EAST RIDING OF YORKSHIRE
5 YEAR STRATEGIC TRANSFORMATION PLAN
2014 - 2019
INTRODUCTION

We recognise that in order to effectively deliver our aims and objectives we need to, through involvement and engagement of our patients, public and partners, co-produce these plans and be able to clearly articulate them.

This Strategic Plan describes our longer term aims and objectives to deliver a system wide view of the future.

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SYSTEM VISION

This document sets out how we, East Riding of Yorkshire CCG (the CCG), as part of a wider health and social care community plan, to approach the commissioning of services for the population covered by the East Riding of Yorkshire Clinical Commissioning Group.

The strategic plan sets out the CCGs vision to transform services over the next five years. As part of delivering the vision a detailed operating plan has also been developed setting out detailed delivery plans for the first two years.

We intend to use Clinical Commissioning to drive the transformation of local services to better meet the needs of our resident population.

Vision and Values

The CCG, along with the East Riding Health and Wellbeing Board, remains focused upon its vision to provide

‘Better care, more locally, within budget through transformation’

With the underlying premise that

‘Everyone needs to do something different’

to improve health and healthcare, including patients, carers, clinicians, wider public, healthcare professionals and social care professionals.

This vision is supported by our organisational values of being patient centred, working in partnership and ensuring transparency, legitimacy and inclusivity in the way we behave as an organisation to achieve our vision.

Our Strategic Objectives

The health needs of our local residents have been, and continue to be, well demonstrated in the Joint Strategic Needs Assessment. We know that we face a significant challenge to meet the needs of our diverse population within our available resources. Our strategic objectives have been derived from the Joint Strategic Needs Assessment (JSNA) and have been agreed jointly with the local Health and Wellbeing Board as part of the work we conducted together in 2012/13. They remain as follows:

i) To support our patients and population to achieve healthy independent ageing
ii) To reduce health inequalities across the East Riding of Yorkshire
iii) To improve the mental and physical health and wellbeing of children and young people
iv) To work within our financial allocation to ensure delivery of value for money in all our commissioned services
v) To meet our commitment to deliver improving outcomes around safe, high quality care in line with national and local drivers for change
Our Challenges and Opportunities

Our major challenges need to be managed effectively to ensure that we deliver our plan, they are:

- An increasingly ageing population
- Rising demand due to the increase in complex patients predominantly linked to ageing
- Advancing technology in healthcare and in general everyday life
- Lifestyle choices around food consumption, exercise and healthy choices
- Financial uncertainty with regard to funding allocations and rising demand and a need to deliver savings to provide investment funding as required to deliver the plan
- Rurality in terms of access to and delivery of services
- Provision of high quality services and meeting national and local performance and outcome targets

To mitigate and manage our challenges to ensure deliver of our plan we need to seize the following main opportunities:

- Service integration with partner organisations across social care, health and the wider community to reduce fragmentation
- The use of none traditional contracting methods which could provide innovative models of delivery
- Technology advances and use of mobile devices
- Choice of treatments, service providers and lifestyle choices
- Partnership working with traditional and none traditional service providers, including the voluntary sector and community groups
- How we use the health and social care estate to its optimum and to provide opportunities to work together
Our System Vision

Through the work we have been conducting over the past year and our engagement with patients, the public and our stakeholders (primary, community, secondary care providers, Health and Wellbeing Board, Health Overview and Scrutiny Committee and other partner organisations) together we have derived a number of principles which we want our services to deliver. These principles provide a framework for developing the health and care system.

As a combined health and care economy our vision is to deliver a system where:-

i) individuals take greater ownership of their own health and wellbeing
ii) services are, in the main, delivered locally in the community
iii) there is integration of health and social care services through locality focused service delivery hubs and that
iv) the remit for hospital based services is clear and reflects where they can add value and expertise

This vision is best illustrated through the words of a patient and the following illustrates how our health and care system will look from a patient’s perspective in two to five years time.
0.1 System Vision from a Patient’s Perspective - Gladys

Gladys has just reviewed her personalised care plan (PCP) with her named care coordinator to make sure it is up to date.

At the same time it was checked that Gladys, and her carer, had the number for the single point of access.

Last year, after a small operation, Gladys didn’t go back to the hospital for follow-up.

The doctor who operated on her rang her and her carer to check her progress.

Gladys was pleased to find out she could have all her diagnostic tests she needed and have her routine reviews in a local community facility.

Gladys feels in control and listened to.

She feels she is getting the care she needs.

Gladys knows that if she needs hospital expertise she will be admitted to the frailty unit for diagnosis and tests as required and discharged with the support she needs as soon as she is ready so she can maintain her independence for as long as possible.

When Gladys and her carer identified that her Chronic Obstructive Pulmonary Disorder was getting worse they rang the number she had been given in her Personal Care Plan.

The Community Urgent Response Support Team came out and assessed her at home within 2 hours of the call and put in place a health and social care package to treat her at home and support her whilst she was recovering.

Gladys’ carers, from both health and social care, knew that they could access all the relevant information they needed in a single electronic document reducing duplication and improving record keeping.
Our Vision for the Future

Looking forward 5 years the CCG expects to see significant differences in the healthcare. The changes that we will work to achieve are as follows:

(i) Individuals take greater ownership of their own health and wellbeing through an increased emphasis on prevention, self-care and responsibility

There will be an increased emphasis on prevention and longer term social and cultural change. The CCG, in partnership with the Local Authority and Public Health are starting to try and influence this by providing individuals with the confidence and knowledge to take responsibility of their own health. The CCG aims to reduce the growth in ill health, especially the development of long term conditions, in our younger population whilst recognising that one of the impacts of aging is the development of poorer health. The aim is also to develop a culture whereby individuals try to manage their own minor ailments or health challenges without recourse to formal/traditional health or social care intervention. For those that do have a long term condition or a social care need they will be supported, wherever possible, to take ownership of their condition and work with health and social care providers to maintain their level of health at an optimum.

