NHS
North Yorkshire
Clinical Commissioning Group

Title of Meeting:	NY CCG Governing Body	Agenda Item: 7.1
Date of Meeting:	24 June 2021	
Paper Title:	Operational Plan H1	

Session (Tick)	
Public	X
Private	
Development Session	

Responsible Governing Body Member Lead	Report Author and Job Title
Jane Hawkard Chief Finance Officer	Jane Hawkard Chief Finance Officer

Purpose – this paper is for:

Decision	Discussion	Assurance	Information
		X	X

Has the report (or variation of it) been presented to another Committee / Meeting?

If yes, state the Committee / Meeting: Yes. A version of this report has been submitted to the Humber, Coast & Vale ICS.

Executive Summary

The purpose of this report is to provide the Governing Body with an update on priorities and operational planning for 2021/22.

The 2021/22 priorities and operational planning guidance, published by NHS England and Improvement, sets the priorities for the year ahead, against a backdrop of the challenge to restore services, meet new care demands and reduce the care back logs that are a direct consequence of the pandemic, whilst supporting staff recovery and taking further steps to address inequalities in access, experience, and outcomes.

The Governing Body previously received the draft plan at the meeting in April 2021. The plan has now been submitted into the Humber, Coast and Vale ICS and consolidated with the Humber system into a single plan submission.

The final submission included four plans:

- Narrative plan
- Activity plan
- Finance plan
- Workforce plan

Appendix A provides an overview of the North Yorkshire & York Operational Plan.

Recommendations

The Governing Body is asked to:

- Note for assurance the final North Yorkshire & York Operational Plan that was submitted into the HCV ICS and consolidated with the Humber system into one single plan submission.

Monitoring

Reports will be received by FPCCC and the Governing Body.

CCG Strategic Objectives Supported by this Paper

	CCG Strategic Objectives	X
1	**Strategic Commissioning:** • To take the lead in planning and commissioning care for the population of North Yorkshire by providing a whole system approach and to support the development of general practice. • To make the best use of resources by bringing together other NHS organisations, local authorities and the third sector to work in partnership on improving health and care. • To develop alliances of NHS providers that work together to deliver care through collaboration rather than competition.	X
2	**Acute Commissioning:** We will ensure access to high quality hospital-based care when needed.	X
3	**Engagement with Patients and Stakeholders:** We will build strong and effective relationships with all our communities and partners.	X
4	**Financial Sustainability:** We will work with partners to transform models of care to deliver affordable, quality and sustainable services.	X
5	**Integrated / Community Care:** With our partners and people living in North Yorkshire we will enable healthy communities through integrated models of care.	X
6	**Vulnerable People:** • We will support everyone to thrive [in the community]. • We will promote the safety and welfare of vulnerable individuals.	
7	**Well-Governed and Adaptable Organisation:** In supporting our objectives we will be a well-governed and transparent organisation that promotes a supportive learning environment.	X

CCG Values underpinned in this paper

	CCG Values	X
1	Collaboration	X
2	Compassion	X
3	Empowerment	X
4	Inclusivity	X
5	Quality	X
6	Respect	X

Does this paper provide evidence of assurance against the Governing Body Assurance Framework?

YES		NO	X

Any statutory / regulatory / legal / NHS Constitution implications	The CCG must submit an operational plan to NHS England and Improvement.
Management of Conflicts of Interest	No conflicts of interest have been identified prior to the meeting.
Communication / Public & Patient Engagement	Not applicable.
Financial / resource implications	Any financial and resource implications are detailed within the paper.
Outcome of Impact Assessments completed	Not applicable.

Jane Hawkard, Chief Finance Officer

North Yorkshire and York

Summary System Operational Plan 2021/22

Compiled through partnership work across all health and care providers and commissioners

	NHS '6' PLANNING REQUIREMENTS	SPECIFIC REQUIREMENTS (draft plan 6th May, Final 3rd June)
A	Supporting the health and wellbeing of staff and taking action on recruitment and retention	Supporting the health and wellbeing of staff and taking action on recruitment and retention
B	Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19	Continuing to meet the needs of patients with Covid-19
C1	Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services	Maximise elective activity, taking full advantage of the opportunities to transform the delivery of service
C2		Restore full operation of all cancer services
C3a		Expand and improve mental health services [incorporated in section A.]
C3b		Expand and improve services for people with a learning disability and/or autism
C4		Deliver improvements in maternity care, including responding to the recommendations of the Ockenden review
D1	Expanding primary care capacity to improve access, local health outcomes and address health inequalities	Restoring and increasing access to primary care services
D2		Implementing population health management and personalised care approaches to improve health outcomes and address health inequalities
E1	Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay	Transforming community services and improve discharge
E2		Ensuring the use of NHS111 as the primary route to access urgent care and the timely admission of patients to hospital who require it from emergency departments
F	Working collaboratively across systems to deliver on these priorities	Working collaboratively across systems to deliver on these priorities [no requirement for narrative submission]

