle the wider underlying causes, including poverty and inequalities.

1.6	**What are the main actions that the NHS and other bodies could take to:** **a) Reduce the burden of preventable disease in England?** **b) Reduce preventable deaths?** **c) Improve healthy life expectancy?** **d) Put prevention at the heart of the National Health Service?**	• Support education into a healthy lifestyle without detracting from the need to have an NHS which is able to deal with illness when it arises. • Health and care integration needs to be viewed as inequalities issue. Consider role of NHS as anchor institutions. • Good quality primary care for all – to identify early and manage LTCs well. Recognise that more than 1 LTC is the norm and arrange services accordingly. • Social prescribing type approaches where take a holistic look at the person and consider wider determinants of health, and what is influencing behaviours and choices. • Funding mechanisms that incentivise prevention to be everyone's business. • Educate all health and social care staff in key the messages about physical exercise, healthy eating and reducing the impact of loneliness • Think differently about how spend NHS budget – we buy services rather than buying health and wellbeing. If we were buying health and wellbeing we would sort out the buses to improve air quality rather than on approaches trying to improve inhaler technique in children etc. Challenge because this overlaps with LA role.
1.7	**What should be the top priority for addressing inequalities in health over the next five and ten years?**	Inequality in health goes hand and glove with inequality in resource and opportunity. Evidence base on Health inequalities is clear –it is Marmot (poverty) – but this is long term. Need to see action at three levels: community based interventions, civic level and service based interventions (systems and scale). If this is about the NHS role and short term quick wins (so around five years) – evidence base is clear (see National Audit Office paper) – it is about identification and good treatment in primary care. Smoking, cholesterol and hypertension. Health and care integration needs to be viewed as inequalities issue. Isn't really featuring strongly at the minute. Frailty and functional decline in older age is an inequalities issue, with origins in childhood. Multi-morbidity is an inequalities issue.
1.8	**Are there examples of innovative/excellent practice that you think could be scaled up nationally to improve outcomes, experience or mortality?**	In Wakefield, look at the work Wakefield Trinity are doing to educate local children in the benefits of good nutrition and exercise, as well as being aware of the importance of mental health. https://wakefieldtrinity.com/disability-teams-enjoy-a-grand-day-out/ https://wakefieldtrinity.com/wakefield-trinity-community-trust-welcome-new-sports-partnership/ Population based partnerships taking system wide approaches. Eg Tobacco Alliances across a geographical footprint 15 minute mile in Scottish schools to reduce childhood obesity

		Innovative GP practices working with local councils to see patients as assets – walking groups, allotments etc. Health optimisation programmes – this has been supported for a while in relation to plastic surgery and IVF, eg supporting individuals with weight loss / smoking cessation. Needs to be further encouraged prior to routine surgery. Focus interventions on patients who are less engaged in their own health. PAMS should be available on GP clinical systems
1.9	**How can personalised approaches such as paying attention to patient activation, health literacy and offering a personal health budget reduce health inequalities?**	These approaches provide individuals with greater choice and feel involved and thus buy into methods to prevent or support care and treatment. By ensuring NHS Staff recognise inherent biases in system and their own role and behaviours in reinforcing status quo and designing services in such a way as counteract differences in health activation and literacy in deprived and hard to reach groups. Unless there is differential investment and support these approaches could reinforce health inequalities as uptake and benefit will be highest among the most affluent. It takes a long time to activate an individual who has low self-esteem and challenging socio-economic circumstances. New models of personalised integrated place based care services can support individuals through an approach that enables more personal understanding and responsibility of their conditions.
1.10	**What is the best way to measure, monitor and track progress of prevention and personalisation activities?**	Reviewing access rates across services on basis on need and disease burden. Reduction in mortality across different social and economic groups in the medium to long-term. The temptation to measure inputs in the short-term must be resisted but outputs such as weight loss, disease control, risk factor reduction could be used. Use of an appropriate Outcome Measure such as PAMs patient activation measure. Personal stories and patient experiences in relation to lifestyle changes that reduce Type 2 diabetes or hypertension etc are powerful and can motivate others.