(ii) Services are, in the main, delivered locally in the community (through Primary and Community Services)

Wherever possible services will be delivered in a community setting close to the patients home location, or work if they so choose. Wherever practical, services will be delivered from a locality hub, which may be a single venue or a network of venues that work together, to deliver a comprehensive service to the local population. The services will also cross both physical and mental health ensuring that both aspects have equitable focus and that the inter-relations between mental and physical disease are recognised and managed.

(iii) Integration of health and social care services through locality focused service delivery hubs

Primary Care, especially GPs, will become the system leaders of primary and community care providing a focal point for the services to their patients. GPs will have reviewed and embraced the opportunities for changes in practice that the closer integration will offer and will often work in collaboration with other primary and community providers and social care to ensure a robust, integrated health and social care service which meets the needs of their local population as well as delivering more generic best practice and outcomes that will be the norm across the CCG.

Community providers will work closely with primary care providing services that complement and integrate with primary care services and provide a responsive unplanned care service which is available 24/7 and reflects the differing needs for unplanned care support across the different segments of the population.

Social Care will be a joint partner in health and social care community services sharing points of contact, documentation and ethos. Social workers and social carers will be integral to the service delivery ensuring that individuals have a holistic assessment and service delivery.

Outreach services, including Consultant led clinics and diagnostic services, will be provided either as an outreach of a local acute hospital or by a community provider working in collaboration with acute provider to deliver an integrated care pathway across community and acute sectors.
The remit for hospital based services is clear and reflects where they can add value and expertise

Our commissioned acute provider hospitals will see a change in focus. They will have an increasing number of complex, ill patients who require their specialist support and who will remain in a hospital setting whilst they can clinically benefit from that setting. Patients who are less complex and can be managed within a community setting will be cared for in that setting with input and advice from Consultants as required supporting the delivery of healthcare in the community.

Once the patient has reached clinically stability and is fit for transfer into a community setting this will occur quickly with the Consultants being able to follow-up and support patients as required via telehealth as well as via community based clinics. Discharge planning will begin at admission and be co-ordinated with community teams as early as possible in the process. Therapy and social care assessments will be at home or community setting, where appropriate, to reduce unnecessarily extended stays in hospital waiting for this type of assessment.

There will be a change in how many beds are available within a hospital and how they are used.

- Surgical beds will start to reduce as patients are treated in an outpatient or daycase setting more regularly and, for those who do need to stay in hospital, this stay will be minimised with a focus on getting the patient up and about and back home as soon as clinically and socially able.

- Emergency beds will reduce but there will be a growth in ambulatory / short stay assessment facilities where individuals are assessed by a senior clinician, investigated and a treatment plan developed for delivery in a home setting. Where clinically necessary stays in hospital will be kept to the level needed to ensure that the expert, specialist care has been provided to optimise patient recovery before being discharged for rehabilitation and re-ablement in the community.
KEY VALUES & PRINCIPLES

Working with Partners

The East Riding Clinical Commissioning Group (CCG) lies within the boundaries of the East Riding of Yorkshire and is responsible for the commissioning of healthcare services for the majority, but not all, of the East Riding of Yorkshire population. As such we work closely with our neighbouring CCGs to promote consistency of commissioning with our major provider organisations and with East Riding of Yorkshire Council (ERYC) to ensure that we are jointly commissioning and transforming services to improve the overall health and wellbeing of our joint population.

The CCG consists of 37 GP Practices who have come together to jointly commission services for their patient populations.

We recognise that we cannot deliver our vision alone and have a number of key partners who we need to work with in the East Riding Health economy:

- East Riding of Yorkshire Council
- NHS England who commission specialist services and primary care services
- Healthwatch
- Voluntary sector in East Rising
- Community Groups in East Riding
- Hull & East Yorkshire Hospitals Trust
- Humber Foundation Trust
- City Healthcare Partnership
- Primary Care Federations in the East Riding of Yorkshire

East Riding of Yorkshire Clinical Commissioning Group (CCG) borders a number of health economies and needs to work with partners in the:

- Hull health and care economy with Hull CCG, Hull and East Yorkshire Hospitals NHS Trust, Hull City Council and City Health Care Partnership
- York health and care economy with York NHS Foundation Trust, Vale of York CCG,
- North Lincolnshire health and care economy with North Lincolnshire and Goole Foundation Trust, North Lincolnshire CCG and North East Lincolnshire CCG

In setting our system vision we have worked with our partners, identified above, to ensure that the vision described is shared by us all and is achievable if we all work together.

Partner Concordat/Agreement

As part of our commitment to working together we have agreed a ‘concordat’ which includes the following principles of how we will work together in a practical way to deliver better outcomes for our patients and residents. We have collectively agreed to:-

- Champion integrated multi-agency working
- Provide information in a considered, co-ordinated and timely way
- Contribute different organisational perspectives to policy development
- Contribute ideas on implication for developing and implementing services
- Strive for consensus as far as possible recognising it is acceptable to disagree
Ensure honest and open communications and maintain confidentiality, where appropriate
Ensure members have appropriate levels of delegation and are representing their organisations
Ensure a ‘no surprise’ culture by maintaining dialogue
Ensure that risks are identified, assessed and mitigating actions agreed
Sign up to delivery of the outcomes of the ‘Better Care Fund projects within the two year operating plan

Co-Production

We recognise that our patients and public as actual or potential service users, as well as our wider community groups, the voluntary and charitable sector, have views and ideas on what they expect and want from their health services.

We see co-production as the process of active dialogue and engagement between the people who use services, and those who commission / provide them to ensure that services meeting the needs of the local population.