Executive Summary of Plan Headline Priorities

Health Inequalities

- 525 additional patients managed to target for **Hypertension** in 21/22
- 235 additional patients with **AF** treated with an anticoagulant
- support 6 practices with highest prevalence for **smoking to increase quits**
- Develop and implement a holistic approach across public services to **reduce obesity** in Scarborough
- Agree a **partnership plan** based on a collective and shared understanding
- **Grow capability** across our **BI and PH intelligence communities**
- Develop (along with opportunities from YHCR) a local **process for linking records**, including ability to access longitudinal data
- Incentivise a **PHM approach**

Acute & Cancer Recovery

- **Numbers waiting remains static** due to return to usual levels of referral demand (due to workforce recovery & IPC, mitigated through increased virtual consultations, PIFU, referral optimisation etc.
- Number of **52 week waits reduces by circa 25%** challenged specialties: ENT, urology, ortho, ophthalmology. 2,760 > 52wks by Sept
- **Sig. reduction in time waiting for Priority 2 patients – 90% seen in 28 days by Sept**
- Sig use of **Independent Sector at a cost of circa £5m per quarter** Apr-Sept
- Waiting well support for those low risk patients waiting
- **Lung Health Check programme expanding to Scarborough**
- Community diagnostic programme in progress

Primary Care

- **Appointments returned to pre-Covid levels**
- **Increasing PC workforce**
- MH Resilience hub available across HCV
- **Flu programme planning for 2021 plus continued Covid Vaccs.**
- **Covid vaccination plans continue to deliver**
- CCG continued support of **Local Care Partnerships** (E Coast, City of York, Vale & Selby, Harrogate, Hambleton & Richmondshire)

Mental Health Services –

- Deliver Mental Health Investment standard (MHIS)
- Implement agreed model of **health workers in primary care**
- Meet **Annual Health Check target for patients with LD (NY&Y met target by Q4 2020)**
- Crisis Alternatives
- Community Transformation (Integration)
- **MH Liaison in Scarborough Hospital**
- Learning Disabilities and Autism **reduce waits**
- Discharge Coordinators
- **CMH transformation**
- HCV Resilience Hub -provide a stepped care model of interventions with emphasis on personal resilience 20/21

Community Services

Admission Avoidance - 2 hour crisis response implementation & Joint health & social care team integrated approach across NYY

D2A –Embed Command Ctrs, Co-ordinators, Beds & Development future pricing & provision strategy

Frailty & Ageing Well

- Finalise PHM / Anticipatory Care model for Frailty –May 2021
- High-level integrated service model described – May 2021
- Prevention strategy focused on deconditioning – from May 2021
- **Whole System Frailty Pathway,** built on RightCare principles, incl. use of community-based assets, Rockwood Scale (CFS), Frailty Stratification Assessment Tool (FAST), ACPs, EHCPs & MDT care co-ordination **described & implementation plan developed – June 2021**
- 7 day frailty turn-around at hospital front door – October 2021

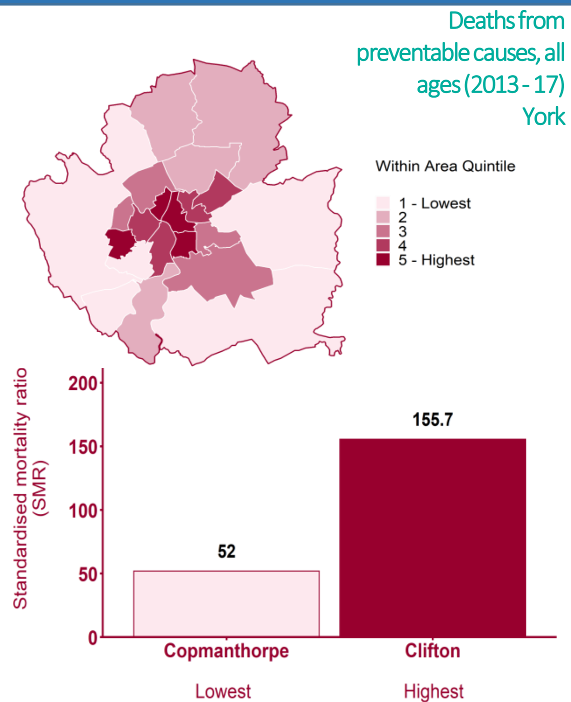
Long Covid & Pulmonary Rehab

- Long covid working group develop services / models – established May 2021
- Providers to develop business cases / recruitment plans to extend and develop **Long Covid assessment clinics and sign-off at place – June 2021**
- Plans to increase Pulmonary Rehab. services - by end June 2021
- Oximetry@Home & Virtual Ward reviewed for ongoing requirements – May 2021