Life stage programmes: Ageing well		
1.11	**What more could be done to encourage and enable patients with long-term health issues to play a fuller role in managing their health?**	Changed relationship between clinician and patient that reduces the dependency, is explicit about what each party's responsibility is (contract - a little like the contract that has been developed for flash glucose monitoring). Supporting individuals to age well by preventing the start of **frailty** and slowing its progression is critical. In 2017 the NHS in England became the first health system in the world to begin routine identification and assessment of older people living with frailty so that we can proactively identify those with the greatest needs, to target and plan their care and support in ways which prioritise what matters most to them. New approaches to meeting their needs have also been put in place across the country through new models of care. This is largely an education issue – we need to look at increasing voluntary sector and District Nursing Teams' input to promote this issue and the opportunity to encourage and enable patients to better manage their health should be taken at any health and/or social care contact. Improved coordination/integration of services to ensure consistent messages across professionals and organisations re how patients can support themselves and being clear on role of health services and responsibility of patient/public.
1.12	**How can we build proactive, multi-disciplinary teams to support people with complex needs to keep well and to prevent progression from moderate to severe frailty for older people?**	This is beginning to happen in West Yorkshire and Harrogate. Providers, Primary Care, the Local Authority and Commissioners are working together to agree a model that is suitable for the locality. We are progressing the development of integrated leadership teams in areas with populations of 30-50,000 and foster sense of joint responsibility for the local population whether at home, in care or in a hospital setting for a brief time. We are progressing better population health management approaches that proactively identify people earlier in the course of their disease and plans effectively for their management.
1.13	**What would good crisis care that helps prevent unnecessary hospital admissions for older people living with various degrees of frailty look like?**	A multi-disciplinary team (GP, Social Worker, Nursing, AHP, Third Sector, Community MH workers) in each area (30-50,000) with a clear list of who was "frail", common record, single governance, rapid access to dedicated specialist advice; and then increased capacity and integration between 111, 999, community nursing, community MH, Social care and GP (GP out of Hours) services to ensure all but the most acute (emergency) patients are accurately triaged and seen in community setting in a timely manner and avoid trip to A&E. A good example of this is the Virtual Ward Hub model in Bradford. This is multi-disciplinary and multi-agency with a CGA approach. Agreed protocols, response time and governance structure are all in place to provide support.

1.14	**What would be the right measures to put in place to know that we are improving patient outcomes for older people with various degrees of frailty?**	A set of measures which are locally defined and owned by the population living with frailty, providers and commissioners within a given 'place'. A&E Attendances in over 80s, Admissions and in particular admissions for issues such as dehydration, falls, and others that are either preventable or which should be managed in the community , Length of Stay, New admissions to long term care, Older People and carers reported satisfaction, the number of interventions per older person within the defined cohort.
1.15	**How can we ensure that people, along with their carers are offered the opportunity to have conversations about their priorities and wishes about their care as they approach the end of their lives?**	Implementation of Respect. Approach requires the conversations to take place. Clinicians would need training and support to have these conversations. Whole system needs to co-ordinate - care homes, emergency services and others. Changing the national message to make discussing end of life care normal and accessible – remove the stigma. Stop the 'heroic medicine' approach – support clinicians to know when to stop providing interventions that prolong life but do not improve individuals quality of life. In order to improve this we need to get better at recognising end of life in patients particularly those with frailty and dementia, and ensure we are having conversations much earlier with patients and their carer's. The challenge is how to ensure we offer equitable high quality end of life care for all patients, regardless of what illness they are dying from, their age or background. Maybe there should be consideration of a "Dying Well" section in this long term plan for the NHS document to encourage wider public debate and openness about dying.
1.16	**What are the main challenges to improving post-diagnostic support for people living with dementia and their carers, and what do you think the NHS can do to overcome them?**	**Challenges:** Significant challenge is the increasing numbers; slow decline leaving families uncertain what support can be accessed and when; families needing to address early together what will happen and what will be needed; providing emotional and possibly mental health support to carers and families. **Response:** • A new approach to the stigma of dementia needs to be identified. • Understanding the patient's prognosis and the services available. We should look to improve voluntary sector input to support this. • Specialist support into local teams looking after the frail cohort

