Public Document Pack

HEALTH AND WELLBEING BOARD

Meeting to be held in Bishop Young C of E Academy, Bishops Way, Seacroft, Leeds, LS14 6NU on
Monday, 16th September, 2019 at 1.50 pm

(Pre-meeting for all Members of the Board at 1:30 pm)

MEMBERSHIP

Councillors
R Charlwood (Chair) S Golton G Latty
A Smart
F Venner

Representatives of Clinical Commissioning Group
Dr Gordon Sinclair – Chair of NHS Leeds Clinical Commissioning Group
Tim Ryley – Chief Executive of NHS Leeds Clinical Commissioning Group
Dr Alistair Walling – Chief Clinical Information Officer of Leeds City and NHS Leeds Clinical Commissioning Group

Directors of Leeds City Council
Dr Ian Cameron – Director of Public Health
Cath Roff – Director of Adults and Health
Steve Walker – Director of Children and Families

Representative of NHS (England)
Anthony Kealy – Locality Director, NHS England North (Yorkshire & Humber)

Third Sector Representative
Alison Lowe – Director, Touchstone

Representative of Local Health Watch Organisation
Dr John Beal - Healthwatch Leeds

Representatives of NHS providers
Sara Munro - Leeds and York Partnership NHS Foundation Trust
Julian Hartley - Leeds Teaching Hospitals NHS Trust
Thea Stein - Leeds Community Healthcare NHS Trust

Safer Leeds Joint Representative
Paul Money - Chief Officer, Safer Leeds, Supt. Jackie Marsh – West Yorkshire Police

Representative of Leeds GP Confederation
Jim Barwick – Chief Executive of Leeds GP Confederation

Agenda complied by: Harriet Speight
Governance Services 0113 37 89954

A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
			WELCOME AND INTRODUCTIONS	
2			**APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS** To consider any appeals in accordance with Procedure Rule 15.2 of the Access to Information Rules (in the event of an Appeal the press and public will be excluded) (*In accordance with Procedure Rule 15.2, written notice of an appeal must be received by the Head of Governance Services at least 24 hours before the meeting)	
3			**EXEMPT INFORMATION - POSSIBLE EXCLUSION OF THE PRESS AND PUBLIC** 1 To highlight reports or appendices which officers have identified as containing exempt information, and where officers consider that the public interest in maintaining the exemption outweighs the public interest in disclosing the information, for the reasons outlined in the report. 2 To consider whether or not to accept the officers recommendation in respect of the above information. 3 If so, to formally pass the following resolution:- **RESOLVED** – That the press and public be excluded from the meeting during consideration of the following parts of the agenda designated as containing exempt information on the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the press and public were present there would be disclosure to them of exempt information, as follows:-	

4			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration (The special circumstances shall be specified in the minutes)	
5			**DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS** To disclose or draw attention to any disclosable pecuniary interests for the purposes of Section 31 of the Localism Act 2011 and paragraphs 13-16 of the Members' Code of Conduct.	
6			**APOLOGIES FOR ABSENCE** To receive any apologies for absence.	
7			**OPEN FORUM** At the discretion of the Chair, a period of up to 10 minutes may be allocated at each ordinary meeting for members of the public to make representations or to ask questions on matters within the terms of reference of the Health and Wellbeing Board. No member of the public shall speak for more than three minutes in the Open Forum, except by permission of the Chair.	
8			**MINUTES** To approve the minutes of the previous Health and Wellbeing Board meeting held 14th June 2019 as a correct record.	1 - 8
9			**PRIORITY 12 - THE BEST CARE, IN THE RIGHT PLACE, AT THE RIGHT TIME: PALLIATIVE AND END OF LIFE CARE FOR ADULTS IN LEEDS** To consider the report of the Leeds Palliative Care Network that provides an overview of the work of the network, including the Dying Matters programme.	9 - 26

10			**LEEDS CARERS PARTNERSHIP STRATEGY** To consider the report of the Leeds Carers Partnership that presents a new draft Leeds Carers Partnership Strategy, including how the strategy will help deliver the Leeds Health and Wellbeing Strategy and Leeds Health and Care Plan.	27 - 98
11			**ANNUAL REFRESH - FUTURE IN MIND: LEEDS LOCAL TRANSFORMATION PLAN FOR CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH AND WELLBEING** To consider the joint report of the Director of Operational Delivery (NHS Leeds CCG) and the Director of Children and Families (Leeds City Council) an update on driving forward the strategy to transform how we support and improve the emotional and mental health of children and young people and therefore, ultimately impact on the wellbeing of all of the population through the annual refresh of the Leeds Local Transformation Plan.	99 - 176
12			**OUR APPROACH TO IMPROVING HEALTH AND WELLBEING ACROSS LEEDS AND WEST YORKSHIRE AND HARROGATE** 12.1 Leeds Health and Care Plan: Continuing the Conversation To consider the report of the Head of the Leeds Health and Care Plan (Health Partnerships) that provides an overview of the review of the Leeds Plan and the significant engagement to date which has supported its development. ***(Appendix to follow)*** 12.2 Development of the WYH 5 Year Strategy for Health and Care To consider the report of the West Yorkshire and Harrogate Health and Care Partnership that presents a draft of the narrative of the Five Year Strategy and the process for further developing and refining it.	177 - 308

13			**UPDATE ON CQC LEEDS SYSTEM REVIEW ACTION PLAN** To consider the report of the Lead for CQC System Review & Leeds CQC System Review Task and Finish Group that provides a summary of the progressions of the Board's action plan made to date.	309 - 332
14			**DRAFT LEEDS BETTER CARE FUND PLAN 2019/20** To consider the report of the Chief Officer of Adults & Health (Leeds City Council) and the Director of Operational Delivery (NHS Leeds CCG) that seeks approval of the draft Leeds BCF Plan 2019/20. ***(Appendix to follow)***	333 - 340
15			**FOR INFORMATION: LEEDS DRUGS & ALCOHOL STRATEGY & ACTION PLAN 2019-24** To note, for information, the report of the Director of Public Health (Leeds City Council) that presents the updated Leeds Drug & Alcohol Strategy and Action Plan 2019-2024	341 - 388
16			**FOR INFORMATION: CONNECTING THE WIDER PARTNERSHIP WORK OF THE LEEDS HEALTH AND WELLBEING BOARD** To note, for information, the report of the Chief Officer (Health Partnerships) that provides a public account of recent activity from workshops and wider system meetings, convened by the Leeds Health and Wellbeing Board (HWB). It contains an overview of key pieces of work directed by the HWB and led by partners across the Leeds Health and Care System.	389 - 396
			ANY OTHER BUSINESS	
18			**DATE AND TIME OF NEXT MEETING** Wednesday 11th December 2019 at 2 pm.	
			MAP OF MEETING VENUE	397 - 398

Third Party Recording

Recording of this meeting is allowed to enable those not present to see or hear the proceedings either as they take place (or later) and to enable the reporting of those proceedings. A copy of the recording protocol is available from the contacts named on the front of this agenda.

Use of Recordings by Third Parties– code of practice

a) Any published recording should be accompanied by a statement of when and where the recording was made, the context of the discussion that took place, and a clear identification of the main speakers and their role or title.
b) Those making recordings must not edit the recording in a way that could lead to misinterpretation or misrepresentation of the proceedings or comments made by attendees. In particular there should be no internal editing of published extracts; recordings may start at any point and end at any point but the material between those points must be complete.

HEALTH AND WELLBEING BOARD

FRIDAY, 14TH JUNE, 2019

PRESENT: Councillor R Charlwood in the Chair

Councillors A Smart, F Venner, S Golton and G Latty

Representatives of Clinical Commissioning Group

Dr Jason Broch – Deputy Clinical Chair, NHS Leeds Clinical Commissioning Group
Tim Ryley – Chief Executive, NHS Leeds CCG

Directors of Leeds City Council

Dr Ian Cameron – Director of Public Health

Representative of NHS (England)

Anthony Kealy – Locality Director, NHS England North (Yorkshire & Humber)

Third Sector Representative

Alison Lowe – Director, Touchstone

Representatives of Local Health Watch Organisation

Dr John Beal – Healthwatch Leeds
Hannah Davies – Healthwatch Leeds

Representatives of NHS Providers

Sara Munro – Leeds and York Partnership NHS Foundation Trust
Dr Phil Wood – Leeds Teaching Hospitals NHS Trust

Safer Leeds Representative

Paul Money – Chief Officer, Safer Leeds

Representative of Leeds GP Confederation

Jim Barwick – Chief Executive of Leeds GP Confederation

1 Welcome and introductions

The Chair welcomed everyone to the meeting.

Councillor Graham Latty was welcomed on his return to the Board as were Councillors Fiona Venner and Alice Smart who had been appointed to the Board for the 2019/20 Municipal Year.

Thanks were expressed to Councillors Lisa Mulherin, Pat Latty and Eileen Taylor who had sat on the Board in the previous year.

The Chair also welcomed members of the public in attendance and gave an overview of the role of the Board.

2 Declarations of Disclosable Pecuniary Interests

There were no declarations.

3 Apologies for Absence

Apologies for absence were submitted on behalf of Cath Roff, Dr Alistair Walling, Dr Gordon Sinclair, Julian Hartley and Thea Stein.

4 Open Forum

The Board heard from representatives of Change Leeds. Change Leeds is a user led organisation which worked for equal rights for people with learning disabilities. Reference was made to the health inequalities faced by people with learning disabilities and the need to have a voice and be included in mainstream commissioning and planning of health care. The group asked how they could work with the Board to make sure those with learning disabilities would be included in health planning.

The Board welcomed the presentation and reference was made to where learning disabilities were considered in various strategies and health planning. Further issues discussed included employment and independent living. It was agreed to arrange a meeting with representatives of Change Leeds to discuss matters further.

5 Developing our approach to improving health and wellbeing across West Yorkshire and Harrogate and Leeds

The Board received the following reports:

- The report of the West Yorkshire and Harrogate Health Care Partnership provided an overview of the development of the 5 year strategy for health and care in West Yorkshire and Harrogate to date.

- The report of the Leeds Health and Care Partnership Executive Group (PEG) that provided an update on the review, success of the plan to date, alignment with the West Yorkshire and Harrogate Integrated Care System and the NHS Long Term Plan

The following were in attendance for this item:

- Ian Holmes, West Yorkshire & Harrogate Health Care Partnership (WYH HCP)
- Rachel Loftus, Health Partnerships
- Tony Cooke, Chief Officer Health Partnerships
- Paul Bollom, Head of Leeds Health and Care Plan

Ian Holmes and Rachel Loftus updated the Board on the development of the 5 year strategy for health and care in West Yorkshire and Harrogate. The following was highlighted:

- Work carried out across West Yorkshire and Harrogate to deliver the strategy.
- The development of the strategy was due to be finished in Autumn 2019.
- Proposed future model for West Yorkshire and Harrogate.
- Improving Population Health and the need for a more focused approach on Children, Young People and Families
- Supporting people to support themselves and how to influence decision making.

Further discussion included the following:

- Positive impact Healthwatch has contributed to WYH HCP.
- Health and wellbeing of children, young people and families and the importance of embedding a 'Think Family, Work Family' approach across West Yorkshire and Harrogate.
- Ensuring that the public version of the narrative is accessible to citizens.
- Role of the WYH 5 year strategy in enabling support within communities to make the 'left shift' approach a reality in how we commission services and address workforce challenges as a 'wicked issue' across the region.
- Importance of subsidiarity of place and working at scale across WYH HCP where it makes sense to do so and there is added value with a clear rationale.
- Importance of ensuring Health and Wellbeing Boards in WYH have early sight of, and conversations about, new initiatives and resources

RESOLVED – That the Leeds Health and Wellbeing Board is asked to:

- Input views and ideas into the overall development of the 5 year strategy for Health and Care in West Yorkshire and Harrogate
- Contribute specific feedback to the development of the 2 new programmes including how these can be achieved through closer working with the 6 Health and Wellbeing Boards across West and North Yorkshire.

Paul Bollom and Tony Cooke updated the Board on the Leeds Health and Care Plan. The following was highlighted:

- How the plan supported the Health and Wellbeing Strategy and links to working across West Yorkshire.
- Population Health Management.
- Key changes over the next 5 to 10 years.
- Refresh of the Plan.
- Ongoing work for aligned and shared priorities.
- Issues to consider including learning disability, mental health and poverty impacts.

Further discussion included the following:

- Welcomed the clarity that the Leeds Plan is the transformation programme for the health and care system rooted within the Leeds Health and Wellbeing Strategy
- Welcomed the focus on mental health and challenges for BAME communities and children and young people.
- Importance of parity of esteem between physical and mental health and the role of physical activity in improving mental health and wellbeing was noted.
- Welcomed the focus on prevention and improving population health by tackling the social determinants of health and wellbeing through a 'causes of causes' approach linked to the wider Health and Wellbeing and Inclusive Growth strategies
- Welcomed the focus on improving the contribution of the NHS and primary care to narrowing the gap in healthy behaviours (smoking, physical activity, healthy eating, obesity, alcohol/drugs), premature mortality and long term conditions as part of the Leeds Plan
- Discussion of the proposed shared priorities and the opportunities to go further in these areas to collectively address the demographic challenges outlined in the Joint Strategic Assessment with a focus on children and older people within communities that experience the highest levels of deprivation.
- Further exploration to occur around creating the strategic infrastructure to tackle poverty through the Health and Wellbeing Board and Inclusive Growth Partnership Board.
- Further work to shape up priorities around tackling homelessness, ensuring better health outcomes for Children Looked After and supporting vulnerable groups into employment as priorities linked to the Leeds Plan and delivered in partnership with other strategies and plans.
- Noted that climate change and health will be increasingly important and shared priorities will emerge from conversations.

RESOLVED – That the Health and Wellbeing Board is asked to:

- Note the progress and process to review the Leeds Plan to ensure it continues to meet the needs of the changing health and care landscape.
- Note further development to occur in the context of the NHS Long Term Plan and West Yorkshire and Harrogate draft 5 year strategy.
- Support the outcomes focused approach to reviewing the Leeds Plan.
- Support the 'obsessions' led approach and to further engage and develop the three proposed 'obsession' areas.
- Support the further strengthening of strategic links with other key boards by developing linking priorities/shared obsessions.

6 Priority 12: The best care, in the right place, at the right time - Update on Urgent Treatment Centre (UTC) development

The report of St George's Urgent Treatment Centre provided the Board with the following:

- Awareness of the national mandate and rationale behind the development of Urgent Treatment Centres (UTCs)
- As part of the Leeds Health and Care Plan, inform Members of the vision and aims of the Leeds Unplanned Care and Rapid Response Strategy and how UTCs support delivery.
- Update on the development of the St George's UTC, the learning from implementing the first designated UTC in Leeds and how we will use this learning when widening out the UTC provision across Leeds.
- Seek continued support from Members around the development of YTCs across the City.

The following were in attendance for this item:

- Jo Thornton
- Andrew Nutter
- Kate Parker
- Deborah Taylor

Key issues highlighted included the following:

- How services had been developed at St George's and how people accessed services.
- The ambition to have 5 UTCs across the City.
- 30,000 patients a year were seen at St George's with approximately three quarters living in the surrounding areas.
- How to get people to access the appropriate services for their needs – case studies were shown
- Next steps – developing pathways with other partners.

In response to comments and questions, the following was discussed:

- Mental health support within UTCs...

- Opportunity to provide greater clarity between different health and care services and when it is appropriate to use UTCs.
- Welcomed engagement to occur with Local Care Partnerships and opportunities around this.
- Considerations around making best use of our estates to improve access to UTCs.

RESOLVED – The Health and Wellbeing Board is asked to:

- Note the role of the Unplanned Care and Rapid Response programme of the Leeds Health and Care Plan in progressing the development of UTCs in line with Leeds Health and Wellbeing Strategy
- Provide feedback and continue to support the development of UTCs across the City using leaning from St George's UTC and the next steps outlined.

7 State of Women's Health in Leeds Report

Leeds was the first city in the UK to produce a comprehensive picture of life, health and wellbeing for women and girls – the State of Women's Health in Leeds Report.

The report of the Director of Public Health summarised the issues highlighted from its findings and next steps in using this learning across the system to understand needs and to commission better services for women supporting the vision of the Leeds Health and Wellbeing Strategy that Leeds will be a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest.

The following were in attendance for this item:

- Dr Ian Cameron, Director of Public Health
- Professor Alan White
- Jeannette Morris-Boam, Women's Lives Leeds
- Tim Taylor, Public Health

The Board received a presentation. Discussion included the following:

- Welcomed the State of Women's Health in Leeds Report and reflected on its launch on International Women's Day.
- Opportunity for a future Health and Wellbeing Board workshop focusing on the key challenges that can only be addresses in partnership.
- Importance of State of Women's Health in Leeds Report to be used to influence how we commission through a Future Generations approach.
- Ensuring that the recommendations of the report are implemented in a way that reflects the diversity of Leeds including for LGBT, BAME and disabled women. Particularly around accessibility and provision of mainstream services.

RESOLVED – The Health and Wellbeing Board is asked to:

- Note the content of the paper.
- Support the findings and recommendations of the State of Women's Health in Leeds report.
- Agree for organisations represented on the HWB to:
    - Invite the authors of the report to their relevant senior board/group meetings to discuss the findings
    - Reflect on gender difference in health and wellbeing in their services and the further actions needed to work to address the findings.
    - Identify comments to support delivery of the recommendations of the State of Women's Health report, which will be overseen and reported to a future HWB meeting.

8 For information: Leeds Health and Care Quarterly Financial Report

The report of the Leeds Health and Care Partnership Executive Group (PEG) provided the Board with an overview of the financial positions of the health and care organisations in Leeds, brought together to provide a single citywide financial report.

RESOLVED – That the 2018/19 April to March partner organisation pre-audit financial positions be noted.

9 For information: Connecting the wider partnership work of the Leeds Health and Wellbeing Board

The report of the Chief Officer, Health Partnerships provided a summary of recent activity from workshops and wider system meetings, convened by the Leeds Health and Wellbeing Board (HWB). The report gives an overview of key pieces of work across the Leeds health and care system, including:

- Leeds System Resilience Plan Update: Winter 2018/19
- Progressing our Leeds Health and Care Workforce Strategy
- Overview of our approach to Leeds City Health Tech
- Leeds Community Safety Strategy: Working together so people can live in healthy, safe and sustainable communities
- Promoting healthy adolescent relationships

RESOLVED – That the report be noted.

10 Minutes

RESOLVED – That the minutes of the meeting held on 25 April 2019 be confirmed as a correct record.

11 Date and Time of Next Meeting

Monday, 16 September 2019 at 2.00 p.m.

Leeds Health and Wellbeing Board

Report author: Lucy Jackson/ Diane Boyne

Report of: Leeds Palliative Care Network

Report to: Leeds Health and Wellbeing Board

Date: 16 September 2019

Subject: Priority 12 – The best care, in the right place, at the right time: Palliative and End of Life Care for Adults in Leeds

Are specific geographical areas affected? If relevant, name(s) of area(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, access to information procedure rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. ***How we care for the dying is an indicator of how we care for all sick and vulnerable people" (National End of Life Care Strategy 2008/ Ambitions for Palliative and End of Life Care: A national framework for local action 2015-20)***

2. There are approximately 6850 deaths per year in Leeds. Over the last 10 years there has been a reduction in the percentage of people dying in hospital and an increase in those dying at home, in a hospice or a care home. However there are still people dying in hospital when this was not their preferred place of death, and there are some key differences for different populations, and communities.

3. This programme of work directly contributes to the Leeds Health and Wellbeing Strategy priority of 'The best care, in the right place, at the right time' through a person centred approach; this is being reflected in the next iteration on the Leeds Health and Care Plan. Leeds has an effective Palliative and End of Life Network which has driven an increase in the quality of care and also an award winning Dying Matters Partnership changing the culture around death and dying. The current Leeds End of Life Care Strategy is due to end this year and engagement has now started on a new Leeds Palliative and End of Life Framework. To support this work a revised Health Needs Assessment has been completed; additional data has been analysed using a Population Health Management approach; engagement with

people has been analysed and draft population level outcomes have been developed.

Recommendations

The Health and Wellbeing Board is asked to:

- Note the breadth of work driven by the Leeds Palliative Care Network including the work of the Dying Matters Partnership
- Recognise people receiving palliative care and those at end of life as a key priority population in city plans
- Provide feedback on the draft population level outcomes for people at end of life, and on further engagement
- Provide feedback on the draft Leeds Palliative and End of Life Framework

1 Purpose of this report

1.1 The aim of this paper is to:

- Provide an overview of the work of the Leeds Palliative Care Network, including the Dying Matters programme
- Provide an overview of the key findings from the recently updated Health Needs Assessment (HNA) and the data from taking a population health management approach to this population.
- Seek strategic steer from the Board in developing the draft outcomes for people at end of life as one of our key population groups.
- Engage the Board in the development of the 'Leeds Palliative and End of Life Framework'.

2 Background information

2.1 There are approximately 6850 deaths per year in Leeds. Common causes of death for adults are: cancer (27.1%), circulatory disease (26.7%) and respiratory disease (12.4%). Over the last 10 years there has been a reduction in the percentage of people dying in hospital and an increase in those dying at home, in a hospice or a care home. When a preferred place of death is discussed during advance care planning people are more likely to die in a place of choice. However there are still people dying in hospital when this was not their preferred place of death.

2.2 A key aspect of enabling the public to engage actively and comfortably with this aspect of life is to encourage planning and conversations about end of life care and dying. Leeds has therefore invested in a sustained five year *Dying Matters* programme, led by Public Health.

2.3 The current Leeds End of Life Care Strategy covers the five years from 2014 to 2019. This paper seeks to outline the steps being taken to agree a revised strategy for the city.

2.4 One of the recommendations from the 2014-19 End of Life Care Strategy was to consider a partnerships forum that would increase collaborative working, improve continuity of care and patient / family experience; potentially a Managed Clinical Network to improve the experience of people requiring palliative care and those at end of life.

2.5 The *Leeds Palliative Care Network* is a collaborative partnership constituted through a formal Memorandum of Understanding and governed through clear terms of reference and reporting to NHS Leeds CCG. It was formed in 2016, and has representation from across the health and care system, and is leading the way as a forerunner of an integrated provider model for this population.

2.6 The purpose of the Leeds Palliative Care Network (LPCN) is to help provider organisations work together to plan and deliver care, in the best possible way for palliative and end of life care patients, their families and carers.

2.7 Recently, the LPCN has been working alongside NHS Leeds CCG and Leeds City Council to refresh the present strategy taking account of the move towards delivering population level outcomes taking a Population Health Management approach.

3 Main issues

Leeds Palliative Care Network (LPCN)

3.1 LPCN delivers quality service improvements through a significant programme of work.[1] Some examples of projects being delivered by LPCN are as follows:

- *Secured additional resources to improve care:* For example, more equipment for nurses across all providers to improve care and a Palliative Care Ambulance Service for Leeds so journeys at end of life are caring, comfortable and safe.

- *Improved the quality of care:*
  - More streamlined systems to support transfer of care between providers
  - Ensuring Specialist Palliatives Care Consultants provide support to other long term conditions clinical teams, so difficult conversations and care planning for end of life happens earlier.
  - Improving access to medications, medicines management and guidelines.
  - Input into the Care Home quality work within the city and ensure care homes can access appropriate training.
  - Improving end of life care for people living with dementia; providing additional clinical expertise, advance care planning and best practice on pain management.

- *Improved information sharing* across all providers for continuity of care and data collection to inform further improvement work and future planning.

- *Focussed on supporting a compassionate workforce:* Delivering significant training in end of life care to organisations across the health and care system; including communications skills and embedding our approach to Better Conversations.

- *Improved public and professional access* to services, advice and support through the LPCN website (https://leedspalliativecare.org.uk); and a useful patient and carer information leaflet has been produced.[2]

[1] Copies of the Programme updates can be found via https://leedspalliativecare.org.uk/wp-content/uploads/2019/07/Programme-Overview-19-20-June.pdf
[2] Leaflet can be found via https://leedspalliativecare.org.uk/wp-content/uploads/2019/04/Palliative-and-End-of-Life-Care-Leaflet.pdf

3.2 LPCN produces annual reports, which are available on the website.[3] A valuable public feedback survey has just been completed and reported, the *Leeds Bereaved Carers Survey*, which will be used to further inform improvements and the HNA.[4]

Dying Matters

3.3 Dying Matters Partnership was established in 2015 to address a gap identified in the HNA 2013 around the need to have an open conversation about death, dying, bereavement and making plans. The partnership is a multi-agency stakeholder group which includes representatives from statutory, academic, voluntary and business sectors. The work of the Dying Matters Partnership was recognised nationally in 2017 when it was awarded:

- National Council for Palliative Care's Dying Matters Awareness Initiative of the Year Award;
- Comms 2.0 Unawards for Best Collaboration

The partnership has developed and manages a programme of work focused on enabling people in Leeds to:

- Feel more comfortable about death and dying.
- Discuss their end of life wishes with family members and/or health and social care professionals.
- Plan for their death including writing their will, registering as an organ donor and communicating their funeral wishes.

3.4 This is being achieved through three work streams:

3.4.1 *1) Stakeholder and community engagement*
Dying Matters Leeds Partnership host an event as part of the national Dying Matters awareness week each year. This gives an opportunity to place the importance of talking about dying, death and bereavement firmly on the local agenda. Events took place throughout the week with a city centre event at Leeds Kirkgate Market ('Death is Coming Ready or Not') and a range of community events supported by the Dying Matters Community Grant Fund. In addition, Leeds Bereavement Forum, in partnership with Leeds Libraries are running a series of 'death cafes' in venues across the city throughout the year. Death Cafés are an international movement dedicated to encouraging discussion about death and dying in a relaxed environment. Library staff are also offering a vast array of books available to loan relating to death, dying and bereavement.

3.4.2 *2) Building capacity*
The community grant scheme was first introduced in 2018 to encourage organisations to run their own events during Dying Matters Week and extend the reach of the programme. It was administered by Leeds Bereavement Forum and

[3] Latest LPCN Annual Report can be found via https://leedspalliativecare.org.uk/wp-content/uploads/2019/07/LPCN-Annual-Report-2018-19.pdf
[4] Leeds Bereavement Survey can be found via https://leedspalliativecare.org.uk/wp-content/uploads/2019/08/LPCN-Bereaved-Carers-Survey-2018-19-Final-report.docx.pdf

applicants could apply for up to £200. The Dying Matters Partnership has also identified a need to provide training for staff and volunteers, focusing on end of life planning and bereavement. One day training, delivered by Leeds Bereavement forum, uses the model piloted by Sue Ryder Wheatfields in 2015.

3.4.3 *3) Communications and Marketing*
A communications plan is in place to ensure clear, consistent messages are given during Dying Matters weeks. A social media plan helps to publicise events and a website has been developed to share real life stories and promote the activities within the programme.

Updated Health Needs Assessment

3.5 A Health Needs Assessment (HNA) on End of Life Care Services in Leeds was published in 2013. This formed the foundations for the Leeds Clinical Commissioning Groups to commission services which met identified needs and contributed to people in Leeds experiencing good end of life care (EoLC).The NHS Leeds CCG EoLC commissioning strategy was published in 2014.

3.6 To further understand the current service delivery and demographic impacts an updated Health Needs Assessment Review has now been produced. This identifies opportunities for improvement and will help inform future priorities for Leeds.

3.7 A summary of the key findings from this update are as follows:

- Common causes of death in Leeds for adults are: cancer (27.1%), circulatory disease (26.7%) and respiratory disease (12.4%).
- Cancer deaths for people aged 65 and over are projected to rise by 16.1% (from 1,836 in 2011 to 2,132 in 2031). Non-cancer deaths expected to rise by 16% (from 4,523 to 5,249).
- Hospital deaths in Leeds have decreased by 10.6% since 2017 (from 56% to 45.4%), whilst the proportion of deaths at home, in hospice and in a care - home have all increased.
- 45% of people that died in Leeds in 2018/19 were on an Electronic Palliative Care Coordination System (EPaCCS; 2627 out of 5841 people). Local incentives have been developed to further improve this towards the national target of 60%. This suggests that at present over half of people that died in Leeds did not have discussions about their preferences towards the end of life.
- 73% of those that died between April 2018 and March 2019 who were on an EPaCCS register achieved their preferred place of death. This demonstrates that when preferred place of death is discussed during advance care planning people are likely to die in a place of their choice.
- Almost a third of people on an EPaCCS register would prefer to die in their own home (31.8%). In 2018-19 26.8% of people did die at home, however there were 5%, of people (131) during this 12 month time period, who would have preferred to die at home, but did not achieve it.
- There is a big gap between the proportion of people who said they would prefer to die in a hospital (1.4%) compared to those that did die in a hospital

(19.9%). This equates to around 484 people during this 12 month time period that died in a hospital when this was not their preferred place of death.

- People aged under 65 and 65-74 are slightly less likely to have a preferred place of death recorded or die in their preferred place of death.
- Males are slightly less likely to have a preferred place of death recorded. Males are also less likely to die in their preferred place of death when compared to females (70% and 76% respectively). They are also more likely to die in hospital.
- Lower proportions of Mixed (e.g. Mixed - Any other mixed background; Mixed - White and Asian; Mixed - White and Black African; Mixed - White and Black Caribbean) and Black ethnic groups have a preferred place of death recorded and die in their preferred place of death when compared to other ethnic groups.
- There is still more work to be done in line with the vision of the Leeds Health and Wellbeing Strategy to improve the health of people of the poorest the fastest and our approach to Inclusive Growth with some areas having a lower proportion of people dying in their preferred place of death (e.g. LS2, LS4, LS23). Further analysis is being undertaken in relation to linkages to areas that experience higher levels of deprivation.

3.8 The qualitative review demonstrated that the majority of health and care professionals that responded felt that progress had been made against the recommendations of the HNA 2013. However, a few respondents felt that there was still room for improvement. Responses suggested that the area for greatest improvement: was around the recommendation to 'Invest further in community services to support increasing care outside of hospital' in line with our Leeds Left Shift approach and 'working with' approach. Whilst some of the comments showed that investment in community services had been made, capacity was still stretched and further investment was needed. This needs to be considered particularly in the context of the capacity and workforce we need to meet future demographic challenges outlined in the Joint Strategic Assessment and as we continue to work to increase the number of people dying at home, in a hospice or a care home.

Future Strategic Plans and delivering Population outcomes

3.9 On 21 November 2018 LPCN hosted a Strategic Planning Event attended by 63 people, which identified early priorities for improvement and further action.[5]

3.10 Over recent months LPCN has worked with partners, commissioners and public health colleagues to start to develop population level outcomes for people in need of palliative care and at the end of life, and to understand *Population Health Management* methodology. Some initial information about variation within each Local Care Partnership has been shared and there is a plan to add hospice data to the Leeds data set to improve future information. Public Health have also revised and updated the HNA 2013 (as detailed above).

[5] https://leedspalliativecare.org.uk/wp-content/uploads/2019/05/The-Future-of-Palliative-and-End-of-Life-Care-in-Leeds-.pdf

3.11 A *Strategy Advisory Group* has also been established so that senior representative from all partner organisations can guide, inform and influence future strategic developments.

3.12 The 'end of life segment' is currently those people identified within GP End of Life Care registers. Quality improvement work is ongoing this year to increase early recognition and registration of people approaching the end of life, and work with the public on this will be part of the 2020 Dying Matters Campaign.

3.13 A key step to improving Population Health is to describe the outcomes we aspire to achieve for that population. The Strategy Advisory Group has created a draft *Outcomes Framework* based on:

- What people in Leeds have told us matters most about end of life care during recent engagement:
  - Staff providing care are caring, considerate and supportive.
  - People's wishes are taking into consideration
  - Information to people and their carers/family's needs to be consistent
  - Privacy
  - Choosing where to die

- National evidence and good practice.

Wider consultation on the Outcomes Framework is being planned with people and providers, jointly with NHS Leeds CCG and Leeds City Council. These outcomes are in draft and the Strategic Advisory Group would welcome Board members' steer both on the outcomes and the engagement process (Appendix 1).

3.14 To support the delivery of the outcomes and from work to date the LPCN are developing a Framework (Appendix 2) which will inform the provider response to the outcomes. The Framework takes account of:

- Priorities for improving end of life care identified at the Future of Palliative Care in Leeds Strategy event (November 2018)
- Ambitions for Palliative and End of Life Care – a National Framework for action (2015-2020)
- NHS Long Term Plan 2019
- Leeds End of Life HNA Review 2019
- Bereaved Carers Survey 2018-19
- What matters most at end of life to people in Leeds
- Strategy Advisory Group and Outcomes working group analysis
- Feedback from Leeds Clinical Senate and Leeds Academic Health Partnership

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

4.1.1 Population Health Management engagement process with people occurred during April and May 2018 which resulted in identifying 'What matters to people at end of life in Leeds'.[6]

Engagement with 18 organisations to collect feedback from those living with frailty, those at the end of their lives and their carers was conducted as part of the development of the Clinical Strategy for Frailty and End of Life. 132 service users identified the priorities for people living with frailty, carers and those at end of life. The latter included the following for end of life:

- Staff providing care are caring, considerate and supportive.
- People's wishes are taking into consideration
- Information to people and their carers/family's needs to be consistent
- Privacy
- Choosing where to die

4.1.2 Bereaved Carers Survey undertaken October 2018 – January 2019 received 204 responses from relatives whose family member had died in various places across the care system.[7]

4.1.3 Stakeholder engagement was conducted as part of the Health Needs Assessment (HNA) for End of Life Care for Adults in Leeds (2013) and a review of these findings is underway. The HNA identified a need to open a debate about death, dying, bereavement and making plans.

4.1.4 Stakeholder and community engagement is a key work stream in the Leeds Dying Matters programme, which ensures that citizens are engaged an involved with the annual programme of activity. A programme of engagement events take place during Dying Matters week each year.

4.2 Equality and diversity / cohesion and integration

4.2.1 Inequalities in health are a key issue for older people with ill health and social impacts affecting the poorest in the city disproportionately.

4.2.2 The Health Needs data review recognises the inequalities in end of life care and outcomes between people in different population groups and recommends gaining further insight into why inequalities exist in relation to end of life for different equality groups. Specific equality issues raised are:

- People aged under 65 and 65-74 are slightly less likely to have a preferred place of death recorded or die in their preferred place of death
- Males are slightly less likely to have a preferred place of death recorded. Males are also less likely to die in their preferred place of death when

[6] https://www.leedsccg.nhs.uk/get-involved/your-views/frailty-what-matters/
[7] https://leedspalliativecare.org.uk/wp-content/uploads/2019/08/LPCN-Bereaved-Carers-Survey-2018-19-Final-report.docx.pdf

compared to females (70% and 76% respectively). They are also more likely to die in hospital.

- Lower proportions of Mixed (e.g. Mixed - Any other mixed background; Mixed
- White and Asian; Mixed - White and Black African; Mixed - White and Black Caribbean) and Black ethnic groups have a preferred place of death recorded and die in their preferred place of death when compared to other ethnic groups

4.2.3 Dying Matters and related activities are delivered in a range of different settings and localities in order to engage with different population groups.

4.3 Resources and value for money

4.3.1 LPCN is funded £105K per annum by NHS Leeds CCG. There is an Executive Group that direct and support the LPCN which delivers significant improvement benefit beyond the value of the resourced clinical and management time, due to the commitment and engagement of staff from all the partner organisations.

4.3.2 The Dying Matters programme is funded by the NHS Leeds CCG. A budget of £36,250 was allocated to the Dying Matters programme in 2015. In 2017 a further sum of £4500 per year for a period of five years was agreed. Additional resources have been provided by private sector partners who have given time and resources free of charge. Officers leading the project are part of Public Health, within the Adults and Health Directorate of LCC. The partnership is led by the Head of Public Health for Older People. The Ageing Well Officer has day to day responsibility for developing the programme and provides the main resource; with other officers covering key areas as part of their roles.

4.4 Legal Implications, access to information and call In

4.4.1 There are no access to information and call-in implications arising from this report.

4.5 Risk management

4.5.1 LPCN hold a Risk Register and a System Issues log. The main challenge to this work is the limitations of the workforce capacity both in delivering care and undertaking improvement work. Looking at new workforce models and working collaboratively will provide some alleviation.

5 Conclusions

5.1 Leeds has an effective Palliative Care and End of Life Network which has driven the increase in the quality of care and an award winning Dying Matters Programme with citizens. However the recent revised HNA demonstrates there is still further improvement that needs to be made to achieve the outcomes that matter most to people.

5.2 The current Leeds End of Life Care Strategy is due to end this year and consultation is now started on a new Leeds Palliative and End of Life Framework. To support this work a revised Health Needs Assessment has been completed; additional data has been analysed using a Population Health Management approach and some draft population level outcomes have been developed

6 Recommendations

The Health and Wellbeing Board is asked to:

- Note the breadth of work driven by the Leeds Palliative Care network including the work of the Dying Matters Partnership
- Recognise people receiving palliative care and those at end of life as a key priority population in city plans
- Provide feedback on the draft population level outcomes for people at end of life, and on further engagement
- Provide feedback on the draft Leeds Palliative and End of Life Framework

7 Background documents

7.1 None.

THIS PAGE IS LEFT INTENTIONALLY BLANK

How does this help reduce health inequalities in Leeds?
It is nationally recognised that there continues to be unacceptable geographic variation and inequality in the end of life care people receive. The recent revised HNA is aiming in part to understand this for Leeds, and the work to agree population level outcomes for people at end of life for Leeds, with a specific focus on those who are the poorest, will aim to redress these issues by focusing on what is important to people and their carers.

How does this help create a high quality health and care system?
This programme of work directly contributes to the Health and Wellbeing Strategy priority of 'The best care, in the right place, at the right time'. The work of the LPCN has shown to increase the quality of care for people in Leeds, and the development of the outcomes framework will aim to drive this further.

How does this help to have a financially sustainable health and care system?
The work of the LPCN is already an excellent example of an emerging integrated provider model. Moving forward the development of the outcome framework , supporting providers to further work in an integrated system to support people to achieve what is important to them and their carers is critical to the sustainability of a future health and care system.

Future challenges or opportunities

- Culture change to ensure everyone is prepared to have conversations about dying and death
- Increasing the use of EPaCCs/Advance Care Planning
- Training of health and care workers
- Increasing funding for palliative and end of life within the community
- Developing a Single Point of Access supporting end of life care for people in Leeds

Priorities of the Leeds Health and Wellbeing Strategy 2016-21	
A Child Friendly City and the best start in life	
An Age Friendly City where people age well	X
Strong, engaged and well-connected communities	X
Housing and the environment enable all people of Leeds to be healthy	
A strong economy with quality, local jobs	
Get more people, more physically active, more often	
Maximise the benefits of information and technology	X
A stronger focus on prevention	
Support self-care, with more people managing their own conditions	X
Promote mental and physical health equally	X
A valued, well trained and supported workforce	X
The best care, in the right place, at the right time	X

This page is intentionally left blank

Appendix 1

Leeds Palliative and End of Life Care Framework for Adults

ACCESS

Equity of Access

Earlier Integration

Recognition

Vulnerable Groups

COMMUNICATION AND CO-ORDINATION

Advance Care Planning

EPaCCS and ReSPECT

Point of Care Information

Single Point of Access

Shared Decision Making

CARE MODELS

COMMUNITY

New Models of Care
Hospital Avoidance
LCPs/ Primary Care Networks
Hospices

CARE HOMES

Enhanced Health in Care Homes Model

HOSPITAL
Specialist Palliative Care

TRANSFER OF CARE

PERSONALISATION

VULNERABLE GROUPS

Learning Disability

Prisons

Homeless

Gypsies & Travellers

Black Asian & Minority Ethnic

LGBT

Dementia

Children to Adults Transition

KIND & CARING COMMUNITIES

Public Awareness and Conversations

Carer Support

Bereavement Services

Neighbourhood Networks

Social Prescribing

Volunteers

Leeds Directory

Dying Matters

MEDICINES MANAGEMENT

DIGITAL ENHANCEMENT

Clinical Data Sharing — Remote Monitoring — Telehealth and Education

WORKFORCE

Recruitment — Retention capacity , capability, culture — Training & development

UNDERSTANDING POPULATION NEEDS

Research — Clinical Audit — Data Analysis

SYSTEM INTEGRATION AND WIDER DETERMINANTS OF HEALTH

This page is intentionally left blank

Leeds Palliative Care Network

Leeds Palliative and End of Life Care

Outcomes Framework

Draft

Outcome	Type	Impact on People ("National Ambitions I statements")	What would we include?	Possible Metrics
1. Each person is seen as an individual who is able to influence their care in a way that matters to them	People	"I, and the people important to me, have opportunities to have honest, informed and timely conversations and to know that I might die soon. I am asked what matters most to me. Those who care for me know that and work with me to do what's possible."	ReSPECT Personalised care plan Advance Care Planning Shared decision making Preferred Place of Care	% of People at EOL with EPaCCS / ReSPECT Number of People achieving Preferred Place of Death
2. People in Leeds with palliative and end of life care needs are recognised and have fair access to services	Systems Recognition	"I live in a society where I get good end of life care regardless of who I am, where I live or the circumstances of my life."	Increasing Recognition Health Inequalities Vulnerable Groups Clinical Audit and Popn data Access to medicines	% Cancer: Non cancer Patients on EOL Register/ EPaCCS /ReSPECT Age breakdown of those with EOL Register/ EPaCCS / ReSPECT Other diversity measures?
3. People in Leeds are supported to live well as long as possible, maximising comfort and wellbeing	Systems Staff	"My care is regularly reviewed and every effort is made for me to have the support, care and treatment that might be needed to help me to be as comfortable and as free from distress as possible"	Pain & symptoms managed effectively; Holistic care Mental well being Care reviewed as needed	Bereaved Carers Survey IPOS reporting (future development)
4. Palliative and end of life care in Leeds is well coordinated	People System	"I get the right help at the right time from the right people. I have a team around me who know my needs and my plans and work together to help me achieve them. I can always reach someone who will listen and respond at any time of the day or night."	24/7 care services Single Point Access EPaCCS Transfer of Care Anticipatory Medicines	Number of People achieving Preferred Place of Death % of People at EOL on EPaCCS / ReSPECT Bereaved Carers Survey
5. People providing palliative and end of life care are well equipped to do so	Staff	"Wherever I am, health and care staff bring empathy, skills and expertise and give me competent, confident and compassionate care."	Workforce Skilled Staff – Training LPCN Website Resources Guidelines - medicines	Education Numbers? Bereaved carers Survey Website Activity
6. Communities are ready, willing and able to support people with palliative and end of life care needs	People	"I live in a community where everybody recognises that we all have a role to play in supporting each other in times of crisis and loss. People are ready, willing and confident to have conversations about living and dying well and to support each other in emotional and practical ways."	Dying matters Social Prescribing Leeds Directory LPCN Website	Dying Matters Stats? Others? Website Activity
7. Family carers, relatives and others close to dying people are well supported during and after their care	Carers	"I, and the people important to me, have opportunities to have honest, informed and timely conversations and to know that I might die soon. I am asked what matters most to me. Those who care for me know that and work with me to do what's possible."	Carers assessment and Support Respite care Bereavement Services	Leeds Carers Stats for EOLC and Bereavement Cruse Stats LBF stats

Leeds Health and Wellbeing Board

Report author: Ian Brooke-Mawson (Commissioning Programme Lead (Carers)

Report of: Leeds Carers Partnership

Report to: Leeds Health and Wellbeing Board

Date: 16th September 2019

Subject: Leeds Carers Partnership Strategy

Are specific geographical areas affected? If relevant, name(s) of area(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☒ Yes	☐ No
Is the decision eligible for call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, access to information procedure rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. This report presents a new draft Leeds Carers Partnership Strategy (2020-2025) for consideration by the Health and Wellbeing Board, including how the strategy will support the delivery of the Leeds Health and Wellbeing Strategy and Leeds Health and Care Plan.

2. Unpaid carers provide the bulk of care in our city and without them the NHS and social services would be overwhelmed. Evidence tells us that not only is the number of carers increasing, but that carers are taking on responsibility for more intensive levels of care, and this is known to impact upon carers' physical, mental and economic health and wellbeing.

3. The Leeds Carers Partnership are committed to developing Leeds as a carer-friendly city and there have been a number of improvements in recent years in the way carers are supported in Leeds, however, challenges remain.

4. The priorities for further work set out in the draft strategy include improving identification of carers, increasing the number of carers accessing support, knowing what works for carers, influencing change and innovation and making Leeds a 'Carer-Friendly city'.

Recommendations

The Health and Wellbeing Board is asked to:

- Note the progress made by the Leeds Carers Partnership in developing the draft strategy
- Comment on and support the development of the strategy including the public engagement proposal

1 Purpose of this report

1.1 This report:

- Presents a new draft Leeds Carers Partnership Strategy, including how it will help deliver the Leeds Health and Wellbeing Strategy and Leeds Health and Care Plan.
- Recognises the health inequalities that carers experience due to their caring role.
- References developments that have taken place in recent years and important challenges that can be addressed by working in partnership, with the support of Leeds Health and Wellbeing Board.

2 Background information

2.1 Carers are people who have a caring responsibility for a family member, a partner or a friend who otherwise couldn't manage without their help. This may be because of illness, frailty, disability, a mental health need or an addiction.

2.2 Carers come from all walks of life, all cultures and can be of any age. The care they provide is unpaid and as such this definition does not extend to care-workers who are paid professionals who work in a variety of settings, from home care agencies and residential care facilities to nursing homes.

2.3 Each caring situation is different and is influenced by factors relating to both the carer and the person they care-for, for example:

- Carers are likely to perform domestic tasks such as shopping, managing finances, cleaning, washing, ironing etc
- Carers are also likely to perform personal care and nursing tasks such as giving medication, changing dressings, helping with mobility, dressing and toileting.
- Some carers may perform fewer physical tasks, but provide a great deal of emotional support, especially if the person they care for has mental health needs or dementia.
- Carers often have to deal with emergencies which rarely happen at convenient times.

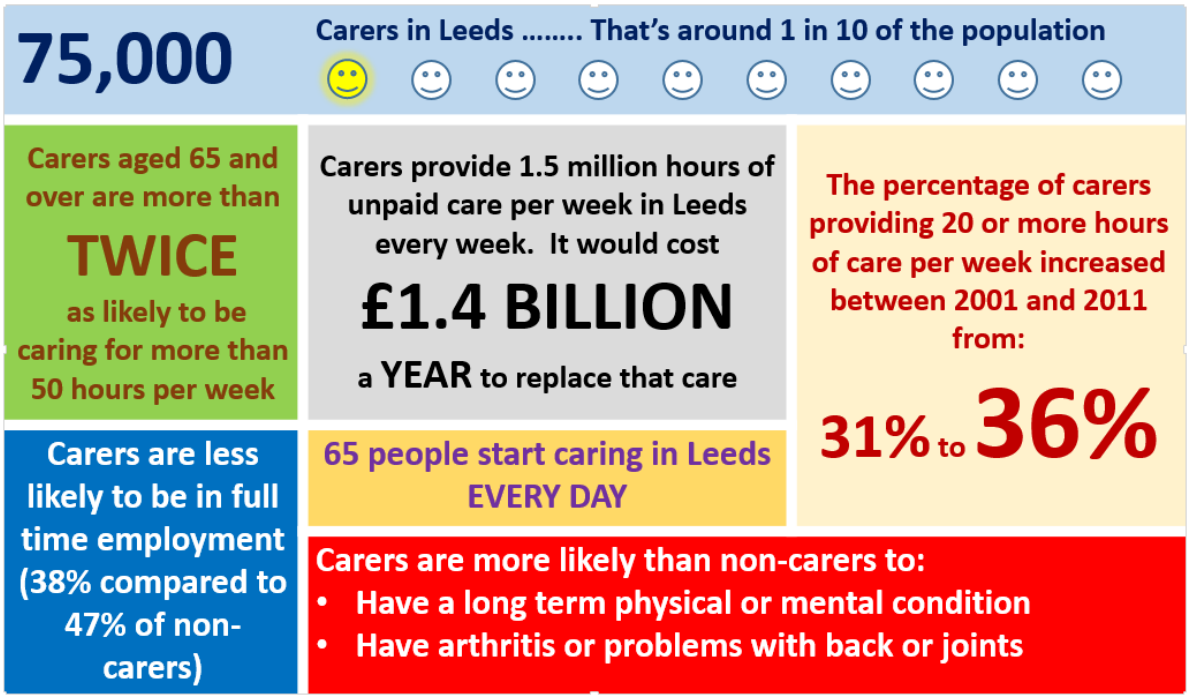
2.4 Evidence tells us that not only is the number of carers increasing, but that carers are taking on responsibility for more intensive levels of care. This is known to impact upon carers' physical, mental and economic health and wellbeing, for example carers are more likely to:

- have a long-term physical or mental health condition, illness or disability
- be isolated and not have as much social contact as they would like
- be worried about finances
- not get enough sleep and time for themselves

2.5 Carers provide the bulk of care in our city and without them the NHS and social services would be overwhelmed. It is estimated that over 1.5 million hours of unpaid care are provided across Leeds every week while research published by the University of Leeds and Carers UK estimates the financial contribution of unpaid carers in Leeds to be around £1.4billion per year.

2.6 Since replacing unpaid care with paid care is not an option, supporting carers to continue caring makes economic and demand management sense as well as being morally the right thing to do. It is widely recognised that good support for carers benefits not only carers by maintaining and promoting their health and well-being, but also the health and well-being of the person they care for. Supporting carers to continue caring is therefore equally fundamental to supporting strong families and communities as it is to the sustainability of the NHS and Adult Social Care.

2.7 The table below summarise a number of key messages relating to carers and caring:



3 Main issues

3.1 In recent years, there have been a number of positive developments in Leeds aimed at promoting carer wellbeing, including:

- Adults and Health have re-procured information, advice and support services for carers on behalf of Leeds City Council and NHS Leeds Clinical Commissioning Group
- 17 teams and/or organisations have undertaken 50 separate actions/activities as part of their contribution to the Leeds Commitment to Carers; these have tended to be focussed around improving support for carers who are balancing work and care, improving identification and recognition of carers, providing

carers with relevant information, signposting/referring carers to specialist information, advice and support, training and supporting the workforce to be carer-aware, supporting carers to access local resources.

- Adults and Health have introduced a new three tier approach to supporting carers to get a break from caring and have allocated additional funding to support community based short breaks
- NHS Leeds Clinical Commissioning Group have developed carer outcomes in their frailty programme of work
- Leeds Teaching Hospitals NHS Trust have developed a Carers Charter as part of their support to John's Campaign which is a campaign for extended visiting rights for carers of patients with dementia in hospitals
- New recurrent funding was distributed by Carers Leeds to support carers with the increased costs of caring in winter months
- Better Care Funding has enabled Carers Leeds to work directly with employers through the 'Leeds Working Carers Employers Network' to help managers and HR teams develop and improve support for their taff who balance their work with caring; the number of organisations involved in the network has increased membership to 27 employers and includes Leeds City Council, British Gas, University of Leeds, St Gemma's, Direct Line Group, West Yorkshire Police, NHS England, Leeds Community Health Care, DWF Law, Irvin Mitchell, Civil Service Charity, DWP, Leeds Teaching Hospitals, HMRC, ASDA, NHS Digital, Clarion, Environment Agency, Skills for Care, Yorkshire Bank, Hainsworth, Forum Central, Leeds College of Music, Yorkshire Building Society, First Group, Cafcass, Home office
- Carers in Leeds can access the Carers UK 'Digital Resource for Carers' free of charge which includes a wide range of digital products, for example on-line guides, Jointly App, building resilience e-learning and links to local support
- Leeds City Council and NHS Leeds Clinical Commissioning Group have provided additional funding though the Better Care Fund to increase the number of carers who receive a Time for Carers grant
- Members of the Leeds Carers Partnership have met with the Financial Services Authority to discuss ways the financial sector can promote Better Banking for carers

3.2 However, challenges remain, including:

- Increasing identification and support for carers through primary care to ensure carers are better prepared for caring and can get support early to look after their own health and wellbeing
- Developing new learning and training opportunities for carers to help them plan, prepare and provide care
- Developing new and additional capacity to enable more carers to have a break and/or keep in touch with friends and family
- Ensuring that support is reaching carers from our diverse communities (including BAME, LGBT+ and migrant communities)

- Ensuring more carers are able to find and/or remain in employment and are able to reach their potential in the workplace
- Ensuring that carers and their families do not suffer financial hardship as a result of caring, for example by giving up work to care
- Raising public awareness of carers and caring and reaching people who do not identify themselves as carers
- Working with West Yorkshire and Harrogate Health and Care Partnership to understand the benefits of introducing Carer Passport schemes
- Influencing initiatives and partnerships in Leeds so that they include carers and are better meet the needs of carers

3.3 The draft strategy has been designed so it is primarily available online. This will mean the strategy is live and interactive and will enable the strategy and the resources available to carers in Leeds to be easily and regularly updated. A printable version of the strategy is appended to this report as Appendix 2. A one page summary of the draft strategy is appended to this report as Appendix 1.

3.4 Each partner organisation would be required to complete their own action plan setting out their contribution towards the achievement of objectives which have been developed by members of the Leeds Carers Partnership. Each of the objectives relate to one of five priorities, again developed by the Leeds Carers Partnership, and which are based on things that carers themselves have said are important to them. The following five priorities are proposed:

- Improving identification of carers
- Increasing the number of carers accessing support
- Knowing what works for carers
- Influencing change and innovation
- Making Leeds a 'Carer-Friendly city'

3.5 Work is also ongoing to develop a Young Carers Strategy, which is being led by Children & Families, Leeds City Council.

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

4.1.1 The draft strategy has been developed by members of the Leeds Carers Partnership, the lead group in Leeds focussed on the development and improvement of services that support carers. Membership of the Leeds Carers Partnership is open and aims to reflect the stakeholders to the Leeds Carers Partnership Strategy. Membership includes carers as well as key staff from the public, private and voluntary sector.

4.1.2 The Leeds Carers Partnership proposes a period of public engagement to give people the opportunity to inform a final version of the strategy with a view to a strategy launch early in 2020.

4.1.3 Carers Leeds will be central to public engagement acting as both a channel of communication and a voice for the 12,500 carers they support each year.

4.2 Equality and diversity / cohesion and integration

4.2.1 The strategy will seek to address the diverse needs of carers in Leeds and the health inequalities that they experience due to their caring roles.

4.2.2 An equality and cohesion screening tool has been completed and is appended to this report.

4.3 Resources and value for money

4.3.1 There are no specific costs relating to the development of the strategy.

4.3.2 The overall approach is consistent with the Leeds Plan shift towards early intervention and prevention, whilst recognising that investment in quality care and support for older people and disabled people is required to ensure that carers are not pushed to breaking point by a lack of support.

4.4 Legal Implications, access to information and call In

4.4.1 There are no legal, access to information or call in implications to this report.

4.5 Risk management

4.5.1 The strategy will seek to set out the ambition of Leeds to be the best city for carers, whilst being practical about opportunities and challenges. Financial and reputational risks will be managed by the governance of Council and Clinical Commissioning Group in the development of the strategy.

5 Conclusions

5.1 The Leeds Carers Partnership draft strategy sets out priorities and objectives which will together improve the quality of life and promote the wellbeing of carers in Leeds. A period of public engagement will enable more people to have opportunity to inform a final version of the strategy with a view to a strategy launch early in 2020.

6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Note the progress made by the Leeds Carers Partnership in developing the draft strategy
- Comment on and support the development of the strategy including the public engagement proposal

7 Background documents

7.1 None.

THIS PAGE IS LEFT INTENTIONALLY BLANK

How does this help reduce health inequalities in Leeds?
Carers experience health inequalities due to their caring role. The strategy aims to raise awareness of carers and caring and to develop a partnership approach, involving public, private and voluntary sector, to improving identification, recognition and support for carers.

How does this help create a high quality health and care system?
It is widely recognised that good support for carers benefits not only carers by maintaining and promoting their health and well-being, but also the health and well-being of the person they care for. Carers also play a significant role in preventing, reducing or delaying the needs for care and support for the people they care for, which is why it is important that we consider preventing carers from developing needs for care and support themselves.

How does this help to have a financially sustainable health and care system?
Promoting carers' wellbeing and supporting carers to continue caring is an argument that in recent years has moved beyond simply one of morality or even duty. It is now widely recognised that supporting carers delivers economic benefits as well as contributing to managing demand. Research undertaken by the University of Leeds estimate the financial contribution of unpaid care in Leeds to be around £1.4billion per year. Supporting carers to continue caring is therefore equally fundamental to supporting strong families and communities as it is to the sustainability of the NHS and Adult Social Care.

Future challenges or opportunities

- Increasing identification and support for carers through primary care to ensure carers are better prepared for caring and can get support early to look after their own health and wellbeing
- Developing new learning and training opportunities for carers to help them plan, prepare and provide care
- Developing new and additional capacity to enable more carers to have a break and/or keep in touch with friends and family
- Ensuring more carers are able to balance work and care with support to return to work alongside or after caring
- Ensuring that carers and their families do not suffer financial hardship as a result of caring
- Raising public awareness of carers and caring
- Influencing initiatives and partnerships in Leeds so that they include carers and are better meet the needs of carers

Priorities of the Leeds Health and Wellbeing Strategy 2016-21	
A Child Friendly City and the best start in life	
An Age Friendly City where people age well	X
Strong, engaged and well-connected communities	X
Housing and the environment enable all people of Leeds to be healthy	
A strong economy with quality, local jobs	
Get more people, more physically active, more often	
Maximise the benefits of information and technology	X
A stronger focus on prevention	X
Support self-care, with more people managing their own conditions	X
Promote mental and physical health equally	X
A valued, well trained and supported workforce	
The best care, in the right place, at the right time	

This page is intentionally left blank

Appendix 1 – DRAFT Leeds Carers Partnership Strategy Plan on a Page

Leeds Carers Partnership: "Putting carers at the heart of everything we do"

Our Vision	**We want Leeds to be a city where carers can say:**	
	I have good quality information and advice which is relevant to me	I get to have a break and some time for myself
	I am listened to and feel part of the team planning care for the person I care-for	I am able to balance caring with my paid work
	I am satisfied with the support that the person I care-for receives	I know where to get help from when I need it including when things go wrong
	I feel that what I do as a carer is recognised, understood and valued	I am able to keep in touch with friends and family
	I fell that I am supported to look after my own health and wellbeing	I feel supported when my caring role ends

Our Approach	**All partners to the strategy agree to**			
	Work in partnership with others to support carers	Promote good practice in the identification and recognition of carers	Ensure that carers are involved in making decisions that affect them and the person they care-for	Work towards being a 'carer-friendly' employer

Our Priorities	**Improving identification of carers**	**Increasing the number of carers accessing support**	**Knowing what works for carers**	**Influencing change and innovating**	**Making Leeds a carer-friendly city**
Our Objectives	Increase the number of patients who are registered with their GP practice as carers	Increase the number of carers who get a break from caring	Establish a Leeds Carers Forum to provide a 'carer voice'	Identify opportunities to work in partnership with Digital Leeds	Increase the number of organisations who complete a 'Leeds Commitment to Carers' declaration
	Increase the number of carers assessments completed and recorded by Leeds City Councils Adults & Health Directorate	Increase the number of carers supported by Carers Leeds	Carry out research with carers from our diverse communities (including BAME, LGBT+ and migrant communities)	Influence initiatives and partnerships in Leeds to include carers and better meet the needs of carers	Establish Carer Friendly Ambassadors
	Increase the number of organisations who are engaged with the Leeds Working Carers Employers Network	Increase the number of carers who have an emergency plan	Undertake an annual carers survey	Collaborate and innovate with partners regionally and nationally (including Integrated Care System, Carers UK)	Hold an annual 'Leeds Carers Fest'

Action Plans	Each organisation that is a member of the Leeds Carers Partnership will develop their own action plan which will set out the actions they will take that will contribute towards the objectives and priorities.

This page is intentionally left blank

Appendix 2

The Leeds Carers Partnership

“Putting carers at the heart of everything we do”

Go to next page

Click to exit

Foreword

DRAFT

Name
Position
Organisation

Dear

I'm writing to you either because you are one of 75,000 people in Leeds who are caring for someone who couldn't manage without your help because of their health and care needs, or because I believe there is something you can do to help improve quality of life for carers.

Carers are the backbone of our society and without them, the health and care system would collapse.

If we are serious about being the best city for health and wellbeing we must be the best city for carers and that means working together to make sure that we are the best at identifying carers, the best at recognising and valuing the role and contribution of carers, the best at ensuring carers stay healthy and the best at supporting working carers.

Putting carers at the heart of everything we do" has been produced by the Leeds Carers Partnership to help us be the best city for carers. I hope you find it both helpful and informative.

Yours faithfully

Photo

Name
Position

Go to next page

Click to exit

Contents

There are three sections to “Putting carers at the heart of everything we do” – click on any of the boxes below to go to that section

Section 1: Information about carers and caring

Section 2: The strategy

Section 3: Resources for carers in Leeds

Click to exit

Section 1: Information about carers and caring

Click on any of the boxes for more information

- Who are carers?
- What do carers do?
- Where do carers live?
- Some facts and figures
- Some things that carers say would help them
- Some things get in the way

Go back to contents

Click to exit

Section 2: The strategy

Click on any of the boxes for more information

- Our Vision
- Our Approach
- Legislation and Policy
- Investment in support for carers
- Our priorities and passions
- Action Plans
- How we will know we are making a difference
- Links to other local plans and strategies

Go back to contents

Click to exit

Section 3: Resources for carers in Leeds

Click on any of the boxes for more information

Carers Leeds	Willow Young Carers Service	Getting a break (adult carers)	Getting a break (parent carers)	GP Yellow Card Scheme
Support for working carers	Digital Resource for Carers	Planning for an emergency	Carers Assessment	Time for Carers grant
Carer Support Groups	Benefits Advice	Support for carers in Leeds Hospitals	Leeds Directory	Telecare Services
Bereavement Support	Connecting Carers Project	Holidays for carers (Carers Trust)??	Social Prescribing Service	Blank

Go back to contents

Click to exit

Who are carers?

Carers are people who have a caring responsibility for a family member, a partner or a friend who otherwise couldn't manage without their help. This may be because of illness, frailty, disability, a mental health need or an addiction.

Carers come from all walks of life, all cultures and can be of any age. The care they provide is unpaid and as such this definition does not extend to *care-workers* who are paid professionals who work in a variety of settings, from home care agencies and residential care facilities to nursing homes.

Adult Carers:

Carers aged 18 or over who care for another adult aged 18 or over

Parent Carers:

Carers aged 18 or over who are caring for a disabled child

Young Carers:

Carers aged under 18 who may be caring for an adult or a disabled child

Back to Section 1

Click to exit

What do carers do?

Each caring situation is different and is influenced by factors relating to both the carer and the person they care-for

Carers are likely to perform domestic tasks such as shopping, managing finances, cleaning, washing, ironing etc

Carers are also likely to perform personal care and nursing tasks such as giving medication, changing dressings, helping with mobility, dressing and toileting

Some carers may perform fewer physical tasks, but provide a great deal of emotional support, especially if the person they care for has mental health needs or dementia

Carers often have to deal with emergencies which rarely happen at convenient times!

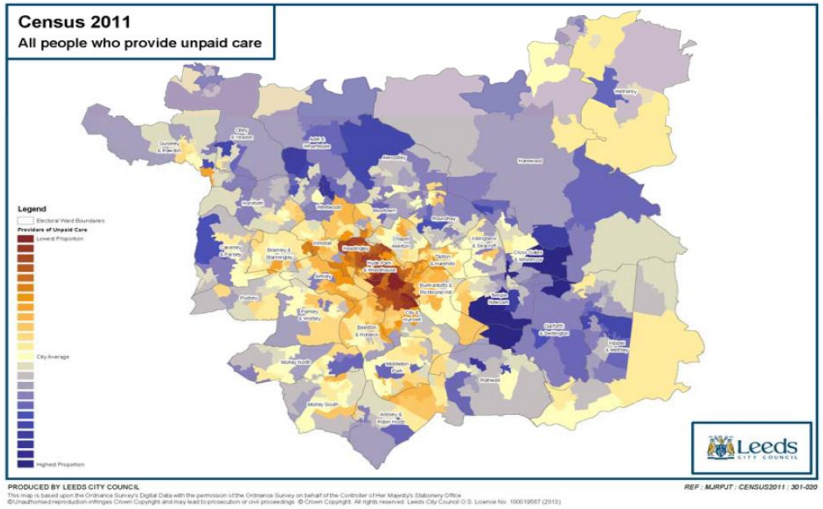
Back to Section 1

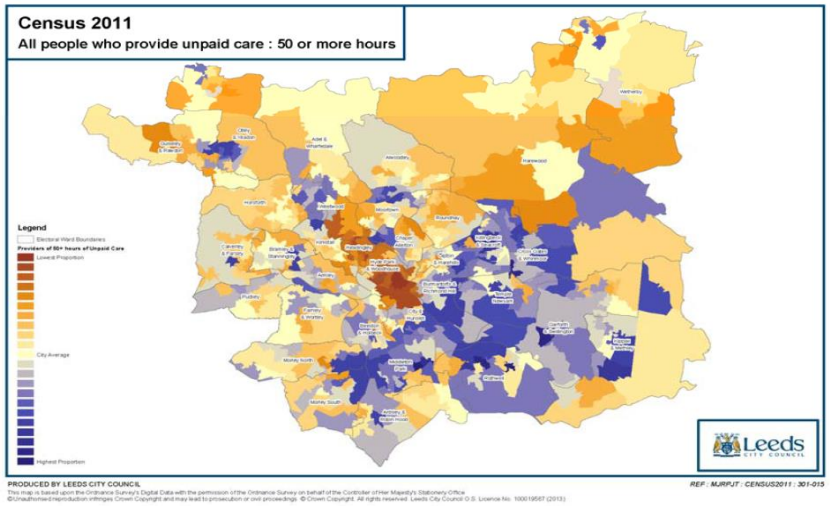
Click to exit

Where do carers live?

The map on the left shows the distribution of carers in Leeds while the map on the right shows the distribution of carers who provide more than 50 hours of care per week.

The maps suggest that greater numbers of carers tend to live in the outlying areas of Leeds with a distinct pattern to the North of the City. However, the distribution changes with carers providing the greatest number of hours more likely living to the south and south east of the City.





Back to Section 1

Click to exit

Some facts and figures

75,000 Carers in Leeds ..... That's around 1 in 10 of the population

Carers aged 65 and over are more than **TWICE** as likely to be caring for more than 50 hours per week

Carers provide 1.5 million hours of unpaid care per week in Leeds every week. It would cost **£1.4 BILLION** a **YEAR** to replace that care

The percentage of carers providing 20 or more hours of care per week increased between 2001 and 2011 from: **31%** to **36%**

Carers are less likely to be in full time employment (38% compared to 47% of non-carers)

65 people start caring in Leeds EVERY DAY

Carers are more likely than non-carers to:

- Have a long term physical or mental condition
- Have arthritis or problems with back or joints

Back to Section 1

Click to exit

Some things that carers say would help them

- Good quality information and advice
- Good quality and reliable support for the person I care-for
- If the NHS and Social Care recognised and valued what I do
- Help to improve my own health and wellbeing
- Having a break and some time for me
- An understanding employer
- Knowing where to get help from when I need it
- Support when my caring role ends
- Having someone to talk to
- Being listened to and included
- Being in touch with other carers
- Advice about money and benefits

Back to Section 1

Click to exit

Some things get in the way

Not knowing where to get help from, or even that there is help available

Not wanting other people to know about the person they care for

Not recognising themselves as carers or using the word 'carer'

Feeling tired all the time

Feeling that saying they are a carer will count against them

The word 'carer' is often used incorrectly to mean 'care-worker'

The person they care for refuses help

The NHS and Social Care don't always identify carers

Carers tend to ignore their own health needs

Employers and managers often lack awareness of carers and caring

Back to Section 1

Click to exit

Our Vision

We want Leeds to be a city where carers can say:	
✓	I have good quality information and advice which is relevant to me
✓	I am listened to and feel part of the team planning care for the person I care-for
✓	I am satisfied with the support that the person I care-for receives
✓	I feel that what I do as a carer is recognised, understood and valued
✓	I feel that I am supported to look after my own health and wellbeing
✓	I get to have a break and some time for myself
✓	I am able to balance caring with my paid work
✓	I know where to get help from when I need it including when things go wrong
✓	I am able to keep in touch with friends and family
✓	I feel supported when my caring role ends

Back to Section 2

Click to exit

Our approach

All partners to the strategy have agreed to:	
✓	Work in partnership with others to support carers
✓	Promote good practice in the identification and recognition of carers
✓	Ensure that carers are involved in making decisions that affect them and the person they care-for
✓	Work towards being a 'carer-friendly' employer

Back to Section 2

Click to exit

Legislative and Policy

The **Care Act 2014** gives carers the same recognition, respect and parity of esteem with those they support. Duties and responsibilities in relation to information and advice, promoting independence and wellbeing, preventing and delaying people from developing needs for care and support, and assessment and eligibility, apply equally to carers as they do to the people they care for.