In producing this plan we have involved a range of our local population, services and organisations to ensure that the plans put forward reflect the views and needs of our local population.
IMPROVING QUALITY AND OUTCOMES

NHS England has set the vision for the NHS to deliver ‘high quality care for all, now and for future generations’ and set seven high level outcome ambitions.

1. Securing **additional years of life** for the people of England with treatable mental and physical health conditions.
2. Improving the health related quality of life of the 15 million+ people with one or more **long-term condition**, including mental health conditions.
3. Reducing the amount of time people spend **avoidably in hospital** through better and more **integrated care** in the community, outside of hospital.
4. Increasing the proportion of **older people living independently at home** following discharge from hospital.
5. Increasing the number of people having a **positive experience of hospital care**
6. Increasing the number of people with mental and physical health conditions having a **positive experience of care outside hospital**, in general practice and in the community.
7. Making significant progress towards **eliminating avoidable deaths in our hospitals** caused by problems in care.

As a CCG we are planning to deliver the NHS wide ambitions and have set out below the impact we intend to make against these.

<table>
<thead>
<tr>
<th>National Outcomes Ambition</th>
<th>The Impact we will make</th>
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<tbody>
<tr>
<td>Securing <strong>additional years of life</strong> for the people of England with treatable mental and physical health conditions</td>
<td>Reduce the years of life lost for patients who would have prematurely died from causes that are amenable to healthcare on average by 2.3 years by 2018/19</td>
</tr>
<tr>
<td>Improving the health related quality of life of the 15 million+ people with one or more <strong>long-term condition</strong>, including mental health conditions</td>
<td>Increase the quality of life reported by patients with a Long Term Condition by 2.3% by 2018/19</td>
</tr>
<tr>
<td>Reducing the amount of time people spend <strong>avoidably in hospital</strong> through better and more <strong>integrated care</strong> in the community, outside of hospital</td>
<td>Reduce the number of days in hospital from unnecessary delays by 220 days p.a. in 2014/15</td>
</tr>
<tr>
<td>Increasing the proportion of <strong>older people living independently at home</strong> following discharge from hospital</td>
<td>Reduce the number of permanent admissions needed to care homes for over 65’s to 690 per 100,000 in 2014/15</td>
</tr>
<tr>
<td>Increasing the number of people having a <strong>positive experience of hospital care</strong></td>
<td>Reduce the proportion of patients reporting a poor experience of hospital care by 4.9% by 2018/19</td>
</tr>
<tr>
<td>Increasing the number of people with mental and physical health conditions having a <strong>positive experience of care outside hospital</strong>, in general practice and in the community</td>
<td>Reduce the proportion of people reporting poor experience of General Practice and Out of Hours Services by 2.5% by 2018/19</td>
</tr>
<tr>
<td>Making significant progress towards <strong>eliminating avoidable deaths in our hospitals</strong> caused by problems in care</td>
<td>Have prevented 2,010 hospital emergency admissions over 5 years</td>
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CCG Commitment to Quality

We are as a CCG committed to delivering high quality services. In particular we are committed to working with all of our Providers (including Primary care) on the delivery of work plans to ensure for:

Patient Safety
- The right number of staff with the right skills are in place
- Robust Serious Incidents investigations, organisational learning, No Never Events/avoidable harm
- SHMI (Mortality Indicator) within expected- Trustwide/weekday, weekend, speciality level and out of hospital SHMI
- No avoidable MRSA bacteraemia and C-Difficile infections reduced to the lowest possible level
- No avoidable Pressure Ulcers

Patient Experience
- Patients consistently reporting a good experience wherever care is delivered through Patient Reported Experience Measures and Friends and Family Test
- Patient needs routinely identified and met in terms of End of Life care preferences
- Mental Capacity Act and Deprivation of Liberty decisions appropriately made in a timely manner
- Community hubs delivering care closer to home providing good patient experience

Effectiveness
- Evidence Based Quality Improvement initiatives using/based on NICE Guidelines, Best practice Bundles and Clinical Quality Indicator (CQUIN) schemes
- A focus on research, generating our own research questions, critical evaluation, research ready practices informing commissioning and decommissioning decisions
- A focus on provider clinical audit activity
- Increased focus on measurable quality outcome metrics in all contracts

SUSTAINABILITY

For the outcomes we want to achieve to be sustained we must also deliver a sustainable health and care system.

There are a number of challenges that we must address to ensure sustainable services into the future as follows:-

Financial

The Challenge

- CCG QIPP(savings plan) of around £5m per annum (1.5%) driven by demographics, need & demand
- Provider Cost Improvement Plans (CIP’s) of around £12m per annum (4%)
- ERY Council total savings requirement £71m to 2017/18 – Social Care impact
- £200m health economy savings required to be made over the next 5 years

Managing Financial Sustainability through:

- Shared Assumptions and aligning aggregate plans
- Transparency and use of Payments by Results Business Rules
- Better Care Fund – a single forum for all partners
- Programme Management Office up and running effectively
- Savings plans focus on transformation with 1% set aside non-recurrently to support
- Creating Headroom – Embedding existing saving schemes and ensuring Productive Elective Care

Estates and Infrastructure

- Optimising the use of NHS and Social Care Estate
- Embracing technology to improve infrastructure; single care records, records sharing
- Continuing the development of effective transport infrastructure with partners

Workforce Development

The Challenge

- Workforce not designed to manage the increasing number of complex patients nor expected changes in locations of service delivery
- Significant gaps in availability of appropriately qualified staff across a number of clinical groups
- Clinicians feel they have a lack of time to spend with patients
- Health professionals are ‘task orientated’ – need to take a holistic view of the patient
- Teams across health and social care operate separately

Future direction

The health and social care economy will need to develop an agile workforce that can adapt to new ways of working. This is a key dependency for both clinical and operational benefits of the new commissioning model to be realised.
The current Neighbourhood Care teams will be developed into locality based, multi-disciplinary co-located, integrated care teams. Key to this will be the development of a number of new roles or functions which will be taken by existing staff. Staff will have the skills, knowledge and experience to work across the teams:

- Discharge team: to support the recovery and re-ablement function.
- Rapid response team: to support the rapid response function.
- Planned care team: to support the care co-ordination and personal care planning function and the community based care function.

