Oxford Health NHS Foundation Trust

Oxford University Hospitals NHS Foundation Trust

NHS Oxfordshire Clinical Commissioning Group

OxFed
Oxford Federation for General Practice and Primary Care

PML PRINCIPAL MEDICAL

Health and Care Transformation in Oxfordshire

Stuart Bell – Chief Executive
Oxford Health NHS Foundation Trust

Monday 6 June 2016

Objectives

- At an event in Oxford on 6th June 2016, we signalled the start of a public conversation about the case for change in transforming health and care in Oxfordshire and the emerging models of care.

- These slides have since been updated to reflect the rich feedback we received from the audience (slide 3)

- We want to get everyone's views to help inform our thinking and help us to develop plans as part of an on-going process that will lead to public consultation later in the year.

What you told us . . .case for change

There was general understanding and agreement on the Case for Change and vision for Oxfordshire. Common issues raised by attendees on the day included:

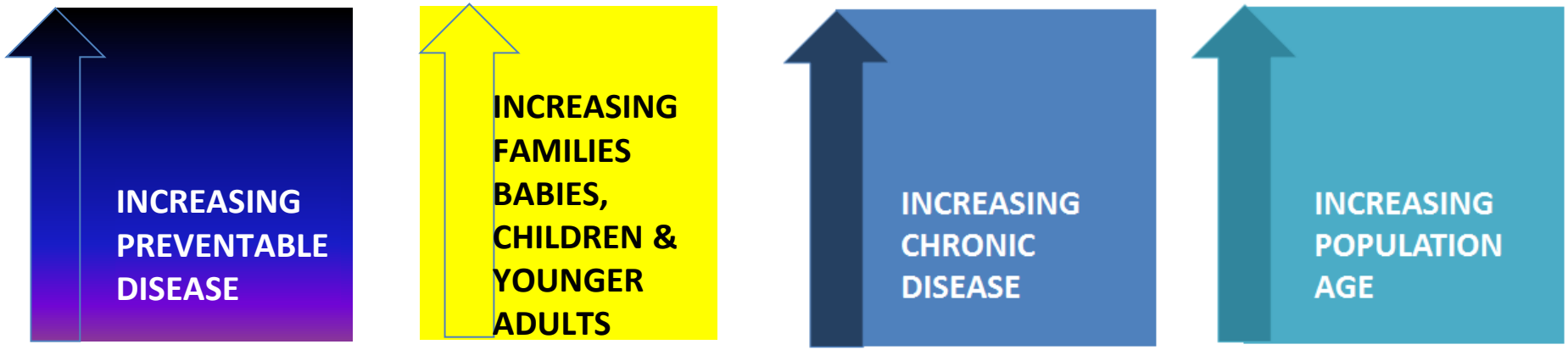
- The need to **change culture** across both patients, public and staff
- To increase messages on importance of **prevention** and behaviour change
- **Acknowledge difficulties / risks** in the Transformation process
- Highlight importance of **extending skill sets of current staff/**workforce
- Include details of finance and **be open about the cost of transition**
- **Consider and manage the impact of change/cuts on other services**
- To much focus is on urban areas, **reflect large rural proportion too**
- Greater recognition of children and young adults esp. prevention & lifestyle
- Greater recognition of the potential for technology to support patients
- Greater focus on voluntary, carers and support to patients

Context: Oxfordshire in a snapshot

- **672,000 population** - increased more than 10% in 15 years and growing
- Families moving in to urban areas, rural areas typically elderly population
- **Increasing** births, people with long term conditions and frail elderly
- **90,000 residents limited** in their daily activities due to disability
- Oxfordshire is generally healthy but **61% are overweight - obese**
- Number of people with **diabetes forecast to increase by 32%** by 2030
- Over half of all **mental ill health** starts by age of 14
- **75% of mental health** developed by the age of eighteen
- Oxfordshire health care services are **comparatively efficient & effective**

➢ To respond to the challenges we face we need to consider fundamental changes – we cannot continue to do more of the same!

In Oxfordshire our health needs are changing



In Oxfordshire our population is changing – this means health needs may change

In 2011: Black and minority ethnic (BME) communities make up 9% of our population - this has increased twofold in the past ten years.

Possible impacts are language and cultural barriers to access services; some BME groups are more likely to get certain illnesses e.g. people from South East Asia are more likely to get type 2 diabetes

22,000

new homes

Planned for Bicester and Didcot

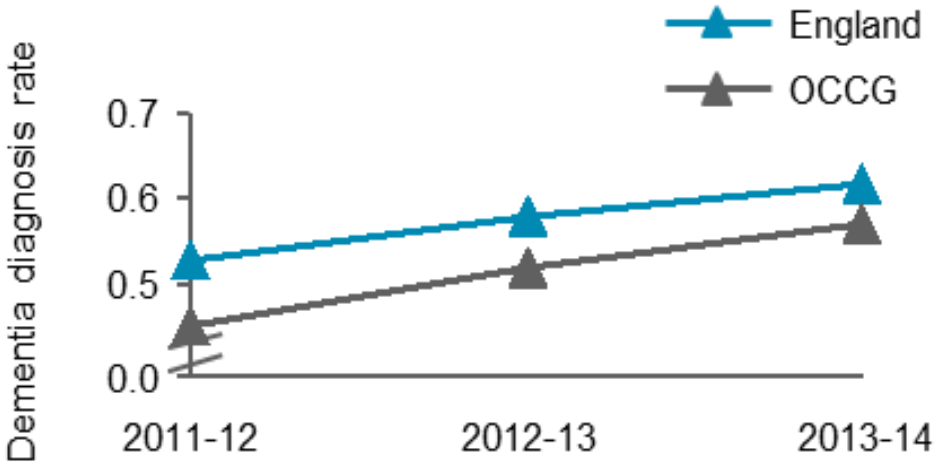
Impact: new facilities might be needed in areas of housing growth including primary care

In Oxfordshire disease levels are rising

Obesity, COPD and diabetes continue to increase

- 61% of Oxfordshire's adult population are overweight or obese
- the number of people with diabetes is forecasted to jump 32% to 41,000 by 2030

Dementia prevalence rising

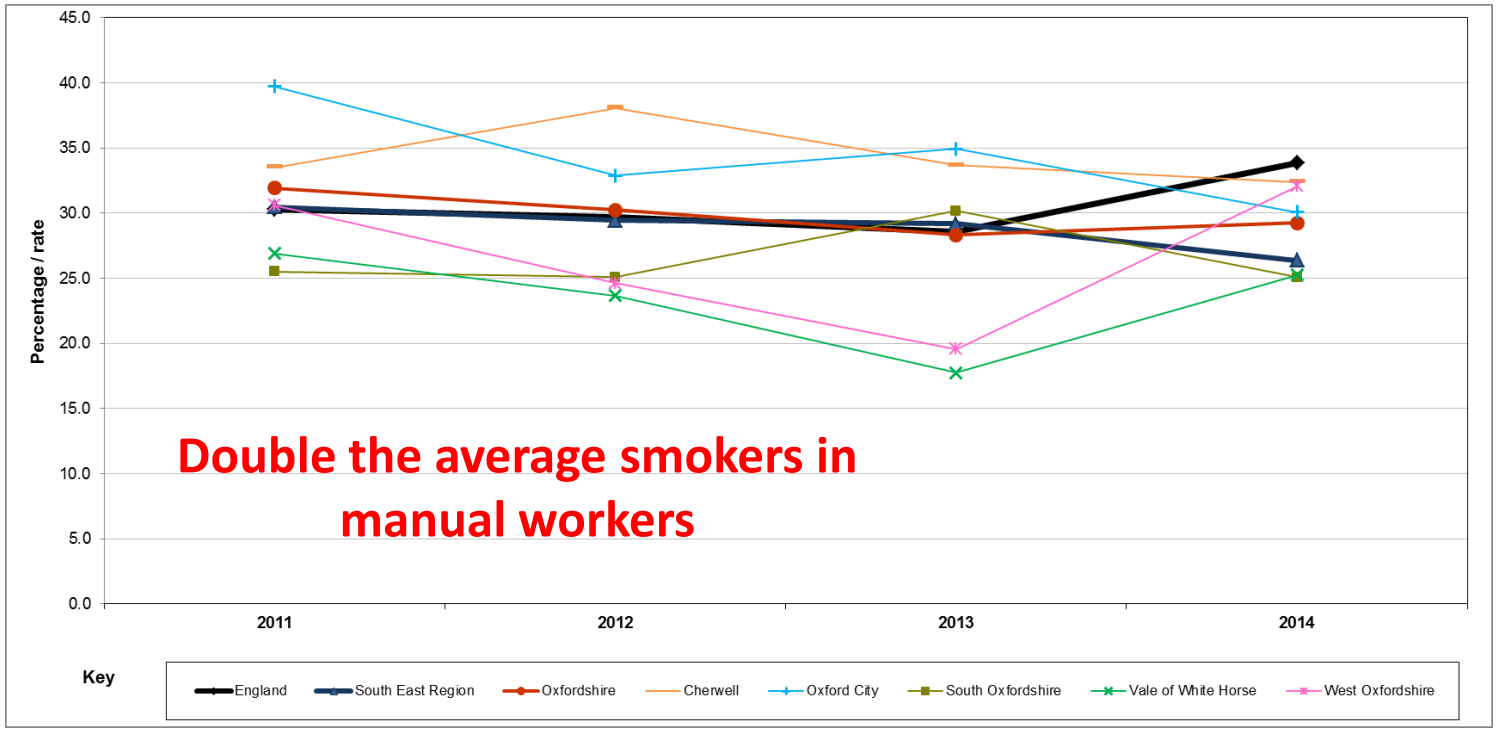


Source: Oxfordshire JSNA, March 2015; APHO Diabetes Prevalence Model for England, 2009; Most Capable Provider Assessment – Older People, June 2014