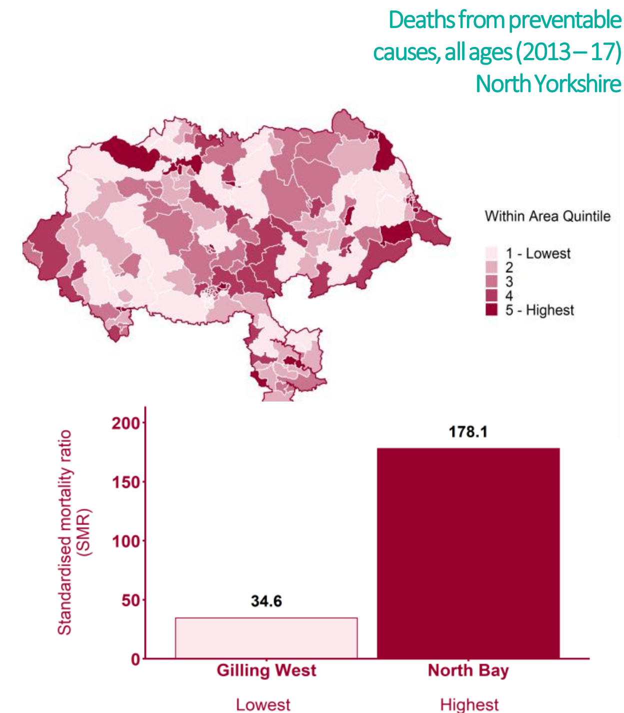
North Yorkshire and York

FOCUSSING ON & TACKLING HEALTH INEQUALITIES

Health Inequalities in North Yorkshire and York – Our Challenge



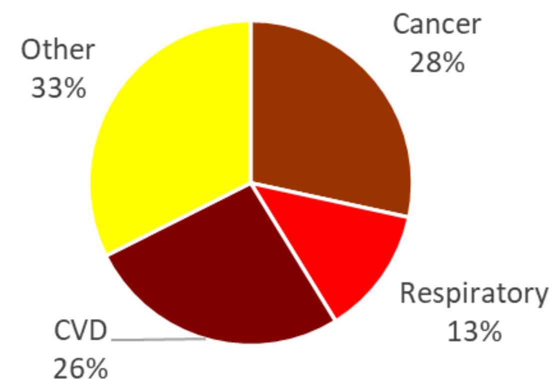
- **Premature mortality**: a three- to five-fold difference in expected deaths from preventable causes across areas within NY+Y
- **Life expectancy**: gap between wards in York of 10.1 years (Male) and 7.9 years (Female), and in NY of 15.2 years (Male) and 12.4 years (Female)
- **Emergency admissions to hospital**: there is a 50% range (York) and 60% range (North Yorkshire) in standardised admission ratio between wards.
- **Deprivation**: 10,000 people in York (4.8%) and 36,000 (5.8%) people in North Yorkshire live in the bottom 20% on the index of multiple deprivation



Disease burden: The prevalence of diabetes (by GP) ranges from 4.5% to 9.8% in North Yorkshire and from 1.4% to 6.9% in York (vs 7.1% for England), while the prevalence of coronary heart disease ranges from 1.6% to 6.4% in North Yorkshire and from 0.8% to 4.6% in York (vs 3.1% for England).

Learning Disabilities: There are 1,153 people on a learning disability register in the Vale of York CCG area (0.3%) 2,460 (0.6%) in the North Yorkshire CCG area vs 0.5% for England

Ethnicity: The proportion of people from a 'non-white' background is lower than averages in NY (5.6%) and York (9.8%), but several wards have much larger populations e.g. Hull Road in York (22.6%), Harrogate Central in NY (21.2%).