1.17	**What is your top priority to enhance post-diagnostic support for people living with dementia and their carers?**	• Building capacity for those patients where behaviour becomes unmanageable i.e. lack of strategic planning of long term care capacity for complex dementia. This results in poor flow out of acute centres. • Education • Support networks • Clear care plan and understanding disease progression and options • Support for carer including respite
Section 2: Clinical Priorities		
Clinical priorities: Cancer		
2.1	**What should the top priority for improving cancer outcomes and care over the next five and ten years be?**	We want to build on progress to date , accelerate what we know works and embrace research and innovation to minimise the burden of cancer on our citizens and provide every person diagnosed with the highest chance of survival. Specifically we would like to see a focus on the following: • Increased public awareness and support for healthy lifestyle strategies (tobacco control, exercise, alcohol and diet) • Capacity building in diagnostic and treatment services to accommodate timely diagnosis and treatment of the growing cohort of people diagnosed with cancer – including workforce • Improved support to help people live healthy and productive lives post treatment and mitigate side/late effects of treatment
2.2	**What more can be done to ensure that:** **a) More cancers are prevented?** **b) More cancers are diagnosed early and quickly?** **c) People can maintain a good quality of life during and after treatment?** **d) People with cancer have a good experience of care?**	a) Prevention – more support for public health engagement and messaging on lifestyle choices and benefits of taking up screening opportunities; b) Early diagnosis • improve access to primary care so there are no disincentives to presentation • Ensure that GPs are not discouraged from referring patients whose symptoms/presentation are covered by Referral Guidance; • Consider expansion of screening/case finding programmes; • Consider alternative investigative service models e.g. Danish model/multidisciplinary diagnostic arrangements; • Align cancer access standards with evidence of impact on outcomes c) Quality of Life during and after treatment • Improve support to regain fitness and confidence during and after treatment – promote 'pre-habilitation' • Ensure treatment services are accessible and delivered as close to home as is clinically safe and effective; • Implement the Cancer Recovery Package consistently

		d) Experience of care • Do more to ensure patients are actively involved in decision making about their own treatment and care • Do more to promote a co-production approach to service improvement • Do more to ensure patient experience metrics are used to inform service developments/improvements
2.3	**How can we address variation and inequality to ensure everyone has access to cancer diagnostic services, treatment and care?**	• Allow greater local determination of local service delivery models to ensure patients are seen, treated and followed up in the most appropriate setting – based on rigorous use of outcomes and experience data – to reduce variation in access/quality/outcomes between tertiary centres and DGHs and support most effective use of challenged specialist workforce. • Promote a system level approach to commissioning and delivery based on regionally agreed site specific pathways. • Develop local community responses to the awareness and presentation challenge through the 30-50,000 model to reinforce national approaches on screening uptake, awareness campaigns etc • Recognise the significant additional work required by health and care staff in more challenged communities, particularly supporting symptom awareness and behavioural change e.g. tobacco control • Do more to track access and experience by socio economic and other groups
Clinical priorities: Cardiovascular and Respiratory		
2.4	**What actions could be taken to further reduce the incidence of cardiovascular and respiratory disease?**	More engagement with people to understand the need for better self-care and improved lifestyle. Prevention being better than cure. Getting people in communities to champion healthy lives and lung health. CVD is, generally, as a result of an unhealthy lifestyle. We need to get people to take responsibility for their health rather than poor health. Survivors of CVD are often positive role models and perhaps we need to take a different approach to health. **Respiratory** • Increasing public awareness on prevention of common respiratory conditions through national health campaigns • Access to effective smoking cessation programmes • Earlier diagnosis in primary care targeting high incidence areas and deprived populations • Effective tools for lung cancer screening • Public health measures to curb spread of contagious respiratory illnesses such as tuberculosis **Cardiovascular** • Public health measures that impact on the prevalence of established risk factors. This means meaningful