The **NHS Long Term Plan** includes key commitments to improve identification and support for carers and to develop more personalised support for patients and carers. This includes joint health and social care assessments and care planning, carers' personal health budgets, more personalised outcomes from Continuing Health Care and Care Programme Approach Assessments and wider use of social prescribing.

The rights of parent carers are addressed within the **Children and Families Act.** The council has a duty to provide an assessment to a carer of a disabled child aged under 18 if it appears that the parent carer has needs, or the parent carer requests an assessment.

The **Equality Act, the Human Rights Act** and the **Employment Rights Act** all include provisions which enable carers to challenge adverse treatment they may experience as a result of their caring responsibilities.

Back to Section 2

Click to exit

Investment in support for carers

The table below shows the planned budget from April 2020 to support carers. This includes contributions from Leeds City Council (Adults and Health & Children and Family directorates) and NHS Leeds Clinical Commissioning Group. It does not include all the support that is provided directly to an adult with care and support needs which may benefit carers (e.g. by helping them to have a break) as it is not possible to quantify this figure. Nor does it include funding for the Young Carers service.

Description	Planned Budget
Information, advice and support service for adult and parent carers	£1,326,539
Community Based Short Breaks (Adults)	£1,201,230
Targeted Short Breaks for Disabled Children	£TBC
Carers Emergency Scheme	£94,950
Time for Carers grant	£150,000
Winter Resilience: Support for carers	£40,000
Employers for Carers & Digital Resource (Carers UK)	£5,000
Total	£

Back to Section 2

Click to exit

Our Priorities and Passions

Click on any of the boxes below to look at the objectives that relate to that priority

- Improving identification of carers
- Increasing the number of carers accessing support
- Knowing what works for carers
- Influencing change and innovating
- Making Leeds a carer-friendly city

Back to Section 2

Click to exit

Improving identification of carers

Objectives	
Objective 1	Increase the number of patients who are registered with their GP practice as carers
Objective 2	Increase the number of carers assessments completed and recorded by Leeds City Councils Adults & Health Directorate
Objective 3	Increase the number of organisations who are engaged with the Leeds Working Carers Employers Network

Back to Priorities

Click to exit

Increasing the number of carers accessing support

Objectives	
Objective 1	Increase the number of carers who get a break from caring
Objective 2	Increase the number of carers supported by Carers Leeds
Objective 3	Increase the number of carers who have an emergency/contingency plan

Back to Priorities

Click to exit

Knowing what works for carers

Objectives	
Objective 1	Establish a Leeds Carers Forum to provide a 'carer voice'
Objective 2	Carry out research with carers from our diverse communities (including BAME, LGBT+ and migrant communities)
Objective 3	Undertake an annual carers survey

Back to Priorities

Click to exit

Influencing change and innovating

Objectives	
Objective 1	Identify opportunities to work in partnership with Digital Leeds
Objective 2	Influence initiatives and partnerships in Leeds to include carers and better meet the needs of carers
Objective 3	Collaborate and innovate with partners regionally and nationally (including Integrated Care System, Carers UK)

Back to Priorities

Click to exit

Making Leeds a carer-friendly city

Objectives	
Objective 1	**Increase the number of organisations who complete a 'Leeds Commitment to Carers' declaration**
Objective 2	**Establish Carer Friendly Ambassadors**
Objective 3	**Hold an annual 'Leeds Carers Fest'**

Back to Priorities

Click to exit

Action Plans

Click on any logo to see the actions that organisation is taking as their contribution to Putting Carers etc

Leeds City Council

jobcentreplus

Carers Leeds

NHS The Leeds Teaching Hospitals NHS Trust

NHS Leeds Clinical Commissioning Group

Believe in children Barnardo's

St. Gemma's Hospice

Forum Central

Leeds Community Healthcare NHS Trust

healthwatch Leeds

Leeds age UK

NHS Leeds and York Partnership NHS Foundation Trust

EPIC LEEDS

Back to Section 2

Leeds Carers

Click to exit

Action Plan: Leeds City Council

What actions are you taking to put carers at the heart of everything you do?	TO BE COMPLETED
What results do you expect to see?	TO BE COMPLETED
How will you know you have been successful?	TO BE COMPLETED

Back to Logo's

Click to exit

Action Plan: Department for work and pensions

What actions are you taking to put carers at the heart of everything you do?	TO BE COMPLETED
What results do you expect to see?	TO BE COMPLETED
How will you know you have been successful?	TO BE COMPLETED

Back to Logo's

Click to exit

Action Plan: Carers Leeds

What actions are you taking to put carers at the heart of everything you do?	TO BE COMPLETED
What results do you expect to see?	TO BE COMPLETED
How will you know you have been successful?	TO BE COMPLETED

Back to Logo's

Click to exit

Action Plan: Leeds Teaching Hospitals NHS Trust

What actions are you taking to put carers at the heart of everything you do?	TO BE COMPLETED
What results do you expect to see?	TO BE COMPLETED
How will you know you have been successful?	TO BE COMPLETED

Back to Logo's

Click to exit

Action Plan: NHS Leeds CCG

What actions are you taking to put carers at the heart of everything you do?	TO BE COMPLETED
What results do you expect to see?	TO BE COMPLETED
How will you know you have been successful?	TO BE COMPLETED

Back to Logo's

Click to exit

Action Plan: Barnardos Willow Project

What actions are you taking to put carers at the heart of everything you do?	**TO BE COMPLETED**
What results do you expect to see?	**TO BE COMPLETED**
How will you know you have been successful?	**TO BE COMPLETED**

Back to Logo's

Click to exit

Action Plan: St Gemma's Hospice

What actions are you taking to put carers at the heart of everything you do?	TO BE COMPLETED
What results do you expect to see?	TO BE COMPLETED
How will you know you have been successful?	TO BE COMPLETED

Back to Logo's

Click to exit

Action Plan: Forum Central

What actions are you taking to put carers at the heart of everything you do?	TO BE COMPLETED
What results do you expect to see?	TO BE COMPLETED
How will you know you have been successful?	TO BE COMPLETED

Back to Logo's

Click to exit

Action Plan: Leeds Community Healthcare NHS Trust

What actions are you taking to put carers at the heart of everything you do?	TO BE COMPLETED
What results do you expect to see?	TO BE COMPLETED
How will you know you have been successful?	TO BE COMPLETED

Back to Logo's

Click to exit

Action Plan: Healthwatch Leeds

What actions are you taking to put carers at the heart of everything you do?	TO BE COMPLETED
What results do you expect to see?	TO BE COMPLETED
How will you know you have been successful?	TO BE COMPLETED

Back to Logo's

Click to exit

Action Plan: Age UK Leeds

What actions are you taking to put carers at the heart of everything you do?	TO BE COMPLETED
What results do you expect to see?	TO BE COMPLETED
How will you know you have been successful?	TO BE COMPLETED

Back to Logo's

Click to exit

Action Plan: Leeds & York Partnership NHS Foundation Trust

What actions are you taking to put carers at the heart of everything you do?	TO BE COMPLETED
What results do you expect to see?	TO BE COMPLETED
How will you know you have been successful?	TO BE COMPLETED

Back to Logo's

Click to exit

Action Plan: EPIC (Parents Partnership)

What actions are you taking to put carers at the heart of everything you do?	TO BE COMPLETED
What results do you expect to see?	TO BE COMPLETED
How will you know you have been successful?	TO BE COMPLETED

Back to Logo's

Click to exit

How we will know we are making a difference

It is important that the Leeds Carers Partnership has a way of knowing that the actions being undertaken are making a difference for carers. Some of the ways that we will do this include:

We will ask partner organisations to tell us how they are getting on with their own action plans

We will look at the results of national surveys e.g. GP Patient Survey & Survey of Adult Carers in England

We will ask Adults and Health to share the information they submit on statutory returns

We will check whether the number of carers registered with GP practices has increased

We will ask commissioned services to share a summary of their performance reports

We will invite carers to share their experiences at partnership meetings

Back to Section 2

Click to exit

Links to other local plans and strategies

This page provides links to other local plans and strategies. Click on the one you want to look at for more detail:

- Leeds Health and Wellbeing Strategy
- Leeds Plan
- Better Lives Leeds
- Leeds Dementia Strategy
- Leeds Young Carers Strategy
- Leeds Mental Health Strategy

Back to Section 2

Click to exit

Carers Leeds

Information, advice and support for adult and parent carers

Carers Leeds is an independent Leeds based charity that provides a single point of access to information, advice and support to carers aged 16 and over. Carers Leeds have an experienced and dedicated staff team who provide a comprehensive information, advice and support service for adult and parent carers. This confidential service ensures that carers have the right information and support, tailored to their individual needs and circumstances.

Carers Leeds
Address: 6-8 The Headrow, Leeds, LS1 6T
Advice Line Phone Number: 0113 380 4300
Email: info@carersleeds.org.uk
Website: https://www.carersleeds.org.uk/

Carers Leeds also produce a regular newsletter which has lots of helpful information for carers. You can ring the advice line and ask to receive the newsletter or you can **register on-line**.

Back to Section 3

Click to exit

Willow Young Carers Service

Willow Young Carers Service

Willow is a support service for young carers aged 5 to 18 years old living in Leeds. You can contact the service and talk to a young carers worker about your situation and the support that might be available to you.

Further information, including a referral form, can be found on the Willow Young Carers website. Their address is:

Barnardo's Willow Young Carers
The Old Fire Station
Gipton Approach
Leeds LS9 6NL

Phone: 0113 249 1634
Email: willow.youngcarers@barnardos.org.uk

Back to Section 3

Click to exit

Getting a break (Adult Carers)

Having a short break from caring can help improve the wellbeing of both carers and the people they care-for.

A short break is anything that means that a carer is relieved of their caring responsibility for a period of time, and in most cases, this will involve someone else taking over their caring role. This can range from very informal relationships where a family member or friend takes over caring for a short time, to support that is available for particular groups of people (e.g. Neighbourhood Networks, Dementia Cafes) or to more formal care arrangements through a care agency or residential care home.

The Leeds Directory can help you to find local services, activities and events that might provide a break. Click here to visit the Leeds Directory.

Leeds City Council's Adults and Health directorate can help you get a break from caring. If you want them to help you, please contact them on 0113 222 4401.

Back to Section 3

Click to exit

Getting a break (Parent Carers)

Short breaks and fun activities are available in Leeds for children and young people with SEN and disabilities.

These can give children and young people a chance to have fun, make new friends and gain independence, whilst their parents or carers have a break from caring.

Leeds City Council's Children and Families Directorate have produced a Short Breaks Guide and a Short Breaks Directory.

Click here for the Short Breaks Guide
Click here for the Short Breaks Directory

Back to Section 3

Click to exit

GP Yellow Card Scheme

Yellow Card Scheme in GP Surgeries

All Leeds GP practices can refer carers to Carers Leeds by completing a 'Yellow Card Referral'.

You can ask your GP practice for a Yellow Card and when you have completed the short form hand it back to the practice and they will send the referral to Carers Leeds.

As part of the process GP practices are encouraged to use the Yellow Card as a prompt to record a patient as a carer on their practice database thereby ensuring that carers can be identified when contacting their practice and offered appointment times and services that fit with their caring role, for example carer health checks and access to flu vaccinations.

Back to Section 3

Click to exit

Support for working carers

Support for Working Carers

Carers Leeds provide support for employers as well as for people who balance their paid employment with caring for someone (working carers) Support includes:

- Self-assessment tool for employers
- Training, information and support for managers
- Training, information and support for working carers
- On-site 1-2-1 support for working carers
- Employer toolkit
- General information for carers

Please contact Carers Leeds for more information on 0113 246 8338 or by email at info@carersleeds.org.uk

Back to Section 3

Click to exit

Digital Resource for Carers

Free Digital Resource for Carers

Leeds City Council have teamed up with Carers UK to give carers in Leeds free access to a wide range of digital tools and essential resources that may help make their caring situation easier.

Visit: www.carersdigital.org and use the unique reference code **DGTL8267**

Once you have registered you will have free access to:

About Me: An online course that aims to help you identify and find resources, technology and sources of support to prevent your caring responsibilities from becoming overwhelming.

Jointly Care co-ordination app: a central place to store and share important information about the person you are caring for. Set up appointments, allocate tasks, save files and notes, manage medication and lots more.

Carers UK guides: Essential reading for carers including: Upfront guide to caring, Looking after someone, Carers Rights Guide and A self-advocacy guide for carers

Back to Section 3

Click to exit

Planning for an Emergency

Carers Emergency Scheme

The Carers Emergency Scheme can provide carers with peace of mind in that they know that if an emergency does happen, and they are temporarily unable to provide care, someone they know and trust, or someone who is appropriately skilled and trained, is stepping into their caring role

From 1st March 2019 to 31st March 2020, the Carers Emergency Scheme will be provided by Comfort Call. The Carers Emergency Scheme can:

- enable carers to complete a carers emergency plan,
- arrange for those plans to be registered and stored safely,
- co-ordinate a response in the event of an emergency where the carer is unable to provide the care they normally provide.

The telephone number for enquiries and referrals is 0113 205 2990

Back to Section 3

Click to exit

Carers Assessment

Carers Assessment

If you are caring for someone who otherwise couldn't manage without your help. because of illness, frailty, disability, a mental health problem or an addiction, you are entitled to an assessment of your own needs, even if the person you care for doesn't want or need services themselves.

Assessment is simply the way professional workers from Health or Social Care organisations find out what your caring situation is, and what would help you to continue.

Carers who don't already have a social worker or other Adult Social Care staff member involved with the family, can ask for a carers assessment by contacting Carers Leeds via the Advice Line on **0113 380 4300.** The assessment will be carried out by Adult Social Care Staff who are based at Carers Leeds Offices. You can also have a home visit if you prefer.

Back to Section 3

Click to exit

Time for Carers Grant

The Time for Carers scheme can provide a carer with a payment of up to £250 so that they can have a break from caring. The scheme is funded by Leeds City Council and administered by Carers Leeds.

Carers are asked in their applications, to say exactly how they would spend the grant and how they hope to benefit from the break (e.g. improved health, reduced stress, re-charge batteries). Carers are also asked to provide a short summary of how they have used the grant and the difference it has made to them.

Funding is advertised at particular times of the year on the Carers Leeds website https://www.carersleeds.org.uk/ and through Carers Leeds Twitter account @carersleeds

Back to Section 3

Click to exit

Benefits Advice

TO BE COMPLETED

Back to Section 3

Click to exit

Carers Support Groups

Group support is a good way to share experiences and get emotional support from other people in the same or a similar situation.

Carers Leeds facilitate around 30 carer support groups each month The groups are welcoming and friendly, give carers a break from caring and gives you the opportunity to get advice, information and support tailored towards your caring role.

Some groups enjoy activities, well-being sessions and have speakers who may be of particular interest to the group.

Please click here for a leaflet which has details of Carers Leeds Support Groups including meeting times and locations.

Back to Section 3

Click to exit

Support for carers in Leeds hospitals

It can be a stressful time for carers if the person you care-for is taken into hospital.

Leeds Teaching Hospitals NHS Trust have made a commitment to ensure that carers are recognised as important partners in the care of patients, and have developed their own Carers Charter.

Click here to see the hospitals Carers Charter and to find out more about the ways in which the hospital trust supports carers

Back to Section 3

Click to exit

The Leeds Directory

The Leeds Directory provides online information about local care and support services, activities and events that support people to live the life they want to live.

It includes information about events, social groups or activities, different housing options, home care services and care homes, information and services that can support keeping healthy and active, and more!

Organisations providing services around the home and garden, or that provide one to one support are checked and vetted for peace of mind. These providers are marked with a Green Tick.

Click here to visit the online Leeds Directory

Back to Section 3

Click to exit

Telecare Services

Telecare is a service that can support older and vulnerable people to live safely and independently in their own home through the use of simple sensors.

Telecare can provide carers with peace of mind which can mean they are able to go to work, take part in leisure activities or just simply go out, knowing that a Response Centre will be alerted if the sensor detects any problems. Response centre staff will have information about the person using the service, will be able to identify which sensor has been activated, and how best to respond.

Please contact the contact centre on 0113 222 4401 to arrange an assessment and they will pass your information onto Adult Social Care, or you can speak to someone at your local One Stop Centre. You can also contact Telecare directly on 0113 3783290

Back to Section 3

Click to exit

Telecare Services

Telecare is a service that can support older and vulnerable people to live safely and independently in their own home through the use of simple sensors.

Telecare can provide carers with peace of mind which can mean they are able to go to work, take part in leisure activities or just simply go out, knowing that a Response Centre will be alerted if the sensor detects any problems. Response centre staff will have information about the person using the service, will be able to identify which sensor has been activated, and how best to respond.

Please contact the contact centre on 0113 222 4401 to arrange an assessment and they will pass your information onto Adult Social Care, or you can speak to someone at your local One Stop Centre. You can also contact Telecare directly on 0113 3783290

Back to Section 3

Click to exit

Bereavement Support

Bereavement brings a number of extra issues for carers, for example the loss of purpose and identity that caring provided, and the loss of, or disconnection from, some the things carers may have lost or given up to care, such as contact with friends or work.

The Bereaved Carer Project at Carers Leeds provides support on a one-to-one and group basis for carers who have been bereaved. In addition the 'Support After Loss' group can offer bereaved carers the opportunity to socialise and build their confidence in getting out and about and enjoying the activities and events in the community.

For more information about bereaved carer support please contact Sue Sutton on 07539 101 014 or by email at susan.sutton@carersleeds.org.uk

Back to Section 3

Click to exit

Connecting Carers project

We know from national research and our own experience that carers can become isolated and lonely as a result of their caring role. Although many carers live with the person they care for, they can still feel isolated, particularly if they have lost contact with friends and family and find it difficult to leave the home.

Carers Leeds run the Connecting Carers project which aims to help carers aged 50 and over to make social contacts and increase their involvement in social activities.

Carers Leeds also provide a befriending service for carers aged 16 and over.

You can find out more by ringing Carers Leeds on 0113 380 4300 or by clicking here

Back to Section 3

Click to exit

Holidays for Carers

TO BE COMPLETED

Back to Section 3

Click to exit

Social Prescribing

TO BE COMPLETED

Back to Section 3

Click to exit

Blank

TO BE COMPLETED

Back to Section 3

Click to exit

Thank you from the Leeds Carers Partnership

The Leeds Carers Partnership champions the needs of carers and aims to influence the way that services are planned and delivered in response to the needs and aspirations of carers.

Membership is open to anyone who has an interest in the development and improvement of services that support carers in Leeds.

For more information about the Leeds Carers Partnership, please contact:

Ian.brookemawson@leeds.gov.uk

Click to exit

Leeds Health and Wellbeing Board

Report author: Dr Jane Mischenko

Report of: Sue Robins (Director of Operational Delivery, NHS Leeds CCG) and Steve Walker (Director of Children & Families, Leeds City Council)

Report to: Leeds Health and Wellbeing Board

Date: Monday 16th September 2019

Subject: Annual refresh of the Future in Mind: Leeds Local Transformation Plan for Children and Young People's Mental Health and Wellbeing

Are specific geographical areas affected? If relevant, name(s) of area(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, access to information procedure rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. Future in Mind: Leeds is our single overarching strategy underpinned by our Local Transformation Plan (LTP). This is the 4th and final annual refresh of the Future in Mind LTP and the final year of delivery of the strategy. However, during 2020/21, informed by the NHS Long Term Plan and our Leeds, all age Mental Health Strategy, (currently in development), a new 5-year strategic plan will be created to continue our journey to improve children and young people's mental health and wellbeing in the city. The all age Mental Health Strategy includes a recognition of some key areas we need to progress, such as embedding a 'Think Family' approach and transforming the services for those in adolescence and approaching young adulthood (16-25).

2. Our Future in Mind: Leeds strategy brings together the Leeds response to the recommendations from the Department of Health's publication Future in Mind (2015) and the duties within the Children & Family Act (2014), in terms of the SEND requirements for pupils with Social Emotional and Mental Health needs.

3. The purpose of this paper is for HWB members to endorse the refreshed LTP (Appendix 1). The refresh clearly sets out for each priority, what has been achieved so far, how we know it is making a difference and the next steps to progress.

Recommendations

The Health and Wellbeing Board is asked to:

- Endorse the refreshed Leeds Local Transformation Plan for publication before 31 October.
- Note and recognise the achievements over the last 4 years.
- Recognise the strength of the child and young person's voice, in particular the impact of the MindMate Ambassadors
- Note the breadth and connection between partners and practitioners across the system and thank them for their continued commitment
- Recognise the strong contribution this strategy and plan delivers to the core prevention agenda of the city
- Recognise there is more to do, in the next year and through the subsequent plan to:
    - To embed a 'think family' approach in the city
    - To address the lack of parity of investment in children and young people's mental health
    - To transform services for those in adolescence and approaching young adulthood (16-25)

1 Purpose of this report

1.1 This report is an update on how we are driving forward our ambitious strategy to transform how we support and improve the emotional and mental health of our children and young people and therefore, ultimately impact on the wellbeing of all of our population through the annual refresh of the Leeds Local Transformation Plan.

2 Background information

2.1 We want Leeds to be the best city for health and wellbeing and for children to grow up in: a healthy and caring city for all ages, where people who are the poorest improve the health the fastest. The Leeds Health and Wellbeing Strategy 2016-2021 and Children and Young People's Plan 2018-2023 are our blueprints for how we will put in place the best conditions in Leeds for people to live fulfilling lives – a Child Friendly, healthy city with high quality services.

2.2 Essential to this is our Future in Mind: Leeds Strategy and Local Transformation Plan (2015-2020, which sets out our vision, progress and next steps to improve the social emotional, mental health and wellbeing of children and young people aged 0-25.

2.3 Our vision is to develop a culture where talking about feelings and emotions is the norm, where it is acceptable to acknowledge difficulties and ask for help and where those with more serious problems are quickly supported by people with skills to support their needs.

2.4 As demonstrated within the plan, Leeds is also part of the West Yorkshire and Harrogate Health and Care Partnership, working together with partners across the sub-region to improve mental health as one of its priorities.

2.5 The key delivery and governance structure for this work is the Future in Mind: Leeds Programme Board made up of officers and leads from across the programme of work and chaired by the Executive Lead Member for Children and Families. This board reports to the Children and Families Trust Board and the Health and Wellbeing Board.

3 Main issues

3.1 To achieve our vision and priorities in a context of tightening resource and evidence of increasing demand we recognise the need to work together in a single approach and to combine and transform our services. The strategy and refreshed plan has evolved from the already strong relationships across our children's partnership, across health, education, social care and the third sector.

3.2 The LTP moves from a truly preventative approach, recognising the importance of the first 1001 days from conception for lifelong emotional wellbeing and moves through universal programmes to support resilience, to early help and targeted support services for the most vulnerable, through to specialist CAMHS. The emphasis is working together as a system to ensure children and young people receive the support and advice they need as early as possible.

3.3 Some of our key areas of achievement are highlighted below, many more are within the LTP document:

- The award winning (several awards) Infant Mental Health Service that developed a universal screening tool for health visiting to identify emerging relationship difficulties in the first weeks of life, thereby enabling very early intervention.

- The programmes and resources that support emotional wellbeing and resilience, such as, the MindMate Champion programme for schools, the new Resilience programme and the MindMate Lesson resource for schools.

- Recent success to be a Trailblazer site and create 2 new Mental Health Support Teams in the city particularly working with FE colleges (starts January 2020).

- The launch of self-referrals at MindMate Single Point of Access, following Healthwatch feedback.

- Launch of Kooth, the new online counselling service in the city.

- We now have 8 employed MindMate Ambassadors, young people with lived experience of mental health difficulties who are passionate about driving forward change and engaging with other children and young people.

- The new specialist education school buildings have delivered to the project deadline (creating capacity for 340 specialist SEMH places in Leeds) rated as Good in their recent inspection by OFSTED.

- Improved waiting times for specialist CAMHS (for routine appointments and for autism assessments).

- The launch of the Teen Connect helpline for young people in crisis.

- The new CYP community eating disorder service is established and is on track to support the expected number of young people and delivery of the national access targets.

- West Yorkshire and Harrogate ICS CAMHS new care model has been successful in reducing the number of admissions to CAMHS beds and reduced the length of stay, thereby freeing up resource for investment into community services. For Leeds this alongside CCG investment has supported the establishment of a dedicated CAMHS crisis team (8am till midnight, 365 days a year).

- Creation of the CAMHS crisis team, currently recruiting

3.4 And key areas to progress over the next 18 months are:

- Expand the Infant Mental Health Service to have a programme to support the mental health needs of 2-4 year olds, which is currently recognised as a gap.

- Further enhance the Perinatal Mental Health (PNMH) specialist support in the city delivering an integrated pathway.

- Strengthen the early help locally embedded service model, working with schools, clusters, the Trailblazer FE colleges and Early Help Hubs.

- Expand and enhance the advice and brief intervention element of the MindMate SPA.

- Fully establish and embed the CAMHS crisis team and commission safe spaces (non-clinical spaces for children and young people in crisis to go to).

- Continue to grow the trauma informed service models across the partnership, particularly those targeting support to our most vulnerable children in the city who have a history of, or currently have Adverse Childhood Experiences (ACEs).

- Embed the new neurodevelopmental pathway within CAMHS and develop a fully integrated autism pathway across the partnership

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

4.1.1 The voice of children, young people and the views of their parents and carers strongly informed our key priorities. The working groups continue with this principle in the delivery of the priorities.

4.1.2 An example is where young people have led from the start the content, design and language of the MindMate website and now regularly co-present at local, regional and national conferences.

4.1.3 We continue to use Healthwatch and Common room to consult with young people and families on progress to date and what we need to improve further. A current review is on our MindMate Champion Programme, where school staff and pupils are being consulted on their experience of the programme and related resources.

4.1.4 MindMate Ambassadors reviewed and advised us on the language and content of this refresh and are increasingly involved in service reviews and procurement of new services (MindMate SPA, Trailblazer development and Crisis safe space procurement).

4.2 Equality and diversity / cohesion and integration

4.2.1 As reflected in the national Future in Mind (2015) publication there has to be an additional effort in Local Transformation Plans to respond to the needs of certain vulnerable groups of children and young people. In Leeds there are examples of multi-agency services supporting young people in the youth justice system and care system.

4.2.2 A specific priority in our LTP is to continue to review and check that the needs of vulnerable young people are met. This is supported by the intelligence gathered

by the commissioned Future in Mind: Leeds Health Needs Assessment (2016). As stated in the plan there is an intention to add to and update the HNA over the next 6 months. A specific BAME HNA is currently being completed and findings will inform our work over the next year.

4.3 Resources and value for money

4.3.1 There are strong principles underpinning our plan that will maximise best value for the available money; these are listed below:

- Prevention (following the principles of the WAVE report, of the importance of the first 1001 days)
- New ways of working to develop emotional resilience and support self help
- Early support/help to prevent escalation
- Evidence based practice
- Use of digital technologies
- Transforming existing services and combining resources across the partnership to prevent duplication
- Noting that getting it right in childhood supports reduced need and demand in adulthood

4.4 Legal Implications, access to information and call In

4.4.1 There are no legal implications from this report. There are no access to information and call-in implications arising from this report.

4.5 Risk management

4.5.1 The programme board reviews the risks to the delivery of the strategy and LTP every time it meets. The key risks reflect those known nationally, reducing resource but rising demand, rapidly changing policy across education, health and social care, and workforce challenges in recruiting the staff with the right skills. Mitigation is in place and constantly reviewed for all of these areas.

5 Conclusions

5.1 The refreshed LTP clearly sets out how progress has been made against all of our strategic priorities. However, we are not complacent, as set out in the letter to our children and young people of Leeds there is more to do. This plan sets out our key next steps in delivering our strategy and improving the outcomes of the children and young people.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Endorse the refreshed Leeds Local Transformation Plan for publication before 31 October.
- Note and recognise the achievements over the last 4 years.
- Recognise the strength of the child and young person’s voice, in particular the impact of the MindMate Ambassadors

- Note the breadth and connection between partners and practitioners across the system and thank them for their continued commitment
- Recognise the strong contribution this strategy and plan delivers to the core prevention agenda of the city
- Recognise there is more to do, in the next year and through the subsequent plan to:
    - To embed a ‘think family’ approach in the city
    - To address the lack of parity of investment in children and young people’s mental health
    - To transform services for those in adolescence and approaching young adulthood (16-25)

7 Background documents

7.1 None.

THIS PAGE IS LEFT INTENTIONALLY BLANK

How does this help reduce health inequalities in Leeds?
The plan adopts a proportional universalism approach in that it is for all Leeds children and young people but additional resource and services are targeted at those in most need. The plan adopts a holistic approach to mental health and wellbeing and a key priority is to ensure the groups of children and young people most vulnerable to mental health needs are recognised and evidence based service models are in place (and outreach) to them.

How does this help create a high quality health and care system?
Partners work in the city together to deliver high quality health and care resources and services. These are informed by the available evidence base, by a commitment to the voice of children and young people being integral to their care plan and service development, There is a partnership group that oversees this agenda and a dashboard to indicate progress against key standards.

How does this help to have a financially sustainable health and care system?
Partners work together to align and maximise investment and resource. Investing and getting it right for infants, children and young people supports the lifelong delivery of improved mental health and wellbeing.

Future challenges or opportunities
There is increasing demand and need; the JSA indicates the increase of children, particularly in deprived areas. This is occurring at a time of increased pressure on resources across the partnership.

Priorities of the Leeds Health and Wellbeing Strategy 2016-21	
A Child Friendly City and the best start in life	X
An Age Friendly City where people age well	
Strong, engaged and well-connected communities	
Housing and the environment enable all people of Leeds to be healthy	
A strong economy with quality, local jobs	
Get more people, more physically active, more often	
Maximise the benefits of information and technology	X
A stronger focus on prevention	X
Support self-care, with more people managing their own conditions	X
Promote mental and physical health equally	X
A valued, well trained and supported workforce	X
The best care, in the right place, at the right time	X

This page is intentionally left blank

DRAFT

Future in Mind: Leeds Local Transformation Plan for children and young people's mental health and wellbeing

Annual refresh: October 2019

Author: Dr Jane Mischenko, Lead Strategic Commissioner: Children & Maternity Care, NHS Leeds CCG

Contents

Open letter to children and young people

TO BE DRAFTED BY JANE

What we did:

What about schools?

Services:

What's next?

Cllr F Venner

Dr Jane Mischenko
Strategic Lead Commissioner for Children and Maternity Services

1. Introduction

We want Leeds to be the best city for health and wellbeing and for children and young people to grow up in; a healthy and caring city for all ages, where people who are the poorest improve their health the fastest. The Leeds Health and Wellbeing Strategy 2016-2021 and Children and Young People's Plan 2018-2023 are our blueprints for how we will put in place the best conditions in Leeds for people to live fulfilling lives – a Child Friendly healthy city with high quality services.

Essential to this is our Future in Mind: Leeds Strategy 2016-2020 and Local Transformational Plan, which sets out our vision, progress and next steps to improve the social, emotional, mental health and wellbeing of children and young people aged 0–25. Our vision is to develop a culture where talking about feelings and emotions is the norm, where it is acceptable to acknowledge difficulties and ask for help and where those with more serious problems are quickly supported by people with skills to support their needs.

As demonstrated in the plan, Leeds is also part of the West Yorkshire and Harrogate Integrated Care System, working together with partners across the region to improve mental health as one of its priorities.

Our Local Transformation Plan is a five year plan that is refreshed every year and we are now in our 5th and final year.

This year we are working across Leeds to develop our all age Mental Health Strategy where improving children and young people's mental health is identified as one of three priority areas. During 2020/21 we will develop our next five year strategic transformation plan for children and young people's mental health, building on the work of our Future in Mind: Leeds strategy. This will reflect shared priorities identified in our all-age strategy, such as, the transformation of the 16-25years offer, the development of service models to reflect a 'Think Family' approach and the recognition of and support of those who have experienced developmental trauma.

We begin with an open letter to the children and young people of Leeds, as we are very clear that we are primarily accountable to them. The letter responds to the key issues they have told us we need to address, our progress to date and the areas we recognise we need to make further improvements and how this will provide our focus this coming year.

We have set out our Local Transformation Plan in clear chapters. The first chapter sets out for each of our priorities:

- Why this is a priority
- What has been achieved so far
- How we know it is making a difference
- Next Steps

We also share best practice case studies in this chapter.

MindMate Ambassadors are a group of young people who are passionate about improving mental health support for children and young people in our city. They are supported by CommonRoom and are paid for their time. They have worked with us to guide the language and content of the cover letter and this first chapter. Meet them here

Subsequent chapters provide more detail on specific key areas; chapter 2 focuses on finance and sets out how we allocate funds to support the delivery of our Local Transformation Plan, as well as working together to make best use of the existing investment across the partnership. Chapter 3 reports our current performance across key national measures and the tools we have developed to monitor this, including our local Future in Mind dashboard. Chapter 4 details how we ensure the voice of children, young people and families informs our priorities. This chapter also evidences how we work with children, young people and families in the development of our resources, pathways and new services. Chapter 5 is our strategic workforce plan; this recognises how investment in our staff across the city is key in delivering transformational and sustainable change. Chapter 6 includes our initial Future in Mind Health Needs Assessment (HNA), our Perinatal Mental Health Needs Assessment and our Young Adults Health Needs Assessment. We will receive the report of our BAME HNA later this year and towards the end of 2019/20 will undertake a full refresh of the Future in Mind HNA. And finally Chapter 7 sets out the issues and risks we recognise in the delivery of our plan along with the mitigating actions we are taking to address them. The programme board oversees the management of these each time it meets. Our governance structure is included as an appendix.

Priority 1: Develop a strong programme of prevention that recognises how the first 1001 days of life impacts on mental health and wellbeing from infancy to adulthood

Why this is a priority

Babies are born pre-programmed to seek out and adapt to the relationship that they have with their parents. The child's first relationship with the primary care giver, acts as a template for all subsequent relationships. The quality and content of this primary attachment has a physical effect on the neurobiological structure of the child's brain that will be enduring. The brain is at its most adaptable, in pregnancy and for the first two years after birth. Secure attachment is a protective factor, which delivers confidence and adaptability. Although not a total guarantee of future mental health, without secure attachment neither child nor adult will be free to make the most of life's possibilities.
Children with problems related to insecure attachment begin to soak up statutory resources when their distress leads to 'externalising' behaviour (aggression, non-compliance, negative and immature behaviours,) and demands a response. The most sensible, ethical and economic time to put in therapeutic resources is into promoting and supporting the first key relationship.

In Leeds we have the Best Start Plan that uses the strong and increasing evidence base of the importance of the first 1001 days of life to inform priorities across the partnership. Those who want to see the full breadth of the Best Start programme of work are advised to review the full Best Start Plan. In our Local Transformation Plan we contribute to the Best Start agenda through our jointly commissioned Infant Mental Health Service and our work to support perinatal mental health (the mental health needs of mothers in pregnancy and early motherhood).

What has been achieved so far

Infant Mental Health Service – Executive Summary 2018-19

Overview
The Infant Mental Health Service supports healthy social and emotional development for babies from conception to their second birthday – a critical time for development.

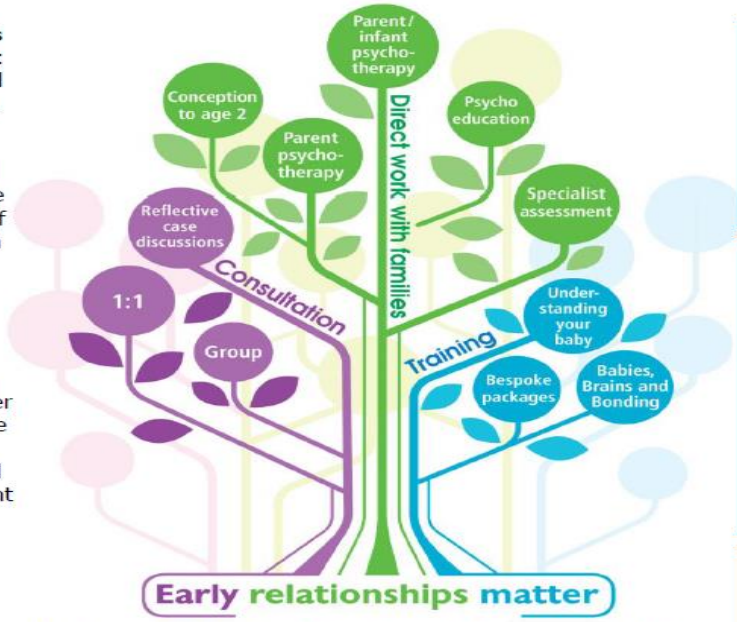
Referrals
The number of referrals received has increased this year and is the highest it has been since the service was commissioned. We accepted 95% of referrals suggesting referrals are appropriate. In addition, we have delivered three times more consultations compared to last year (7 to 21) despite having less resources this year.

Innovations
In July we organised a city-wide conference for perinatal practitioners on how dads can be better engaged in services. The conference was a huge success with over 50 attendees! Themes from discussions on the day have been published and we hope to continue to promote the engagement of dads across the city in the coming year.

Research and Evaluation
The Early Attachment Observation (EAO) has gone from strength to strength. Formal evaluation found that both aspects of the tool are being well used across health visiting teams in the city which is a great achievement.

"I feel incredibly lucky to have been referred to this service and this is available in my area. Excellent care and really changed our lives."
Client feedback following direct work.

"The best training course I have attended so far - excellent! [It's] relevant to the development of all human beings."
'Babies, Brains and Bonding' attendee.



We have had 6 publications this year which is a record number in one year!
These have included:

- "Connecting with Dads: The Importance of Fathers in the Lives of their Babies" published in Clinical Psychology Forum
- "The Infant Mental Health Service: Early Attachment Observation" Poster session presented at the BPS Faculty of Children, Young People & their Families Annual Conference
- "Leeds Infant Mental Health Service: Early Relationships Matter" Poster session presented at the Institute of Health Visiting National Multi-Agency Perinatal and Infant Mental Health Conference

Investing in the emotional wellbeing of our babies is a wonderful way to invest in the future.
72% of our direct work was delivered to infants aged 6 months and under which demonstrates we are providing **early intervention**

Highlights in numbers:
- **353** practitioners received our training 'Babies, Brains and Bonding' taking us to a momentous milestone of over **2500** practitioners trained since 2012!
- **110** Reflective Case Discussions delivered
- **133** referrals to our service
- **21** targeted consultations delivered

Presenting problems:
- **98%** of parents referred were experiencing **mental health difficulties** (e.g. low mood)
- **57%** of parents had experienced **trauma and/or unresolved loss**
- **48%** had safeguarding concerns **and social care involvement**
- **28%** had **domestic violence** in the home

NHS
Leeds Community Healthcare
NHS Trust

Infant Mental Health Service - We have a dedicated infant mental health service. This service provides a really well evaluated training programme to key children and adult service staff groups on the importance of a secure attachment and how to support this. This has expanded

its reach from universal services such as midwives, health visitors and children centres to specialist service groups (including, adult mental health practitioners, third sector practitioners, social workers and more recently family court personnel). In addition the team provides consultation and supervision to key groups of staff and works directly with families who have the greatest need, for example working with those primary caregivers who struggle to have a secure attachment due to their own traumatic childhood, or due to mental health needs.

The number of referrals received for direct work has increased this year and is the highest it has been since the service was commissioned: 95% of referrals were accepted suggesting referrals are appropriate. In addition, consultations have increased threefold compared to last year.

The Early Attachment Observation tool (EAO) has gone from strength to strength since its development. The EAO is used by health visitors with all families in Leeds to identify any emerging relationship difficulties between infants and their caregivers in the first few weeks of life. This supports early intervention to resolve the issues. The infant mental health service and health visiting service received recognition in the national Innovation in Health Visiting Practice award. Formal audit of the use of the EAO this year showed that both aspects of the tool (the 3 questions and the 2 minute observation) are being well used across health visiting teams in the city, which is a great achievement.

The 'Understanding Your Baby: A Course for Parents and Carers' was developed by the IMHS and successfully piloted in 2016-17. The aim of the course is to increase parental knowledge, confidence and sensitivity. Caregivers and their babies are invited to four 1.5-hour sessions infant brain development, relationship building, infant states and cues, and understanding baby's behaviour. Following the success of the pilot phase, the course has been rolled out across the city this year. Seventeen courses have been delivered in 14 areas of the city with approximately 70 parents completing the course. It is clear from this feedback that the roll out of the group has been successful and that parents are finding the course a useful and positive experience.

Perinatal mental health - The Leeds Best Start Plan prioritises the development of support for women with perinatal mental health needs in recognition of the impact this can have on infant mental health.

Partners across Leeds have worked together to develop a clear plan and pathway of care for women's mental health needs in pregnancy and early motherhood. Women who have experience of perinatal mental health needs have developed an anti-stigma campaign with us; this includes an animation encouraging women and partners to speak out and ask for support when they need it. This can be found on the widely promoted Leeds Mindwell website alongside advice about where and how to access support. Maternity services have worked together with IAPT practitioners to develop a pilot of mindfulness sessions, to be delivered universally during pregnancy.

This year Leeds has worked with partners across West Yorkshire and Harrogate, to successfully bid for money from NHS England to expand our community perinatal mental health service, which will be further expanded over future years. The Infant Mental Health Service offers specific support for mother baby attachment within the Leeds PNMH Mother and Baby unit and for Leeds women as continued support in the community following discharge home.

Our NEST (Nurturing, Enabling, Sharing, Transforming) ambassadors; people who have experienced perinatal mental health problems, were recruited this year. These ambassadors are promoting our anti-stigma resources in local communities, promoting our existing services to professionals as well as families, and gathering further feedback which can be used to refine our pathway of care.

How we know it's making a difference

The Infant Mental Health Service evaluates all the training and consultation that they provide to the workforce groups across Leeds and continue to receive extremely positive feedback scores on content and delivery. The team uses a range of recognised psychological measures in their direct work with families and consistently demonstrate improved outcomes. Their annual report provides a number of case-studies that powerfully illustrate the impact their work has in the city.

In order to better identify how we know our perinatal mental health services are making a difference, we have brought together several sources of data into a city-wide perinatal mental health dashboard, which will allow us to look at the numbers of people in Leeds who have perinatal mental health issues, whether they are accessing our services (and how quickly), and what the outcomes are for those that access the services. Quarterly reports from the specialist perinatal mental health services and perinatal elements of universal services (primary mental health, IAPT, voluntary sector services) support this by providing more detailed feedback.

Next Steps

Infant Mental Health - A key development is the expansion of the service in order to provide support to school age children aged 2-4 years (a recognised gap in the city). This will be established towards the end of 2019/20 and a key focus will be to support the health visitors within the 0-19 service who are the key workers for children and families of this age group, as well as providing direct therapeutic support where there are significant needs.

The service will support the ongoing roll out of the UYB Short course for parents/carers from children centres and also develop this offer within the perinatal mental health inpatient and community service.

The service will expand the service-user group and establish protocols for service-user involvement in recruitment and selection as well as service development.

Perinatal Mental Health - We will mobilise the new primary mental health care service, which includes IAPT, primary care link practitioners, and our specialist voluntary sector perinatal mental health support. We will ensure that this new service encourages and enables priority access for women and partners within the perinatal period, including ensuring that barriers such as lack of childcare and daytime-only appointments are overcome.

We will continue to expand the specialist community perinatal service, further increasing the families supported by this service and will incorporate further peer support roles, including a peer support role focussed on Dads and partners. We will analyse the demographic groups who are not currently reached by this service, and do targeted work to encourage professionals to refer these families, and to allow appropriate families from these groups to engage with the service.

We have shared our Leeds produced anti-stigma resources with the Yorkshire and Humber PNMH network and shared the work of the NEST ambassadors with the LMS Maternity Voices Partnership work-stream. Leeds commissioners and providers will be closely involved in the Local Maternity System and Integrated Care System PNMH developments.

We will start to universally roll out our mindfulness sessions pilot, starting with the most deprived areas of Leeds.

We plan to refresh our pathway document, incorporating the changes to services which have been made and working with our NEST ambassadors, and will re-launch this alongside a communications campaign to various professionals.

We will build an ongoing programme of perinatal training to be accessed by any appropriate professional, which will take place regularly throughout the year.

Case Study

Rosa - Birth Trauma

Here is a case study example taken from the Infant Mental Health Service Annual Report (April 2018- March 2019) of how a traumatic loss can interfere with a new relationship. The case demonstrates how co-working within the team can address different elements of the block to a mother-infant bond.

Priority 2 - Work with young people, families and schools to build knowledge and skills in emotional resilience and to support self-help.

Why this is a priority

Children, young people and families have repeatedly told us that they need accessible, trusted information to support them to build emotional resilience and to help them know where to go when they need help. They have told us that stigma around mental health is still an issue and that raising awareness is crucial. We recognise that working alongside children, young people and their families is critical to ensure the development of resources and programmes that will be used, trusted and valued.

What has been done so far

Young People and Parent/ Carers -This year we have increased the size of our MindMate Ambassador team, we now have 8 young people recruited). This enables us to expand further peer led projects, helping raise awareness about MindMate and promoting good mental health in the city. The Ambassadors continue to engage across all areas of our work from developing content on the MindMate website to being part of the procurement panel for our Safe Space provision. They attend our programme board and have a standing agenda item.

We continuously work with the MindMate Ambassadors and the wider MindMate Youth Panel (including other engagement activity, e.g. with parents and other partners) in order to:

- Develop our MindMate website (particularly around how to cope with exams, panic and to increase the blogs by young people)
- Raise awareness of MindMate across the city
- Increase the voice and influence of children and young people in the different work streams e.g. Trailblazer and crisis support
- Increase engagement and promote good mental health for young people in the city

Phase 1 delivery of the **Young People's Resilience Programme** is complete. Lessons learnt have informed Phase 2 and rollout has commenced in a further seven secondary provision establishments, including Springwell specialist academy for SEMH needs.

We are working with Dance Action Zone Leeds (DAZL) and Leeds Beckett University to explore the impact of physical activity on SEMH in some of the most disadvantaged areas. These young people are 3 times more likely to develop a mental health problem and are less likely to engage in physical activity. This 12 month project will build our evidence base to inform future service delivery.

The Calm Harm app provides young people with different tasks, which all aim to help the user to resist and manage the urge to self-harm. Calm Harm is based on the principles of an evidence-based theory called Dialectic Behaviour Therapy (DBT). The app enables young people to start to manage impulsiveness and to explore underlying trigger factors. Leeds City Council have partnered with the charity Stem4, so when a young

person from Leeds downloads the app they will be guided to a version that is designed with MindMate branding and has information about local support services.

Following the findings from our work with Voluntary Action Leeds, to understand the support parents require in order for them to feel equipped to respond to their child's mental health needs, we:

- Now have focused content on our MindMate website, developed with and for parent/carers.
- Introduced self-referrals this year into MindMate SPA and a brief intervention offer, delivered by Child Psychology Wellbeing Practitioners
- Are working with school clusters to identify how to ensure parent support and involvement within the clinical model
- Are working with colleagues across the Future in Mind partnership to review the pre and post diagnosis support pathway for children and families affected by autism
- When commissioning our adult services, we ask providers to take on the "think family approach", supporting not just the person with the mental health issue. This action specifically recognises the impact parent and carers' mental health can have on their children.

The new Leeds Children and Family Bereavement Service contract was awarded to Child Bereavement UK (CBUK) and the service was mobilised earlier this year. The bereavement service is now fully staffed and providing support to a number of children and families.

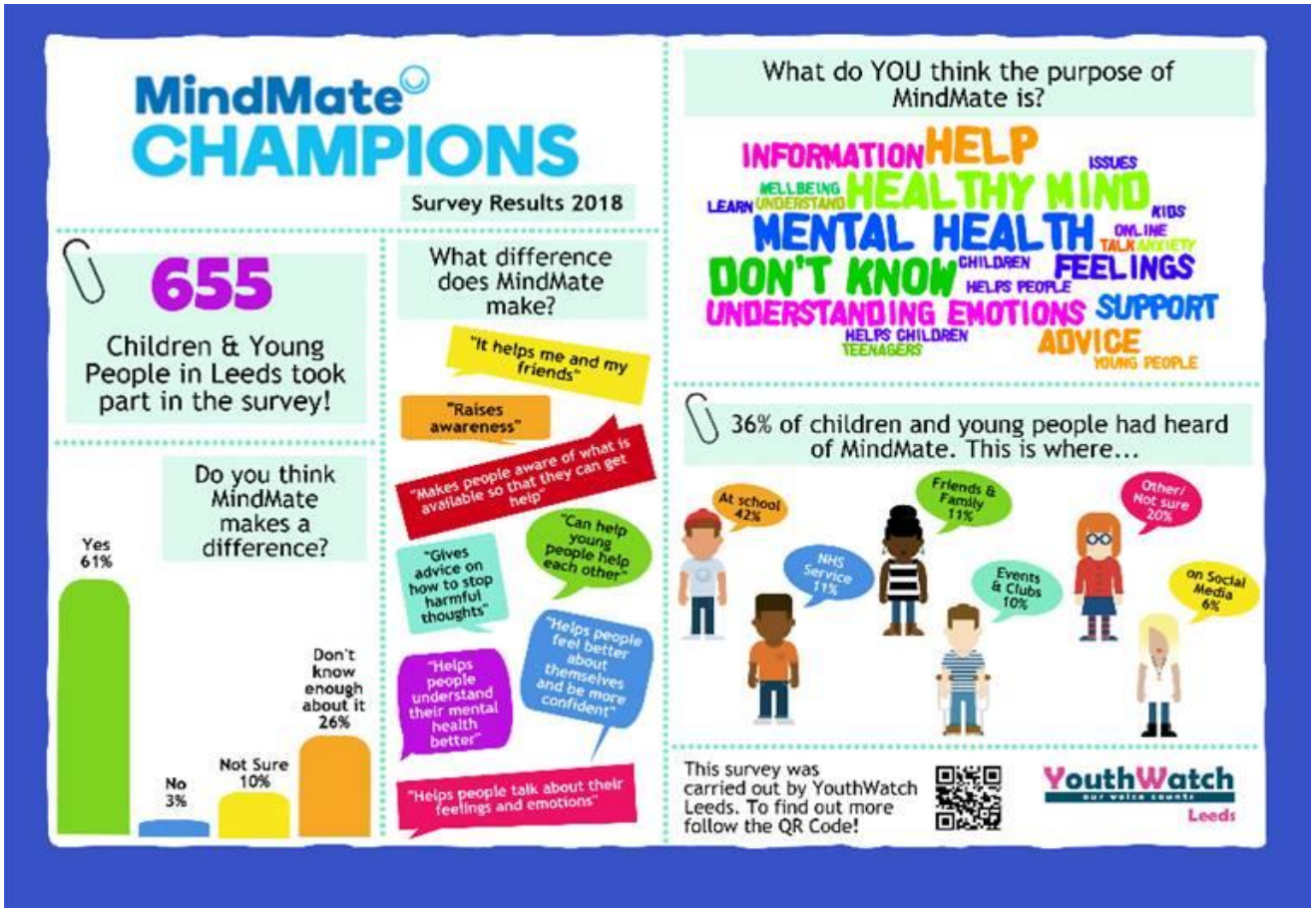
Settings - The Leeds City Council Health and Wellbeing Service provide support to schools via the Leeds Healthy Schools programme. The MindMate Champion programme is the SEMH offer https://mindmatechampions.org.uk/. This takes a whole school approach to create an environment and the staff confidence and capability to both support children and young people's mental wellbeing and to help develop their emotional resilience.

97% of schools are now registered on the MindMate Champion website, with 66 schools assessed for MindMate Friendly status. 9 schools have achieved MM Champion status with 16 more settings working towards the award.

Last year the CCG and Leeds Health and Wellbeing Service launched the MindMate Lessons for use in schools. This is a brand new social, emotional and mental health curriculum for Keystages 1 – 4. The 'MindMates' take you through the Powerpoint lessons, which are full of multimedia content, for easy teaching.

The Health and Wellbeing Service has reviewed the content of the MindMate Lessons and Personal Social Health Education (PSHE) scheme of work to ensure that all of the updates in the scheme of work are covered. Going forward, it will ensure that any identified gaps are addressed.

This year we received valuable feedback from pupils and schools on their experience of the MindMate Champion programme and Lessons. This was via a commissioned Healthwatch and CommonRoom review. Two members of Youthwatch who had been part of the review team reported directly to the programme board, the findings and the recommendations.



As a result of this review the Health and Wellbeing Service is compiling resource banks to feed into the MindMate Lessons curriculum, including a Specialist Inclusion Learning Centre (SILC) specific resource bank. This is in direct response to the schools feedback. This will help schools tailor the content of MindMate Lessons to meet the needs of their setting and increase the impact of the emotional literacy lessons.

The 'Open Mind' anti-stigma programme led by Space2 has been funded by Leeds City Council for a final year to explore how to build the principles of the work into ongoing SEMH work in Leeds. Campaigns are developed in school and youth settings, including a Specialist Inclusive Learning Centre (SILC).

How we know we are making a difference

We continuously review activity on the MindMate website and our social media channels. We use this to identify which resources are most popular and also where we can make improvements to the site. This also allows us to target our social media posts to be relevant and appropriate.

Traffic to our site steadily continues to grow; in 2018/19 we had 48,700 visits to the site which equates to 33,100 unique users. This is an increase from 2017/18 where we had 19,300 visits to the site from 13,600 unique users. Since the launch 5 years ago we have had 131,401 visits to the website.

We receive informal (and invaluable) feedback through the comments left on the website and through the many and varied conversations with children and young people, parents, carers and professionals. These comments allow us to make continuous improvements to meet the needs of those who are accessing the MindMate website.

The Young People's Resilience Programme utilises a range of outcome measurement tools, including Short Warwick Edinburgh mental health well-being scale (SWEMWBS), Strengths and Difficulties Questionnaire (SDQ) and student resilience survey, in order to monitor ongoing progress (click here). The programme will also undergo an external evaluation.

The Children and Family Bereavement Service will undergo a full external evaluation in year one. CBUK Leeds continually monitors progress and collects a range of feedback. Early feedback from families is very positive.

External evaluation showed statistically significant improvements in knowledge and attitudes about mental health for those involved and receiving the Open Minds campaigns.

Next steps

We will work with schools and colleges to enhance the Leeds MindMate Champion Programme by the introduction of the recommendations in the Green Paper, "Transforming children and young people's mental health provision" (2018), such as the Designated Senior Lead for Mental Health.

We will finalise the development of Leeds Calm Harm self-harm app for young people. We aim to launch in September 2019, with support from young people and partners, via a range of social media channels.

Following ethics approval earlier this year, we plan to rollout out the DAZL Dance Mental Health and Wellbeing project for young people aged 12-19 years from diverse groups across the city. Working with Leeds Beckett University, we will evaluate the impact dance has on young people's mental health and wellbeing.

We will continue to rollout the Young People's Resilience Programme in educational settings to secondary age young people at risk of poor mental health and wellbeing.

Open Minds is working with the Leeds City Council Health and Wellbeing team to develop a sustainable pupil leadership programme drawing on the learning from the programme so far. This will follow a 'mini MindMate' approach.

MindMate Champion Programme will be further embedded into the Healthy Schools programme. MindMate Lessons will be adapted to keep in line with the PSHE scheme of work and also being developed to use with SILCs.

We will continue to engage with children, young people and their parents as well as the workforce, through:

- Work with the MindMate Ambassadors and peer led initiatives
- Through public and professional events
- Ongoing development and approval of MindMate resources and content by children, young people and parents
- Development of the MindMate section for professionals and practitioners. This will add useful tools and resources to help them support children and young people they come into contact with during their day-to-day work
- Ongoing MindMate Youth Panel meetings and activity on and off line
- Further user testing workshops to ensure our website is fit for purpose for all who access it particularly looking at the way in which older young people access the website (including students)

Best practice

Leeds Children and Family Bereavement Service - Child Bereavement UK case study- We were contacted by the carer of a young adult with learning difficulties who is non-verbal. Mum had died last year and nobody in the family had spoken to her about the death, she was struggling to deal with what had happened and didn't understand here Mum was.

To read more click here

Open Minds case study - The school had identified that they wanted to improve the provision of Social, Emotional and Mental Health support available to students. We supported a group of young people from Bishop Young to create a campaign to improve awareness of mental health problems and stigma in the school.

To read more click here

Best practice case study

Healthy Schools and MindMate Champion case study - Reduce the levels of perceived exam stress

Lawnswood School - We noticed that on the My Health, My School Survey data for 2017/18, and the percentage of children that said they were 'MOST WORRIED ABOUT EXAMS' was 23.21%. This was confirmed as high when we compared this to the city-wide average. It has also been noticed by staff. Students have also verbally confirmed that they are affected by the stress of exams. We decided to look into a variety of strategies to improve on this issue. Use of MindMate resources reduced this by 10%.

To read more please click here

Priority 3 – Continue to work across health, education and social care to deliver local early help services for children and young people with emotional and mental health needs who require additional support.

Why this is a priority

Children and young people in Leeds tell us they want to be able to easily access mental health support locally, in or near to their schools or colleges. The Green Paper, 'Transforming children and young people's mental health provision' (2018), notes that 'We know that half of all mental health conditions are established before the age of fourteen and we know that early intervention can prevent problems escalating and has major societal benefits. Informed by widespread existing practice in the Education sector and by a systematic review of existing evidence on the best way to promote positive mental health for children and young people, we want to put schools and colleges at the heart of our efforts to intervene early and prevent problems escalating.' A key commitment in Leeds is to provide help and support early in the life of a problem to reduce suffering and prevent problems escalating.

What has been done so far

In Leeds we work closely with the school clusters; they offer flexible support for a whole range of family and life circumstance and issues. A multi professional conversation at the cluster support and guidance meeting determines the support for families in their area and children attending their schools. The clusters take Social Emotional and Mental Health (SEMH) referrals directly from schools and from MindMate SPA. Schools with contributions from health and social care fund the cluster SEMH offer.

During 2019/20 we have worked with school cluster colleagues to coproduce the service specification and commissioning model to sustain the integrated local provision in school settings. The new model builds on existing strengths of the Leeds school cluster model (of local integrated delivery) and draws from the evidence base and principles of the new national Mental Health Support Teams. The development is also ensuring data flows into the MHSDS and assures commissioners of quality and consistency in the commissioned services.

In July 2019 we received confirmation that our bid expressing an interest in being a site for the next wave of Children and Young People Mental Health Trailblazer was successful. This funding will be used to establish mental health support teams to support 10 further education settings across Leeds. The mental health support teams will bring an additional resource in to the city, as they will help support young people in further education and some other cohorts, such as home educated pupils, with their mental health and emotional wellbeing.

Following the success of our pilot during 2017/18 to recruit Children Psychology Wellbeing Practitioner (CPWP) posts within our MindMate Single Point of Access (SPA), to test out a health coaching brief intervention approach, we have secured funding for three permanent CPWPs. The CPWPs see children and their families who are in need of brief support for their mental health and wellbeing. They provide a fantastic opportunity to offer swift access to time-limited evidence-based treatment. CPWPs therefore are able to see a high volume of children and young people, with a view to preventing escalation of need and a requirement for additional input.

In December 2018 we commissioned XenZone to provide Kooth online counselling to children and young people up to the age of 18 in Leeds. This provision has seen an increasing number of children and young people choosing to access this online provision.

In July 2019 our newly commissioned Young People's Social, Emotional and Mental Health service launched. This is being delivered by The Market Place and is a joint commission with Leeds City Council. The service offers independent, direct access, free at the point of use support for young people with social emotional and mental health needs aged 11- 17 years old (up to 25 years old in the case of disability or learning disability, or if they are a care leaver). This support includes counselling services, open access youth work, group work sessions, time limited, individual support and (up to 4 sessions of) fast access counselling for young people who are experiencing a (self-defined) mental health crisis.

How we know it's making a difference

We monitor and evaluate the interventions provided by the SEMH services within the cluster model. Six monthly reports are produced to assure the programme board that children and young people are being supported and that the interventions are having a positive impact. Evaluations demonstrate positive change and service satisfaction.

The review of the cases that the Children Psychology Wellbeing Practitioners have supported demonstrates that the young people reported an increase in their goal scores from the Goal Based Outcomes approach taken. Feedback from children, young people and their families supported by the CPWPs has also been extremely positive. These roles enable a high volume of children, young people and their families to be supported. During training, each of the CWPs is able to see 30 cases each (making a total of 90 cases). On completion of their training it is expected that they will be able to see up to 200 cases each over the space of a year.

Our commissioned services are monitored on a quarterly basis to ensure that we are achieving the outcomes set within the agreed service specifications. We meet with our providers to discuss activity and themes that have occurred during the quarter to ensure we develop our services in line with current service and service user intelligence.

Next steps

January 2020 is the start date for our successful Trailblazer site. By January 2021 we will be launching the full offer. Two new Mental Health Support Teams will be established and working in Further Education (FE) colleges, independent learning providers and supporting elective home educated pupils. This will help address a recognised gap in the city's provision and target a vulnerable cohort of pupils particularly at a higher risk of Social, Emotional and Mental Health needs. The new teams will be co-located with education colleagues.

By June 2020 we would like 100% of schools, children's centres and colleges to have enrolled onto the MindMate Champion programme. We are currently at 97% of these settings. We also intend to utilise this programme for the Trailblazer FE colleges.

From November 2019 to March 2020 we will be undertaking our commissioning exercise for our new cluster Social, Emotional, Mental Health (SEMH) offer. This will include the direct procurement of the new offer from providers through a commissioning framework. School clusters will then be able to choose the provider they wish to work with and draw down the allocated resource. Operationally the provider/ practitioners will

work in an integrated way, locally within the school clusters. We are also piloting with selected cluster providers different information systems to allow us to flow cluster data into the Mental Health Service Data Set (MHSDS).

Working with all our partners we will continue to monitor and explore ways of reducing the waiting times across services. This will include service reviews (e.g. MindMate SPA), transformation of pathways (e.g., the Neurodevelopmental pathway) and commissioned service developments.

Best practice case Study - Kooth

Kooth was commissioned in Dec 2018 by NHS Leeds CCG to provide an online counselling and well-being support service for the children and young people of Leeds. This service is free at the point of access, no referral is needed and is open 365 days a year 12-10pm weekdays and 6-12pm weekends.

In addition young people can access Kooth.co, a website to get advice, support and guidance from qualified counsellors via a live chat service, or from young people their own age via moderated forums, for any problem, no matter how big or small.

This year we received 971 new registrations on the website (up from 598 in Q4 2018/19)

To read a case study on body image please click here

To read a case study on Peer support please click here

Priority 4 – Commit to ensuring there is a clear Leeds offer of the support and services available and guidance on how to access these.

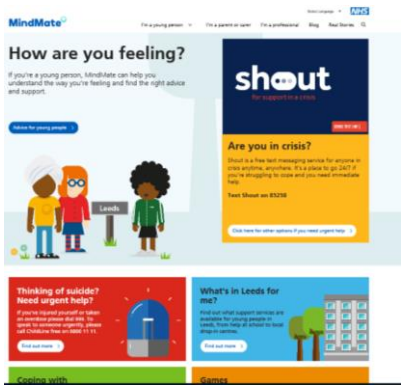
Why this is a priority

Children, young people and their families told us that they want it to be easy to find information about mental health and wellbeing. The MindMate website has been created with the help of many Leeds children and young people in response to this.

What has been done so far

It has now been 5 years since the formal launch of the MindMate website MindMate.org.uk and we have continued to make improvements to the site with the help and guidance of children, young people and parents and professionals. We have a MindMate Professional Approval Panel which is made up of Leeds based clinical practitioners who meet regularly to discuss new content and other digital aspects of the service offer to ensure that all content is evidence based and clinically safe.

We want to ensure that the MindMate website is the 'go to place' for children and young people's mental health support in Leeds.



With the steer and approval from young people the MindMate website now has a comprehensive outline of local services with detail on how to how to access them, in young people friendly way.

https://www.mindmate.org.uk/im-a-young-person/whats-in-leeds-for-me/

https://www.mindmate.org.uk/im-a-young-person/coping-common-issues/thinking-of-suicide-need-urgent-help/

We did specific targeted promotion of some of these services via social media and on the MindMate homepage e.g. Teen Connect, Shout.

In 2019 we undertook a social media 'sprint' – posting different messages across different social media channels at different times to understand what works best with our audience. We used our knowledge from previous campaigns and the 'sprint' to produce a social media strategy for 2019 / 2020.



In 2019 we have continued to increase our brand awareness with scheduled campaigns and publicity dates which included the MindMate 5th Anniversary, #MindMay8 day and Mental Health Awareness week.

We engaged several new young volunteers to the MindMate involvement panel and agreed new aims and goals.

We now have a team of eight MindMate Ambassadors following the successful recruitment of three more. Please click here to watch the YouTube video 'meet the team'.

We are working with GP's across Leeds to improve understanding of the services available and the referral process. This has included presenting to around 600 colleagues from across Primary Care in Leeds to ensure they are aware of the new service developments across the Future in Mind programme of work and a reminder of the referral process into our MindMate Single Point of Access.

We continued to publish blogs and promote these on our social media platforms. All the blogs are written by young people in Leeds sharing their personal views on topics they care about. To date in 2019 we have covered many topics;

- Domestic Violence - We need to discuss domestic violence
- Find out about the MindMate Ambassador team - A short YouTube film about the Leeds MindMate Ambassadors
- Why do we pitch women against one another? - Comparing women to one another needs to stop
- The tragedy of millennials – How much time do you spend on the internet?
- The small things – Or MindMate assembly
- Talking On Transphobia - Why we need to tolerate and embrace the trans community.
- Don't fit the mould – break it! - Why you should love yourself for you who you are.
- Social media is NOT reality – My top tips for social media
- 16? I might as well have been 30 - Exam stress imprisoned me in the mindset of an adult at just sixteen years old!
- We need to talk about FGM - Female Genital Mutilation and what to do about it

To read the blogs please click here

How we know it's making a difference

We continuously track traffic on the MindMate website to ensure it is fit for purpose and to identify which campaigns have been most successful.

We know that the traffic to our site steadily continues to grow for example in 2018/19 we had 48,700 visits to the site which equates to 33,100 unique users. This is an increase from 2017/18 where we had 19,300 visits to the site from 13,600 unique users. Since the launch 5 years ago we have had 131,401 visits to the website.

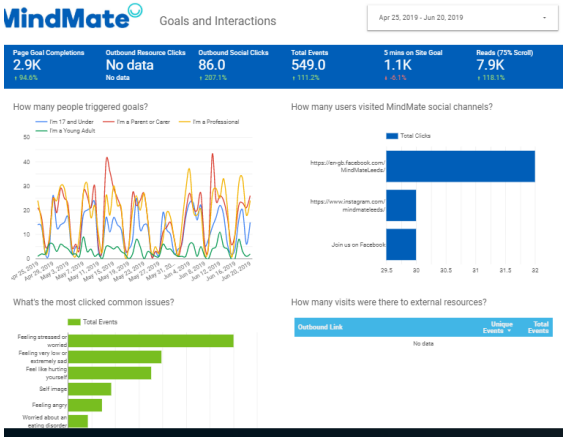
We monitor the website performance via a dashboard that allows us to track the website performance (please see the best practice case study for further information)

Next steps

We will continue to ensure the site is fit for purpose for children and young people by carrying out further user testing sessions with specific groups in particular testing out the navigation, content and age appropriateness.

To ensure that children, young people and professionals understand the offer available to them we will develop a clear visual pathway which will include all new developments i.e. direct contact to MindMate SPA, brief interventions and online counselling.

Best practice – MindMate website performance dashboard



We have developed a dashboard that allows us to track the website performance. This helps us understand how users are accessing the site and which pages they are using. We are able to look at a specific timeframe to see how successful a particular campaign was. We use the information from the dashboard to help inform future campaigns and target content based on the intelligence we have gathered.

Priority 5 - Deliver a Single Point of Access for referrals that works with the whole Leeds system of mental health services so that we enable children and young people to receive the support they need, as soon as possible.

Why this is a priority

The MindMate Single Point of Access (SPA) came about in response to feedback from children, young people, parents and professionals in the initial Leeds local review. Everyone reported confusion about what support and services were available and this resulted in people often having to try lots of routes before finding the right provision.

What has been done so far

The aim of MindMate SPA is to support a smooth referral process with timely access to the right service for the child or young person's SEMH needs. The MindMate SPA team carefully considers each referral and liaises with a range of local health, education, social care services and third sector agencies to ensure that the most appropriate service is identified. The team also tries to contact the young person and/or family, so that they are part of the decision-making process.

The MindMate SPA has been running for over 3 years. In this time the number of referrals has increased with an average of 446 per month for the twelve months to July 2019.

Self-Referrals were introduced in October 2018 with a total of 511 self-referrals being received since it was launched. Self-referrals give an opportunity to gain relevant information from the young person or parent /carer. It is acknowledged that this can take longer than managing a professional referral however the quality of the information given by the family or young person is often richer in detail.

The offer includes providing advice and strategies and advising young people and families of the MindMate website, as well as signposting to relevant services such as the Teen Connect crisis line and the Kooth online offer.

The service has recently recruited three CPWP and is in the process of recruiting to 2 trainee CPWP's. The team are establishing and implementing the service offer of delivering time limited, outcome based brief interventions to those children and young people identified as benefitting from this clinical approach.