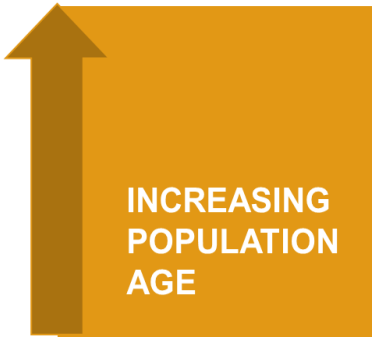
Much of this disease is preventable and stems from

- Unhealthy lifestyles - inactivity, obesity, smoking & alcohol consumption
- Inequalities - smoking rates 2x higher in manual workers to county average

Table shows average prevalence of smoking among persons aged 18 years and over in the routine and manual group (2011 to 2014)



In Oxfordshire our health needs are changing



Ageing population

65+: **18% increase →**

forecast to grow to 140k people by 2025

85+: **30% increase →**

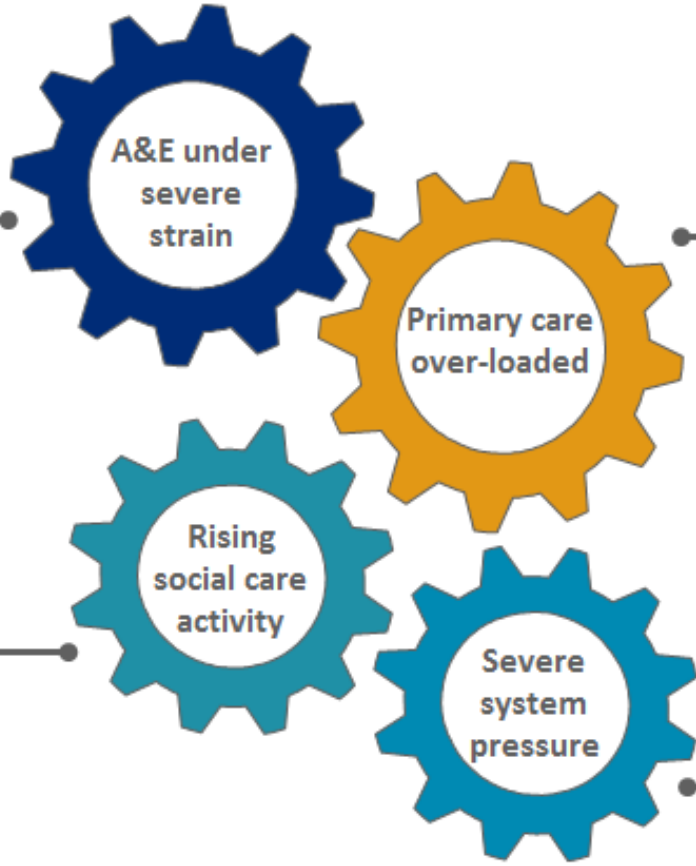
forecast to grow to 22k people by 2025

Source: Oxfordshire JSNA, March 2015; APHO Diabetes Prevalence Model for England, 2009; Most Capable Provider Assessment – Older People, June 2014

In Oxfordshire we could do better . . .

…we are increasingly struggling across the system to deliver good access for our people when they need it

20% of our people choose A&E rather than GP
A&E attendances rising by 1-3% yearly.



Some patients struggle to see their GPs.
29% reported the length of wait as unacceptable

An average of 12 days between clients' being ready and receiving long-term home care.
Commissioning 53% more home care than in 2011.

Management of long term conditions.
31% said they received good care managing their long term condition

In Oxfordshire we could do better

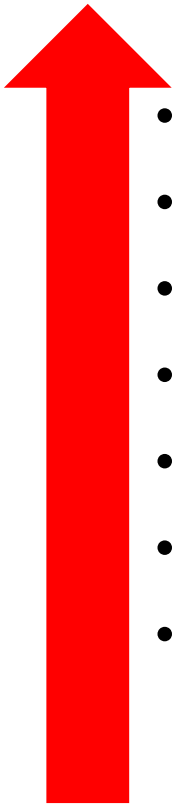
We have identified 3 health and wellbeing gaps we can help to fill:

- A lifestyle and motivation gap - making it easier for people to help themselves using apps and the web
- A service gap – helping clinicians prevent ill health by improving unhealthy lifestyles
- A community gap - healthier community design and, as the county's largest employer, our workforce's health

In Oxfordshire we are facing many challenges

The challenges facing health & care are many and varied:

- Increasing hospital demand
- Increasing complexity
- Increasing cost pressures
- Workforce pressures
- GPs under pressure
- 'Sickness'- crisis response
- How to make a shift from sickness services to preventative services



- 15% over next 5 years
- Long term conditions & frailty
- New drugs and inflation
- Recruitment & retention
- Extended hours & 7 day services
- New model of 'anticipatory' care
- How to tackle inequalities at source

The Oxfordshire Transformation Programme

NHS and partners, with Healthwatch and lay representative

Our aims are to:

- Reduce preventable ill health and reduce inequalities
- Propose innovative models for delivering high quality services, experiences and outcomes that are sustainable and meet the needs of an expanding population that lives longer with increasing healthcare needs
- Maximise the value and impact of the Oxfordshire health and social care £
- Find ways to become better at preventing illness and managing our health
- Help individuals to take greater responsibility for their own health
- Interactions and expectations are changing, for example Health 'Apps'

We are:

NHS Oxfordshire Clinical Commissioning Group

Oxford University Hospitals NHS Trust

Oxford Health NHS Foundation Trust

South Central Ambulance Service NHS Trust

PML Principal Medical

OxFed

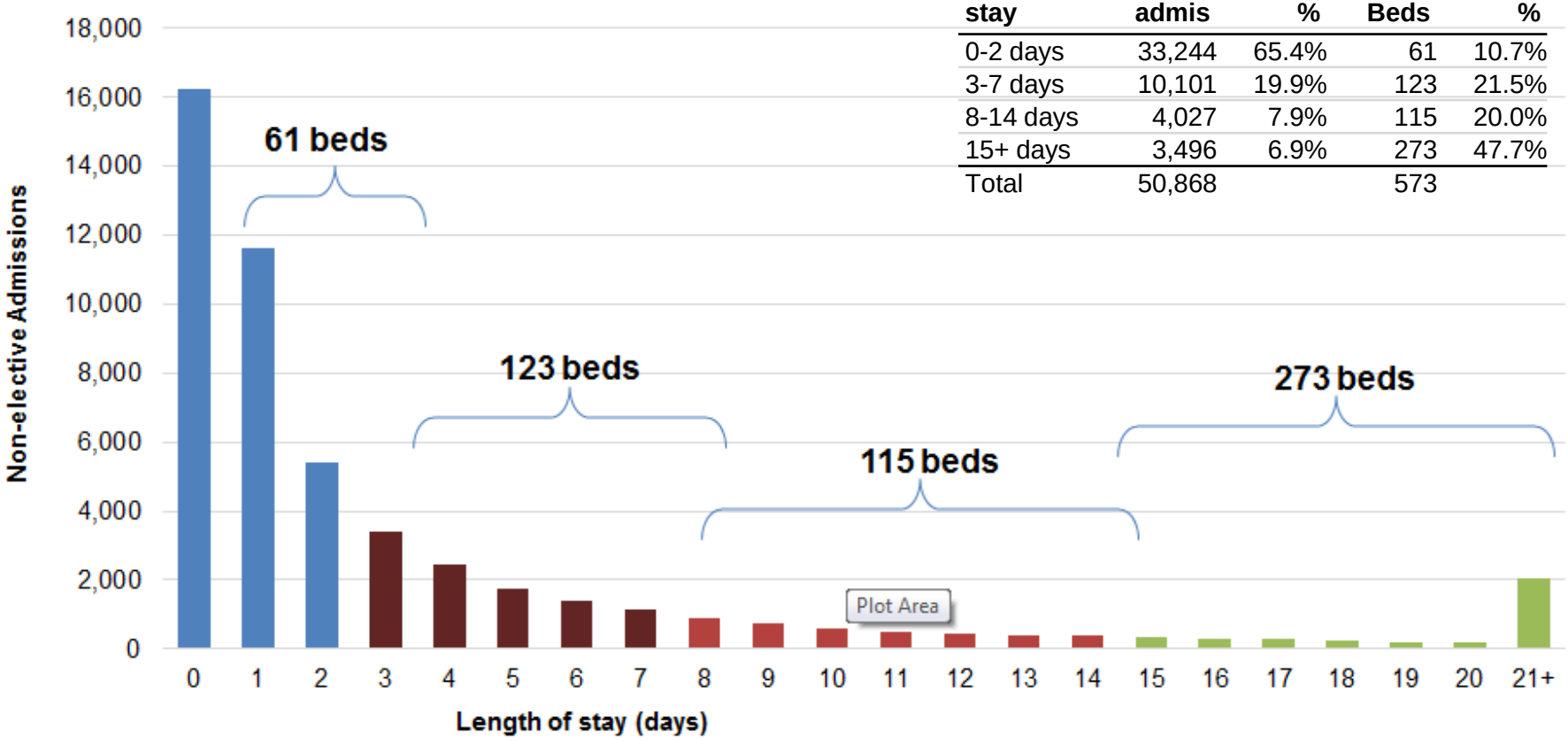
Abingdon Federation

South East Federation

Early messages – non elective admissions

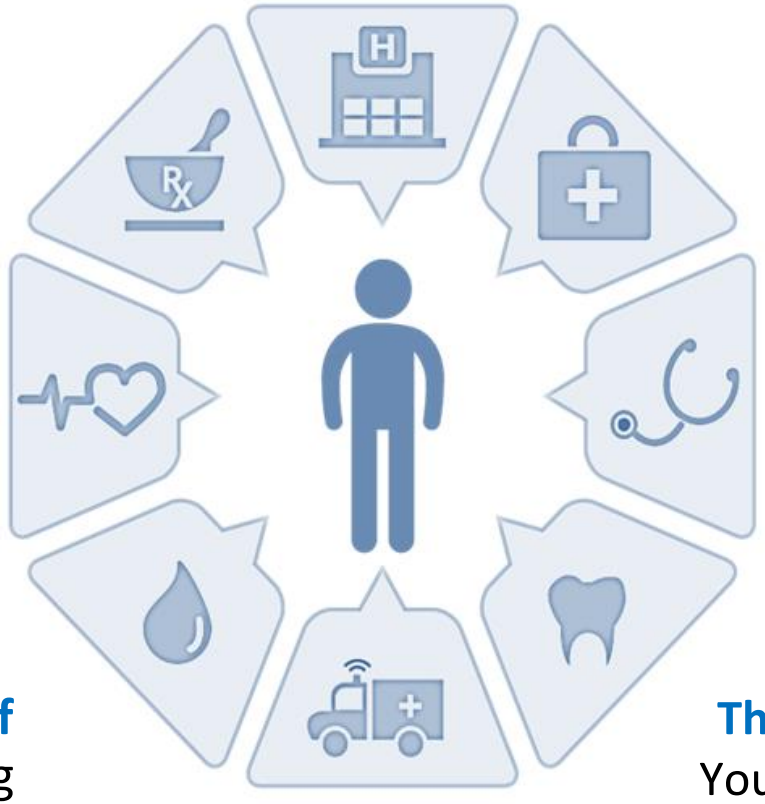
Are our resources spent in the right place?