		regulation of high sugar foods, interventions to address obesity epidemic, reductions in smoking, increase physical activity – encourage walking etc. • Earlier identification of individuals with risk factors and targeted support and intervention to help those individuals address their risk factors including follow up. • Better support for genetic screening services for inherited cardiac conditions including Familial Hyperlipidaemia
2.5	**What actions should the NHS take as a priority over the next five to ten years to improve outcomes for those with cardiovascular or respiratory disease?**	**Respiratory** Empowering and resourcing primary care to be able to effectively manage common respiratory conditions and complex case management; Secondary care focussing on more specialist and complex work; Provision of adequate secondary care resources to be able to truly cope with demands for acute and long term respiratory care. **Cardiovascular** Start young with children, stopping smoking around schools, incentivising good healthy habits using role models that children will relate to. Working closely with public health and counsellors to reduce the number of unhealthy eating places and improve the content of the food they serve. We need to take action quickly and be firm in our approach if we are to make any kind of a difference. There have been major strides forward in the management of patients with established disease but increasingly long term follow up is a challenge. Primary care services need to be resourced to ensure they continue to actively manage patients with cardiovascular conditions rather than await discharge after the next acute episode. Patients should be encouraged and supported to engage with this for the long term.
Clinical priorities: Mental Health		
2.6	**What should the top priority for meeting people's mental health needs over the next five, and ten years be?**	i) **Children and young people's mental health services:** improved capacity to services ensuring much improved transition to adult services not solely based on reaching 18yrs. ii) **Core mental health services:** enhancing the core service offer for people with severe and enduring mental health problems which includes community mental health; acute inpatient care and complex care/rehab/AOT all of which have not received sufficient investment or focus nationally in recent years (consequence of targeted funding for specialist services) to either keep up with demand nor make the necessary transformation that is needed. Opportunity to develop multifunctional CMHTs for an integrated patient offer, rather than multiple fragmented teams (IHTT, EIP, AOT). iii) Develop a **comprehensive neurodevelopmental service** (including autistic spectrum, ADHD, Tourette Syndrome) that assesses across ages, treats the high rate of concurrent mental illness and provides consultation to allow other services to limit secondary harm.

2.7	**What gaps in service provision currently exist and how do you think we can fill them?**	• Transition services / children and young people – increased investment, regional collaboration, place-based integration. • Access to rapid diagnosis and support for autism and ADHD both in children and in adults. Small services do exist but not sufficient. • Services for people with chaotic lifestyles / people with a 'personality disorder' –increased investment, regional collaboration, place-based integration. • Culturally and religiously appropriate services, using broader assessment tools that acknowledge and allow for difference. • More nuanced and comprehensive model of primary care mental health support - one of the priorities / gaps in service provision is for there to be services provided for people who have experienced trauma who need more than IAPT but do not meet criteria for CMHT and for these trauma-focused therapies to be provided across the age range. • Access to specialist psychological therapies for people with SMI (should be on a par with IAPT). • Post diagnostic support in dementia. Services are commissioned to diagnosis then nothing until individual has significantly deteriorated. • Dual diagnosis for substance misuse/alcohol and mental health issues. Models very variable and generally restricted to recovery and treatment of the addiction only. Mental health in acute physical health services - building/investing in psychological therapies skill set.
2.8	**People with physical health problems do not always have their mental health needs addressed; and people with mental health problems do not always have their physical health needs met. How do you think we can improve this?**	• Develop fully integrated "one stop shop" services, integrating physical/mental health care for older people (and potentially for younger people with complex needs). ACOs/ICSs could be used to accelerate the process, particularly removing barriers caused by current organisational structures. • Need to review the current training of staff across nursing and social care to ensure that staff are equipped to deal with both physical and mental health issues. The medical mental health workforce could be extended using new roles including physician associates who are well placed to play a role in identifying multiple issues in those using services. • Mental health provision for physically ill people can be improved by building on the liaison service models which currently works well. It would be worth exploring a similar model for the reverse of specialist physical health in reach to mental health services. • Direct links between primary care and secondary care mental health services should be established /strengthened. General nurses could be embedded in CMHTs. Improve cross training of professionals to address low level needs.