How we know it's making a difference

The performance data shows an increase in referrals from both professionals and self-referrals to the MindMate SPA. The services that the SPA refers on to following triage report that the referrals they receive are appropriate. The MindMate SPA team include the information they have gathered as part of the triage process to the receiving team.

On the occasion that a service raises a question in relation to a referral that has been made to them the team will review and discuss the reason for the referral.

The MindMate SPA performance data (click here) shows that following triage referrals are made across the services in Leeds.

We know that since the launch of the SPA (mid 2016) there has been a significant reduction the number of rejected referrals to CAMHS. This data helps demonstrate how the SPA has simplified access to help.

Percentage of rejected referrals from CAMHS -
2014 - 32.0%
2015 - 41.2%
2016 - 11.5%
2017 - 0.9%
2018 - 0.7%

Next steps

There are two key developments underway for MindMate SPA. There is a full service review to understand demand and capacity and to review current processes and systems. The increase in referrals, introduction of self-referrals and some staffing changes have led to delay in the process from the point of receipt of referral to the completion of triage. The team is continually reviewing the current caseload and prioritising as appropriate.

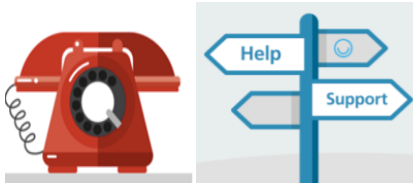
The relationship with the Market Place has been strengthened and an additional two members are joining the MindMate team. Recruitment to vacant posts is on-going and a number of temporary posts are being recruited to whilst awaiting the outcome of the full service review.

An on line self-referral mechanism has been developed and is waiting testing before going live. Once launched this will be evaluated to understand how children, young people and families experience the service to inform further development and improvements. MindMate Ambassadors are supporting the review by gathering in depth feedback from young people and families about their experience of engaging with MindMate SPA.

The second key focus is to expand at scale and optimise recent developments that have enhanced and expanded the function of MindMate SPA, to beyond simply triaging referrals. The vision is to establish a first response (advice and delivery) element into the model. This builds on recent pilots and developments such as, brief intervention via the CPWPs, online Kooth provision and digital prescription approaches. This transformation takes a whole system approach and whilst initial discussions have taken place in existing partnership forums there is an intention to hold a service development workshop with all the key stakeholders.

Best practice case study

Self-Referrals -MindMate SPA



Following feedback re accessibility the service has introduced a telephone based self-referral service. The service is available Mon- Fri 9am – 5pm for Young people 13-17 or for parents/careers of children 5-17. When the service receives a self-referral the initial details are taken by a member of the admin team. The call is then passed to a clinical member of the team, if there is not a clinician available a convenient time for a call back is agreed.

The clinician will take a full referral asking question to ensure the relevant information is obtained. Whilst taking a self-referral, the clinician will explain the process and indicate potential time frame for triage. The parent/carer or young person are also offered advice and sign posted to other support i.e. Market Place, Kooth, Teen Connect. This process is well received and often receives positive feedback and comments.

Priority 6 - Ensure vulnerable children and young people receive the support and services they need

Why this is a priority

A number of factors can make some children and young people more vulnerable to experiencing mental health difficulties. Children who have had adverse childhood experiences, such as abuse, or have witnessed domestic abuse; those who have experienced significant loss and bereavement are at increased risk. Children and young people in the care system and, or the criminal justice system are more likely to have mental health needs as well as those who have special educational needs and disability. The full range of children and young people with a

greater risk of mental health difficulties is well referenced in our Health Needs Assessment, which also sets out the protective factors that help reduce risk (see chapter 6).

In Leeds we work together across the partnership to mitigate this risk and to strengthen the protective factors. We recognise the need for specialist and targeted services for our vulnerable children and support the approach where mental health expertise is embedded into the team working closely with the child.

What has been done so far

Children with Learning Disability Special Educational Needs (and supporting the Transforming Care Programme)

In Leeds earlier this year partners from health, education and social care committed to the development of an integrated Autism pathway for children, young people and their families in the city. This work reports to the SEND Partnership Board and is initially focusing on mapping provision and gaps in the existing offer.

This work will connect with the West Yorkshire and Harrogate Health and Care Partnership Programme Board for Mental Health, Learning Disabilities and Autism. Each locality has confirmed their commitment to working together on some components of children and young people's Autism. As each place is reviewing their current assessment and diagnosis provision, learning will be shared at a West Yorkshire level. Leeds, Wakefield and Bradford, however, are keen to explore opportunities to work together on the:

- Pre diagnosis offer
- Post diagnostic offer
- Training and awareness raising (across a number of different services including primary care). This could include a digital resource pack that would bring together the good work already in place.
- Digital offer – on line resource/support to families

Leeds Community Healthcare trust has offered to act as the provider lead for this work.

The CCG and LCC have jointly commissioned an Intensive Positive Behaviour Service (IPBS) for children and young people with Learning Disabilities, and/or Autism, alongside behavioural challenges. This is funded on an 'invest to save' model and launched in February 2019. It is located within Rainbow House (which provides short break provision for children with SEND). The IPBS works intensively with children and families (and their schools) to enable children to remain with their families and in their local communities. This improves experience and outcomes for children and young people and reduces the risk of admission to a CAMHS bed, or residential educational setting.

To support this we have developed a Community Support Register (at risk of admission register); this uses CAMHS and Children's Social Care knowledge to ensure early identification and proactive case management of children and young people requiring multi-partnership support. This is held within the IPBS and is managed by the service manager. Fortnightly risk management meetings are attended by the commissioners and providers and progress is reported to the TCP programme.

We have a small Learning Disability CAMHS team and they are redesigning their service to provide early support for parents and families and a new LD worker has been recruited to the CAMHS transition team. This coordinator role works closely with a new adult LD transition coordinator to facilitate effective transition from child to adult service provision.

Children in Care

Leeds has a Therapeutic Social Work Service (TSWS) (with embedded CAMHS psychologists), which has significant expertise in supporting children and young people who have experienced trauma from abuse and neglect. This service has fast track access to NHS CAMHS pathways when needed for those children and young people they have been working with.

The TSWS now do ADHD and autism assessments for all children who meet the criteria who would otherwise be seen in CAMHS – not just children in care but also subject to supervision orders, child protection plans or in Kinship care who would otherwise be looked after.

The CCG commissioned the TSWS to offer oversight and support to Leeds children and young people in care placed outside of Leeds (within 80 miles) since spring 2017. There is a new senior social worker in post to enhance the capacity of the team, though all members of the team are involved in providing this service.

The primary issues for these children and young people are consistently around experiences of emotional harm, neglect, physical and sexual abuse. Approximately one third of young people had been exposed to domestic violence. In the majority of cases the primary offer is through phone contact – either with the system or with the carer. There is also some face to face carer support. Direct work with individual young people is the least common offer.

It has become evident that one additional post is insufficient to meet demand and that the offer to those children within a closer (10-15 mile radius) is different to those who live 20+ miles away. The commissioners and the service are discussing options to address this challenge and inequality.

The city centre Youth Access and Counselling service (The Market Place) is commissioned to prioritise children in care and care leavers for accessing the counselling offer.

BUSS model: Building Underdeveloped Sensorimotor Systems as a result of trauma. The CCG has funded an exciting new pilot to enhance and support our response to children's developmental trauma within Leeds. This recognises the impact the

experience of trauma has on infants and children's physiological development and addition to their mental health. An expert Occupational Therapist is working within the TSWS 2 days a week and West Yorkshire One Adoption service 1 day per week. Key strands of work are:

1. Training and follow up support to foster and kinship carers
2. Direct work with children, parent/carers and school for children with more complex needs
3. Supporting Foster carers, who foster mums and their babies
4. School Readiness (LEAPlets)
5. Research and Evaluation

Youth Justice Service (YJS)

Leeds YJS continues to benefit from three embedded CAMHS clinical nurse specialists; one placed in each area team. There is a focus on embedding trauma informed practice in the service and the nurses have been contributing their expertise to this. They facilitate case formulation meetings for all young people on Intensive Supervision and Surveillance (ISS) and other complex cases. The ISS workforce has received training in the principles of Dialectical Behaviour Therapy (DBT) and the nurses are offering them group supervision. This enables them to manage young people's behaviour with trauma informed principles in mind. A DBT programme has started in ISS, facilitated by the clinical nurse specialists. This is a modular programme which teaches young people mindfulness skills and strategies relating to distress tolerance, personal effectiveness and emotional regulation.

Two of the clinical nurse specialists are EMDR (Eye Movement Desensitisation Reprogramming) therapists and have offered this therapeutic approach to young people. One young person attended both the YJS briefing and the Future in Mind Programme Board to explain the significant impact that completing EMDR has had on his life, including being able to sit and pass his GCSEs.

The YJS clinical nurse specialists continue to attend risk management panels and provide advice on how emotional and mental health impacts on managing risk. They have completed SAVRYs (Structured Assessment of Violence Risk in Youths) alongside case managers. SAVRY is useful in the assessment of either boys or girls between the ages of 12 and 18 years and is used to support assessments, interventions and supervision plans concerning violence risk in young people. The nurses have also made referrals over the year to the new sub regional Forensic CAMHS, provided by South West Yorkshire Partnership Foundation Trust, commissioned by NHS England.

Leeds YJS recognises the extent of speech and language difficulties experienced by the young people we work with. The NHS England Health and Justice commissioning team supported a bid to enhance the health expertise in the YJS last year. As a result a speech and language assistant has been recruited to provide interventions to young people after they have been assessed by the speech and language therapist. She has also been providing consultation to the interventions team to ensure sessions are clear and easily understood. The recruitment of LD

psychology support for the team has been less successful, despite a number of attempts. The service and health colleagues are currently exploring alternative approaches to ensure access to this expertise.

The Youth Justice Service (YJS) has revised the knife crime programme and are now delivering a safety based intervention called 'Lives Matter' which is comprised of 4 sessions.

The previous material focussed on the consequences of knife crime and showed videos and pictures that were graphic and upsetting. This has now been redesigned following the whole service trauma informed training, as trauma research tells us this approach is unlikely to work as it 'blocks learning'. The new programme is more focussed on harm reduction, safety and first aid. Each young person ends the programme with a personalised safety plan printed on a card, plus a reminder of basic first aid in a situation where a weapon has been used.

Young Carers

The NHS and Local Authority jointly fund a young carer's group, recognising that children and young people who hold caring responsibilities are at increased risk of emotional and mental health problems. The Leeds Young Carers Strategy is in its final stages of being developed and two of our MindMate Ambassadors, with lived experience of being young carers, are involved in this work. The ambassadors recently worked with the young carers group to develop useful content on the MindMate website and wrote a blog with them to raise awareness of the challenges of being a young carer.

The Strategy will inform the development of a new jointly commissioned Young Carers service from 2020. The service specification for the new service is currently in development.

LGBTQ+

The NHS Leeds CCG Communications team have been shortlisted in the 2019 CIPR Yorkshire and Lincolnshire Pride Awards for the public health campaigns category for its success in breaking down barriers in mental health. The CIPR PRIDE Awards are among the most prestigious awards in the communications industry. The winners are selected by a team of leading industry experts and will be revealed at an awards ceremony in Leeds in November 2019.

On Sunday 4th August our MindMate Ambassadors joined in Yorkshire's biggest celebration of Lesbian, Gay, Bisexual and Trans* life. This year over 40,000 attended Leeds PRIDE weekend celebrations. Whilst taking part in the parade our MindMate Ambassadors took the opportunity to promote the MindMate website by handing out rainbow MindMate wrist bands to show our support for the LGBTQ+ community.


How we know it's making a difference

The Transforming Care Programme National Benchmarking Exercise in March 2019 identified that Leeds has developed some innovative multi-agency approaches to developing services to keep children and young people with their families and communities, which when combined with the quantification and management of Children and Young People at risk of admission, will offer a significant and effective system of support.

A key success measure of the Intensive Positive Behaviour Service will be the reduction in numbers of young people needing to be placed in CAMHS beds, or residential settings. External evaluation has also been commissioned from East Anglia University.

The TSWS introduced a new assessment and formulation model in January 2019 which includes the use of standardised clinical measures to use alongside Goal Based Outcomes. This will allow us to better track progress. It also improves the clinical 'fit' of our first offer in line with a neurodevelopmental trauma informed response to children and their families. The TSWS also continue to collate satisfaction data in all clinics and after any intervention.

In addition to case studies and videos evidencing impact, there are research and evaluation studies underway for the innovative BUSS pilot. The Service Evaluation Project is being undertaken by a clinical psychologist in training at the University of Leeds, which comprises interviews with TSWT staff and foster carers about the BUSS model and their experience of it. In addition there are 4 clinical psychologists in training from the University of Hull, who each are using some aspect of the BUSS model as the basis for their doctoral thesis.

Commissioners receive quarterly reports from the YJS and CAMHS clinical specialist nurses; these reports include powerful case studies that demonstrates the vulnerability of the young people, the significant support provided and often include outcome metrics evidencing improved mental health.

The work of the Young Carers Strategy will ensure services identify Young Carers that they are working with; this will give us a more accurate picture of the number of Young Carers accessing services in Leeds.

Next steps

Transformation Care Programme - Work will continue to improve the experience of the Community CETR and to meet the demand and requirement for a Community CETR compliance rate of 75% of all those admitted to Hospital with a diagnosis of Autism; Learning Disability or both., acknowledging that this requirement will rise to 90% from March 2020. We will continue to work with colleagues in the ICS on this critical agenda.

Specific Triple P Parenting Programme is to be undertaken by 20 members of Staff, the entire team of the IPBS service and a number of LD Nurses during 2019.

Complete the review of the integrated autism pathway with clearly identified areas for improvement and a SMART plan for delivery by June 2020.

Children in Care - Unaccompanied asylum seeking children (UASC) have always been able to access the TSWS but have been under-represented in referrals. The service has met with UASC workers to ensure they understand the service offer and how to access it.

To complete the review of the service specification in relation to the TSWS offer to oversee and support to Leeds children and young people placed outside of Leeds (within 80 miles).

We will review the current impact of the new BUSS model we are testing (Building Underdeveloped Sensorimotor Systems) with a view to move from a pilot secondment and testing approach, to become integral to our future commissioned response for children and young people who have experienced developmental trauma.

The CCG is working with our social care colleagues as they are undertaking significant service improvement to their children's homes; we are jointly funding the creation of a dedicated therapeutic service, as a distinct team within the TSWS wider offer.

YJS – The YJS is planning to recruit an Educational Psychologist through the additional NHS England Health and Justice funding (following an inability to recruit to the LD psychology post). This will support the work of the service around developing a greater understanding of the young people's educational needs and the provision needed to meet these. This post will monitor and improve outcomes for the SEND population (and wider) within the YJS who are accessing less than 25 hours provision, are excluded, or at risk of exclusion, have SEND needs and are NEET.

Sport and Youth Justice in Leeds: Following on from the Sport and Youth Justice event last month, Leeds YJS is developing a referral pathway for vulnerable young people into appropriate physical activities in partnership with StreetGames.

A series of 'Coffee mornings' with local providers are being arranged in each of the 3 area teams, with a small number of local sporting organisations being invited to speak to staff about sporting opportunities for young people in the local area. The aim of this is for area teams to start building relationships with local sporting organisations to increase uptake in sporting and physical activities for young people.

StreetGames are developing a Charter Mark / award for Youth Justice Services and for Sports providers and we are in discussions about Leeds becoming a pilot area for the new award.

Commissioners and the YJS continue to work with the NHS England Health and Justice commissioning team and their commissioned services, such as SARC, Forensic CAMHS, Secure Settings and Liaison and Diversion to ensure integrated pathways and whole system connection.

BAME -Public Health is undertaking a Health Needs Assessment on our school age Black and Ethnic Minority Ethnic groups in relation to Social Emotional and Mental Health. This will enable us to identify where there are gaps in support and service, which in turn inform our commissioning and service development. We haven't received the full report yet but have received early headline areas that will need action. Chinese young people have particularly poor mental health in Leeds and White British, Chinese and Mixed groups have high rates of self-reported self-harm. Service data analysis mirrors national research with underrepresentation of BAME groups within CAMHS and broader services, though slightly better proportions in two voluntary sector services. Black Caribbean and Mixed White /Caribbean boys are over-represented in SEMH statistics in Leeds and in exclusion statistics, alongside Gypsy and Traveller for the latter. Focus groups exploring these issues with BAME young people and questionnaires with parents are ongoing.

Priority 7 - Ensure there is a coherent citywide response to children and young people in mental health crisis.

Why this is a priority

Mental health crisis support needs to improve for children and young people in Leeds. All too often the only place to go when a child is in crisis is to the Emergency Department, which in the majority of cases is not the best place. Young people are clear that they want to be seen in a safe, non-clinical place whenever possible.
Local and National drivers promote the need for ensuring that appropriate 24/7 support is available to children, young people and their families.

What has been done so far

Teen Connect: The Teen Connect online/phone support for young people aged 13-18 and their parents who are experiencing mental health crisis launched in June 2018. The helpline is open 6pm-2am every night of the year. We have reviewed the service specification (which was

based on the adult Connect helpline) to ensure the service reflect the learnings from the first year of the service being operational and to allow us to truly evidence impact based on caller outcomes.

Safe Space for children and young people experiencing a mental health crisis: As part of our work to deliver a safe non clinical space for children and young people experiencing mental health crisis we commissioned The Market Place to pilot a six month safe space provision building on their drop in and counselling model of support. This pilot was extended pending the launch of the 'safe space' provision in late 2019.

Community CAMHS Crisis team: Following the successful bid for West Yorkshire New Care Models (NCM) money for Community CAMHS to develop a dedicated crisis team (in normal working hours) additional funding has been secured from NHS Leeds CCG for the service to be extended to 7 days a week until midnight. A Crisis development lead has been appointed with temporary monies from NCM. Recruitment of the Crisis manager post, 4 Band 6's, a band 3 assistant and band 3 admin has taken place. Commencement of moving some of the crisis work from community CAMHS has begun.

Local young people (notably our MindMate Ambassadors) have played an active role in steering the above key developments. Examples include being members on the Teen Connect steering group, being part of the procurement process of the safe space offer and supporting Leeds CAMHS on the development of the new crisis team.

The Market Place has been commissioned to provide up to 4 sessions of fast access to counselling sessions to those young people, who are experiencing crisis.

Specialist Practitioners (from Leeds and York Partnership Foundation Trust (LYPFT)) are working in the Emergency Department 5pm-9am to provide support to anyone presenting to Emergency Department in mental health crisis. This currently provides support to a significant number of young people and data from this offer has been used in the development of the new CAMHS crisis team. Training and supervision for working with young people is provided by CAMHS to these practitioners.

A new purpose-built specialist community CAMHS unit is being built in Leeds. The unit will provide 18 specialist places and six psychiatric intensive care unit (PICU) beds. Leeds Community Healthcare, working on behalf of the West Yorkshire and Harrogate Health and Care Partnership, was one of 12 successful bids to NHS England for capital funds in the Chancellor's Budget. The unit will support young people from across West Yorkshire suffering from complex mental illness, such as severe personality disorders and eating disorders.

Leeds Community Healthcare is the lead CAMHS provider for the West Yorkshire New Care Models (NCM) 2-year pilot, which commenced in April 2018. This programme aims to reduce admissions and length of stay in CAMHS beds. Any expenditure gains are retained by the provider partnership to invest in improving community CAMHS services. An example of this reinvestment is the development of the CAMHS crisis team detailed above.

Work is underway between Leeds Teaching Hospital NHS Trust (LTHT) and CAMHS with regards to the support to children and young people who are admitted to LTHT experiencing mental health crisis.

There is now a clear process for the police to contact a mental health practitioner (in and out of hours) when they need advice regarding a possible Section 136 assessment

The Care, Education and Treatment Review protocol has been shared between NHS Leeds Clinical Commissioning Group and Leeds Community Healthcare regarding children and young people who have a learning disability and/or autism and are at risk of hospital admission – to ensure a multiagency plan is in place.

How we know it's making a difference

The West Yorkshire NCM delivered a 45% reduction in CAMHS inpatient occupied bed days in the first 6 months; it has reduced the distance children and young people are from home when admitted to a CAMHS bed by 33% and has reduced the length they stay in a hospital bed by 49%.

The goals we want to achieve from our local crisis care developments to complement this are:

- Reduction in inappropriate attendance to Emergency Department
- Reduction of inappropriate admissions to paediatric and acute medical wards
- Reduction in inappropriate admissions to mental health inpatient beds as more intensive, appropriate wrap around care will be available in the community from a range of agencies
- Reduction in length of stay on mental health inpatient units
- Improve children, young people and their families experience of crisis support
- Provide non clinical settings for children and young people experiencing crisis
- A CAMHS team dedicated to this work will significantly improve the quality of emergency and crisis care for children and young people

We will obtain children, young people and families' views and experience.

Next steps

- To award the contract for the non-clinical safe space for children and young people experiencing mental health crisis and launch the service.
- The launch of the new CAMHS crisis team
- The new inpatient building to be completed in Leeds 2021, with 18 general beds and 6 paediatric intensive care unit beds. This should ensure that fewer young people are placed out of area and discussions are underway to locate the CAMHS crisis team there
- Exploring integration of a dedicated children and young person Section 136 suite in the new CAMHS building
- Continue to check with service users that the approach fits with their vision – through our MindMate Ambassador team.
- A crisis focussed marketing campaign will be delivered in line with World Mental Health day in October 2019.

Priority 8 - Invest in transformation of our specialist education settings to create world-class provision.

Why this is a priority

Children's Services within Leeds City Council set upon a journey to review and remodel its specialist educational provision for children and young people with SEMH difficulties, in relation to the growing needs within the city. The existing specialist provision for young people with SEMH had been deemed inadequate and consequently many learners were not achieving their potential or were being placed outside of the local authority. Our aim was to reform the model of our local offer of social, emotional and mental health specialist educational provision. There was a need to create new purpose built provision, specifically designed to meet the needs of young people with SEMH difficulties, which could offer a range of therapeutic approaches, resources and curriculum opportunities personalised to meet a wide range of diverse and complex individual needs.

What has been done so far

Springwell Leeds is based on four sites in the North, South and East of the city. At a total cost of £45M, the Springwell Academies provide a world-class education for young people with SEMH needs in state of the art buildings. This new provision creates 340 specialist places for young people with SEMH difficulties.

The Executive Principle of Springwell Leeds is a member of the Leeds programme board. The new estate is designed specifically to support pupils with Social, Emotional and Mental Health (SEMH) needs and the values and ethos of the provision is to take a nurturing approach with unconditional positive regard.

Area Inclusion Partnerships (AIPs) provide timely interventions and support to ensure most children with SEMH needs succeed within a mainstream educational setting. Investment from the Leeds high needs block fund, secures the future of these partnerships to continue to provide quality early intervention and support for this vulnerable cohort of children and young people. The SEMH pathways panel continues to meet weekly and is successfully enabling vulnerable children and young people to access the right support.

In June 2019 all four sites of Springwell Leeds SEMH provision were inspected by HMI OFSTED inspectors.

How we know it's making a difference

We are expecting the final HMI OFSTED report at any time and will share widely. By September 2019 we anticipate that Springwell Leeds, SEMH specialist provision to be up to full capacity and to be working with approximately 300 learners. The provision is for those learners across primary and secondary school phases who have an Education Health and Care Plan (EHCP) with complex SEMH needs that cannot be met within a mainstream setting. Every individual learner's plan is personalised and carefully monitored and reviewed against identified outcomes.

Next steps

The Local Authority will continue to work with Springwell Leeds to ensure that young people are receiving appropriate support. The outcomes of learners, in terms of attendance, attainment and achievement will be carefully monitored and reported.

Priority 9 - Work with children and young people who have mental health needs as they grow up and support them in their transition into adult support and services.

Why this is a priority

Children and young people told us that when they get older and if they need to move into adult support services, they want to feel supported and not abandoned. We know that when young people transition to adult services they can feel lost and that the level of support they have been used to is no longer available. We want to ensure that young people will be supported better when they approach adulthood and involved more in decisions about their care.

What has been done so far

We have been working closely with colleagues in adult services to support children and young people transitioning between services.

We have facilitated joint working (as part of our contractual quality requirements) between Leeds and York Partnership Foundation Trust and Leeds Community Healthcare. This has included a review of the transition pathways in adult services, where young people are likely to be referred to ensure that these are as clear as possible to support timely referral to the right service. Work has also been undertaken to ensure that expectations are manged for the young person and their family and carers with regards to the offer from adult services and how this will vary from the service they have received from CAMHS.

THRU peer support groups- We have committed to supporting the continued development of peer-to-peer support work for young people through transition in the city. We now have three THRU groups. Two run weekly, providing a combination of support group sessions and activities to increase young people's skills relating to particular topics e.g. managing anxiety, self-image, and healthy relationships. The other group is entirely led by former group members and provides a progression opportunity for those who still require support at the end of their time in the main groups.

Teen Connect and Connect- We launched the Teen Connect helpline (via a partnership with Leeds Survivor Led Crisis Service and The Market Place) to support children and young people experiencing mental health crisis. This helpline works alongside the Connect helpline which is available to support those over 16 years old. By working closely together we are able to support young people in transition who may be experiencing crisis by delivering a consistent and joined up service.

Improving access to psychological therapies (IAPT) procurement – we have been involvement in the review and development of the service specification for the new IAPT Service to ensure that young people in transition are supported by this new model.

Early Intervention in Psychosis - Leeds has an excellent track record in meeting the needs of people in crisis and has consistently met the nationally designated access standards. The Leeds system is committed to expanding the Early Intervention in Psychosis service to ensure we continue to meet the national standards outlined within the Mental Health Forward View. The system has a three-year investment trajectory in place that will ensure that at least 60% of people with first episode psychosis start treatment with a specialist early intervention in psychosis (EIP) service within 2 weeks.

How we know it's making a difference

Ensuring that the principles of joint working between LYPFT and LCH through our contractual quality requirements allows for us to have a robust mechanism to monitor the performance of services in terms of the timely support to young people in transition**.**

The weekly THRU groups hold an evaluation session every 8 weeks to gather feedback and evaluation data from the young people and get their input into the next block of sessions.

Our MindMate Ambassadors are able to provide real feedback in terms of how our children and adult services are meeting the needs of young people in transition.

We are working with colleagues from both Further Education and Higher Education establishments across the city to ensure students are able to access the appropriate mental health services.

Next steps

We want to ensure that for young people in transition we provide support that is easily accessible. As services develop we will ensure this group of young people are visible and their needs considered. This will involve close working with our colleagues in Adult Mental Health Commissioning. We are starting to gather data which will allow us to develop our offer for young people in the transition period (notably our offer for 14-25 year olds). There is a need for significant review and transformation as set out in the NHS Long Term Plan. This will be given a particular focus from 20/21 onwards.

Safe space development – as we develop our safe space for children and young people experiencing mental health crisis we will work with colleagues around the current adult provision and understand and develop links across both models to ensure consistency and ease of access for young people in transition**.**

THRU peer support - We aim to work with education providers and other services to provide further skills courses and workshops to increase our reach across the city.

Best Practice case Study - Transitions Team Leeds CAMHS

It has long been recognised in Leeds CAMHS that transition between child and adult mental health services can be a difficult time for young people. Leeds has had a dedicated transition team for the past 9 years, whose role it is to support young people out of CAMHS and into adult mental health services. Over the past year or two, the team has expanded to include dedicated transitions workers for young people with eating disorders and those with learning disabilities and pathways for these cohorts of young people are being developed, tested and reviewed.

To read more please click here

Priority 10 - Establish a city-wide Children and Young People's Community Eating Disorder Service in line with national standards and access targets.

Why this is a priority

The creation of a distinct community based eating disorder (ED) service for children and young people was a key priority for the first year of the Leeds Local Transformation Plan. This recognised that eating disorders are severe mental illnesses with serious physical, psychological and social consequences that can interrupt educational goals. Anorexia Nervosa has the highest mortality amongst all psychiatric disorders. The funding allocation in 2015 created the opportunity to enhance and transform the existing offer into one dedicated citywide team.

What has been done so far

The Leeds children and young people's dedicated community eating disorder service has been operational for 3 years. The team is now fully recruited to. Paediatricians continue to improve the pathway for young people requiring medical stabilisation and contribute to ongoing development work with local GPs about assessment and monitoring. All clinicians are trained in NICE compliant evidenced based interventions including Family Based Treatment (FBT) for anorexia nervosa and bulimia nervosa and others have CBT-E, DBT, FT, EMDR, and CRT training to be used when appropriate. We routinely use evidence bases outcome measures in order to evaluate the effectiveness of the support and intervention.

We have increased Parental support and provision. We have a year round Parent Group also available to parents of Inpatients in Leeds. We offer additional wraparound support to parents who are struggling. We have introduced a Coping with Christmas pack and support session which was very well received.

The service has become a member of the Quality Network for Community CAMHS-ED. We have received our first inspection which was overwhelmingly positive.

CAMHS Assistant: We have established the role within the team and it is successful and embedded. The assistant has carried out some stellar work and is a huge asset to the team.

We have commissioned two service evaluation projects in conjunction with the University of Leeds, which are due to complete in November 2019. These are focussing on Clinicians and young people and families views of FBT, to assist the team in understanding how best to use FBT within the service and what might help with adherence to treatment.

The new format for the assessment clinics continues and has evaluated positively both by families and professionals. Families now attend one, three hour multi-disciplinary team (MDT) assessment with the aim of providing a diagnosis and commencing an intervention in the next session.

How we know it's making a difference

The service continues to perform well with regard to the national waiting time standards for children's community eating disorder services we have had our first Quality network for community CAMHS peer review in April 2019.

The summary states

"The Leeds ED team are an innovative and education-focused team who work hard to promote and share knowledge with organisations in their local area about the work they do. They are committed to promoting the ED service, and have found novel and interesting ways to do this, including partnering with the Northern School of Contemporary Dance to provide training to them on Eating Disorders, signs to look out for and tips on nutrition and diet. Training is also provided to inpatient paediatrics wards, schools, school nurses and primary care teams, all in the interests of upskilling different teams and sharing knowledge and skills. The team also hold parent groups and are planning many more e.g. a siblings group and nutrition group, and this again highlights the innovative spirit within the team. "

We have had positive feedback from parents and service users including some constructive comments that have allowed us to tailor our support to make more accessible and useful.

What Next

- The team has developed a Risk & Review Pathway. The focus of this is to establish a clear treatment pathway within the EDE service. It consists of a bespoke and individual treatment plan and review and action structure that will apply to all young people in the service. It provides clear governance and treatment structures and focuses on involving young people & families in planning and review. It incorporates both mental and physical health and includes a bespoke risk assessment that we are working on. The pathway will be fully operational by autumn, 2019. This will be reviewed and evaluated over the next 12 months.

- We are continuing to develop and enhance the work already underway with the northern school of contemporary dance. An event is planned for September 2019. This will think about food, dance and nutrition with the parents of their new 2019 intake into the Centre for

Advanced Training In Dance Scheme (CAT) for 13-17 year olds. This will be co-facilitated by NSCD and Leeds Children and Young Peoples Eating Disorder Service. A similar event will then be offered to dance schools and their instructors throughout the region.

- CAMHS Assistant: work continues around fine tuning the role and ensuring training and support is in place to provide the best possible service to our Young People and their families.

- Nutrition Group – our Dietician has planned a new group alongside our CAMHS Assistant. This needs implementation and evaluation.

- The service is also about to embark on an exciting new venture with Park Lane College and will be involved in working with staff and students to enhance their understanding of eating disorders and embed support within the college. Our Senior Child and Adolescent Mental Health Practitioner and our Assistant Psychologist are leading on this.

- Co – morbidity: The team manages increasing levels of co-morbidity when the primary diagnosis is eating related. We do need to do more work on thresholds and when referral to our wedge colleagues is appropriate.

- As a service we are planning a Siblings Group following feedback at our Awareness Event.

- Our CAMHS Assistant has set up the first ED Participation Group and we are really keen for involvement from our Young people.

Priority 11 - Improve the quality of our support and services across the partnership through evidence based interventions, increased children and young people participation and shared methods of evidencing outcomes.

Why this is a priority

Partners from health, education and social care are keen that the services and interventions we provide to support Children and young peoples' mental health are informed by the best available evidence base. We are also committed to ensuring that children and young people are involved in decisions about their own care, and consulted on their experiences. Constant involvement and feedback provides the opportunity for continual service improvement.

What has been done so far

The HOPE (Harnessing Outcomes Participation and Evidence) steering group is supported by CORC (the national Child Outcomes Research Consortium) and involves all agencies delivering and supporting SEMH services. The group have focussed their work on:

- Ensuring more effective analysis of outcome data collected in the system

- Supporting services to implement 'outcome friendly' information systems which support day-to-day work with children and young people and service reports. (CORC have recently supported The Market Place to look at how they will adopt an evidence based outcomes framework within the service)
- Ensuring evidence based interventions are used by services and if there is no available evidence base that strong evaluation is undertaken (both internal and external)
- Reviewing the evidence of presenting need and demand in the city and comparing this with workforce skills
- Reviewing annually the main referral reasons across the services. In 2018/19 across SEMH services in Leeds Anxiety has been identified as the top referral reason and the group will now develop a system wide approach to tackling this issue.
- An analysis of training needs across the system based on presenting need and related evidence based interventions, which is supporting the workforce strategic plan
- Ensuring all NHS funded SEMH services report into the Mental Health Service Data Set

In addition a Future in Mind: Leeds dashboard (Click here) has been created to report quarterly to the programme board to provide an overview on progress against key indicators. These take the broad themes of:

- How much did we do?
- How well did we do it?
- What difference did we make?

How we know it's making a difference

The Future in Mind HOPE Outcomes Framework enables us to ensure that services are meeting the needs of children and young people and that they are delivering services that reflect the priorities that sit within our Local Transformation Plan. Services will be able to self-assess against the outcomes within the Framework (the outcome framework is included in chapter 3).

The group are responsible for the Future in Mind: Leeds dashboard, which is now reported quarterly to the programme board to give a useful oversight on delivery against key performance indicators.

Next steps

Continue to support services to ensure systems are in place to flow information through to the Mental Health Services Data Set (MHSDS). This will ensure national reports accurately reflect the number of Leeds children and young people receiving support. Work will also continue to deliver the required information for outcome measures in CAMHS services into the MHSDS.

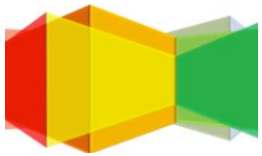
Continue to look at ways that maximise the quality of the data from across the system (existing and new) to understand the need, demand and the impact of the SEMH services.

Through the development of our workforce strategy, continue to develop and transform our services through a strong workforce across universal, targeted and specialist services in Leeds. This will include increasing the impact of specialist knowledge through embedding expertise in teams and utilising supervision and consultation models and maximising the opportunities held within digital technology.

Develop and deliver a system wide programme of work (re evidence base and workforce competencies) to tackle the main service referral reason in 2018/19 – Anxiety.

Best practice case study – Mental Health Dataset

The Market Place is making preparations to start uploading data to the Mental Health Data Set. To comply with latest GDPR laws we recognise the importance to ensure that young people feel fully informed about these plans. It is important that this information is presented in a manner that is understandable and concise, so that young people genuinely feel informed and fully understood that they can choose to opt out.



Over the years, young people who access The Market Place have told us that they choose our service specifically because they are not connected to NHS records. This made us determined to be as open and honest about flowing data to the MHSDS. This transparency then enables young people to either opt out, or alternatively consent for it to be shared, once they understood exactly what was being uploaded.

The Market Place already places strong values on openness and honesty with young people; therefore it felt that a leaflet specific to the MHSDS should be an addition to our Privacy and Brief Privacy (young people friendly) statements.

These new leaflets for the MHSDS also reference other data that we collect and store, so also act as a good reminder to young people who may want to ask questions about their data.

Please click here to see the leaflet.

Author's acknowledgement to contributors

Dr Jane Mischenko would like to thank the following colleagues for their contribution to the report

Name	Title / Organisation
MindMate Ambassadors	N/A
Jayne Bathgate-Roche	Children's Mental Health and Wellbeing Commissioning Manager, NHS Leeds CCG
Hannah Beal	CAMHS Clinical Lead, Leeds Community Healthcare
Debbie Cowell	Commissioning Finance, NHS Leeds CCG
Alun Ellis	Principal Finance Manager (Children's Services)
Dr Julie Franklin	Consultant Clinical Psychologist , Leeds Children and Young People's Eating Disorder Service
Charlotte Hanson	Advanced Health Improvement Specialist CYP EMH and Wellbeing, Public Health Leeds City Council
Kay Jeffries	Operational Manager, Leeds MindMate Single Point of Access
Louise Jones	Clinical Team Manager CAMHS Eating Disorder, Leeds Community Healthcare
Michelle Kane	Health Improvement Principal / Young Peoples Resilience, Public Health Leeds City Council
Saira Mumtaz-Jones	Health and Wellbeing Service
Liz Neill	Engagement and Coproduction lead, Common Room
Andy Peaden	Head of Leeds Youth Justice Service
Sue Ranger	Consultant Clinical Psychologist and Team Manager (Infant Mental Health Service)
Andrea Richardson	Children & Families, Head of Service, Learning for Life, LCC
Donna Ryan	Head of Service CAMHS and MindMate SPA, Leeds Community Healthcare
Yoshiko Stokoe	Peer Support Team Leader, Leeds Mind
Val Waite	Head of service - Learning Inclusion, Leeds City Council
Liz Wigley	Maternity Commissioning Manager, NHS Leeds CCG
Claire Wilde	Senior Infant Mental Health Practitioner/Cognitive Behavioural Therapist
Katie Wrench	Team Manager, Therapeutic Social Work Team

2: Finance

There are three primary funding streams for mental health and wellbeing, NHS Leeds Clinical Commissioning Group (CCG), the Local Authority (LA) and NHS England.

Implementing the Five Year Forward View for Mental Health services sets a trajectory for increased access, which is based on existing prevalence data and allocates funding to this on a national level. This funding will then be allocated locally to support the increase in capacity and system transformation. Table 1 (on the next page) sets out the trajectory for national allocations to LA budgets, CCG budgets and investment for key programmes of work in mental health.

Funding Type	£'000	£'000	£'000	£'000	£'000	£'000
CCG Baseline Allocations	**2015/16 spend**	**2016/17 spend**	**2017/18 spend**	**2018/19 spend**	**2019/20 budget**	**2020/21 initial estimated plan**
CYP Mental Health (LTP)	1064	1,277	1,293	1,248	2,013	3,065
Eating Disorders (LTP)	425	425	425	657	660	678
CYP Mental Health The Market Place*	178	178	178	178	178	178
CAMHS main community provider	7,400	7,400	7,400	7,731	7,821	8,032
CAMHS Youth Offending Service main community provider				163	170	175
CAMHS ad-hoc	20	20	21	18	21	21
Perinatal Mental Health				444	1,519	1,400
MHST Trailblazer bid					93	347
	9,087	**9,300**	**9,317**	**10,439**	**12,475**	**13,896**
Therapeutic Out of Area Placements (CCG Contribution for Psychology Element)*		**982**	**1,085**	**846**	**1,000**	**1,000**
	1,042					
CCG Non Recurrent NHSE Allocations						
Mindmaze		64				
Autism Waiting lists		360				
Perinatal Mental Health				742		
	0	**424**	**0**	**742**	**0**	**0**
Local Authority Core Funding						
MST Core Funding		1,136	1,326	1,337	1396	Unknown
Therapeutic Social Work (services targeted at Looked After Children)		740	796	819	853	Unknown
Emotional Resiliance Activities eg Healthy Schools		193	261	281	235	Unknown
Northpoint Wellbeing LTD Counselling		173	167	160	160	Unknown
Spot purchase of mental health OOA placements		466	195	175	100	Unknown
Services targeted at other Vulnerable children eg SILCS YOS etc		3,643	6,320	8,840	8363	Unknown
		6,351	**9,065**	**11,612**	**11,107**	**0**
Grand Total	**10,129**	**17,057**	**19,467**	**23,639**	**24,582**	**14,896**

Table 2, below provides an overview of the allocation of the LTP funding

Detailed Breakdown of LTP Spend			2018/19 spend	2019/20 plan/budget	2019/20 Q1 spend	2020/21 estimated initial plan
CYP MH promotions			1,145.00	5,000.00		5,000.00
Perinatal Mental Health			12,000.00			
School Clusters*			250,000.00	250,000.00		750,000.00
SILC			88,000.00			30,000.00
Mindmate website including promotions			58,050.00	51,700.00	11,900.00	51,700.00
Mindmate Champions			23,200.00			
CYP Single Point of Access - LCH			347,275.00	376,181.00	94,045.00	386,338.00
Therapeutic social work			48,000.00	50,000.00		50,000.00
CYP Single Point of Access increase- LCH				44,131.00		45,323.00
The Market Place trajectory work and The Market Place increase to contract			79,716	79,736.00	19,929.00	79,736.00
The Market Place Fast Access Counselling				100,020.00	25,000.00	100,000.00
1 Adoption (Trauma Work)			12,500.00	20,000.00		70,000.00
Feasibility research to online counselling / Online counselling service			50,000.00	175,000.00	100,000.00	354,050.00
ADSD/AHD match funding for assessment				15,000.00		200,000.00
Crisis Telephone line			150.00	66,622.00	16,655.50	68,421.00
Crisis Safe Space				25,000.00		100,000.00
Eating Disorders Service - LCH			657,162.00	660,477.00	165,119.00	678,310.00
Common room - consultancy and ambassadors			54,454.00	56,210.00	14,053.50	57,728.00
Increase to SPA provision LCH				58,581.00		73,739.00
MH First Aid Training			8,333.33			
THRU (Talk, Help, Relate, Understand) Peer Support Work			39,810.00	39,810.00	9,952.50	40,885.00
Child Outcomes Research Consortium			18,600.00			
Infant Mental Health Team LCH				99,388.00	-	102,071.00
Ad-hoc			4,227.00			
CAMHS School Training				500,000.00		500,000.00
LCC Contribution to trauma team development*			153,000.00			
			1,905,622	**2,672,856**	**456,655**	**3,743,301**
			1,905,622	**2,672,856**	**456,655**	**3,743,301**

*Table 3 below shows the joint partnership CYP Mental Health Budgets 2019/20

Recurrent	£'000 CCG	£'000 Local Authority	£'000 Total
The Market Place	178	92	270
	178	**92**	**270**
Non Recurrent			
Contribution to trauma team	300	To follow	300
School Clusters ** (more detail below in table 5)	250	250	500
	550	**250**	**800**
Grand Total	**728**	**342**	**1,070**

Table 4 below shows the Public Health Spend for 2019/20

Recurrent	£'000 Public Health
Infant Mental Health	243
Leeds Healthy Schools Programme #	317
Young People's Resiliance	100
Childrens and Family Bereavement Service	150
	-
Grand Total	**810**

#It is not possible to identify how much of this budget is solely mental health

**Table 5 shows the investment to school clusters from 2017 to 2020

	CCG £'000	LCC £'000	£'000
Original CCG investment in service	750	-	**750**
2017/18	250	250	**500**
2018/19	250	250	**500**
2019/20	250	250	**500**
	1,500	**750**	**2,250**

The CCG invested an initial £750k in the service to pump prime for the 3 years. For each year after that the CCG and local authority invest a further £250k each bringing the total value of the pot over the 3 year period to £2.25m.

From 20/21 the CCG will invest a minimum additional £500k on the cluster service

Table 6 shows the Specialised Commissioning Acute Inpatient Spend Funding from NHS England for specialised acute inpatient spend was as follows:

AWAITING INFORMATION

3: Performance

One of NHS England's objectives within the Five Year Forward View for Mental Health is that by 2020/21, there will be a significant expansion in access to high-quality mental health care for children and young people. Nationally, at least 70,000 additional children and young people each year will receive evidence- based treatment – representing an increase in access to NHS-funded community services to meet the needs of at least 35% of those with diagnosable mental health conditions.

In Leeds this equates to approximately 5435 children and young people. In the 2018/19 the data validation exercise undertaken by NHS England services recorded 4590 (29.6%).

Published figures must be received with caution as we are aware that a number of our commissioned services (particularly those providing cluster based support) are not yet flowing their data to the MHSDS. Locally Commissioners within Leeds CCG are working with providers to ensure that this target is met and is being accurately reflected within performance reports; this includes providing assurance through the CCG's Integrated Quality and Performance Report.

There are a number of challenges for our smaller providers including developing MHSDS compliant databases and the delay in the launch of the NHS digital 'cloud based MHSDS system', which has led to the delay in all our commissioned services being able to flow their data.

There is a greater challenge within the cluster model in order to be able to accurately record the number of young people being supported by NHS funded community mental health services. As part of our newly commissioned cluster SEMH support model there will be a contractual requirement that all providers are able to flow their data to the MHSDS. To support this development we are working with local cluster commissioned services to trial new methods of data flow.

Alongside the additional 70,000 children and young people who should have access to high-quality mental health care when they need it, the NHS Long Term Plan also sets out that by 2023/24, at least a further 345,000 children and young people aged 0-25 will be able to access support via NHS-funded mental health services and school or college-based Mental Health Support Teams. We are working with our local Clinical Network to understand the local target for Leeds and to then understand how we can achieve this requirement through additional resource with our Transitions programme of work which we will deliver alongside our Adult Mental Health Commissioning colleagues. We will also be able to deliver additional support to more young people through the establishment of our 2 Mental Health Support Teams supporting 10 of our further education settings.

The NHS Long Term Plan states that by 2020/21, 95% of those in need will start treatment for an eating disorder within 1 week if urgent and 4 weeks if non-urgent. In Leeds we have been monitoring our local Eating Disorders service in line with these targets (see section below 'Community based Eating Disorder Service') and the team continue to meet these requirements.

In line with recommendations from the Five Year Forward View for Mental Health, NHS England, NHS Improvement and other Arms-Length Bodies have agreed an outcome indicator for children and young people's mental health drawing on learning from the CYP Improving Access to Psychological Therapies (IAPT) transformation programme. It has been agreed to focus on reliable improvement in symptoms, functioning or other relevant domains for those accessing services as part of a suite of indicators to help assess impact of services.

In order for the Future in Mind: Leeds Programme Board to be fully assured that our work across the partnership is making a difference a Future in Mind Partnership Dashboard has been developed (Click here). This is reported every quarter to the Programme Board.

The Future in Mind HOPE Outcomes Framework has been developed (Click here) by the HOPE steering group. This Outcomes Framework enables us to ensure that services are meeting the needs of children and young people and that they are delivering services that reflect the priorities that sit within our Local Transformation Plan. The group are responsible for the Future in Mind: Leeds dashboard, which will be reported quarterly to the programme board to give a useful oversight on delivery against key performance indicators.

Finally a Yorkshire and Humber Outcomes Data Dashboard has been developed to demonstrate the impact of Future in Mind on our children and young people, which is also taking into consideration data from across systems and not just health. The intention of this is to provide a picture at Yorkshire and Humber, Sustainability and Transformation Plan/Integrated Care System and CCG/Provider levels.

Child and Adolescent Mental Health Service (CAMHS)

The Leeds CAMHS has recently undertaken significant work to reduce the waiting times for children and young people accessing the service, notably for those waiting for an Autistic Spectrum Disorder assessment. However the demands on the service continue to grow (in line with the national position). In the last two years demand has increased by 70% across pre-school and school age for autism assessments. These are appropriate referrals as 80/90% of them convert to diagnosis.

At the end of June 2019 waiting times were:

	Number of Patients Waiting	Average Wait Time (Weeks)
Autistic Spectrum Disorder Assessment	168	38.4
Next Steps (formally Consultation Clinic)	114	9.2

The service are making further improvements including the launch of a Neurodevelopmental (ND) Pathway that will group children with both a query around Autism and/or ADHD (Attention Deficit Hyperactivity Disorder) in addition to other complex ND needs, into one ND pathway. This is of benefit as children previously were assessed in the initial Next Steps clinic before waiting for either an ASD or ADHD assessment and then could wait a further length of time before moving on to the next assessment pathway. This pathway delivers a timely and streamlined patient

experience with less duplication. The challenge at the moment is that there are children in the 'old' pathways as well as in the new neurodevelopmental one.

In light of this increased service demand and dual running of 'old and new' pathways additional funding is being allocated to the service to provide additional capacity for assessments to be undertaken within the ND pathway notably Autism assessments.

Community based Eating Disorder Service

The creation of a distinct community based eating disorder (ED) service for children and young people was a key priority for the first year of the Leeds Local Transformation Plan. The initially ring fenced funding allocation created the opportunity to enhance and transform the existing service into one citywide team. We continue to monitor this service based on the national performance targets. The team consistently meet the targets set in the Access and Waiting Time standards where all young people are seen within 4 weeks of referral if routine, 5 calendar days if urgent and 24 hours if emergency. Any breaches of these targets have been in relation to patient choice.

Eating Disorder Wait Times
Summary of Waiters from Eating Disorder Service Quarterly Submission

-4 week target for routine (non urgent) referrals
-1 week target for urgent referrals

Quarter 1 2019-20 (01-April-19 to 30-June-19)

		Wait in Weeks												TOTAL	% of waiters seen within target
Priority		**0-1**	**1-2**	**2-3**	**3-4**	**4-5**	**5-6**	**6-7**	**7-8**	**8-9**	**9-10**	**10-11**	**11-12**	**12+**	
Routine	Completed pathways (episodes started in Period)	2	8	4	3		2								**19**	89.5%
	Incomplete pathways (waiters as at 30-June-19)			1	3										**4**	100%
Urgent	Completed pathways (episodes started in Period)														**0**	-
	Incomplete pathways (waiters as at 30-June-19)														**0**	-

% Routine waiters seen within target	91.3%
% Urgent waiters seen within target	-
% of all waiters seen within target	91.3%

Notes on waiting time target breaches:

Patient choice applies to breaches of wait time target:

Completed pathways (episodes started in period):

5-6 week waiter: Family called to cancel appointment booked for April-19 (2.9 week waiter at this date)

5-6 week waiter: DNA appointment booked in March-19 (2.6 week waiter at this date)

Future developments

We continue to work as a system to ensure that children, young people and their families are able to access support as quickly as possible.

In response to the digitally changing landscape and feedback from young people we have commissioned XenZone to provide Kooth online counselling for children and young people. Since its launch in December 2018 we have seen a steady rise in registrations. We will review demand in line with capacity to inform our commissioning intentions from 2020 onwards.

The launch of the ability for parents and young people to directly contact MindMate SPA for advice, support and if required a referral into a service will facilitate children and young people to be able to access support in a timely manner. Further developments of the MindMate SPA model will also provide support additional capacity for early brief intervention.

Finally through the review of our Crisis response to children and young people in Leeds we plan to develop a response that is locally based within existing provision supported by a strong community CAMHS response. This will allow for those who are experiencing crisis to receive the appropriate support they need at the time the crisis occurs. Leeds CAMHS are working to develop a model that will allow them to be able to provide an emergency and crisis response for children and young people presenting in mental health crisis within the national four hour target.

4: Children and Young People's Voice

Young people's voice and influence has been central in our Future in Mind: Leeds developments. This has been in guiding and shaping services, information and systems. Our relationships with children, young people and families are ongoing and their engagement is actively encouraged. We do this through different mechanisms to reach as many different Children and Young People as possible through;

- Our MindMate Youth Panel which currently has 70+ online members including many active members who attend regular meetings
- The MindMate Ambassador peer-led work programme
- A quick suggestion box on every MindMate page and an interactive feed on the MindMate Blog
- Regular contact with relevant parents who help us develop and approve content for other parents and carers across the MindMate site
- Working with Children and Young People and parents on specific local digital innovation projects e.g. the Happy Vault app and MindMate2U Digital Information Prescriptions
- Linking with many other vulnerable groups of Children and Young People in the city, e.g. Willow Young Carers and the Care Leavers Council to make sure they are part of the conversations.
- Actively involving the Ambassadors in our procurement of new services

Our engagement and coproduction activities for Future in Mind: Leeds 2018/19 (click here) and 2019/20 (click here) give a flavour of the volume and breadth of our engagement with children, young people and parents/ carers on an ongoing basis.

Children and Young People helped shape the priorities in the Local Transformation Plan in different ways, from designing, approving and steering the content on MindMate.org.uk, to advising on developing our crisis offer and being embers of the Teen Connect steering group. They are involved in scrutinising the plan and asking what impact it is having. We have our young-person-friendly Future in Mind: Leeds Plan 'quick guide', which was designed by our youth panel for a young audience (and everyone else!) https://www.mindmate.org.uk/resources/future-mindleeds-quick-guide/

here (2015) and here (2017) are two consultation reports produced in partnership with HealthWatch Leeds. They give in-depth insight into the experiences of young people, their families and the staff who provide mental health services within the local offer. Various young people helped steer this process, including designing surveys, co-facilitating workshops, inputting and analysing the findings. Young people also helped us draft and present the recommendations from these reports - all of which have been formally responded to by commissioners and key providers. These reports have been key in the shaping and refreshing of our Local Transformation Plan.

A new development suggested by our youth panel is the MindMate blog platform - written by young people for young people, which encourages social media shares, comments and conversations. MindMate has published almost 40 blog posts to date.

Finally - the MindMate Real Stories micro site has been getting a lot of media attention and winning national awards. The idea is to have relatable young people on there with real but hopeful stories - and the interactive platform means you can pull off relevant information at key points of the films. Children, Young People have co-designed this platform with the digital design team – find out more here. https://vimeo.com/279676895/efc17e0fba

Best Practice

Involving Ambassadors in our procurement

Rachael and Gage (two of our MindMate Ambassadors) were involved the procurement of the Young Peoples Social, Emotional and Mental Health service. Here are their thoughts on the process.

"The process involved exploring the range of questions as part of the procurement; after breaking down these sections within the service specification and we selected each a handful of evaluative questions which we would be focusing on.

Once the tenders had submitted, we rated the response against the award criteria independently. This was a great experience for me, as the questions I had selected talks about the practical nature of the service, but also about the future-proofing and continual improvement and means to adapt with time. This is something I'm very passionate about, and felt important to be involved with as a young person who is affected by the service.

Overall, I found the experience to be interesting from a procurement process - and I continue to be incredibly thankful that the tender was opened to allow young people's consultation on the future of the mental health service." Gage

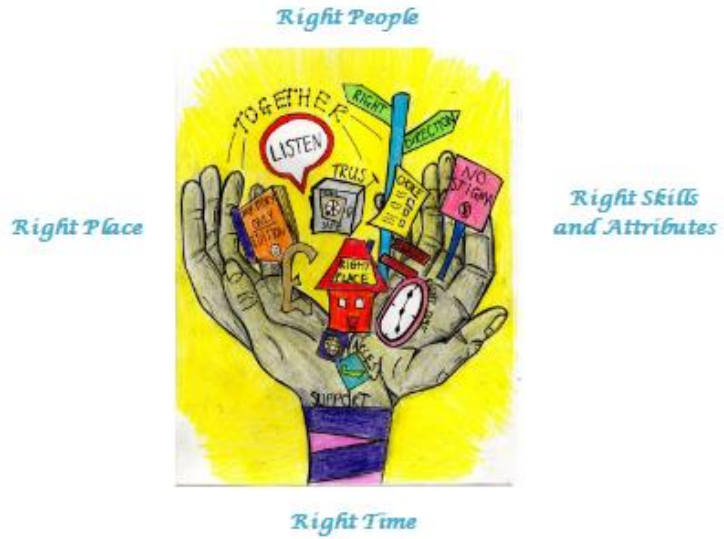
"At the start of the process we discussed the outlines and what needs to be imputed, before the tender evaluation began. Gage and I were involved in the process as he has explained above.

I found the experience to be insightful into how it all works and I'm thankful to of had the opportunity to be involved in it" Rachael

5: Strategic Workforce Plan

This strategic workforce plan was developed last year and the development and delivery of this plan sits with the HOPE group (Harnessing Outcomes, Participation and Evidence). This is a well-established partnership group that reports to the programme board and is supported by CORC.

Developing a Workforce Strategic Plan for Delivering Future in Mind: Leeds Strategy and Local Transformational Plan



5.1 Background

With the Leeds Future in Mind Strategy and Local Transformation Plan 2016-2020 already in place a need was identified to develop a workforce strategic plan to support their delivery and implementation. The purpose of the workforce strategy is to ensure there is an articulated plan that ultimately enables Leeds to work towards having the right people, with the right knowledge, skills, experience and attributes, in the right place at the right time in order to improve the social, emotional, mental health (SEMH) and wellbeing of children and young people aged 0-25 years.

An essential element of the workforce strategy is that it is inclusive of the wider range of providers in the Leeds SEMH services for Children and Young People (CYP) across the system (i.e. health, local authority, and voluntary and education sectors) and that it articulates how these agencies can work together in an integrated and systemic way. It is acknowledged that many people are involved in making a positive difference to the mental health of children and young people; this strategy recognises the role early help, targeted and specialist services have in supporting the universal workforce and settings in Leeds and the contribution the wider system makes in supporting prevention and self-care.

In many ways the strategic direction for children and young people's mental health services has been mapped out at a high level through a series of national policy and guidance documents including the most recent Government's Green paper on 'Transforming Children and Young People's Mental Health Provision'; noting that Leeds has applied to be a trailblazer site in implementation of elements of that latter policy. At a regional level Health and Care Partnerships Plans are viewed as providing the local vehicle for strategic planning, implementation at scale and collaboration between partners. At a local level there is a recognition that SEMH services for Children and Young People in Leeds sit within a wider system and that changes within this system, including at a workforce development level, will need to be taken into account in the implementation of this strategy. In developing this strategy it is acknowledged that a considerable amount of work has already been undertaken both in terms of service and workforce development and that the task focused more on drawing already existing data into a strategic plan/ framework. In addition to the desk top review it was agreed to capture and collate the views of a range of the key providers on the workforce challenges and opportunities presented in delivering the Leeds Future in Mind Strategy.

Due to the changing landscape and architecture of the system at various levels, including a local review of the commissioning of the SEMH Clusters offer for 2019, it is recommended that this workforce strategy is reviewed and refreshed in a timely fashion and on a regular basis to ensure it remains current and continues to act as an enabler to the Leeds Future in Mind Local Transformation Plan. Whilst the various strategies refer to a timescale of 2020/21 it is acknowledged, with particular reference to workforce that a longer term, integrated health and care workforce strategy that recognises the longer term nature of training and career pathways for some posts and in attracting young people to work in health and care in the future would be invaluable but needs to be balanced with some short term goals.

5.2 Why and what we need to focus on

Half of all mental health problems have been established by the age of 14, rising to 75% by age 24

Leeds future prevalence = predicted increase in overall disorders and common MH disorders in CYP of approx. 1.2% to 29,200

National

Future in Mind (March 2015), Five Year Forward View for Mental Health (February 2016), Green Paper Transforming Children and Young People's Mental Health Provision (December 2017)

Focus on working in partnership to:

- Involve children and young people and their carers in making choices
- Promote resilience, prevention and early intervention
- Improve access to effective support – simplifying structures, dismantling artificial barriers and developing a system without tiers
- Care for the most vulnerable
- Demonstrate

Vision- "Developing a culture where talking about feelings and emotions is the norm, where it is acceptable to acknowledge difficulties and to ask for help and where those with more serious problems are quickly supported by people with skills to support those needs"

Leeds LTP Priorities

1. A strong programme of prevention that recognises the first 1001 days of life impacts on mental health and wellbeing (Best Start Plan)
2. Build knowledge and skills in emotional resilience and to support self-help
3. Deliver local early help services for CYP with emotional and mental health needs who require additional support
4. Commit to ensure there is a clear Leeds offer of support and services available and guidance on how to access these
5. Deliver a Single Point of Access (SPA) to include assessment and initial response for referrals that works with the whole Leeds system of mental health services to enable CYP to receive the support they need, as soon as possible.
6. Use an integrated approach to ensure vulnerable CYP receive the support and services they need
7. Ensure there is a coherent city wide response to CYP in MH crisis
8. Invest in transformation of specialist education settings to create world class provision.
9. Work with CYP who have mental health needs as they grow up and to support their transition into adult support and services.
10. Establish city wide CYP community eating disorder service with national standards and access targets
11. Improve the quality of our support and services across the partnership through evidence based interventions, increased CYP participation &

5.3 How we need to do it – Expectations and Principles

There is a national vision for everyone who works with children, young people and their families to be:

- ❑ Ambitious for every child and young person to achieve goals that are meaningful and achievable for them
- ❑ Excellent in their practice and able to deliver the best evidenced care
- ❑ Committed to partnership and integrated working with children, young people families and their fellow professionals
- ❑ Respected and valued as professionals

The Leeds Children and Young Peoples Plan: In a Child Friendly City…

All children and young people are safe from harm
All children and young people do well at all levels of learning and have the skills for life
All children and young people choose healthy lifestyles
All children and young people are happy and have fun growing up
All children and young people are active citizens

Children and young people themselves have a clear and consistent view about the skills, qualities and behaviour they would like to see in the SEMH workforce:

- A workforce that is equipped with the skills, training and experience to best support children and young people's emotional and mental wellbeing
- Staff who are positive, have a young outlook, are relaxed, open-minded, unprejudiced, have a judgement-free attitude and are trustworthy
- Behaviour that is characterised by fairness, a willingness to listen, to empathise, to trust and believe in the child or young person
- Everybody should work from a basis of asking and listening, being prepared to be helpful in creating understanding among other members of the workforce
- The workforce should provide real choice of interventions supported by enough resources to follow through, whilst remaining honest and realistic

5.4 Workforce related achievements / strengths

Training Partnerships and Delivery eg:

- Infant MH training programme: Babies, Brains and Bonding (completed by over 2,000 H&SC professionals)
- MindMate Champion subsidised training offer
- Training Programme for Universal staff in schools
- Child Wellbeing Practitioner training
- Restorative Practice Training
- Health Coaching Programme Training
- Applied Suicide Intervention Skills Training
- Early Intervention in Psychosis training programme
- Numbers of staff completing CYP IAPT courses
- Delivery of workshops to local area/clusters promoting evidence base, participation and value of outcome monitoring
- CEDS-CYP specialist team training
- Training Programme for Young People Champions

Digital Solutions to support clinical work eg:

- StepUP App (CAHMS)
- Contributions to the Baby Buddy App (IMHS)

Having psychologists based in the TSWT has been seen as positive

"National recruitment has been an issue with some occupational groups but locally recruitment has improved in areas previously challenging eg Social Work.

Wellbeing workers – provide early intervention prior to the need for qualified counsellor

Development and Implementation of New Models of Care commencing eg

Good retention noted in many areas where permanent and longer term funding in place or good succession planning/career progression

Training Protocol Development eg

- Training protocols in place between CAMHS and acute paediatric settings
- Training protocols developed between new A&E MH practitioners and CAMHS

5.5 System Workforce challenges and priorities

Recruitment	Retention
▪ Challenges in some areas particularly where contracts are fixed term due to short term funding where the work environment is perceived to be more challenging eg inpatient areas. Difficult to recruit to some posts in Clusters ▪ Longer term contracts required to recruit quality staff ▪ Nationally 1,700 more therapists and supervisors needing to employed – requiring local recruitment initiatives. ▪ New Mental Health Support teams (Green Paper Proposal) *"Whilst recruitment of professionals may have improved there is still an issue about whether those people coming in have the required additional therapeutic skills to hit the ground running"*	▪ Good retention noted in many areas where permanent and longer term funding in place or good succession planning/career progression evident - Longer term contracts required to retain quality staff ▪ Noted potential 'retirement crises' in 2yrs time due to numbers able to retire at 55 yrs (Staff with MHO status) Cluster and targeted services leads noted to be leaving
Skill Mix/Diversity	**Supervision**
▪ CAMHS services still have relatively highly graded staff – what are the opportunities for a skill mix with lower banded registered staff and non-registered staff? ▪ Ensuring a the gender and ethnicity mix at service level is reflective of the local population - requires good system wide workforce data ▪ Skill mix in the Clusters is different in each Only 2 clusters have CAMHS in school staff, what roles are required and what are the roles that link universal and specialist services In complex cases in clusters but data disagrees – define complexity ▪ Creating a skill mix with the new roles being developed and using more widely across the system eg CWP in SPA, CYP IAPT and wellbeing workers to provide early help ▪ recognising the role of families and school workers eg Playtime supervisors and Dinner ladies ▪ MH specialists in each practice - Funding for MH Champions to promote/demonstrate good practice in GP surgeries	▪ Challenge of meaning, language and understanding - it means different things to different people (reflective practices, case management etc) ▪ Often/usual to be profession specific - would it be helpful to have intervention/therapy specific supervision available? (system wide) ▪ Challenge of fulfilling current need and future demand eg the Green Paper proposes that the new Mental Health Support Teams will be supervised by NHS children and young people's mental health staff and the expansion in therapists will required new staff to be trained and supervised by more experienced staff

Training, Learning and Development	Skills/Skill application and CPD
▪ The opportunities for cross sector/cross agency training and learning together are limited ▪ Training is not commissioned on a system wide basis but service by service ▪ There is no overall system view of the numbers required for which intervention or at what level ▪ The training undertaken is not always indicative of best evidence based interventions, there needs to be more use of evidence based training but cost is a barrier *"There are limited resources for training (feast or famine over the years) and in some areas it leads to more ad hoc or opportunistic training rather than longer term planning around needs and succession planning."* ▪ We need to train staff to have strategies to engage young people i.e. teachers to provide Early intervention earlier (Green paper proposal for designated MH lead in schools) ▪ Generic counselling is adult focussed – need to develop specific training courses with local FE/HE and provide placements that give students experience in CYP ▪ Maximising expertise in the system and working together more - Using expertise in system to train the trainer + key link for those with expertise	▪ Presenting issues from CYP are changing with more PD (regular self-harming) – this requires a different skills set ▪ A predicted change in the profile of CYP in Leeds shows the future prevalence for SEMH problems as a predicted increase in disorders in children reflected as an increase in the number of emotional, anxiety, conduct, hyperkinetic and autism spectrum disorders this will require more staff with the required skills to manage this. ▪ A wider skill set is required in the system including specific skills such as trauma informed training to support the drive for early help and interventions as well as more generic problem solving skills and effective questioning. ▪ The expectations of young people and to promote accessibility of interventions and information requires the workforce to be digitally 'savvy' - Exploring digital + Apps eg for GPs, HVs. NA ▪ More group work is needed - group work is perceived to have diminished as an intervention in some areas (eg parent groups stopped) *"Having people not just with a skill but a range of people with a skill at the right level is important - having a range of skills is difficult in small teams"* ▪ Agreement needed on the core skills set required for front line practitioners involved in SEMH services for CYP - what would that look like? ▪ Also a challenge of maintaining professional identity whilst understanding shared skills sets and the value of working together in a systemic way

5.6 Recommendations for action

These recommendations for action reflect the broad areas that will form an overarching system wide workforce strategy to support the ambitious aims of Future in Mind: Leeds. They reflect much of what is expected of SEMH services for CYP at a national, regional and local level and also reflect the views of SEMH CYP services providers, partners and practitioners in Leeds. Should these recommendations for action be accepted as the way forward, there is recognition that a more detailed programme of work will need to be developed with milestones, resource implications and ownership clearly identified.

Successful implementation of the strategy will require open mindedness, a genuine desire for change, commitment and enthusiasm to participate and collaborate across all partners.

5.7 Recommendations for short-term goals (Next 12 – 18 months)

- Develop a more robust system wide profile of the current workforce for SEMH CYP services (Universal, targeted/specialist and across providers) by starting to collect WTE, gender and ethnicity data across all key services (see linked LT goal).

- Explore the opportunity of having a local SEMH CYP voice at Leeds One Workforce group as it develops and to operate as a direct SEMH CYP workforce link with HEE

- Agreement on the core skills set required (core competences/competencies) for front line practitioners involved in SEMH services for CYP in Leeds (note one already developed nationally for CAMHS also review IAPT competences)

- Develop and establish cross sector/cross agency training, learning and development sessions starting with the 3 termly system wide events per annum coordinated by the Health and wellbeing Service

- Create and develop opportunities for leaders across the SEMH CYP providers to share and learn together, with a focus on SEMH system wide leadership and system activation. Action learning sets and Communities of Practice may also be useful to explore and work on common issues/challenges

- Agree a common definition/language for supervision (reflective practice/reflective case discussion) and develop system wide network of supervisors (allowing practitioners to access the most appropriate supervisor for their needs – which maybe based on therapeutic intervention rather than professional background)

5.8 Recommendations for Medium-term goals (18/36 months)

- A future focused and needs based system wide training needs analysis to be conducted, with the skills required, and at which level mapped against the skills audit that has already been produced by CORC

- Reduce the more ad hoc or opportunistic training and develop a longer term learning and development plan around CYP SEMH needs with clear levels of skill and succession planning built in and utilising expertise within the system.

- Develop a wider range of opportunities for cross sector/cross agency training, learning and development including opportunities to gain a greater understanding of each other's services through job swaps, experiential learning, secondments etc.

- Consider the opportunity for co-ordinated and co-commissioned system wide training of evidence based interventions – deciding and agreeing on how many staff across the system need to have which skills and to which level across services and the system. This will require a view from expert clinicians on which evidence based interventions should be prioritised across the SEMH CYP system.