Focussing Our Plans: Pattern of risks affecting health and wellbeing

C Attributable risks

Physiological risks:
High Blood Pressure
High Cholesterol
Chronic Stress hormones
Anxiety/depression

B Causes

Behavioural risks:
Smoking
Poor diet
Lack of activity
Substance abuse

A Causes of the causes

Psycho-social risks:
Isolation
Lack of social support
Poor social networks
Low self esteem
High self blame
Low perceived power
Loss of meaning/purpose of life

Risk conditions: eg
Poverty
Low social status
Poor education
Attainment
Unemployment
Dangerous environments
Discrimination
Steep power hierarchy
Gaps/weaknesses in services and support

Improving Health Inequalities – Priorities for 2021-22

Priority Areas of Focus 2021-22 and 2021-22	What do we want to achieve, by when?	How are we going to achieve?
Hypertension • NY+Y has the lowest diagnosis rate in HCV (60.5% in VOY, 66.0% in NY vs STP average of 67.7%) • 10,500 patients with hypertension not managed to target Atrial Fibrillation • 470 NY+Y high risk AF patients need to be anti-coagulated. • NNT to prevent 1x stroke = 60 (vs 1000 for diet, exercise etc).	525 additional patients treated for Hypertension to target by end of 2021/22 (the 10,500 is an ambition over more years) 235 additional patients with AF treated with an anticoagulant by end of 2021/22	• Treat to target through QOF process • Case finding (practice searches, RAIDR, ARDENS) • NHS Healthchecks (15.4% (York) and 45.2% (NY) of the eligible population received an NHS Health Check 2015-20 • Digital interventions eg BP@home, ECG for people on antipsychotics
Smoking • 6 GP practices in NY+Y with smoking prevalence higher HCV average • Cigarettes kill 1 in 2 users, still leading cause of preventable mortality Obesity • 36 out of 77 GP practices in NY+Y have obesity prevalence higher than national GP average • Variation in physical inactivity rates between Harrogate (14.6%) and Scarborough (23.4%)	Work intensively across health and care supportively with 6 practices with highest prevalence for smoking to increase quits Develop and implement a holistic approach across public services to reduce obesity in Scarborough	• Tobacco dependency treatment in inpatient, outpatient and maternity settings (LTP, £4.2m for HCV by 2024) • Support and integrated working with local authority public health services (example of York Health Trainer model) • Weight management and NHS Diabetes Prevention Programme
Unequal distribution of the Wider determinants of Health	• local Authority lead	• Anchor institution work – procurement, training, local employment, investing in communities • Sustainable practice eg green general practice, sustainable Rx, travel planning, work with fleet and energy providers to tackle emissions and air pollution • VCSE links and capacity building • Green social prescribing

Health Inequalities Planning - Five priority areas

Priority 1: Restore NHS services inclusively	Priority 2: Mitigate against digital exclusion	Priority 3: Ensure datasets are complete and timely	Priority 4: Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes	Priority 5: Strengthen leadership and accountability
• pre-existing disparities in access, experience, and outcomes, have been exacerbated by the pandemic. • systems use their data to plan the inclusive restoration of services, guided by local evidence. • NHS performance reports that are delineated by ethnicity and deprivation	• providers offer face-to-face care to patients who cannot use remote services • more complete data collection of face-to-face, telephone, or video consultations, broken down by protected characteristic and health inclusion groups • take account of their assessment of the impact of digital consultation channels on patient access.	• continue to improve the collection and recording of ethnicity data across primary care, outpatients, A&E, mental health, community services, and specialised commissioning. • Health Inequalities Improvement Dashboard, including e.g. for people experiencing post- COVID syndrome. • mandatory ethnicity data reporting in primary care, to enable demographic data to be linked with other datasets and support an integrated approach to performance monitoring for improvement.	• increase vaccination uptake in groups that had a lower uptake than the overall average as of March 2021. • Ongoing management of long-term conditions • Annual health checks for people with a learning disability • Annual health checks for people with serious mental illness • In maternity care, implementing continuity of carer for at least 35% of women, with ethnicity and socio-economic groups meeting and preferably exceeding the proportion in the population as a whole.	• Systems and providers should have a named executive board-level lead for tackling health inequalities. and should access training made available by the Health Equity Partnership Programme.