2.9	**What are the major challenges to improving support for people with mental health problems and what do you think the NHS and other public bodies can do to overcome them?**	Need to work on the causes of mental health ie employment, poverty, addiction. This requires a cross-government approach. It can't be tackled by the NHS alone. Public understanding of MH improving but still a tendency especially among older generations to not see it on par with physical health – more work needed to change culture. Navigating the system. Need to improve integration and sign posting of services. Need to improve links with third sector. Continue with parity of esteem but in such a way that allows for greater integration of physical, mental and social care.
2.10	**How can we better personalise mental health services, involving people in decisions about their care and providing more choice and control over their support?**	
Clinical priorities: Learning Disability and Autism		
2.11	**What more can the NHS do, working with its local partners, to ensure that people with a learning disability, autism or both are supported to live happy, healthy and independent lives in their communities?**	**In relation to Autism only**. Reduce the waiting times for assessment and diagnosis of autism across the full age spectrum and ensure that both pre diagnostic and post diagnostic support is available in an easily accessible way. Reduce variation across the health and social care system in terms of what is and isn't available in terms of support ie standard offer Ensure services are flexible enough (both in terms of criteria for access and skills to support people with autism) to be able to respond to the differing needs of children and people with autism **In relation to LD/MH and Autism:** Awareness-raising of autism within primary and secondary health care provision for people who have a learning disability and mental health needs. This approach could mirror the national directive that supported the Dementia awareness work that has been very successful. This will support the sustainability of the work currently undertaken within ICS around autism Having a LD/autism champion within primary and secondary health care. Developing a joint pathway across health and social care that supports people with LD/MH and autism effectively –

		recognising that someone primary need or presentation may not necessarily be their diagnosis of learning Disability.
2.12	**How can we best improve the experiences that people with a learning disability, autism or both have with the NHS, ensuring that they are able to access the full range of services they need?**	Raise awareness of what Autism is amongst all service providers and ensure that our workforce has the skills to support people to access mainstream services (including both routine services such as primary care and dentistry and urgent care provision), with reasonable adjustment, to keep mentally and physically well and to maximise opportunities to live a fulfilling life (ie links to education, job opportunities, relationship support etc). More targeted approach to general physical health and wellbeing. Less reliance on specialised services and more on getting generic services LD and Autism friendly. Reduce waiting times for assessment and diagnosis (as above). Ensure physical environments of services are autism friendly.
Section 3: Enablers of improvement		
3. Enablers of improvement: Workforce		
3.1	**What is the size and shape of the workforce that we need over the next ten years to help deliver the improvements in services that we would like to see?**	As a primary goal we should focus on being more effective at workforce planning at both organisational, systems and national level. We need to have sufficient focus on non-medical workforce models including growth of advanced practice roles the development of other new roles using workforce transformation tools and development the non-registered workforce in order to maximise the contribution of existing teams. The workforce needs to be a system based workforce, organised to deliver pathways of care that transcend organisation boundaries. A lot of workforce capacity is wasted at the interface. Need to challenge the model of employment that reinforces the organisation silos. We need people who can move seamlessly and confidently between these worlds and be multi-skilled. We would also expect a greater emphasis on self-management and care at home, and an increase in family members and carers providing support, and that activity becoming a possible pipeline into the wider health and care workforce. Technology should also play a role in de-skilling some of the technical clinical roles and so increasing local delivery. So whilst the size of the combined health and care workforce might remain static, or even increase, there might be less people working in the NHS.