- Develop a common system wide induction/induction module for all new starters in SEMH CYP services focusing on values and behaviours, core skills, understanding of other services and the system

- Develop specific CYP SEMH training courses with local FE/HE eg Counsellors, teaching assistants

    - Level 4 counselling courses
    - Consider developing a module to focus on

        - Working with YP
        - Spotting issues before they escalate
        - Equality and diversity
        - Working within a system

5.9 Recommendations for Long-term Goals (3 – 5 years)

- Develop a more robust system wide profile of the current workforce for SEMH CYP services (Universal, targeted/specialist and across providers) by developing/using a shared workforce information system (See Leeds One Workforce section 7.3.2) so data can be captured in the same way. Data collection needs to create a data set that delivers a meaningful workforce profile i.e. WTE/FTE, establishment and staff in post, age, tenure, gender, ethnicity, disability etc.

- Develop a needs/prevalence based view of what an ideal population centric and system wide workforce for SEMH CYP services for Leeds would look like. NB this requires partners to be open to exploring this from a system wide perspective to think about a workforce free of organisational boundaries that reflects the diverse nature of the local population. It is recognised that this will require further work on

developing a ‘service model’ for 0-25 yrs. This type of workforce modelling could be carried out using a tool such as WRaPT (Workforce Repository and Planning Tool), which enables data processing, modelling and visualisation of a workforce at a team, department, organisation and cross economy/system levels.

- Develop a co-ordinated approach to attracting, promoting and recruiting new entrants to Leeds SEMH CYP services, working directly with schools, colleges and universities (perhaps as part of Leeds One Workforce approach). Working particularly with Colleges to secure placements in CYP MH for student counsellors

- Develop career pathways across services including working with FE/HE to maximise the use of apprenticeships and higher apprenticeships and with employers to make best use of the apprenticeship levy (working with and through the WY Excellence Centre if appropriate)

6: Health Needs Assessment

Undertaking health needs assessment is central to planning and commissioning services. It is a vital tool to understanding the needs of the population as well as identifying assets and gaps in local provision. Analysis of patterns, causes and effects of health needs within defined populations along with stakeholder engagement determines current need and future provision. Findings from the health needs assessment(s) inform and drive future priorities and enable the targeting of resources to address inequalities. To date, three individual health needs assessments have been undertaken to support the development and ongoing refresh of the Future in Mind: Leeds LTP. These have supported a better understanding of the local issues relating to children and young people, young adults and perinatal mental health.

Findings from the children and young people's mental health needs assessment (2016), (Click here) has informed the development and annual refresh of the Leeds LTP. It indicates the need to continue to tackle the stigma associated with mental health, to improve knowledge of local services, to ensure online advice and support and equitable support for those children and young people who are particularly vulnerable to having SEMH needs. This latter recommendation informs priority 6 in our LTP where we set out our plans for ensuring we meet the needs of vulnerable children and young people in the city, such as those that have experienced abuse and trauma, e.g., those that are in the care system, of which there are currently 1280 (Oct 2018) in Leeds, children and young people in the criminal justice system, and those that have SEND.

The young adult's mental health needs assessment (2018), (Click here), shows an increase in levels of need of young women, which is compounded by service configuration, where we have a division between CAMHS and adult mental health provision. This creates a significant risk that young adults 'fall through the gap'. The report also highlights specific issues relating to transition for those young people with eating disorders, self-harm and personality disorders with recognition of a need for further work to understand the experience of young BAME people.

The Leeds in Mind 2017 perinatal mental health needs assessment (Click here), examines the needs of pregnant women/mothers and their infants during pregnancy and in the first year after birth. The report highlights limited national and local data leading to an under representation of the level of need. The report also noted that communication across mental health and midwifery and early start services required improvements and that there were gaps in provision between acute mental health and low level need interventions. These key issues have informed the development of the PNMH offer and pathway in Leeds and have lead to improving data collection, and have informed commissioning decisions.

Identified gaps and areas for action cotinue to steer key deliverables within the Leeds LTP. In response to a limited understanding of Leeds Black, Asian and Minority Ethnic (BAME) population needs, future work includes undertaking a BAME health needs assessment (currently in development). A refresh of the Children and Young People's health needs assessment, carried out in 2016, will be undertaken in 2019/20 to review changes across the City.

7: Issues and Risks to Delivery

Project/Aims: To highlight to the Programme Board key areas of slippage or risk in the workstreams of the Future in Mind: Leeds Local Transformation Plan (LTP).		**Expected Outcomes:** • To ensure that there is a whole system view of risks and mitigating actions that may affect implementation of the LTP. Risks will be updated at each programme board to identify those risks in need of escalation and action by Programme Board members. This will include projects of work where timescales have been significantly delayed. Risks that have been resolved will also be updated.		
Summary of key risks	**LTP Priority area (where applicable) and Lead**	**Risk score**	**Risk grade**	**Mitigating actions**
Sustainability of local early help offer given changes in national policy and investment.	Priority 3 – Jane Mischenko / Julie Longworth /Val Waite	12	3	• The current review of the cluster SEMH offer is the critical piece of work to address this risk and to strengthen the provision and sustainability of our early help offer. • Leeds CCG and Council are currently working closely with schools and clusters to establish a shared cluster model of support with aligned resource from all parties. The MindMate Champion programme co-produced with schools, the investment into subsidised training for school staff, the development of MindMate Lessons are significant mitigating actions we have taken to support and strengthen these key relationships in the city.
The whole system approach in Leeds is not visible through the NHS England new Key Performance Indicator (access trajectory of young people receiving support). The innovation of the early help offer through clusters is not captured in the MHSDS and there are many logistical challenges for submission.	Priority 3 - Jane Mischenko/Jayne Bathgate-Roche	8	3	• Work is underway to ensure the Market Place (third sector organisation) and the NHS funded element delivered by the clusters are able to submit their activity to the MHSDS in the forthcoming year. A number of pilots are in the process of being instigated to test new systems which will allow our providers to flow their data.

Recruitment risk in securing the workforce needed to deliver all of the transformational changes and new services in the city.	All	8	3	• There has been considerable effort to be proactive in Leeds in recruitment campaigns, promoting the exciting opportunities within our local Transformation Plan and in testing out new roles, such as the Children's Wellbeing Practitioner. The workforce strategic plan which has been developed will further strengthen our mitigation of this risk.
Waiting times in certain parts of the system are showing pressure.	All	12	3	• Waiting times across the system continue to be closely monitored. There have been targeted waiting list initiatives in cluster, 3rd sector and NHS. We are working across the system to develop initiatives to support those on waiting lists (i.e. Brief interventions in SPA and Kooth online counselling)
Whole system information sharing and join up cannot be achieved due to lack of inter-operability of information systems and data sharing challenges	Priority 3 - Jayne Bathgate-Roche Julie Longworth	8	3	• Looking at solutions through the HOPE group aiming to make outcome measures integral to agency information systems (e.g. current work with The Market Place to adopt the Child Outcome Rating Scale (CORS). • Work being undertaken by Social Finance within Leeds City Council should also provide solutions to this risk.

Impact	Likelihood				
	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
Insignificant 1	1	2	3	4	5
Minor 2	2	4	6	8	10
Moderate 3	3	6	9	12	15
Major 4	4	8	12	16	20
Catastrophic 5	5	10	15	20	25

Risk Grading		Priority	**Risk response:** Suggested management action
Critical Risk (20-25)	**Black**	1	Urgent Action required, introduce controls to mitigate (inc CCG Risk Register)
Serious Risk (15-16)	Red	2	Introduce strict controls to mitigate (inc CCG risk register)
High Risk (8-12)	Yellow	3	Monitor and maintain controls (via FiM Operational Group)
Moderate Risk (4-6)	Green	4	Monitor and manage(via FiM Operational Group)
Low Risk (1-3)	White	5	Monitor(via FiM Operational Group)

Leeds Health and Wellbeing Board

Report author: Georgia Blaney
(Project Officer, Health Partnerships)

Report of: Paul Bollom (Head of the Leeds Health and Care Plan, Health Partnerships)

Report to: Leeds Health and Wellbeing Board

Date: 16 September 2019

Subject: Leeds Health and Care Plan: Continuing the Conversation

Are specific geographical areas affected? If relevant, name(s) of area(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, access to information procedure rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. There has been significant engagement to date on the refresh of the Leeds Health and Care Plan (Leeds Plan) with local people and elected members, which supported by local connections, assets and knowledge, have an invaluable role in helping us developing high quality, safe and sustainable health and care services in Leeds.

2. The connections and strong partnership working of the organisations who are members of the Health and Wellbeing Board have led to the development of a draft Leeds Plan.

Recommendations

The Health and Wellbeing Board is asked to:

- Note the engagement and progress to date in developing a draft Leeds Plan
- Provide strategic consideration and feedback on the draft Leeds Plan

1 Purpose of this report

1.1 In order for the Leeds Plan to continue to be responsive to the needs of the city, it was agreed at Health and Wellbeing Board (28 Feb 19) for a process of review and refresh to be undertaken. The purpose of this report is to respond to this request and provide an overview of the significant engagement to date which has supported its development.

1.2 A draft Leeds Plan will be a late supplementary appendix to this report. A summary of the contents of the Plan will be provided in this report.

2 Background information

2.1 We want Leeds to be the best city for health and wellbeing and be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest. The Leeds Health and Wellbeing Strategy is our blueprint for how we will achieve that. Working together as a joined up health and care system is essential to reducing health inequalities, promoting inclusive growth and tackling climate change.

2.2 Our Leeds Plan sets out the transformational actions that our health and care partnership will take to help realise our ambitions. It is owned by the Health and Wellbeing Board (HWB) with delivery delegated to the Partnership Executive Group (PEG).

2.3 The refreshed Leeds Plan aims to build on what we have done well and respond to the changing local, regional and national contexts as highlighted in previous papers to the Board. As such the refresh will include our Leeds response to the NHS Long Term Plan. The refresh is wholly aligned with the development of the West Yorkshire and Harrogate Health and Care Five Year Strategy (which sets out a whole ICS response to the Long Term Plan). The draft West Yorkshire and Harrogate Health and Care Five Year Strategy is also on this Board's agenda.

3 Main issues

3.1 There has been significant engagement which has supported the development of the refreshed Leeds Plan since the HWB in February 2019. We recognise and value the significance of ensuring peoples' voices are at the very heart of all we do and remain fully committed to actively listening and working with people in developing our plans and we are providing more opportunities for people to do so.

3.2 In drafting our refreshed Leeds Plan we analysed the feedback that we have received from local people through various engagement platforms and a summary of this analysis, in line with the Leeds Plan priorities. This will also be provided in the supplementary appendix alongside the Plan narrative published as a late item. Recent examples of engagement include:

3.3 *Big Leeds Chat*

Understanding the assets and preferences of local people is essential to developing high quality, safe and sustainable health and care services in Leeds. The Big Leeds Chat was the first time that organisations in Leeds have come

together to listen to local people, as one system. People were connected to senior decision makers and Leeds Plan Senior Responsible Officers, many of who are members of the HWB, to listen to their views. The themes raised through the listening event cover both health and care related issues and wider determinants of health, such as education and housing.

The next Big Leeds Chat will be held on 7th November 2019 to ensure that local people are involved in ongoing conversations about health and care in Leeds and we continue to hear people's views and this shapes the way we plan, design, deliver and evaluate our services.

3.4 *Healthwatch Report, 'What would you do'*

Led by Healthwatch Leeds, Healthwatch's latest report #whatwouldyoudo gives insight into what people in West Yorkshire and Harrogate think about the NHS Long Term Plan and key areas such as digital, mental health, prevention, urgent care, children and young people's health and more. People's voices captured in the report have shaped the West Yorkshire & Harrogate 5 year strategy for health and care and the Leeds Health and Care Plan.

Healthwatch colleagues reached over 1,800 people and coordinated over 15 focus group sessions across the region with seldom heard people from different groups such as those with mental health conditions, dementia and carers, LGBTQ, disability, faith groups and young people.

3.5 *Ward Conversations*

Elected members, supported by local conversations and data, have a diverse and invaluable role in connecting the power of the community for local solutions to health and care challenges. This is why conversations were convened by Cllr Charlwood (Chair of HWB / Executive Lead Member for Health, Wellbeing and Adults) on a ward by ward basis. Local health data was reviewed and discussed and members shared how health and care feels in their wards.

3.6 *Community Committees*

A strength in Leeds is our commitment to regular local community and democratic engagement. That is why we have engaged all ten Community Committees (local meetings led by elected members) during June and July 2019 on the Leeds Plan to date and the refresh. These were attended by senior health and care leaders alongside a local GP representative to talk about health and care in their locality. From these we know that an approach of linking elected members to the emerging Local Care Partnerships was welcomed and some common themes were identified including access to GPs and Mental Health Services and the link between healthcare services and the wider determinants of health such as housing and green spaces.

3.7 *Developing our plans across the Leeds health and care partnership*

The value of our health and care partnership in Leeds lies in the diversity and inclusivity of all health and care partners, the connections, and the strong

relationships between us. To develop the refreshed Leeds Plan we have collaborated with our partners in the city regularly through a number of mechanisms. These include:

- Discussions at Health and Wellbeing Board (Feb and June 2019)
- HWB: Board to Board sessions (Mar and July 2019)
- Ongoing conversations at PEG, Integrated Commissioning Executive (ICE) and Leeds Plan Delivery Group
- Discussions at leadership groups of third sector leaders
- Leeds Plan Review Task & Finish Group that is representative of the wider partnership.
- A series of partnership wide workshops

Refreshed Leeds Plan

3.8 Through our conversations outlined above we have:

- Set out the Leeds Plan high level goals for the next 5-10 years.
- Developed greater clarity on the differences we are seeking from transformation through co-producing three obsession areas focusing on prevention, care closer to home and mental health.

3.9 Using what we learned we have developed a draft Leeds Plan narrative to describe the context of the Leeds Plan, the continuous improvement and transformational actions that will help us realise our ambitions and meet the commitments in the NHS Long Term Plan as a single health and care system in Leeds. The document will remain iterative and will be further designed and refined as our commitment to engagement with people continues.

3.10 The Plan sets the context for the an iteration of the Leeds Plan within a broader understanding of our challenges and opportunities as a city in relation to the Leeds Health and Wellbeing Strategy, Inclusive Growth and Climate Change within the framework of ensuring a sustainable Leeds The opening of the document brings together a number of conversations that have taken place to date to articulate our vision for Leeds in the future.

3.11 The Plan also emphasises the ownership of the Leeds Plan by the HWB and connections to the West Yorkshire and Harrogate Health and Care Integrated Care System (ICS). The Plan comprises one of six place based plans across the local authority areas within the ICS footprint. It is envisaged the majority of resourcing and change that the ICS promotes is facilitated through these local place based plans.

3.12 The heart of the plan restates our agreed health and care system principles and sets out our goals, our approach, the focussed action we will take to accelerate transformative change and the enablers required to support sustainable change. As a result of the actions we will take, it describes how transformed services will look in 3-5 years' time and the measures we will use to tell if we are improving outcomes for the people of Leeds.

3.13 The plan captures our requirements for service change. In an appendix to the Plan there will be a more extensive local response to the NHS Long Term Plan. It should be noted there is no requirement for this to be submitted to either the ICS by any partner to NHS England/ Improvement, but is an important statement of Leeds' intentions. Not least in helping project what are the ICS and local options and proposals to invest the NHS budget uplift associated with the Long Term Plan.

Governance and progress reporting

3.14 The refreshed Leeds Plan will require updated governance arrangements to support its implementation which will continue through PEG delegation. These arrangements are in discussion and will be brought forward in full to a later HWB meeting.

3.15 Work is currently ongoing to explore a more flexible and targeted approach to governance which builds on the current governance arrangements in the city. Proposals will therefore agree a reporting approach for specific projects with a series of deep dive discussions. Overall progress monitoring will be supported through an agreed dashboard and a system wide plan will be introduced and maintained outlining what will be happening and when. Impact measures (our 'obsessions' approach) will be provide regular data feedback on progress on key measures in the context of a wider suite of operation indicators. Ongoing feedback on people's journeys of care will be integral to this in line with CQC recommendations.

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

4.1.1 As referenced in section 3 significant engagement has been done to support the refreshed Leeds Plan. Fuller details will be provided in the supplementary appendix when published. Further engagement will be done throughout Autumn 2019 to further design and refine the plan with people and partners. There is a timeline for continued engagement with partnership strategic boards including subsequent meetings of this Board. There are also engagements planned with partners Boards and leadership groups.

4.1.2 A programme of public and staff engagement is in development based on the Big Leeds Chat as an opportunity to listen and align the Plan with public views.

4.1.3 Following from previous engagements with Community Committees further public facing community workshops are planned in some areas. Further joint development is planned between Elected Members and Local Care Partnership leads (comprising local GPs).

4.2 Equality and diversity / cohesion and integration

4.2.1 We are committed to working with people every step of the way, listening to the voices of those who experience inequality, and using the strengths of communities, services and our wider partnerships to respond accordingly.

4.3 Resources and value for money

4.3.1 The Leeds Plan demonstrated how we will work together across health, care and community organisations to focus resources where they can make the biggest difference. We are committed to using our collective buying power and resources to get the best value for our Leeds £, to enable a sustainable, high quality health and social care system fit for the next generation.

4.4 Legal Implications, access to information and call in

4.4.1 There are no legal, access to information and call in implications from this report.

4.5 Risk management

4.5.1 Risk will be managed through existing partnership board / groups of the Leeds Plan with escalation occurring the PEG and HWB as appropriate.

5 Conclusions

5.1 To focus on ensuring robust engagement across the health and care partnership, not all the information to complete the draft version of the refreshed Leeds Plan will be in place at the time of publication of papers for HWB (16 September 2019). This cover paper will be followed by the draft Leeds Plan as a late supplementary appendix.

5.2 Following strategic steer from the Board on the draft Leeds Plan we will further develop and engage with wider partnership stakeholders on the draft Leeds Plan throughout autumn to ensure the plan fully reflects and is owned by our health and care partnership.

5.3 We have a commitment to developing shared priorities which provide additional focus on the citywide partnership between Leeds Plan, Inclusive Growth, Poverty, Children and Young People and Safer Leeds.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Note the engagement and progress to date in developing a draft Leeds Plan
- Provide strategic consideration and feedback on the draft Leeds Plan

7 Background documents

7.1 None

THIS PAGE IS LEFT INTENTIONALLY BLANK

How does this help reduce health inequalities in Leeds?
The Leeds Plan enacts the Health and Wellbeing Strategy ambition to reduce health inequalities through transformation actions aligned to that purpose. The NHS Long Term Plan response in Leeds is framed within a clear partnership understanding of reducing health inequalities and for people who are the poorest to improve their health the fastest.

How does this help create a high quality health and care system?
The Leeds Plan provides an agreed basis for transformation and system change in which shared partnership ambitions and roles are described and agreed collectively and publically. The Plan supports the development of clearer measures of quality and reporting which increases partnership assurance of high quality experiences for people using services.

How does this help to have a financially sustainable health and care system?
The Leeds Plan provides a shared approach which agrees investment opportunities and supports collective partnership projection of financial risks and their management. It supports an approach of aligning financial incentives across commissioners and providers. It promotes creative investment in evidence based actions that reduce the proportionate usage of higher cost interventions.

Future challenges or opportunities
The Leeds Plan has a positive aspiration for improving outcomes for citizens in Leeds through jointly agreed changes to our health and care system. Our challenge is to ensure that the Plan is "real" and guides commissioning, financial investment, partnership development and staff communications to make the changes outlined in the Plan.

National NHS and Social Care strategy and funding continue to change with Government policy. Most pressingly the Social Care Green Paper promised shortly by the Government will have a significant impact on our understanding of available resources in the partnership and their likely medium term direction. The Spending Review will have implications across NHS and local government funded services and for children there are consequences for changes in education funding.

Priorities of the Leeds Health and Wellbeing Strategy 2016-21	
A Child Friendly City and the best start in life	X
An Age Friendly City where people age well	X
Strong, engaged and well-connected communities	X
Housing and the environment enable all people of Leeds to be healthy	X
A strong economy with quality, local jobs	X
Get more people, more physically active, more often	X
Maximise the benefits of information and technology	X
A stronger focus on prevention	X
Support self-care, with more people managing their own conditions	X
Promote mental and physical health equally	X
A valued, well trained and supported workforce	X
The best care, in the right place, at the right time	X

Leeds Health and Wellbeing Board

Report author: Ian Holmes / Rachael Loftus:

Report of: West Yorkshire and Harrogate Health and Care Partnership

Report to: Leeds Health and Wellbeing Board

Date: 16 September 2019

Subject: Development of the WYH 5 Year Strategy for Health and Care

Are specific geographical areas affected? If relevant, name(s) of area(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, access to information procedure rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. The West Yorkshire and Harrogate Health and Care Partnership is developing a 5 Year Strategy for health and care in response to the NHS Long Term Plan. The 5 Year Strategy describes the actions that partners will take jointly at the West Yorkshire and Harrogate level that will complement and enhance the actions that partners are committing to at Leeds level, through the Health and Care Plan.

2. The WY&H 5 Year Strategy and the Leeds Health and Care Plan are designed and developed to work cooperatively together for the benefit of the health and wellbeing of the people of Leeds.

3. Comments and feedback from the Leeds Health and Wellbeing Board on this draft are sought to help to further refine the content of the plans and the relationship between them.

Recommendations

The Health and Wellbeing Board is asked to:

- Provide comments and feedback on the draft 5 Year Strategy
- Note the timescale and process for the further refinement and sign-off of the strategy

1 Purpose of this report

1.1 The purpose of this paper is to present a draft of the narrative of the West Yorkshire and Harrogate Health and Care Partnership Five Year Strategy and to describe the process for further developing and refining it.

2 Background information

2.2 On 7th January 2019 the NHS Long Term Plan (LTP) or England was published. This set out the Government's ambition for how the NHS and its partners can respond to the challenge of planning future health services for England in the context of demographic changes, increased demand and the overall environment of finite public sector resources.

2.3 The NHS Long Term Plan includes the commitment that every Integrated Care System in the country will develop a new 5 Year Strategy for Health and Care.

2.4 At the end of June 2019, NHS England/NHS Improvement (NHSE/I) published the NHS LTP Implementation Framework that set out their expectations on what needs to be included in the 5 Year Strategies.

2.5 At the WY&H HCP Partnership Board on 4th June, the direction was set by all partners, that whilst we are committed to fully meeting the expectations set in the Implementation Framework – our commitment to each other as partners, is to set a 5 Year Strategy that first and foremost works for the benefit of the 2.7 million people who live in West Yorkshire and Harrogate.

2.6 All partners were clear that it is our strategy and it will reflect our priorities and our way of working. And that this will include:

2.6.1 **A System Narrative**: to describe how we will deliver the required transformation activities to enable the necessary improvements for patients and communities as set out in the NHS LTP.

2.6.2 **A System Delivery Plan**: to set the aggregate plan for delivery of finance, workforce and activity, and setting the basis for the 2020/21 operational plans for providers and clinical commissioning groups (CCGs). The system delivery plan will also cover the NHS LTP 'Foundational Commitments'. This relates to the NHS components of the strategy.

2.7 During the spring and early summer, our existing WY&H programmes have been working to refresh their objectives and it was agreed that we would develop new WY&H programme on Children, Young People and Families, and expand the existing prevention programme into a new Improving Population Health programme.

2.8 The process to develop the WY&H 5 year Strategy has worked in collaboration with the planning for each of the 6 Places that make up the WY&H partnership area (Bradford District and Craven, Calderdale, Harrogate, Kirklees, Wakefield and

Leeds). Some areas have made small changes to their existing health and care partnership plans, and other places, like Leeds, have taken the opportunity for a more substantial refresh of their local health and care plan.

2.9 In common with most ICSs around the country, the WY&H Partnership estimates that approximately 80% of the work of partners is arranged around either neighbourhood or Health and Wellbeing Board footprints. As such, we only work at the bigger footprint when it makes sense to do so, and that it passes at least one of the three subsidiarity tests: work that needs critical mass, has unacceptable variation or is classed as a "wicked issue." We consistently refer to the WY&H Partnership as the servant of place.

2.10 Therefore, the Leeds Health and Wellbeing Strategy 2016-2021 continues to set the context for how the WY&H Five Year Strategy and the refreshed Leeds Health and Care Plan will work together and deliver for the people of Leeds, including the ambition to be the Best City Best City for Health and Wellbeing and to improve the health of the poorest the fastest

2.11 The Health and Wellbeing Strategy firmly situates the health of the whole population in the wider context of all the factors that determine healthy lives – not just the collective actions of the health and care providers in the city or region. Therefore the sister strategy, the Inclusive Growth Strategy for Leeds and the development of the new regional Local Industrial Strategy, continue to be key to delivering on these ambitions.

2.12 Both at city wide level and in the bigger regional geography, it makes sense to work together with other partners to direct our collective resources to dealing with the multiple interlocking factors that promote good health for everyone - access to green space, strong communities, decent housing and the kind of inclusive growth that expands employment and opportunity for all.

2.13 Through the influence and advice of Health and Wellbeing Boards the development of the WY&H Five Year Strategy has been done with this ambition central to it and running throughout.

2.14 Getting this relationship right between local and regional health and care partners remains one of the highest priorities for the WY&H Partnership, and as such, the role of local Health and Wellbeing Boards is pivotal.

3 Main issues

3.1 Part of our WY&H commitment to working in Partnership at ICS level is to ensure openness and transparency about how our plans are developed and iterated.

3.2 The draft document attached as an appendix to the report is the first draft of the system narrative, and this was first published on 27th August 2019 as part of the WYH Partnership Board papers.

3.3 It incorporates the updated priorities from each programme and builds on the existing work of our Partnership to date. It also incorporates a first draft of our

new priorities on improving population health and children, young people and families.

3.4 Leeds Health and Wellbeing Board is asked to contribute comments and feedback on this first draft which we will continue to further refine and develop in the coming weeks ahead of an expected publication date in December 2019.

3.5 There is a range of work still to be done as we further develop the document, specifically:

Further engagement in place

3.6 There is further work to do to engage with each place on the draft contents of the document. We will continue to engage with each of the 6 Health and Wellbeing Board through to autumn.

3.7 All Leeds partner organisations and their boards will receive the draft document to review and comment and a number of public facing engagement activities are scheduled – including the Big Leeds Chat.

Strengthening programme content

3.8 The programme content generally strong, but in some cases further work is needed to quantify and specific ambitions over the five-year period. Wherever possible, we need to demonstrate this clearly. We also need to ensure that we are fully building in the main messages from the engagement report coordinated by Healthwatch for West Yorkshire and Harrogate.

Cross-checking against the NHS Long Term Plan Implementation Framework

3.9 The NHS LTP Implementation Framework includes a number of specific asks of Integrated Care Systems. The majority of these are covered by our programmes, but some of the specifics requirements are not yet adequately addressed in our written plans, so we will continue to work this through in our programmes.

3.10 We anticipate further feedback from NHSE/I following submission of our draft plan to them on 27 September 2019.

Case studies

3.11 In line with our 'Next Steps' document (published in February 2018) we will use case studies to illustrate how these priorities are being taken forward across all the places that make up our WY&H footprint. A number of these are included in the draft as an example, and we are keen to use the very best to ensure there is a good spread across places.

3.12 Leeds Health and Wellbeing Board is invited to suggest any further good examples for case studies to illustrate our partnership progress to date.

Planning Timetable

3.13 The latest version of the timescales we are working to is included here for reference.

Milestone	Date
WY&H Partnership Board consider approach to developing the 5-year strategy	3 June 2019
Engagement with Health and Wellbeing Boards (HWBs)	June/July/August 2019
Publication of the NHS Long Term Plan Implementation Framework	27 June 2019
Main technical and supporting guidance issued	c. 26 July 2019
WY&H Partnership Board to consider draft system narrative	3 September 2019
Engagement with place through HWBs	Through September 2019
CCGs and Trusts submit draft strategic planning tool templates	6 September 2019
WY&H programme teams and sector groups to review strategic planning tool submissions and provide feedback to place leads	13 September 2019
CCGs and Trusts submit second draft strategic planning tool templates	20 September 2019
WY&H and place level aggregations of strategic planning tool	23 September 2019
Initial WY&H system plan submission	27 September 2019
Regional assurance of WY&H submissions	Through October 2019
Further refinement of WY&H strategic narrative	Through October 2019
WY&H to consider strategic narrative and system plan	5 November 2019
Strategic narrative and system plan submitted to NHSE	15 November 2019
WY&H Partnership Board to consider final system narrative and publication date	3 December 2019
Publication of the national implementation programme for the NHS Long Term Plan	December 2019

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

4.1.1 As partnership, we are committed to meaningful conversations with people (specifically including staff), on the right issues at the right time. We believe that this approach informs the ambitions of our Partnership - to work in an open and transparent way with communities' something that we have reiterated in all plans to date: initial STP Plan, November 2016; 'Next Steps', February 2018.

4.1.2 We are committed to continuous effective public involvement in our work and specifically to working to include those voices that are seldom heard. We believe that is the best way to ensure that we are truly making the right decisions about our health and care services.

4.1.3 There are numerous ways in which we ensure that public / patient voice is consistently "in the room", for example through public representation on our boards, continual engagement with existing reference/advisory groups, opportunities for public questions at meetings, ensuring that people's stories are embedded in all our decision making, events and focus groups. We have written more about this on our website here.

4.1.4 We have lay member and voluntary sector representation on our WY&H programme boards, for example improving planned care, stroke, maternity as well as a patient public panel for the work of the Cancer Alliance. We are currently in the process of recruiting a lay member representative to our digital programme for the Partnership.

4.1.5 We publish engagement reports of findings from all the Partnership's events and rely on our local partners to ensure representation from their local areas in all such activities. Everyone receives a copy of the report to help with their local insight and intelligence.

4.1.6 Engagement and consultation mapping reports are produced with the support from local communication and engagement leads. These composite reports provide rich intelligence and can identify key emerging themes as well as identifying where there may be gaps both locally and at a WY&H level.

4.1.7 In all communications and engagement activity, we work on a local level and tailor our messages and methods accordingly to each individual group to ensure we maximise all opportunities for connecting with, informing and engaging with our target audiences at a community level. This means making the most of community assets / organisations / champions and resources at a local level in order to reach everyone. This also helps to ensure there is a coordinated approach and that we are not 'getting in the way' of valuable local work.

4.1.8 Our Communication and Engagement Network has over 100 representatives from our six local place areas. It meets every three months and includes Healthwatch, voluntary and community organisations, such as Macmillan, all NHS organisations, commissioning and community organisations including NHS England and Public Health England, all eight councils, the Academic Health Science Network, and Leeds Academic Health Partnership.

4.1.9 Local communication and engagement leads are sent updates every week so they have the opportunity to share views and have advanced awareness of communications and engagement work taking place across the area. This helps to ensure their expertise is considered in advance of any communications being published and/or any engagement activity.

4.1.10 Specifically, for the development of the 5 Year Strategy, as a partnership we have worked with Healthwatch and engagement leads from across partner organisations.

This included over 1,500 people across WY&H completing survey and a series of focus groups aimed at seldom heard groups of people, as well as some condition specific focused work including Cancer and long term conditions.

4.1.11 The combined WY&H Healthwatch groups collated this feedback into an excellent report, published here WY&H Healthwatch Engagement Report, in June 2019 that is being used by all Programme to cross reference feedback against the plans we are developing.

4.2 Equality and diversity / cohesion and integration

4.2.1 The NHS Long Term Plan and specifically this first draft of the WY&H 5 Year Strategy makes consistent and explicit reference to addressing health inequalities – the unjust and unwarranted differences in health outcomes based on age, ethnicity, gender, class or socio-economic status.

4.2.2 Our 5 Year Strategy includes the intention to specifically monitor our progress as a partnership against these health inequalities and to take specific action to addressing the barriers to equitable health and care for all people who live here.

4.3 Resources and value for money

4.3.1 In June 2018, the government set out the funding increases that NHS England would receive between 2018/19 and 2023/24. In real terms this equates to a real terms increase of £20.6bn for England, an average of 3.3% per year. This rate of increase is below the historic average of 3.7% per year, but is above the average growth rate across the last decade of 2.1% per year.

4.3.2 Local Government budgets have fared significantly worse over this decade. Public health grants have fallen significantly since 2012. Social care spending has fallen across the country by 5% in real terms since 2010/11 and despite recent increases, spending was around £1bn less than in 2010/11, at £17.8bn. The government has yet to set out long-term funding plans for social care.

4.3.3 The NHS LTP proposes to achieve better outcomes by focussing the additional funding on the key areas of mental health, and primary and community services. The national expectation is that spending on mental health services will rise by £2.3bn over the next five years (4.6% per year), while spending on primary and community health services will rise by £4.5bn (3.8% per year). Funding for these areas will therefore grow at a faster rate than the overall NHS budget. This national policy requirement is in line with our WY&H local ambition to invest differentially in mental health and learning disability services, and primary and community health services.

4.3.4 However, this results in a challenge to other areas of NHS activity, particularly hospital-based services, which will see lower growth in spending despite having to tackle the needs of a growing and ageing population with increasingly complex health needs.

4.3.5 The NHS LTP Implementation Framework also identifies two additional sources of transformational funding which will be allocated to support the commitments in the NHS LTP, as well as previous requirements from the Five Year Forward View; these are in addition to the published five-year CCG allocations. These are:

4.3.6 Indicative Transformational Funding (up to £1.8bn for the NHS by 2023/24) – this is being made available to all systems for commitments in the NHS LTP which apply across the country, and funding is to be distributed on a fair shares basis to each ICS / STP, and between four different categories: mental health, primary care and community services, cancer, and 'other'. The table below breaks down the funding by category.

4.3.7 Targeted Transformational Funding (up to £1.5bn for the NHS by 2023/24) – this is money to fund targeted schemes and for specific investments, where a general distribution is not appropriate.

4.3.8 The level of indicative funding that is expected to come to WY&H over the next five years is £26.7m in 2019/20, rising to £83.5m in 2023/24. At a summary level, the values are shown below:

Category (£m)	2019/20	2020/21	2021/22	2022/23	2023/24
Mental Health	2.9	3.1	10.5	21.1	28.3
Primary Medical and Community Services	16.7	18.6	21.2	27.6	33.6
Cancer	5.5	4.1	3.2	3.1	3.1
Other	1.7	1.8	4.3	6.2	18.5
LTP funding allocation – Total	**26.8**	**27.6**	**39.2**	**58.0**	**83.5**

4.3.9 The level of indicative funding that is expected to come to WY&H over the next five It is not clear the level of targeted funding that may be available to the ICS, or the bidding processes to access this. We will provide further information when it is available.

4.4 Legal Implications, access to information and call In

4.4.1 At this stage there are no legal implications for the Health and Wellbeing Board specifically relating to the 5 Year Strategy.

4.5 Risk management

4.5.1 At this stage there are no significant risk implications for the Health and Wellbeing Board specifically relating to the 5 Year Strategy.

5 Conclusions

5.1 The First Draft of the 5 Year Strategy specifically aims to address many of the ambitions set out by all 6 Health and Wellbeing Boards for the strategic delivery of better health and care for the people who live in West Yorkshire and Harrogate – this includes looking at the factors that drive health and healthy lives as well as improving the services and support for people living with ill health.

5.2 The first draft of the 5 Year Strategy is intended to complement and enhance the work being done on the Leeds Health and Care Plan.

5.3 Through sharing this first draft, all partners and places are being asked to contribute ideas and views to ensuring that subsequent drafts further improve

6 Recommendations

The Health and Wellbeing Board is asked to:

- Provide comments and feedback on the draft 5 Year Strategy
- Note the timescale and process for the further refinement and sign-off of the strategy

7 Background documents

None.

THIS PAGE IS LEFT INTENTIONALLY BLANK

How does this help reduce health inequalities in Leeds?
The 5 Year Strategy will specifically target its efforts at reducing the health inequalities experienced by different socio-economic, disability, geographic and age related groups.

How does this help create a high quality health and care system?
Working together to learn from best practice will reduce unnecessary variation in outcomes and improve clinical and social work practice across the Partnership.

How does this help to have a financially sustainable health and care system?
Shared ambitions and focusing our collective resources to where they can have the biggest impact, will alleviate pressure in some of the most stressed parts of the system. Long term, the focus on reducing health inequalities, targeting prevention and working with partners on the wider determinants of health will contribute to a greater financially sustainability.

Future challenges or opportunities
The benefits of an Integrated Care System, with a well articulated 5 Year Strategy, that complements and enhances local place systems are manifold. However, the delay in the publication of the Green Paper on Social Care means that continued uncertainty on the long term resourcing of social care, as a significant partner in the integration of the Health and Care system, is a risk for the success of the whole system.

Priorities of the Leeds Health and Wellbeing Strategy 2016-21	
A Child Friendly City and the best start in life	X
An Age Friendly City where people age well	X
Strong, engaged and well-connected communities	X
Housing and the environment enable all people of Leeds to be healthy	X
A strong economy with quality, local jobs	X
Get more people, more physically active, more often	X
Maximise the benefits of information and technology	X
A stronger focus on prevention	X
Support self-care, with more people managing their own conditions	X
Promote mental and physical health equally	X
A valued, well trained and supported workforce	X
The best care, in the right place, at the right time	X

This page is intentionally left blank

West Yorkshire and Harrogate
Health and Care Partnership

D R A F T 1 [27 August]
Five Year Strategic Plan

[Better Health and Wellbeing for Everyone / Planning for the Future Together – title to be decided]

Contents

Front inside cover

Take a look back at some of the improvements West Yorkshire and Harrogate Health and Care Partnership has been making with local people to improve their lives in our short **film**.

We also want to say **'thank you'** to all the people who've shared their stories and given their views about health and care in West Yorkshire and Harrogate and for their contributions to this Plan.

We are committed to honesty and transparency in all our work and also producing information in alternative accessible formats. This Plan is also available in:

- Audio
- EasyRead
- BSL

There is also a public summary which you can read here **[make link once produced].**

You can get involved in the Partnership's work by:

- Tel: 01924 317659
- Email: westyorkshire.stp@nhs.net
- Visiting www.wyhpartnership.co.uk
- Twitter @wyhpartnership
- **[Text: xxx]**

Foreword

[To include: signature/s. Produce foreword in film / animation]

Stronger, better, healthier together

Since our Partnership began in 2016, we have worked hard to build health and care relationships locally and across West Yorkshire and Harrogate so we can improve people's lives with and for them.

We are pleased with the start we have made. The right principles and values are in place to guide us and we are keen to make sure we join the dots so when people experience care, advice and support it feels easier and is joined up for the better.

We know that more needs to be done to give everyone the very best start and every chance to live a long and healthy life. When you read our Plan, you will see why this is very important.

To have the greatest chance of achieving the very best for people's health and wellbeing, we need to think and work differently with each other and within our communities.

We are including more community partners in our conversations and are listening better to what staff and local people have to say. Now is the time to take this to a whole new level so that everyone in West Yorkshire and Harrogate is part of our journey.

Our Five Year Plan tells the story of how we are going to do this together. It is also our response to the NHS Long Term Plan.

Our campaign 'Looking out for our neighbours' is a great example of how our staff, partners and communities are already making a positive difference through simple acts of kindness – we are stronger, better, and healthier together. They have touched the lives of over 46,000 people. You can read the evaluation report here.

Proud to be a partnership

We are happy to be working together in our six local areas (Bradford District and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield) and are proud to be part of the West Yorkshire and Harrogate Partnership. Our relationships are very important to us because we will only make a positive change when there is a strong commitment by all to do so and there is.

We have already come a long way and our journey continues to break down the organisational and geographical barriers that sometimes get in the way of giving people the best care possible. As partners we are having better conversations with one another.

We do however, need to get better at talking with people about what they want and need. Our conversations with communities will continue to grow; they often know far better than us what keeps them happy, healthy and well.

Together we want to reduce unnecessary costs, by stopping things that don't meet people's physical and / or mental health needs together or make them feel any better. We need to rethink how we can continually improve and free up money to re-invest in our community partners. There are some great examples in this Plan to show you what we mean.

We also want to make the best use of staff time and make West Yorkshire and Harrogate the best place to live and work. This is very important to us all.

Our story

This Plan belongs to us all; it covers neighbourhood activities, rural communities, busy towns and vibrant cities. Above all it sets out what we need to do in our local areas and how our Partnership will help through working together.

When reading our Plan what we hope you will see is a shared goal, to make life better regardless of where people live and their life experiences. Everyone is valued and we want to make sure equitable opportunities exist for all.

Reaching further than ever before, we not only want to keep people safe and well; we want them to be happy too. Connecting people to places and local neighbourhood activities; working with communities to make healthier choices and breaking down feelings of loneliness which harm our health.

Making the most of every opportunity, our Plan will embrace fully what our Partnership and communities have to offer. It will also set out our approach to new technology and how this can make a positive difference to our staff's work and people's lives.

We are equal partners

Regardless of where people work, we are partners. Whether you are a community champion, receiving health and care support, attending local wellbeing activities, recovering from an illness, or caring for someone you love, we are equals. There are no boundaries. We are in this together.

Why work together?

People's lives are better when we work together to provide health and social care along with physical and mental health support. We also know that sharing good ways of working makes the money go further. It also creates the best use of staff expertise and importantly gives children the best start in life whilst improving people's chances to live a long, healthy life in their homes and communities.

We are connectors

Our role is to join things up locally and at a West Yorkshire and Harrogate level, to connect organisations and individuals in ways that make better care easier - whether this is delivering services in the home at hospital or putting people in touch with local groups for support. We also want to enable people to take action and improve their own health and wellbeing.

Health and care is more than about services

There are so many factors in keeping people well that are just as important as traditional health and social care services. This includes the house you live in, how warm it is, whether people feel isolated or alone, whether you experience financial or fuel poverty, the food you eat every day, how mobile and independent you are, whether you have a job and have access to parks.

We are challenging traditional ways of working so we see the whole person's needs rather than their stand-alone illness. Listening to people, asking them what they want and acting on what works for them is a good place to start. We have been doing a lot of that. Between us all, we have the power to change things for the better as part of one team. Our Plan sets out our intention to do just that.

Executive summary

[To be done last thing once all partners have contributed, made comments, approved etc. Info graphic format once document draft signed off. Include a map of the area].

[To include] In 2018 the government announced that the NHS budget would be increased by £20 billion a year in real terms by 2023/24. In January 2019, the NHS in England published a Long Term Plan for spending this extra money. This covers a broad range of areas, including making care better for people with a learning disability, cancer, heart failure and mental health conditions, investing more money in technology and helping more people stay well.

Partnerships like ours, also known as integrated care systems (ICS) and sustainability transformation partnerships (STP), have been tasked with developing a Five Year Plan. This Plan will set out how we will achieve the ambitions of the NHS Long Term Plan for the 2.6million people living across West Yorkshire and Harrogate with the money we have available.

[To include: summary of the more outcome-focussed five year ambitions in info graphic format].

This Plan sets out what we are going to do together at a West Yorkshire and Harrogate level over the next five years and beyond. It aims to complement the work taking places in our six local areas and does not replace the local plans.

Our vision

[To do: amend vision circle include the 56 PCNs]

Content page

[To be done last thing]

About our Partnership

Introduction

[**In a box** – list partners, info graphic of the number of people living across our area (2.6million people) with a £5.5b budget. Add in box health inequality stats and figures. Add Healthwatch report front cover. Add map].

What is an Integrated Care System?

West Yorkshire and Harrogate Health and Care Partnership is also known as an 'Integrated Care System' (ICS). An ICS is given flexibility and freedoms from government in return for taking responsibility, for the delivery of high quality local services. **Throughout this Plan we will refer to ourselves as the Partnership because we believe this describes what we do more clearly.**

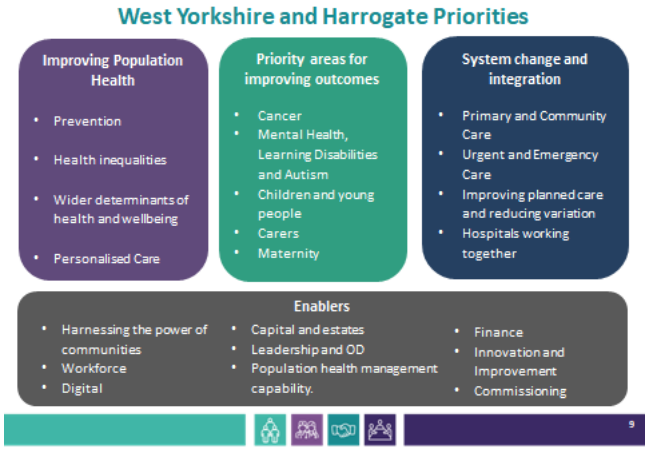
Our staff, partner organisations, six local places, and communities are the integrated care system. Our six local places are:

- Bradford District and Craven
- Calderdale
- Harrogate
- Kirklees
- Leeds
- Wakefield

West Yorkshire and Harrogate Health and Care Partnership focuses on the health and wellbeing of local people living in these six places.

The Partnership is not the boss of the partners, it is their servant. And this is crucial. It allows the power and energy to remain aligned to statutory accountabilities and to be given to the Partnership when it matters. The reality is that without our local partners working together, including housing, public health, education, and community organisations, none of us would be able to tackle any issues alone.

As a Partnership, we agreed that we need to address three gaps across West Yorkshire and Harrogate: health inequalities, differences in care people receive, and financial sustainability. In order to do this we agreed to work at a West Yorkshire and Harrogate level on the following priority areas of work (please see diagram below). These important priorities and our five year ambitions are set out in this Plan. **[To do:** rework diagram].



[In a box]
We only work at a West Yorkshire and Harrogate level when one or more of the following three tests apply:

- **We need to work at scale to deliver the best care possible to people**
- **Examples of good practice can be shared across the area**
- **There is a complex issue that we all face and working together is likely to deliver better health and wellbeing results for people.**

Partners

The Partnership is made up of many organisations including the NHS, councils, Healthwatch, voluntary, and community organisations who work to provide the best health and care possible to the 2.6million people living across our area. This support is delivered by committed, dedicated staff; unpaid carers and volunteers. It includes a health and social care workforce of over 100,000 people.

We have 56 Primary Care Networks (also known as Primary Care Homes / Communities: see page 40) seven local care partnerships, and eight councils.

We also work with hundreds of other organisations, including the Police, West Yorkshire Fire and Rescue Services, independent care providers and charities. Watch our short animation to find out more here **[To do: once produced].**

This is our five year plan

This Plan is our response to the NHS Long Term Plan. It sets out the work we will do over the next five years together at a West Yorkshire and Harrogate level and how we plan to achieve the ambitions we have for everyone working and living across the area. It does not replace the plans of our six local places.

- Bradford District and Craven
- Calderdale
- Harrogate
- Kirklees
- Leeds
- Wakefield

[To do: Make links to local plans].

We are proud of the 'Positive difference our Partnership is making' yet we are not complacent. There are some big challenges around rising, unmet health and care needs and significant barriers to better health and health inequalities we need to address. This Plan sets out how we will work with our communities to achieve our ambitions. **[To add: image of case studies].**

Our ultimate goal is to put people, not organisations, at the heart of everything we do so that together, we meet the diverse needs of all communities.

This means at all levels of the Partnership:

- **We are working to improve people's health with and for them and to make life better**
- **We are working to improve people's experience of health and care**
- **We want to make every penny in the pound count so we offer best value to the people we serve and to taxpayers.**

Our healthcare services are treating more people than ever before, providing better services faster, safely and in better environments, as well as supporting more people to live at home independently. This is after all what we all want.

Most importantly we are working locally together with people in our six local places to give them the best start in life and the opportunity to live and age well, whilst working hard to tackle health inequalities we know exist for various reasons (see page 24) for more information about how we work).

We are proud to be the home to many world leading new treatments delivering care to people at the forefront of technology. For example, surgeons at Leeds Teaching Hospitals NHS Trust made history in 2018 by performing the UK's first double hand transplant in a female patient in the UK. In many areas, we are leading the way to develop a culture of innovation across health and care organisations - you can see many examples throughout our Plan.

Despite facing the most significant challenges in health and social care for a generation, we are addressing these issues head on and working to better meet people's needs in care homes, hospitals and communities.

Demand for services is growing faster than resources, and we must keep innovating and improving if we are to meet the needs of people to a consistently high standard.

The current adult social care system is under unprecedented strain. There are increasing demands, especially due to the ageing population living with a number of health conditions and increasing numbers of adults with significant learning disabilities and mental health illness.

The social care sector has experienced many years of under investment. Most care is provided by a huge number of independent sector providers and there are issues across the sector with market stability, quality and workforce shortages. There is also evidence that an even greater burden is falling on unpaid carers.

The delays in publishing the long awaited 'green paper' on the future of adult social care has led to a succession of short term funding announcements and a lack of clarity over long term planning. This Plan has been developed in this context, and we recognise that the publication of the 'green paper' and the subsequent policy changes should have a significant impact on this Plan.

From our conversations with local people (find our more here) and a recent West Yorkshire and Harrogate Healthwatch report (June 2019), we know that people want things to be better, more joined up so organisations don't work against each other, and care is more suited to individual need (see page 40).

People with lived experience, staff, carers and volunteers who deliver care are the experts, they know what works well and doesn't in their local areas. It is also essential, that the voice of staff, all communities and people from seldom heard groups are involved in the planning of services, for example people with learning disabilities. Our Plan sets out our commitment to ensure this continues to happen over the next five years. You can see examples of how we plan to do this throughout our Plan.

We want West Yorkshire and Harrogate to be a great place to work and an outstanding place for care and support; whether in the community, in one of our hospitals or online. This commitment binds us together and we have a Partnership Memorandum of Understanding which sets this out clearly. You can find out more about the way we work on page 12).

Our Partnership is also based on the belief that working together and not competing for funding is the only way we can tackle these challenges. The only way is to put people, rather than organisations at the heart of all we do. It is also the only way we can maximise the benefit of sharing our expertise and assets we have, including staff, buildings and money.

We benefit from strong local partnership working in each of our six places and this is where most of our work with communities takes place and the majority of care is provided. Throughout this Plan, you will hear about how health and care services are being joined up to improve the support people receive locally and the added value brought by working together at a West Yorkshire and Harrogate level.

Case study
Leeds is the first city in the UK to report a drop in childhood obesity. The decline is most marked among families living in the most deprived areas, where the problem is worse and hardest to tackle. There is an opportunity to share and spread learning across West Yorkshire and Harrogate through our Children and Young People Programme (see page 69).

The importance of joining up services for people at a local level is at the heart of all our plans. This work is centered on the plans of local Health and Wellbeing Boards, which brings councillors, NHS leaders and community organisations together.

You can see an example of how this works at a West Yorkshire and Harrogate level through the work of the Partnership Board. This brings elected members, non-executives, and independent members into the decision making process. Over 70 representatives make up the Board, including Chairs of the local Health and Wellbeing Boards. The list of members is available here.

How we work

[In box]

We are entering a significant period for the health and care system, with the social care green paper imminent and the 'Advancing Our Health: prevention in the 2020s' green paper consultation document published in July 2019. The development of primary care networks is an opportunity to further improve care in every neighbourhood. Local Government funding, innovation, inclusive growth, and housing also all have a role in our future. There are risks around funding, capacity, staffing, and service pressures. We need to deal with these and be hopeful that national political choices will support our Partnership to meet the needs of local people.

Joining up services to improve the health and wellbeing of communities

In our communities, GPs, community nurses, social care workers, community organisations, charities, mental health services, pharmacists, and other care providers are working together to provide better joined-up services for people.

The new Primary Care Networks (also known as Primary Care Communities / Homes) are an important part of this because they build on local partnerships already in place (see page 40 for more information).

Primary Care Networks (PCNs) are often described as the 'front door of the NHS' providing people with community-based access to medical services for advice, prescriptions, treatment, or referral, usually through a GP or nurse.

It's important to note that our local place approaches go much further than this; to us it is all about communities, supporting carers and the work we do alongside community partners. We want people to be able to get care, information and advice on the full range of support available to them in their community easily and when they need it the most.

[Case study: need picture and sign off]
Cross Gates Leeds Primary Care Network
Nurse Andrea Mann is Clinical Director of the Cross Gates Leeds Primary Care Network (PCNs). The Cross Gates PCN is part of the East Leeds Collaborative (made up of three PCNs) with an approximate 95,000 population altogether or around 30-32,000 patients each. They work together to join up care more effectively to deliver new services. Andrea said: 'Over the next five years we could have a really wide range of workforce roles so patients will be able to access a variety of professionals for different health conditions. Where we have higher prevalence of, for example a specific long term health conditions, we can tailor the models of care and services available to those populations. We will also be engaging more with our patients, community services, third sector volunteers, social care, and patients; we will build relationships with organisations around our populations and start to see better care and outcomes for their personal needs as the models develop. There is so much we can do with it to improve the care for our patients across economies of scale. I'm keen to bring my skills to the table as a nurse leader, practice partner and from a management perspective to help shape the future of general practice.'

Working with our eight council partners (Bradford Metropolitan District Council; Calderdale Council; Craven District Council; Harrogate Borough Council; Kirklees Council; Leeds City Council; North Yorkshire County Council; Wakefield Council) and communities is central to this way of working. Primary Care Networks (PCNs) are key to the work in our communities on the wider determinants of health; for example, housing and health, poverty and employment. Our system leaders are very clear about this.

As the PCNs develop there will be a greater use of an approach called 'Population Health Management' (see page 28). Population health brings together an understanding of the health needs of a given population using big-data analytics, public engagement, and health and care insights.

Watch this animation from the Kings Fund (August 2019): What is a 'population health' approach? And what role do we all play in keeping our communities healthy?

PHM is important because it gives us the information we need to tackle a range of health and inequality issues and ultimately give us the ability to organise services around people, including those most disadvantaged. It also gives us the opportunity to engage with people on a wide range of health and inequality issues that affect them.

We know people's health is influenced by various factors and the interactions between them. This includes the conditions in which people live and work; social and economic factors like education, income and employment; lifestyles including what people eat and drink, whether they smoke, and how much physical activity they do; as well as the barriers they experience to accessing health care and other public and private services.

Age, sex and genes make a difference to health too, as well as social networks and the wider society in which people live. There is a lot of good work taking place across the area, for example the Born in Bradford research and we want to share good practice and spread learning across West Yorkshire and Harrogate (see page 12).

Jacqui Gedman, Chief Executive at Kirklees Council, and Sarah Roxby from WDH and NHS Wakefield Clinical Commissioning Group talks about the importance of good housing and health **in our film here.**

At a local and West Yorkshire and Harrogate level we are working hard to provide more personalised care for people, including greater take up of personal health budgets, peer support and social prescribing.

Social prescribing involves helping people to improve their health, wellbeing and social welfare by connecting them to community services which might be run by the council or a local charity. For example, signposting people who have been diagnosed with dementia to local dementia support groups.

The NHS Long Term Plan highlights the need to move towards a more personalised approach to health and care so that people have the same choice and control over their mental and physical health as they would have in any other part of their life. We want this way of working to become every day practice. Supporting people to be more knowledgeable, skilled, and confident in engaging with and managing their health care brings benefits for everyone (see page 34).

Daz from Wakefield explains the importance of personalised care and social prescribing **in this film.**

Local area partnerships

The number of people living in our six places ranges from 160,000 in Harrogate District to 785,000 in Leeds. In each of these places, councils, NHS organisations (including clinical commissioning groups who buy local health services), Healthwatch, and community organisations are working together to understand people's needs better. These local partnerships organise how they use their collective resources, including buildings and staff, to deliver better joined up care for people.

[Case study: picture to be added]
Living a larger life
Using creative activities to help people 'Live Well in Calderdale', is a partnership between Calderdale Council, South West Yorkshire Partnership NHS Foundation Trust, West Yorkshire and Harrogate Health and Care Partnership, Calderdale Clinical Commissioning Group, Creative Minds, and other creative organisations. The vision is to make Calderdale a leader in using arts and culture to support people's health and wellbeing, whilst tackling health inequalities. The mission is to enable people to engage in creative approaches so that they can live well in their community and achieve their potential.

[Case study: picture to be added]
Harrogate and Rural Alliance
Harrogate and Rural Alliance (HARA) is bringing together primary care, community health and adult social care in Harrogate, Ripon, Knaresborough, Nidderdale and the surrounding areas, covering a population of 160000 people. From autumn 2019, integrated community health and adult social care teams are working across four communities, wrapped around primary care practices, to prevent ill health and to provide joined up care. The NHS, social care, mental health, community organisations and independent care providers are working together as one multi-disciplinary team. The Alliance was established as a commissioner and provider partnership in the wake of the national New Models of Care programme demonstrator site in the area and in response to the local clinical commissioning group strategy, 'Your Community, your care: developing Harrogate and Rural District together' and the transformation of adult social care services to promote prevention and reablement of people following an illness or stay in hospital.

The whole approach links to the development of Primary Care Networks (see page 40) as part of community asset building. The five organisations leading the transformation are Harrogate and District NHS Foundation Trust; NHS Harrogate and Rural District Clinical Commissioning Group; North Yorkshire County Council; Tees, Esk and Wear Valleys NHS Foundation Trust; Yorkshire Health Network – working around the local Primary Care Networks.

HARA is taking forward the West Yorkshire and Harrogate priorities at 'place' level:

- **Improving health and well-being for everyone: HARA have developed a new model, anchored in primary care, based on prevention, planned care and unplanned care, optimising all available resource. A Population Health Management approach (see page 28) to frailty within the integration of community teams has been agreed as the first test piece in improving population health by identifying people at risk earlier and working with them to manage their care better, pre-empting and planning responses to future health crises that could result in an admission to hospital. HARA will facilitate a holistic approach by investing in improved care co-ordination; community health assets and workforce developments.**
- **HARA will ensure the person is at the centre of their care, and provide accessible, high quality services and information to make it easier for a person to make healthy choices and stay well. To be able to prevent ill health and move services closer to home, they have committed to working collaboratively across health and social care, and also with community partners, recognising that the workforce and communities are its greatest asset. A workforce and organisational development plan to engage with, empower and develop staff across the alliance is established. This includes development of the leadership, talent and workforce skills needed to provide services in community settings. Flexibility in service delivery will be achieved through the development of generic roles which can work across the system. They will be working jointly with the public as experts with experience, exploring opportunities to improve participation and co-production of services.**
- **The integrated teams will be a primary care network centred model (hybrid model between networks and geography). In addition, options to simplify access to urgent care within primary care are being explored.**
- **The HARA model recognises the need to harness assistive technologies in delivery of the new model. Data sharing agreements are progressing between providers. NYCC are an early adopter site for LHCRE which is seen as a solution for achieving a shared care record.**
- **The current estates model is being evaluated to improve the efficiency of team working across primary and community health and adult social care services.**
- **This new way of working will prioritise people's needs while managing demand effectively to deliver high quality services that offer value for money for the Harrogate £.**

Health and Wellbeing Boards are driving joined up health and social care and making sure that preventing ill health is at the heart of everything - helping to keep people well in the first place, rather than just managing ill health better. You can read examples of how Health and Wellbeing Boards are working with partnerships like ours, in a publication by the Local Government Association here.

[Case study: picture to be added]
The maternity services at the Calderdale and Huddersfield NHS Foundation Trust have been awarded Unicef's first joint The Baby Friendly Achieving Sustainability Gold Award – shared with their Locala partners. The services work together to provide parents across Calderdale with the best possible care to build close and loving relationships with their baby and to feed their baby in ways which will best support health and development. The UNICEF assessment of the service said: 'There is an excellent specialist service in place and there is evidence of integrated working within the community, to ensure that babies, mothers and their families receive seamless care. Of particular note is the peer support programme and Baby Cafes which are well evaluated and effective monitoring suggests they are helping to support a rise in breastfeeding rates'.

The large majority of hospital services will continue to be provided in each of our six local places. These hospital services will work seamlessly with primary and community services (primary care is the day-to-day healthcare available in every local area and the first place people go when they need health advice or treatment). Increasingly they will operate in networks with other providers across the Partnership to reduce the difference in care people receive, regardless of where they live.

[Case study: picture to be added]
Working together across West Yorkshire on vascular services
In 2018, West Yorkshire Association of Acute Trusts (hospitals working together) agreed it would be best for people needing vascular care if all vascular services in West Yorkshire (except Harrogate, who work with York Teaching Hospitals NHS Foundation Trust to provide vascular services for people in their area) were brought together into a 'single regional service' under one management team. This will create one of the largest vascular services in England covering a population of over 2million and with almost 40 specialist vascular consultants (surgeons and interventional radiologists). For people receiving treatment it will improve ease and equity of access to vascular services as well as continuity of care. Although our outcomes are very good, there are pockets of knowledge, expertise, and technical developments held in different unit across the area. We need to embrace the 'best' practice and share the skills and break down any organisational boundaries. Regional working as a single service should also work to importantly give people increased choice. If there is a long waiting list at one site for a certain type of procedure but a shorter wait on another site, we should be able to offer the person the procedure sooner by moving outside of organisational boundaries. [This will need to be updated following NHS E work].

[In a box]
The majority of our work happens in our six local places. This means we only work together at a West Yorkshire and Harrogate level where it makes sense to do so – where there are economies of scale, where expertise and skills can be shared and where it is better for the workforce.

Working at scale to ensure the best possible health outcomes for people

We know that for some complex services we need to plan and work across West Yorkshire and Harrogate to achieve the very best health outcomes for people. There are many examples of this in our Plan, including our work around hyper acute stroke (the care people receive in the first 72hrs after a stroke), vascular services, and cancer. Our work at a West Yorkshire and Harrogate level reflects the fact that very complex services should be provided in centres of excellence; and that hospitals need to work in close partnership with each other in networks to offer the very best care to people (see page 59).

[In a box]
Following extensive public and staff engagement it was agreed in 2018 that West Yorkshire and Harrogate would have four units to provide specialist hyper acute stroke care (the care people receive in the first 72 hrs. after a stroke.). These are in Bradford, Calderdale, Leeds and Wakefield. We agreed to create a stroke clinical network and improve quality and health outcomes across the whole of the stroke pathway for example preventing stroke; support after having a stroke; long-term care and end of life care. We aim to have a standardised 'whole pathway' stroke service specification across West Yorkshire and Harrogate – so that no matter where people live they receive the best quality care possible. We listened to over 2500 people over 18 months, including voluntary, community organisations, people who have had a stroke, unpaid carers, councillors and staff. You can find out more here.

Sharing good practice across the Partnership

We have a history of innovation across West Yorkshire and Harrogate; but we need to get better at sharing and spreading these new ways of working.

Working together means we can identify share and spread good practice across partners. For example we are making good progress on our ambition to spread 21 innovations, including preventing cerebral palsy in preterm labour (PReCePT). We met or exceeded these ambitions for 18 of those innovations and for six of them we exceeded our ambition for adoption 12 months earlier than expected. This included a medicines optimisation project and treatment for people with an enlarged prostate.

Our Partnership is demonstrating how open we are to innovation and how the whole system can work together with organisations such as the Yorkshire and Harrogate Academic Health Science Network (AHSN), Leeds Academic Partnership and the health tech industry (see page 99).

[Case study: add picture]
Reducing cardiovascular disease
Atrial Fibrillation (AF) causes devastating strokes every year with one in every 20 sufferers left with a life changing disability. Yorkshire and Humber AHSN has provided hands-on support to GP practices across Yorkshire and the Humber to improve their ability to detect people who have AF and protect them through anti-coagulation drugs. The AHSN has issued hundreds of mobile electrocardiogram (ECG) devices to facilitate testing across the region. Since April 2018 in West Yorkshire and Harrogate 1,500 patients have been identified as having AF with approximately 2,000 people receiving anticoagulation drugs. As a result of this, it is estimated that 81 people with AF in West Yorkshire and Harrogate did not have a life-changing stroke because they received protective medicines.

Yorkshire and Humber AHSN has also worked with Healthwatch Kirklees to make mobile testing devices available to its public engagement team. This included providing training for the team and creating information and sign-posting resources for members of the public who took the test. The AHSN also linked the Healthwatch Kirklees team to the British Heart Foundation, which provided information on AF and the importance of early identification of the condition, its impact on health and wellbeing and the type of treatments required to manage it.

We have some excellent examples of where this is making a positive difference to people's lives. For example we are sharing work from Bradford to reduce the number of people experiencing heart disease by 10% across our area by 2021 via our West Yorkshire and Harrogate Healthy Hearts Project. This would mean 1,100 fewer heart incidents by 2021.

[Case study: add picture]
Leeds researchers have been awarded £10.1m from UK Research and Innovation (UKRI) to expand a digital pathology and artificial intelligence programme across the North of England. The successful partnership bid was led by the University of Leeds and Leeds Teaching Hospitals as part of a network of nine NHS hospitals, seven universities and ten industry-leading medical technology companies, called the Northern Pathology Imaging Co-operative (NPIC). The cooperative is set to become a globally-leading centre for applying artificial intelligence (AI) research to cancer diagnosis.

Working together to tackle complex (or 'wicked') issues

As partners we share many common challenges, including health inequalities linked to wider determinants, and barriers to accessing care; threats to health and wellbeing from poor mental health and substance misuse and the availability of affordable social housing. Like many other areas we have financial pressures and challenges around staff recruitment.

As our Partnership develops we will take collective responsibility for financial and operational performance across West Yorkshire and Harrogate. NHS organisations have agreed to a financial framework which includes a single control total which means that NHS partners will take greater ownership of managing NHS money. In return we hope to be rewarded for delivering financial balance overall (see page 104).

Throughout this Plan you will hear more about the challenges we face, and importantly how we are going to work together over the next five years to make things better.

Re-thinking the care market

Care services (home care, residential and nursing homes and other services) are a pivotal part of the health and social care system: helping people to stay independent at home, and providing support in a 24 hour setting where they require greater assistance.

In the West Yorkshire and Harrogate area alone, in excess of £800 million [provisional figure] is spent annually by councils, the NHS and individuals who fund their own care.

As with the national picture, the care sector regionally faces a multitude of challenges ranging from: provider viability, variable supply, variations in quality, difficulties with workforce recruitment and retention (especially for nurses), and a fragmented and inadequate funding landscape. These issues when combined have created a system that is going to struggle to meet care needs of communities in the future. We are working already to address the short to medium term issues that are within their gift.

However beyond these issues, is a more fundamental question about what will people need in the future to support them to live a good life and how does the care sector evolve to enable this.

In this context, our Partnership has embarked on a piece of work to fundamentally re-think the care provision of the future. The intention is to look at short, medium and long term interventions that can be put in place to help manage the more immediate problems; whilst shaping a future vision for our care sector.

The early work across the partnership has identified the need to explore the potential of how the combination of taking an asset-based based approach to working in partnership with people and communities, alongside smarter use of housing and technology, and a more joined up approach to the health and social care workforce, can create a care sector that is fit for the future and helps us overcome the systemic, structural, financial and cultural issues that we now face.

Working in partnership with people and communities

[Case study: add picture]
Craven District Council worked with a local community group to upgrade the facilities in their local park (Aireville Park) in Skipton. They agreed a masterplan, which included a new pump track, skate-park and a really ambitious new play area. It was a far-reaching programme and one they could not have funded on their own. The Friends of Aireville Park raised money and applied for grants (which the public sector was excluded from), whilst relying on the council's procurement and project management expertise, as well as their negotiations with developers over contributions from s106 agreements to bring it all together. In just over three years everything has been completed and the play provision for tots to teenagers and beyond is vibrant, incredibly popular and well used. The whole project was a real testament to the power of community development and what can be achieved when we work together with our communities.

We know that hospitals and doctors not only keep people well. Where people live, their homes, the community environment, family support and the life choices they make are vital.

Working alongside our communities is therefore a crucial part of our Partnership – recognising people as equal partners who often know what keeps them well and happy much better than us.

The role of voluntary and community organisations, councillors and staff is essential if we are to improve health and wellbeing in our communities. The big long term challenge facing our public services is how they can help people to live well for increasing lifespans, avoiding or delaying the onset of long term health problems wherever possible, and effectively self-managing those conditions they do develop, where safe to do so. This will require a different kind of relationship with people and families, with support that reaches them earlier and in their homes and communities.

A key part of the work we do is around building trust with communities and groups who face barriers to equitable care.

We will continue to do this by listening to the views of people on what is important to them, and acting on what we hear. Our aim is to provide support to communities in a way that enhances community power.

We are committed to meaningful conversations with people on the right issues at the right time. Effective public involvement, particularly with those with lived experience and who are seldom heard, will ensure that we are truly making the right decisions about the planning of our health and care services. This approach is central to our communications and engagement strategy. [To do: make link to new one and easy read when produced].

Community conversations

We have refreshed our existing engagement and consultation mapping documents and are drawing on the wealth of other expertise via our West Yorkshire and Harrogate priority programmes and local place engagement networks to inform the development of our Plan. These include public assurance groups, patient reference groups, and community champions. We aim to maximise all our networks without duplicating effort and cost.

[Case study: add picture]

Our community/patient panel is just one of the ways in which West Yorkshire and Harrogate Cancer Alliance is working with those affected by cancer across our area, including patients, their families and carers. This helps to make sure their experiences and views influence the work we do and the decisions we take.