Preparation for the Workforce for the Future

In order to ensure that our workforce continues to change and be fit for purpose we are undertaking a wide range of programs designed to support workforce recruitment, retention and skill development including:

- Promoting leadership skills training across a wide range of clinical discipline
- Support to undertake an executive MBA offered to GPs in under resourced areas
- Working through the LETB to encourage Universities and Colleges to provide the range of training programme we need now not in the future
- Reviewing the model for advanced training practices to support the training of a wider range of clinicians and support staff

Developing a comprehensive range of training will support the CCG in attracting and retaining good quality clinicians.

Benefits
- Multi-disciplinary workforce
- More patients treated closer to home
- Attractive and rewarding roles for clinicians – helps attract and retain talent
- Better continuity of care

Additional detail is provided in Appendix 1

Provider Sustainability

National thinking around hospital based care has been influenced through high profile reviews such as the Keogh review of Mid-Staffs, and the Berwick and Cavendish Reviews.

Recommendations and responses from these reviews have influenced the thinking of commissioners locally. In his review of hospital services Sir Bruce Keogh recommended that serious or life threatening care should be delivered from centres of excellence, with the best expertise and facilities to maximise chances of survival and recovery. This has led to national recommendations moving towards commissioning of serious, life-threatening emergency care and rare services from centralised locations to ensure clinical and cost efficiencies are maximised.

The national direction is reiterated by the requirement to establish Operational Delivery Networks (ODNs) which are hosted by providers and whose remit is to support providers to work collaboratively sharing information to narrow variation in quality and costs.

Moving towards a system consisting of networked providers delivering a full range of specialised services between them means that there will be a greater range of providers delivering care for the population of each CCG. For all other provision, hospitals will be
expected to utilise generalist-led, multi-disciplinary teams to provide continuous care around each patient for example in-reach/outreach services.

Improvement in technology may also have an impact on how care is delivered. For example most health consultations and diagnosis could be delivered in local primary care centres and the home, as modern technology allows specialists to consult virtually from a small number of large specialist hospitals; and better understanding of genetic medicine could result in more tailored personalised care preventing long term health problems.

This is leading the CCG to consider how it can effectively commission services that reflect the national principles, and underpinning best practice guidance, to ensure that commissioned services are patient focused, delivered by high quality, sustainable, effective and efficient service providers that recognise the benefits of working cooperatively and jointly rather than persisting in an isolated, disconnected manner.

At a local level the CCG will work with local NHS Providers to manage change in a managed and sustained way. We recognise the challenges for our Providers in delivery cost saving programmes and in releasing fixed costs as services move to other specialist centres or the community.

Technology

The use of improved technology is a significant enabler for the East Riding of Yorkshire due to its geographical distribution and that is not only the use to telecare, telehealth, telemonitoring but also the use of basic technology to support the delivery of enhanced levels of care.

The schematic on the next page (page 17) identifies some of the expected benefits we expect from adopting more technological solutions.

The CCG is committed to using technology to provide shared care records and a single point of access in the next couple of years and to using the technology where is can help to deliver our plan.
0.2 Benefits of Adopting Technological Solutions

- Option to deploy a Patient Portal to engage patients in their own care and to add to their care record under guidance
- Option to deploy a Patient Portal to engage patients in their own care and to add to their care record under guidance
- ECR supports a whole system approach to health and well being
- Prevention of duplication of diagnostics, thus improving patient experience, cutting time wastage and avoiding cost for both patient and provider
- Technology can help overcome remoteness and other impacts of rurality and a geographically dispersed population: "Connected Care"
- Enables more proactive and predictive care
- Reduction in hospital admissions because clinicians have a fuller picture of the patient
- Improves patient safety and reduces clinical risk
- Increases clinicians' ability to deliver services in non-acute settings
- Efficiency gains, e.g., professionals no longer have to chase each other for information because they can access it themselves
- Auditable system with access to and activity within care records recorded, monitored and reported
- Through storing patient data on an electronically-based and smartphone capable system, it can be accessible to all authorised users 24/7, concurrently, in multiple locations
Becoming an Innovative Organisational System

Innovation is a significant enabler to the planning and delivery of a sustainable and fully integrated health and social care system. It supports the ongoing sustainability of services and the delivery of improved patient experience and outcome.

Innovation falls broadly into two groups:

- ‘Disruption’ and ‘leap’ innovation where a radically different approach/idea is described and enacted with newcomers exploring/delivering innovation at scale
- Adoption and/or adaptation/replication where improvement arises from existing innovations/services

To this end the CCG alongside its planning unit and local and wider partners including the:

- National Innovation, Health & Wealth team
- Regional Innovation Hub (Medipex)
- Academic Health & Science Network (AHSN)
- Area Team
- Public Health England
- National Institute for Health Research & Development (NIHR)

will look to cultivate and embed innovation throughout every stage of the commissioning cycle and planning processes, recognising the objectives and best practice outlined in:

(i) NHS England Research & Development Strategy (draft) [August 2013]

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

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

See Appendix 2 for additional information around innovation areas.
IMPROVEMENT INTERVENTIONS

To deliver our overall system vision we have identified five key delivery programmes as follows:

1. Transforming primary and community care services
2. Integration of services to provide “Better Care”
3. Enhanced unplanned care services
4. Provision of productive planned care services
5. Supporting Vulnerable people