North Yorkshire and York

Acute, Cancer & Mental Health

Accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services

Acute Hospital Recovery trajectories (draft)

	Baseline	Forecast					
York and Scarborough Teaching Hospitals NHS FT	Mar-2021	Apr-2021	May-2021	Jun-2021	Jul-2021	Aug-2021	Sep-2021
Total incomplete RTT pathways at end of month	28,691	29,336	29,152	28,968	28,784	28,600	28,416
Incomplete RTT pathways over 52 weeks	2,446	2,339	2,232	2,125	2,018	1,911	1,804
Incomplete P2 pathways at end of month	688	695	681	688	674	681	667
Incomplete P2 pathways over 4 weeks (28 days)	334	313	238	172	135	102	67
Percentage of P2 pathways under 4 weeks	51%	55%	65%	75%	80%	85%	90%

Humber, Coast, and Vale Acute Providers: Referral to Treatment Times Forecasts 2021/2022 Q1-Q2

from draft plans, April/May 2021

		Baseline	Forecast					
Organisation	Item	Mar-2021	Apr-2021	May-2021	Jun-2021	Jul-2021	Aug-2021	Sep-2021
Harrogate and District NHS Foundation Trust	Total incomplete RTT pathways at end of month	17323	18,568	19,313	19,758	19,903	20,220	20,337
	Incomplete RTT pathways over 52 weeks	1345	1,334	1,289	1,237	1,143	1,058	956
	Incomplete P2 pathways at end of month	362	398	393	386	378	385	369
	Incomplete P2 pathways over 4 weeks (28 days)	108	102	86	70	54	39	37
	Percentage of P2 pathways under 4 weeks	70%	74%	78%	82%	86%	90%	90%

Cancer Services Recovery

Cancer Metrics by Provider

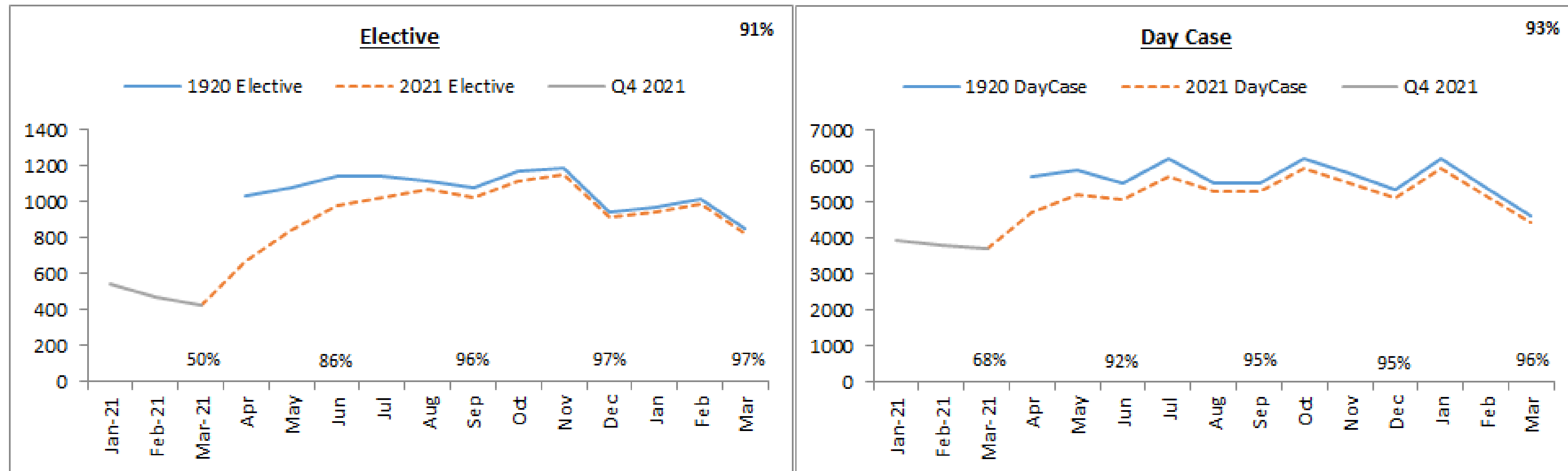
Provider Level					Feb-21	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021
RCB	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	E.B.32	Count	The number of cancer 62 day pathways (patients with and without a decision to treat, but yet to be treated or removed from the PTL) waiting 63 days or more after an urgent suspected cancer referral excluding non site specific symptoms	137	163	157	151	145	140	135
		E.B.31	Count	Total number of patients receiving first definitive treatment for cancer within 31-days for all cancers (ICD-10 C00 to C97 and D05)	280	250	256	259	264	220	260
		E.B.30	Count	Numbers of patients seen in a first outpatient appointment following urgent referrals	1229	1826	1735	2009	2009	1918	2009