[In a box]

Our engagement and consultation mapping report captures intelligence collected from engagement and consultation activities carried out across West Yorkshire and Harrogate during the period January 2014 to March 2019. It also includes reference to any work stream specific mapping exercises that have taken place, for example mental health, and where available provides details of any issues raised by protected groups. This insightful report helps to ensure we don't duplicate effort and people's time - and most importantly points us to public conversations that have already taken place to inform our planning. We do of course do engagement work where there is a gap in knowledge and where we need to understand people's views more clearly, for example carers.

Over the past three years we have produced and published on our website all engagement activity we have been involved in. This includes:

- Digitisation and personalisation (June 2019)
- Mental health and learning disabilities (March 2019)
- Mapping of organisations for young people across West Yorkshire and Harrogate (July 2018)
- Audit of urgent and emergency care communication messages (July 2018)
- Review of engagement and consultation activity on elective care and standardisation of commissioning policies (March 2018)
- Communication needs for people with a sensory impairment (November 2017)
- Standardisation of policies (September 2017)
- Maternity services (August 2017)

Reports are produced following community engagement activity. These have informed the development of this Plan. Other engagement work includes:

- Healthy Hearts Cholesterol Public Engagement (June/July 2019)
- Young carers engagement event (25 June 2019)
- NHS Long Term Plan and Harnessing the Power of Communities showcase event (May 2019)
- Assessment and treatment units engagement for people with learning disabilities (February/March 2019)
- How the NHS Long Term Plan can support better outcomes for unpaid carers (April 2019)
- Our Journey to Personalised Care (February 2019)
- Developing the NHS Long Term Plan for the NHS (October 2018)
- Public involvement panel development (July 2018)
- Unpaid carers and primary care event (May 2018)
- Stroke stakeholder event (May 2018)
- Public involvement panel (April 2018)
- Public workshops on stroke (March 2018)
- Stroke care event (February 2018)
- A vision for unpaid carers (December 2017)
- Working with voluntary and community organisations (November and December 2017)
- Stroke services (April 2017)
- Follow-up appointments (April 2017)
- Urgent and emergency care (Autumn 2016).

You can view more here.

The Healthwatch engagement findings (June 2019) are also an important part of developing our Five Year Plan. The engagement report was discussed at our leadership meetings, including the Clinical Forum; West Yorkshire Association of Acute Trusts (hospitals working together); The Mental Health, Learning Disability and Autism Collaborative; and Joint Committee of the Nine Clinical Commissioning Groups; as well as the Partnership Board. Our priority programme colleagues are taking the findings seriously.

All of the above will help us to tackle the significant health needs and inequalities for people. You will see other examples of engagement work taking place and planned, when reading our Plan. Further community conversations will take place as our programmes develop their work further.

We are also working with learning disabilities partners and programme areas, including cancer, improving planned care, hospitals working together; and mental health, to develop a 'health champions' network of people with learning disabilities (read more here). Their role is to advise and help us talk to other people with learning disabilities so we can hear their views and experiences to improve care and support for them. This will give us the insight needed to deliver on some of our big ambitions.

[In a box]
In April and May 2019, the six West Yorkshire and Harrogate Healthwatch organisations engaged with over 1,800 people to ask their views on the NHS Long Term Plan and the Partnership priorities. As well as surveys, local Healthwatch colleagues coordinated over 15 focus group sessions across the area with seldom heard people such as those with mental health conditions; dementia, carers, LGBTQ, disability, faith groups and young people. Feedback on preventing ill health highlighted: *'more awareness for both children and parents of long-lasting problems from living an unhealthy lifestyle and the benefits of being healthier'.* People said they wanted to be: *'listened to, trusted and taken seriously as experts of their own bodies'.* This is central to our work to personalise health care and join up services. Working alongside partners, stakeholders and the public in the planning, design, and delivery of services is essential if we are to get this right'. You can read the report here.

[Case study: add picture]
More than 80 voluntary and community organisation representatives including Age UK, Bradford VCS Alliance, Touchstone, and Community First Yorkshire attended a Partnership event in Bradford in May 2019. The event aimed to raise awareness of the NHS Long Term Plan and how voluntary community organisations could get involved as equal partners. Workshops covered the development of the Partnership's community and voluntary sector plan and its focus on priority areas, including preventing ill health, cancer, mental health, urgent emergency care, supporting unpaid carers, and tackling health inequalities.

To find out how you can get involved in the work of the Partnership visit www.wyhpartnership.co.uk

Voluntary and community sector funding

In 2018 we allocated £1m to support our 'Harnessing the Power of Communities Programme'. Community and voluntary partners in our six places were allocated funding through their partnership work with local councils and the Health and Wellbeing Boards to help tackle loneliness and social isolation, which has a major impact on people's health and wellbeing.

Community organisations make a tremendous difference in their areas. Work in Bradford focused on befriending support to prevent ill health. In Calderdale, the money was used to support 'Staying Well' which takes referrals and supports/signposts people into local support organisations and groups. The funding was used to reach local communities and groups which either do not engage or have barriers to access.

In Harrogate the focus was on making the best use of existing community health assets, for example community health asset mapping and a district strategy and action plan to tackle loneliness and isolation.

Kirklees have brought together partners Better in Kirklees, Barnardo's Young Carers Service, LAB Project and Support to Recovery to deliver an 'arts on prescription' approach to men over 40 with mental health issues experiencing depression and worklessness.

In Leeds, Health Impact Grants have been given to third sector organisations working on tackling loneliness, carer support in helping people to remain independent, and reducing health inequalities. Wakefield has invested in Age UK Wakefield District to further support short-term, overnight/day support in times of crisis for people over the age of 65 in their own home, when hospital admission is inevitable due to lack of available carer support, or when they are unable to be discharged from hospital due to a lack of support at home. You can read more here.

[Case study: add picture]
When Mr and Mrs G moved home it resulted in them feeling lonely and isolated. Even though they live amongst a community, they miss their former neighbours. They now have regular one-to-one visits from New Horizons at Royd's which they enjoy. Their daughter says this support has proved invaluable. From the one-to-one sessions they have developed the confidence to join a befriending group and are taking part in exercise sessions in their own surroundings. They are developing new friendships and reminiscing around old Bradford, especially their old social meeting places and schools. They have become part of their new community'.

Watch these short films to find out how Julia, Salman, Steve and many others made a positive different to people in their local neighbourhoods through the 'Looking out for our neighbours' campaign.

[In a box]
To further enhance community asset approaches in our six places advocates are being trained to develop neighbourhood level engagement. Funded by the Partnership, each area received £5k to support local community building initiatives. This built on the work of the Harnessing Power of Communities Programme and Asset Based Community Development (Nurture Development). We worked closely with our communication and engagement colleagues to make sure that we were supporting existing community based work in our local places without duplication.

[Case study: add picture]
Building health partnerships
The aim of our collaboration with the Institute for Voluntary Action Research, through its Building Health Partnerships programme, has been to work with community and voluntary groups to improve the health of people in Calderdale and Wakefield. Each locality has focussed on a different initiative but both emphasise the importance of preventing ill health and self-care.

The project in Calderdale is focussing on conditions that lead to muscle and joint pain and how, through promoting good health and activity at an earlier age, people can reduce the early onset of such conditions. For the Wakefield project, the Partnership in collaboration with Wakefield Council's Public Health team, worked with its partner organisations, local people and voluntary groups to raise awareness of eye health. Half of all cases of sight loss are preventable and one of the key factors in preventing sight loss is having regular sight tests. Community groups were introduced to the Eyes Right Toolkit which is a simple tool designed to screen near and distant vision in adults that can be used by anybody. The toolkit is currently being used by Carers Wakefield which provides this free eye screening for some of the 36,000 carers in the area routinely as part of its support work.

This initiative is offering real benefits for local carers who often forget about their own health because they are too busy thinking about someone else's. We want to share this good practice wider.

Working in partnership with staff

Our Plan will only be delivered through staff. They are central to better health for people, whilst reducing inequalities, tackling unwarranted variation in care and managing resources.

We engage with staff at a Partnership, local place and neighbourhood level, depending on the issue. Most engagement takes place at local place or neighbourhood level. For example, in Calderdale and Kirklees plans for local changes to hospital services have been informed by both clinical and non-clinical staff.

All West Yorkshire and Harrogate priority programmes, such as stroke care, cancer and mental health, are informed by the clinical voice. The West Yorkshire and Harrogate Clinical Forum provides clinical leadership and expertise into all the programmes of work. It is supported by networks of nurses, allied health professionals and medical directors. For example our stroke programme was underpinned by clinical evidence from the Yorkshire and Humber clinical senate, and informed by a clinical summit in 2017.

Improving health and wellbeing for everyone

Preventing ill health

Improving health and wellbeing is at the heart of the Partnership and runs through all our priorities at a local and West Yorkshire and Harrogate level. We work together to help create the conditions for people to be healthy and to better understand the causes of ill health and wellbeing. This approach aims to improve the physical and mental health of people, whilst reducing health inequalities.

Working at a West Yorkshire and Harrogate level gives us the opportunity to build on the work led locally by Health and Wellbeing Boards and to consider what action we must take to improve health and wellbeing for people living here on a larger scale. Working as a Partnership also allows us to consider and influence the role that wider factors such as housing, employment, education, social networks and the environment have on people's health.

We will continue to work with, communities and organisations on the things which are key to being able to lead healthy lives - in doing so we will help people to have the best start in life, to be healthy into adulthood, to have more control over their health care and to age well.

We will work together to reduce the risk factors that cause ill health, promote earlier diagnosis and support people living with long-term health conditions to help them to be as healthy as they can be, reduce their risk of crisis, promote independence and reduce need for reactive care.

[Case study: add picture]
People with learning disabilities as health champions
People with a learning disability have worse physical and mental health than people without. On average, the life expectancy of women with a learning disability is 18 years shorter than for women in the general population; and the life expectancy of men with a learning disability is 14 years shorter than for men in the general population (NHS Digital 2017) We are working with

people with learning disabilities so they can become health and care champions for our priority programmes, including cancer, mental health, maternity care and hospitals working together. We are doing this by working with an organisation called Bradford Talking Media (BTM). Over the next 12 months they will help us identify health and care champions with learning disabilities from all equality groups. Their involvement will help us become more informed in their experiences of using health and care services and will inform and improve the way we plan services together. This Partnership approach is supported by councils and NHS organisations.

[In a box]
Poor housing and the impact on health is one area we have pledged to tackle together; it costs the NHS £1.4bn a year but by reducing excess cold to an acceptable level alone we could save £848m nationally and, more importantly, improve people's lives.

[In a box]
Reducing Violent Crime in West Yorkshire
West Yorkshire Police received £4million and West Yorkshire Police and Crime Commissioners have £3.5m to support their crime reduction unit programme to focus on reducing violent crime, including knife crime within West Yorkshire. Currently this is for 2019/20. This could potentially be for a three year programme based on the success of the Glasgow programme which has seen a reduction of 70% over the 10 years of its development. Funding is based on data available, including the number of hospital attendances/admission reported. There is concern that in West Yorkshire this is under reported. Areas for West Yorkshire have the 2nd highest rates outside of London. Discussions are taking place with public health colleagues around the best approach for West Yorkshire. Working together gives us the opportunity to address this.

Tackling health inequalities

Health inequalities are avoidable and unjust differences between people or groups due to social, geographical, biological or other barriers. These differences have a huge impact, because they can result in people who are worst off experiencing poorer health, shorter lives and who find it harder to get better.

In West Yorkshire and Harrogate the numbers of people smoking in routine and manual occupation groups is higher than people in other occupation groups; people living with mental health conditions are more likely to die prematurely and people living in our most deprived communities are less likely to receive hip replacement surgery.

A focus on reducing health inequalities will aim to address some of the preventable differences that contribute towards inequalities. Working as a Partnership we will consider differences in; risk factors for ill health, early diagnosis and screening and access to effective support – all of which contribute towards inequalities in health outcomes**.**

[In a box]
People in West Yorkshire and Harrogate have a shorter average life expectancy than the rest of England. Males lives are on average 1 year shorter than the England average and females almost 10 months shorter.

Life expectancy varies between our six places and also within our neighbourhoods. Figures for 2009-2013 show a 17 year difference in life expectancy in males and females within different areas across the 382 smaller community areas that make up West Yorkshire and Harrogate and a 22 year difference in the years of life that they live disability free.

There is a strong association between health outcomes and deprivation. Around 480,000 people in West Yorkshire and Harrogate live in the 10% most disadvantaged areas in the country, and one of our local clinical commissioning groups, Bradford City, is ranked as the most deprived nationally.

[In a box]
In West Yorkshire and Harrogate those living in deprived areas are more likely to die prematurely (before the age of 75 years), figure 3. They are also more likely to be living with a long term illness or disability and to have been diagnosed with stroke or lung cancer than those living in areas where people are on higher incomes. They are also more likely to be living with risk factors for disease such as higher smoking rates and higher levels of childhood obesity.

For people living in West Yorkshire and Harrogate the leading cause of death is cancer which accounts for just over a quarter of deaths as a whole. This is followed by heart disease and stroke, which account for a quarter of deaths. Other leading causes of death are dementia and lung conditions which account for around 1 in 10 deaths each.

[Produce an infographic]
For people who are dying prematurely, before the age of 75 years, cancer remains the leading cause of death, contributing to around four in 10 premature deaths. This is followed by heart disease and stroke accounting for around two in 10 premature deaths and conditions related to lung health which account for around one in 10 of those who die before the age of 75.

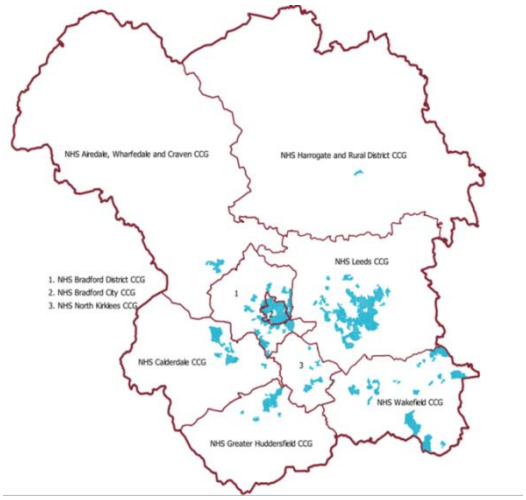
Many early deaths from cancer, heart disease and lung conditions are preventable. This can be through changes in lifestyle factors, such as stopping smoking and reducing obesity, earlier diagnosis and treatment; for example cancer screening and equal access to high quality care, for example prescribing the right medications for people living with heart conditions. All of these opportunities to influence are underpinned by the wider factors that impact on the causes of health.

It is not only how long people live that is an indicator of the health of a population but how many years of their life they spend in good health and how many years they live with ill health or disability.

The leading causes of poor health are musculoskeletal conditions (those that affect our joints and muscles) and mental health conditions. In West Yorkshire and Harrogate in 2018 nearly 2 in 10 people reported living with a musculoskeletal condition and around 1 in 10 people reported living with a mental health condition. These conditions impact on a person's quality of life including their ability to work and take part in activities that they enjoy.

John Walsh, Organisational Development Lead and Freedom to Speak up Guardian at Leeds Community Healthcare NHS Trust, tells us about the importance of tackling health inequalities in West Yorkshire and Harrogate **in this film here.**

[Rework as infographics]

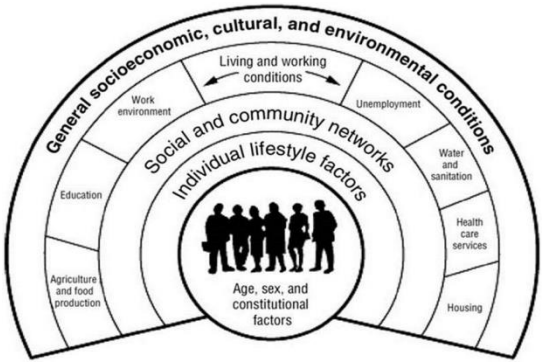


[Case study: include a picture:
The Phoenix Shed in Halifax is open to all men over 55 looking to make a new start in life. Funded by Staying Well, Calderdale Council and charitable donations, it has a kitchen, social area, computers and a workshop. 'It's a place for guys to hang out, have a chat and support each other" says 55 year old Michael Leech, a regular at The Phoenix Shed. Michael was a successful businessman but his life fell apart when he became ill with bipolar disorder. Since spending time at Phoenix Shed, he's needed less face to face support from his mental health support worker, often just talking to them via text. Michael says that being at the Shed helps him stop feel lonely and gives him a 'sense of belonging'.

Conditions for healthy lives

We understand the majority of factors that influence our health are much wider than health services alone. When encouraging people to make healthy choices we need to understand the wider factors which influence this and how this impacts on the ability to lead a healthy life. Factors such as income, housing, transport, crime, education and income all impact on the health of an individual and may impact on the control they have of their health. For example poorer neighbourhoods are more likely to have higher numbers of fast food outlets and fewer safe spaces to be physically active, which in turn impacts on unhealthy weight.

[To include: infographic Dahlgren and Whitehead 1991]



Factors such as income, housing, employment, crime and transport contribute towards health, and we need work as a Partnership to understand and influence these factors together and their combined impact on health. It therefore makes sense to pool resources to tackle these factors and promote good health for everyone - access to green space, strong communities, decent housing and the kind of inclusive, equitable growth that expands employment and opportunity for all.

Creating fair employment and work for all

There is a strong link between economy prosperity and the wellbeing of people. One of West Yorkshire and Harrogate's strong economic assets is the health and care sector. Working with our large organisations can help us understand the role they play as a big employer in promoting good health and contributing towards the local economy.

In West Yorkshire and Harrogate one in three employees are living with a long term health condition which can affect their ability to work. As a Partnership, we have a strong relationship with our Local Enterprise Partnership. We will continue to work in collaboration with them to promote healthy work places that support and encourage healthy behaviours to enable people to participate fully in working life, whatever their health status.

Housing

Housing has a really important impact on health. A safe, settled home is the cornerstone on which individuals and families build a better quality of life, access the services they need and gain greater independence. Good housing is affordable, warm, safe and stable, meets the diverse needs of the people living there, and helps them connect to community, work and services.

In West Yorkshire and Harrogate we have a health and housing working group to help spread good practice. It has identified where partnerships between health, housing and care organisations have enabled people to continue living independently or with support in a place they have chosen, delayed and reduced the need for primary care and social care, prevented hospital admissions, enabled timely discharge from hospital (and prevented re-admissions) or have promoted rapid recovery from periods of ill health or planned admissions. You can find out more here.

Creating and developing healthy, sustainable places and communities

Health is not only influenced by the home we live in but the wider environment. In West Yorkshire and Harrogate we have a wealth of natural environments, areas of outstanding beauty, national parks, waterways, dales as well as many parks with the prestigious Green Flag status**. [To include photos of the area].**

Access to them is unequal for those living in neighbourhoods already suffering the most economic disadvantage because they have the fewest opportunities for outdoor play or recreation.

Access to safe outdoor space is important for providing opportunities for our communities to be more active because it has positive impacts on both our physical and mental health. For people living in urban or built up areas, we know that well maintained and animated spaces, such as pocket parks, community gardens or urban trails encourage physical activity in areas that have limited green space.

We also know that connection to people and communities has a huge impact on people's wellbeing – and there is strong evidence about the impact of loneliness and isolation on a range of conditions including dementia.

In 2014 it was estimated that close to 5,000 people aged over 65 living alone in Calderdale felt lonely or trapped in their own home. Loneliness can be as harmful as smoking 15 cigarettes a day - those affected are more prone to depression and have a 64% increased chance of developing dementia. Socially isolated people are more likely to visit their GP, take more medication, have falls and enter adult social care services earlier. Partners want to reduce social isolation and loneliness. Preventing ill health and putting people in touch with others for support can help improve their lives and reduce pressure on health and social care services.

[Case study: add picture]
'Looking out for our neighbours is making a difference because it is a very simple message. What I think is really good about the campaign is the way it shows people that you don't need to do big things to make big changes. It's the small things, it's talking to people and enquiring if they're alright, offering to do a little bit of shopping. It's that kind of thing, and that's the kind of ethos we offer at Memory Lane Café. Memory Lane Cafe has used the campaign to engage the community in conversations around being neighbourly'. Watch this film to find out more.

Community organisations provide help, support and services to reduce loneliness and isolation. They have deep local knowledge; have earned positions of trust in their communities and often include people experiencing the same issues as those living in the communities they serve. This community infrastructure – made up of community-led activity, of small, medium and large charities and not-for-profit organisations is vital to help people get well or stay well.

[Case study: include picture]
Bradford District Care NHS Foundation Trust's Champions Show the Way (CSW) programme offers a range of free activities, with the help of local volunteers, to encourage local people to stay physically and socially active and stay well, often whilst living with long term conditions. Barbara joined a CSW walking group and opted to take the CSW walker leader training so she could start her own CSW walking group; she also runs a CSW singing group. Pauline said: 'I started in the singing group four or five years ago and I've not regretted it since. We have fun and for me, being a senior citizen, it gets me out of the house, I make friends and I meet different people'.

Climate change
Working as Partnership gives us an opportunity to reduce future climate change. Together we can:

- Maximise opportunities to improve population health at the same time as making climate friendly choices. For example improving walk ways and encouraging active travel to offset reliance on cars; or promoting community allotments to reduce food miles and promote healthy eating.
- Use the responsibility of our Partnership organisations to reduce their carbon footprint; such as reducing unnecessary single-use plastics in hospitals and care homes; reducing transport costs and carbon; reducing overall waste in medicines and medical equipment and investing the use of lower carbon options.
- Redefine the links between good public transport and affordable and easy access to health care facilities for people and reductions in air pollution.
- Document the impact air quality has on poor health outcomes across our Partnership and the contribution this makes towards widening inequalities.
- Use our collective voice as a Partnership to influence regional and national organisations to deliver on their obligation to transition us to sustainability.

Population health management

Population health management is a way of bringing together health-related data to identify ways to improve services for specific groups of people. For example, data may be used to identify groups of people who are frequent users of accident and emergency departments.

All our work is informed by knowledge from local places and people. It helps our understanding of inequalities within our communities. We will develop the Partnership through:

- Working with Public Health England to better understand the current analytical workforce across the system to inform future workforce planning.
- Developing information governance arrangements which will allow Population Health Management (PHM) to happen.

- Looking at how we can use intelligence to influence how services are designed and money is allocated within a system so we can focus on improving health.
- Supporting places with organisational and leadership development to support PHM. Including working with partners to promote Chief Information Officer representation on each NHS organisation's board
- Sharing learning from exemplar sites within the Partnership to allow others to learn from their experiences. For example the approach Leeds has taken to using a PHM approach to improve outcomes for those living with frailty (see page 59)
- Working with the expert partners including Academic Health Science Network, Imperial College Health Partners and the National Association of Primary Care to support the development of PHM in Primary Care Networks, with a particular focus on reducing health inequalities.
- Using population priority areas, such as those living with frailty, means we are learning about the application of population health management how it can be used to improve outcomes.

Our five year ambitions

- **By 2020 we will have an understanding of the analytical capacity in the system to undertake Population Health Management (PHM).**
- **In 2019/20 and 2020/21 we will support Primary Care Networks with the development of their population health management** (see page 28)
- **Throughout the next five years we will continue to share learning from exemplars within the system and across the country to support the implementation of Population Health Management in West Yorkshire and Harrogate.**

[Case study: add picture]
Starting with the people living with frailty in four areas of Leeds, data was used to understand which groups of people would be most likely to benefit from improved care. This approach was used to bring together people delivering care from across the system to improve outcomes. One example of improved care was a man who was living in a care home and had been admitted to hospital three times in the past year. All health and care professionals working with him met with his family and drew up a new advanced care plan. A copy of this plan was left in his care home. This plan was to help him spend the final months of his life at home rather than in a hospital bed. Using intelligence to bring everyone together made it easier when a move to end of life care was needed – and most importantly gave a lot of comfort to his family.

Health inequalities

To contribute towards a reduction in inequalities we will:

- Take a system wide approach for improving outcomes for specific groups known to be affected by health inequalities, starting with those living in our most deprived communities.
- Use intelligence to identify the inequalities that exist in our population related to risk factors for ill health, early diagnosis, disease prevalence and health outcomes. We will use this intelligence to understand the people in our population we need to be engaging with to understand how we can change our approaches to improve health outcomes.
- Gain insight by seeking the views of specific population groups about planning and priorities (where we haven't done this already). We will start with population groups we know to be greatly affected by inequalities in health; those living in poverty and those living with learning disabilities, those living with serious mental illness, veterans, those in contact with the justice system, ethnic minority groups and homeless people.
- Engage and work with all West Yorkshire and Harrogate Priority Programmes to support an approach that reduces inequalities.
- Work as a partnership to understand the impact of living in a rural or remote area on access to services and on health outcomes.

- Be informed by local information and expertise of working in partnership with people with lived experience.

Our five year ambitions

- **We will work towards a reduction in the gap in average life expectancy and healthy life expectancy between those living in the most and least deprived areas of West Yorkshire and Harrogate by 5% by 2023/24 and by 10% by 2028/29.**
- **We will reduce the gap in life expectancy and healthy life expectancy between West Yorkshire and Harrogate and England as a whole by 5% by 2023/24 and by 10% by 2028/29.**
- **By 2020 we will design and implement a health inequality profile for use across all Partnership programmes. This will make sure health inequalities are considered at the beginning and transformation takes place to meets people's needs.**
- **By April 2021 we will have supported Primary Care Networks in the implementation of the service specification for Tackling Neighbourhood Inequalities.**
- **By 2021/22 we will have spoken to different population groups and have a better understanding of the action we can take to reduce inequalities.**

Wider determinants

Working as a Partnership we can have greater impact on preventing ill health if we focus on the wider factors that impact on health and wellbeing. We will:

- Build on learning from the Health and Housing Partnership in Wakefield. We will identify opportunities to improve health through improving the environment and in which people live and considering the role housing services can play in supporting good health and wellbeing.
- Working with other key partnerships for example Leeds City Region, West Yorkshire Combined Authority and West and North Yorkshire Local Industrial Strategy to contribute towards the inclusive growth agenda.
- Work with organisations across the system to maximise their contribution to reducing climate change.
- Understand the impact of transport, green space, active travel and air quality on our population outcomes both in terms of air quality and inequalities in access to services.
- Look for opportunities to influence an increase in safe green space to promote physical activity particularly in our poorer communities.
- Through continued strong relations between the West Yorkshire Combined Authority and the Partnership, we will take steps to:
    - Improve transportation access to health and care facilities, including looking at making this more affordable for people with ongoing treatment.
    - Improve the quality and availability of active travel options across the region.
    - Reduce the carbon emissions and harm caused by public transport.
- We will support Primary Care Networks to make the links with wider services that impact on health including debt advice, housing, support with benefits and employment.

Our five year ambitions [to quantify at next draft]
By 2024 we will:

- **Continue to share good practice by making the most of the links between health and housing.**
- **Work with our partners to improve access to green space specifically for those living in poorer communities.**
- **Work with primary care to improve links with the wider community assets.**
- **Reduce inequalities in access to employment for those living with long term physical and mental health conditions.**

Prevention 1: Reducing risky behaviour that contributes towards ill health and promoting what keeps people well.

What we have achieved so far: Prevention at Scale Programme
In October 2016, our Partnership set out three ambitions for preventing ill health:

- To reduce smoking
- To reduce alcohol related hospital admissions
- To reduce the number of people at higher risk of diabetes developing the condition.

The reasons for these ambitions were to prioritise areas that would have the greatest potential impact on people's health in the shortest timescale.

Progress to date

Tobacco harm
The ambition for the tobacco programme was to reduce the number of people smoking from 18.6% in 2015/16 to 13% by 2020-21; a reduction of 125,000 smokers.

To date the programme has seen tobacco smoking reduce to 17.3%, in line with our planned trajectory, a reduction of 23,000 people who no longer smoke. This already equates to a five year financial impact on the NHS of £17million. In addition, this also means that those 23,000 people in West Yorkshire and Harrogate have £84m per year to spend in ways other than on smoking.

[Case study: add picture]
In May 2019, the Partnership launched a quit smoking 'Don't be the 1' campaign as part of our prevention of scale programme work. It delivered a hard-hitting emotional message that at least one in two long-term smokers will die from long-term tobacco smoking, balanced with a positive, empowering call to action that if you quit you can reduce those risks and signposting local quit smoking support. Surveys show around 9/10 smokers under-estimate the 1 in 2 risk of dying early from tobacco smoking, but most find the true figure worrying.

Alcohol harm
Every year, hundreds of people across West Yorkshire and Harrogate are admitted to hospital because of drink. Alcohol accounts for 10% of the UK burden of disease and death but is entirely preventable. Our ambition is to reduce the number of people affected by alcohol related harm by supporting those admitted to hospitals with appropriate help and support. The ambition related to alcohol was to reduce alcohol related hospital admissions by 500 a year and achieve a 3% reduction in alcohol related non-elective admissions by 2021. We have already seen a reduction of 9%, which greatly exceeds the trajectory of 3%.

[Case study: add picture]
The Alcohol Liaison Service (ALS) based at The Mid Yorkshire Hospitals NHS Trust (Pinderfields) emergency department is run by Spectrum Community Health CIC. The ALS team has reduced alcohol specific hospital admission episodes by 34% fewer in 2016/17 compared to 2013/14. Over the same period they have reduced the number of hospital readmissions by 36% and the number of associated bed days per year by 26%. An estimated £1.5 million has been saved in the past 4 years.

Diabetes (also see page 84)
The ambition was to offer 50% of those at high risk of diabetes preventative support through the National Diabetes Prevention Programme. To date the programme has exceeded the target for number of referrals, with 5022 referrals received against a target of 4829, from June 2017 – November 2018. [To do: produce info graphic].

We will build on this to:

- Support local places with the development of joined up well-being services. Sharing learning on approaches, such as the Living Well in Bradford, which tackle the experiences/causes of risk behaviours, for example smoking and promotes positive health behaviours, such as physical activity. This will include approaches to building resilience and exploring affordable ways to improve and maintain good health and reduce the experience of barriers
- Design and run targeted campaigns, which will be co-produced with communities to promote early help
- Support the delivery of targeted smoking cessation services. Specifically for people who are in hospital who smoke, pregnant women and users of hospital outpatient services
- Reduce the inequalities in the number of people who smoke between those in routine and manual occupations and other groups of people we know are more likely to smoke
- Build on and embed a partnership approach which will tackle illicit tobacco use
- Build on existing good practice in Wakefield and continue to share learning to support the development and improvement of alcohol care teams in hospitals
- Work together to audit immunization programmes so we understand differences in uptake across different groups of people. This will include making the most of the information we have between us all
- Run targeted suicide prevention campaigns for those identified as being at higher levels of risk.
- Develop the skills and capacity of the workforce to deliver preventative interventions, including the use of Making Every Contact Count
- Work towards a reduction in Anti-Microbial Resistance (AMR). AMR happens when infections change and as a result, standard medication treatments no longer work, infections are then more difficult to treat and they may spread to others. We can work together to reduce AMR by; reducing the number of people catching infections, making sure they are diagnosed early and treated appropriately and reducing the number of anti-biotics prescribed where they are not needed.

Our five year ambitions
By 2023/2024 we will:

- **Reduce smoking prevalence in West Yorkshire and Harrogate to 11.5%.**
- **Reduce the proportion of people smoking in Routine and Manual Occupations at a faster rate than other groups.**
- **Ensure all people who smoke who are admitted to hospital are offered support to stop smoking.**
- **Support places within our partnership to establish alcohol care teams.**
- **Reduce the number of Anti-Microbial Resistant (AMR)-infections by 10% and reduce antibiotic usage by 15%.**

Prevention 2: Make the most of the techniques and approaches that identify and diagnose conditions earlier.

We will:

- Work as a partnership to improve uptake of our cancer screening programmes to contribute towards three in four cancers being diagnosed at an early stage when curative treatment is an option by 2028. We will work with the West Yorkshire and Harrogate Cancer Alliance to review our screening programmes to better understand the inequalities that affect uptake. We will reduce the 160,000 people annually who decline an invitation for bowel screening, the 170,000 women who decline the offer of cervical screening, and the around 90,000 women who decline the offer of breast screening.
- Gain insight from communities to make screening and diagnostic services more accessible to those groups who are under-represented.

- Monitor and work with places to support an increase in uptake of the Diabetes Prevention Programme across our system (see page 84), which identifies people at risk of developing diabetes and supports them to make healthy lifestyle changes
- Take an intelligence led approach to support earlier identification of respiratory disease particularly in areas where we suspect there to be people living with undiagnosed Chronic Obstructive Pulmonary Disease (COPD) – a long term lung condition. This will include supporting training for the use of spirometry in primary care (see page 81)
- Make the best use of NHS Health Checks to identify those at risk of heart conditions earlier. We will support places to share good practice and target checks towards groups of our population who are underrepresented such as men and those living in poorer communities and ethnic minority groups
- Work with the Mental Health, Learning Disability and Autism Programme (see page 71) to support earlier diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) in the children living in West Yorkshire and Harrogate.

Our five year ambitions
By 2024 we will:

- **Understand inequalities in uptake of cancer screening by different population groups and target approaches which will improve access to screening for those who are under-represented.**
- **Increase diagnosis of COPD in areas where we expect there are people who are living with the condition who are not receiving support.**
- **Reduce inequalities in uptake to NHS Health Checks.**
- **Increase uptake of the National Diabetes Prevention Programme.**

[Case study: add picture]
Residents most at risk of lung disease in the South Kirkby and Hemsworth areas of Wakefield are reaping the benefits of a pioneering lung health check programme being run from their local GP surgeries. Around 100 patients attended the Church View Medical Centre on Langthwaite Road in South Kirkby to receive their 'lung MOT' during the first week of a targeted lung health check pilot programme led by the West Yorkshire and Harrogate Cancer Alliance, in partnership with Yorkshire Cancer Research. Invitations have been sent to patients of the practice aged 55 – 74 who smoke or used to smoke – individuals who are considered to be most at risk of lung diseases, such as chronic obstructive pulmonary disease and asthma, as well as cancer. Around 95 per cent of all invitations have resulted in patients attending appointments. A number of patients have also taken up free advice and help to quit smoking which is being provided on site by specialist advisors from Yorkshire Smokefree, with funding from Yorkshire Cancer Research. Access to such support gives smokers the best possible chance of giving up. The Wakefield project is part of the Cancer Alliance Tackling Lung Cancer programme, which also includes similar projects in Bradford and North Kirklees, the selected West Yorkshire and Harrogate site for the national roll-out of targeted lung health checks.

Prevention 3: We will support people living with long term physical and mental health conditions to live as well as they can, for as long as they can in their own homes.

We will:

- Support the best outcomes for conditions where we know we could work together to make more of a difference, this includes mental health, respiratory disease, diabetes and heart disease (see from page 88). We will look particularly at the inequalities people living in our local areas face with access to support such as rehabilitation, stopping smoking, weight management and vaccination
- Build into our plans the wider factors that impact on the physical and mental health of people living with long term conditions such as benefits advice, housing, employment and transport

- Offer care and support to people living with mental health conditions, learning disabilities and autism so we can improve physical health and reduce inequalities in life expectancy. This will include increasing the number and quality of annual physical checks for people living with learning disabilities and autism and a stop smoking offer for specialist mental health and learning disability services.
- Work with the Mental Health, Learning Disability and Autism Programme (see page 71) to learn from Learning Disability Mortality Reviews (LeDeR) to inform future service planning which will contribute towards a reduction in health inequalities.
- Review inequalities in unplanned admissions to hospital for long term conditions which could be managed in the community. To help better understand variation across the system, the causes of this and how alternative approaches could be taken to reduce avoidable admissions to hospital.
- Gain a better understanding of the inequalities in access to planned hospital care. Starting with a review of the inequalities in the numbers of people having hip replacement surgery for people living in the most deprived areas of West Yorkshire and Harrogate.
- A new universal smoking cessation offer will also be available as part of specialist mental health services for long-term users of specialist mental health, and in learning disability services.

Our five year ambitions
By 2024:

- **75% of people with learning disability and autism aged over 14 years will be offered (annual?) physical health checks.**
- **Inequalities in access to planned hospital care will be reduced for those living in the most deprived communities in West Yorkshire and Harrogate.**
- **We will offer targeted stop smoking support for people in contact with specialist mental health and learning disability services.** .

[In a box]
We will continue to work together in Partnership to make a positive difference to people's lives with and for them. This will involve having conversations with people about what they need to stay, happy, healthy and well and making the most of the community insight we have and having further conversations where needed.

Personalised care

Personalised care means that:

- People and their carers will be supported to manage their physical and mental health and wellbeing, build community resilience, and make informed decisions and choices when their health changes
- People with long-term physical and mental health conditions will be supported to build knowledge, skills and confidence and to live well with their health condition
- People with more complex needs will be empowered to have greater choice and control over the care they receive.

We will ensure personalised care is embedded in the work of all priority programmes and learn from our council partners who have been working in this way for many years. By embedding personalised care approaches across all programmes and in all services we deliver and commission (buy) we will be able to scale up our capacity to deliver the personalised care model to everyone in West Yorkshire and Harrogate.

Lucy Jackson and Johnathan Lace from Leeds Council talk about 'better conversations' which is all about personalised care **in this film here.**

The model of personalised care

This model is defined by a standard set of practices:

1. Shared decision making
2. Personalised care and support planning
3. Enabling choice, including legal rights to choice
4. Social prescribing and community-based support
5. Supported self-management
6. Personal health budgets and integrated personal budgets

The NHS Long Term Plan says that within five years over 2.5 million more people will benefit from 'social prescribing', a personal health budget and new support for managing their own health in partnership with patients' groups and voluntary organisations.

Across West Yorkshire and Harrogate many of the elements of the personalised care model are already in place or being developed. As part of the NHS England Personalised Care Demonstrator Programme, West Yorkshire and Harrogate have been working to build, develop and spread the model of personalised care delivered locally across our six local places.

Why is personalised care important?

Only 55% of adults living with long-term health conditions feel they have the knowledge, skills and confidence to manage their health and wellbeing on a daily basis and yet 70% of the health service budget is spent on people who are living with long-term health conditions. People with one of more conditions account for 50% of all GP appointments and occupy 70% of hospital beds.

An evaluation of 9,000 people by the Health Foundation (August, 2018) found that people who had the highest knowledge, skills and confidence had 19% fewer GP appointments and 38% fewer A&E attendances than those with the lowest levels of activation.

[Case study: include picture]
In the West Yorkshire and Harrogate Healthwatch Engagement Report (June 2019) findings showed that people were interested in support from NHS and partners to make it easier to keep fit and healthy. It identified that people were unsure of what 'personalised care' is all about. Over the coming months we will be raising awareness of what personalised care means so that we can importantly change the relationship we have with people so that they are supported to be active partners in their health, wellbeing and care. 9% of people also said the NHS could help them to self-care by providing more information and advice about healthy lifestyles so they can monitor their own health. We will take these views forward into our plans over the next five years.

How we will spread the benefits of personalised care?

We will build our model of personalised care at scale across West Yorkshire and Harrogate. The sustainability of our health and care system relies on the need for more choice and control for people on the decisions and support which makes the positive impact on their health. Communities are our biggest asset. We need to give people choice in how their needs are met whilst considering what they need so they have the knowledge, skills and confidence to look after themselves, where safe to do so. Social prescribing involves helping people to improve their health, wellbeing and social welfare by connecting them to community, groups, activity and peers who can offer support.

This will also lead to healthier sustainable communities.

This way of working brings many benefits. It:

- Improves people's health and wellbeing
- Improves people's resilience to stay well and their knowledge skills and confidence to be engaged as active partners in their health, wellbeing and care
- Can reduce pressure on health and care services and provide efficiencies by joining support together.

For people at the end of their life we will embed personalised care and support planning so that we understand their specific needs and wishes at the end of their life and share this information digitally to make sure all care providers are aware of what is important to the person and acts accordingly.

To do this our workforce will develop new skills to work differently with people so we can change the relationships and conversation we have with our communities. Working in partnership to join up services and prevent ill health is the priority. We will establish an approach to support our six local places to meet the needs for people of all ages and the 260,000 carers. This will include young carers across our area so they are able to manage their physical health, and mental wellbeing whilst making well informed decisions and choices should their health change. Key to this way of working is our council partners, community organisations and links to our other priority programmes, such as carers and mental health.

We will focus on building personalised care approaches into clinical and care pathways, for example we have started to build personalised care and support planning, supported self-management, social prescribing and shared decision making into the cancer pathway.

Programme aims and ambitions over the next five years

We will focus our ambitions around four key areas:

1. **Changing the relationship between people and practitioners**
2. **Embedding personalised care across West Yorkshire & Harrogate**
3. **Building our network for Personalised Care**
4. **Building the case for investment and change**

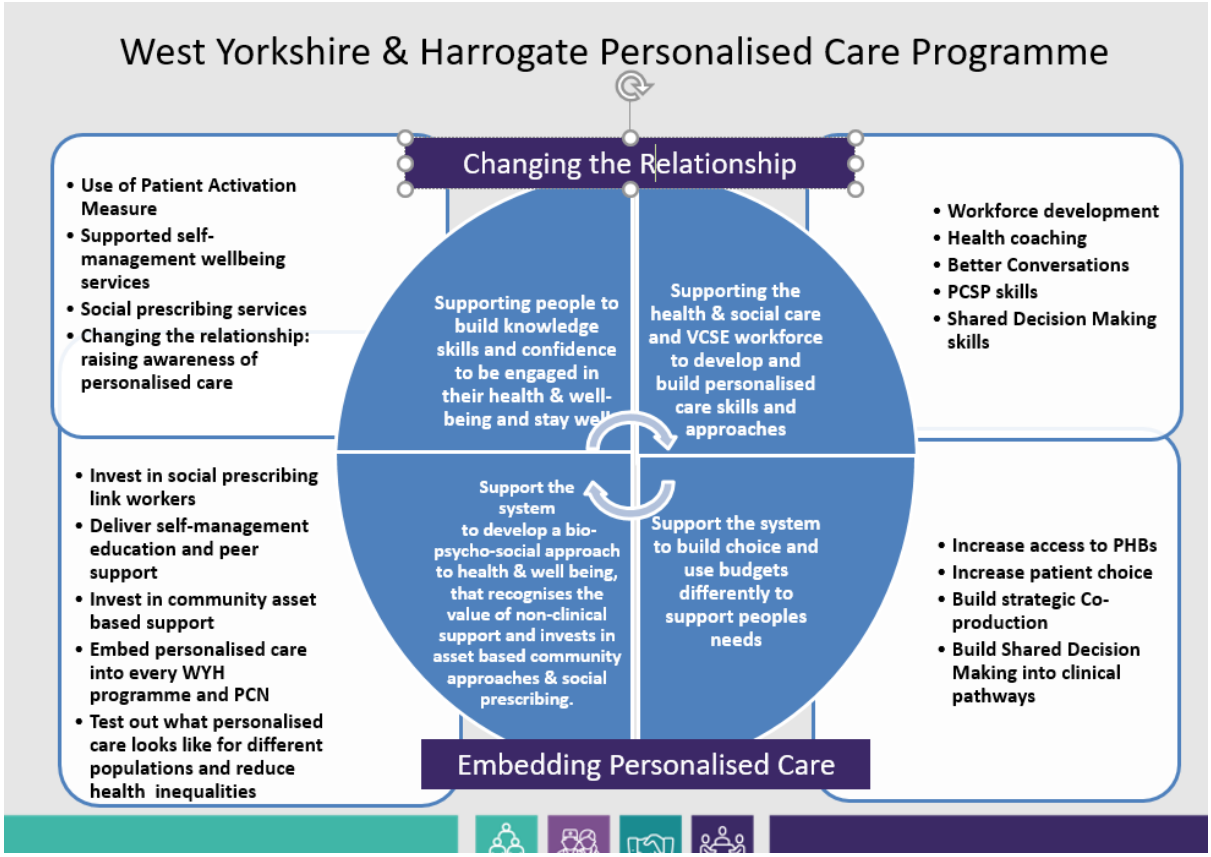
[To do: rework table into a graphic]

Work stream	Ambition
1. Changing the relationship	To change the relationship that people have with practitioners so that they are an equal partner in their health and care. People will be supported to be more knowledgeable, skilled and confident to manage their own health and care, involved in decisions about their care and work with practitioners to maximise their health and wellbeing. We will develop the skills knowledge and culture change in our workforce across West Yorkshire & Harrogate that will change the relationship we have with people and communities so that the relationship will deliver our ambitions for personalised care.
2. Embedding Personalised Care across West Yorkshire	To integrate personalised care work with the work to progress Primary Care Networks and to make specific links to how we use the intelligence we have about our communities to target our work at Place level. To deliver targeted pilots exploring what good personalised care looks like for people with a Learning Disability and people with lung problems (COPD).

& Harrogate	
3. Building our Network for Personalised Care	With representation at each of the 6 places, a network for change has been built to map, plan and deliver actions that will realise our ambition to make 'personalised care' the way we do things around here, and the words in the stick of rock that run through everything that WYH HCP does. We will work as a 'federation' of 6 places, learning and sharing with each other, and agreeing which things that make sense to do at Partnership and what makes sense to do at a place level. The impact of our work will be through the whole health and social care system. We will build a model of champions to provide leadership for our targeted areas of work and continue to build our network of place based leads across NHS, Local Authority and VCSE organisations.
4. Building the case for investment and change	In 19/20 will work with the Academic Health Science Network to develop and deliver a programme that will measure and evaluate the impact of personalised care on a group of people with lung problems (COPD). We will identify what good looks like from national and local evidence and build business cases for investment, demonstrating the impact on people and the health and care system.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

[To do: Rework model at graphic stage]



Our five year ambitions

- **There will be an increase in the number of people in West Yorkshire and Harrogate who have choice and control over their health and care using personal health budgets and integrated personal commissioning**
- **Social prescribing will be part of usual care across all health and social care services**
- **The number of social prescribing link workers employed in Primary Care Networks increases by 55 whole time equivalents**
- **Personalised conversations through health coaching/ better conversations shared decision making and support planning training will become part of usual care.**
- **Everyone with a long term health condition or complex needs will be offered a personalised care and support planning conversation which sets out 'what's important to and for them'.**
- **Decision support tools are used in all clinical and care pathways**
- **Everyone who has a long term condition or complex needs is offered opportunities to self-manage their own health tailored to their needs and activation level**
- **There are an increased number of peer supporters and volunteers engaged in supported self-management activity.**

Five year measures of success [To do: rework table].

	19/20	20/21	21/22	22/23	23/24
Personalised Care reaches x people by 23/24	xxx personalised care interventions benefitting over xxxx people				xxx people by 23/24

Social Prescribing Link Workers in PCNs **Referrals to social prescribing link workers**	50 SPLW recruited and trained 15,000 people referred to social prescribing link workers (from whole system)	45 SPLW 15,000	55 SPLW 15,000	55 SPLW 15,000	55 SPLW 15,000 people referred to social prescribing link workers
Support for self-management	3,300 PAMs	3,300 PAMs	3,300 PAMs	3,300 PAMs	3,300 PAMs
Personal Health Budgets	3,570 PHBs total - All CCGs delivering PHBs as default for CHC homecare packages - All CCGs offering Personal Wheelchair Budgets - 40% of all PHBs delivered as a direct payment or third party budget 1-2/1000 people benefitting from a PHB				7,000 people benefitting from PHBs/ IPBs: - CCGs delivering to a range of cohorts and responsive to local needs - 40% of all PHBs delivered as a direct payment or third party budget - All CCGs delivering to areas where there is a legal right 3/1000 people benefitting from a PHB

Transforming services

The way people want to access services is changing and the use of technology is increasing. This has influenced how people access and receive care. You can see evidence of this in local engagement work and also from West Yorkshire and Harrogate's Healthwatch NHS Long Term Plan engagement report findings (June 2019), where comments were raised about the '*better use of IT and electronic records'* and how all hospital trusts should have computer systems that talk to each other.

The importance of: *'partners working together to make it easier and affordable for people to say fit and eat healthily,* as well as *'more pro-active support around weight loss';* and concerns around *'better emergency support for people in mental health crisis*' were all raised. These are all area we are working hard to address together (see page 71). The voice of carers in the report also endorses our programme approach that: *'carers needed more support to keep them safe and healthy including regular health checks, respite care and flexible appointments to fit round caring responsibilities'* (see page 91).

Helping people and families to plan ahead, stay well and get support when they need it in the most appropriate way with the resources we have available is key to the way we work. Overall people want to be: *'listened to, trusted and taken seriously as experts of their own bodies'* and that *'a lot of people saw social prescribing as a positive and wanted more access to this support'.* We couldn't agree more and this is central to the work we are doing (see page 34).

This section sets out how we are working to transform and join up services.

Primary and community services

It's good news that people are living longer and we want everyone to have the best chance in life to age well. Between 2017 and 2027 there will be 2million more people nationally aged over 75.
As a result of this changing population we need to change our focus from treating individual episodes of illness to working with people to manage one or more long term conditions.

Much of the new money for the NHS announced in June 2018 is directed at primary and community services, and a large amount of this will be channelled through networks.

Primary care is often described as the 'front door of the NHS' and provides people with community-based access to medical services for advice, prescriptions, treatment or referral, usually through a GP or nurse. Other primary care providers include dentists, community pharmacists and optometrists. It has been estimated that around 90 per cent of interactions in the NHS take place in primary care.

Primary medical care is locally led in our six places. Clinical Commissioning Groups have continued to progress the primary care agenda in accordance with their own local commissioning strategies alongside the national work to transform primary care, supported by the General Practice Forward View document and NHS Long Term Plan.

Our Primary Care Strategy (to do: make link when published) goes much further than this – it is all about communities, carers and the work we do alongside our voluntary and community partners.

[In a box]
Primary and community care services including dental, eye care and community pharmacy and general practice are central to bringing care closer to home, managing long term health conditions, preventing unnecessary hospital admissions and helping people stay well and healthy.

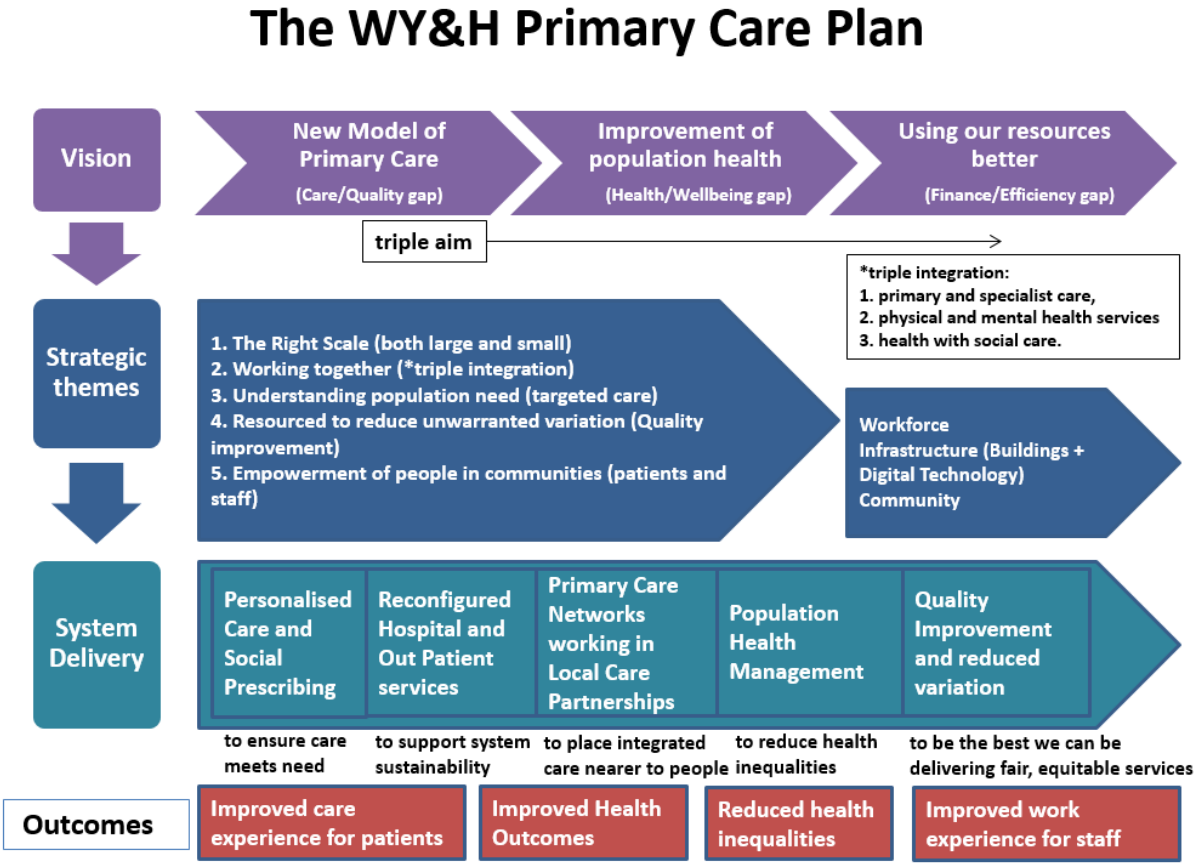
The Healthwatch engagement work (June 2019) told us that people want better access to GP and wider primary care services; to be better informed about self-care and health services generally and wrap around joined up care when and where needed.

Our vision for primary care is to:

1. Deliver a model of primary care that is new
2. Lead to an Improvement of population health
3. Use our resources better.

We will do this through building primary care at the right scale, working together in integrated teams that target services based on the understanding of population need and resourced to reduced unwarranted variation with empowerment of people in primary and community care.

Our primary care plan can be summarised as follows **[To do: rework graph below]**



We want to transform primary and community care by enabling the integration of services based on the needs of the local population. Triple integration cuts through our strategy, bridging the gap between primary and specialist care, physical and mental health and health with social care.

This will result in our patients having a better experience in accessing consistent high quality joined up care, with empowered Communities involved in service developments, with localised more accessible solutions

We will be the best we can be in primary care delivering;

- Improved experience of our staff, volunteers and carers with more staff retained, resulting a more sustainable workforce
- Improved financial sustainability
- Improved population health, patient outcomes and reduced health inequalities.

Primary Care Networks are a key part of the NHS Long Term Plan, with all general practices being asked to be part of a network by June 2019. Primary Care Networks (PCNs) generally cover populations of 30,000 to 50,000 patients. They involve wider health care providers and staff to deliver services that reflect local people's needs.

Improving how community services are delivered is essential to achieve the aims of the NHS Long Term Plan. The joining up of primary and community care is important for our workforce, service stability and patient choice. We will explore further opportunities for community services and voluntary and community organisations to support PCNs by facilitating local conversations and provider presence. We plan to build on the relationships with community providers with a view to enhancing existing community delivery methods.

We aim to respond and agree a Partnership approach to NHS Improvement's recently published Community Services Operating Model Guidance. This sets out recommendations to achieve the ambitions of the NHS Long Term Plan in particular for improving response time, quality of care and productivity of the workforce.

[Case study: add picture]
Alan took early retirement after suffering a heart attack and although he's feeling well and keeping healthy, he takes daily heart medication and needs regular checks with his GP. He uses GP online services to book appointments with his GP to review his condition, and to order the medication he needs. Alan told us: 'I can use the online system to order my medication at any time and I don't even need to remember the names and dosages of the individual items as they are all detailed on my 'prescribed medication' page. I can also check when my medication is due to be assessed by logging on and viewing my personal patient record.'

Our Primary Care Strategy **(To do: add link once published)** sets out the detailed ambitions, achievements to date and the actions we will take to achieve our vision. Our deliverables for primary care in 2019/20 and 2020/21 are:

Workforce

- Development of a training needs analysis in place to contribute to commissioning of the future workforce required for skills and competencies primary and community care
- Increase our numbers though GP International recruitment
- Improve workforce planning through the operationalisation of the apex/insight workload/workforce tool
- Support the further development of our training hubs
- Development of partnership rotational and preceptorship models for PAs and paramedics in primary care
- Implement at scale 'In at the deep end' retention initiative, supporting health inequalities in areas where recruitment is problematic
- Increase our primary care workforce numbers
- Increase the number of mental health therapists co-located in primary care.

Access, resilience and workload

- Increasing usage of online consultations and self- care digital options
- Building on the outcomes of the Healthwatch Report (June 2019), progress a West Yorkshire and Harrogate access review to primary care services
- Develop an implementation plan to address the outcome of the national access review.
- Support Increased utilisation rates for extended access appointments
- Enable PCNs to support access and resilience in primary and urgent care through the national network impact assessment fund.

Primary care transformation

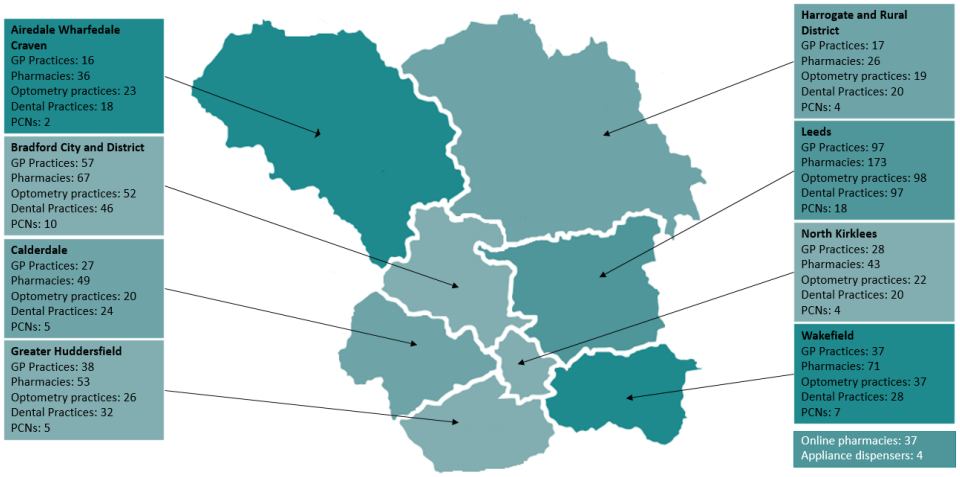
- Continued support to the development of networks and highlighting opportunities for at scale working.
- Each PCN will have a development plan and identified support to enable progression
- PCNs to demonstrate progression to the next step of maturity
- A collaborative approach with other priority programmes in supporting PCNs in the implementation of the national service specifications
- PCNs will be expected to implement the medication review and enhanced health in care homes in April 2020. This presents a huge opportunity to build on the local system work already in place to support this work.

Quality improvement

- Implementation of carers quality markers in practices and PCNs
- Reduce variation in screening and immunisation for people with learning disabilities at PCN level
- Support place-based population health management to enhance knowledge and understanding of population health management (see page 28).

We want to support people so that they can manage their own health where safe to do so, closer to home and in their communities. Some people who have a health condition could potentially take an increasing role in managing their condition alongside health professionals, and are often more motivated when they share their experiences with others in the same situation (see page 34).

The Primary Care Strategy reflects the work taking place in each of our local six places. It also reflects the needs of the areas whilst highlighting where it makes sense to work together for better health and wellbeing outcomes for people.



[To do: rework the map].

Our priorities

- We will develop Primary Care Networks (also known as Communities/Homes) and bring together joined up teams to deliver better ways of working. Services will be tailored to need and will deliver better health and wellbeing outcomes for people at a local level
- Develop a flexible workforce with the right values, skills and competencies to deliver improved health care and satisfying roles for staff
- Improve access so that people have greater choice and more flexibility.

Joining up health care

In West Yorkshire and Harrogate we have 56 primary care networks (PCNs) of varying sizes and demographics. They have been designed around local population needs (please see map above). The development of the networks is led locally in our places.

PCNs build on current primary care services and will enable greater provision of proactive, personalised, coordinated and more joined up health and social care, based on the needs of local people. Working at scale across West Yorkshire and Harrogate will bring organisations and staff together to deliver population health management through the development of Primary Care Networks (see page 40). Clinicians describe this as a 'change from reactively providing appointments to proactively caring for the people and communities they serve'.

[In a box]
The Partnership has invested £2.6m in 2018-19 (around £1 per head of population), to help develop Primary Care Networks and accelerate local approaches.

[Case study: add picture]
Community Partnerships (CPs) are Bradford District and Craven's way of working differently with people and communities to deliver improved health and wellbeing outcomes for people. Covering 14 communities of approximately 30-60,000 population sizes, the CP's bring together NHS, social care community organisations and other local services to focus on health and wellbeing. Recognising the impact that wider determinants have on the health and wellbeing of people, for example housing, poverty and employment, the CP's have adopted a strength-based community developed approach to service redesign. Community staff and local people have the opportunity to say what is important to them based on local information, to ensure that future health, care and wellbeing services meet their needs.

Primary and community care workforce

The Partnership aims to support the primary and community care workforce to have the right values, skills and behaviours to work with people as equal partners in their health and care delivering positive outcomes for patients, staff and the population.

[In a box]
West Yorkshire and Harrogate will be a vibrant place to work with a responsive, passionate, engaged, compassionate, and diverse and fit for purpose workforce with great opportunities. Our workforce helps people to live their best lives.

The challenges of recruiting and retaining a skilled primary care workforce are similar to many other areas. Our aim is to ensure that our workforce strategies support the wider system in addressing health inequalities. Our focus will be to attract, develop, support and retain the workforce in the most deprived communities.

Delivering our vision will not simply need more of the same but a different skill mix, new types of roles for different ways of working. PCNs are key to delivering this vision. Each will develop workforce plans to reflect the services and needs of people they support whilst aligning this to their local place priorities.

Nationally workforce targets have been set and our local and Partnership wide plans reflect these in their planning. The targets are as ambitious and challenging. This is reflected in our Primary Care Strategy (To do: make link when published) with our aim being to focus on target delivery whilst fully supporting the workforce transformation and showing an overall capacity increase.

Working together with West Yorkshire Local Workforce Action Board (including Health Education England colleagues) the Partnership aims to develop 'one' approach to workforce through a system which aims to:

- Deliver integrated working models across organisational boundaries
- Develop a stable workforce with the right knowledge, skills and competencies.

This work will be taken forward at local place level whilst creating the opportunity for other work, for example the West Yorkshire and Harrogate International GP Recruitment Programme and Physicians Associates Acceleration Programme.

[Case study: add picture]
Wakefield GP Resilience Academy
Wakefield is supporting a locally sustainable, resilient general practice workforce by growing its own staff. They are delivering the training they need and providing good career development opportunities with the expansion of skills and new roles.

Wakefield Clinical Commissioning Group (CCG) responded to the pressures within their primary care workforce by launching the Wakefield General Practice Resilience Academy. The team is funded by the CCG. It has developed a 'virtual practice' model which focuses on training, advice and intensive support. The virtual team is made up of a nurse consultant and practice manager consultant. Where needed, the team work with other colleagues to provide tailored and targeted support in the following areas:

- **Diagnostic reviews where there are identified areas for development**
- **Development of remedial action plans**
- **Change management support**
- **Signposting to specific support including education and training**
- **Direct advice and mentoring to clinical and administrative staff for example practice managers**
- **Team building and development**
- **Targeted reviews within the Practice on issues that have been reviewed and highlighted.**
- **Training support on business skills, HR and finance.**

This means the clinical commissioning group is able to identify practices in need of additional support but also provide them with follow-up advice where appropriate.

Improving access to services and choice

Our aim and one of our key outcomes is for people to have easier to access and more convenient services based on their health need and preferences. There is significant variation in day time access, reflected in patient experience rates in general practice and it is recognised that a proportion of activity carried out in A&E or out of hours primary care setting is often of a routine nature and could be managed more appropriately in a different setting (see page 49).

Access to more convenient services is important to the transformation of general practice; enabling self-care with direct access to other services, best use of the wider workforce, greater use of technology and working at scale across practices to shape capacity.

Our Partnership has built on the learning and successes of the National Access Fund as well as the acceleration sites in Leeds, Wakefield and Harrogate. These sites have helped people to access timely, convenient care and accelerate the achievement of the national expectations for extended access in primary care.

[In a box]

Since October 2018, 100% of our population have been able to access GP services on evenings and weekends. Put simply this means 137,000 additional appointments being made available to patients in general practice.

In 2018/2019 £11.5m of national funding was invested in Primary Care Extended Access. Patient experience rates show there remains considerable variation in terms of access to services and in some areas in West Yorkshire and Harrogate poor patient satisfaction rates with appointment times. As a system we compare favourably with national satisfaction rates, however within our six local places there are high levels of dissatisfaction. Whilst we are seeing an increase in extended hour's appointments, there is still room for improvement.

There are various ways in which people can access care, including 'in hours' and 'out of hours' GP, extended access hubs, NHS 111 urgent treatment centres and A&E resulting in many patients struggling to understand what services to access, how and where. This is also reflected in the Healthwatch Report (June 2019). Access to appointments was the single most mentioned theme in the Healthwatch survey with 18% of responses citing access as the biggest thing the NHS could do differently to help them stay healthy and well. People want the NHS to provide easier access to appointments, not only with their GP but also with hospitals. We also know that:

- There are inequalities in access and some groups of people struggle to access services in a timely way.
- Urgent and emergency care is relied upon because other services are not available or sufficiently responsive.
- Approximately 40% of patients do not require GP input. Social prescribing and community empowerment through personalised care will be a key feature of primary care delivery which will enable more self-care and more resilient communities, enabling more capacity in GP practices for complex care.

We have made a commitment to align areas of the health system to enable simpler access into the most appropriate pathway. Progressing digital approaches will greatly enhance the way patients and clinicians interact with services, bringing about improved access and experience, a positive impact in practice workload, care closer to home, and better use of the primary care buildings. We will improve access for people making sure that general practice and PCNs continue to adapt and deliver the national initiatives that will improve people's choice and facilitate greater more convenient access.

[In a box]

- **Everyone in West Yorkshire and Harrogate has the option of an extended access appointment if needed including evenings, weekends and bank holidays.**
- **By March 2020 all West Yorkshire and Harrogate patients calling 111 will if clinically appropriate to do so be directly booked into an appointment in an Extended Access Hub. Currently 23% of our Extended Access hubs can accept bookings in this way.**
- **We are piloting e-Referral Service (eRS) roll out in ophthalmology where community optometrists will be able to refer directly into hospital eye services where required, impacting positively on workload for GP practices (see page 40)**
- **One plan for enabling Online Consultation capability for every practice across 2019/2020 and 2020/2021 is being delivered.**

Our ambition is to offer more convenience, choice and control for people when accessing GP services, helping them to be more informed and involved in decisions about their own healthcare.

Our five year ambitions

- **We will support health care providers including PCNs to deliver improved choice and options for people including:**
  - **Online and skype consultations**
  - **Online access to appointment booking and medical records**
- **We will work with partners, including our Partnership priority leads to enable a streamlined access point for people. 111 will be able to book direct into GP practices and extended access hubs**
- **Have one point of call for accessing primary and urgent care services, supported through a Direct Booking Service**
- **Have a fully integrated model for primary and urgent care**
- **Improved people's experience of accessing primary and urgent primary care services.**

[In a box]
Booking GP appointments online helps to reduce the number of missed appointments because it's easy for people to cancel or re-book their appointment online – there and then - without having to wait until their practice opens or wait in a call queue.

[Case study]
Greater Huddersfield Integrated Partnership
The out of hours provider and the local GP Federation are working in partnership to provide a more joined up delivery model to provide extended access and urgent and emergency care. The model is hub provision at Huddersfield Royal Infirmary, clinics at two physiotherapy locations with a number of GP practices acting at satellites. Since March 2018, the hub service has been expanded to include physiotherapy and phlebotomy (blood test) appointments. User rates are consistently high, with monthly rates ranging from 80-100%. The hub GP appointments are fully open and directly bookable by the out of hours provider and NHS111, enabling the wider healthcare system to support people to access the support at the most appropriate point. The service was evaluated by Healthwatch in October 2018 and a further survey was undertaken by the providers in April 2019. Findings from surveys showed the service is highly valued by people.

Primary care transformation and infrastructure investment

To deliver transformation, funding for primary medical and community services will increase by over £4.5billion by 2023/24. This will be available through the GP Forward View, the GP Contract Reform package, the Partnership transformation funding and local investment from commissioners and Providers across West Yorkshire and Harrogate. The partnership has to date;

- Invested £2.6m, to develop and accelerate PCNs
- Utilised transformation funding supporting new workforce roles
- Utilised transformation funding to support Population Health Management for PCNs
- Invested additional funds for workforce initiatives from the Local Workforce Advisory Board and Health Education England.
- Invested in primary care infrastructure estate through the estates transformation, technology funding (ETTF).

Some examples of what ETTF has supported in West Yorkshire and Harrogate include:

- Building new health centres which have a greater range of health services for patients in one place, including learning disability premises schemes. New consulting and treatment rooms to provide a wider range of services for patients, including improved reception and waiting areas
- Building new facilities to deal with minor injuries
- Creating better IT systems to improve the way information is shared between health services in the area

- Extending existing facilities to house a wider range of health staff.

Pharmacy, dental and eye care

Our Primary Care Strategy recognises the opportunities and value of the wider primary care community. This includes dental providers, community pharmacy and optometry providers. We will work hard to integrate these wider services in our transformation priorities and will ensure engagement of wider primary care in the PCNs across the Partnership.

The Partnership is supported by clinical leadership through our existing local professional networks for dentistry, pharmacy and eye health.