A brief description of these programmes is given below with the main outcome improvements for patients which we intend to deliver. Full information on each project including delivery milestones is set out in the CCGs two year operating plan.
0.3 Transformation Programmes Overview

All five areas of work report into the overarching Programme Board

<table>
<thead>
<tr>
<th>Transforming Community and Primary Care Services</th>
<th>Integration of services to provide “Better Care”</th>
<th>Enhance Unplanned Care services and outcomes</th>
<th>Productive Elective Care</th>
<th>Supporting Vulnerable People</th>
</tr>
</thead>
</table>

Key objective / alignment to CCG strategy

- Improve capacity and capability of primary, community and the wider community to enable shift of care from acute services
- Integration of services across health and social care
- Patient treated in most appropriate environment for their condition when needing unplanned care
- Create headroom to enable transformational change across planned care services
- Ensuring responsive and high quality services are in place to support our most vulnerable population

Key projects

- **Transforming Community and Primary Care Services**
  - Implementation of Primary Care and Community Strategies - service integration and co-location
  - Primary Care Market Development
  - End of Life services improved to increase preferred place of palliation

- **Integration of services to provide “Better Care”**
  - Implement single point of access and single assessment process
  - Shared care records
  - Increased range of prevention and self care programmes
  - Development of Ambulatory Care models and integrated teams in both hospital and community settings (through unplanned care programme)

- **Enhance Unplanned Care services and outcomes**
  - Development of Ambulatory Care models in both hospital and community settings with dedicated frail and complex pathways and urgent community teams
  - Improved performance of ambulance response times
  - Engagement to ensure wide knowledge of urgent care systems and processes

- **Productive Elective Care**
  - Adoption of best practice guidelines providing standardised service offer
  - Creating Headroom:
    - Unnecessary OP follow-ups reduced
    - Daycase / Outpatient Shift maximised
    - Increase range of guidelines on Map of Medicine
    - Goole Health and Wellbeing Campus

- **Supporting Vulnerable People**
  - Improvements in dementia/minor cognitive impairment support
  - Implement Winterbourne recommendations for people with learning difficulties
  - Improve access and outcomes for Looked After Children and Child & Adolescent Mental Health Services
  - Increase access to Improving Access to Psychological Therapy (IAPT) services
  - Extend personal health budgets

* Ambulatory Care is care that is provided on an outpatient setting in either the patient’s own home or a community setting
Community Hubs

One of the main programmes of development is that of providing community hubs, illustrated as follows. The main functions of a community hub are illustrated diagrammatically on the following two pages and are set out in more detail in the CCGs Community Strategy.

Community System Model

This diagram (0.4) has several components

- Top Left: This is our offer to our patients and public
- Top Right: This demonstrates how our population is split in relation to care needs. At the bottom is the healthy wider population. As you move upwards individuals have increasing levels of poorer health and increasing need for more intensive health and social care support.
- Bottom Left: The circles, which are laid on top of each other, demonstrate the levels of service required by an individual as they have increasing health and social care needs. The outer circle represents the wider community which supports all individuals in the East Riding. Moving through the progressively smaller circles you see increasing intensity of service provision to support those individuals, which are smaller in number than the general population, who need more intensive health and social care support. At the centre is the Community Hub which will be the focus of the different tiers of service to ensure that services remain patient centred.
- Bottom right: This illustrates some of the changes we expect to implement across primary/community and acute services.

Key Functions of a Community Hub

This table (0.5) sets out the functions we expect to be delivered by a Community Hub. More detail is provided in our Community Strategy document.
0.4 Community System Model

Our Offer
1. Healthy independent ageing
2. Consistent quality across all areas
3. Home/Community is the default setting
4. Joined up care
5. Widely understood patient pathway
6. Flexible access to services

Community Based Care

Recovery & Re-ablement

Complex Case Management

Wider Community Support

Staying Healthy & Independent Living

Locality Hub

Communication & Navigation

Care co-ordination & Personal care planning

Primary & Community Care

Secondary Care

GP Co-ordination & Enhanced Care including Case Management
Rapid Response Team
Community/Care Home/Palliation
Personalised Care Plans/Personal Budgets
Community Groups/3rd Sector integration & inclusion

Ambulatory Care Model
Rapid Access Diagnostics
Discharge to Assess
Meets specialist requirements
## 0.5 Key Functions of a Community Hub

<table>
<thead>
<tr>
<th>Function</th>
<th>Description</th>
</tr>
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</table>
| **Communication & navigation**                                | • An information and co-ordination centre within a community hub  
• Can be contacted by the citizens, patients & healthcare professionals seeking the most appropriate care for their patients  
• Covers statutory & non statutory services  
• Fill gaps between 111, Map of Medicine and NHS Choices                                                                                                       |
| **Care co-ordination & personal care planning**              | • Development of co-ordinated, integrated and consistent care plans for those who need them  
• These will be managed by a care co-ordinator and primarily but not exclusively aimed at those patients already ‘in the system’  
• Integration of care teams across primary, community and social care to reduce fragmentation and increase consistent and systematic treatment                                                                 |
| **Wider community support**                                  | • Multi-agency initiative – local authority, community and voluntary sector  
• Links to non health related statutory services – for example housing and benefits advice  
• Independent sector organisations will either be delivered or signposted to in the hub                                                                                                                                  |
| **Staying healthy & independent living**                     | • Prevention and social inclusion initiatives to better enable independent living  
• Recognition and support for carers to support patients in their own home  
• Promotes self care and management                                                                                                                   |
| **Community based care**                                     | • Efficient planned episodes of care delivered through the hub eg Wound Care  
• Efficient and effective delivery of planned care services separate to urgent care services (when appropriate)  
• 7 day service provision  
• Delivered by integrated community, primary and social care teams                                                                                                   |
| **Recovery & re-ablement**                                   | • The hub will manage referral to and discharge from hospital more effectively including an efficient discharge to assess system  
• End to end support for patients who require an acute stay.                                                                                                  |
| **Complex case management & rapid response**                 | • An urgent response frailty pathway team located at a hub delivering a rapid response to appropriate patients including rapid access to care packages as required  
• Access to rapid access diagnostics and clinic assessments when required  
• A ‘discharge to assess’ process in place – patients are discharged when medically fit and assessed in their home environment  
• 7 day service provision integrated with Out of Hours service                                                                                          |
GOVERNANCE

The CCG recognises that it must have robust governance arrangements to ensure delivery of its plans and as such has invested in a programme management function within the CCG. The structure diagram on the next page illustrates our committee structures which assure the CCG Governing Body that delivery is on track and risks are managed appropriately.