Length of stay	NEL admis	%	Beds	%
0-2 days	33,244	65.4%	61	10.7%
3-7 days	10,101	19.9%	123	21.5%
8-14 days	4,027	7.9%	115	20.0%
15+ days	3,496	6.9%	273	47.7%
Total	50,868		573	



Oxfordshire Vision

Accountability to patients will be clear and consistent
A designated clinician responsible for their patient 24/7



Resources and infrastructure reallocated to match need and enhance convenience
on-line monitoring, longer appointments, diagnostic centres in the community

Staff make full use of their skillsets, cutting across organisational boundaries, supported by modern technology

Prevent what can be prevented and level up inequalities

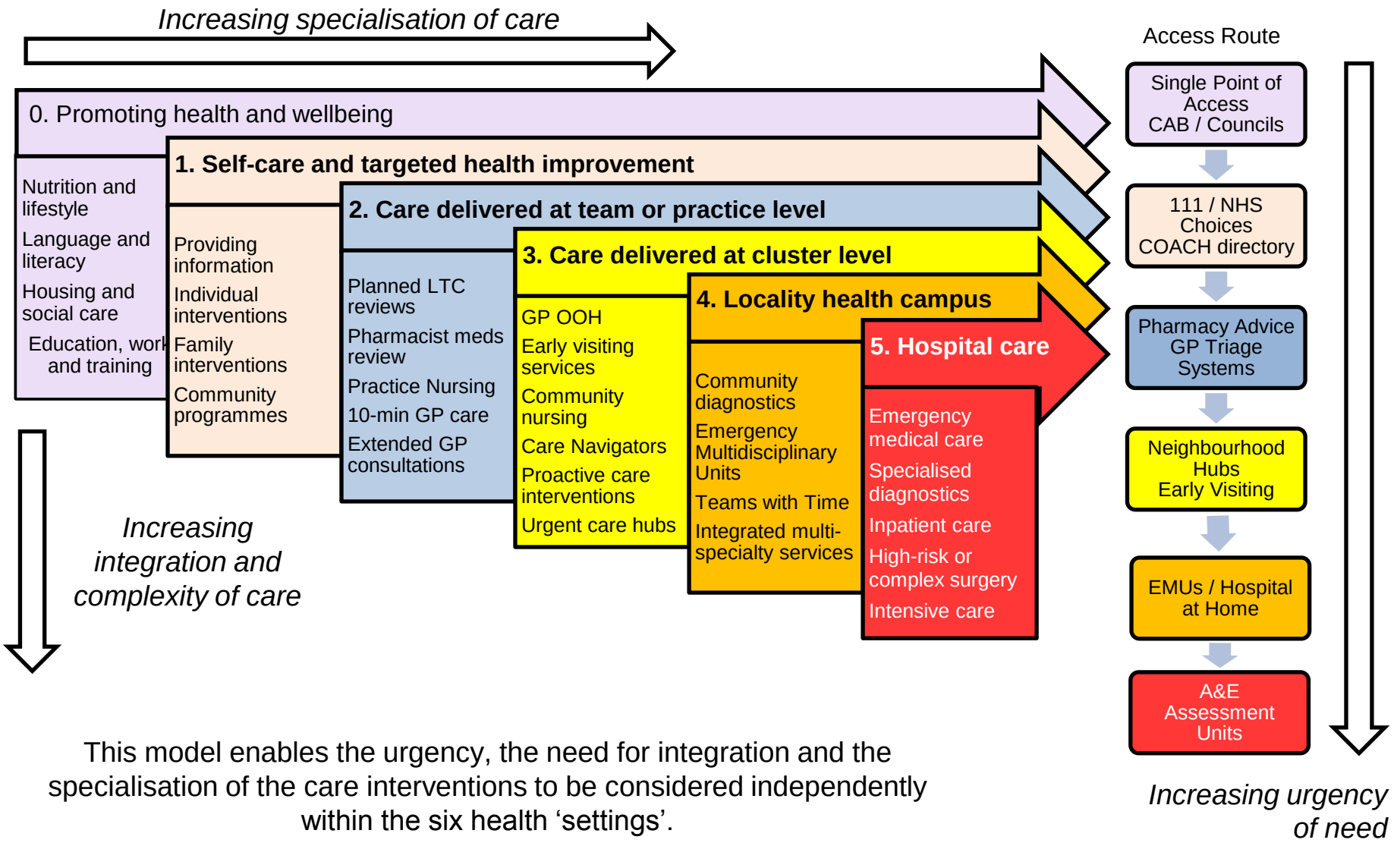
The best bed is your own bed
You are only admitted to a bed when and where it's absolutely appropriate to your needs

Care closer to home

So that people in Oxfordshire can get more care at home – or closer to home. To do this we will:

- increase people's confidence to manage their own care
- General Practice as 'the gate keeper'
- deliver more integrated GP, community, hospital & social care
- manage the population's health to improve outcomes
- increase the capacity of community workforce
- organisations working together across Oxfordshire
- services focusing on quality, experience and outcomes

Care Closer to home Model

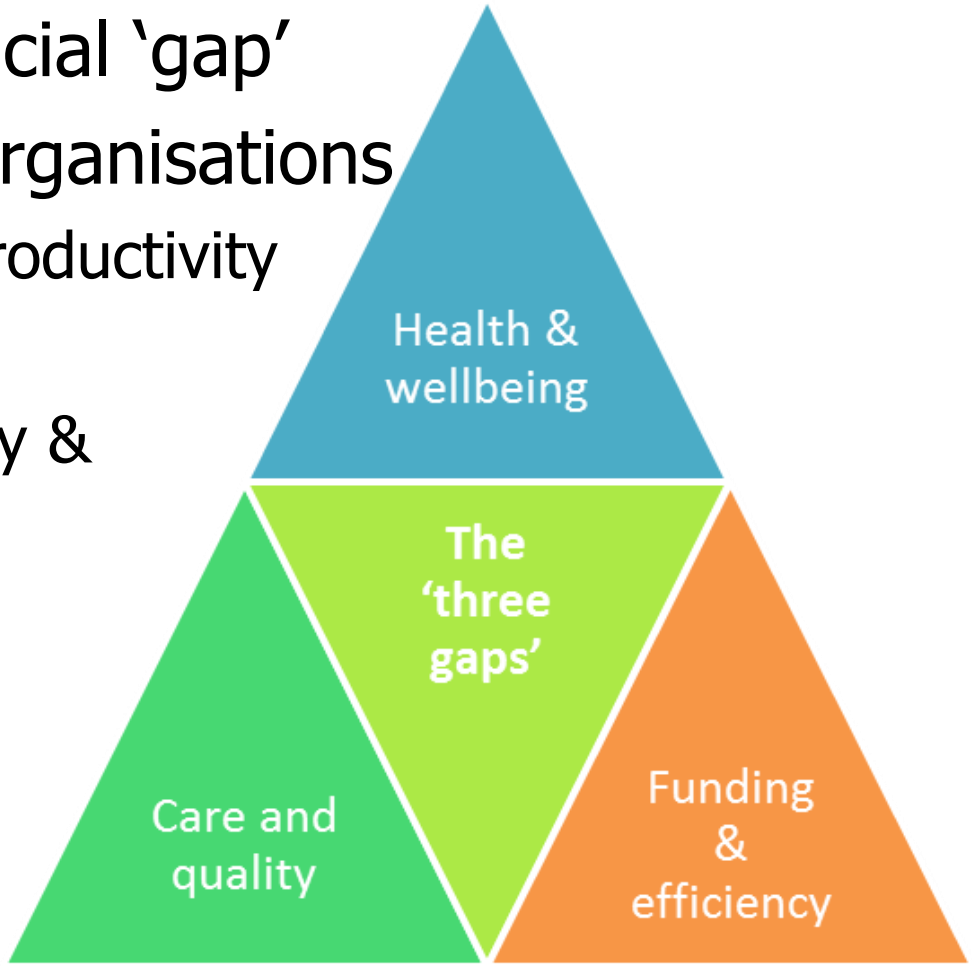


This model enables the urgency, the need for integration and the specialisation of the care interventions to be considered independently within the six health 'settings'.

How can we achieve our ambition?