Pharmacy

Community pharmacy provides a huge opportunity to support the wider health care system in both the delivery of primary care and urgent care. The Partnership's Primary Care Strategy (make link once strategy is published) supports the integration of community pharmacy services across the area.

In July 2019 a new five year Community Pharmacy Contractual Framework deal was announced which builds on the aspirations and direction of community pharmacy within the Primary Care Strategy.

The future of community pharmacy recognises the valuable contribution that our contractors can make to the management of minor conditions through the Community Pharmacist Consultation Services. The Partnership recognises the opportunities of making the most of pharmacy and how it can support the demand in primary and urgent care.

We will work together to effectively implement the Community Pharmacist Consultation Service to support the urgent and emergency care system.

We are also working to make sure that community pharmacists are engaged in the work of Primary Care Networks alongside practice-based pharmacists.
There are some good examples across the area which demonstrates the difference community pharmacy make to people's experience of care and support but more needs to be done to ensure a consistent approach across all areas.

The Primary Care Strategy describes how the digital transformation agenda will support how services are delivered in community pharmacy. You can see a recent example in the roll out of NHS mail to community pharmacy. This work has provided a structure for the management of referral information and will drive forward future ways of working.

The Partnership recognises the work needed to progress how community pharmacy will develop and transform in line with PCNs. We are working hard to ensure that community pharmacy becomes an effective partner in the delivery of primary care services.

Eye care

Community based eye care services in primary care will be developed within each of our six local places to bring activity closer to home. The aim is to provide an integrated Primary Eye Care Service within each PCN across the Partnership. An eye health care capacity review led by the Improving Planned Care Programme (see page 55) has been undertaken to support service transformation in programmes such as; age-related macular degeneration (AMD), cataracts, diabetic eye disease, glaucoma and children's eye care services.

Dental services
We are seeing a growing number of people with dental problems accessing medical care with poor health outcomes. It's important that we strengthen the working relationship between dental and other sectors involved in PCNs ensuring better and more efficient care for people. Our aim is to join up dental and oral health services with the wider primary care systems working in PCNs and emergency care to improve people's oral health. We will encourage partnership working arrangements with dental and medical professions through local professional networks.

Starting Well is a nationally led pilot, which aims to reduce oral health inequalities and improving child oral health in the under-fives. Of the 13 local authority areas identified as having the greatest need, one is in Wakefield.

Seven practices in Wakefield successfully bid to be part of the pilot project. Some of the key deliverables are 'Prevention Champions', good oral health promotion and training for all staff in the principles of 'Delivering Better Oral Health', 'Making Every Contact Count' and basic oral health messages. An advanced practice must also adopt a setting to work with (for example a local nursey) to promote oral health and work with health professionals (for example Health visitors) to create referral/signposting opportunities.

Our five year ambitions

- **Dental and oral health services will be integrated with wider primary care systems working in Primary Care Networks and emergency care systems ensuring benefits to patient's oral health, also linking to wider health and social care provision where appropriate.**

Urgent and emergency care

[In a box]
Our vision for urgent and emergency care is that we should provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for people including unwell children and young people, carers and families. For those people with more serious or life-threatening emergency care needs, we aim to support people in specialist centres with the right expertise, processes and facilities to maximise a good recovery.

Our approach

Our urgent and emergency care system includes primary care, mental health, social care, urgent care, dentistry, community pharmacy and voluntary organisations. Our aim is to further develop our system so it delivers a highly responsive service for people. This involves working with other priority programmes who share common themes, such as mental health (see page 71) and supporting carers to avoid carer breakdown (see page 91). It means making sure that people's needs are met in the right place, at the right time, with the right support.

Watch this film of Dr Adam Sheppard, Clinical Chair for the Urgent and Emergency Care Programme Board to find out more.

How we work

Working together to improve our urgent and emergency care services is not new. In July 2015, West Yorkshire was selected by NHS England as one of eight Urgent and Emergency Care (UEC) Vanguards as part of its New Care Models Programme. Building on this solid platform, the West Yorkshire Acceleration Zone (WYAZ) was the first of its kind. It was set up to deliver improvements at pace in urgent and emergency care across West Yorkshire.

Our Yorkshire Ambulance Service partners are key to our urgent and emergency care work. As well as providing the 999 response service across Yorkshire and the Humber, they also provide the Integrated Urgent Care NHS 111 service. The role of this service is to help people in our six local places receive the best care possible in the most appropriate place.

[In a box]
West Yorkshire and Harrogate has five Local A&E Delivery Boards (Airedale and Bradford, Calderdale and Greater Huddersfield, Harrogate and Rural Districts, Leeds and Mid Yorkshire) covering the six places we work across. The Boards bring together the people and organisations that are responsible for delivering and coordinating local services. By working together they identify solutions to make sure that people receive the same quality of care wherever they live.

The difference we have made

Our programme leads on three improvement targets:

- Clinical Assessment Service: This joined up service allows for a greater level of clinical expertise in assessing a person's health needs than would normally be expected of a referring clinician (such as a GP). People are directed to the most appropriate care. We have achieved the target for 100% (To do: when to be added) of the population to have access to an Integrated Urgent Care (IUC) Clinical Assessment Service
- Direct Booking: This means that when a person calls NHS 111 and needs an appointment at their registered GP practice, call handlers at NHS 111 can make a booking for them. This saves people having to be 'passed around' the system. We have achieved the target for bookable face to face appointments in primary care services through NHS 111
- Clinical advice: We have increased the number of people receiving clinical advice via NHS 111.

[In a box]
A Health Foundation report (December 2018) highlighted how living alone can make older people 50% more likely to find themselves in A&E than those living with family. Pensioners living alone are also 25% more likely to develop a mental health condition. Social isolation can raise the risk of having a stroke by a third and is considered as unhealthy as smoking 15 cigarettes a day. In March 2019 we launched our first Partnership campaign 'Looking out for our neighbours' (see forward) which encourages communities to look out for each other through simple acts of kindness.

Our future priorities

Access to unplanned health and care services
There are too many entry points into the unplanned care system which causes confusion for staff and the public (see Healthwatch Engagement Report, June 2019). The majority of unplanned care services offer walk in options – yet this offer differs across our six local places.

People present at the service they are most familiar with, as opposed to the place that best meets their needs. Health and care colleagues report that the unplanned care landscape is difficult and complex to navigate. There is inconsistency in messaging and we need to get better at communicating what is available to who and when.

Across West Yorkshire and Harrogate there are multiple points of access, some available to the public, some to health and care colleagues only, some to both. One of our priorities is to bring the points of access together in each of our six places and where appropriate develop a consistent multi-disciplinary clinical offer.

The national concept of 'Talk before you walk' encourages people to ring NHS 111 before choosing to attend an unplanned care service, such as A&E. Our NHS 111 Integrated urgent care service will

create greater working together between the urgent (NHS 111) and emergency (999) services. This will allow for a more seamless transition between services and ultimately people accessing the right care based on their need.

[Case study]
The jointly commissioned Integrated Urgent Care service for Yorkshire and the Humber began on 1 April 2019 for an initial five-year term. It replaces the old NHS 111 service. The main changes are:

- Increase in clinical advice and direct booking
- Clinical validation for emergency department referrals
- Managing dental calls for children under five only and working with the new dental clinical assessment and booking service (CABS) provider who will manage callers aged five and over
- Additional patient pathways utilising local clinical advice services
- Greater collaboration and integration with locally commissioned services.

Shifting care from unplanned care to planned care as well as early help in our communities
Planned and unplanned (emergency 999) Patient Transport Services (PTS) is key to making sure the needs of people can be met within various healthcare settings. We want to create a hybrid service model between emergency and planned patient transport to safely manage the non-emergency cases in a timely way. The development of transport services programme will improve the National Ambulance Response Programme (ARP) targets, and accelerate access and joined up care between health and care transportation.

Our five year ambitions (To do: numbers for be added)

- **To improve access into the unplanned care system for public and staff**
- **To make the right thing to do, the easiest thing to do**
- **To support people's needs being met as close to their home as possible.**

Objectives

- To deliver the integrated urgent care specification and support people to navigate the system and access advice more easily.
- 100% of public will have the ability to access NHS 111 for clinical advice for unplanned health and care problems and where appropriate, onward referral.
- 100% of appropriate staff are able to access a single entry point into unplanned health and care services for advice and/or placement of people as needed. Including discharge from care services.
- Where appropriate, people will travel to planned and unplanned care appointments via timely Patient Transport Services (PTS)
- People receive a prompt and appropriate response when accessing emergency transport services.

Community urgent care

People tell us that there is a confusing mix of services for urgent care. These include walk-in centres, minor injuries units, urgent care centres and A&E's. In addition, general practices (GPs) offer different appointment systems and varied offers of core and extended services exist.

The publication of the NHS Long Term Plan (January 2019) and the NHS Operational Planning and Contracting Guidance 2019/20 highlights that commissioners who buy health services, should continue to redesign urgent care services outside of A&E and establish the majority of urgent treatment centres (UTCs) by December 2019.

[In a box]

Urgent treatment centres (UTCs) are GP-led; open at least 12 hours a day, every day. They offer appointments that can be booked through NHS 111 or through a GP referral, and are equipped to deal with many of the most common ailments people have who attend A&E.

UTCs ease the pressure on hospitals, so they are free to treat the most serious cases. Our UTC offer will reduce attendance at A&E or and offer people the opportunity to get to the right place for care.

UTCs should meet national standards so they operate effectively as part of a network of services including primary care, integrated urgent care, ambulance services and A&E.

At present we have two UTCs in West Yorkshire and Harrogate; St Georges (Leeds) and Pontefract Hospital (Wakefield). Key to the development of more UTCs will be the establishment of clear commissioning principles across our area to ensure access through 111.

As primary care networks (PCNs) and local care partnerships come together (see page 40), we will be clear on how they link with the UTC's to develop clearer more appropriate, additional services for people.

Looking at the development of UTC gives us the opportunity to support the development of 24/7 urgent primary care. This will include a review of GP Out of Hours and making the most of digital technology and the role of Primary Care Networks (PCN's). This will help us to make the most of resources and improve the health and wellbeing of people.

Yorkshire Ambulance Service responds to significant amounts of urgent care in the community, the needs of people is wide and varied. It includes falls, mental health, and respiratory conditions.

As UTCs models develop, transportation to UTCs will be reviewed and developed, to ensure that people are taken to the most appropriate place for care and treatment. We will work together through the UEC Programme to develop alternative care pathways and increase ambulance service capacity whilst reduce attendance at A&E (where safe to do so). This work will be commissioned and developed in partnership with our ambulance service.

Community urgent care priorities

- Implement UTCs where required to meet the 27 national core standards and provide a consistent 24/7 urgent primary care offer
- Agree key commissioning principles for the flow of people across the UTC's
- Contribute to the achievement of early help / preventing ill health in the community through implementation of UTCs
- To support the development of 24/7 urgent primary care across West Yorkshire and Harrogate, and providing an alternative capability to support the left shift.
    - Maximise opportunity to left shift by supporting the uptake of the Community Pharmacy Consultation Service (NHS 111 to community pharmacy).
    - Explore using the Community Pharmacy Consultation Service model (which is currently from NHS 111 to community pharmacy) to other interfaces such as A&E to community pharmacy and UTCs to community pharmacy.

[In a box]

The left shift is about moving clinically appropriate care and treatment for people from hospitals into the community; with the intent that this will lead to better health and wellbeing, better quality of care as well as sustainable and efficient services.

Acute hospital flow

Acute hospital flow relates to the movement of people through a hospital from the moment the person arrives at the hospital, until their discharge for an unplanned episode of care.

Efficient acute hospital flow is all about quickly, skilfully, and effectively meeting the demand of hospital care. It involves effective coordination of patient care, moving people through pathways safely, to achieve the best possible health outcomes for them. Poorly managed patient flow in hospitals can lead to adverse health outcomes, including increased re-admissions and mortality rates.

[In a box]

Care pathways are a way of setting out a process of best practice to be followed in the treatment of a person with a particular condition or with particular needs.

Priorities

- Ambulance handovers
- Non elective pathway development (see page 55)
  - Supporting the development of new pathways of care so that people do not get admitted to hospital
- Same day emergency care (SDEC) and ambulatory care
  - There will be an agreed timelines and targets for SDEC and the Integrated Urgent Care Services (IUCS)
- Co-located UTCs (see page 49)
- Provide an acute frailty service for at least 70 hours a week, and work towards achieving clinical frailty assessment within 30 minutes of arrival at hospital. Frailty can be defined as a state of high vulnerability for poor health outcomes, including disability, dependency, increased risk of falls, need for long-term care and mortality. Frailty is more common amongst older people. It can also affect younger people with long term health conditions as well.
- Hospital discharge processes working in partnership with social care services
- Reviewing emergency department areas including:
  - Developing new ways to look after patients admitted to A&E with the most serious illnesses and injuries particularly in relation to people who arrive in A&E following a stroke, heart attack, major trauma, severe asthma attack or with sepsis
  - Developing a standard model of delivery in smaller acute hospitals who serve people living in rural communities.

Our five year ambitions

- **Reduction in the number of admissions**
- **Contribute to the left shift through working in partnership**
- **Provide same day emergency care services for 12 hours a day/7 days a week**
- **Ensure same day emergency care areas are all recorded consistently.**
- **Implement the SAFER bundle ensuring 33% of people are discharged before midday**
- **Increase the number of people discharged over the weekend**
- **Reduce and maintain the number of delayed transfers of care at below 2.4% of the total acute hospital bed base**
- **Reduction of long length of stay patients to agreed targets**
- **Reduce the amount of people who are discharged when they are not as well as they could be – ensuring community support is in place**
- **Reduce the number of people who are medically fit to leave hospital but who have no community support in place**

- Ensure people with the most serious illnesses and injuries receive the best possible care in the shortest possible time in line with the NHS Clinical Standards Review (publication due Spring 2020)
- Achieve 95% Emergency Care Standard Target.

[In a box]
Winter is always tough but if we can help people quickly and get them home once they're medically fit then everyone benefits.

[Case study: add picture]
A special team on the wards at Bradford Royal Hospital link social care staff and nurses. They visit wards seven days a week to help patients to prepare to leave as soon as they are able reducing delays helping solve the non-medical issues which can delay discharge such as housing, social care packages and correct equipment.

[Case study: add picture]
Calderdale and Huddersfield NHS Foundation Trust routinely involve families and carers in decision making, and recognise the valuable input they provide in maintaining safe delivery of ongoing care. They have developed and changed to the needs of the patients and are successfully implementing Advance Care planning. The team is highly motivated and passionate around the care they deliver for frail patients, they have been particularly successful in building a strong team which not only incorporates the immediate members but reaches out to community, palliative care, care of the elderly wards, GP surgeries and voluntary sectors. The frailty service is successful in avoiding an average of 180 admissions every month and has reduced the length of stay for the frail patients that have been admitted. The team work very closely with patients, carers, community, social, mental health services and voluntary sector to deliver all care in the community and ensure we can avoid admission and discharge timely from when a patient has been admitted.

[Case study: add picture]
The Connecting Care Hubs in Wakefield is where health, social care, housing, voluntary and community organisations work side-by-side - helping those people most at risk stay well and out of hospital. This presents the opportunity to share learning and good practice. The Hubs are funded by both Wakefield Council and NHS Wakefield Clinical Commissioning Group. The Hubs have multiple agencies working together, all under one roof, to seamlessly support people with health and/ or social care needs who could otherwise receive fragmented care, with multiple referrals and handovers. This is joined up care at its best and in the last six months they've seen almost xxx people including xxx urgent referrals [To do: numbers to be updated].

Children and young people talk about their experience of using ambulatory care **in this film here.**

Our five year ambitions

- **From October 2019 we will maximise opportunity to support the uptake of the Community Pharmacy Consultation Service (NHS 111 to community pharmacy). During 2019/2020 we will embed the Same Day Emergency Care (SDEC) model in every acute hospital with a type 1 A&E department. This will increase the proportion of acute admissions discharged on the day of attendance from a fifth to a third**
- **During 2019 – 2020 we will ensure every acute hospital with a type 1 A&E department has an acute frailty service for at least 70 hours a week, and work towards achieving clinical frailty assessment within 30 minutes of arrival at hospital**
- **Work will be undertaken in 2019 – 2020 to ensure streamlined access to urgent mental health services including preparation towards NHS 111 being the single point of access to crisis services**

- **Between 2019 – 2021 we will aim to maintain an average DTOC figure of 4000 or fewer delays and over the next five years (2019 – 2024) reduce them further. We will reduce and maintain the number of delayed transfers of care at below 2.4% of the total acute hospital bed base**
- **The new emergency and urgent care standards are being tested as part of the Clinical Standards Review. We will not know the outcome of this until spring 2020**
- **As part of the NHS Clinical Standards Review, during 2020 we will further develop ways to look after people arriving at A&E with the most serious illness and injury, ensuring that they receive the best possible care in the shortest possible timeframe**
- **Commissioners will work together to commission an appropriate, effective and efficient GP Out of Hours service for 2020 and beyond, taking in to consideration the impact of Primary Care Networks, Extended Access and UTCs. The West Yorkshire and Harrogate ambition is to ensure there is access to 24/7 urgent primary care, to ensure appropriate care is delivered in a timely way and reduce the likelihood of unnecessary admissions via A&E**
- **By March 2020 we will ensure 100% of the population of West Yorkshire and Harrogate has access to bookable in hours GP appointments via NHS 111 by rolling out the full direct booking programme**
- **By March 2020, NHS 111 will be able to book more than 40% of people that have been triaged into a face to face appointment where this is needed**
- **By March 2020 50% + triaged calls receive a clinical assessment. Clinical Commissioning Groups will develop local Care Clinical Assessment Service to support the core Clinical Advice Service (CAS) at 111**
- **By March 2020 we aim to record 100% of patient activity in A&E, UTCs and SDEC via the Emergency Care Data Set (ECDS)**
- **By March 2020 100% of hospital handovers across Yorkshire and Humber occur within 30 mins.**
- **By autumn 2020 we will fully implement the Urgent Treatment Centre model so that all localities have a consistent offer for out-of-hospital urgent care, with the option of appointments booked through a call to NHS 111**
- **A three year plan (2019 – 2021) has been agreed at regional level for workforce and fleet changes to deliver the Ambulance Response Programme and the programme is committed to supporting this**
- **By 2023, CAS will typically act as the single point of access for patients, carers and health professionals for integrated urgent care and discharge from hospital care.**

Transforming planned care

The demand for planned care continues to increase year on year so our work to transform these services, to make sure they are the best they can be now and for the years to come, is crucial. To do this, we are:

- Shifting the focus away from hospitals by developing sustainable service models and clinical pathways that provide patient focussed health services in community settings where appropriate;
- Promoting prevention, self-care and supporting healthier choices so that people become their own healthcare experts and less reliant on medical interventions; and
- Standardising our clinical pathways, clinical thresholds and commissioning policies to reduce any unnecessary differences that currently exist. Having a single approach means the requirements that must be met to access and receive planned care services are the same for everyone.

Clinical pathways set out the various steps in the care of people referred for treatment by their GP or other health professional. For patients on a clinical pathway, there are various points at which decisions are made about their care. Decisions are based on medical evidence to make sure that patients receive the best and most appropriate course of treatment for them. These points on a pathway are known as clinical thresholds and are used to decide which treatments will be provided and funded by the NHS to provide the best care for patients. In episode 1 of our #WeWorkForYou podcast, Dr James Thomas,

Clinical Lead for the Partnership's Improving Planned Care Programme, explains more about clinical pathways and clinical thresholds. He also talks about commissioning policies, and why standardisation of clinical pathways, clinical thresholds and commissioning policies is a priority for the Partnership.

Our ambition is to transform local planned care services to make sure that we provide the right care to the right people at the right time. Further feedback from service users, and from those who work in planned care, will be invaluable in supporting us over the next five years in continuing to bring about this transformation.

In June 2019, Healthwatch carried out engagement around the NHS Long Term Plan and this revealed that people are committed to self-care but want the NHS to help them with this by providing more information and advice about healthy lifestyles and how they can better monitor their own health. The programme recognises the importance of providing self-care information and uses the Partnership's various communications and engagement channels, and those of our partner organisations, to do this at every opportunity. In addition, we incorporate self-care initiatives and guidance into our revised clinical pathways and policies whenever possible.

Our programme has an emphasis on personalised care (see page 34) and supports shared decision making which means a shift in emphasis from clinicians telling people what will happen, to clinicians discussing the best options with patients so they can make an informed decision about their own care. Feedback from the Healthwatch engagement highlighted the need for patients to be fully involved in all discussions regarding their care plan to make sure it meets their needs as far as possible. It's not a case of 'one size fits all'. Shared decision making is essential to successful implementation of our standardised clinical pathways, clinical thresholds and commissioning policies so we're working with clinicians and other health care colleagues to make sure that these important conversations routinely take place.

We will invest our funding as efficiently as possible to get the best personalised care for the greatest number of people. Whether it's community-based support or a surgical procedure, personalised care means that people receive the care that is right for them.

Musculoskeletal (MSK) services for muscles, joints and bones
In May 2019, the newly developed West Yorkshire and Harrogate MSK pathway was agreed for implementation across West Yorkshire and Harrogate. This single pathway supports the recurring theme of self-management with its inclusion of services that promote physical activity, pain management and psychological therapy. People have told us they want it to be easier and more affordable to use leisure facilities which can be expensive and not equitable for all. The pathway reflects this patient insight and includes a full range of treatment and support services, many of which can be accessed from GP surgeries or in the community.

[**Case study: add picture]**
People have told us they want to be able to access health care closer to home, including more specialist 'hospital' services available in community settings, so initiatives like our First Contact Practitioners (FCP) scheme are reflecting this feedback. The scheme moves appointments related to MSK conditions away from busy GPs and onto physiotherapists who are able to spend more time with patients. This is something patients have told us they would benefit from and in addition, longer appointments allow FCPs ample time to discuss self-care with their patients. This community-based scheme also links in with one of the priorities detailed in the NHS Long Term Plan and the GP contract (2019), which is the need for an expanded primary and community care workforce, developed around primary care networks. By 2023/24, this scheme should be extended throughout West Yorkshire and Harrogate offering all patients access to a FCP physiotherapist as part of the national elective care programme.

[In box]
The programme is also embracing advancements in technology for the MSK pathway and hopes to explore the potential for extending 'any to any' electronic referrals to MSK services to help speed up and streamline the referral process. Implementation of the MSK pathway and local service development is underway and is expected to continue up to May 2022.

Our five year ambitions MSK services

- Implementation of the MSK pathway and local service development is expected to continue up to May 2022.
- Ongoing work to develop single clinical pathways, clinical thresholds and commissioning policies for: knees; shoulders; hips; feet and ankles; and children's shoulder surgery is currently taking place. The implementation of shoulder policies is expected to start in late 2019 and will be followed by knees and hips in early 2020.
- September 2019 – work will start on the MSK policies included in the second EBI list due to be released in August 2019.

Eye care services (ophthalmology)
As with MSK services, our work on ophthalmology services will help manage rising demand by providing patient focussed services in 'out of hospital' settings where appropriate. The introduction of advanced clinical practitioners for eye health in community settings will also help to support this shift.

[In a box]
Our ambition is to make the best use of the eye care expertise we already have in our communities. Having some eye care services in local settings rather than hospitals makes them easier and more convenient to access. This will encourage more people to attend for the important checks that could potentially save their sight.

We are also making the best use of technology with initiatives such as the NHS e-Referral Service (eRS) that will enable community optometrists to refer directly into hospital eye services (case study) for conditions that are not urgent (i.e. not related to an accident or an emergency). The pilot (20 sites) will reduce unnecessary delays in referrals and take some of the pressure off GPs by using technology that makes it possible for optometrists to connect to eRS and refer patients directly to the hospital eye service they need.

[Case study: picture to be included]
The West Yorkshire and Harrogate Local Eye Health Network, working with Bradford University, has been successful in its bid for workforce development funding from Health Education England. The funding will enable optometrists to gain the accreditation required for earlier detection, decreasing false positive referrals and managing more people in a community setting. Health Education England has already funded over 200 local optometrists to train for the Professional Certificate in Glaucoma. This means that 15% of the area's optometrists are qualified to identify this common eye condition that can lead to loss of vision if it isn't diagnosed and treated early.

[Case study: pic to be included]
Half of all cases of sight loss are preventable. Through the Institute for Voluntary Action Research's 'Building Health Partnerships' programme, we are working with Wakefield Council and local community groups to raise awareness of sight loss prevention and promote eye health and regular checks from birth right through to old age.

Working with teams from **West Yorkshire Association of Acute Trust**, Getting It Right First Time (**GIRFT)**, **NHS RightCare** and **Public Health England**, we are building on data collected from a regional eye health capacity review to progress the transformation of local eye care services.

We have established teams of commissioners, clinicians, Local Optical Committee (LOC) representatives, eye clinic liaison officers, charity workers, service managers and vision rehabilitation workers to work on various transformation projects for eye care services. The project areas are: age related macular degeneration; diabetic retinopathy; glaucoma; cataracts; and children's eye services.

Each team is developing plans related to their assigned area of eye care with the aim of developing plans for service improvement to be implemented across the region. These plans could be in the form of a shared pathway, a new use of technology or a workforce initiative. All plans will reflect clinical evidence, best practice and patient insight.

We have been talking to service users, who are all members of the Kirklees Visual Impairment Network (KVIN), about their experiences of local eye care services. Public involvement around eye care service transformation is in the very early stages but this patient insight, and hopefully a great deal more to follow, will be invaluable in supporting the project teams as their work progresses over the next year or so. We expect to have these plans agreed by November 2019, with local service development and implementation taking place from May 2020 to May 2023.

Our five year ambitions for eye care services
We expect to have the eye care project plans agreed over the next year with local service development and implementation taking place over the next five years.

- September 2019 - a clinical pathway for monitoring of patients taking hydroxychloroquine agreed for adoption.
- Ongoing – clinical pathways, clinical thresholds or commissioning policies related to the eye care services project areas (age related macular degeneration (AMD); diabetic retinopathy; glaucoma; cataracts; and children's eye services) will be progressed over the next five years.
- 2019/20 - a single commissioning policy for dry eyes (keratoconjunctivitis sicca) will be developed.
- Other policies that fit in with the eye care project plans may also be considered for standardisation?

Clinical thresholds
Clinical thresholds are points on a pathway used to decide which treatments will be provided and funded by the NHS to provide the best care for people. In West Yorkshire and Harrogate we have unnecessary differences in some of our pathways and thresholds, meaning that some people may be receiving different treatments depending on where they live – often referred to as the 'postcode lottery'. We are working to remove this difference by making sure all treatments reflect the most up-to-date medical evidence and best practice. We have already standardised clinical pathways, including the new MSK pathway, and commissioning policies, including a single policy for flash glucose monitoring (for some people with type 1 diabetes) and a single policy for liothyronine to treat underactive thyroid gland. We estimate that by March 2024 we will have introduced a total of xxx standardised pathways and xxx single commissioning policies for West Yorkshire and Harrogate – do we include something like this?

Medicines and prescribing
We are working with pharmacy leaders and clinicians to identify and address unwarranted variation and waste in prescribing and this work is expected to continue until the end of March 2024. One example of this is our medicines optimisation scheme in care homes which is reducing the risk of harm from medicines and cutting down on waste.

[**Case study: add picture]**
The Medicines Optimisation in Care Homes (MOCH) scheme aims to reduce the risk of care home residents being harmed by medicines taken inappropriately or incorrectly. The scheme is a two-year project that is due to finish in our region in September 2020. The new GP contract announced on 31 January 2019 has a focus on care home patients with an Enhanced Health in Care Homes (EHCH) scheme. It is hoped that pharmacists and pharmacy technicians will have a role to play in the future as part of this scheme to further reduce the risk of medicine-related complications and unplanned

hospital admissions. In addition, the scheme is addressing the issue of medicines waste in care homes which is estimated to cost the NHS around £300 million each year, and it is helping to support care home staff with training and advice.

Everyone should have the same access to the same treatments, including when new medicines become available on the NHS, so one of our main priorities for medicines and prescribing is to introduce standard prescribing policies.

We are already very efficient in relation to prescribing and achieving best value from our medicines budgets, but there are still opportunities to improve. We will continue to reduce the prescribing of medicines that have little evidence to show that they work well, and raise awareness of medicines that can be bought 'over-the-counter' such as paracetamol and antihistamines for short term use. This national scheme involves carrying out in-depth reviews of the medication being taken by individual care home residents to make sure that it is still appropriate and working well for them. In West Yorkshire and Harrogate, we are already carrying out these reviews in care homes for people with learning disabilities and have started reviews in care homes for older people too.

Our five year ambitions for medicines and prescribing [To include: next draft]

Transforming outpatients

By offering people more options and supporting them to have greater involvement in choosing what care to have and where, we can reduce unnecessary referrals to outpatients. We are working with the West Yorkshire Association of Acute Trusts (also known as WYAAT and hospitals working together) and NHS Improvement to transform outpatient appointments and support the delivery of the NHS Long-Term Plan ambition to reduce face-to-face outpatient appointments by 30% in five years, by the end of March 2024. We know that people want to see more availability of virtual appointments, and telephone appointments so we are working to make the best use of technology that will allow this to be done effectively and securely (see page 102).

Hospitals working together

The West Yorkshire Association of Acute Trusts (WYAAT) is a collaboration of the six NHS trusts who deliver acute hospital services to the 2.6 million people across West Yorkshire and Harrogate. These are:

- Airedale NHS Foundation Trust
- Bradford Teaching Hospitals NHS Foundation Trust
- Calderdale & Huddersfield NHS Foundation Trust
- Harrogate and District NHS Foundation Trust
- Leeds Teaching
- Hospitals NHS Trust
- Mid-Yorkshire Hospitals NHS Trust.

The purpose of the association is to work together on behalf of patients and the population to deliver the best possible experience and outcomes within the available resources. In order to deliver more integrated, high quality and cost effective care for patients, services will increasingly be organised around the needs of the whole West Yorkshire and Harrogate population rather than planning at the level of each individual trust.

In support of this purpose, since 2016, WYAAT has created several joint programmes of work. They cover clinical services, clinical support services and corporate support services.

[In a box]
Since 2016, our acute hospitals have been working together to look at how we can use our collective resources, such as buildings and staff, to deliver the best possible experience and outcomes for people living across West Yorkshire and Harrogate. This reflects the need to consider the requirements of everyone together so we can deliver more integrated, high quality, and cost effective care for people.

Clinical services

Our clinical teams are working collaboratively in a number of ways.

We believe that patients should be seen and treated locally wherever possible; however for reasons of expertise and economies of scale some services may need to be delivered in a smaller number of centres of excellence and therefore require a networked approach to provide fair access to specialised care for all.

We have already created networks in five specialties – cardiology, dermatology, oral and maxillo-facial surgery, urology and gastroenterology. These teams have started to come together to share best practice, policies and procedures with the aim of increasing the consistency of care given to patients wherever they live in West Yorkshire and Harrogate. We will build on this work in other specialties.

In addition to better collaborative working across our hospitals, our clinical teams will work in a more co-ordinated way with their colleagues in primary and community care, social services and mental health services. Two examples are in elective orthopaedics and ophthalmology where the solutions to best care will require streamlined pathways between the hospitals and community care services.

By teams working together and seeing their place in the wider system, we will be in a good position to deliver services that are integrated and offer best treatment and care for all our citizens wherever they live in West Yorkshire and Harrogate.

[In a box]
'We all know that health and social care in the UK is under increasing pressure. If you have read the NHS Five Year Forward View you will know that it identified the triple challenge of better health, transformed quality of care delivery and sustainable finances. It is clear that we need to do things differently as a Partnership, and where appropriate, take a systems view. Dr Robin Jeffrey, Clinical Lead for West Yorkshire Association of Trusts.

[Case study]
GIRFT ('getting it right first time') is a national clinically led programme, that is designed to improve the quality of care within the NHS by encouraging standardisation of our practice and reducing unwarranted variations in care. By looking in detail at each specialty it focuses with our own staff on sharing best practice and delivering efficiencies and cost savings. In WYAAT we have started to work with GIRFT not just at individual trust level but as a system. This allows us to look at collaborative solutions, innovation and new models of working. It also puts clinicians at the heart of change and development. We shall continue this approach as the GIRFT programme rolls out to all of the major hospital specialties.

Elective surgery
This programme has had an initial focus on patients needing a hip or knee replacement. This work led by clinicians from all six acute hospitals, is based on using data and evidence to agree a consistent approach to patient pathways. Progress to date has been on developing standard referral

policies for GPs, designing a new approach for operating procedures to improve productivity in theatres and developing a common approach to patient information and education. In terms of the latter, we are exploring the potential for an interactive app to support patients in their journey.

We will complete and implement these initiatives across all acute hospitals, with our next focus being on how we help patients recover after surgery, for instance through physiotherapy. We are also piloting a national project for the procurement of orthopaedic prostheses, which we hope will increase consistency of practice and save money.

Vascular services
We have agreed to establish a single vascular service for West Yorkshire. Harrogate is not part of the service as their vascular services are provided by York Teaching Hospital NHS Foundation Trust. This will bring together the skills and expertise of staff from five acute hospitals, helping to attract and retain staff to support the delivery of sustainable services for all patients with conditions affecting their veins and arteries.

We are working with NHS England on proposals to consolidate the provision of complex and high risk vascular care into two major arterial centres, bringing together clinical expertise and high-tech facilities to provide specialist care. One centre will remain at Leeds General Infirmary, alongside the major trauma centre for the area. Following a comprehensive options appraisal process, involving senior vascular clinicians and independent clinical experts, WYAAT has recommended that the second centre should be at Bradford Royal Infirmary. A public consultation on this proposal will take place **[To do: add more information when we know more].**

[In a box]
'For people receiving treatment the West Yorkshire Vascular Service will improve ease and equity of access to vascular services as well as continuity of care. Although our outcomes are very good, there are pockets of knowledge, expertise, and technical developments held in different unit across the area. We need to embrace the 'best' practice and share the skills and break down any organisational boundaries. A single vascular service would allow development of regional wide sub-specialist teams to ensure everyone receives the same care and treatment no matter where they live'. Neeraj Bhasin, Regional Clinical Director for the West Yorkshire Vascular Services; West Yorkshire Association of Acute Trusts.

Pathology
We are working to develop a network for pathology services in West Yorkshire and Harrogate. This will mean collaboration across the area to address challenges around staffing, increasing demand and equipment upgrades. Standardisation of processes and increased consistency will release resources that can be invested in developing staff and services such as digital pathology to improve services for patients. While each trust will retain onsite testing to support urgent and acute care needs, other testing will be done in fewer places.

To underpin this standardisation of processes, we have been successful in securing £12 million national capital funding to implement a single Laboratory Information Management System (LIMS) across West Yorkshire and Harrogate. This will enable all data to be captured consistently in one system, provide an ability to track samples moving between laboratories and with results available for all clinicians to view across the area, reducing the need for duplicate testing of patients. It is expected that a single LIMS will be operational in every trust by the end of 2022 with implementation of the whole programme being concluded by the end of 2023.

Radiology

The WYAAT hospitals are working together with hospitals in Hull, North Lincolnshire and York as the Yorkshire Imaging Collaborative. Their objective is to ensure that every patient in our part of the region is able to attend an appointment at any hospital and the clinicians there will be able to access the patient's medical images and associated reports irrespective of where the image was taken. This will avoid the need for patients to travel to other hospitals, have repeated scans and exposure to additional radiation.

The first step towards achieving this objective is the implementation of a new, common picture archiving and communication system (PACS) across the hospitals. This is the system that allows doctors to view medical images such as x-rays and MRI scans. As well as improving care for patients by providing access to images and reports across the region, this programme has reduced the costs of running the system. The new software is being implemented in a phased approach: five trusts are already using the new software with the remainder of the programme to be completed by July 2020.

The next phase is the implementation of a sharing solution, technology that will deliver the ability for images taken in one hospital to be reported by radiologists and reporting radiographers working in different hospitals to where a scan took place. This will maximise the collaborative capacity of these radiology reporting staff and shorten the elapsed time between images being taken and the necessary reports reduced. For the WYAAT hospitals this work is due for completion in late 2020/21.

In order to maximise the benefits of the common PACS and sharing solution; clinicians have begun working in Special Interest Groups (e.g. Breast, Neurology) to harmonise how they undertake patient scans and reporting across our hospitals, in order to allow them to work together to deliver better patient care.

[In a box]

Working in a collaborative image sharing network is good for radiologists. It allows them to share expertise, balance workload during times of staffing shortage and work better at scale. This is one of many reasons why our Partnership exists.

Pharmacy

This is another programme where the WYAAT hospitals are working with hospitals in other parts of Yorkshire to improve our medicines supply chain. This aims to reduce costs, improve service levels, manage any risks and drive innovation, ensuring that the medicines supply chain is able to meet future challenges and demands. This collaborative approach has allowed the nine trusts to reduce the value of stock held. A future programme may involve a joint approach to the preparation of parenteral products including chemotherapy; reducing the risk of medication error and freeing up nursing time from preparing medicines.

Corporate Support Services

Workforce

Our dedicated staff is our biggest asset and we employ over 50,000 people between us. Supporting them to work together is a priority. We have pursued a number of initiatives.

We have put in place a 'portability' arrangement to make it easier for staff employed in one trust to work in any of the others. This will give staff the chance to develop a wider range of skills and experience without the need to leave their current job and be recruited to another elsewhere. We have moved to a single occupational health system across our organisations supporting our staff in a consistent manner. We have also developed a new standard job description for band 2 and 3 clinical support workers, again increasing the ability for staff to work across the WYAAT hospitals.

Plans for the future include working to introduce a common approach to electronic rostering of staff, which will help free up time ward and other department managers. We are also exploring opportunities to reduce fees paid to agencies who supply staff to meet a temporary need. This is initially focussed on junior doctors. Building on the 'portability' arrangement we are looking to establish a shared staffing bank so that doctors employed by one trust on NHS terms and conditions can not only look to fill vacant shifts in their employing organisation but can also fill vacant shifts at other WYAAT hospitals.

Planning for our future workforce is a key issue. As part of this we are developing a policy and pay framework for apprenticeships, maximising the use of this route for training staff. We are also working with NHS Improvement and Huddersfield University regarding new nursing roles in medical assessment units, which will be piloted at Airedale NHS Foundation Trust

Scan4Safety

Scan4Safety is a digital innovation that will deliver huge benefits to the NHS. The programme uses barcodes and scanning technology to track patients and the products used in their healthcare, improving patient safety and experience and also reducing costs significantly, releasing funds to provide better care.

The idea is to make sure we have the 'right patient, right product, right place and right process' every time. Mobile applications are used to capture a person's details at their bedside, increasing the amount of time staff can spend providing care. Scan4Safety will improve data quality in patient records and administrative systems, such as stock control, and it is estimated it will deliver annual savings of £7-10m across West Yorkshire and Harrogate.

Leeds Teaching Hospitals NHS Trust took part in a national pilot programme, following the success of this pilot, in 2018 West Yorkshire and Harrogate made a successful bid for national funding. Work has begun to start the roll out of Scan4Saftety across all the other WYAAT hospitals, with large scale transformation planned for 2020/21.

Procurement (sourcing products and services)

We are working together to identify areas where we can standardise products and purchase them collectively to reduce prices and achieve better value for the public purse. For example, standardising the selection of surgical gloves will save £200,000 and also help staff as they can access the same gloves when working at different sites. So far, this work has resulted in savings of just over £1 million. We are continuing to look for opportunities and to provide procurement expertise into the work of other WYAAT programmes.

In response to the implementation of the new national procurement model and proposals to make changes at a regional level, Heads of Procurement in the WYAAT trusts are now starting to look at ways in which they can collaborate in the delivery of the procurement function itself. Initial priorities are the development of a collaborative sourcing plan, with individual trusts managing the process for particular categories on behalf of the others; and the central management of the implementation and maintenance of procurement systems including product catalogues, e-sourcing tools, inventory solutions and a central contract database.

You can read the West Yorkshire Association Annual Reporter here **(To do: add link once completed).**

Priority areas for improving outcomes

Our Partnership has a number of priority programmes which are designed to improve services and health outcomes for specific groups of people.

Maternity

Better Births, the national maternity review published in 2016, celebrates the improvements that have been made in maternity services and identifies how we can work together to ensure women are healthy, make informed choices and are able to have the safest possible birth for themselves and their babies. It is also the starting point for the development of Local Maternity Systems which are responsible for implementing the recommendations of the review.

[In a box]
We aim to be the place where women and their families choose to receive their maternity care and birth their babies with as much choice as possible but also make sure that we have specialist help available within our area. Rather than working in isolation we now work together as a local maternity system (LMS). This gives us the opportunity to give women choice across a wide geographical area and also allows us to concentrate specialist services where they are most effective. This way we can make sure that women get the right care, in the right place, at the right time. Wherever women choose, they will be looked after by highly trained staff offering a quality, safe and personalised service. You can read more here.

West Yorkshire and Harrogate Maternity Programme has been working to establish the Local Maternity System (LMS) since 2017. It is now firmly embedded as a priority programme in our Partnership.
A comprehensive LMS Plan has been co-produced with women and staff and is available here. This includes our measures over time and performance to date, including our risks and how we will address them.

The LMS has a robust Governance structure, with all key decisions being approved by the LMS Board, including how our transformation monies are allocated and spent.

The LMS brings together partners with one ambition to deliver the vision to transform maternity and neonatal services across West Yorkshire and Harrogate. The partnership includes maternity, neonatal and paediatric services, primary care, health visitors, commissioners, our councils, women and their families. Carol McKenna, Senior Responsible Officer for the Maternity Programme outlines **our ambitions in this film.**

The LMS vision is based on a partnership approach with women, their partners and families. It considers all their needs and wishes. To deliver the vision, strong leadership is embedded from the delivery of Better Births and we will continue to build on this to fulfil the requirements of The NHS Long Term Plan. We have identified interdependencies with our other Partnership priorities, such as mental health, urgent care and preventing ill health and most importantly working with communities in partnership with our six local places (Bradford District and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield).

Working together with women, their partners and families

We hear and act on the voices of women and their families through working together and supporting local Maternity Voices Partnerships (MVP).

Where areas did not have an MVP the LMS has successfully supported their development. MVPs have co-produced our local maternity offer (My Journey) in a variety of accessible formats. You can read the easy read version here.

LMS next steps include:

- Continuing to support and develop our MVP network
- Increasing engagement and co-production with men as parents
- Work with the emerging national volunteering programme to develop volunteering across our maternity services at a local and West Yorkshire and Harrogate level.

Highly skilled and knowledgeable maternity workforce

The LMS has nationally recognised maternity services that attracts and intends to retain a highly effective workforce that is well led, innovative and will continuously learn. The LMS workforce priority areas include: a staff health and wellbeing project to support sustainable organisational change to working patterns and models of care for the maternity workforce; staff preceptorship; leadership and recruitment. The LMS will continue to support staff to deliver care which is women centred, work in high performing teams, in organisations that are well led, in a culture which promotes innovation and continuous learning. We are working together to coordinate recruitment activity to minimise inefficiencies, support the most vulnerable services and avoid duplicate job offers.

LMS next steps include:

- Improving the cost effectiveness and consistency of training for the maternity workforce with early focus on standardising the preceptorship programme for newly qualified midwives and mandatory and primary training for existing and new staff
- Investing in the capability and skills of the maternity workforce, concentrating on the maternity support worker role
- Improving leadership culture by establishing the cultural values and behaviours we expect from our senior leaders through the new LMS Professional Midwifery Advocate Network.

Making our maternity services safer for women, babies and staff

Stillbirths and neonatal deaths have been reduced by 10% across WY&H (Yorkshire and Humber Maternity Dashboard). There has been a focus on improving care for preterm infants - more mothers in preterm labour have received magnesium sulphate to prevent cerebral palsy in their preterm infant**.** Mechanisms have been established for reviewing incidents across the LMS to share the learning. Collaborative work has been undertaken to improve pre-hospital maternity care with Yorkshire Ambulance Service. The LMS has supported hospitals to achieve safety standards in the NHS Resolution Maternity Incentive Scheme. We will continue to work towards the ambitions of Saving Babies Lives v2 with particular focus on the new element on reducing pre-term births.

LMS next steps include:

- Increasing uptake of magnesium sulphate by women in preterm labour to prevent cerebral palsy in preterm infants
- Participating in exception reporting and review of babies less than 27 weeks born outside of a Neonatal Intensive Care Unit, ensuring themes and lessons are learned and shared
- Establishing a multi-disciplinary preterm prevention working group
- Full implementation of Saving Babies Lives v2 by 2020
- Review and implement where appropriate the recommendations from the National Patient Safety Strategy (2019), to improve women and baby's safety, preventing harm and the costs associated costs with it.

The LMS ambition is to

- **Reduce stillbirths, neonatal brain injuries, neonatal and maternal mortality by 20% by 2020 and 50% by 2025**
- **Reduce preterm births to 6% by 2025.**

We will also:

- **Continue working with the Maternity and Neonatal Health Safety Collaborative**
- **Publish and circulate crib-cards for community midwives to improve pre-hospital transfers**
- **Participate in the development of a Maternal Medicine Network**
- **Deliver new specialist services and clinics including Maternal Medicine and Preterm clinics**
- **Consider recommendations and actions for women with specific physical and mental conditions before, during and after pregnancy e.g. diabetes, respiratory, perinatal mental health**
- **Ensure that pregnant women with Type 1 diabetes are offered glucose monitoring from April 2020, where clinically appropriate**
- **Co-produce system wide guidelines along the maternity care pathway with staff and women**
- **Work in partnership with the Neonatal Operational Delivery Network (ODN) to improve neonatal care in line with the NHS Long Term Plan Implementation Framework to support the expansion and improvement of neonatal critical care services and develop allied health professional (AHP) support; and ensure that there are care coordinators within each of the clinical neonatal networks across England to support families to become more involved in the care of their baby (please note the regional specialist commissioning team and ODN are responsible for this work).**

Working together to provide choice and personalised care for women and their families

Women are able to choose where they have their antenatal, birth and postnatal care, and we are working across the LMS to ensure women are fully informed about the choices available. Our Partnership has **i**ncreased the number of babies born in midwifery settings, such as home or a birth centres; we have worked with women and their families to co-produce and publish the LMS choice offer. Training has been developed for staff to ensure all women have a meaningful conversation about where their baby can be born and what choices they can make**.**

You can watch Becky's story explaining the importance of personal choice and her experience of using local maternity services.

One in four mothers suffers from mental health problems during pregnancy or in the first year after childbirth and the LMS works collaboratively with the Partnership's Mental Health, Learning Disabilities and Autism Programme to support women and their families (see page 71).

LMS next steps include:

- Offering personalised care to all women and their families and co-producing a personalised care plan framework for women and their families to record their choices and wishes

The LMS ambition is to increase the number of women…

- **With a personalised care plan to 50% by 2020 & 100% by 2021**
- **Reporting they have received personalised care to 50% by 2020 & to 95% by 2021**
- **Able to choose from three places of birth to 75% by 2020 & 90% by 2021**
- **Giving birth in midwifery settings to 30% by 2020 & 60% by 2021.**

Continuity of carer

Women who receive continuity of carer from a small team of midwives, whom they know and trust, build trusting relationships and receive safer care (Sandall et al: 2016). In 2018 less than 1% of women received continuity of carer throughout their pregnancy journey in our LMS. Over 10% of women in WY&H were placed onto continuity pathways in March 2019. New models are being developed and learning from these will be shared, through our Continuity of Carer Forum, so that by 2021 the majority of women across our area will experience and benefit from continuity of carer.

LMS next steps include:

- Evaluating the current continuity of carer models
- Continuing to involve our MVP network and sharing lessons learned as we proceed
- Increase the number of models and teams delivering a continuity of carer pathway
- Focussing on continuity of carer models for those women and families for whom we believe we can have the biggest impact and improve outcomes for women and families, including for women in the most deprived areas, to address health inequalities.

The LMS ambition is to increase the number of women receiving continuity of carer:

- **To 35% by March 2020**
- **To most women by 2021**
- **To 75% women from black and minority ethnic groups and areas of greatest deprivation by 2024**

Better postnatal care

The LMS has brought partners and families together and begun to explore how postnatal care can be personalised to the needs of each family to support their best start. LMS next steps include:

- Co-producing a strengthened postnatal action plan for the LMS
- Improving the transfer of care and information between midwifery and primary care & health visiting services
- Scoping our current obstetric physiotherapy services; then improving access and care pathways to specialist pelvis health clinics.

The LMS ambition is

- **To ensure all providers are accredited or have commenced the process to achieve the UNICEF Baby Friendly initiative by 2020.**

Prevention and health inequalities

We want to ensure preventing ill health and tackling health inequalities is at the heart of all we do in all areas of improvement and change. The LMS has undertaken and published a comprehensive Health Needs assessment and Equality Impact Assessment. Providing support for parents as early as possible is essential to ensure infants and children live healthier lives.

Every woman and their family should experience a healthy pregnancy wherever possible – starting from supporting women and their families to plan for pregnancy through to being in the best possible health before, during and after.

Our LMS Maternity Prevention and health inequalities work stream is led by public health colleagues from our six local places, who work at a local level to identify good practice which can be shared across the whole of our area.

They also identify issues that impact on the health and wellbeing of women and their families, such as some of the challenges parents face around whole family health and activities.

LMS next steps include:

- Ensuring all maternity units have an accredited, evidence-based infant feeding programme, such as the UNICEF Baby Friendly Initiative
- Working with women and families experiencing multiple unhealthy risk factors and understand how the social and clinical needs of women are interlinked
- Exploring the many health inequalities faced by women and their partners in pregnancy which add to the clinical risk to both women and their babies
    - Identifying and working with specific target groups of women and families including Black and Ethnic Minority Groups, poor socio-economic back groups, Gypsy and Traveller communities and vulnerable women to fully understand their needs and the barriers to care

The LMS ambition is to

- **reduce smoking in pregnancy to 6% by 2025**
- **increase breastfeeding initiation rates**
- **offer continuity of carer to 75% women from black and minority ethnic groups and areas of greatest deprivation by 2024**

Birth to 1001 Days

We will identify strategies to contribute to the 1001 Critical Day's manifesto and the findings of the All Party Parliamentary Group to ensure that babies born in West Yorkshire and Harrogate have the best possible start in life from conception to age two.

Our next steps include:
The LMS will work closely with the Children and Young People's (CYP) Programme and the National CYP Transformation Programme, to achieve the following ambitions:

- Improve performance of childhood screening and immunisation programmes and meet the standard in the NHS public health functions agreements
- Improve maternal nutrition and infant feeding to prevent childhood obesity
- Improve parenting and bonding to provide loving and safe environments to support social and emotional development.

Digital

We have completed an LMS digital maturity assessment and are developing a plan to respond to the recommendations and meet the national ambition for digital maternity records. Within the LMS, we will learn from the local digital maternity pilot site. There is a number of different electronic patient record systems utilised across the LMS.

Our next steps include a review of the interoperability (IT systems which talk to one another) opportunities to facilitate the safe transfer of information between providers when care is transferred.

The LMS ambition is for all women to have their own digital maternity record by 2023/24

Communications and engagement

We have co-produced and are delivering our communications and engagement plan. We have identified areas of excellent engagement and areas for improvement.

Our next steps include:

- **A series of LMS Roadshows in provider trusts**
- **Targeted engagement sessions with identified professional groups.**

Alison Pedlingham, Head of Midwifery at Harrogate and District NHS Foundation Trust, talks about how the West Yorkshire and Harrogate local maternity system is improving maternity services. You can **watch it here.**

Children and young people

The health of children and young people is crucial to our f this country, but England's levels of care and wellbeing currently lag behind the rest of Western Europe. The health of children and young people is determined by far more than healthcare. Household income, education, housing, stable and loving family life and a healthy environment all significantly influence young people's health and life chances. By itself, better healthcare can never fully compensate for the health impact of wider social and economic influences.

[Case study}
'I was terrified when I became pregnant with my first child aged 18. All I could think about was that I had 'messed up'. I lived with my grandmother who was so disappointed in me she threw me out. I had to move in with my partner. Living off his sole wage life was tough. When my baby arrived I struggled with the responsibility and found I couldn't bond with him. I felt isolated and would lie awake at night crying. I attended the Home-Start young parents group. The Peer Educator (PE) made me feel so welcome. I had lots of support and learned a lot. I decided to train as a PE myself but a couple of days before the course started I found out I was pregnant again. I was so determined I completed it anyway. Returning to college was a way to sort myself out. My confidence has grown massively, I have been through some hard times but I can officially say I have signed off support and have stepped up to being a PE and am now supporting other young mums currently attending group.' Jane is a Peer Educator.

Children and young people (0-18) account for 23% (570,000) of the total West Yorkshire and Harrogate population. Improving the health and wellbeing of children and young people is an investment in future generations and the prosperity of this country.

Many of our children and young people are already achieving positive outcomes across aspects of well-being and enjoy life to the full. Over recent years we have seen improvements across West Yorkshire and Harrogate most notably:

- School readiness has increased from 51.2% in 2012/13 to 67.5% in 2017/18.
- 6% of 16-17 Year olds in West Yorkshire and Harrogate are not in education, employment or training. This is the same as the England rate (To do: add what it has improved from).

However, we know that too many of our children and young people still live with poor mental health, in poverty, experience homelessness or insecure/unsafe environments. Recent figures show

- Deprivation rates vary, with Bradford being the 11th most deprived area in the country, Kirklees the 95thand Harrogate the 188th.
- Rates of children looked after are higher in West Yorkshire at 72.1 per 10,000 compared to 63.6 for England.

- Infant death rates for England are declining, however in West Yorkshire and Harrogate the rates have been increasing year on year since 2012.
- The rate of hospital admissions for dental caries (0-5 years) per 100,000 is 64% higher in West Yorkshire and Harrogate (534 per 100,000) compared to England (325 per 100,000).
- 19.2% of West Yorkshire and Harrogate children aged 0-16 are living in families in receipt of Child Tax Credit whose reported income is less than 60 per cent of the median income or in receipt of ISA/JSA. The England average in 2016 was 17%.
- The rate of children who started to be looked after due to abuse or neglect across West Yorkshire and Harrogate is 17 per 10,000 children aged under 18.
- The rate of children and young people killed and seriously injured on England's roads per 100.000 is 10% higher in West Yorkshire and Harrogate (45 per 100,000) compared to England (41 per 100,000).

All our six local places have a Children and Young People Plan; some of these are in draft or under review.

Ofsted inspection findings vary across West Yorkshire and Harrogate for Education, Childcare and Children's Social Care, Local Area Special Educational Needs or Disability (SEND).

The local child health profiles show that there are common challenges across the system for example children and young people road accidents and there are outcomes where inequalities can be seen across the system.

Many of the West Yorkshire and Harrogate Priority Programmes include a focus on children, young people and families, for example carers, maternity and mental health and we will work across these areas to ensure links are made.

The West Yorkshire Association of Acute Trusts (hospitals working together) have been developing a Clinical Strategy on behalf of the Partnership and have produced a report on the early engagement work on children, young people and families.

[Case study: add picture]
Bradford Teaching Hospitals NHS Foundation Trust has developed a service with families called the 'Ambulatory Care Experience' (ACE). In collaboration with Bradford Clinical Commissioning Groups and GPs, ACE aims to provide an alternative to a hospital referral or admission for children and young people who have become acutely unwell with common childhood illnesses and need a period of observation after initial assessment for up to three days. Referrals are accepted from GPs, nurses, A&E and the paediatric ward at the Bradford Royal Infirmary. Ongoing clinical monitoring is undertaken in the community by specially trained children's nurses.

We also know there are recruitment and retention challenges in health and social care. Over the next decade, technologies and treatments will advance; changing demographics will result in further changes to the population. There will be a reduction in acute illnesses and children with single gene disorders and cancer will have better, more effective treatments. This will be offset by an increasing population of children with complex needs, technology dependence and 'normal' children presenting with 'normal' symptoms or psychiatric / psychosomatic problems. This will require a different workforce and delivery methods to meet those changing needs.

The NHS Long Term Plan sets out the priorities for improving care quality and outcomes, addressing unmet need, unexplained local differences and developing new models of care fit for the changing needs and demands of the population. The plan calls for the NHS to increasingly be:

- More joined up and coordinated in its care
- More proactive in the services it provided

- More differentiates in its support offer to individuals.

The NHS Long Term plan also calls for closer working relationships between health and local councils for a greater focus on preventing ill health, health inequalities and the wider social and economic determinants of health (see page 23).

To achieve the aspirations of the NHS Long Term Plan for the Children and Young People Programme we will focus on the added value of working together as a system to improve children, young people and their families health and life chances. This will include opportunities to address heath inequalities, complex issues and influence or implement actions at scale or standardise practice to improve outcomes for children, young people and their families.

[Case study]
In West Yorkshire and Harrogate there are many children and young people growing up in poverty and higher than average childhood obesity levels. Our aim is to improve the way that services are provided with a greater focus on helping people earlier rather than later and keeping people well. One example of how we are working more closely in our local areas is the 'Kirklees Integrated Healthy Child Programme, working under the banner of 'Thriving Kirklees'. It is made up of Local Community Partnerships, South West Yorkshire Partnership NHS Foundation Trust, Northorpe Hall, Home-Start and Yorkshire Children's Centre. You can find out more here.

Our five year ambitions
Initial scoping work for the programme has identified the following priorities:

- **Acute Paediatrics (children's hospital care) linked into the West Yorkshire Association of Acute Trusts work with an initial focus on ambulatory care experience**
- **Early intervention and prevention by 'intervening early in the life of a problem'**
- **Complex needs, Special Educational Needs and Disabilities (SEND)**
- **Long term health conditions**
- **Palliative and end of life care- link into the Yorkshire and Humber Pediatric Palliative Care network**
- **Working with the Mental Health, Learning Disability and Autism Programme to agree collective priorities alongside a focus on the behaviour of adults impacting on the lives of children.**

Mental health, learning disabilities and autism

We aim to deliver excellent health and wellbeing outcomes for people with a mental health condition, learning disabilities and autism.

[In a box]
Up to one in 4 of us will suffer from poor mental health at some point in our lives and for those with a severe illness it can lead to dying 20 years earlier than the rest of the population. Having a learning disability also increases the likelihood of experiencing health inequalities and poverty, whilst having autism limits people's opportunities of employment and good wellbeing (see page 71).

Working together in partnership gives us a greater opportunity to improve people's lives. If we use our collective expertise and resources (money, buildings and staff) we can provide higher quality services and reinvest financial savings to support care closer to home, such as for people with an eating disorder, anxiety and depression, or a child with complex behaviours who needs specialist understanding.

Good hospital and community services are only part of the picture. We want people to be at the centre of their care with all their physical, mental and social needs met through joined up care and support.

By sharing what works well across West Yorkshire and Harrogate we can tackle the wider social determinants of poor mental health, ultimately seeing fewer people in crisis, less people reliant on hospital beds and smaller numbers of people left behind without the support they need to lead a fulfilling life.

We intend to:

- Eliminate people who have to go outside of West Yorkshire and Harrogate for their treatment, including for those with complex needs
- Work together to make best use of our hospital beds
- Ensure people in crisis get treatment at any time of day either at home, or close to home
- Reduce the number of people who end up being treated in A&E
- Reduce the number of people being held in police cells when they are in crisis
- Reduce the number of people who take their own lives
- Develop new ways of working for specialist services such as children & young people's mental health, eating disorders and mental health services for those who may be a risk to others
- Reduce waiting times for autism and attention deficit hyperactivity disorder (ADHD) assessments
- Support people with a learning disability and challenging behaviours in the community rather than hospital settings
- When people with a learning disability do require hospital care we want to make sure this is of the highest quality and tailored to their needs
- Help people with a learning disability and or autism have a longer, better life by improving their physical and mental health.

Just like our other programme areas, the majority of work takes place in our six local places (Bradford District and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield) through partnerships of NHS organisations, councils and community groups.

Mental health is receiving an increased share of the overall NHS budget and the programme will be overseeing achievement of the Mental Health Investment Standard, holding local places to account so that they spend at least the minimum expected levels of funding to improve mental health.

Each area has a Local Transformation Plan overseen by the Health and Wellbeing Board. Mental health and wellbeing features heavily in Primary Care 'Home' developments through increased focus on early help, preventing ill health (including health-checks), support across the full age spectrum and as providers of psychological therapies for common mental health conditions (see page 71).

Our Mental Health, Learning Disability and Autism Programme works work closely with 'place' to ensure local and the West Yorkshire and Harrogate work is connected. This helps to ensure we avoid duplication and adopt a 'do once' approach to commissioning (buying services). The programme has developed a more detailed strategy which underpins this chapter and it can be accessed here [to add once completed].

The story

Many people's mental health problems begin in childhood, are shaped by where and how they live, and can have a lifelong impact within their family and across generations. Poorer mental health is associated with higher rates of smoking, substance abuse, lower educational attainment, poor employment prospects/rates, along with decreased social relationships and lower resilience.

We know that people with autism and/or learning disabilities have much higher rates of mental health illness than many other groups of people alongside the other challenges posed by their diagnoses. The contribution of wider determinants of health and the impact they have on keeping children and people with learning disabilities and/or autism and those with mental illness well is a priority for the improving population health programme (see page 28).

Creating one programme of work across all these areas will enable greater understanding of the challenges people who access care and their carers' face. Care services will adjust what they do to support those more challenging needs, from improving access to providing information in accessible formats and ensuring staff demonstrate the right attitudes to people.

Addressing these issues requires close working with other programmes of work such as maternity, cancer and primary care. The table below sets out why this work is so important to the health and wellbeing, and life chances of all those we support.

[Info graphic to be produced for the table]

Mental health/Illness Approx. 25% prevalence per year	**Learning disability (LD**) approx. 10% prevalence	**Autism/ADHD** Between 1-4% prevalence
-75% of people with long term MH illnesses are unemployed -50% of people with anxiety/depression for over12 months are unemployed -50% of MH problems are established by age 14 -62% of Looked After Children (LAC) are in care because of abuse/neglect - 1 in 6 adults has experienced MH problems in the last week - People with severe Mental illness die on average 15-20 years earlier than the general population (often from poor physical health)	- twice as likely as the general population to suffer mental health issues -more likely to experience deprivation, poverty & other adverse life events early in life - higher risk for poor physical health - 4x more likely to die of something that could have been prevented -dying on average 20 years earlier than the general population -unlikely to be in paid employment (less than 6% in 2017) - can spend too long, inappropriately in hospital and be over medicated	- wait too long for diagnosis across the age spectrum & receive little pre or post diagnostic support - have worse physical and mental health than the general population - suffer from lack of awareness about their condition (& late diagnosis) - need better understanding of what reasonable adjustment to services looks like to ensure access to care, employment, education is improved - leading cause of premature death for adults is suicide - only 16% of adults in full-time paid employment; 32% in any paid work
Carers/families – unpaid carers save the UK over £132 billion a year and are particularly relevant for individuals diagnosed with mental ill health, learning disabilities and/or Autism/ADHD. As part of this strategy particular attention will be paid to how, as an integrated system, we can better support carers and recognize the daily challenges that carers face when either trying to navigate support/care for their loved one or trying to support them to keep them psychologically and physically well. The programme will also actively support the Worker Carers Passport Initiative.		

We need to not only work on these wider determinants but also increase access to specific services, including to other important physical health services such as dentistry, opticians screening and health checks. And we also need to ensure support is provided where transition/change occurs within a person's life, as their resilience and often their carer's resilience, can be destabilised.

Further education and employment opportunities also remain low, contributing to those with a learning disability or severe mental illness finding it hard to keep in work. Yet we are optimistic we can address this together at a West Yorkshire and Harrogate level, by testing employment schemes such as individual placement and support, looking at good practice elsewhere in the country and lobbying locally for change.

[Case study: add picture]
South West Yorkshire Partnership NHS Foundation Trust runs a network of recovery colleges in Calderdale, Kirklees, Wakefield and within forensic services at Fieldhead Hospital. Colleges focus on developing people's strengths, helping them understand their own challenges and how they can best manage these in order to live fulfilling lives. Courses are developed and delivered by people with lived experience of health problems alongside professionals. Some of the colleges are already offering training packages to workplaces and there are plans to extend the offer across the region to help raise awareness of mental health issues and reach even more people. Recent evaluation of learners' progress at Wakefield & 5 Towns Recovery College found that 29% of students have self-reported a decrease in their contact with health services and 18% have gone into employment, volunteering or education following attending the college.

[In a box]
As a Partnership we commit to all new health and care buildings being learning disability and autism friendly, that the company building the development supports learning disability apprenticeships and we also employ them to work as peer supporters.

Programme priorities

We adopt three approaches across West Yorkshire and Harrogate depending on the challenges we face and what these mean for each of our six local places. We:

- Share learning across our places, collaborating to reduce differences in practice but ultimately leaving decisions on what to do to be taken locally
- Standardise practice, ensuring that for those services that cross local boundaries there is common practice, agreed by each place but undertaken locally in the same way
- Reconfigure services, doing things across West Yorkshire and Harrogate on behalf of all places to meet unmet need and build resilience, particularly when care needs to be highly specialised.
- As we receive more accountability from NHS England to make and take decisions relating to services such as adult eating disorders, Tier 4 CAMHS and forensics, future decisions on reconfiguration of specialised services will be taken by our provider collaborative.

Access to high quality care

Common mental Illnesses
Each of our six local places across West Yorkshire and Harrogate is committed to improving access to psychological therapies for adults. Primary Care Networks will ensure that a multidisciplinary approach is provided for people, on top of the necessary increases in therapists within primary care settings (see page 40). We will share good practice across West Yorkshire and Harrogate to support this increase in access and to achieve referral to treatment times and recovery standards from 19/20 onwards.

Care in a crisis

We know, from those who have had experience of a mental health crisis, the importance of being able to depend on a fast, 24/7, appropriate response. We are working alongside the Urgent and Emergency Care Programme to develop our urgent and emergency mental health care response in collaboration with regional providers such as Yorkshire Ambulance Service and police with the aim of meeting national expectations of 100% coverage of 24/7 crisis teams by 20/21. This includes ensuring that NHS111 can be used as a consistent access point for help, standardising how care plans are used by all agencies, training the ambulance workforce and developing how mental health staff can support police in 999 control rooms. We are also testing in places how to make reasonable adjustments for autistic people when in crisis.

Watch this film about Bradford District Care NHS Foundation Trust's First Response service and partnership working with Haven at the Cellar Trust to find out how they are supporting people in crisis in their communities.

In our local places, alternatives to A&E (safe spaces) are being developed for adults and children and we will ensure that these include access for those with learning disabilities and/or autism and those with conditions such as dementia.

Children and young people's mental health and wellbeing

We want young people to receive care closer to home when they have serious mental health problems, such as severe personality and eating disorders, so they don't need to travel outside the area for specialist care. Our Partnership information shows that by adopting a shared approach across West Yorkshire and Harrogate the number and length of hospital bed days for children and young people across the area has reduced in the last six months from 708 occupied days in April 2018 to 536 in September 2018. The money saved means our places have been able to invest £500k in community services - ensuring more children and young people are cared for closer to home. This is progress, yet we know much more needs to be done to support children, young people and their families. We will continue to build on this progress for as long as needed.

Getting services right for childhood mental health and wellbeing means we can prevent the development of more significant problems later in life.

This is why we are using trailblazer funding from NHS England to establish Mental Health Support Teams (MHSTs) in Bradford, Leeds and Kirklees. These teams will test new ways of working between health and education, identifying what works to roll out across West Yorkshire and Harrogate by the end of 2023.

[Case study]

Around one in 10 children are believed to have a diagnosable mental health disorder, with half of all mental health conditions beginning before the age of 14, making it vital that children with early symptoms receive the support they need

Mental Health Support Teams (MHSTs) will support several schools and colleges, covering a population of around 8,000 children and young people. Their new workforce of Education Mental Health Practitioners will work with education settings to provide early intervention on mild to moderate mental health issues and provide help to staff in schools and colleges. A programme jointly delivered with the Department of Education, teams will also act as a link with local children and young people's mental health services and be supervised by NHS staff. Bringing mental health and education professionals together is a positive step forward and this much needed support is going into three areas of our Partnership. We can then share learning and spread good practice everywhere – which is one of the very reasons why our Partnership exists'.

We recognise the need to treat each child and young person as an individual, encompassing their mental and physical health. We are working in partnership with the children and young people (see page 69) and Improving Population Health Programmes (see page 28) to better understand their needs and those of their families. This work will put our places in a good position to redesign community services, alongside primary care and councils, creating a comprehensive 0-25 mental health service (in line with national funding from 2021/22).

We will also continue to explore the opportunities that new care models offer us to refocus on intervening early and supporting children as close to home as possible, including providing the very best hospital bed services in West Yorkshire and Harrogate, so that people do not need to go out of area for treatment.

[Case study: add picture]
West Yorkshire to get new child mental health unit
A new £13million child and adolescent mental health unit is set to be built in Leeds after it was announced in 2017 as one of 12 successful bids to receive NHS England capital funds. The successful bid, led by Leeds Community Health Care NHS Trust on behalf of the West Yorkshire and Harrogate Partnership, will see a new purpose built specialist community child and adolescent mental health (CAMHS) unit to support young people suffering complex mental illness, for example severe personality and eating disorders. The Trust finalised plans for the new unit based on the experience for young people accessing care.