3.2	**How should we support staff to deliver the changes and ensure the NHS can attract and retain the staff we need?**	We need to work at scale (with STP's) and nationally to professionalise and modernise our efforts at promoting careers in health and social care to secure a talent pipeline. Retention activities should also be strategically focussed to help anticipate and plan for future retention challenges such as increasing number of working carers in NHS roles. We know that traditional work patterns and career expectations are changing. People expect more of their employers in terms of support on health and wellbeing and value engagement and interaction, increasingly via social media. Work/life balance is assumed and expected. We need to be ahead of the game in exploiting these new communications channels and in creating attractive opportunities that fit with changing aspirations. We also need to get away from competing for the same people – the idea of working for the NHS is powerful, but we dilute that by offering different terms in different organisations and that encourages people to switch employers and so artificially increase turnover. Similarly, if we are looking to greater collaboration, we need to create a more portable package of learning, eligibility and skills.
3.3	**What more could the NHS do to boost staff health and well-being and demonstrate how employers can help create a healthier country**	The ten year plan should have a significant focus on providing strategic impetus and financial support to enable NHS organisations to invest in the provision of 'best in class' employee health and wellbeing services including rapid access to treatment, psychological therapies, occupational health services and associated wellbeing activities. The NHS should lead by example: Ensure that workplaces are designed to encourage health lifestyles e.g. active travel, work based gyms for large organisations, healthy diet options with time allocated and enforced for breaks. There are great examples across the NHS. We need to get better at sharing best practice and pooling resources to offer support across a wide range of options – and certainly self-managed and online is likely to become the norm.
Enablers of improvement: Primary Care		
3.4	**How can the NHS help and support patients to stay healthy and manage their own minor, short-term illnesses and long-term health conditions?**	The aim should be to move primary care to increasingly move focus upstream i.e. move increasingly towards prevention and early intervention - population health management approach which looks after list whether ill or not to prevent future ill health. Strong communications out that are educational in their messages about how to care for self but also how to access care. People massively underestimate the skills of pharmacists and how they can support patients to care. The NHS must fully integrate community pharmacy into the clinical care of patients. Community pharmacy is in a unique position where it is accessible without the need for appointment, supports primary prevention and self-care and access to pharmacists; experts in the use of medicines. To fully use the community pharmacy asset a change in the community pharmacy contract will be required - and consideration giving to aligning the GP and community pharmacy contracts to support joint working. Invest in social prescribing and other programmes. Embed shared decision making approaches. Continue to deliver patient held care plans. Co-produce approaches towards technology with patients.

3.5	**How could services like general practice and pharmacy, work with other services like hospital services to better identify and meet the urgent and long-term needs of patients?**	Improves signposting for patients, improved access to pharmacies (ensuring availability of deprived neighbourhood) and improvement in approach to urgent care signposting of services by 111 and Ambulance triage. Community pharmacy is in a unique position where it is accessible without the need for appointment, supports primary prevention and self-care and access to pharmacists; experts in the use of medicines. Community pharmacy is already open at times that the rest of the system consider to be out-of-hours. Multi-disciplinary teams. I think this is phrased incorrectly, I think it's more about hospitals working better with primary care. Primary care's level of risk taking is much higher, need secondary care clinicians to work with primary care to better understand the complexity of patients that can be managed within the community. First option should always be whether the patient can go home and everyone should be asking 'why not'. Also need to consider role of VCS services, as they are often better placed and able to be more flexible in their approach as to how the needs of patients can be supported.
3.6	**What other kinds of professionals could play a role in primary care, what services might they be able to deliver which are currently delivered elsewhere and how might they be supported to do so?**	We need to identify which acute services are currently primarily outpatient and diagnostic focussed and move as much as possible off hospital sites. E.g. cardiology, rheumatology, dermatology, physio, OT, dieticians, endocrinology, psychology, psychiatry etc. This may mean investment in estate, IT and other infrastructure in localities to support clinics e.g. low cost imaging (us/x-ray) and pathology. Would need a shift in current thinking re Trust model of provision and change in incentives to shift resource. VCS and community services. HCPs such as physios – need to roll out trusted assessor model across all services so patients are only answering questions once. Not sure there is a limit on who can play a role but this is currently limited by indemnity issues. Indemnity issues hold up a number of service developments as cover isn't possible or far too expensive - Nationally this needs to be looked at asap.
3.7	**How could prevention and pro-active strategies of population health management be built more strongly into primary care?**	Development of primary care network model – Look at system outcomes to support development of communities at 30-60K population levels. Need prevention messages to be national so public continuously aware to support primary care to deliver these messages and get people to act on them. Got to look at use of technology to meet needs of new generations and how people access care and information. This may also require an overhaul of the existing GMS contract – specifically enhanced services and QOF elements. Training and resourcing for NHS staff to understand and deliver a population health management approach. Close working with public health teams and use of existing resources such as the JSNA and Health and Wellbeing Strategies.
Enablers of improvement: Digital Innovation and Technology		