The NHS Five Year Forward View (5YFV)

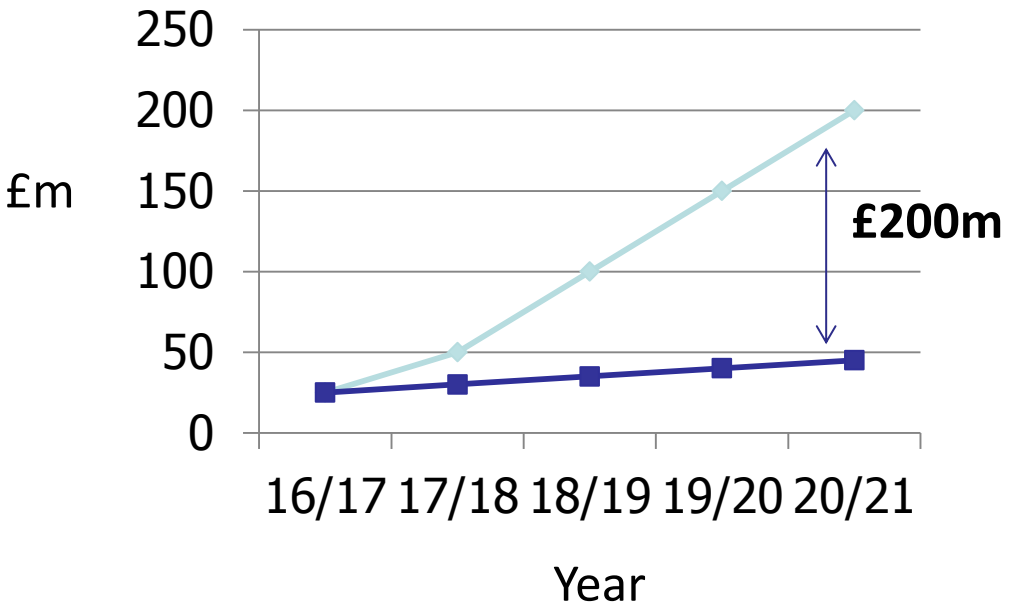
- £8.4 billion real terms growth for *Sustainability & Transformation* by HM Treasury
- But leaves £22bn financial 'gap'
- To be closed by NHS organisations
  - Improved efficiency & productivity
  - Demand management
  - Changing service delivery & pathways



The NHS Five Year Forward View (5YFV)

For Oxfordshire:

- £1.2 billion pa
- Oxfordshire £ increasing - £125m more between 2016-'21
- £200m gap in 2020/21 if we do nothing



"this is not about 'cutting' budgets, but about identifying the best possible use of resources so that we can meet the forecast rise in demand, and wherever possible, reduce that demand by improving the population health."

Buckinghamshire, Oxfordshire & Berkshire West - A Snap Shot of 'BOB' STP

Alliance with Bucks & Berks West:

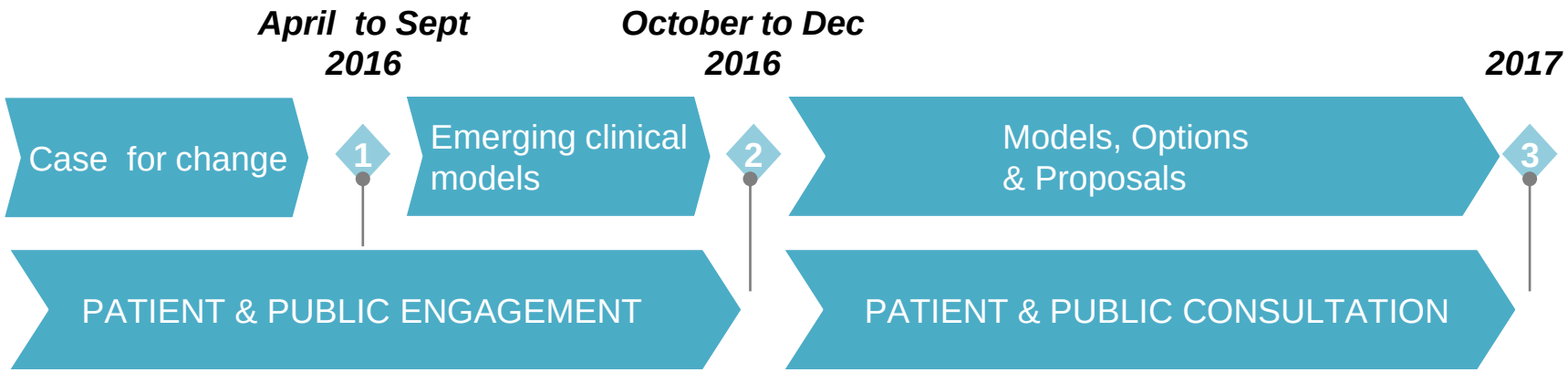
- 1.8m population
- £2.5bn funding allocation
- £500 funding gap if we do nothing
- 7 Clinical Commissioning Groups
- 6 Foundation & NHS Trusts
- 14 local authorities
- STP Lead David Smith OCCG

Buckinghamshire, Oxfordshire & Berkshire West - A Snap Shot of 'BOB' STP

Alliance with Bucks & Berks West:

- scaled public & population health
- mental health services
- urgent & emergency care, cancer & maternity
- workforce
- primary care sustainability
- reducing/avoiding variation

Next Steps



- Discuss the Case for Change, focusing on trends & challenges in our current health care provisions along the pathways
- Review best practices and case examples on models of care and discuss potential implications for Oxfordshire

- Discuss and input into emerging views on the best practice care models
- Discuss with consultants and clinicians involved in driving this work
- Public review and input into emerging models of care

- Launch public consultation on new care models
- Review / refine models of care
- Discuss high level requirements from different care settings, including out of hospital care
- Consult on options and proposals for the new care models
- Seek public feedback on models and options

Clinical review & overview of emerging models of care

Bruno Holthof – Chief Executive
Oxford University Hospitals NHS Foundation Trust

Dr Joe McManners – Clinical Chair
Oxfordshire Clinical Commissioning Group (OCCG)

Clinical Pathway Reviews

The starting point in developing future models of care is:

- to identify current challenges
- discuss what 'good' looks like for pathways
- look at what patients are telling us about their care

We are reviewing:

- Maternity services
- Children's services
- Urgent and emergency care
- Planned, diagnostics & specialist care
- Mental health, learning disabilities & autism

Maternity & Children's services

Sarah Breton - OCCG

Maternity - background

- approximately 7400 births at the Oxford University Hospital Trust (OUHT) to women registered with an Oxfordshire GP last year. Another 400 Oxfordshire women delivered outside of the OUHT
- OCCG commissions maternity services from the OUHT at a cost of about £32m a year
- women are offered the full range of maternity choices including home birth, Midwifery Led Unit (MLU), alongside MLU and Obstetric Units
- when we ask women what they want from maternity services they say:
  - healthy baby, partner involvement, continuity of midwife, better postnatal support and improved breastfeeding support.
  - overall women are very positive about the services they receive.

Maternity - vision

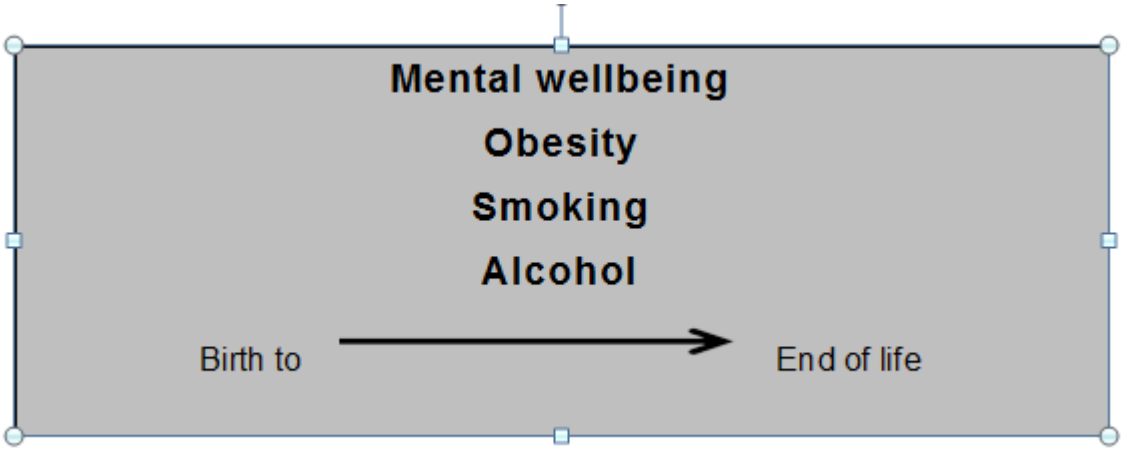
- the right woman, into the right part of the service and cared for by the right professional
- early booking with effective early risk assessment
- informed choice but real choice
- appropriate pathways of care including birth
- sustained continuity of care

Maternity - health and wellbeing gap

How do we radically upgrade prevention over the next 5 years?

- Directors of Public Health
  - Inequalities and health, life expectancy
  - Preventable long term conditions
  - Ensuring a better start in life
  - Mental wellbeing = Perinatal mental health

PRECONCEPTUAL CARE



Maternity - quality gap

- informed choice – impact on capacity, balanced with clinical safety
- preconception care – consistency of provision
- continuity of care – guidelines, pathways, midwifery and medical care, affordable and sustainable
- medical risk assessment – consistency of delivery, early enough in pregnancy
- staffing – RCOG standards for obstetric units, midwife to birth ratios
- estates – some not fit for purpose, some under-utilised, others need more capacity
- technology – community based diagnostics, care records

Maternity - best practice

- differential approach to preconception care
- single pathway for perinatal mental health
- risk managed approach to antenatal care pathway based on early risk assessment
- medical staff and midwives providing continuity of care.
- women having the right information to make an "informed choice" about place of birth
- where appropriate, access to full offer of 4 places of birth – home birth, MLU, alongside MLU and obstetric unit

Maternity – potential future pathway

PRECONCEPTION

Universal:

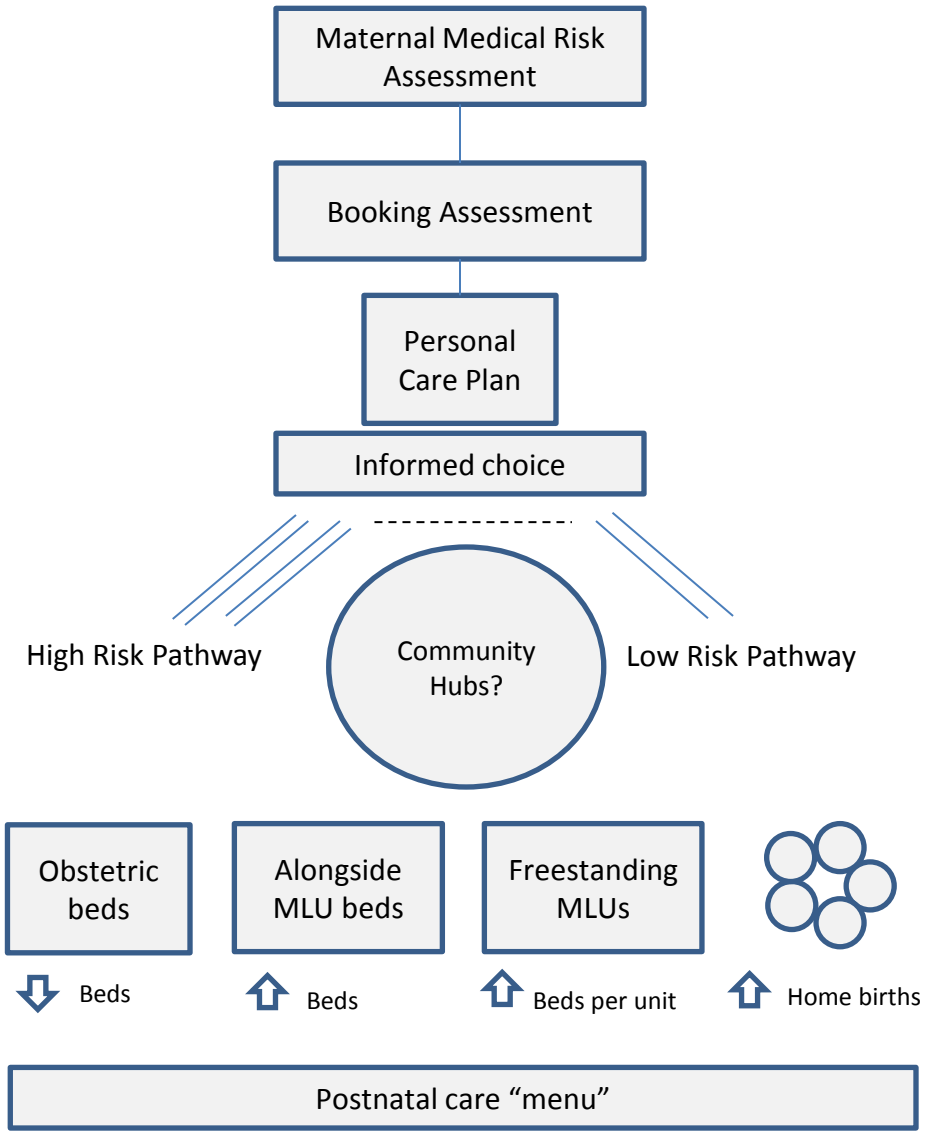
- Healthy weight
- Exercise
- Smoking
- Self – esteem and resilience

Targeted:

- Pre-existing conditions
- ⇧BMI
- Previous serious mental illness
- Substance misuse

Specialist:

- Long-term conditions
- Previous stillbirth
- Current mental illness



PRINCIPLES

- Personalised care
- Continuity of care
- Safer care
- Postnatal and perinatal mental health
- Multi – professional
- Working across boundaries

Children's services - vision

We want Oxfordshire to be the best place in England for children and young people to grow up in. We will work with every child and young person to give them the best start in life and to develop the skills, confidence and opportunities they need to achieve their full potential. This means we will:

- work with others, including parents, schools and the third sector to promote health and to build resilience in all children and young people
- work with families and communities to support successful self-care for minor illnesses, injury and long term and/or life limiting conditions so that children can live productive lives (e.g going to school) in ways they choose
- provide care as close to home as possible, when clinically feasible and when hospital inpatient care is the best option, enable the family to stay close to their child and their child to stay in hospital for as short a time as possible
- deliver care through clinical pathways and multi-disciplinary teams
- develop the skills of our staff through working in multi-disciplinary teams
- aspire to have every child and family who has contact with our services report having had a great "experience" of them.
- aspire to employ and develop a workforce who have a great "experience" of working for children in Oxfordshire

Children's services - health and wellbeing gap

How can we radically upgrade prevention over the next 5 years?

- NHS England "Right Care" programme for Oxfordshire
  - admissions for respiratory in the under 1s
  - admissions for unintentional and deliberate harm in under 5s
  - dental (decayed, missing, filled teeth) in under 5s

- Directors of Public Health
  - inequalities and life expectancy
  - preventable long term conditions (e.g. asthma)
  - ensuring a better start in life
  - mental wellbeing

- Big ticket items
  - children's mental wellbeing
  - childhood obesity

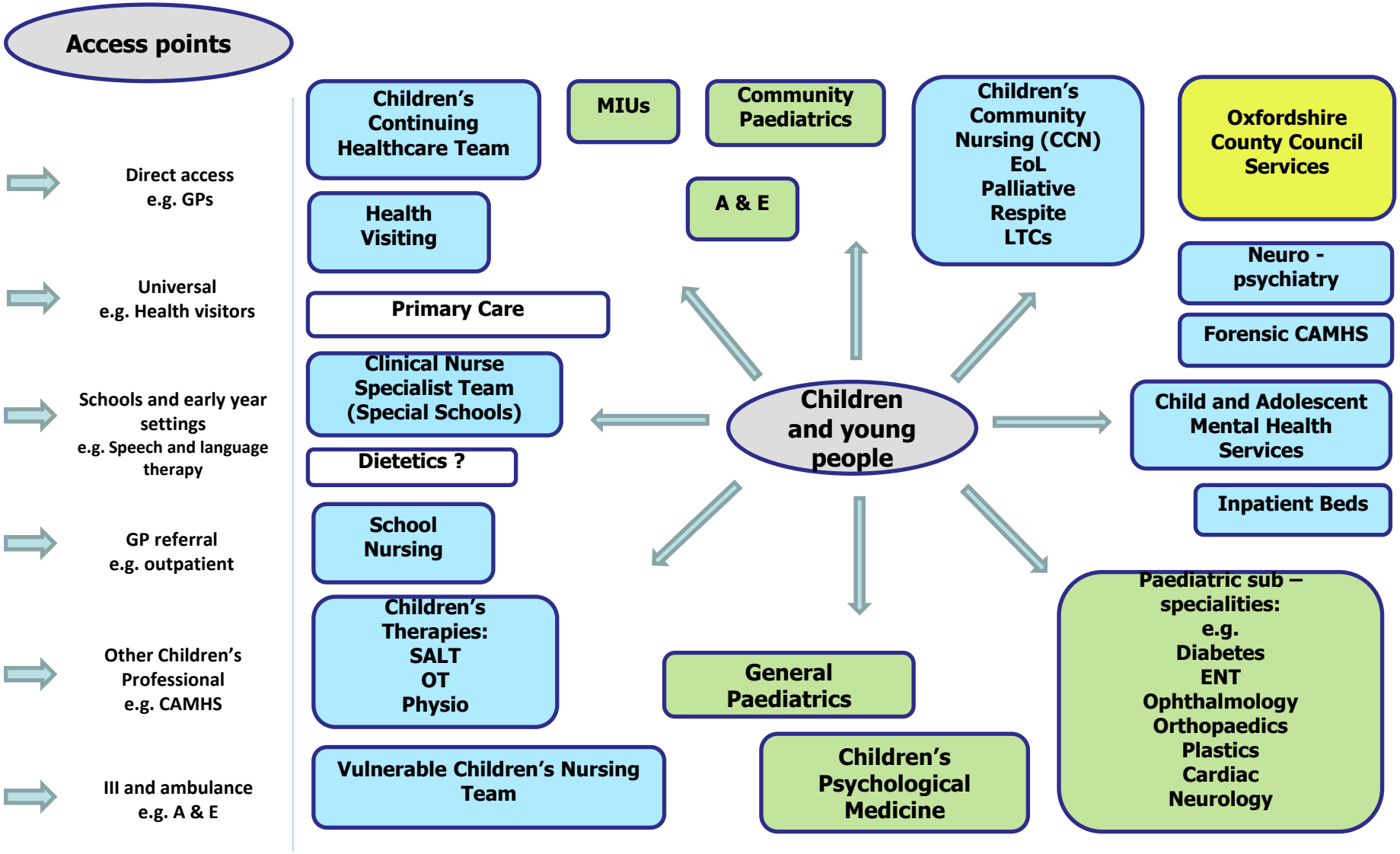
Children's services - quality gap

- severe pressure in primary care, particularly in terms of capacity, confidence, knowledge and skills
- using hospitals to treat conditions that could be managed in the community
- access to high quality paediatric/child health expertise in the community
- lack of integrated pathways
- inappropriate use of services, health literacy
- early intervention – poverty and disadvantage
- patient experience – travel, waiting times