Provider Level					Feb-21	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021
RCD	HARROGATE AND DISTRICT NHS FOUNDATION TRUST	E.B.32	Count	The number of cancer 62 day pathways (patients with and without a decision to treat, but yet to be treated or removed from the PTL) waiting 63 days or more after an urgent suspected cancer referral excluding non site specific symptoms	35	25	25	25	20	20	20
		E.B.31	Count	Total number of patients receiving first definitive treatment for cancer within 31-days for all cancers (ICD-10 C00 to C97 and D05)	68	78	94	99	93	102	82
		E.B.30	Count	Numbers of patients seen in a first outpatient appointment following urgent referrals	612	826	995	844	993	941	801

Key progress to notes:

- Lung Health Check programme expanding to Scarborough
- Community diagnostic programme in progress
- Trajectories include assumptions on bounce back of demand following supressed demand through Covid period

South Tees Trust – Elective Planning Trajectories



POD	APR	MAY	JUN	JUL	AUG	SEP
Elective Overnight	65%	79%	86%	90%	95%	96%
Elective Daycase	83%	88%	92%	92%	96%	95%
National Planning	70%	75%	80%	85%	85%	85%

Recovery Mental Health Services

	2020-21					
	Q1	Q2	Q3	Q4 Provisional	Annual provisional	14+ LD List Size Q4 - RAIDR
VoY CCG LD Health Checks	48	174	376	413	1011	1,273
VoY CCG Performance	3.80%	13.70%	29.50%	32.40%	79.40%	
NY CCG LD Health Checks	106	281	577	734	1698	2267
NY CCG Performance	4.70%	12.40%	25.50%	32.40%	74.90%	

LD Health Checks

	Q1 Plan (Cumulative)	Q2 Plan (Cumulative)
Vale of York CCG	18.6%	37.1%
North Yorkshire CCG	8.5%	22.0%
National Expectation by Q4	70.0%	70.0%

Adults with LD in Inpatient Care - CCG Commissioned

	Q1 Plan	Q2 Plan
Vale of York CCG	9	8
North Yorkshire CCG	2	2

Adults with LD in Inpatient Care - NHSE Commissioned

	Q1 Plan	Q2 Plan
Vale of York CCG	5	5
North Yorkshire CCG	7	7

North Yorkshire and York

PRIMARY CARE RECOVERY

Expanding primary care capacity to improve access, local health outcomes and address health inequalities

Primary Care Planning 2021/22 – PCNs, Place and Priorities

NHS North Yorkshire and York ICP

North Yorkshire			Vale of York	
Harrogate	Hambleton & Richmondshire	East Coast	Vale	York Health and Care Alliance
Heart of Harrogate Knaresborough and Rural Ripon and Masham District Mowbray Square Yorkshire Health Network	Hambleton North Hambleton South Richmondshire (Whitby Coast & Moors) Heartbeat Alliance	Ryedale Scarborough Core Filey and Scarborough Stronger Communities (Whitby Coast & Moors)	Selby Town Tadcaster & Rural Selby South Hambleton & Ryedale	Priory Medical Group York Medical Group West, Outer and NE York York City Centre York East NIMBUS Care

Digital and technology

Priority 1 – Good access to Primary Care services and reducing any backlog

Priority 2 – Supporing Practice workforce wellbeing

Priority 3 – Covid-19 Vaccination Programme, winter flu campaign, Covid booster

Priority 4 – PCN organisational development and partnership working

Priority 5 – Estates plans and local partnerships

Population Health Management

Primary Care Recovery Priorities

Priorities

- Restoring and maintaining **good access to Primary Care services for all**, whilst using learning from the past year to manage demand differently
- **Reducing any backlog** around routine reviews for chronic conditions and screening work, and supporting patients waiting for hospital procedures and appointments
- Continuing to support Practice **workforce wellbeing** – both clinical and non-clinical
- Continuing to lead on delivery of the national **Covid-19 vaccination programme**
- **Supporting PCN organisational development** and strengthening partnership working
- **Advancing estates plans in Place** with local Partners to address new ways of working and growth in population and housing
- Using **Population Health Management** programmes to identify areas of inequality, disease burden, and high volume/cost pathways in order to prioritise service transformation work
- Developing a targeted programme of work to **use digital/technology to improve access** to care for our population

Plans

- Appointments already returned to pre-Covid levels
- Increasing PC workforce
- MH Resilience hub available across HCV
- Flu programme planning for 2021 plus continued Covid Vaccs.
- CCG continued support of Operating Locality development (E Coast, City of York, Vale & Selby, Harrogate, Hambleton & Richmondshire)
- Catterick plus other ETTF programme pipeline continues
- Optum programme and Operating Locality programme development
- HCV digital programme implementation