Key to Abbreviations:

CCGs: Clinical Commissioning Groups
SRCC: Service Redesign and Commissioning Committee
NY & Humber: North Yorkshire and the Humber
BCF: Better Care Fund
FT: Foundation Trust
H&ER: Hull and East Riding
0.6 System Governance

Chief Officer Meetings

CCG Collaborative
8 CCGs across NY & Humber

Strategic Clinical Networks

Council of Members

Governing Body

SRCC

Health & Wellbeing Board

Health Overview & Scrutiny Committee

BCF Board

H&ER Productive Elective Care Steering Group

Unplanned Care Board

Joint Strategy & Commissioning Meetings

- Hull & East Yorkshire Hospitals NHS Trust
- York FT
- Northern Lincolnshire & Goole Hospitals FT
- Humber FT
- City Healthcare Partnership
- East Riding of Yorkshire Council
**SYSTEM VISION**
- Individuals take greater ownership of their own health and wellbeing
- Services are, in the main, delivered in the community by a range of providers
- Integrated health and social care through locality focused service delivery hubs
- The remit for hospital based services is clear and reflects where they can add value and expertise

**SYSTEM OBJECTIVES**
- Secure additional years of life for people with treatable mental/physical conditions
- Reduce avoidable time in hospital
- Increasing positive experience of care outside hospital
- Improving health related quality of life for people with LTC
- Increasing positive experience of hospital care
- Eliminating avoidable deaths

**SYSTEM CHANGE INITIATIVES**
- Transforming Community & Primary Care / Enhanced Unplanned Care

Ambulatory Care becomes principle delivery model where clinically appropriate across primary, community and hospital based settings. Delivers increased step up and step down services to deliver admission avoidance and reduced days in hospital

- Transformation of Community Services
  - Ensuring individuals are able to access a range of services close to home which enhance their healthcare experience
  - Single point of contact
  - Locality Hubs

- Productive Elective Care ensuring that:
  - Best practice applied as the norm
  - All organisations embrace and adopt innovation

- Standardised Offer of Care delivering accessible, quality services to all at the point of need

**SUCCESS CRITERIA:**
- Individuals and their carers at the heart of a new joined up care and support system; being cared for in their home as a matter of course.

**SYSTEM VALUES AND PRINCIPLES**
- Patient Centred – Quality, Safety, Patient Experience
- Partnership Working - integrate care, reduce fragmentation, increase efficiency, respect
- Transparency - Being clear on the decisions made and on the rationale for decision making
- Legitimacy - effective involvement and engagement
- Inclusivity – In engagement of groups and individuals
Appendix 1: Additional Workforce Development Information

In order to deliver our plans we need to ensure that we have sufficient capacity and capability within our workforce. This means that staff, both existing and future, will need to change and adapt to deliver the new ways of working. This may range from changes to working patterns to accommodate 24/7 working through to retraining and adaptation of skill sets to successfully deliver the move from a hospital focused system to a community focused system.

Age Profile
Specific East Riding of Yorkshire Figures are not currently available but across the health and social care workforce in North Yorkshire & Humber as a whole it is known there is an aging workforce. As of Oct 2013 approximately 20% of the workforce is aged 55+, and hence close or eligible to retire. The workforce of today is in general terms the workforce we will have in ten years’ time; in ten years time 55% of the current health and social care workforce will be aged 55 and over. This has implications around leadership and development, coaching and loss of skills across the area. This calculation does not account for any new entrants to the workforce.

7 Day Working
In order to align 7-day working across primary, community and secondary care there will be the requirement to develop multi-disciplinary teams equipped to support clinical decision making and to deliver an urgent and emergency care service to match the changing needs of the population. Education portfolios will need to accommodate the delivery of the skills and competencies required to deliver a 7-day service across the sectors.

GP Workforce
CCGs have voiced concerns of an aging GP workforce in the NY&H. Workforce planning trends indicate that there are not enough GPs in training to meet current demand. However, there are additional factors (geography in particular) which may affect the ability for NY&H to recruit GPs. Innovative approaches to recruitment may prove beneficial. The extended training time for GPs (approximately 10+ years) adds an extra dimension of complexity. The role of GPs as commissioners needs further exploration. In particular a more thorough understanding of GP business skills, workforce planning capabilities etc needs to be undertaken. An integrated approach to health and social care in the community will also denote that GP practices will need to form partnerships/relationships with social care providers. There are opportunities to develop nurses (or admin/clerical staff) into more business type roles.

Social Care
There is a large gap in the skills/training/education of social care staff in comparison to health staff. Approximately 40% of social care staff have no qualifications; therefore if social care staff are to reduce unnecessary admissions to hospitals there will be a need to educate/up skill this staff group. Whilst the social care sector has a common induction programme which could be adapted for this reason, the high turnover of staff makes the retention of knowledge/experience less likely.

Two thirds of social care providers are independently run therefore the intentions of such providers may at times be contradictory to the NHS. A culture change will be necessary for any form of integration between health and social care to be successful along with aligning of processes, financial and governance structures.