3.8	**How can digital technology help the NHS to:** **a) Improve patient care and experience?** **b) Enable people and patients to manage their own health and care?** **c) Improve the efficiency of delivering care?**	NHS deployment of technology has not kept pace with outside world. There is significant opportunity to improve sharing of information as well as scheduling of care using new technologies. The NHS needs to digitise the lower valued transactional encounters with its service users, such as booking appointments and ordering repeat medications, and concentrate on efforts to focus on the highly valued relationship between patients and their healthcare professionals. This will not only help to move the NHS to a more efficient system to manage the high volume transactional elements of services but will also allow patients to take greater control with the power of technology in their own hands through things like sharing and controlling their own electronic records. Operational efficiencies and back office functions are also on the cusp of transformational reform if we are to fully embrace digital, especially through harnessing the power of information. This could allow for fully informed and data led decision making for strategic, operational and real-time business intelligence tools for providers and commissioners alike.
3.9	**What can the health and care system usefully learn from other industries who use digital technology well?**	Over the last 5-10 years digital technologies have revolutionised other industries such banking. Local branches were consolidated and larger 'super banks' were established due to the increase in online 'transactional' contacts with their customers. The increase in mobile banking reduced the need for the local branches and the focus was turned to 'relationship' high-value encounters with their customers. Marketing – Many industries are much better at targeting public on line using new technologies; Manufacturing – Ordering and scheduling of services; Transport – Logistics company scheduling services – best use of resource; Airlines – Direct booking of services.
3.10	**How do we encourage people to use digital tools and services? (What are the issues and considerations that people may have?)**	Uptake within the NHS remains slow despite this digital phenomenon. People take their security and confidentiality seriously and this aspect has no doubt led to anxieties from people and healthcare professionals in their uptake of digital. Evidence bases of digital interventions are equivocal at best. We need more robust yet pragmatic evaluations of clinical effectiveness, safety and security of digital technologies to allow these technologies to flourish as and where they are found to best support our patients. The elderly (65+) often struggle with technology, particularly the frequency of updates which change the look and feel of hardware and software. We need to target the tools at the populations that are intended to use them, work with groups of targeted population to design tools and services.

3.11	**How do we ensure we don't widen inequalities through digital services and technology?**	It is essential that digital doesn't replace existing means of healthcare access, especially for those less tech savvy or unable to access digital through no fault of their own. We must ensure we personalise services for patients, so we can offer digital by default but if this isn't appropriate, other more traditional routes are also available. We need to listen to our service users and immediately act on any feedback to ensure we don't fall into the trap of making healthcare more accessible for the privileged. We should provide programmes of support and learning in deprived communities. Consider providing technology to patients as part of their package of care from primary care settings.
Enablers of improvement: Research and Innovation		
3.12	**How can we increase opportunities for patients and carers to collaborate with the NHS to inform research and also encourage and support the use of proven innovations (for example new approaches to providing care, new medical technologies, use of genomics in healthcare and new medicines)?**	Ensure each and every patient can take part: Provide information about taking part in research and opportunities to self-refer to studies; Enable all patients to take part in appropriate research wherever they live Ensure that research is patient-centred: Involve patients in setting priorities for research; Appropriately publicise where patients have been involved in the design of a study; Ensure the results of research studies are made available to research participants Ensure that research is embedded in good care: Require clinicians to consider patient's suitability to take part in research; Ensure research activity is specified and reviewed in contracts; Require appropriate sharing of data. Ensure NHS staff know how to take part in research and use its findings: Include research knowledge in training for all NHS staff; Include a research element to annual appraisals; Enable research activity to be a desired skill for NHS jobs. Ensure NHS staff understand the benefits of research to their patients: Publicise locally the role of research in improving the quality of care; Explain how research evidence informs clinical practice. Enable NHS staff to be engaged with research: Ring fence time for research in contracts; Develop local guidance for those wanting to become involved; Use local awards to recognise staff that take part in research.
3.13	**How can we encourage more people to participate in research in the NHS and do so in a way that reflects the diversity of our population and differing health and care needs?**	Ensure that patients are provided with opportunities to participate in research: • Raise awareness of clause 26 in the new NHS contracts which says that providers should offer opportunities to participate in research, ensure similar provisions in AQP contracts • Work so that involvement in research activity and getting research into practice is seen as usual practice • Include the requirement for provider services to offer research • Enable more practices to become research ready –working closely with National Institute for Health Research Clinical Research Network to facilitate this Work with partners on research grants to ensure that research ideas reflect NHS priorities:

		• Build up partnerships with key staff in Universities; • Retain the expertise of key academic staff that understand the research needs of the local NHS landscape • Identify key NHS staff to be included in the work-up of bids, so that they can influence the agenda • Engage with patients to shape our research priority setting agenda and be active partners in our research, participating across a broad range of health research topics that are important to them • Improve engagement with PPI organisations • Improve engagement with the Association of Medical Research Charities to access their funding streams Maximise the success rate of submitted bids: • Support researchers with grant submissions • Signpost researchers to expert help via the Research Design Service, the NIHR Clinical Research Network, the Academic Health Science Network and Applied Research Collaborative Yorkshire and Humber when required • Locate suitable partners as potential collaborators;
3.14	**How can we increase research in topics that have traditionally been under-examined?**	We should continue to work to maximise our opportunities as a region by • Working with the NIHR CRN Cluster E office to support the networks strategic project 'Innovations in Clinical Trial Design and Delivery for under-represented groups' ○ The ultimate aim is to propose a framework enabling the identification of groups who are historically under-represented in standard clinical trials and to review innovations in clinical trial design and delivery leading to their increased recruitment • Extend our reach of expertise to understand the health challenges specific to under-represented patient groups • Improve engagement with the Association of Medical Research Charities (AMRC) to understand their more diverse partners to enable additional research to come into the area • Being regarded as a research workforce with a can do attitude that can deliver
3.15	**What should our priorities be to ensure that we continue to lead the world in genomic medicine?**	We should increase the profile of existing participatory research across the West Yorkshire and Harrogate Health and Care Partnership; promote international best practice led by our area and the additional benefits that this brings to patients, practitioners and researchers. This is done by continuing to engage with the MIC: • https://www.leedsmic.nihr.ac.uk/ the Leeds In-Vitro Diagnostics Co-operative is an internationally recognised centre to promote the uptake of new diagnostic tests and methods • Seek out more projects such as those we currently have in progress, enabling them to work through the HRA process; one project is about improving diagnostics for cancer, the second focusses on personalised medicine for those that may become diabetic • Work with the team at the regional 100,000 genome research centre in Leeds to promote and enable participation in the project and the uptake of the results that will drive personalised medicine

		http://www.genomicsengland.co.uk/the-100000-genomes-project/
Enablers of improvement: Engagement		
3.16	**How can the NHS encourage more people to share their experiences in order to provide an evidence base for checks on whether changes introduced under the long term plan are driving the changes people want and need?**	Each area is different and national guidance/standards might not always be that helpful. Local organisations are in the best place to understand their communities rather than a one size fits all. There are already guidance/standards out there but it isn't always that clear and often open to interpretation. Potential solutions to address these problems: ○ **One place to complain**/compliment the NHS. The existing system is complex and complicated. ○ A **national database of patient experience intelligence** would be really useful. ○ There needs to be a general move towards seeing **patients as partners** in their care. ○ Better **partnership working** locally is also a great way to access a wider group of people. ○ Better involvement of **local business** would help us involve more people. ○ More opportunities to **share best practice** would be welcomed. There is great, innovative work going on across the country but it's not always easy to find out about it. ○ Including some **standards** around engagement and equality in all service specifications/procurement processes might help us when it comes to embedding engagement in the NHS ○ A lot of stuff out there or happening but bring it **all together in one place** might be helpful
3.17	**How can the NHS improve the way it feeds back to people about how their input is shaping decisions and demonstrate that the NHS is the world's largest learning organisation?**	We should adopt a 'you said… we did' (and where necessary a 'you said we didn't') approach so that people can see how their feedback has informed developments. Open and transparent sharing of patient experience feedback between organisations and different parts of health and care system would enable true learning about the way service work from patient perspective. Clear examples need to be given of how NHS plans have been changed as a result of people's views and experiences. There needs to be honesty in responding to feedback, i.e. including 'you said, we didn't'.

		Feeding back after public engagement needs to be timely, and the actions which will be taken need to be clear and tangible for the public.