Humber, Coast and Vale

NY&Y SYSTEM PRIMARY CARE INVESTMENT PLAN

Envelope Growth CCG Delegated Primary Care Allocations

Half Year Uplifts (£000)	North Yorkshire	Vale of York	Total NYY	**Purpose**
Uplift to 21/22 published allocation level	632	853	1,484	GP Contract and other PC uplifts
Additional Roles Reimbursement Scheme	599	470	1,068	FYE & expansion of existing scheme to include 3 additional roles (Social Prescribing Link Workers, Health and Wellbeing Coaches, and Care Coordinators). 44% £746m still held centrally.
Investment & Impact Fund (IIF)	193	146	339	Incentive scheme to support PCNs. Triple aim: improving health and saving lives (medicines safety); improving quality of care for people with multiple morbidities (increasing referrals to social prescribing services); and helping to make the NHS more sustainable.
Care Home Premium	296	162	458	Strengthen support for people who live and work in and around care homes. People living in care homes should expect the same level of support as if they were living in their own home.
Increase in Practice Funding	76	58	134	To fund updates to the GP contract agreement: 2020/21-2023/24
NEW QOF Indicators	311	236	547	Share of £24m for the new QOF indicator for mental health – severe mental illness (new for 2020/21), and • £58m for the new QOF indicators for vaccinations and immunisations, previously funded from public health budgets (new for 2020/21)
Other	61	0	61	Including recurrent 20/21 transfers
Total 2021/22 Uplift	**2,167**	**1,924**	**4,091**	

Service Development Funds (Directly Allocated) £000	North Yorkshire	Vale of York	Total NYY
GP IT Infrastructure and Resilience (revenue)	49	37	86
Improving Access	386	1,012	1,398
Total SDF Directly Allocated	**435**	**1,049**	**1,484**

Additional SDF is also held within HCV for investment in the following areas.
The method of distrubution has not yet been agreed:

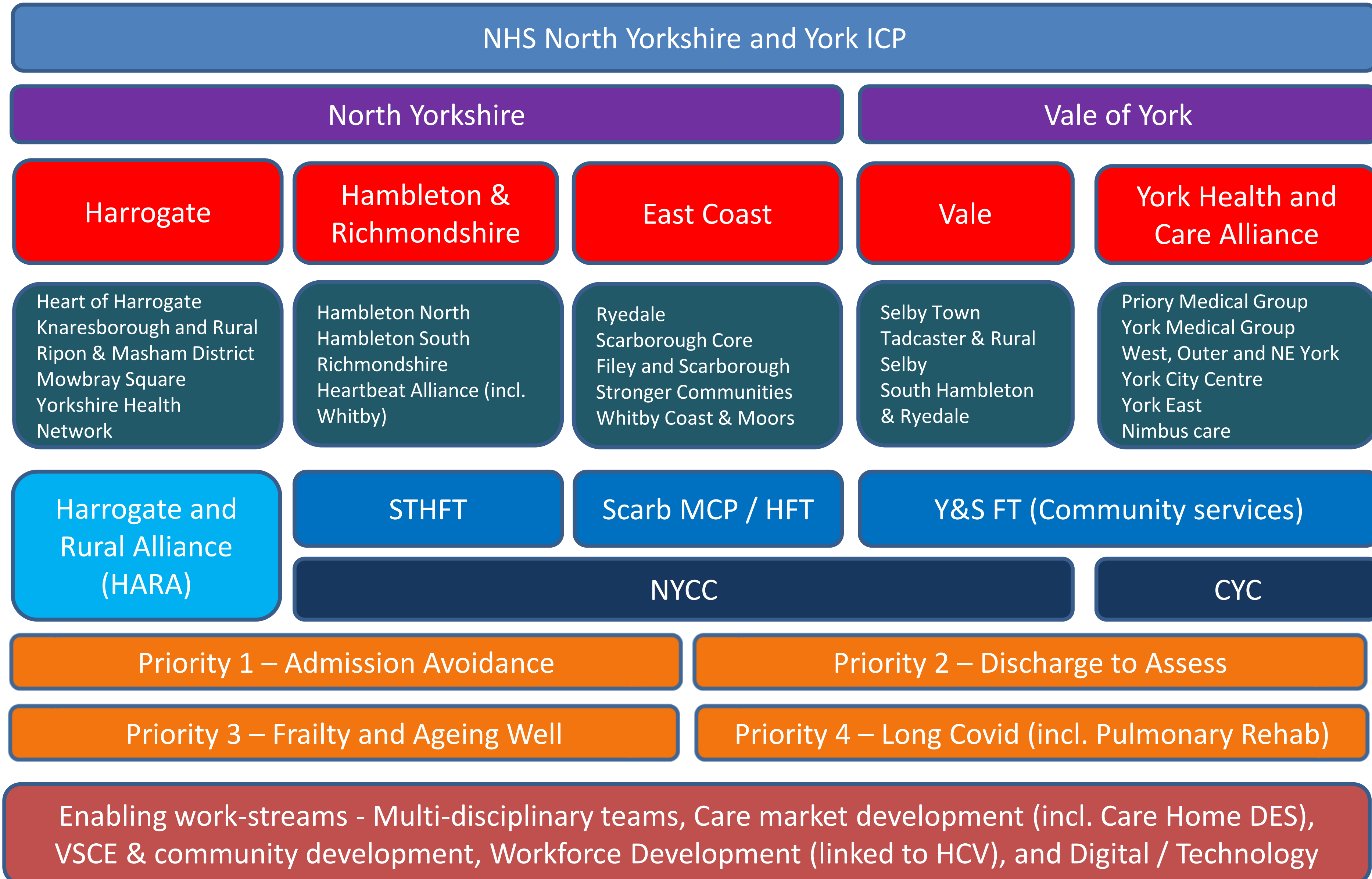
Workforce: Training Hubs
Primary Care Networks - development and support systems - circa £589k for NY&Y
Practice resilience programme - local
Online consultation software systems (local)
Primary Care - Covid Support share of £120m circa £2m for NY&Y