Anne Worrall-Davies, Clinical Lead for West Yorkshire Child and Adolescent Mental Health Services, talks about how health and care partners are working together to improve the way we deliver mental health services for young people in our areas, including through the role of care navigators. **Watch the film here.**

We will also continue to work together to ensure that by 2023/4 all children and young people experiencing a mental health crisis, including those with a learning disability and/or autism will be able to access crisis care 24 hours a day, 7 days a week through a single point of access and that every area will have age appropriate, urgent and emergency assessment, intensive home treatment and liaison functions in place.

Hospital care

Our ambition is to ensure that people are cared for within their community by primary care services where possible and only those who need a hospital admission are admitted, and when they are, that as many people as possible are kept within West Yorkshire and Harrogate for support.

The Programme will continue to work in partnership with our six local places to review hospital and community provision, including the availability of psychiatric intensive care, the configuration of assessment and treatment beds (you can read the engagement report here), inpatient learning disability beds via the Transforming Care Programme, forensic services and rehabilitation and recovery. In line with national ambitions for mental health our programme will learn from good practice in other areas to develop new ways of working that help reduce length of stay, including better use of personalised care planning and new roles such as care navigators; sustaining these from 2020/21 once new NHS England funding is made available for each place.

We will also review current delivery across all service providers against the Learning Disability Improvement Standards during 2019/20 and 20/21 to identify what is needed to improve our service offer and share these findings so that everyone with a learning disability and/or autism feels more comfortable, confident and cared for in all our health and care services by 2023/24.

We will also continue to expand the range of specialised services we provide across West Yorkshire and Harrogate, including the creation of the only problem gambling clinic outside London.

Eating disorders

There are now no inappropriate out of area admissions for adult eating disorders. By piloting a new way of working across WY&H we have achieved a saving of £240k and invested in the CONNECT team to achieve improvements in length of stay, the amount of time people spend in hospital and how close to home their care is given (you can read more here). We will continue to develop and refine this model; ensuring it meets the needs of people with a learning disability and/or autism. [To do: info graphic].

Metric	Current/Baseline	2018/19 target	2018/19 achieved
# admissions	54	49	42
LoS	90 days (average)	81 days (average)	92 (median)
Number out of area placements	22	7	0
Distance from home	40 miles	16 miles	6 miles
OBDs	6,545	5,449	5229

[Case study: add picture]
CONNECT: a new community eating disorders service for West Yorkshire and Harrogate aims to provide fair access to NHS care for adults with eating disorders across the area – something that had not been in place until 2018. The team includes doctors, psychologists, therapists, nurses, dietitians, occupational therapists, social workers, health support workers and peer support workers - who have experienced mental health problems either themselves or as a carer. 148 people have been allocated for treatment over the past year. The service won an award at the Positive Practice Awards for Mental Health in November 2018 and was nominated and shortlisted for two HSJ awards in the specialist services and mental health provider categories. The service received a 'highly commended' award in the mental health category for its outstanding work in this area.

Suicide prevention

West Yorkshire and Harrogate and the wider Yorkshire and Humber region have some of the highest suicide rates in England. The biggest killer of males under 50, mental health issues and financial problems are some of the biggest contributing factors of suicide in our region.

Suicide prevention takes place at both a local and West Yorkshire and Harrogate level. There is a multiagency Suicide Prevention Advisory Network (SPAN) across all Partner agencies. The Partnership has a vision that all suicides are preventable and is adopting a collaborative, evidence-based approach to ensuring fewer people die by suicide. Funding from NHS England/NHS Improvement will allow support workers with lived experience to provide advice, training and support for up to 600 men in the area, drawing on voluntary organisations like State of Mind and Luke's Lads to help.

We are also working to improve suicide bereavement services across the area, and with public health colleagues we are creating a high risk decision support tool for primary care and non-mental health services to identify people at risk of suicide and target support where necessary.

[Case study: add picture]
A Leeds based postvention suicide bereavement support service will be rolled out across West Yorkshire and Harrogate in the latest funding boost for mental health services in the area. The Partnership secured £173,000 from NHS England/NHS Improvement to enhance suicide bereavement support services in the region. The new service will be an extension of the Leeds Suicide Bereavement Service, now in its fourth year; set up in 2015, led by Leeds Mind with support from Leeds Survivor Led Crisis Service and funded by Leeds City Council.

[In a box]
'Losing someone to suicide is an experience that no-one should have to go through. Having spoken to people who have thought of taking their own lives I think it is important that we work with our partners to make our staff aware of the warning signs, to enable them to support both colleagues and community members. By working with the Partnership we can hopefully raise awareness of this subject and most importantly help to save more lives.' Deputy Chief Fire Officer Dave Walton. You can also read our Suicide Prevention Annual Report here.

Autism (and other neurodiversity like ADHD)

Autism (and other neurodiversity like ADHD) can be a barrier to some services. We will increase awareness about the challenges faced, improve access to mainstream services for this group of people and make reasonable adjustment to ensure barriers are removed. Children and adults wait too long for assessment and diagnosis of both autism and ADHD and we will work across West Yorkshire and Harrogate to improve this, both within each place and across the wider system.

[Case study: add picture]
Following an OFSTED and CQC inspection in June 2017 and a revisit in June 2019, Wakefield services have been assessed as making significant progress to improve autism services for children and young people. In June 2017, 614 children and young people aged 0 to 14 were waiting for ASD assessments – the average waiting time was almost two years. By June 2019, this had been drastically reduced to 57, with a waiting time of no more than 26 weeks. Local health, council, schools and community partners will now focus on their learnings from the under 14's programme of work, which made up around 88% of all referrals across the district; replicating ideas and changes, where appropriate, to ensure waiting times for over 14's are reduced in the future.

Integrating physical and mental health support

People using health and care services commonly find that their physical and mental health needs are addressed in a disconnected way despite the evidence that neglecting one can damage the other. . Poor mental health is a major risk factor implicated in the development of diabetes, chronic obstructive pulmonary disease and cardiovascular disease. Conversely, we know that those who are dealing with or surviving a cancer diagnosis, or have a long term condition are more likely to suffer from depression and anxiety. We know the opportunities presented by joining up physical and mental health have not yet received sufficient attention – we will work with other programmes to address this. We are also supporting the expansion in community provision for perinatal care for new mothers within each place, alongside the regional inpatient mother and baby unit in Leeds see (page 64).

Mum Lindsay talks about the mental health support she received following the birth of her third child, and specialist midwife and perinatal team leader Alex Whincup from Leeds Teaching Hospitals NHS Trust tells us about the variety of perinatal services available to women and their families **in this film.**

Underpinning all of the above are several enablers that have not yet been fully exploited. We are developing our plans across all of these in tandem with other West Yorkshire and Harrogate programmes and national guidance.

[To do: develop an info graphic]

- Co-production: we need to do more to ensure our service users shape how services are designed
- Personalisation: we need to ensure service users always have choice and control over their care
- Digital: we need to ensure staff can communicate across West Yorkshire and Harrogate services effectively and where people who access care can be empowered to manage their own care where appropriate
- Workforce: we need to understand the common challenges across the system, develop new attractive roles and ensure our staff are supported and valued.

The way we work

NHS mental health providers in West Yorkshire have set up new shared governance arrangements. Known as the West Yorkshire Mental Health Services Collaborative, the organisations have been working together to improve mental health services for local communities.
The Mental Health Collaborative includes:

- Bradford District Care NHS Foundation Trust
- Leeds and York Partnership NHS Foundation Trust
- Leeds Community Healthcare NHS Trust
- South West Yorkshire Partnership NHS Foundation Trust.

Our mental health, learning disabilities and autism five year ambitions:

- **Achieve IAPT referral to treatment times and recovery standards from 19/20 onwards.**
- **100% coverage of 24/7 crisis teams in all places by 2020/21 with all children and young people able to access crisis care 24/7 by 23/24**
- **Mental Health Support Teams tested in 2019/20 and 2020/21 for further roll out across West Yorkshire and Harrogate by 2023/24**
- **A comprehensive 0-25 mental health service across all places rolled out from 2020/21**
- **Reduce inpatient (hospital beds) provision for people with a learning disability in line with national expectations by 2023/24**
- **Sustain new ways of working that help reduce inpatient length of stay from 2020/21**
- **Test West Yorkshire and Harrogate models for suicide prevention and postvention in 2019/20 and 2020/21**
- **Review current delivery across all service providers against the Learning Disability Improvement Standards during 2019/20 and 2020/21, meeting requirements by 2023/24.**

Stroke care

[In a box]
In 2018/19 there were 3,441 strokes in West Yorkshire and Harrogate (Apr 2018-Mar 2019). Our ambition is to reduce the number of people who have strokes; save more lives and improve recovery outcomes. Providing the best stroke services possible to further improve quality and stroke outcomes is a priority for us all.

Our aim is to improve quality outcomes for people requiring stroke care, ensuring that services are resilient and 'fit for the future'. Work has taken place cross West Yorkshire and Harrogate to improve the quality of care and recovery for people who have had a stroke. This includes preventing

stroke happening in the first place, improving specialist care, making the most of technology and valuable skilled workforce – and connected high quality support for people recovering from a stroke.

Watch these films to find out why this work is so importing to saving people's lives:

- Dr Andy Withers talks about how we want to improve stroke services
- Malcolm and Sue's experience of stroke
- Geoff talks about his experience of stroke

Identifying and supporting people at risk of stroke

Atrial fibrillation (also called AFib or AF) is a quivering or irregular heartbeat (arrhythmia) that can lead to blood clots, stroke, heart failure and other heart-related complications. In West Yorkshire and Harrogate there are around 12,000 undiagnosed (and therefore unmanaged) atrial fibrillation (AF) patients. We know that this increases the likelihood of stroke (see page 79).

Since spring 2018 we have been working with our partners at the Yorkshire and Humber Academic Health Science Network to more proactively detect, diagnose and treat people who are at risk of stroke so that around 9 in 10 people with AF are managed by GPs with the best local treatments available. This will save lives and contribute to reducing both the health and well-being gap and the care and quality gap.

The Yorkshire and Humber Academic Health Science Network is working with each of our six local places to roll out best practice care for people with AF in every GP practice and aims to prevent over 190 strokes in the next three years. We are also reducing other risks linked to stroke. For example the treatment of hypertension (high blood pressure) which has the potential to reduce a further 620 strokes within three years.

Our stroke engagement work

A key part of the way we work is being open and honest, so that people can get involved and have their say from the beginning. People who access health and social care often know better than us what keeps them well and healthy and what care they need to support their return to independence. It is also important that people know how their views have shaped our work.

We talked to over 2500 people over 18 months, including voluntary and community organisations, people who have had a stroke, unpaid carers, councillors and staff.
You can find out how these views have shaped our work by reading the 'You Said, We did'. You can also find out more about all of the engagement that has taken place by clicking here.

Whole stroke care pathway approaches

Our conversations with people have highlighted the importance of further improving care from preventing stroke, hospital care, community rehabilitation services, through to after care. In view of this we have produced a draft whole pathway service specification which recognises the minimum standards and service outcomes for each of part of the stroke pathway.

The draft service specification includes specific outcomes we aspire to achieve, for example rehabilitation and community services. Each of our six places will use this specification to determine what further actions, if any, will be required to achieve these standards.

To support the six places we asked the Stroke Association to fund a project manager for six months to undertake a gap analysis of the community rehabilitation services for stroke. The project will aim

to help identify the actions either locally or at West Yorkshire and Harrogate level required, if any, to improve community rehabilitation stroke services.

Providing high quality hospital stroke services

We are re-establishing a clinical network across West Yorkshire and Harrogate, so that we can further support, develop and retain our skilled workforce.

The stroke clinical network will provide learning and development opportunities through master class type events and an annual conference for colleagues who provide specialist stroke care. The network is also a place where clinicians can review, progress and provide peer support to implement the new standards and new developments in the treatment of stroke such as Mechanical Thrombectomy.

In addition our clinical lead has worked with the Local Workforce Action Board to ensure our work is aligned with our wider workforce strategy.
The stroke clinical network will harness clinical leadership, expertise and encouraging a culture of continuous improvement across West Yorkshire and Harrogate. It aims to further reduce differences in key clinical standards and ensure new guidelines and national developments are aligned. For example, the establishment of Integrated Stroke Delivery Networks (ISDNs), the further roll out of mechanical thrombectomy services (this aims to remove the obstructing blood clot from arteries within the brain directly by introducing a clot retrieval device delivered via an intravascular catheter, thereby restoring blood flow and minimising tissue damage), improvement in the use of thrombolysis (emergency treatment to dissolve blood clots that form in arteries feeding the heart and brain), development of higher intensity care models for stroke rehabilitation and changes to workforce models.

Our five year ambitions

- **By 2022 will deliver a ten-fold increase in the number of people who receive a thrombectomy after a stroke so that each year 1,600 more people will be independent after their stroke.**
- **By 2025 will have amongst the best performance in Europe for delivering thrombolysis to all who could benefit.**
- **By April 2020 we will have established an Integrated Stroke Delivery Networks (ISDNs) to support discharge, meet seven-day standards and National Guidelines for stroke - there needs to be an accountable ISDN governance structure in place.**

Respiratory

Respiratory conditions include common cold, flu, whooping cough, bronchitis and chronic obstructive pulmonary disease (COPD).

[In a box]
Respiratory diseases may be caused by infection, by smoking tobacco, or by breathing in second-hand tobacco smoke, radon, asbestos, or other forms of air pollution. Respiratory diseases include asthma, COPD, pulmonary fibrosis, pneumonia, and lung cancer.

Levels of smoking tend to be higher across West Yorkshire and Harrogate when compared to national averages. The numbers of people stopping smoking also tends to be below the national average. For these reasons an early objective was to tackle the difference in the levels of smoking and quit rates so that people have healthy longer lives.
To date there has been a reduction in the number of smokers within West Yorkshire and Harrogate of 23,000 (check time period).

Most socio-economically disadvantaged groups of people are disproportionately represented amongst smokers (as they are within respiratory disease incidence); this work is supported in our programme to tackle health inequalities. The successful work to reduce tobacco dependency will continue (see preventing ill health on page 29 for further details).

Our Partnership has worked with the other six northern partnerships (sustainability and transformation partnerships and integrated care systems) to build on work with RightCare to identify and spread good practice to improve respiratory outcomes.

Our Partnership has led on identifying and promoting good practice in the provision of pulmonary rehabilitation. We have focused on understanding the barriers to people being referred to pulmonary rehabilitation; and once referred the barriers to them completing programmes. This work will support our Partnership's ambition to tackle health inequalities, and across the north as a whole.

Working closely with RightCare the Partnership's Clinical Forum reviewed clinical practice across our six local places and the impact this had on people with respiratory disease. It identified good practice that we shared across West Yorkshire and Harrogate.

[In a box]
We will learn from existing good practice within West Yorkshire and Harrogate, as well as other successful models of improving respiratory outcomes such as a current Welsh national programme.

The Clinical Forum has now started a collaborative programme across the Partnership to share and support learning across our six places. This will accelerate improvement in respiratory outcomes and reduce unwarranted variations in people's care.

The programme will:
- Emphasise patient choice and empowerment
- Be clinically driven and led
- Increase the focus on upstream prevention
- Integrate with other relevant programmes, including cancer and population health management
- Support moving delivery as locally as possible
- Reduce health inequalities
- Reduce the differences in support that people receive
- Make the most of digital solutions.

Our five year ambitions

Treating tobacco dependency
The successful work to reduce tobacco dependency will continue (see page 34).

Diagnosis
Identify 'missing cases' - analyse records to find people at risk of COPD or asthma and not on the register for either of these conditions:
- Are recorded as current or ex-smokers
- Are aged over 35 years
- Are prescribed inhaler therapy
- Are prescribed at least one course of Prednisolone for respiratory symptoms in the last two years
- Are prescribed two or more courses of antibiotics for respiratory symptoms in the last two years.

Offer spirometry to those people mentioned above (spirometry is a standard test doctors use to measure how well your lungs are functioning).

- Monitor key performance indicators and explore the gap in performing spirometry - how many people are on the COPD register with no record of spirometry.
- Explore the gap in quality of spirometry - how many surgeries providing spirometry meet the standards for equipment and staff.
- Make primary care spirometry results available when a person is admitted to hospital.
- Make hospital spirometry results available to GP and any other point of care in the community.
- Comply with the requirement of the COPD Care Bundle to check spirometry result at admission in all cases of acute exacerbation of COPD. This can be monitored via the National COPD Audit.
- Develop a variety of options to provide quality assured spirometry for all patients across Yorkshire including spirometry services in individual GP services, local diagnostic centres offering spirometry and access to hospital based respiratory function laboratories.

Pulmonary rehabilitation
Pulmonary rehabilitation should be available for a range of respiratory conditions including COPD, asthma, interstitial lung disease and bronchiectasis.

Pulmonary rehabilitation should be considered as a group of interventions with a choice to select the ones most appropriate for each person.

These should include:
- Standard 6-8 week pulmonary rehabilitation course.
- Individually tailored rehabilitation in the home.
- MyCOPD App supported pulmonary rehabilitation.
- Breathe Easy Groups
- Local signposting to physical activity

Monitor the performance of the pulmonary rehabilitation services according to NICE QS10, Quality Statement 4 and through participation in the National Asthma and COPD Audit Programme (NACAP): pulmonary rehabilitation work stream.

Assess indications and willingness to participate in pulmonary rehabilitation at key points of care:
- Annual clinical review at GP practice.
- Review after acute exacerbation - GP practice or Integrated COPD Service.
- Hospital admission for acute exacerbation of COPD - part of the COPD Care Bundle.

Provide swift access to pulmonary rehabilitation for all who need it including:
- Opportunity to start pulmonary rehabilitation within four weeks of discharge from hospital following acute exacerbation of COPD.
- Suitably timed pulmonary rehabilitation before and after lung volume reduction intervention.

Medicines management
The local guidelines for inhaler therapy for COPD and asthma are documents that reflect the up to date clinical evidence and are produced after extensive consultations with all involved. These need to be updated every three years following a well-structured approach.

Check of inhaler therapy should be performed on a regular basis in consistence of NICE quality standard QS10, Quality Statement 2. There are several key points for this intervention:
- Annual clinical review at GP practice.
- Review after acute exacerbation - GP practice or Integrated COPD Service.

- Hospital admission for acute exacerbation of COPD - part of the COPD Care Bundle.
- Continuous monitoring of the pattern of prescribing inhaler therapy in both primary and secondary care to identify trends for deviation from the local guidelines.

We will develop teams of suitably qualified specialists to support units showing deviation from the agreed guidelines with the objective to improve prescribing. These teams could include hospital based specialists, intermediate care (respiratory/primary) specialists, senior pharmacists or GPs with special interest in respiratory disease. It will involve developing adequate services for prescribing and monitoring 'specialist only' treatments such as biological agents, Roflumilast, which is recommended as an option for treating severe chronic obstructive pulmonary disease in adults with chronic bronchitis as and when appropriate.

Diabetes

There are currently 3.4 million people with Type 2 diabetes in England with around 200,000 new diagnoses every year. While Type 1 diabetes cannot be prevented and is not linked to lifestyle, Type 2 diabetes is largely preventable through lifestyle changes.

The prevalence of Type 1 and Type 2 diabetes in West Yorkshire and Harrogate ranges between 5.7% in Harrogate and Rural District to 10.4% in Bradford Districts. One in six of all people in hospital have diabetes – while diabetes is often not the reason for admission, they often need a longer stay in hospital, are more likely to be re admitted and their risk of dying is higher.

As well as the human cost, Type 2 diabetes treatment accounts for around 9% of the annual NHS budget. This is around £8.8 billion a year.

[In a box]
The large geography and diverse population of West Yorkshire and Harrogate poses some key diabetes challenges. We aim to ensure that the diabetes prevention programme and structured education programmes are both targeted to address health inequalities and tailored to the needs of local communities.

Our Partnership will work to prevent the development of Type 2 Diabetes in those people who are at high risk.

This will involve a diabetes treatment programme which focusses on:

- Improving the achievement of the NICE recommended treatment targets (HbA1c, cholesterol and blood pressure) and driving down variation between clinical commissioning groups.
- Improving uptake of structured education
- Reducing amputations by improving the timeliness of referrals from primary care to a multi-disciplinary foot team for people with diabetic foot disease; and
- Reducing lengths of stay in hospitals for diabetics.

Working together to prevent the development of Type 2 Diabetes

There are 110,000 people at high risk of developing Type 2 Diabetes in West Yorkshire and Harrogate. There are currently five million people in England at high risk of developing Type 2 diabetes. If these trends continue, one in three people will be obese by 2034 and one in 10 will develop Type 2 diabetes.

The Healthier You: NHS Diabetes Prevention Programme (NHS DPP) identifies people at high risk and refers them onto a behaviour change programme. The NHS DPP is a joint commitment from NHS England, Public Health England and Diabetes UK. We will continue to deliver the programme across West Yorkshire and Harrogate.

Our ambition is to increase the number of people referred to the NHS Diabetes Prevention Programme. This will include the roll out of the digital NHS DPP from August 2019 to increase access to the course, particularly for those of working age and people from ethnic minority groups. We will also explore options to pilot NHS DPP courses that expand access to the programme for people with learning disabilities and mental health illness.

Improving the achievement of NICE recommended treatment targets

Over the past two years some of our Partnership's clinical commissioning groups have worked to improve the achievement of the three NICE recommended treatment targets and eight care processes. The treatment targets and eight care processes are monitored via the National Diabetes Audit which is mandatory for all GP Practices. The achievement differs across our areas and addressing this difference is a priority for the Partnership.

Our five year ambition for diabetes includes:

- **Using the funding available until 2023/2024 to increase the achievement and reduce variation particularly around education and the sharing of best practice**
- **We will offer personalised care for people. Along with increasing the achievement of the three NICE treatment targets we will ensure that diabetes care is individualised ensuring that frailty is recognised and targets are adjusted according to the person with diabetes. Frailty is related to the ageing process that is, simply getting older. It describes how our bodies gradually lose their in-built reserves, leaving us vulnerable to dramatic, sudden changes in health triggered by seemingly small events such as a minor infection or a change in medication or environment.**
- **West Yorkshire and Harrogate is an early engagement site for the national HeLP diabetes online self-management platform which will provide education for people with Type 2 diabetes. The roll out will commence in February 2020 and will be accessible to all areas across the Partnership for three years.**

Diabetes education is the cornerstone of diabetes management, because diabetes requires day-to-day knowledge of nutrition, exercise, monitoring, and medication. The Diabetes Transformation Funding has been used to expand provision and increase the uptake of digital and face to face education for people with Type 1 and Type 2 Diabetes.

Work is ongoing to look at different models of structured education which are accredited. The Partnership is also working to ensure that health inequalities across the diverse geography are targeted by ensuring delivery of culturally sensitive support that makes adjustment for people with learning disabilities including help in the evening and at weekends.

Reducing diabetes related amputations and reduction in length of stay for diabetes hospital stay
Multi-disciplinary team working is at the heart of providing best treatment and care. Over the past eighteen months a number of diabetes specialist clinical teams have been testing approaches to streamline the way diabetes multi-disciplinary foot teams work with the aim of sharing the findings.

Diabetes Inpatient (hospital stays) Specialist Nurse Teams have been expanded to provide support to people in hospital with diabetes. The Partnership will continue to support the specialist teams using funding available to ensure universal coverage across West Yorkshire and Harrogate.

Diabetes technology

We will ensure that pregnant women with Type 1 diabetes are offered continuous glucose monitoring from April 2020. West Yorkshire and Harrogate will ensure that up to 20% of people living with Type 1 diabetes will receive flash glucose monitoring devices if they are eligible using the agreed clinical criteria.

Diabetes remission

We will explore low calorie diets for people who are obese with Type 2 diabetes to reduce HbA1c levels (HbA1c is your average blood glucose (sugar) levels for the last two to three months and turn the clock back on diabetes putting it into remission.

The Partnership will work towards improving joined mental health services to ensure people with Type 1 and Type 2 diabetes are supported with issues such as stress and anxiety due to needle phobia and phobia to insulin pens and also anxiety around hypoglycaemia (also known as low blood sugar, is when blood sugar decreases to below normal levels. This may result in a variety of symptoms including clumsiness, trouble talking, and confusion, loss of consciousness, seizures or death).

We will also express interest in being a pilot to ensure expansion of the diabetes prevention programme to include learning disabilities and severe mental health illness.

Cancer

Cancer survival is the highest it has ever been. In West Yorkshire and Harrogate the percentage of people surviving at least one year following diagnosis increased from 66.2% in 2005 to 71.7% in 2015.

More cancers are also being diagnosed early when curative treatment is more likely and patient reported experience of care is high (as measured through the national Cancer Patient Experience Survey). Despite this too many people have their lives cut short or significantly affected by cancer, with consequent impact on their families and friends. Within West Yorkshire and Harrogate the overall one year survival figure hides a variation from 69.6% (Calderdale) to 74.7% (Harrogate and Rural District).

Some places with lower survival rates also perform less well than comparable populations across England, meaning these local differences in outcome cannot be explained away by population mix. This 5 year strategy gives us the opportunity to ramp up our ambition and sharpen our focus to tackle variation, learn from and support each other to accelerate what we know works to improve outcomes and offer quality to life through personalised health and wellbeing support.

Our Cancer Alliance is in a strong place to deliver this with a clear national strategy and a long history of collaboration amongst providers of cancer care which is essential to support patient pathways which cross the system – but we need to pull together as a whole system to **deliver our ambition that by 2028 three in four cancers will be diagnosed at an early stage when curative treatment is an option**.

Working together to reduce preventable cancers before they appear

Lung cancer is our biggest cause of cancer deaths. One in two smokers will develop cancer and there are around 351,000 smokers in West Yorkshire and Harrogate. Tobacco use remains the most important preventable cause of lung cancer and the focus of the Alliance prevention effort. The Alliance will continue to support the NHS Smokefree Pledge and through our Tackling Lung Cancer Programme we have invested in boosting specialist smoking cessation support and community

support, focusing on capturing patients at teachable moments. Mid Yorkshire Hospitals is leading the way locally on delivering a smoke free NHS.
We will push as far as possible to replicate their approach across West Yorkshire Association of Acute Trusts (also known as hospitals working together) in the next five years.

We will find more cancers before symptoms appear by increasing screening uptake
Over the past year the Alliance has worked with local and regional screening leads to boost screening uptake. During 2019/20 and beyond we will use transformation funding to develop a Healthy Communities programme which will increase screening uptake in all the national screening programmes. In the first year we will focus on the bowel and cervical programmes where uptake is lower and more variable across our geography. Across West Yorkshire and Harrogate around 160,000 people annually decline an invitation for bowel screening with uptake in Bradford City at around 30%. Around 170,000 women annually across West Yorkshire and Harrogate decline the offer of cervical screening, and around 90,000 women decline the offer of breast screening. We will be using best available evidence to encourage more people to accept their screening invitations. We will work with local communities and primary care networks to co-design campaign activities that suit the needs of the local population, with particular care to tailor approaches to the needs of ethnic minority groups and other seldom heard groups such as people with learning difficulties. We will also make access to screening easier for people for whom current settings present a barrier to uptake, for example people with physical or sensory impairments.

We will diagnose more cancers faster and earlier

Over the past two years Cancer Transformation Funding has been used to make more efficient use of diagnostic resources and improved pathways to provide rapid diagnosis or reassurance. This has included support for use of technology (digital pathology, tele dermatology), new roles within diagnostic teams to improve skill mix and career progression, support to the Yorkshire Imaging Collaborative to enable the radiology community to work more closely together and support each place to improve our offer to people with non-specific but worrying symptoms.
In relation to lung cancer there is now robust evidence that earlier diagnosis can be encouraged through a combination of targeted lung health checks to high risk areas, public awareness, clinician education and better access to diagnostic testing. **(To note: possible case study piece here based on Elaine's story)**

We will take a systematic approach to finding and diagnosing lung cancers at an earlier stage, thereby making more cancers curable. Our pilot work has been focussed in parts of Bradford and Wakefield which have a combination of high smoking rates and poor clinical outcomes.

Our work combines support to stop smoking, raising awareness so people seek information and advice earlier, providing easily accessible community based 'lung health checks' for those at most risk of cancer, and improving the experience of people affected by lung cancer by ensuring care and treatment pathways are as speedy and efficient as possible. The estimated outcomes from the Wakefield and Bradford pilots is 100-120 cancers being detected, 80% of which are expected to be at an earlier stage. Early in 2019, North Kirklees was invited to join the national Targeted Lung Health Check Programme with funding for a four year pilot. In addition a 5 year research programme, the Leeds Lung Health Check service, funded by Yorkshire Cancer Research has started in Leeds. This means that many of our areas are now prioritising lung cancer outcomes. We will be carefully evaluating this early work and will spread and expand the scope across the Alliance, guided by those findings in line with the NHS Cancer Programme.

Key to earlier diagnosis is the availability of rapid diagnostic pathways to get people onto the correct managed treatment pathway as early as possible. Over the next five years we will continue to work with the developing primary care networks and our hospital based colleagues to make best use of

knowledge and resources to spot symptoms that could be cancer and investigate promptly through managed approaches.
There are a number of nationally agreed optimal pathways for different types of cancer which we are in the process of implementing across West Yorkshire and Harrogate. Where such nationally developed pathways don't yet exist we will work with clinical colleagues and patients to develop local versions to ensure a consistent offer to people regardless of where they live. Whilst there is often strong clinical consensus about the pathway steps, having the capacity to move patients along that pathway in a timely way is often a challenge.

The Cancer Alliance already works closely with provider colleagues and West Yorkshire Association for Acute Trusts for leadership to improve our pathways. We will continue to support providers to develop systems to monitor capacity and demand for diagnostics, make the most of the diagnostic resources at our disposal through networking, use of digital technologies, flexible and integrated use of workforce (in collaboration with Health Education England). This work will inform discussions about the case for expanding diagnostic capacity and increasing the emphasis on proactive investigation of symptoms.

This will also lay the foundations for a new Faster Diagnosis Standard from 2020 which aims to provide an answer to the 'could it be cancer?' question within a month of initial referral. We already have a number of optimal diagnostic pathway groups involving clinicians, patients and managers established for prostate, lung and colorectal cancers. Over the next year we will be expanding the range of tumours supported by a cross system optimal pathway group, providing stronger and more sustainable clinical leadership.

Unfortunately less than 40% of all cancers nationally are diagnosed following an urgent suspected cancer referral, (or 'two week wait' referral) which takes the person straight into a rapid managed pathway. The majority of cancers are still found following non cancer specific urgent or routine referrals, or they present as emergencies. This is often because the symptoms of many cancers are quite vague or could indicate a range of conditions, such as unexplained weight loss, pain or fatigue. Over the past two years the Alliance has invested transformation funds across our providers allowing them to test a range of approaches to managing these vague but concerning symptoms, supported by a Community of Practice and building on learning from our two national pilot sites in Leeds and Airedale.

Over the next five years we will be further developing a more consistent approach to integrated rapid diagnostic services, honouring the national requirement to have at least one rapid diagnostic service established in each Alliance during 2019/20. The objective will be to design services which deliver a holistic diagnostic service featuring a rapid and coordinated set of investigations designed to establish the cause of the troubling symptoms and appropriate onward referral, rather than just to exclude or confirm cancer. This will be a service model (making the most of resource and expertise in primary and secondary care) rather than necessarily a physical centre, and not necessarily a one stop shop, but a personalised and planned rapid series of tests with a single point of contact. Over time it is envisaged that this 'single front door' concept could expand to cover anyone with cancer symptoms.

We will deliver more consistent access to optimal treatment and faster, safer and more precise treatments

Multi-disciplinary team working is at the heart of providing optimal treatment and care. However it is just as important that team working processes do not slow the patient pathway through investigation and treatment unnecessarily and also that they make efficient use of the specialist workforce. Over the past eighteen months a number of clinical teams across the Alliance have been testing approaches to streamlining the way teams work and sharing the progress and findings.

Over the next year we will be establishing optimal pathway groups led by a clinical director covering key adult tumours, children and young people and, teenagers and young adults. These will bring together clinicians, patients, provider and commissioner managers to drive out unwarranted variation and improve outcomes and experience (including delivery of national waiting times standards). They will build on and develop our pilot work on multi-disciplinary teams.

Other specific priorities to support delivery of optimal treatment are:

- During 2019/20 we will support the development of a Yorkshire and the Humber Radiotherapy Operational Delivery Network accountable to the three Yorkshire and the Humber Cancer Alliance Boards for the delivery of a national service specification.
- During 2019/20 we will work with WYAAT colleagues and Health Education England (liaising with our neighbouring Alliances where appropriate) to develop a more sustainable workforce model for clinical and medical oncology. Implementation of the plan will form a work programme for subsequent years of this strategy.
- We will work with the regional Genomic Laboratory Hub to promote the use of and support providers implement whole genome sequencing for all eligible cancer indications. This in turn will support use of genomics to target treatments more effectively, using the established Alliance and West Yorkshire Association of Acute Trusts infrastructure to support engagement;
- We will work with Teenage and Young Adult (TYA) services in Leeds Teaching Hospitals NHS Trust to support the service in becoming a Principle Treatment Centre (PTC) for TYA with Cancer, according to the new service specification. The service would work in partnership with TYA designated hospitals to ensure that teenagers and young adults receive the right care in the right place at the right time. NHS England also requires that a PTC should host and support a TYA Cancer Network which would have agreed criteria and functionality.
- We will work with NHS England Specialised Commissioning colleagues to develop plans to build capacity in treatment for key under pressure pathways, for example prostate and lung.
- Through our Optimal Pathway Groups we will encourage increased numbers of cancer patients at all ages, children, young people and adults being entered into clinical trials due to the strength of evidence around the link between active research and development and improved outcomes.

We will offer personalised care for all patients and transform follow up care. With improvements in survival more and more people are living beyond their initial cancer diagnosis. There are currently around 88,500 people across the Alliance living with cancer and this figure is expected to rise to around 117,000 over the next ten years. The effects of cancer do not suddenly stop once cancer treatment is over and many people face long term difficulties such as worry and depression, concerns about money, family and relationship issues, as well as dealing with the physical effects of having cancer which can effect patient outcomes and experience. Our goal is to provide personalised care and support to people affected by cancer which meet both their ongoing cancer related health needs and the more emotional, social and practical support needs that currently often go unmet. These can be addressed at least in part by better coordination and signposting to services already based within communities.

During 2018/19 our focus has been to understand our baseline position against a set of evidence based interventions known collectively as the 'Recovery Package' and the availability of risk stratified follow up. We have worked with front line staff to develop and promote a common understanding of these interventions and begin to embed them in everyday practice. Over 100 front line staff have attended training sessions. In the past year we have focused on four common tumours and the programme is developing momentum, for example five more teams are now offering end of treatment health and wellbeing events, three more teams are offering treatment summaries and three more teams are offering holistic assessment at the end of treatment.

We have also undertaken a significant piece of engagement work with patients, carers and professions on the particular needs of people who are treatable but not curable to inform local action planning and improvement. By providing people with access to support beyond their clinical needs, we can empower patients to manage their health, provide tailored support to patients, harness the power of existing community services and create capacity within clinical teams.

In 2019/20, with support from Macmillan Cancer Support we will be providing additional intensive improvement support to front line staff in our acute hospitals to spread the availability of the Recovery Package and risk stratified follow up pathways. The Alliance team will also be working on our longer term aim to provide improved community based support to meet the needs of people affected by cancer. We will build on the findings from a pilot started in February 2019 with partners in Bradford to support people to live better with and beyond cancer (case study video in development). By 2021, every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support. By 2023, stratified follow up pathways will be in place for all clinically appropriate cancers.

Our five year ambitions for cancer include:

- **By 2028, 55,000 more people will survive cancer for five years or more each year; and**
- **By 2028, 75% of people will be diagnosed at an early stage (stage one or two).**
- **From September 2019, all boys aged 12 and 13 will be offered the HPV vaccination.**
- **By 2020, HPV primary screening for cervical cancer will be implemented across England.**
- **From summer 2019, the Faecal Immunochemical Test will be used in the bowel screening programme.**
- **By 2023/24, significant improvements will be made on uptake of the screening programmes**
- **By 2023 the first phase of the Targeted Lung Health Checks Programme will be complete, with a plan for wider roll out (depending on evaluation).**
- **By 2020, one Rapid Diagnostic Centre will be implemented in each Cancer Alliance, with further roll out by 2023/24.**
- **From April 2020, all local systems should be recording their Faster Diagnosis Standard data.**
- **By 2023/24 Primary Care Networks will be working with the Cancer Alliance to help to improve early diagnosis of patients in their own neighbourhoods**
- **The Yorkshire and Humber Radiotherapy network will be established by 2019/20 to fully implement new service specifications by 2021/22.**
- **New service specifications for children and young people's cancer services will be implemented by 2021**
- **More children and young people will be supported to take part in clinical trials, so that participation among children remains high, and the NHS is on track to ensure participation among teenagers and young adults rises to 50% by 2025.**
- **From 2019, whole genome sequencing will begin to be offered to all children with cancer.**
- **From 2020/21, more extensive genomic testing should be offered to patients who are newly diagnosed with cancers so that by 2023 over 100,000 people a year can access these tests.**
- **By 2021 everyone diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support.**
- **By 2020 all breast cancer patients will move to a personalised (stratified) follow-up pathway once their treatment ends, and all prostate and colorectal cancer patients by 2021.**
- **From 2021, the new Quality of Life (QoL) Metric will be in use locally and nationally.**
- **Recruit an additional 1,500 new clinical and diagnostic staff nationally across seven priority specialisms between 2018 and 2021.**
- **All patients, including those with secondary cancers, will have access to the right expertise and support, including a Clinical Nurse Specialist or other support worker.**
- **We will also support the development of a Yorkshire and Humber Children and Young Persons Cancer Operational Delivery Network.**

[Case study: add picture]
Putting people with cancer at the centre of the way we work together
Our Cancer Alliance has ambitious plans to transform services and improve care, treatment and support for those affected by cancer in West Yorkshire and Harrogate. We are working together to break down organisational barriers so we can improve people's experience in a number of ways. This includes improving cancer waiting time performance across the area. We launched a new way of working together to improve waiting times in July 2019 to get everyone together in one room to discuss how we can do this. Led by the Chief Executives of our six acute hospital Trusts, the launch of the West Yorkshire and Harrogate Cancer Alliance improvement collaborative was attended by more than 100 patients, clinicians, managers and cancer team members from across Bradford District and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield. The initial focus is on lung and prostate cancer. However, we plan to roll out this new way of working across all tumour pathways in the future. By listening to people who have cancer, sharing learning and spreading good practice we can improve the care given to people, so that no matter where they live they receive high quality services which puts them at the very heart of planned improvements'.

Supporting unpaid carers

[Case study]
In April 2019 we brought together over 100 carers and health and social care professionals to discuss how the NHS Long Term Plan can support better outcomes for unpaid carers. This has helped us align the West Yorkshire and Harrogate carers' strategy with the NHS Long Term Plan.

It's estimated that there are 260,000 unpaid carers in West Yorkshire and Harrogate and as our population ages; this number is set to increase. This combined with changes in retirement age means the demographic of unpaid carers is also altering; people are working until much later in life, sometimes juggling work commitments, whilst caring for others longer. Evidence shows people who are carers have poorer health and can be socially isolated (Carers UK).

[In a box]
We recognise the huge contribution of unpaid carers. We aspire to be a region where carers are recognised, given the support they need to both manage their caring role and remain in work and education.

Watch this film with Karen, who is a carer for her wife, talking about her experiences and the support she receives from Carers Leeds.

Carers often suffer social deprivation, isolation and ill health. They may have fewer opportunities to do things that many people take for granted, including having access to paid employment or education, or even having time to themselves or to spend with friends. A recent NHS England GP Survey (make link) showed 61% of carers are more likely to have a long term condition, disability or illness compared to 50% of non-carers.

Our six local places provide vital support in a variety of settings, including GP practices and hospitals, to support carers to maintain their caring role and avoid carer breakdown. Carers Wakefield and District work closely with local hospital and community services to support carers who are struggling to cope with the demands of caring. Carers organisations also support carers to have essential time out from caring.

[Case study: add picture]
In Bradford, Christopher Fisher 57, is able to receive respite from his caring role looking after birds of prey due to receiving a time out grant from his local carers organisation' Carers Resource. Christopher who carers for his wheelchair-bound father, 89, five days a week, with support from his brother. He carries out tasks such as washing, cooking and cleaning. His sister cares for their mother, 85, who has dementia. Christopher spends his two days of respite each week volunteering in many different roles, but despite all the busyness in his life the birds of prey really caught his attention. He adds: 'Getting so close to the birds was a special and unique encounter I'll never forget'.

Many carers, including children and young people, are hidden. They are caring for a loved one with a long-term health condition and often provide the majority of care without formal support. For young carers, it can often mean life chances are severely limited. A key priority is to strengthen support for carers by using quality markers, and using personalised care approaches that identify and address the health and wellbeing needs of unpaid carers (see page 91).

In this film young carer Kirsty talks about her experiences and the support she receives from Carers Leeds.

Emerging evidence suggests that investing in support for carers can contribute significantly to the sustainability of health and social care. In particular, that early help and targeted support for carers reduces carer breakdown and limits the use by the cared for person for hospital services, social care and other care. Investment in supporting carers helps prevention and self-care which can in turn support carers to stay in work, to the benefit of the wider local economy.

The Department of Health (October 2014) estimates that each £1.00 spent on supporting carers would save £1.47 on care costs and benefit the wider health and care system.

[Case study: add picture]
We held the first in a series of events, named by the young carers as 'Couldn't Care Less', which aims to show young carers how their skills can be transferred into exciting and varied roles in the health and care sector, supported by role models from across local business and the NHS. The event was attended by young carers from across Kirklees and Calderdale and included representation from five schools with pupils aged between 12-15 years old. Following the event, survey results showed 83% of pupils who attended were interested in pursuing careers in health and social care. The following shows the words mentioned throughout the student feedback surveys. You can read the report here.

Our achievements

It is important that partners and carers see that we are making a positive difference. By working in collaboration with all our six places we share good practice more widely and create better results for carers. We have:

- Engaged 240 young carers with a series of workshops to encourage them pursue careers within health and care sector, develop their confidence and support their resilience.
- Signed up all acute and mental health trusts to *John's campaign* which gives carers of people living with dementia greater access to the hospital beyond normal visiting hours
- Created processes within GP practices to identify and signpost carers to support in their local area.
- All mental health and acute hospitals have agreed to adopt the 'carers working passport' which identifies members of staff who are carers so that appropriate support can be put in place.
- Supported all of our 6 places to access tailored and joint-branded digital platform hosting Carers UK's products and resources combined with local information and support for carers. This is

available for all NHS and Local Authority organisations as well as small and medium sized organisations.

Our five year ambitions

One of our key priorities for the next five years is e to identify and support carers. We work closely with our six local places to share good practice and continuously improve the lives of carers. Carers have also told that they think a priority should be to address the needs of carers from minority communities. We recognise these particular groups can experience inequalities and may not always be identified and supported effectively within their caring role. We will be working with our partners to highlight the fact that carers exist and their contribution to the health and care system and beyond. This is to ensure that all carers, irrespective of their background or where they live, have the same standard of support.

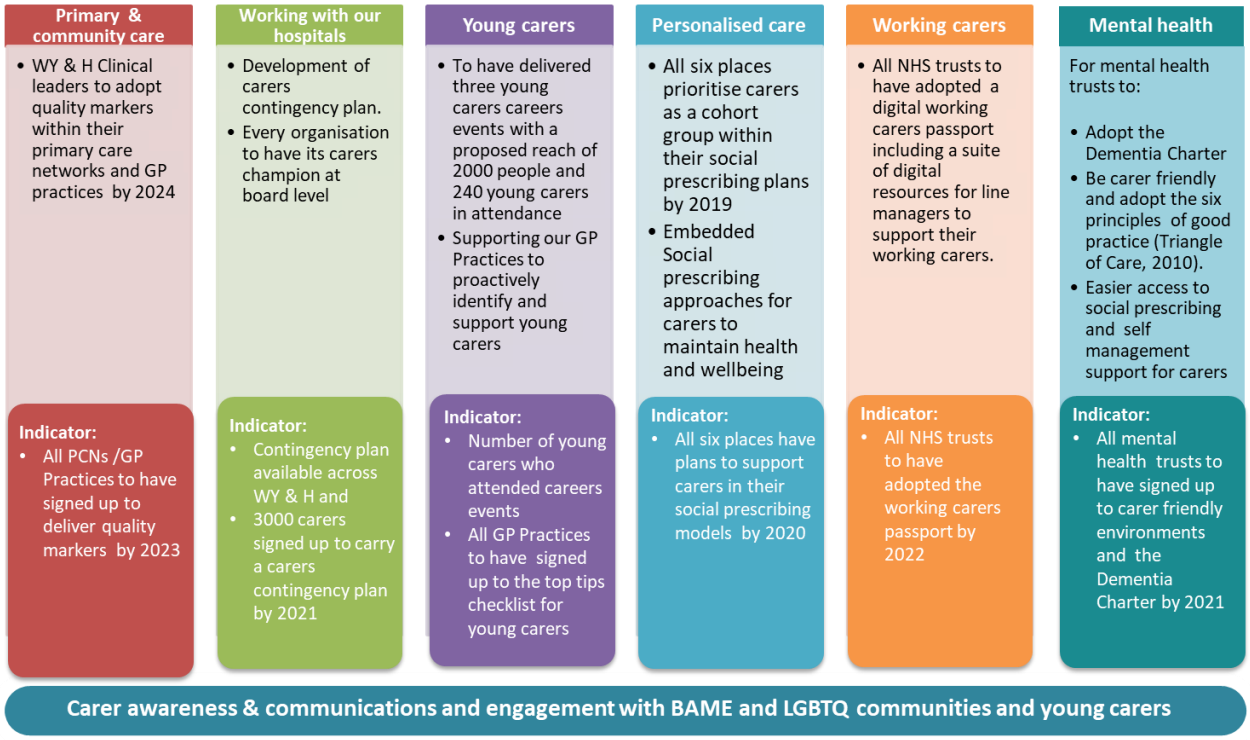
We are working with NHS England's Dementia Networks to engage with carers and the people they care for who are living with dementia from a wide range of communities. The work focused on working with organisations embedded within these communities and with carers from different backgrounds. The aim is to support a better experience of care for both the carer and their people they care for.

We aim to improve the lives of all carers over the next five years. This includes:

- **Making sure that more carers have access to a contingency plan supported by all mental health and acute hospital trusts across West Yorkshire and Harrogate**
- **Supporting a consistent offer for emergency care and out of hours support to ensure carers know how to access out of hours care when they need it.**
- **Supporting in excess of 43,000 working carers across our acute trusts and mental health trusts to ensure our carer NHS acute workforce has access to a working carer passport to enable them the flexibility and support to continue their caring role and remain in employment.**
- **Working with our partners in primary and community care to ensure that all carers when visiting their GP practice are recognised, have access to flexible appointments and are signposted to effective support to maintain their caring role**
- **Raising awareness of the contribution of our young carers, ensuring that they are identified and supporting them to access careers in health and social care.**

Our priorities for supporting carers over the coming years are as follows **(To do: rework infographic)**.

Our five year ambitions include XXX (different ambitions to run along the top of each page)



Supporting people who work in health and care

Staff are our most important asset. Over 100,000 people work in health and care across West Yorkshire and Harrogate. This number has been increasing year on year. However, the increasing pressures of work and ongoing national pay restraint have made it difficult to recruit and retain enough staff to meet people's health care needs.

Health and social care is changing to meet the needs of our communities. Reshaping healthcare requires a reshaping of the health and care workforce. New teams are emerging with an increased role for non-medical staff to work alongside medical staff, non-registered staff to work alongside registered professionals, new roles alongside traditional roles and the unpaid volunteers and carers working in partnership with health and care sector employees. There is a greater role for people working outside of hospitals, where most health and social care takes place.

We want West Yorkshire and Harrogate to be a great place to work. This means ensuring that staff represents the people we serve, including ethnic minority staff in leadership roles. The Interim People Plan (June 2019) emphasised the need to promote positive cultures, build a pipeline of compassionate and engaging leaders and make the NHS an agile, inclusive and a modern employer. This is especially important if we are to attract and retain our workforce.

If we are to truly transform our workforce and make West Yorkshire and Harrogate the best place to live and work, then we need to be more ambitious and show system wide working with all our partners to tackle the issues we face.

We have an opportunity to take on a greater leadership role in workforce planning. This will require investment and partnership working in a way which has never been done before.

We are developing a system wide workforce plan to include the social care workforce, primary care and community workers as well as the traditional NHS workforce.

This will outline how future demand can be achieved through various routes such as increasing supply, retention strategies, upskilling the current workforce, supporting new models of care, international recruitment and new role development.

Volunteers, carers, and community sector engagement is critical. There is a need for a shared understanding of their role across the Partnership so we can support, develop and promote the work they do. This will be done in partnership with our priority programmes, including supporting unpaid carers and community organisations.

This means planning the future health and social care workforce together rather than looking at individual organisation demands. In return this will enable funding to be distributed accordingly and future investment planned on a system wide level.

As well as the six local places taking greater ownership for developing their workforce, there is a need for our priority programmes to collectively identify and work with partners, such as the Local Workforce Acton Board and Health Education England, to develop solutions.

Primary care, maternity and mental health has workforce groups taking forward specific challenges. They are working across the Partnership to develop solutions. The intention is for our other priority programmes to follow suit.

Local Workforce Action Board

The Local Workforce Action Board includes a wide range of key stakeholder from across the health and social care system. It is chaired by a CEO from one of our hospital trusts. We are currently reviewing membership with the aim of having an executive decision making board and various groups feeding into this.

In April 2018 we published our workforce strategy 'A healthy place to live, a great place to work'. It identified strategic workforce priorities around increasing supply; maximising the contribution of the current workforce; improving productivity; transforming teamwork; making it easier for people to work in differing places and different organisations. It also includes growing the general practice and community workforce to enable to 'left shift' (see page 51) where people are cared for in the community as opposed to hospital settings wherever possible.

We are aligning out priorities to the recently published NHS Interim People Plan, whilst keeping in view all the Partnership workforce challenges. Below is a summary of current initiatives and future priorities. Local places are already making great progress against the NHS Interim People Plan.

Making West Yorkshire and Harrogate the best place to work

The NHS is the largest employer in England, yet we have a higher than average sickness rate and the number of people leaving the NHS is rising.

Reports of poor experiences in the workplace are particularly high for black and minority ethnic (BME) staff.

We need to work hard to improve their experience and make sure that staff are engaged and supported to deliver the highest quality of care by making the NHS the best place to work.

Staff are often working in an environment of operating at full capacity, where unmet need is prevalent and resources scarce. Culture change is needed to make sure staff feel supported when things go wrong.

Following the establishment of the West Yorkshire and Harrogate Excellence Centre we have made progress in supporting our workforce through identifying training and development opportunities. Focusing on school children we have developed best practice guidance on work experience and produced a tool kit for placements.

A central hub has been developed which directs schools, colleges, higher education, employers and employment seekers to quality information, advice and guidance at a place, regional and national level. A careers hub has also been developed which is a central portal for information for all sectors. This includes career ladders.

Specific career campaigns have been produced including one around Operating Development Practitioners (see below).

[Case study: add picture]
Operating Department Practitioners (ODPs) are a vital part of the multidisciplinary operating theatre team, providing a high standard of patient- focused care during anaesthesia, surgery and recovery, responding to patients physical and psychological needs. In 2018 we developed a campaign in partnership with Huddersfield University to recruit more people. The campaign called 'the most rewarding job you probably never heard of'. You can find out more here and watch the campaign film.

You can find out more about other workforce developments on our website here.

Our five year ambitions [to do: quantify numbers]

- **Share and promote best practice across our six places, and work collectively to ensure all have the same opportunities**
- **Engage the younger generation by changing the narrative around retention and provide more flexible models of working**
- **Change the role of HR directors to move away from operational to transformational areas of work**
- **Put the health and wellbeing of our employers at the forefront of everything we do**
- **Make the NHS an attractive place to work by looking at some basic principles around travel, parking and pension issues**
- **Look at the redistribution of trainees to areas of greatest need**
- **Further develop and promote initiatives that are underway via Health Education England to enhance the lives of junior doctors, including piloting various initiatives including:**
  - **Less than full time training in emergency medicine**
  - **Flexible training portfolios for physicians**
  - **General practice nursing and GP fellowship pilots. We are looking at a day a week for personal development/leadership**
  - **Clinical educators in emergency medicine who will be specifically dedicated to supporting education and training one day a week as opposed to providing clinical care.**

Improving leadership

Inclusive, person-centred leadership culture at all levels across the NHS is needed. This work will be led by the Leadership and Organisational Development Programme (see page 109) and Talent Management Board with support from the Local Workforce Action Board.

Work is taking place nationally to expand the NHS graduate management training scheme whilst also identifying high-potential clinicians and others to receive career support to enable career progression to the most senior levels of the service.

Locally, we have promoted Health Education England Clinical Leadership Fellows Programmes and have been successful in appointing these to the Local Maternity System (see page 64) and across West Yorkshire Association of Acute Trusts (see page 59). Many fellows take up senior leadership roles earlier if they feel better supported.

Our five year ambitions

- **Work across priority programmes to prioritise actions to prevent duplication**
- **Ensure our Partnership is a visible leader in making sure that talented black and minority ethnic (BAME) leaders emerge. This will include celebrating the talent that exists and continuing to make the business case for diversity**
- **Leadership team sessions on BAME staff will showcase talent**
- **Look at the impact of programmes such as Future Leaders at Health Education England to review the impact**
- **Identify and encourage aspirational leaders and develop them as system leaders.**

Tackling the nursing shortage

- We need to ensure we are supporting and retaining the nurses we already have whilst looking at how we can increase the supply of newly qualified nurses at home and through international recruitment
- We are developing specific mental health nursing, learning disabilities nursing and social care nursing career campaigns to try and improve recruitment into these areas. Health Education England has agreed a training grant for learning disability nursing apprenticeships with £2 million funding to support an increase of 150 trainee nursing associates and up to 230 registered learning disability nurse apprentices in 2019/20 across the country
- Health Education England has introduced nursing associates. This is a new role that sits alongside existing healthcare support workers and fully-qualified registered nurses to deliver hands-on care for people. In 2018 we had 379 nurse associates starting and have a target of 373 in 2019/20
- NHS Improvement and Health Education England are working together with local organisations and universities to increase clinical placements with an aim to facilitate the Department of Health and Social Care's intended 25% increase in nurse graduate places. Local places have been successful in securing additional funds from NHS England for clinical placement expansion with a particular focus on supporting community and mental health providers to prepare staff to take increased numbers of students including in primary care and care homes
- We are piloting a programme with our Local Maternity System to improve employee engagement and wellbeing whilst delivering service change.

Our five year ambitions

- **Increase placement capacity whilst not compromising quality**
- **Look at how our Universities can work together to increase supply**
- **Focus on return to practice and flexible working models**
- **Explore leadership development for nurses.**

Delivering 21st century care

The NHS Long Term Plan sets out a new model of care for the 21st century which includes increasing care in the community; redesigning and reducing pressure on emergency hospital services; more personalised care; digitally enabled primary and outpatient care; and a focus on population health and reducing health inequalities (see page 29).

We will look at transforming the workforce and explore new ways of working with a different skill mix. New roles will emerge. Our current workforce will need new skills to achieve the aspiration of integrated primary care and community health services.

More emphasis is needed around population health needs and a greater knowledge of wider issues that will impact on people living across our area, for example climate change and ageing population.

We will support the growth of new roles, such as advanced clinical practitioners (ACPs), physician associates and nurse associates.

[In a box]
In 2018, 110 ACP's began training in West Yorkshire and Harrogate funded by Health Education England and this has increased to 140 in 2019. The Local Workforce Action Board has also supported the pilot of existing roles in new settings such as psychologists and occupational therapists in general practice. We will work with the newly established primary care workforce steering group to look at joint development and collaborative work plans.

Nationally there has been a push to increase medical school places from 6,000 to 7,500 per year. The University of Leeds had an additional 20 places. There has also been a shift from highly specialised roles to more generalist ones and recruitment for core medical training has improved in the region. All college curricula are looking at more generalist training; however this is moving at differing pace across our area.

We are working together to support the expansion of apprenticeships through information and advice from the Excellence Centre. Health Education England has provided funding to facilitate levy transfer between apprenticeship levy paying organisations and organisations that are non-levy paying or have spent their levy.

Several of the larger levy paying organisations have committed to transferring over £880,000 to pay for apprenticeship training in other health and social care organisations. This money could pay for at least 108 apprenticeships across the region. We are looking to grow apprenticeships in both clinical and non-clinical jobs, with the expectation that employers will offer all entry-level jobs as apprenticeships before considering other recruitment options.

We need to work closely with the digital programme (see page 102) to ensure we have a digital ready workforce with a clear plan for developing the workforce to run, manage, improve and transform the healthcare technology environment. Digital leadership capacity and capability needs to be mapped with upskilling of current staff to deliver digitally-enabled care. Mapping of roles where technology will release staff for redeployment or retraining needs to be in place.

Our five year ambitions

- **Develop a model of employment for physicians associates (PAs) in primary care to promote the role and increase the number of PAs within the next 12 months**
- **Prepare people for different ways of working and provide a system wide model and approach**
- **Preventing ill health needs to be much higher on the agenda both in curricula for trainees and also in terms of Making Every Contact Count**
- **We will work with the digital programme to enable a digital ready workforce.**

A new operating model for workforce

We will continue to work collaboratively and be clear what needs to be done locally, regionally and nationally, with more activities undertaken by the Partnership.

Funding the development of a Workforce Hub will involve current Health Education England staff as well as two programme managers and various project managers dedicated to mental health and cancer.

In August 2018, a £1million investment plan (utilising Health Education England funding made available to the Local Workforce Action Board) was approved by the Partnership to support the delivery of the workforce strategy. A further £1m was made available in 2019 and successful bids have been agreed which again support transformation across the area.

In 2018/19 Health Education England invested £3.8million **(is this national?)** in workforce development and in 2019/20 this will be £4m. This is largely being used to buy continuing professional development programmes from universities and other education, training providers.

Our Partnership agreed to pool the budget for West Yorkshire and Harrogate. Decisions are made with local NHS providers via the newly formed delivery group. This group brings together employer education and training leads from acute hospitals, mental health, primary care, social care, councils and hospices alongside universities.

The Local Workforce Action Board also works closely with the West Yorkshire Association of Acute Trusts (WYAAT) and provides capacity to help take forward projects such as the planned collaborative medical bank. WYAAT in turn engages with the work of other Partnership programmes to support initiatives, such as the plans to support working carers.

We are also working with the Harnessing the Power of Communities Programme to develop a standardised approach to the training of volunteers to ensure they feel valued, supported and developed whilst ensuring consistency across the Partnership.

Our five year ambitions

- **Consider our capacity and capability to take on devolvement of workforce planning**
- **Inequality between places needs to be taken into account**
- **Population health needs to be taken into account when developing a workforce plan for the Partnership.**

Innovation, improvement and digital

Innovation is transforming health and care across our Partnership. As a health and care system we have a track record for innovation and as a region we have a wealth of assets, including a thriving university sector, over 250 HealthTech businesses, and a strong Academic Health Science Network (AHSN).

[Case study: add picture]
South West Yorkshire Partnership NHS Foundation Trust is working with the University of Huddersfield to pioneer the use of computer artificial intelligence (AI) to predict which mental health patients are most likely to take their lives.

Now that the potential to predict suicides using AI has been established, work will continue so that the technology can be used by healthcare professionals in their day to day work. The prototype of the automated suicide predictor is locally adapted to the Trust; but the AI could be adapted for other mental health services.

By driving forward new approaches to keeping healthy, the management of long-term health conditions and by curing illness, we have the potential to further harness expertise and capability in HealthTech. Working as a Partnership gives us a greater opportunity to spread good practice, learn what works well and also implement innovation faster.

Working in this way will speed up improvements in care, and drive inclusive economic growth and productivity across the region and the UK. By working in partnership, we will advance a mutually beneficial approach to the development, evidence-based testing, adoption and spread of clinically effective and cost-effective innovation. We will position the region as an area of expertise, growth and productivity that will deliver high quality outcomes and clear benefits for people.

People will receive the benefits of innovation as it drives faster, more convenient, higher quality care which is supported by services that are digitally connected and striving forward to make improvements.

Our strategy has three themes:

- Spread and adoption of innovation: Led by the AHSN we will spread nationally and locally identified good practice that meets our ambitions. The AHSN will be the bridge between the national Accelerated Access Collaborative Support Programme and the local system to capitalise on regional test bed clusters from 2020/21.
- Discovery: We will work to identify NHS and care-sector system needs and generate innovative responses including Medtech and new processes, pathways and techniques.
- Improvement: Foster the systemic adoption of continuous improvement for quality, safety and innovation. This includes the work of the Yorkshire and Humber Patient Safety Collaborative.

Spreading good practice

The commitment to national funding for the AHSN until April 2023 enables the Partnership to deliver system wide innovation including:

- AHSN's portfolio of nationally funded technologies and innovations
- Innovations with significant opportunity to improve care through the Propel@YH digital accelerator
- Innovations identified by the Leeds Academic Health Partnership and the Centre for Personalised Health and Medicine.
- Real-world evaluations as part of the nationally funded Innovation Exchange and the Leeds Academic Health Partnership.

Work in West Yorkshire and Harrogate has already had significant impact:

- The Atrial Fibrillation project has prevented 123 strokes over 18 months **(To note: need dates).**This is as many as 400 strokes avoided over five years (see page 79)
- 'Healthy Hearts' for Cardio-Vascular Disease has already implemented a new simplified protocol for managing high blood pressure.
- Connect with Pharmacy (Transfer of Care Around Medicines) has helped over 4000 people to use their medicines well and avoid being re-admitted to hospital.
- PreCePT has protected 40 pre-term infants from developing Cerebral Palsy.
- The Emergency Laparotomy Collaborative is supporting doctors from across the region to exchange ideas on how to protect patients needing emergency abdominal surgery.

- Patient Safety Collaborative has prevented over 2000 people from having a fall whilst in hospital. The majority of people live in West Yorkshire and Harrogate. This means they left hospital earlier and with a better quality of life. This work has prevented over £7m of healthcare costs across Yorkshire.
- 491 staff from the Yorkshire and Humber workforce have taken part in the AHSN programme to use quality improvement methods including human factors and achieving behaviour change in A&E. We have 47 case studies showing how quality improvement methods have improved work.
- Housing for health is identifying work in the housing sector that has a direct benefit on health. The initial work identified 40 case studies. Six of these will be fully evaluated to inform housing policy and decision makers on how to maximise the benefits of housing to improve healthier lives.

Closer partnership working with industry

Since our Partnership was established in March 2016 we have had a clear ambition to foster innovation in health and care services. Developing a closer and mutually beneficial working relationship with the HealthTech sector is an important part of this ambition. As well as improving health services and outcomes, it also has the potential to attract inward investment into our region, drive productivity and promote inclusive growth (jobs).
We have been working with the Leeds Academic Health Partnership to develop a new way of working with the health tech sector across the Leeds City Region. We have produced a Memorandum of Understanding (MoU) which defines a new way of working between the health tech sector, universities, and health and care organisations. More information is available here.

Improvement

We recognise the value of improving care through both the adoption of innovation and the application of continuous improvement. With the support of AHSN we will mobilise the capacity and capability for quality improvement across the Partnership. This includes bringing together improvement expertise from within the region, such as the Bradford Institute of Health Research Improvement Academy, the region's members of the Health Foundation Q community and innovators such as Clinical Entrepreneurs and NHS Innovation Champions – this will help attract national and global partners.

The Partnership will establish a network to support hospital trust and other health and care providers that already have an approach to continuous quality improvement; and to support those organisations that are planning to adopt and embed a systemic method.

Building on the work of the Yorkshire and Humber Patient Safety Collaborative, the Partnership will continue to reduce avoidable harms. The initial focus will be on medicine safety, people whose illnesses are getting worse and maternity services.

Our five year ambitions

- **Continue our programme of system wide innovation led by YHAHSN to ensure that our patients can fully benefit from breakthroughs enabling prevention of ill-health, earlier diagnosis, more effective treatments, better outcomes and faster recovery.**
- **Work collaboratively with YHAHSN to identify opportunities for innovations in real world settings.**
- **Implement the regional Test Bed Clusters from 2020/21 to further strengthen our processes and capacity to undertake real world testing to ensure that future innovations are backed by real world data on benefits and costs.**

- **Build on the work of the Yorkshire and Humber Patient Safety Collaborative, and continue to reduce avoidable harms. The initial focus for 2020-21 will be on medicines safety, people's whose illnesses are worsening and maternity services.**
- **In partnership with YHAHSN establish a network to support hospital trusts and other health and care providers that already have an approach to continuous quality improvement; and to support those organisations that are planning to adopt and embed a systemic method.**

Digital work and connecting systems together (interoperability)

[Case study: add picture]
Calderdale and Huddersfield NHS Foundation Trust (CHFT) is now one of the most digitally advanced Trusts in the country and currently shares number 1 ranking in the digitalhealth.net league table for digital maturity. CHFT has some of the highest utility of the national electronic staff record (ESR) and has been successfully using an App (application software) for recruitment of bank staff for several months, as well as leading the way nationally on implementing the K2 Athena maternity patient record and recently the same system went live in Leeds Teaching Hospitals Trust again providing consistency of approach in West Yorkshire.

Our lives are being transformed by digital every single day. Digital is also transforming our Partnership – the way we interact with people, the way we deliver our services, and the way in which we work together across West Yorkshire and Harrogate.
The Digital Programme is 'harnessing digital - working together - to promote health and wellness and ensure high quality care.

This past year the Digital Programme has primarily focussed on improving our infrastructure to make access easier for people.

- Over 870,000 people can now book and cancel their GP appointments online and we expect 950,000 people to have access by the end of the year. These people are also now able to seek medical help virtually using the online triage tools
- 100% of first-time referrals for patients from GPs to medical specialists are now electronic, making the process to receive an appointment faster
- In 70% of our GP practices there is now free Wi-Fi. We are targeting 100% by the end of the year.
- In all unplanned care settings we have provided access for health care workers to information about vulnerable children to ensure these children are cared for
- Working with the Cancer Alliance and the Yorkshire and Humber Care Record Exemplar, the Partnership is now sharing key data to expedite cancer care. The first wave included Leeds Teaching Hospitals Trust, Harrogate Foundation Trust and Yorkshire Ambulance Service. The second wave will be completed this year and include Bradford Teaching Hospitals
- We are supporting easier working for our staff by putting in the 'GovRoam' Wi-Fi and 'federated' email allowing staff to access a single email address book for everyone and work digitally from any of our sites. Over 50% of organisations have installed GovRoam with 100% planned by this year
- A new, secure health and social care communications network is being put in to replace the old, separate networks for 64+ organisations. This d will be completed by the end of the year
- Working with the Yorkshire Imaging Collaborative, across the Partnership and the Humber Coast and Vale Partnership, it is expected that this year all hospitals will have access to all radiology images. This has already been successfully tested between Mid Yorkshire Hospitals and Bradford Teaching Hospitals.

[Case study: add picture]
Yorkshire Ambulance Service
Designed and developed by our staff for our staff, the intuitive and easy-to-use YAS ePR electronically captures assessment and interaction information about our patients. This enables us to accurately share relevant and timely information with other healthcare providers involved in their care, leading to improved quality, clinical safety, audit and patient experience. Future developments of the YAS ePR will enable a seamless transfer of care with the wider healthcare economy. This will be done by:

- **Supporting clinical decision-making by incorporating Paramedic Pathfinder, NHS Service Finder and JRCALC**
- **Facilitating the sharing of patient data, e.g. the Yorkshire and Humber Care Record, Local Health and Care Records Exemplar and the National Record Locator Service**
- **Integrating with electronic referral via our Clinical Hub, the NHS Spine, defibrillator data and community first responders.**

[Case study: add picture]
Kirklees Council
With the use of Alexa in Kirklees, more people will be using technology to help them stay well and independent at home where possible. With more and more technology we need to be careful to also ensure that people feel comfortable with this change. We will aim to make digital as easy as possible for everyone.

Our five year ambitions

We are developing a digital strategic plan for the Partnership. This will help define the model for delivering our digital initiatives, including

- **How the digital ambitions in the NHS long term plan are realised.**
- **How different organisations and places within our Partnership work together on digital**
- **How digital could enable the other ICS priority programmes.**

This is of course only part of an important picture – we also need to understand what people accessing health and care think about digital. We welcomed the Healthwatch engagement findings and the recent report on digitisation and personalisation. We are taking these views seriously and are including them in our strategy.

Our top priority is sharing information between all health and care partners in the six places. This sharing will, for example, this year ensure A&E departments have time-sensitive information before patients arrive by ambulance. We will also prioritise sharing information with care homes, community pharmacies, hospices and social care to support carers and in support of safeguarding.