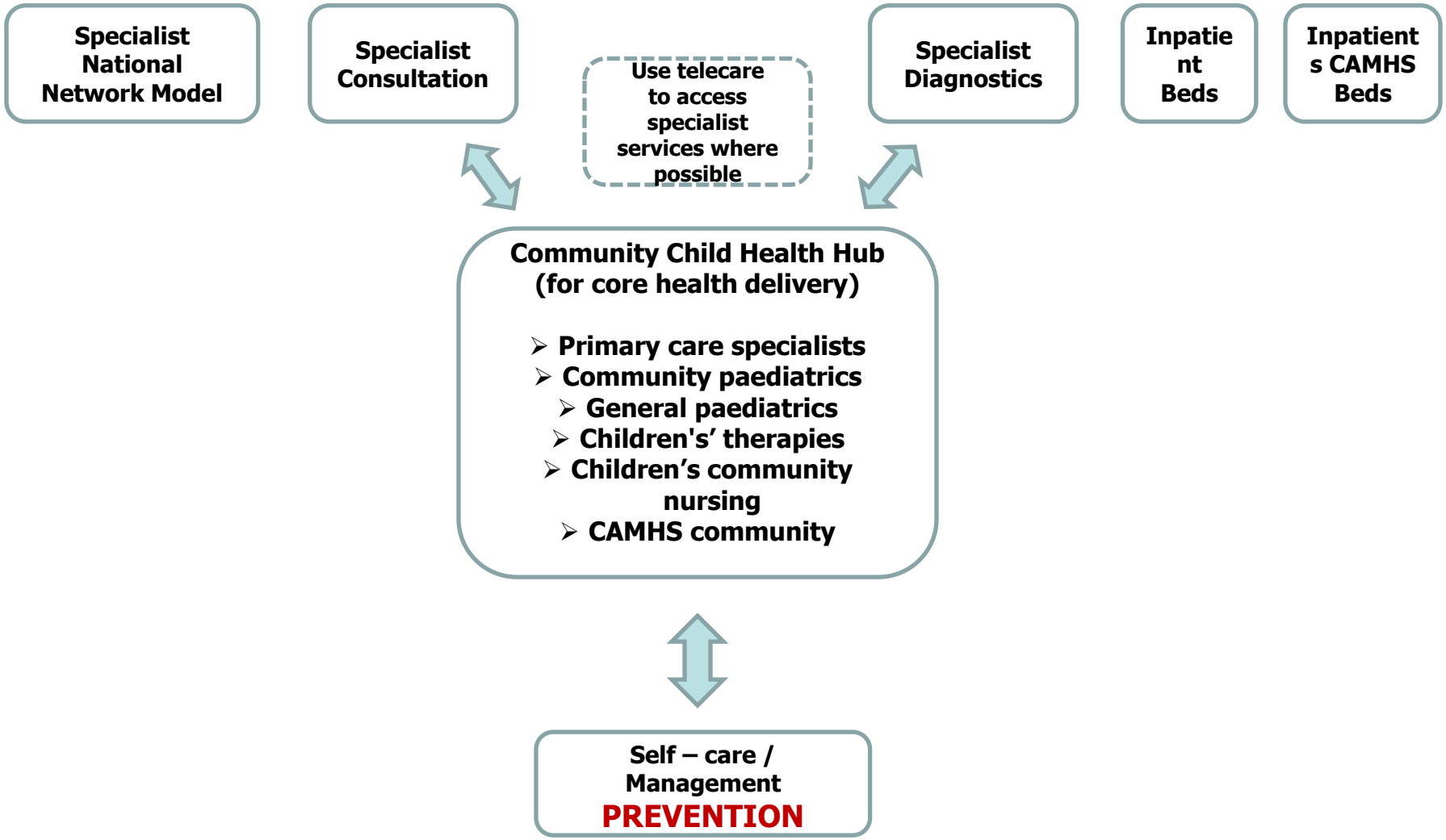
Children's services - trends and challenges

- increased demand for services including GP appointments, A&E attendances, admissions
- however, Oxfordshire benchmarks well with neighbouring CCGs in terms of variation in care for top 5 causes of admission
- impact of wider determinants of health; poverty, housing etc. and integration with other public programmes such as Troubled Families
- workforce across all children's sectors
- space, environment, patient experience and economics

Children's Pathway current (by provider) (Aged 0-18 years old)



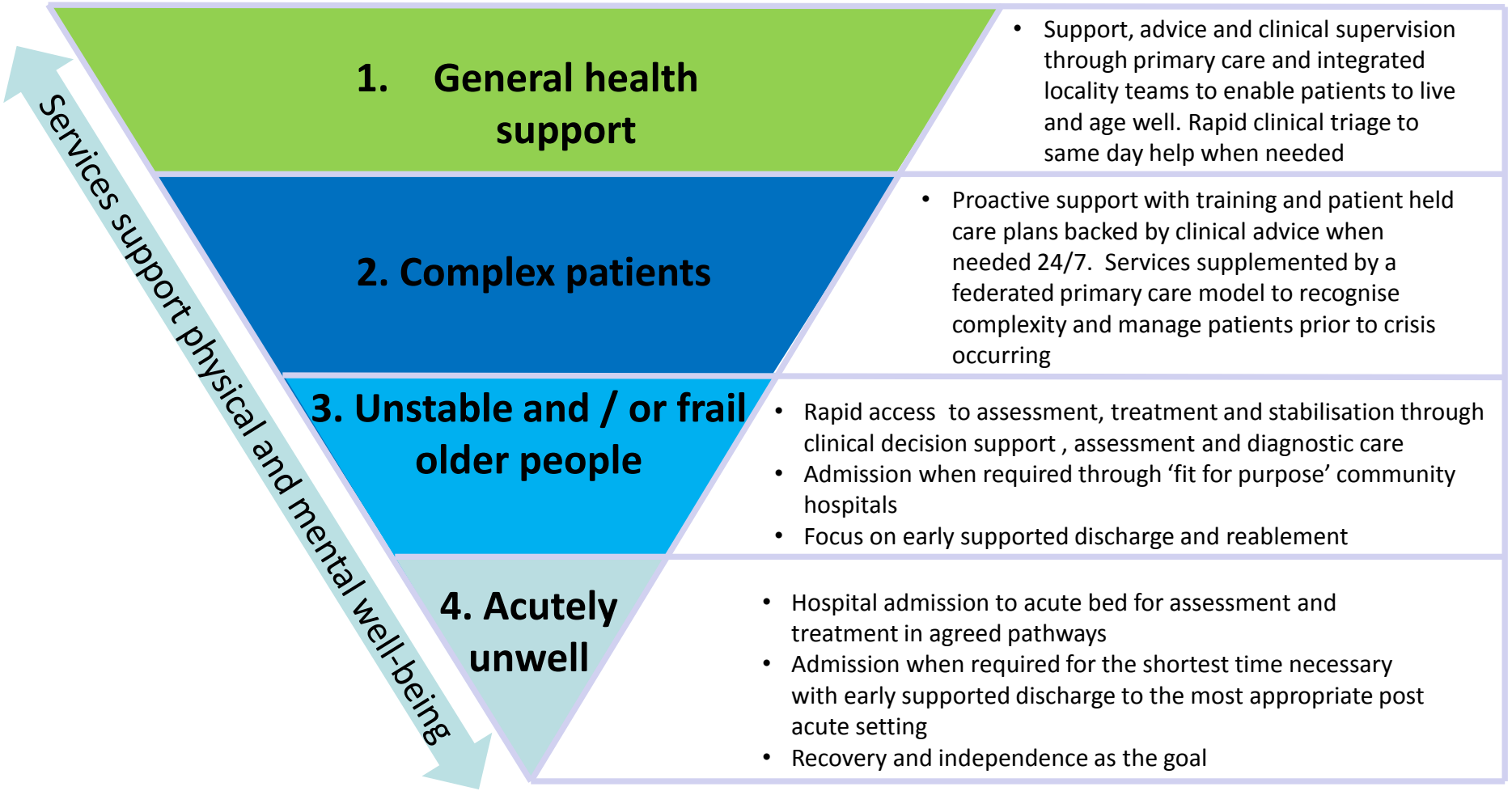
Proposed future pathway (Aged 0 - 25 ?)



Urgent & emergency care

Diane Hedges- OCCG

Urgent & emergency care - vision



Urgent & emergency care - quality gap

- insufficient primary care capacity to meet same day demand, routine requests and also serve complex patients with the longer appointment times they need - an essential transformational gap given the context of our Practices performing above national average on access
- Clinicians not able to seek advice on decisions from each other at the time the patient needs it - right here, right now and 7 days a week
- not enough capacity to meet known home care and reablement need
- excess length of stay in beds and delayed transfer of medically fit patients across acute and community hospitals
- constraints in ability to admit directly and for the full range of appropriate conditions to community beds
- poor estate, value, and limited evidence of patient outcomes from community hospital episodes
- stroke:
  - poor audit scores of national stroke measures, waits to enter rehabilitation
  - 50-60% of patients unable to access Early Supported Discharge service
- technology – systems that do not talk

Primary care challenges

- Growth in demand:
  - Consultation rates have increased by 11% between 2010/11 and 2013/14
  - 89% of patients report being able to get an appointment with a GP or practice nurse but 34% of patients report that they wait too long
- Workforce recruitment and retention problems:
  - 30% of Oxon GP respondents report that they plan to retire within 5 years[2]
  - Some practices report that it takes 6-12 months to recruit a GP
- Reduction in practice income:
  - Some practices in Oxfordshire have seen their income reduced by the removal of MPIG and PMS premia.
- Practice capacity and sustainability :
  - 9 practices have merged in the last 2 years, 3 have requested that their lists are closed.
- Population Growth in Oxfordshire
  - Bicester , Banbury, Science Vale and other areas
- Inequalities
  - Rose Hill - plus other Oxford City areas, Banbury & Berinsfield
- Premises (capacity and state of build)
  - E.g. Beaumont Street, Summertown, Kidlington
- Some practices identifying themselves as vulnerable