North Yorkshire and York

TRANSFORMING COMMUNITY & URGENT CARE SERVICES

Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay

Community Planning 2021/22 - Place and Local Care Partnership integrated models and Priorities



2021/22 Operational Planning Guidance

Community System requirements

A. Health and wellbeing of staff / recruitment and retention

- Major expansion and development of integrated teams in the community, with PCNs serving as the foundation
- Local workforce supply plan with a focus on both recruitment and retention

B. Continuing to meet the needs of patients with COVID-19

- Continue to prepare for future potential surge requirements
- Continued use of home oximetry and Hospital-led 'virtual wards'
- Access to Post COVID Syndrome ('Long COVID') assessment services.

E. Transforming community services and improve discharge

- More patients to be cared for in the optimal setting to reduce pressure on hospitals
- Accelerate the rollout of the 2-hour crisis community health response accessed through NHS111 (8am-8pm, seven days a week) by April 2022 through agreed plans.
- Complete and accurate data to the Community Services Dataset (CSDS) in 2021/22.
- Timely and appropriate discharge from hospital inpatient settings
- Improvement in average length of stay particularly for 14 and 21 days

F. Develop local priorities that reflect local circumstances and health inequalities

- Systems are asked to develop their own set of local health and care priorities
- NYY sub-system shared priority is **Frailty**.

Priority projects & timescales

- **Admission Avoidance**
  - 2 hour crisis response implementation
  - Joint health & social care team integrated approach across NYY
- **D2A**
  - Build on Covid arrangements – Command Ctrs, Co-ordinators, Beds
  - Market Development with NYCC on future pricing & provision strategy
- **Frailty & Ageing Well**
  - Finalise PHM / Anticipatory Care model for Frailty –May 2021
  - High-level integrated service model (incl. care record requirements) described – May 2021
  - Prevention strategy focused on deconditioning – from May 2021
  - Whole System Frailty Pathway, built on RightCare principles, incl. use of community-based assets, Rockwood Scale (CFS), Frailty Stratification Assessment Tool (FAST), ACPs, EHCPs & MDT care co-ordination described & implementation plan developed – June 2021
  - Implementation of model & pathway by place –July 2021 to March 2022
  - Strengthened utilisation of community assets – September 2021
  - 7 day frailty turn-around at hospital front door – October 2021
  - Frailty competency development at place – by end March 2022
- **Long Covid & Pulmonary Rehab**
  - Friarage service for H&R patients to commence – by end April 2021
  - Long covid working group develop services / models – established by end May 2021
  - Providers to develop business cases / recruitment plans to extend and develop Long Covid assessment clinics and sign-off at place – by end June 2021
  - Long Covid capacity and capability to be reviewed ahead of winter – by end Sept 2021
  - NY&Y Pulmonary Rehabilitation working group established – by end April 2021
  - Plans to develop PR services - by end June 2021
  - Oximetry@Home and Virtual Ward reviewed for ongoing requirements – by end May 2021