Integrated Teams
The move towards an integrated health and social care system may benefit from experiences/learning of multi-agency (or multi-disciplinary) team working within the children’s sector. A team around the patient approach may be most appropriate, led by a lead-professional
(someone with advanced skills across a wide-range of disciplines). Such an approach would require a change of culture, new trainingdevelopment approaches, rotational training programmes, development of a common induction programme and shared language. Social care workers will need to have basic understanding of health issues and have the confidence to either manage patients directly, or have access to a specialist nurse for referral purposes (either directly or virtually).

The move towards community settings may have an impact on the staffing numbers available for 24/7 staffing and out of hours care. This will have an adverse effect of increasing bank/locum costs in order to meet safeappropriate staffing levels. To mitigate this risk health staff may be required to work across both community and secondary care settings, possibly on a rotational basis.

The move towards a greater level of self-care, assisted by technology, will require that staff are appropriately trained and have the confidence to usemanage/support the technology. Such skills and abilities could be built into trainingContinuing Professional Development programmes for new staff. Existing staff would need to undergo training as appropriate.
## Appendix 2  Innovation Areas

<table>
<thead>
<tr>
<th>Innovation Areas to Embed</th>
<th>Actions required:</th>
<th>Tools, resource or partners for support:</th>
</tr>
</thead>
</table>
| Fitness for purpose – OD, culture, staff, tools & resources | ▪ Self diagnostics for CCG to identify current clinical and management leaders and innovation strengths and weaknesses  
▪ Assess current capacity, infrastructure and effectiveness against each stage of the innovation process  
▪ Strengthen leadership and accountability through identification of a lead Director for Innovation to champion and drive innovation, as well as a clinical lead to champion research with regular updates to Governing Body  
▪ Access advocacy and external advisors to stimulate and drive  
▪ Implement a culture across the CCG that values, supports and incentivises learning from innovation and research | Innovation Scorecard  
Innovation Health and Wealth (IHW) |
| Embedding Innovation in Commissioning | ▪ Review and refresh how the innovation cycle can be embedded throughout all structures, staff, processes and programmes of work  
▪ Create an end to end system to deliver innovation—designing a defined and co-ordinated approach for embedding innovation  
▪ Developing people and their skills, competencies and ability to:  
  o use tools to understand and evaluate research evidence  
  o work collaboratively embedding research into practice and service evaluation  
▪ Allocate sufficient resources to both manage the overall innovation system and project management of the innovation work programme (including across relevant multi-disciplinary teams)  
▪ Ensure research and innovation is a primary function aligned to patient care and experience and embedded in Project Management Office approach  
▪ Identify all relevant partners nationally, regionally and locally which can provide support, expertise, tools, learning, engagement and collaboration to help the CCG in embedding innovation and accessing evidence-based practice | Innovation expertise from NHS Quality Improvement including NHS Change Model |
| Promotion of research and evidence-based practice | ▪ Increasing participation in research through single system of research approvals and costing commercial studies  
▪ Work with providers, Public Health England (PHE) and other partners to allocate and grow capacity to identify research opportunities and undertake research and evaluation across the whole patient pathway which improve patient outcomes and delivery  
▪ Development of a R&D strategy clearly linked to sustainable future health and care model which drives local innovation | Work with the National Institute for Health Research & Development Committee and local networks to embed research into practice |
| Access concept development and horizon scan | ▪ Support learning from user feedback, incidents, audits and clinical reviews  
▪ Ensure patient, carer and staff participation in identifying priorities for research or concept ideas  
▪ Ensuring patient participation in all research programmes for which they are eligible/practicable (this is a national planning objective)  
▪ Systematic, continuous and far-reaching horizon-scanning and health & care system scanning to identify innovative new ways of working/practice for each relevant pathway  
▪ Assess each provider in relation to the scale and progress of innovation being undertaken and identify areas where there is a shared agenda and direction  
▪ Share local CCGs' ideas, implementation and lessons learnt | Establish Innovation 'Hub/ Incubator' pilot sites for health and social care staff within organisations to drive concept development (e.g. Hull 2020, Innovation Hub bid to Regional Improvement Fund)  
Assess against Innovation Roadmap  
Experience-led commissioning  
Public Health England (Commissioning for Value; Quality Outcomes Framework analysis) |
| Share an enhanced knowledge base assessment of current innovations | ▪ Knowledge management and systems to share information on evidence base and innovative practice (across practices, CCGs, providers and regionally through the Academic Health Science Network (AHSN) Innovation Forum & Improvement Academy)  
▪ Ensuring patients, staff and public can (and are empowered to) access the relevant information required to share and diffuse evidence  
▪ Improve quality, access and transparency of innovation metrics, and more accessible evidence and information about new ideas from industry | New Health & Well Being Framework due out in June 2014 with menu of prevention interventions  
Work with the local Comprehensive Local Research Network (CLRN) to support patient recruitment studies managed by the National Institute of Health Research  
IHW Innovation Portal  
IHW Industry Council |
| Collaboration & Partnership | Collaborate and co-ordinate with neighbouring CCGs with shared providers/similar health inequalities/variations in unmet need and aligned transformational programmes – identify key opportunities for research topics and innovation that can be explored and resourced collaboratively (e.g. funding opportunities & bids, co-development/testing/evaluation, learning, early use & dissemination)  
R&D Strategy which is shared, triangulated against other R&D strategies across the NY & Humber CCGs with the support of the NYHCSU  
Work with Innovation Hub to enable connecting with academia and industry and facilitate commercialisation including small business research initiatives  
Work to build trust between NHS & industry  
Forge partnerships with innovative providers | AHSNS  
Medical Deaneries  
Universities  
NYHCSU  
Regional learning groups |
|-----------------------------|--------------------------------------------------------------------------------------------------|-----------------------------------------------|
| Adoption & Diffusion of Innovation (radical/leap innovation or multiple innovations) | Strengthen compliance and spread of best practice, especially where mandated and reinvigorate adoption and adaptation of the evidenced high impact innovations  
Business Case development for each innovation scheme and Action Planning for implementation with adequate programme management support  
Work with AHSN to rapidly advance ideas into practical products and services and speed up adoption into practice and wider uptake at quicker pace and scale  
Tools and upskilling for staff to rapidly translate innovation into practice and service developments  
Promotion of innovations to 3rd parties | NHS Change Model – Spread of Innovation component (NHS Spread and Adopt tool)  
Anytown Toolkit  
CQUINs  
QIPP  
Service redesign Contracts  
IHW Strategy for UK Life Sciences recommendations  
NICE Implementation Collaborative  
PRASE – patient reporting and action for a safe environment  
Interactive learning tools for safety |
<table>
<thead>
<tr>
<th>Address Barriers to Success</th>
<th>NHS Technology Adoption Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Fear of change and need to protect status quo;</td>
<td>Association of Healthcare Industries</td>
</tr>
<tr>
<td>▪ fear of failure (most innovations have 3-10% success rate)</td>
<td>WSD programme on telehealth – lessons learnt</td>
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<tr>
<td>▪ Entrenched behaviours</td>
<td></td>
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<tr>
<td>▪ Systems barriers</td>
<td></td>
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<tr>
<td>▪ Risk adversity</td>
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<tr>
<td>▪ Lack of ability/ empowerment to drive &amp; deliver change</td>
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<tr>
<td>▪ Professional and organisational resistance/reluctance</td>
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<tr>
<td>▪ Narrow funding streams</td>
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<tr>
<td>▪ Onerous regulatory and tendering processes – need non-conventional evidence-based methodologies of evaluation</td>
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<tr>
<td>▪ Fragmented procurement leading to marketing delays and exclusion of smaller companies</td>
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<tr>
<td>▪ Chronic lack of implementation experience across the NHS</td>
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<tr>
<td>▪ Fragmentation between NHS organisations</td>
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<tr>
<td>▪ Lack of appropriate incentives</td>
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<tr>
<td>▪ Access expertise in health service improvement and behavioural change</td>
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Appendix 3: Local Health Landscape