Quality gap – workforce shortages

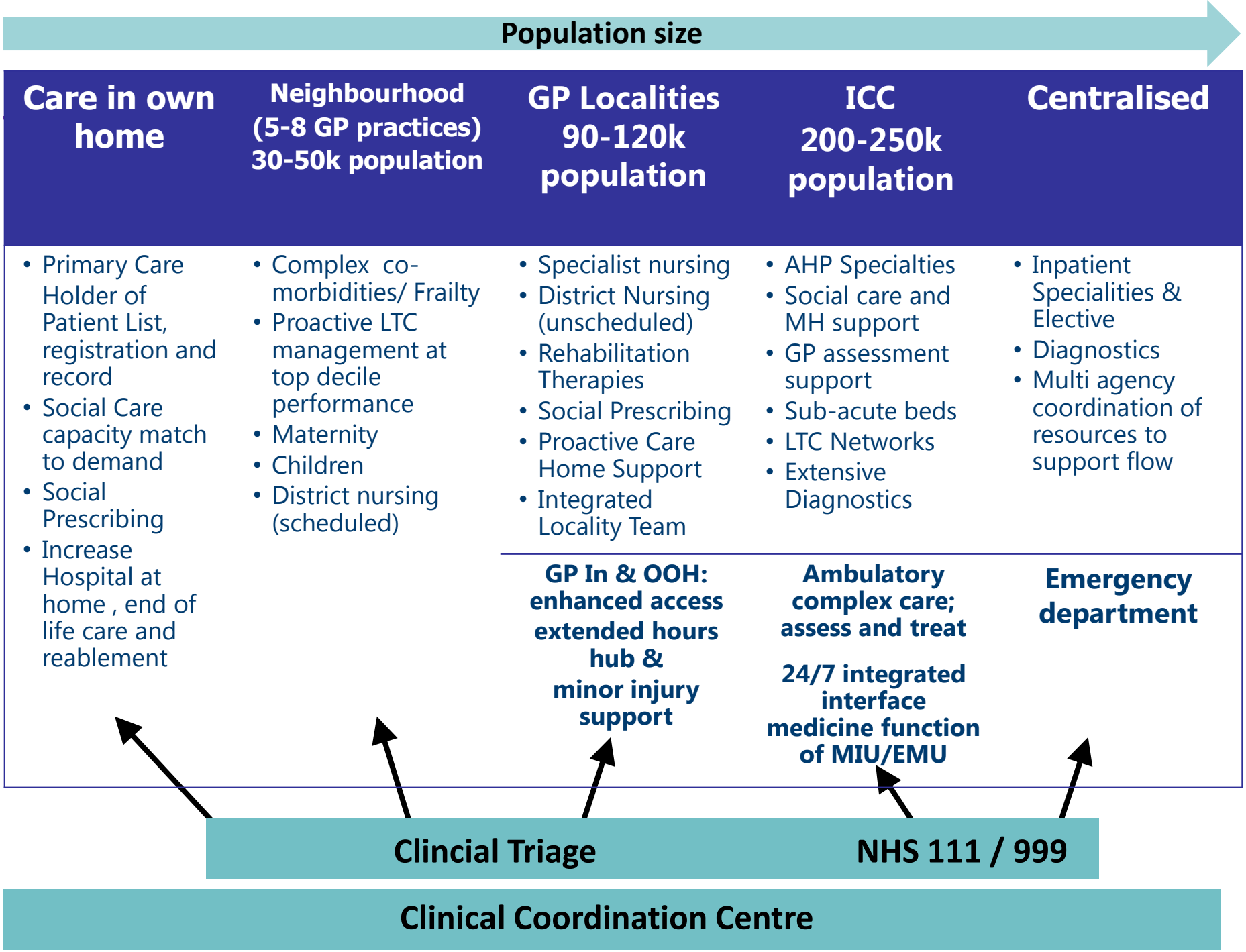
- Oxfordshire cost of living, difficulty to retain staff
- primary care – increased pressure on GPs
  - GPs retiring early
  - lack of capable generalists
  - out of hours GPs
- emergency care practitioners
- domiciliary care
- skills in non-hospital settings e.g. podiatrists
- nurses for nursing homes
- weekend opening of West Oxfordshire EMU
- Rapid Access Care Unit (RACU) recruitment challenge in Henley
- 7 day working shortfalls to be reviewed

What people have told us

- the importance of ensuring new services are tailored to support a diverse range of needs
- the needs of patients in rural areas are often different and patients would benefit from services located closer to home where this is possible
- the importance of more preventative measures - particularly in relation to the health and wellbeing of older people, and to prevent obesity
- more integrated working across different agencies
- the differences and/or inequalities that exist in health across the population of Oxfordshire as well as the differing needs/issues affecting those who live on the county boundaries
- the importance the carer plays in supporting a person, to involve the carer more and the need for more support for young carers
- a need to change attitudes and empower patients to take control and ownership of their own health
- a need to change the belief that hospital is the only place where professionals can be seen

Urgent & emergency care - model for future care

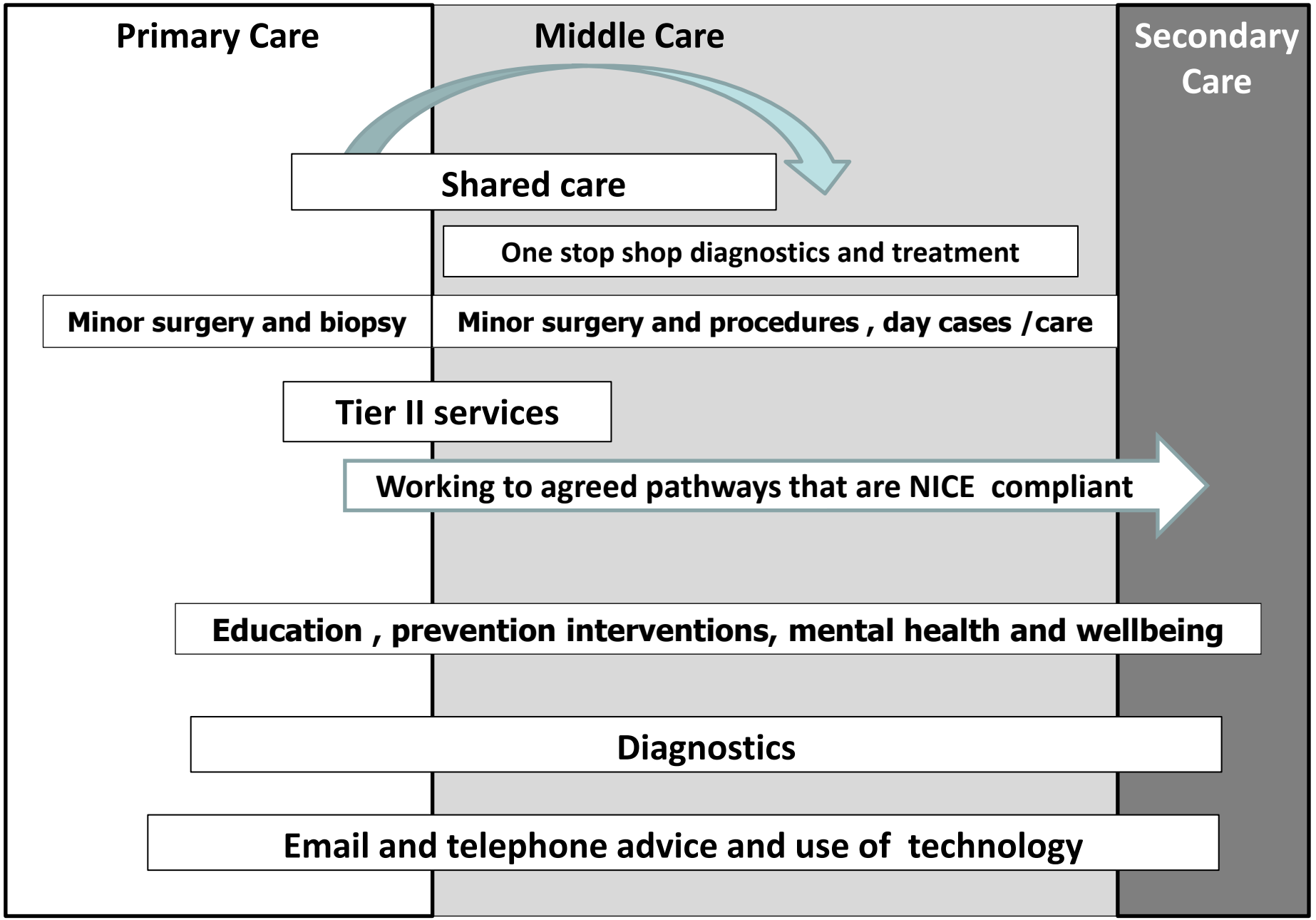
- more time for primary care and the integrated locality teams to support patients with complex conditions
- clinical triage leading to same day GP access where appropriate
- ambulatory care by default – emphasis on clinician to clinician and decision support
- diagnostics locally to aid assessment and decision making
- improving access to care and education for people with LTCs developing robust educational self-care programmes and driving local staff skills mix and expertise
- integration of physical and mental health services
- care homes supported proactively and skills built in staffing
- focus on dementia support
- social care capacity matched to demand - supporting hospital discharge and ambulatory care


Population size
Care in own home
Neighbourhood (5-8 GP practices) 30-50k population
GP Localities 90-120k population
ICC 200-250k population
Centralised
• Primary Care Holder of Patient List, registration and record
• Social Care capacity match to demand
• Social Prescribing
• Increase Hospital at home , end of life care and reablement
• Complex co-morbidities/ Frailty
• Proactive LTC management at top decile performance
• Maternity
• Children
• District nursing (scheduled)
• Specialist nursing
• District Nursing (unscheduled)
• Rehabilitation Therapies
• Social Prescribing
• Proactive Care Home Support
• Integrated Locality Team
• AHP Specialties
• Social care and MH support
• GP assessment support
• Sub-acute beds
• LTC Networks
• Extensive Diagnostics
• Inpatient Specialities & Elective
• Diagnostics
• Multi agency coordination of resources to support flow
GP In & OOH: enhanced access extended hours hub & minor injury support
Ambulatory complex care; assess and treat
24/7 integrated interface medicine function of MIU/EMU
Emergency department
Clincial Triage
NHS 111 / 999
Clinical Coordination Centre

Planned, diagnostics & specialist care

Sharon Barrington - OCCG

Planned, diagnostics and specialist care - vision



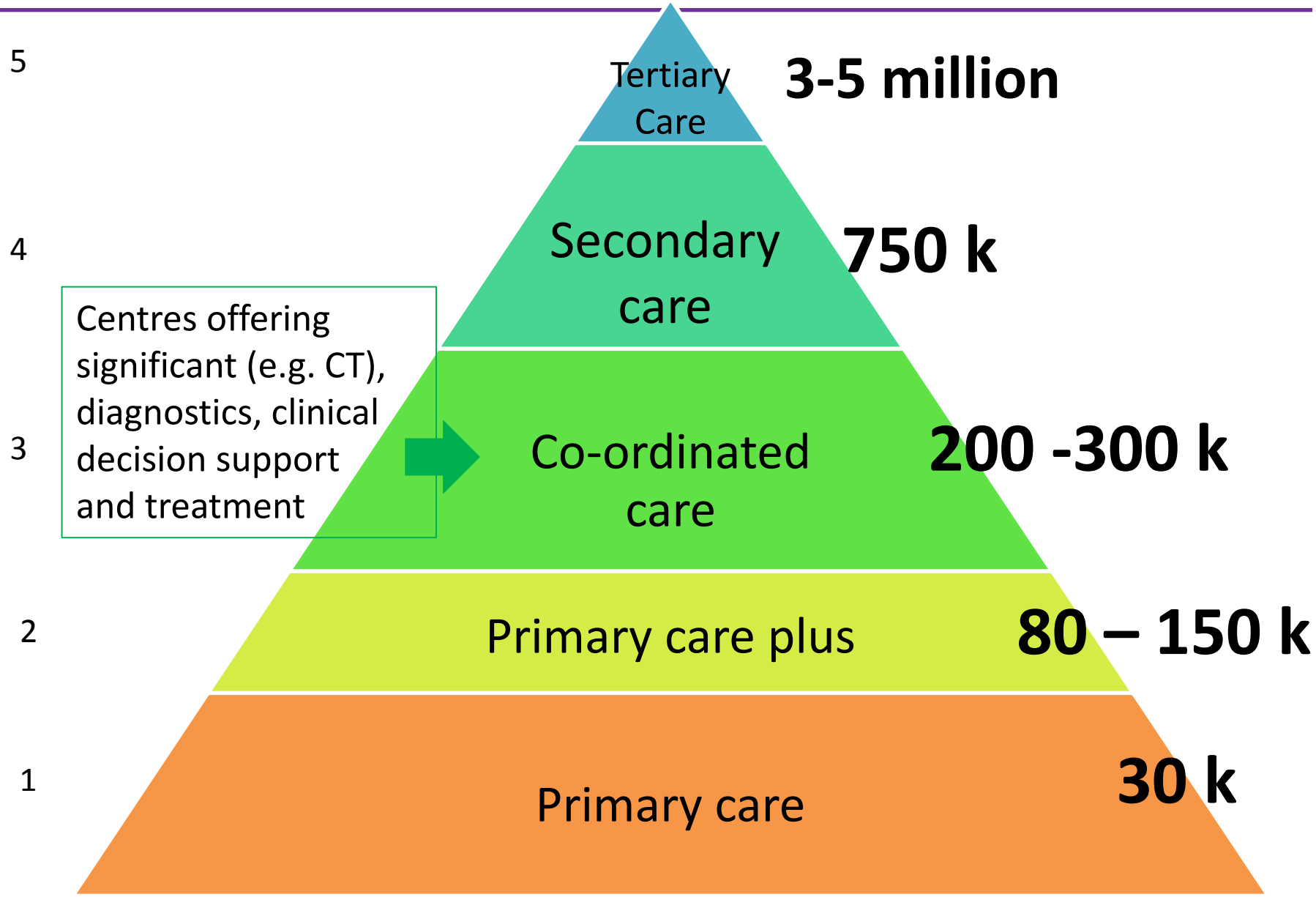
Planned, diagnostics and specialist care – quality gap

- workforce particularly primary care under pressure so making more referrals
- availability of workforce to deliver; specialist nurses, physio, GPs and doctors in specific areas
- NHS constitution standards (waiting times) not met in some specialities (non-admitted and admitted); ENT, Ophthalmology, T&O, Gynaecology, Cardiology
- access to outpatients and surgery needs to be sooner particularly after waits for diagnostics
- cancer standards met but not consistent
- late diagnosis of cancer meaning treatment prolonged and more expensive
- estate not fit for purpose and requires repair and upgrading
- patient experience; parking, processes, communication
- no shared patient record across the system
- development of information management and technology solutions not keeping pace with developments in technology
- fragmented communication between professionals; direct discussion and advice for GPs to avoid referral, clinic letters
- variation across the system with no best practice clear pathways in many areas

What patients have told us

- use innovation and technology, to benefit patient care and create greater efficiencies within the NHS - this includes social media, mobile technology, electronic patient records and telehealth
- improve quality of services, staff and ensure consistency of quality
- a need to change attitudes and empower patients to take control and ownership of their own health
- a need to change the belief that hospital is the only place where professionals can be seen

Vision - planned care pyramid

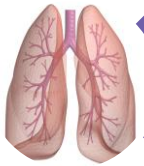


Specialties

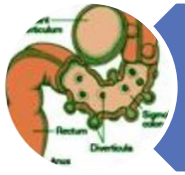
Planned care and diagnostic hubs for 200,000 – 300,000 population and more local settings for ‘primary care plus’ level planned care

Cardiology

Urology



Respiratory



Gastroenterology

Ophthalmology

Gynaecology

Mental health, learning disabilities & autism

Ian Bottomley - OCCG

Learning Disability & Autism - vision

Mental health, learning disability & autism - vision

- all age access to MH, LD and ASC triage within one week of planned referral
- a dedicated 24/7 MH urgent care pathway for those in distress or at risk
- a system wide approach to managing risks around MH, LD and ASC
- patient level outcomes that deliver and evidence resilience and the ability to self-care
- better physical health outcomes for people covered by the STP
- system level outcomes that reduce in-patient beds, repatriate out of area patients and support safe and effective discharge from secondary community services
- management of demand through new models of care

Mental Health – quality gap

- differential access to services depending on age; waits for Children & Adolescents Mental Health Services
- lack of specialist local accommodation: autism (children & young people and adult) and elderly mental illness
- clarity around urgent care pathway
- clarity around perinatal pathway
- lack of mental and physical health integration
- secondary waits for higher tier psychology
- support for carers that supports the cared-for
- lack of integrated patient records

Learning Disabilities – quality gap

- there is a variation in health checks that people with LD receive in primary care and the overall level is <50%
- people with higher functioning autistic spectrum disorder (without LD) often fall between services
- people with LD and /or Autism Spectrum Disorder (ASD) report significant challenges in accessing healthcare, especially in an emergency
- people with LD and co-morbid MH are more likely to be detained under Mental Health Act83
- lack of a forensic pathway for people with LD leading to unnecessarily long inpatient stays

What people have told us

- young people said that their appointments were in school hours, which created problems for them. They didn't want other students to know where they were going and so sometimes skipped school altogether to attend the appointment and avoid the situation
- Concern that certain groups might 'fall between services' and be missed e.g.
  - People with dementia
  - Infant/children's mental health
  - People from different ethnic backgrounds or cultures, including asylum seekers
- there was a different level of quality service from different staff, some being very cooperative and responsive while others were very slow to respond
- support to young people and families while waiting for appointments
- post diagnosis support for ASD and attention deficit hyperactivity disorder (ADHD)
- support for families while they are waiting for their first appointment

New models of care

- new model of CAMHS to deliver Future in Mind
- new model of intervention that divides our population:
  - at age 25
  - if / when people move into frailty pathways
- all adult approach to severe mental illness - extending OBC to older adults
- integration of assessment functions and approaches across MH/LD/ASC for planned and urgent presentations
- integration of physical health care into specialist MH/LD/ASC services
- system-wide behaviour management services across MH/LD/ASC, based on intensive support models
- a new primary care MH function:
  - social support to address health inequalities
  - community psychological medicine for MUS or complex MH-PH
- development of approach to specialist in-patient and community forensic pathways that release resources to support prevention and step down
- integration of substance misuse and MH services

Workshop sessions

- We would like your views on:
  - What (if anything) needs to be added to our case for change across the transformation programme?
  - What (if anything) needs to be added to our vision in this area?
  - What do you like about the emerging model(s) of care?
  - What do you think we can do to improve the model(s)?

Patient Panel

Rosemary Wilson
Liz Smith
Carol Moore (Healthwatch)

We want to continue the conversation . . .

- The Oxfordshire Transformation Programme will be involving patients and the public in the development of proposals for new models of care and possible service options.

- A full public consultation will take place later in the year.

We want to continue the conversation . . .

There is a range of communications and engagement activities which will take place during the pre-consultation period to include:

- patient and public engagement events throughout the summer
- presentation and discussion at meetings of key community and voluntary sector groups
- briefings for the county council and district councils
- briefings for Oxfordshire MPs
- updates and reports to Oxfordshire's Joint Health Overview and Scrutiny Committee, including a discussion at the June meeting about the plans for pre-consultation engagement planned for the summer period
- updates to Oxfordshire's Health and Wellbeing Board
- online information on the Transformation Programme website which we hope to launch next week.

How do you want to be involved and kept informed of developments?

- **Sign up to Talking Health**: the CCG online consultation tool and we will send you notifications of the work and updates: consult.oxfordshireccg.nhs.uk

- **Send us a letter:** Communications & Engagement Team Oxfordshire Clinical Commissioning Group, FREEPOST RRRKBZBTASXU, Jubilee House, 5510 John Smith Drive, Oxford Business Park South, OXFORD, OX4 2LH

- **Phone:** 01865 334638

- **Email:** cscsu.talkinghealth@nhs.net

What you told us . . .key themes

A number of common themes emerged from the workshop discussions. These themes were highlighted by stakeholders across a number of the clinical work steams:

- **Prevention** is a recurring theme that clearly resonates with people who attended the event, with a need for more investment/activity in preventing ill health
- Many raised the need for a **culture change** towards people taking more responsibility and ownership for their lifestyle and own health, including prevention
- Recognition of the important **role of the third sector and the involvement of the patient** themselves in their care
- The need to **work in partnership with those educating the next generation** to ensure prevention is instilled in young people to prevent avoidable ill-health later in life
- Greater **involvement of young people** and inclusion of their voice throughout all clinical work streams to shape services for young people

What you told us cont'd

- Recognition of **urban and rural differences** in health, highlighting the need to ensure equality and consistency of care across the county
- Identifying the need for **existing staff to be used/trained differently** to support new models of care
- **Education and awareness raising** as people need to understand what services are available and how to use them appropriately
- Consider **reliance on technology** – the benefits of technology and social media were recognised, with the need to be mindful that it is used to facilitate good care, not relied on to automatically deliver good care.