The map below identifies the acute providers that operate across the whole of Yorkshire and North Lincolnshire. From a local health and social care economy the main providers we interact with are:

- Hull and East Yorkshire Hospitals NHS Trust
- York Teaching Hospitals NHS Foundation Trust
- Northern Lincolnshire and Goole Hospitals NHS Foundation Trust

Leeds Teaching Hospitals NHS Trust, Sheffield NHS Foundation Trust and Sheffield Children’s Foundation Trust provide tertiary services alongside Hull and East Yorkshire Hospitals NHS Trust.

The next two pages provide a summary overview of our three main acute providers.
**Hull & East Yorkshire NHS Trust**

HEY provides a comprehensive range of acute hospital, specialist and major trauma services for approximately 1.25 million people living in the Hull, Yorkshire, East Riding and Northern Lincolnshire area. The trust provides networked services with other providers in the area, including: major trauma, major vascular, neurosciences, cardiology, oral surgery urology, cancer services, and a range of screening services. The only major services not provided locally are transplant surgery, major burns and some specialist paediatric services. HEY employs approximately 8,664 staff working across the hospitals and community, with an annual turnover of £495m.

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

**York Teaching Hospital NHS Foundation Trust**

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

| York Hospital | The largest hospital site run by YTH. This is a 700 bed hospital, offering a range of inpatient and outpatient services. It has an Accident and Emergency department and provides acute medical and surgical services, including trauma, intensive care and cardiothoracic services to the population and visitors to York and North Yorkshire. |
| Scarborough Hospital | Scarborough Hospital is the Trust’s second largest hospital. It has an Accident and Emergency department and provides acute medical and surgical services, including trauma and intensive care services to the population and visitors to the North East Yorkshire Coast. |
| Bridlington Hospital | Bridlington Hospital is a district hospital which provides surgical, rehabilitation, and outpatients services to the local Bridlington community. The hospital has two rehabilitation wards providing surgical and elderly care rehab. The hospital also has a minor injuries and GP access centre which are operated by City Healthcare Partnership. The GP |
MacMillan Wolds Unit and Buckrose Ward are run by Humber NHS Foundation Trust. The Hospital also has a renal dialysis unit which is run by Fresenius Medical Care Renal Services.

Northern Lincolnshire & Goole NHS Foundation Trust

Northern Lincolnshire & Goole NHS Foundation Trust (NLaG) provides acute secondary health care services to residents of North and North East Lincolnshire, East Riding of Yorkshire and East & West Lindsey, Lincolnshire and community services in North Lincolnshire. Networked services are provided in collaboration with HEY as the Trust’s main adult tertiary service provider, and the trust hosts pathology services for Northern & Greater Lincolnshire (there is currently a review of Pathology Services across the Midlands). NLaG employs approximately 6000 staff, with an annual turnover of £310m.

| Diana Princess of Wales Hospital (DPoW) | DPoW has approximately 400 beds, and currently provides a full range of emergency and secondary health care services, including an emergency care centre, intensive and high dependency care. |
| Scunthorpe General Hospital (SGH) | SGH with approximately 380 beds, provides a full range of emergency and secondary health care services, including an emergency care centre with an integrated model, and intensive and high dependency care. |
| Goole & District Hospital (GDH) | GDH has approximately 55 beds, and provides a Minor Injuries Unit, and a range of outpatient and diagnostic facilities, supported by SGH. GDH also houses a specialist rehabilitation service offering general medical and surgical rehabilitation. |
Equality Impact Assessment

Sustainability Impact Assessment

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