We have also prioritised the following initiatives:

- Helping people, to stay healthy and manage their help in their own homes when possible, for example with the use of home monitoring devices or apps
- Improving digital literacy across all staff. This improvement will help staff analyse and use new data and new technology
- Supporting work to digitally streamline urgent and emergency care
- Continuing the work to digitally mature our organisations, including electronic prescribing.
- Mechanisms to easily share resources, conduct joint procurements, apply standards, blueprint ‘how to’ guides, and to optimise voice and communication and telecare infrastructures
- Ensuring cyber security compliance by 2021 along with ensuring we meet all other aims outlined in the NHS Long Term Plan, for example, ensuring all staff utilise electronic rostering and expanding our use of analytics and modelling for planning purposes.

[Case study]

Often people feel like they are pulled from one place to another as they try to find the help they need, with multiple visits to different organisations which might all seem very disjointed. The Partnership is working together to break down these barriers, and provide a more joined up approach to delivering care. One way we are doing this is through the introduction of a system wide Local Health Care Record. One of the main frustrations of both patients and staff is that medical records aren't currently shared between organisations. This means that often people need to repeat things all the time, and potentially have repeat tests for the same thing because there is no record in one place of a visit to another. This new system will stop that from happening by pulling together information into one single, secure place. This will lead to better outcomes for people because more informed decisions will be made with more information available to health and care professionals.

Finance

Current financial outlook

With the announcement by the Prime Minister in June 2018 of additional funding to the NHS, growth is forecast to increase to an average of 3.3% in real terms for the next five years. In recent years demands on our resources have grown faster than the funding that has been available, and as a result services have come under ever increasing pressure, with many organisations finding it difficult to deliver care within what they have available. Across West Yorkshire and Harrogate there are still organisations who have underlying planned deficits going into next year and beyond, so while increases in funding are very welcome, much of it is likely to be needed to help restore financial balance.

Local Authority budgets have fared significantly worse over this decade. Public health grants have fallen significantly since 2012. Social care spending has fallen across the country by 5% in real terms since 2010/11 and despite recent increases, spending was around £1bn less than in 2010/11, at £17.8bn. The government has yet to set out long-term funding plans for social care.

For 2019-20 the scale of the financial challenge remains significant, but the NHS system is now forecasting the delivery of a £21m surplus for the year. This surplus position is after the provision of incentive funding (£69m) and non-recurrent support funding to organisations that would otherwise be in deficit (£32m); without this funding, we would have a planned deficit of £81m. This position is subject to a lot of potential risk, and needs us to deliver efficiencies higher than the 1.1% minimum – failure to manage either has the potential to impact heavily on how much of that money our Partnership may get.

Whilst the 2018 announcement of additional NHS funding is very welcome, it will be critical that additional resources identified for West Yorkshire and Harrogate allows us to apply our local discretion to meet local priorities.
The NHS Long Term Plan set out a number of financial tests that the NHS (and each local system) will need to satisfy to demonstrate that the additional investment is being put to good use

[To include figures and description from the data collection]

Approach to financial delivery

Although the NHS financial settlement will go some way to improving the financial outlook of the West Yorkshire and Harrogate health system, all organisations will need to maintain focus on delivering services in the most efficient way possible.

The aspiration included in the NHS Long Term Plan is that the scale of these targeted efficiencies will be significantly lower than in recent years, but set against the context of lower than required growth for the last few years and the fact that many organisations have already had to reduce costs as a result, continuing to deliver efficiencies locally will present a challenge.

This is why it is important that we continue the work collaboratively within each of our six local places and across the Partnership to improve services in a more joined-up, efficient way. We will do this by sharing best practice and working closely together.

[Case study]
We can make savings by buying things together. Buying medical equipment as a single Partnership, for example, will mean we get better prices than if each organisation negotiated their own deals. By 2022 we aim to double the products bought through one centralised organisation called Supply Chain Coordination Limited, driving savings as a result, and will also bring together local and regional teams to keep costs down. This would be much more difficult to achieve if we didn't negotiate as a Partnership, and more savings means more money to spend on improving the care needs of the population.

[In a box]
We will continue to focus on system-wide efficiencies and delivering improvements that benefit people across the Partnership. This will mean considering the total available funding and how it can be best used to deliver the best care possible across West Yorkshire and Harrogate.

We have reviewed the funding system known as 'payment by results'. This was designed to pay individual hospitals for each episode of care that they provided, but encouraged individual organisations to focus on their own requirements rather than working collaboratively with other partners to minimise demand and improve overall population health. We have now moved to a risk-sharing approach to contracting where income is dependent on pre-agreed broader outcomes rather than hospitals being paid on a case by case basis. By sharing information and moving to open-book accounting across the system (where each organisation shares its financial information with each other) the Partnership has a clear understanding of the financial allocations in each place.
By removing the barriers that payment by results created, and focussing as a Partnership on the resources available as a whole, broader discussions about collaborative ways of working to improve services across the Partnership have now become the norm.

Working together to meet the diverse needs of our citizens and communities
Financial resources will remain constrained, so it is important that we work together to make difficult choices about how we prioritise the resource we have available.

All partners have signed a memorandum of understanding that describes the way organisations across our Partnership work together, and how and where decisions are made. It builds on mutual trust built up since the Partnership was created in 2016.
As long as money is a finite resource, difficult choices will still need to be made around where it is best deployed, and while we will ensure that these choices are made locally wherever possible, there will be occasions where we will make decisions that impact on services across West Yorkshire and Harrogate. In all cases, we will be transparent and honest, and constructively challenge where necessary.

Innovation and best practice is at the heart of how we work together, and we will make sure that our learning benefits the whole population. Over the last few years NHS organisations have been expected to work towards a specific financial target each year, set by NHS England and NHS Improvement, known as a control total with some areas accepting that target and others not. Those that did were eligible to receive incentive funding to help their financial positions, but those that didn't received no additional support. To try and avoid this mismatch, our Partnership has established shared control totals. This means that we support each other in delivering a shared financial target, with ups and downs in individual organisations being offset by each other so no one loses out on incentive funding.

This, together with risk-sharing contracts and system-wide efficiencies means that we will continue to make financial decisions for the benefit of the people we serve. All West Yorkshire and Harrogate priority programmes will have senior finance support to help them maximise access to funding, and make sure that investments are prioritised in a way that delivers the greatest impact for everyone. The Partnership will receive additional funding over the next 5 years to help deliver all of the targets set out in the NHS Long Term Plan – by 2023-24. This will bring in an additional £83 million of funding per year. We will use these funds in the most efficient manner, and will work together as a system to ensure these funds are distributed on a fair share basis to all places across the Partnership, with organisations needing to account for how best they will spend the money to deliver the maximum benefit to people living in West Yorkshire and Harrogate.

Managing NHS resources across the Partnership

As well as collectively managing commissioning risks across the system, the Partnership will also take on greater responsibility for system financial management. Our goal is that by demonstrating maturity as a system we will have more access to additional funding, as well as a greater say in how we spend it. We have already had access to new money called transformation funding (see box) and can decide on how that is spent across the Partnership. We have seen real improvements in services for people as a result.

We want to expand this approach over the next few years, working together as a successful Partnership.

The shared control total is a way of demonstrating this commitment to work together. With the Partnership now adopting a risk-sharing approach, 15% of the incentive funding available to the Partnership is dependent on us delivering our shared financial position; for 2019-20 this is worth £8m. This means that there's a clear incentive for organisations to work together to manage within their allocated financial envelope, and in doing so maximise income for the Partnership and the people it serves.

The absence of a long term settlement combined with demographic and socio-economic pressures on social care budgets, as well as ongoing workforce issues, means that there are significant concerns about the sustainability of social care in our health and care system. There is a causal relationship between decisions made on health budgets and costs in social care budgets. A lack of local authority funding for prevention services, decisions made about healthy environments, housing quality and support services for people with a range of needs and conditions, has a direct link to health spending. We are clear that the future sustainability of social care is dependent on collaboration with the NHS and vice versa.

[In a box]

Main types of funding

- **Incentive Funding: as part of the NHS financial framework, organisations can get additional money if they agree to and deliver a financial position that has been set by NHS England and NHS Improvement. This is called sustainability funding and is available to NHS providers and commissioners. For 2019/20 15% of this funding is now dependent on our Partnership delivering a shared financial position i.e. the sum of all the financial balances of NHS organisations in the system. This encourages us to work much more closely together to maximise funding for the Partnership and the people it serves. There are two types of incentive funding; Provider Sustainability Funding for Trusts and Commissioner Sustainability Funding for commissioners**
- **Non-recurrent support funding: since 2019-20 NHS organisations that are forecasting to make a deficit can gain access to a non-recurrent Financial Recovery Fund. This helps support their financial positions in this financial year so they can continue to provide services, but is part of a recovery package where all those in receipt have to demonstrate how and when they will return to surplus. Transformation Funding – by agreeing to work together as a Partnership to deliver our shared financial target, we are able to access additional money called Transformation Funding. This is then allocated by the Partnership to support the work of its programmes**
- **Capital: as well as day-to-day expenditure incurred throughout the year (to pay for staff, drugs or clinical supplies, for example), organisations also have to invest in new equipment, IT infrastructure and buildings, and this is known as capital expenditure. Traditionally most of this is funded by organisations using specific money put aside for that purpose, but in recent years the NHS has had access to additional capital which it gains access to through a bidding process. The Partnership have worked collaboratively to maximise the amount of money we can get for this, by prioritising bids that provide the maximum benefit to the system's populations.**

In box: (move into a glossary)

Financial terms explained

- **Control total: for the last few years NHS organisations have been set a financial target to achieve by NHS England and NHS Improvement. Financial incentives have been made available for those that successfully achieve that target**
- **Shared control total: rather than individual organisations being incentivised to achieve a control total specific to them alone, a shared control total sums the targets from across the Partnership and a proportion of the individual incentives (15% in the case of West Yorkshire and Harrogate) is now only payable based on the delivery of that joint target**
- **Financial Recovery Plans: these are the plans that organisations in deficit need to take to return to financial balance. Where this isn't going to happen in just one year, a stepped approach will be agreed with annual improvements expected year on year – these annual improvement targets are also known as trajectories**
- **Provider: a term used in the NHS to describe organisations that provide services to patients.**
- **Commissioner: a term used in the NHS to describe organisations that pay providers for the services that they provide**
- **Efficiencies / efficiency targets: each year the NHS is expected to reduce the cost of delivering the services it provides, either by making savings on the costs of things it buys, reducing waste, looking for more streamlined ways of working, or seeing more patients without increasing the costs (known as higher productivity). The combined term for all of these things is 'efficiencies' and each year NHS organisations having a target amount of efficiencies to deliver in order to achieve financial balance.**
- **Unwarranted variation: with such a diverse range of communities it is inevitable that many will have specific needs, characteristics or personal circumstances that means there may be differences in the way they are treated for the same condition. These types of variation are referred to as "warranted", and are considered acceptable in any healthcare system,**

anywhere in the world. However, whenever these variations are unacceptable or harmful to patients, their families or their carers, this is known as unwarranted variation

- **Risk: anything which may stop an organisation from achieving what it needs to achieve. In a financial sense this could be where efficiencies are dependent on something needing to happen which is not certain to happen or it could be where providers and commissioners have different assumptions about how demand for services may grow in the future.**

Capital and buildings

We have significant capital requirements to ensure that our buildings are fit for purpose and meet people's needs. We will work together to understand capital priorities across the system and, as a Partnership rather than as individual organisations, prioritise those that support new and improved ways of working. By embracing the Partnership approach to capital prioritisation, since 2018 the Partnership has secured national capital investment for eight schemes totalling £270m. These include £200m to support the reconfiguration of the hospitals at Calderdale and Huddersfield NHS Foundation Trust, £26m for the consolidation of pathology services and £11m for child adolescent mental health services.

We will transform hospital services by investing in a world class children's hospital and adult facilities at our regional specialist centre the Leeds General Infirmary.

Building the Leeds Way will deliver sustainable clinical models by creating much needed critical care and theatre capacity to support demand for specialist services such as spinal surgery. In addition the centralisation of maternity, neonatal and children's services will improve patient experience and enable safe and sustainable staffing models. The new hospitals will be digital by design and enable the transformation of outpatient services, supporting the 'left shift' and a 30% reduction in face to face attendances. The development will deliver around £1bn economic benefit, release 155000m2 poor quality estates and reduce back log maintenance by £100m.

[To include: Table of successful schemes to be added]

Transformation funding

The Partnership works hard to secure transformation funds, and this is key to enabling new ways of working across the system. To date we have been successful in securing £**Xm (to add)** of transformation funding from national organisations to support these projects.

[To include: Table of transformation funding – five year outlook to be added]

Our five year ambitions

- **NHS budget to be increased by £20 billion a year in real terms by 2023-24**
- **Partnership to develop 5 year plan to address all deliverables in the NHS Long Term Plan, while working to deliver financial balance for all NHS organisations in the Partnership by 2023-24**
- **Deliver a system surplus of £21m by the end of 2019-20**
- **Double the volume of products bought collectively as a Partnership (to drive down cost) by 2020**
- **Continue to operate shared control totals and improve access to additional funding as well as getting a greater say in how we spend it**
- **Develop shared programmes to deliver at least 1.1% efficiencies per year for the next five years.**

[Case study: to add picture]

The Pathology Department in St James's University Hospital in Leeds, is one of the largest in the UK processing over 1,000 pathology slides a day, and is now digitally scanning every slide. This makes getting a second opinion much quicker and easier than the traditional method.

[In a box: develop info graphic]

- **National pathology exchange [£2million] - To deliver a lab-to-lab messaging solution that connects Laboratory Information Management Systems (LIMS) together across the area to facilitate the electronic transfer of pathology test requests and results. The solution is based on NHS Digital standards and connects to a large number of LIMS regardless of supplier and vendors. This will be led by the Health Informatics Service which is a shared service hosted by Calderdale and Huddersfield NHS Foundation Trust. [To do: update with system LIMS)**
- **Telemedicine in care homes [£1.5million] - Commissioning of the Airedale NHS Foundation Trust (ANHSFT) care home telemedicine service across a number of our care homes in the WY&H area. The funding will enhance the Digital Care Hub infrastructure, reduced activity pressures generated from nursing homes across West Yorkshire and Harrogate and improve people's care. This will be led by Airedale NHS Foundation Trust.**
- **Scan for Safety [GS1 - £15million] - GS1 is a global not-for-profit organisation dedicated to the design and implementation of standards that improve organisational efficiency. Leeds Teaching Hospitals NHS Trust is currently a demonstrator site. The work will increase data accuracy and reliability enabling improved analytics and decision making; patient safety and experience improvements through "right patient, right product, right treatment". It will increase automated data transfer between systems and organisations reducing potential errors and time delays. This work will support the roll-out in the other five NHS acute providers in West Yorkshire and Harrogate**
- **Yorkshire Imaging Collaborative [£6.1million] - The funding will be used to collaboratively procure imaging solutions to transform radiology services to meet capacity and demand issues. Yorkshire Imaging Collaborative will improve quality and create efficiencies and enable further regional clinical service transformation. This work is being led by the Yorkshire Imaging Collaborative which comprises the six NHS acute hospital providers in West Yorkshire and Harrogate plus a further two NHS acute providers from outside our health and care partnership**
- **The Partnership will receive £12million of NHS Capital Funding to develop a single, shared Laboratory Information Management System (LIMS) for the area. The funding will be used to deliver a one system wide approach for pathology across West Yorkshire and Harrogate acute hospitals.**

A new health and care partnership

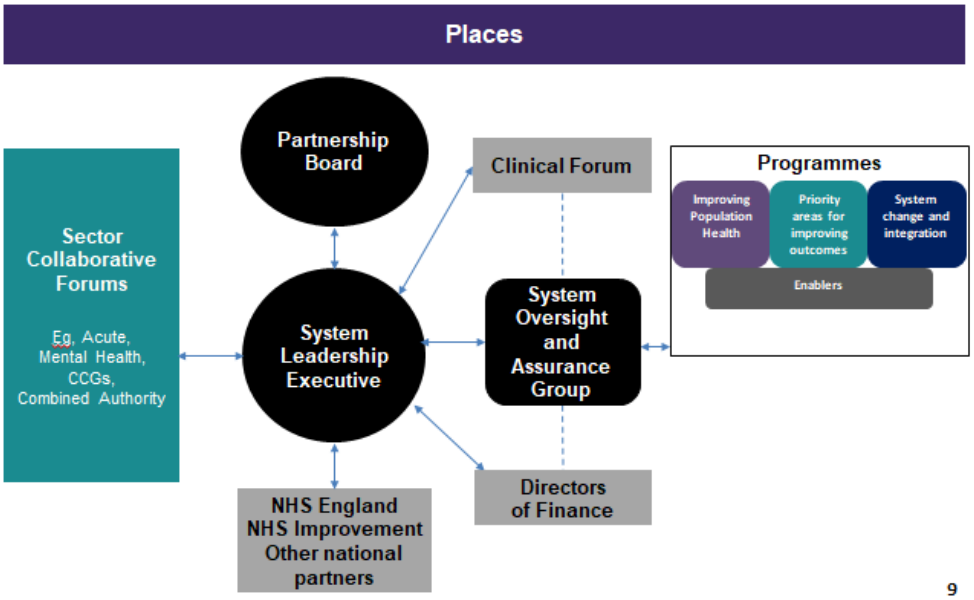
The way that we do things, is as important as what we do. We need to take time to describe 'the way we do things round here'. How we do 'change' is as important as the change we are making. We know change is deeply personal and if we think of any change we have been involved the crux tends to always be about relationships and how they are changing. We have adopted the mantra of 'be the change you want to see' (Gandhi, 1945).

If our Partnership is transforming what it does, we need give people the tools to engage with it on both a personal and professional level, if the partnership is also to transform how it does it. To support delivery of this transformational approach, the System Leadership and Development programme has been established, aiming to create an environment and culture conducive to change, collaboration and partnership that enable people to flourish and our citizens to benefit directly as a result.

Our Partnership has been created through the authority of the boards and governing bodies of its constituent organisations. Each of them remains sovereign, and of course, local councils remain accountable to their electorates. The large majority of work, delivery and decision making will still be taken locally.

We have established a set of arrangements to facilitate joint working which are set out in our Partnership Memorandum of Understanding (MoU). You can read it [here].

The diagram below shows how the various components of how this fits together [rework graph].



We are a Partnership of places, sectors and programmes.

There are well established partnership working arrangements at place level, and Health and Wellbeing Boards have a critical role as the vehicle for joint system leadership at place level.

The Partnership Board, System Leadership Executive and System Oversight and Assurance Group provide the core infrastructure for our joint working at a West Yorkshire and Harrogate level.

- The Partnership Board is responsible for setting the strategic direction. It brings together Chairs and Chief Executives of NHS organisations in West Yorkshire and Harrogate, council leaders, chief executives and senior representatives from other partner organisations. It meets quarterly in public. You can find out more here.
- The System Leadership Executive includes the chief executive / accountable officer leadership and representation from other partner organisations. The group is responsible for overseeing delivery of our strategic priorities and building leadership. They have collective responsibility for our shared objectives.
- The System Oversight and Assurance Group is the mechanism for partner organisations to take ownership of system performance and delivery.

We have established a set of sector collaborative forums, which bring together similar organisations across West Yorkshire and Harrogate to work on shared priorities within sector.

This includes the Committees in Common for acute trusts (West Yorkshire Association of Acute Trusts) and mental health trusts; the Joint Committee of Clinical Commissioning Groups; and the

Local Workforce Action Board. Further information on the priorities and ways of working for each of these sector forums can be found on our website at www.wyhpartnership.co.uk

Each of the West Yorkshire and Harrogate priority programmes work by bringing together place and sector representatives to work on shared priorities. Each programme has a senior responsible officer (SRO), typically a chief executive or accountable officer and has a structure that builds in clinical and other stakeholder input. The programmes are underpinned by strong governance and programme management arrangements. Programmes provide regular updates to the System Leadership Executive and System Oversight and Assurance Group.

Useful information

- Where people can get involved in our work
- Web links to documents
- Available publications
- Acronym buster link
- For the printed version – all links to documents to be included in a list
- You tube account
- More information
- Contact details
- Alternative formats

This page is intentionally left blank

Leeds Health and Wellbeing Board

Report author: Emma Geary, Project Officer, Health Partnerships Team

Report of: Paul Bollom (Lead for CQC System Review & Leeds CQC System Review Task and Finish Group)

Report to: Leeds Health and Wellbeing Board

Date: 16th September 2019

Subject: Update on the CQC Leeds System Review Action Plan

Are specific geographical areas affected? If relevant, name(s) of area(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, access to information procedure rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

The 2018 CQC Local System Review resulted in the Health and Wellbeing Board (HWB) agreeing thirty six actions to improve people's experience of care across the Leeds system. This report updates on progress of these actions highlighting areas of development and challenge. Good progress is being made across all of the actions which has resulted in improved quality and outcomes for people with the any further work to be undertaken detailed within the updates per action.

Recommendations

The Health and Wellbeing Board is asked to:

- Review, challenge and unblock progress where needed of the action plan
- Provide comments and challenge to help drive the forward implementation of the actions.
- Confirm what if any further review is required by HWB
- Confirm how HWB may wish to share progress on the action plan.

1 Purpose of this report

1.1 In September 2018 Leeds was informed that the Care Quality Commission (CQC) were intending to undertake a Local System Review (LSR) of Leeds on how services are working to care for people aged 65 and over, including those living with dementia.

1.2 The LSR report published in December 2018 recognised a range of strengths in Leeds while acknowledging system challenges that required addressing. A workshop of key stakeholders developed a robust action plan owned by the Health and Wellbeing Board with cross system actions embedded within our existing partnership boards / groups.

1.3 Attached is the updated action plan of which the Health and Wellbeing Board received and approved on 23rd January 2019. This report aims to provide a summary of the progressions made to date.

1.4 The Health and Wellbeing Board are asked to review the progressions of the action plan and provide comments and challenge to help drive the forward implementation of the actions.

2 Background information

2.1 The government commissioned CQC to work beyond its single agency quality inspection role to review health and social care systems based on the footprint of local authority areas. The purpose was to find out how services are working together as a system to care for people aged 65 and older. There was a particular emphasis on the experience, quality and consistency of people's journeys of care across agencies in a system. The reviews were carried out under Section 48 of the Health and Social Care Act 2008. CQC have already carried out similar reviews in other local authority areas across the country.

2.2 Within a Local System Review CQC are looking at how hospitals, community health services, GP practices, care homes and home care agencies work together to provide seamless care. They look at how well systems are:

- maintaining people's health and wellbeing at home;
- providing care and support when people experience a crisis;
- supporting people when they leave hospital;
- how people move between health and social care; and
- how services are commissioned and how funding is used.

2.3 The reviews test if the support and services offered in each local system are safe, effective, caring and responsive. They also assess the leadership across services and across the local system – asking the question, are they well led?

2.4 The choice for CQC to review Leeds was made by the Secretary of State for Health and Care and was predicated on data indicators that suggested Leeds was facing local pressures particularly in patient flow. Leeds (at the time of the data analysis) was a national outlier for average lengths of stay in hospital, and Delayed Transfers of Care (DToC).

2.5 During the CQC review, CQC were provided with a summary of local information, including local plans and data sets, as background information about the current position of the health and care system in Leeds, and the likely future direction.

2.6 The review team visited Leeds during September and October 2018 to hear the experiences of service-users and community groups. They returned to listen to the views of our workforce and strategic leaders and decision-makers. They also carried out a number of site visits to our health and care settings (including hospitals, care homes and nursing homes).

2.7 The timetable for the CQC visits included:

- Engaging and meeting service users from older adults groups and those living with dementia, carers and independent care providers.
- Visits to Wykebeck Day Centre, Crossgates Neighbourhood Network, The Arch Age Concern and Carers Leeds.
- Host focus groups with Yorkshire Ambulance Service, representatives from the Third Sector, health and social care professionals, commissioners and providers.
- 1-2-1 interviews with key leaders and partners.
- Acute hospital visits including emergency teams, discharge management, Chapeltown Health Centre, Church View Surgery Crossgates, Recovery Hub@South Leeds, Pennington Court and BAME Hub, Leeds Community Healthcare.

2.8 In total, CQC hosted 34 interviews, held 18 focus groups and completed 15 site visits. They received three presentations, and interviewed 250 people (1-2-1 or in focus groups). They also received 170 completed questionnaires by private providers and staff.

2.9 The CQC report is published on their website. The full version of the report can be seen at: https://www.cqc.org.uk/sites/default/files/20181219_local_system_review_leeds.pdf%20 . All other system review reports for the other areas can be found at: https://www.cqc.org.uk/local-systems-review

2.10 On 17th December, a Summit of key stakeholders was convened where CQC shared their findings and senior leaders from across health and care came together to discuss how Leeds would respond to the recommendations

2.11 Using the feedback during the Summit and further discussions across the partnership, a draft action plan was developed. The HWB agreed the action plan on 23rd January 2019 and takes oversight and responsibility for the driving forward the implementation, using the findings to challenge the system to deliver the outlined actions.

2.12 The action plan is a local process. Leeds has no formal requirement after the review to further update CQC on progress with actions. It should also be noted that some systems have been revisited by CQC after their initial review.

2.13 The Health and Wellbeing Board agreed actions would be progressed within existing partnership governance structures, e.g. System Resilience Assurance Board (SRAB), Integrated Commissioning Executive (ICE) and Partnership Executive Group.

3 Main issues

Overview

3.1 Appendix 1 details the progression made on the plan actions. Each of the original action owners in the plan have agreed a brief description of progress and a determination of whether progress matches the action objective (yes – green, in progress – orange, insufficient or no progress – red)

3.2 Of the 36 actions that were agreed within the CQC action plan, 27 are rated as green, 9 amber and none rated as red.

Progress highlights

3.3 Health and Wellbeing Board were clear in their January meeting that in their view the most important action and finding from the CQCs work was highlighting a lack of the collective understanding of people's experiences of care across the Leeds system.

3.4 Progress in this area has been good. Leaders in the city agreed to delegate progress to a newly constituted "*A How Does it Feel for Me?"* group. The Group has full partnership representation and have agreed three key actions which are well underway:

- The first is to develop a better route to recording in-depth people's experiences. Starting with four individuals initially, video and audio records are being made across time by the participants providing verbatim feedback on their current care journey in Leeds.

- The second action has been to agree a rolling programme of comprehensive, multi-agency case reviews to understand across partners how professional decision making has influenced the experience of care.

- The third action seeks to think systematically about how do we capture, hear and act on people's experiences of health and care services and then when they move in and out of health and care settings. The focus of this work is to particularly identify and work with those mechanisms where people are already telling their story/sharing their experiences. The experiential stories and case note review results will be shared in a planned sequence including partner agencies, partnership groups and Health and Wellbeing Board.

3.5 The CQC challenged the clarity across the partnership that the hospital pressures are recognised as a system issue. Progress has been made by way of a full review of the governance supporting the system resilience agendas and by ensuring this is reflected in system-wide strategic plans.

3.6 There has been extensive partnership development and support for the 2018-19 System Resilience Plan. Actions that had been previously planned and completed

through the review process helped Leeds to significantly shift the experience of people needing hospital care in winter 2018. Actions challenged growth in admissions and a more proactive bed planning strategy and improved discharge arrangements helped ensure no person was required to stay in a non-designated bed area in the hospital. Analysis of the winter response is being used to refine and improve plans for 2019-20 to ensure progress is maintained and improved upon.

3.7 There has been development and action to embed a culture of 'Home First' – challenging ourselves to think why can a person not be at home today (allowing home to be a variety of health enhancing options). The purpose is to share a collective ambition to ensure people wherever appropriate can move away from hospital needs to a community setting, key updates to note are:

- The Home First strategy was agreed by the PEG in May 2019. The Home First work stream is now established with all system partners represented.

- Leeds Clinical Commissioning Group (CCG) has commissioned primary care to ensure that all care homes could be supported by targeted resources enhancing care and increasing capacity to remain in the care home for a range of conditions that may lead otherwise to a hospital visit. The commitment increasing the resource available with effect from 1 April 2019. Additional detail can be found in the update on action 12.

- There are continued plans to work with Primary Care Networks (PCNs) during quarter three to ensure a 100% coverage of targeted resources for the care home population in preparation for the national specification to be implemented from 1 April 2020.

- A re-audit was undertaken by Newton Europe in May 2019 of the destinations people reach after a stay in hospital. The review demonstrated modest progress with 41% of people reaching a non-ideal outcome on discharge compared with 56% a year earlier.

3.8 The CQC challenged the Leeds system to have a more coherent and jointly agreed strategy for workforce matters.

3.9 Progress made to date on the Workforce Strategy includes:

- Co-creating and finalising shared workforce priorities with final reporting to PEG due in October 2019. This work is being linked to the Leeds Plan refresh, and the ongoing national and system work on the NHS Long Term Plan implementation.

- Our "one workforce" approach encompasses all partners including the NHS social care, public health and the independent and voluntary sectors. We recognise that the majority of our health and care workforce operate outside of the statutory sector and they are increasingly the workforce we will rely upon to deliver the new service model of care focussed on prevention and care closer to home and as such are integral to any future workforce planning. Whilst the NHS People Plan is focussed on "Making the NHS the best place to work" our approach in Leeds is focussed strongly on making "health and care" the best place to work.

- There is strong agreement that by focussing some of our workforce activity in priority neighbourhoods, especially employability and outreach programmes, we can significantly impact on the wider determinants of health and transform those communities' health outcomes.

- Leeds health and care place-based representation now confirmed for Local Workforce Action Board to support the West Yorkshire & Harrogate Integrated Care System workforce priorities and Organisational Development programmes.

- In June 2019 partnership governance for workforce matters was streamlined in Leeds. Agreement was reached to jointly appoint a Director role to coordinate workforce matters across the Leeds footprint.

- Leeds and the West Yorkshire & Harrogate Integrated Care System has been selected to participate in the national pilot to test and develop the workforce readiness assessment tool - supporting NHS Interim people plan operating model workstream. Impact and funding of any resource implications of the citywide workforce strategy yet to be finalised.

3.10 Work in underway to develop 'one' system dashboard/scorecard for health and care which will provide an indication of day to day progress against achieving our outcomes. This work will be finalised in-line with the refresh of the Leeds Health and Care Plan. Recognising the holistic nature of our Health and Wellbeing Strategy we are also developing a simple way of providing regular assurance to the HWB of progress against all of the priorities and indicators within our Health and Wellbeing Strategy.

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

4.1.1 Please refer to points: 2.6 – 2.8 which provides more detail the journey of engagement taken by the CQC Review Team who visited Leeds during September and October.

4.1.2 The CQC Review Team met with service-users, community groups, our workforce and strategic leaders and decision-makers. They also carried out a number of site visits to our health and care settings (including hospitals, care homes and nursing homes).

4.1.3 The CQC Action Plan has been developed based on the findings of this review and subsequent discussions and Summit (17th December 2018)

4.1.4 Any specific changes undertaken within the CQC Action Plan affecting any areas of the system will be subject to agreed statutory organisational consultation and engagement processes.

Please also refer to the actions noted in the key progress (point 3.4) which details improvements made to citizen engagement, experiences and journeys.

4.2 Equality and diversity / cohesion and integration

4.2.1 The CQC Action Plan embodies actions to review and improve our health and social care system to the benefit of people aged 65 and older. This contributes to improving health of the poorest the fastest in line with the Leeds Health and Wellbeing Strategy.

4.3 Resources and value for money

4.3.1 High rates of admissions and poor or slow journeys of care are recognised resource and financial risks for the Leeds system. The agreed actions will help to ensure that these are minimised.

4.3.2 The CQC Action Plan supports actions to encourage integrated commissioning frameworks putting people's experiences central to the framework. This approach promotes the efficiency of the collective Leeds £.

4.4 Legal Implications, access to information and call In

4.4.1 There are no legal, access to information or call in implications from this report.

4.5 Risk management

4.5.1 The CQC Action Plan is a system responsibility with oversight from the Health and Wellbeing Board. The Health and Wellbeing Board agreed to delegate day to day risk management and progress management to appropriate partnership boards in the city. There boards have used a range of risk management methodologies to ensure action progress.

4.5.2 The Leeds Health and Wellbeing Board are requested to use the findings on progress to support and challenge the system if there are risks that actions are not delivered or are no longer correct as target areas for improvement.

5 Conclusions

5.1 At the end of 2018, the Care Quality Commission (CQC) undertook a Local System Review (LSR) of Leeds on how services are working to care for people aged 65 and over, including those living with dementia.

5.2 This has led to the system responding by developing a robust action plan owned by the Health and Wellbeing Board with cross system actions embedded within our existing partnership boards / groups.

5.3 The CQC Action Plan has provided in the main a successful approach to capturing and sharing partnership priorities and progressions. This has allowed for efficient and effective working in the city and linking enabling and supporting programmes together.

5.4 There is further opportunity to drive forward and implement the actions detailed which will improve how services are working to care for people aged 65 and over, including those living with dementia.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Review, challenge and unblock progress where needed of the action plan
- Provide comments and challenge to help drive the forward implementation of the actions.
- Confirm what if any further review is required by HWB
- Confirm how HWB may wish to share progress on the action plan.

7 Background documents

7.1 None

THIS PAGE IS LEFT INTENTIONALLY BLANK

How does this help reduce health inequalities in Leeds?

- It is recognised that those with lower economic or social resources may be more susceptible to delays in their transitions of care. Reducing delays overall may help tackle this inequality.
- Significant delays in peoples care journeys are in some cases associated with disability or conditions where mental health is also implicated. Reducing delays overall may help tackle this inequality.
- People's experiences of care will provide better insight in how inequalities affect journeys of care in the city allowing action to be taken to address these.

How does this help create a high quality health and care system?

- Feedback from people's experience of care is that poor journeys of care across settings are a significant cause of distress and delayed recovery. Direct feedback has raised where use of non-designated beds has historically led to distress in people using them. Changing patterns of care to journeys of care of high quality and minimal use of.
- High quality systems are recognised as having a cohesive culture maximising the use of community settings and home as a basis for recovery wherever appropriate.
- Systems which include voices from all partners in planning and consider themselves as a single cohesive system are more likely to provide cohesive high quality services.

How does this help to have a financially sustainable health and care system?

- Services which do not account for the experience of users between them, and/or go on to provide delayed care or provide care which does not maximise changes of recovery to someone's home present a financial risk. This risk would be likely to grow with demographic changes if no action is taken.
- Leeds can create a more sustainable system by reinvestment in community and preventative resources which reduce financial risks experienced in high usage of hospital care where not warranted.

Future challenges or opportunities

- The future opportunities are to track the impact of the CQC Action Plan and related System Resilience Planning activity in Leeds through concrete data. This is an ongoing action in the plan. This will be an area of further review by HWB.
- Additional work prompted by analysis of attendance and admission patterns at hospital could extend the scope of the current CQC Actions and is an area for further consideration by the Board.
- There is an opportunity to consider if the Board wished to share progress proactivity with CQC to date.
- Poor progress could present a risk of further CQC review and intervention.

Priorities of the Leeds Health and Wellbeing Strategy 2016-21	
A Child Friendly City and the best start in life	
An Age Friendly City where people age well	X
Strong, engaged and well-connected communities	
Housing and the environment enable all people of Leeds to be healthy	
A strong economy with quality, local jobs	
Get more people, more physically active, more often	
Maximise the benefits of information and technology	
A stronger focus on prevention	
Support self-care, with more people managing their own conditions	
Promote mental and physical health equally	
A valued, well trained and supported workforce	X
The best care, in the right place, at the right time	X

This page is intentionally left blank

Appendix – CQC Leeds System Review Action Plan: Progress Update

#	CQC system wide recommendation	Leeds comments and actions to be completed in 2019	Alignment with a current work stream, group or Board, including Lead	Progress made Sept 2019	RAG
	Strategic areas for improvement				
A.	The review highlighted above all a need to strengthen the focus on people's experiences across their journeys of care. As a partnership we feel this requires the highest emphasis, with specific actions and is a theme throughout our action plan.	1. By the end of March to have completed an assessment of the current approaches to capturing people's experiences across partners.	People's Voices Group (Hannah Davies)	Assessment completed and shared with PEG April 2019. Further assessment completed July 2019 which in process of being written up to inform future options for better collation of people's experiences across health and care journeys.	
		2. By the end of April to agree an approach to the development and monitoring of collective quantitative and qualitative intelligence to give better assurance of patient's experience across their journey of health and care across organisations.	Cross-partner group which will include leads for quality is being established. Jo Harding, Shona McFarlane, Paul Bollom and Hannah Davies	Cross partner group set up and meeting monthly which is chaired by Healthwatch. Three actions underway including i) video blog of small sample of older people who are likely to move between care settings, ii) a rolling programme of case note review using a multi-agency review protocol, iii) Options appraisal of how to both improve current capture of experience, identify gaps and potential to develop new/improved tools. A quality process is being developed that will provide assurance as well as areas for service improvements directed by these three mechanisms.	
		3. By June ensure that the findings of action 2 are incorporated into the Leeds Frailty Strategy, in ensuring that people's experience outcomes, are the basis for commissioning and performance managing relevant services.	PEG (Chris Mills)	Agreement with chair of Clinical Frailty Strategy Group that this item is on the forward plan. To discuss at Frailty Programme Board 8th August. A number of patient experiences measures are in development linked to the Frailty person-focused outcomes. Work is underway to co-ordinate this work to action 2.	

Appendix – CQC Leeds System Review Action Plan: Progress Update

B.	The HWB should continue to maintain oversight and hold system leaders to account for the delivery of the health and wellbeing strategy.	4. By the end of March develop an easy to follow flowchart of governance, remit and flow of risk at both operational and system level incorporating any lessons which can be learned from other high-performing systems.	Health Partnerships Team (Tony Cooke)	Existing charts of governance provide flow of governance, remit and risk between key system groups. Leeds Plan refresh is considering current city governance and mapping 'as is' state and how it will provide coherent progress reporting in light of refreshed plan.	
		5. By the end of April agree 'one' system suite of measures dashboard / scorecard and accompanying process for ensuring that all appropriate Boards/groups are regularly sighted and inform decisions taken.	Health and Wellbeing Board (Cath Roff)	HWB have asked for action to improve HWS reporting based on clearer metrics reporting trend and health inequalities. Operational system has developed metrics suite around key operational measures (SRAB dashboard). System has moved towards headline measures for system change. Approach supported and agreed by HWB but further work required.	
		6. Through 2019 participate with WY&H ICS peer review process.	Health Partnerships Team (Tony Cooke)	Leeds has engaged with conversations on peer review programme within WY and Harrogate ICS with ICS colleagues. Request for deferment from late Spring / early Summer date was agreed. Peer review programme has slower pace whilst implications of new ICS and LTP performance management structures emerging.	
C.	The remit of the ICE should be further developed so that it extends more widely to underpin the development of wider integrated working.	7. By April develop an Integrated Commissioning Framework and review the role and function of the Integrated Commissioning Executive (ICE) inline with the Integrated Commissioning Framework. This will also include we ensure people's experience is placed at the heart of commissioning activities.	Integrated Commissioning Executive - ICE (Cath Roff and Phil Corrigan > Tim Ryley)	Commissioning Framework developed and agreed. Reporting on a regular basis to ICE for progress. Consideration given to development requirements for senior / strategic commissioning the city and the resources required. People's experiences central to framework. Evidence from complaints, incidents, and information from action 1 above are regular discussion at ICE.	

D.	There is a recognition from system partners that hospital pressures should be addressed as a system. This should be reflected in system-wide strategic plans.	• Also covered by action 5.			
		8. By the end of March ensure there is a clear document that explains which groups are in place, their role, frequency of meeting, membership etc, which in turn will be used to ensure that all of these groups/boards are clear of their responsibilities for delivering the Leeds Resilience Plan.	System Resilience and Assurance Board (SRAB) - Leeds Resilience Plan (Phil Corrigan > Tim Ryley)	A full review of governance supporting the System Resilience Agendas commenced in June 2019. The recommendations have been signed off by the System Resilience Assurance Board August 2019.	
		9. By the end of May complete a lessons learned of the impact on citizens experience and system performance of the 2018/19 Leeds Resilience Plan and begin development of the Leeds Resilience Plan for 2019/20.	SRAB - Leeds Resilience Plan (Phil Corrigan > Tim Ryley)	Lessons learnt exercise completed with sharing within SRAB, PEG and board level partnership discussions. Improved performance basis for future plan but recognising further work to do / not complacent approach. 19/20 plan is in development. The Leeds system conducted a full winter evaluation exercise in May, this involved gathering all system partners' challenges and experience of the past winter. A full report will form part of the 19/20 System Resilience Plan for Leeds which is currently in development with a sign off date in October 2019 across the Leeds system and will be submitted to NHS England.	
		10. By the end of summer 2019, to have a refreshed Leeds Plan reflecting the Leeds Resilience Plan 2019/20, Frailty and End of Life Strategy and the NHS 10 Year Plan. This will provide the place based contribution into the West Yorkshire and Harrogate Integrated Care System planning.	Health Wellbeing Board (Paul Bollom, Tim Ryley, Katherine Sheerin, Chris Mills)	Leeds Plan refresh set in context of LRP, LTP, JSA, Big Leeds Chat, MH needs assessment, CYP MH needs assessment. Refresh is the place based contribution to the ICS in response to NHS LTP.	

E.	The culture of 'home first' and moving people away from hospital needs to be embedded throughout the system, especially in the hospital setting where there remains a risk averse approach to discharge and a lack of understanding of community support.	11. By the end of February set out a plan to embed the 'home first' approach and the implications for the workforce and citizens, which is supported by all partners.	Decision Making Workstream (Julian Hartley)	The Home First strategy was agreed by the Partnership Executive Group in May 2019. Home first workstream now established with all system partners attending.	
		12. By the end of March, develop an OD, communications and engagement plan to support the embedding of the 'home first' approach. This needs to link with the work also being undertaken by the Clinical Strategy Group around training to better support people to manage their frailty in community / home settings.	Decision Making Workstream (Julian Hartley)	CCG made provision to commission primary care to ensure that all homes could be covered by increasing the resource available with effect from 1 April 2019: • New service specification has been implemented reflecting the outcome of the CQC report and aligning the previous 3 schemes into 1. • Some new practices are delivering the scheme • Some practices have opted not to deliver (minimum of 10 patients prevents some practices from participation). Other practices are offering an enhanced service out with the scheme. • Retains choice for patients • Approx. 70% of all care home beds covered by the scheme (49 practices) All patients in homes registered with a Leeds GP will respond to urgent / acute primary care needs and continue to roll out the provision of telemedicine in care homes (currently in 30 homes). A 3 year phased plan for 100% coverage of telemedicine is in development. A three stage OD, communications and engagement plan has been developed based on gathering insight through a deliberative event, refining home first messages and embedding these in routine communications.	
		13. By the end of June undertake 80 case file audit (i.e. re-run of the Newton Europe analysis) to assess the embedding of 'Home First' within a managed risk way, and that we have demonstrated we have taken the right action with our service users.	Decision Making Workstream (Julian Hartley)	Plans to continue to work with Primary Care Networks during quarter 3 to deliver the scheme across the care home population in preparation for the national specification to be implemented from 1 April 2020 which will ensure 100% coverage A re-audit was undertaken by Newton Europe in May 2019. The review demonstrated modest progress with 41% of people reaching a non-ideal outcome on discharge compared with 56% a year earlier.	

		14. By the end of February to identify any learning from other areas around patient risk management protocols to prioritise patients for discharge. Evaluate if they offer an improved approach for Leeds.	Clinical Senate (Yvette Oade, Simon Stockill)	Criteria for virtual wards has been reviewed and in collaboration with community partners more patients are now eligible.	
F.	Communication between health and social care professionals and their leaders needs to be addressed across the system. Although there are good relationships at system leader level, and where multidisciplinary working is embedded, this can become fragmented at other levels leading to a breakdown in communication which can impact on people's care.	15. By the end of July, partnership to agree communications approach which encompasses recommendation G (see below) and flow of information between all levels of the organisations. Key products will include: • Approach for developing 'one pager' explainers of key terms, concepts, groups, processes etc. • Clear communication, engagement and OD plans for each key partner of what they individually need to action to deliver the partnership vision. • Clear consistent narrative and case studies for all partners (including the 3rd sector) to use.	Citywide Comms and Engagement Group (Jane Westmorland) OD Hub (Steve Keyes)	City-wide communications, engagement and marketing strategy approved by PEG. The strategy outlines our partnership approach to workforce communications and engagement with an accompanying action plan. The first product to come out of that strategy is a regular partnership e-bulletin update aimed at the workforce. Further actions including 'one page' guides, case studies etc in appropriate digital/audio/visual materials to support flows of information are being scoped and then developed. The publicly available partnership website and a staff collaboration site will be updated and act as a hub of up-to-date information for the workforce. The agreed workforce engagement approach and processes will be implemented for the Leeds Plan once the process for the refreshed Leeds Plan is completed. Leeds has continued to rollout its System Leadership Programme which is open to all staff from all partners at all levels and allows for sharing of ideas The programme also enables developing a consistency of understanding of the partnership ambitions and agreeing action for the delivery of the ambition. To date around 400 staff and service user reps have been part of the programme. A business case is in the process of being developed to continue the rollout of the programme for 2020. The System Leadership Programme has been enhanced with the addition of complimenting system leadership modules which are being incorporated into individual partnership leadership programmes.	

				Leeds has delivered a Shadow PEG programme for aspiring execs. One of the benefits of this programme is broadening understanding of the work of the partnership, flows of information between levels of organisations and what action we need to take to deliver the partnership vision. Links to a more detailed succession planning in the system and talent development programme are being considered.	
		16. As part of the ongoing development of Leeds Care Record, ensure that there are robust processes for assessing the use, benefit and identifying any improvement requirements of the Leeds Care Record in sharing information accurately, safely, securely and timely to ensure good patient care the gaps of the use of the Leeds Care Record.	Informatics Board (Alistair Walling)	Activity including a breakdown of users and areas accessed is reviewed monthly and analysed to understand any issues. Reported benefits are also analysed at this point in the citywide Leeds Care Record Board meetings. We are in the process of updating our overall benefits analysis (including estimated cost saving). Interim reviews are undertaken after significant developments- eg following the recent switch to GP connect as a richer source of GP data- this showed clear benefit in enhanced data for admitting teams in hospitals, this has led to a review of the need for letters from admitting GPs. All providers of data have been consulted as part of the annual review to identify current and future needs to develop the next years roadmap. A wider stakeholder event is planned for September 2019 to shape the 3-5 year plan taking regards of new developments such as LHCRE, and a move to greater access to data from clinical systems. We regularly assess if further rollout across the city is appropriate to support the sharing of information accurately, safely and securely, e.g community pharmacy, commissioned providers in the third sector. Currently supporting the Leeds City Council adult social care digital pathfinder's work to see if the Leeds Care Record could be used to support person centred planning and the sharing of information.	

G.	The workforce strategy for Leeds should be developed at pace, pulling together the different strands of activity to develop deliverables and timescales which include the independent social care sector.	17. By the end of April have developed, finalised and agreed the citywide workforce strategy and action plan for Leeds. This will develop and contribute to the West Yorkshire and Harrogate Integrated Care System workforce plan during the summer.	Citywide Workforce Group (Sara Munro, Sheree Axon)	Work on co-creating and then finalising the shared workforce priorities and plans is well developed, with final reporting to PEG in October. This work is being linked to the Leeds Plan refresh, and the ongoing national and system work on the Long term plan implementation. A detailed briefing was provided to Councillor Charlwood on 24 July, and feedback sought in respect of HWB. Leeds health and care place-based representation now confirmed for LWAB and WY&H ICS workforce and OD programmes. In June streamlined decision-making and leadership arrangements for workforce also agreed with further investment from partners – formal delegation from PEG as sub group. Leeds part of WY&H ICS national pilot of workforce readiness assessment tool – supporting NHS Interim people plan operating model workstream. Impact and funding of any resource implications of the citywide workforce strategy yet to be finalised. RAG rating reflects this and slippage from April to October.	
H.	There should be improved engagement with GPs and adult social care providers in the development of the strategies and delivery of services in Leeds.	18. By the end of February produce communication material bespoke for GPs that describe the Leeds Health and Wellbeing Strategy and Leeds Plan in the context of primary care. Include the processes by which GPs can shape the plans and delivery and future iterations of the Strategy. Use the existing GP Confederation Strategic Board and Locality Leadership to share materials.	GP Confederation (Jim Barwick, Chris Mills)	The governance structure for the Confederation is fully established. This has allowed specific agenda items the Health & Wellbeing Strategy. There is a two way feedback mechanism being developed between the Health & Wellbeing Board and the Confed Strategic Board. We will use the Confed website to share and publish materials for GPs, this work is ongoing.	
		19. From March onwards, enact a process of improved engagement with GPs, via their localities and the GP Confederation Strategic Board, whereby GPs can shape the refreshed Leeds Plan and future iterations of the Strategy. This being in the context of Local Care Partnership and Population Health Management approaches.	GP Confederation (Jim Barwick, Chris Mills)	The Confeds governance and communication approach encompasses full engagement with GPs, localities and Primary Care Networks. There is significant leadership by GPs, facilitated by the Confed, in the development of LCPs. The Confed has contributed to the refresh of the Leeds Plan, based on its members strategic voice. Updates on the Leeds Plan refresh have been shared with the Confed	

		20. Use existing provider forums to engage providers on how social care providers can contribute to delivering the Health and Wellbeing Strategy and to shape the refreshed Leeds Plan. Existing forums include: the Strategic Directions Care Homes meeting; Care Homes Provider Forum; Home Care Providers meetings, Third Sector Partnership Forum.	Adults and Health (Caroline Baria)	Discussions being held regularly with providers at relevant forums, with the inclusion of providers' response to LCC's commitment to Climate Emergency.	
		21. By end of February 2019, discuss with the forums referenced in action 16, how the social care provider sector would like to be involved in ongoing conversations for example, further discussions at forum meetings, engagement events, questionnaires, contract management meetings etc.	Adults and Health (Caroline Baria)	Work is being progressed through the Leeds Care Homes System Oversight Board and Delivery Group	
		22. From January 2019, use the existing Care Homes Strategic Directions meeting to engage with care home providers on market shaping of care home services and in the development of the Integrated Market Position Statement.	Leeds Care Homes Strategic Direction meeting (Cath Roff)	Care home strategic direction meeting well attended by system organisations and representatives from care home providers. Integrated Market position statement now developed and signed off.	

Appendix – CQC Leeds System Review Action Plan: Progress Update

	Operational Areas for Improvement				
I.	A clear process, such as a risk stratification tool, should be implemented so that health and social care professionals can be assured that they are able to identify and support the members of their communities who are most at risk.	23. By the end of June, review the use of the Risk Stratification approach used in primary care and ensure that the tool, process and communications (to ensure understanding and consistency of language) are effective and fit for purpose. Ensure that the developing population health management (PHM) approach adopted in Leeds provides a partnership approach to the early identification of people at risk of poorer health and care outcomes. Implement Person Led Proactive Care Plans to address the risks identified.	Clinical Senate (Simon Stockill, Yvette Oade) PHM Programme (Chris Mills, Tim Ryley, Lucy Jackson)	Leeds has participated in Wave 1 of the national Population Health Management programme and has worked with 4 Local Care Partnerships to test interventions for people living with frailty. PHM techniques were developed and applied to identify cohorts within frail populations where the greatest impact can be made. Wave 2 of the programme is aiming to work with 7 further LCPs from autumn 2019 and will be fully rolled out during 2020.	
J.	Signposting to services needs to be clearer so that people can access the wide range of services in the community and get the support that they need.	24. Healthwatch to evaluate how the effectiveness of Leeds Directory and other sign-posting resources which provide information to citizens and staff. Make recommendations on how sign-posting can be improved to ensure that staff and citizens feel they have sufficient on the range of community services, ensuring that the wide range of 3rd sector provision is included.	Healthwatch Leeds (Hannah Davies)	Healthwatch is a member of the Leeds Directory steering group and is working in partnership with LCC around measuring the effectiveness of the Leeds Directory post launch in October 2019. In addition, Leeds Directory will be an integral part of the Big Leeds Chat 2019	
		25. By April launch the redesigned Leeds Directory which will improve information available to citizens and staff (including NHS Choices and 111).	Adults and Health (Caroline Baria)	Leeds Directory has now been successfully relaunched. The service now sits within LCC. The Leeds Directory Team are attending team meetings and liaising with LCPs and GP practices about the directory	
		26. By October assess the recommissioned social prescribing service for activity and effectiveness, including that these services are reaching the diversity of people in Leeds.	Leeds CCG (Simon Stockill)	The referrals to the social prescribing service are monitored by the CCG and reported through CCG quality and performance committee	

		27. By July ensure that there are clearer processes and easily accessible clear information for ensuring that front-line staff are aware of support available in the community in order to signpost people. This will be informed by recommendations from action 24 and emerging proactive community support model through the Population Health Management work.	SRAB / ORG (Phil Corrigan > Tim Ryley) Urgent Care & Rapid Response Programme (Sue Robins, Cath Roff) Self-management and Proactive Care Programme (Chris Mills, Jim Barwick)	Leeds Providers' Integrated Care Collaborative has sponsored the development of a new integrated proactive community model for people living with frailty. This is being tested and implemented using Population Health Management approaches (see 23 above). The model describes a case management / care coordination function in all LCP areas which will be key in managing and supporting people living with frailty. Once implemented, this will result in streamlined processes for linking community services with hospital staff enabling coordinated care to be delivered. A clear priority for the System Resilience Assurance Board (A&E delivery Board) is to ensure that front line staff are aware of services to support people in the community. This was evidence through the diagnostic work Leeds carried out and will be taken forward as a clear priority in 2019/20	
K.	There should also be consistent and proactive input from GPs to support care homes.	28. By January agree a phased approach to re-specify the primary care support to care homes in Leeds – to include all care homes and provision of rapid response.	Leeds Care Homes System Oversight Board (Jo Harding, Caroline Baria)	A Care homes support team has been commissioned from community provider LCH. The Care homes oversight group is now well established with a matrix working approach in place. They have a clear system wide action plan.	
		29. Following the completion of action 28, commission primary care support provision as specified.	Leeds CCG (Simon Stockill)	All Care homes in Leeds have a primary care support offer. This is under review to increase standardisation. Pharmacy support to care homes also planned.	
L.	Specific pilot schemes were helping people to receive support in the community. There should be evaluations and exit plans in place to reassure or inform people who benefitted from good support about what their future options were.	30. By April develop consistent approach for evaluations and exit plans. Lessons learned to be used to inform the strategy and commissioning of future services. Consistent approach must include how services and service users are engaged with future options. Linked to action 7 and action 27.	ICE (Cath Roff, Tim Ryley) Leeds Plan Delivery Group (Paul Bollom, Sue Robins, Steve Hume)	Leeds Plan Delivery Group around iBCF projects has a decision making approach to mainstream proven interventions based on data and outcomes. The approach is based on robust evidence collation of impact, strategic alignment and shared recommendations to ICE. Recommendations enacted by commissioning prioritisation / commissioning planning processes in partners. The root of this particular recommendation came from looking at the Time to Shine Projects - each of which now have an exit plan. LOPF are reviewing in September.	

M.	Wards for people who are medically fit for discharge should have a plan in place to reduce the numbers of beds on these and to reduce the reliance on these as part of the discharge process.	31. By May have an agreed trajectory to reduce beds and plan agreed between providers and commissioners of how to achieve this.	Decision Making Workstream (Julian Hartley) SRAB - Leeds Resilience Plan (Phil Corrigan) LTHT Contract Management Board	From November 1st 2018 to June 2019 we have closed 60 MOFD beds. We are implementing the NHSI Super Stranded patient review process and anticipate that this will lead to a further reduction in the requirement for MOFD beds. The system has a clear trajectory for reducing the number of stranded and super stranded and reducing the number of beds occupied by people who are medically fit for discharge. Since May we have closed one ward and are working closely with our community bed providers to increase flow. Community bed criteria have been reviewed and expanded and we are working to promote the discharge to assess pathway.	
N.	Systems should be put in place to ensure that people who go into hospital are seen in the appropriate wards and remain there until they are medically fit for discharge without multiple moves.	32. By March agree sample audit process and metrics for monitoring moves out of hours to ensure that the processes in place are effective.	Decision Making work stream SRAB - Leeds Resilience Plan (Julian Hartley)	A daily audit of patients who move for non-clinical reasons out of hours (22:00 - 07:00) has been undertaken since June 2019 and is reported to the weekly quality meeting chaired by the Chief Nurse/Chief Medical Officer. The focus of the work is at St James's Hospital where we have seen a step change reduction in the number of patients being moved.	
O.	System leaders should continue the work to reduce hospital admissions as admissions are higher than the England average.	33. By July, Newton Europe to return to Leeds to look at complete additional analysis on admissions and repeat the original analysis to assess the actions in the Leeds Resilience Plan are being delivered effectively and the right impact being made.	SRAB	Re-audit of the Newton Europe diagnostic demonstrated that the system has made progress against the agreed actions within the Resilience Plan. It is recognised that there is still improvement to be made for both discharge and admissions avoidance. A full review of the actions in conjunction with the winter evaluation will inform the System Resilience Plan for 2019/20 currently in development.	
		34. Data needs to be assessed regarding the effectiveness of the Crisis Café, 'See, Hear and Treat,' Frailty Unit and other initiatives etc, results to be used by commissioners and the Hospital Avoidance Group to make recommendations for further admissions avoidance.	(Phil Corrigan > Tim Ryley)	As above	

P.	The patient choice policy should be rolled out as a priority and leaders should have a system to gain assurance that this is understood and implemented.	35. Implementation of the Transfer of Care Policy has been signed off by all CEO's and rolled out. By March will agree an ongoing process for auditing case files to ensure adherence to policy.	Decision Making work stream (Julian Hartley) SRAB - Leeds Resilience Plan (Phil Corrigan > Tim Ryley)	The Transfer of Care policy has been implemented. Audits have taken place and identified that letters are being issued however the process of escalation is not yet fully embedded. The operational leadership responsible for the TOC policy implementation is currently being reviewed and this process will require further agreement. Roll out of TOC policy being overseen by the Decision making workstream in LTHT, attended by CCG commissioners.	
Q.	The system should ensure that staff, particularly hospital staff understand and respect the dignity of people who use services and to understand the impact that issues such as multiple ward moves can have on people's wellbeing.	36. By the end of February agree the approach and timeline for assuring system-wide quality and ensuring that all staff are clear of the dignity and respect expectations. This will include: • System statement of expectation agreed to by all CEOs • Continuing and developing the regular senior manager walk-abouts approach to provide greater system assurance of quality. • Ensure that all front line staff have current dignity and privacy training / awareness.	Cross-partner group which will include leads for quality is being established. Jo Harding, Dawn Marshall, Paul Bollom and Hannah Davies	The development of a city wide system for assurance of quality of experience is detailed in responses to action 1 in this plan. Further work is underway to create system alignment on broader quality improvement approaches (for example joining the Leeds Improvement Method in the hospital to initiatives in other partners). LTHT undertakes weekly leadership walkrounds and the corporate nursing team oversee a programme of assurance visits, which includes observations re privacy and dignity. There has been a specific focus on the wards managed by Villa Care (patients medically optimised for discharge) following the CQC inspection visits. There is an embedded approach to training on dignity and respect issues across staff working in the hospital. This takes plance across issues specific training (eg falls) or more generic courses for aspiring leaders the importance of dignity and respect for people is reinforced. Audit processes across wards supporting older adults include a review of the experiences of five patients a week. The responses are documented and reviewed. Initiatives for people leaving hospital have included in the Bexley Wing using donated clothes to ensure those who do not have their own clothes with them to leave hospital do so wherever possible in normal dress.	

Leeds Health and Wellbeing Board

Report author: Lesley Newlove (Commissioning Support Manager, NHS Leeds CCG)

Report of: Steve Hume (Chief Officer, Adults & Health, Leeds City Council) & Sue Robins (Director of Operational Delivery, NHS Leeds CCG)

Report to: Leeds Health and Wellbeing Board

Date: 16th September 2019

Subject: Draft Leeds BCF Plan 2019/20

Are specific geographical areas affected? If relevant, name(s) of area(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, access to information procedure rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. The Better Care Fund (BCF) was established in 2013 and the current two year Leeds BCF Plan ended in March 2019. The Ministry of Housing, Communities and Local Government (MHCLG) is jointly leading a review of the BCF with the Department of Health and Social Care (DHSC) therefore 2019/20 is to be a year of minimal change with any major changes from the review being implemented from 2020 onwards.

2. Both the BCF 2019/20 policy framework and planning template have now been received and Leeds is required to set out in the planning template, its vision for health and social care integration (including where appropriate how the activities in the BCF align with system level plans), confirm expenditure and set out how the National Conditions and metrics will be met. BCF Plan 2019/20 has to be signed off by the Leeds Health and Wellbeing Board.

3. The date for submitting a completed planning template is 27 September 2019. In order to ensure robust partnership engagement is fed into this process and feedback from the Yorkshire and Humber BCF Assurance panel is incorporated into the final version of the Leeds BCF Planning Template 2019/20, it will follow as a late supplementary appendix.

Recommendations

The Health and Wellbeing Board is asked to:

- Review and agree the draft Leeds BCF Plan 2019/20.

1. Purpose of this report

1.1. The purpose of this report is to obtain sign off from the Leeds Health and Wellbeing Board for the draft Leeds BCF Plan 2019/20.

2. Background information

2.1. The BCF was established in 2013 and is a national programme spanning both the NHS and local government. It represents a unique collaboration between NHS England, the MHCLG, DHSC and the Local Government Association. The four partners work closely together to help local areas plan and implement integrated health and social care services across England, in line with the vision outlined in the Long Term Plan.

2.2. The BCF encourages integration by requiring CCGs and local authorities to enter into pooled budget arrangements and agree an integrated spending plan.

2.3. An improved Better Care Fund (iBCF) was announced in the Government's 2015 Spending Review with additional iBCF funding announced in the 2017 Spring Budget.

3. Main issues

3.1. The current two year Leeds BCF Plan ended in March 2019. The MHCLG is jointly leading a review of the BCF with the DHSC therefore 2019/20 is to be a year of minimal change with any major changes from the review being implemented from 2020 onwards

3.2. Initial discussions between health and social care colleagues indicated that due to the BCF review, it would be appropriate for the Leeds BCF Plan 2019/20 to continue to fund services as per the existing Leeds BCF 2017/19 plan. It was acknowledged that Leeds had made significant progress since 2017 and therefore to continue to invest in these existing services at this time made the best use of the Leeds £. This ensured that BCF funding had the greatest level of impact by being aligned to our strategic priorities as outlined in the Leeds Plan. It was also agreed that once planning for 2019/20 was completed that there will be a series of strategic workshops and robust engagement in order to prepare for the next version of the BCF Plan that will be in line refreshed Leeds Health and Care Plan. Approval for this approach was sought and obtained from the Integrated Commissioning Executive (ICE) on 21 August 2019.

3.3. The Leeds Health and Wellbeing Strategy 2016-21 clearly articulates Leeds' vision to be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest. The Leeds BCF Plan 2019/20 helps to deliver this vision by continuing to build on the strong integrated health and care working that has already been put in place in the city enabling easier access to services in the community, preventing admissions to hospital and reducing delays getting out of hospital.

3.4. It also supports the principles of the Leeds Health and Care Plan (Leeds Plan) by focusing on preventative services including mental health, out of hospital services

including community beds and proactive services including reablement services and support for carers.

3.5. The principle of providing person-centred integrated care is at the heart of the Leeds BCF Plan 2019/20 with partnership working including with Leeds' Third Sector being fundamental to its success.

3.6. The key points of the Leeds BCF Plan 2019/20 to note are:-

- The plan is for one year only
- The National Conditions are the same as in 2017/19
- CCGs are required to pool a mandated minimum amount of funding
- Local Authorities are required to pool grant funding from the improved Better Care Fund, the Disabled Facilities Grant and the Winter Pressures Grant – this is the first time the Winter Pressures funding is to be pooled into the BCF. Reporting on this funding will be managed through the wider BCF reporting
- A separate narrative BCF plan is not required - narrative elements are included in the planning template
- Currently there is a shortfall showing under the section 'Expenditure' of £524k approx. in respect of the Adult Social Care services spend from the CCG minimum allocations. This is because the overall increase in the CCG minimum contribution has not been allocated at a flat rate of 1.8% (as per the CCG operating planning guidance) but a 5.3% uplift nationally. NHS England is making funding available to cover this financial pressure and NHS Leeds CCG are undertaking a separate assurance process in order to receive this funding
- In addition, the 2017-19 plan included a planning assumption for the release of £2.8m additional funding to Adult Social Care within the 2020/21 financial year. This planning assumption will be carried forward into the 2019/20 BCF plan (see para 4.5.1 of the Risk Management section below)
- There are some minor issues with the planning template itself mainly that the completion checks (red/green flags) on the checklist are not functioning correctly for some fields and scenarios

3.7. As in 2017, plans will be assured by NHS regional teams and local government representatives. Regional assurance outcomes will be calibrated with support from the Better Care support team (BCST) and plans approved by national partners. NHS England will send approval letters, giving specific approval to CCGs to spend from the CCG minimum contribution.

4. Health and Wellbeing Board governance

4.1. Consultation, engagement and hearing citizen voice

4.1.1. Routine monitoring of the delivery of the BCF is undertaken by the Leeds Plan Delivery Group (LPDG). This group reports into ICE which is the BCF Partnership Board with quarterly reporting to the Health and Wellbeing Board.

4.1.2. The BCF Plan has been developed based on the findings of consultation and engagement exercises undertaken by partner organisations when developing their own organisational plans. Any specific changes undertaken by any of the

schemes will be subject to agreed statutory organisational consultation and engagement processes.

4.2. Equality and diversity / cohesion and integration

4.2.1. Through the BCF, it is vital that equity of access to services is maintained and that quality of care is not compromised. The vision that 'Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest' underpins the Leeds Health and Wellbeing Strategy 2016 - 2021. The services funded by the BCF contribute to the delivery of this vision.

4.3. Resources and value for money

4.3.1. The agreed approach in Leeds to date has been to use the BCF in such a way as to derive maximum benefit to meet the financial challenge facing the whole health and social care system. Continuing to invest in existing services not only provides stability for those services and service users but also delivers value for money and makes the best use of the Leeds £ as well as addressing the aims of the BCF.

4.3.2. The additional iBCF Grant monies allocated through the Spring Budget 2017 is focussed on initiatives/schemes that have the potential to defer or reduce future service demand and/or to ensure that the same or better outcomes can be delivered at a reduced cost to the Leeds £. As such the funding is being used as 'invest to save'.

4.4. Legal Implications, access to information and call in

4.4.1. There are no legal, access to information or call in implications from this report

4.5. Risk management

4.5.1. The CCG continues to accept a risk share agreement with Leeds City Council regarding £2.8M and the Leeds system's continued focus remains on preventing admissions and facilitating early discharges. The Newton Europe analysis has provided the system with detailed actions and the Leeds system resilience plan details all cross organisational transformation to mitigate the £2.8M risk. This resilience plan will be assessed by the BCF/Leeds Plan Delivery Group to check it is robust in meeting the requirements of the BCF.

4.5.2. There is a risk that some of the individual funded schemes do not achieve their predicted benefits. This risk is being mitigated by ongoing monitoring of the impact of the individual schemes.

5. Conclusions

5.1. The Leeds BCF Plan 2019/20 is a continuation of the existing BCF programme and continues to align itself to the Health and Wellbeing Strategy and Leeds Plan. Once the planning process for 2019/20 has concluded, strategic discussions and robust engagement will take place in preparation for the next version of the BCF Plan.

5.2. Leeds continues to work closely with the NHS England/ MHCLG/DHSC/LGA BCF collaboration attending quarterly regional meetings and sharing with others, the work that Leeds is doing.

5.3. National quarterly returns in respect of monitoring the performance of the BCF and impact of the additional iBCF/Spring Budget monies will continue to be completed and submitted to NHS England/MHCLG as required under the grant conditions. Locally we will continue to provide assurance to HWB by monitoring the impact of the schemes and plan towards the exit from the Spring Budget funding period.

6. Recommendations

The Health and Wellbeing Board is asked to:

- Review and agree the Leeds BCF Plan 2019/20

7. Background documents

None.

THIS PAGE IS LEFT INTENTIONALLY BLANK

How does this help reduce health inequalities in Leeds?
The BCF is a national programme, of which the iBCF grant is a part, spanning both the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and wellbeing and live independently in their communities for as long as possible.

How does this help create a high quality health and care system?
The BCF has been created to improve the lives of some of the most vulnerable people in our society, placing them at the centre of their care and support, and providing them with integrated health and social care services, resulting in an improved experience and better quality of life.

How does this help to have a financially sustainable health and care system?
The iBCF Grant funding has been jointly agreed between LCC and NHS partners in Leeds and is focussed on transformative initiatives that will manage future demand for services.

Future challenges or opportunities
The initiatives funded through the iBCF Grant have the potential to improve services and deliver savings. To sustain services in the longer term, successful initiatives will need to identify mainstream recurrent funding to continue beyond the non-recurrent testing stage.

Priorities of the Leeds Health and Wellbeing Strategy 2016-21	
A Child Friendly City and the best start in life	
An Age Friendly City where people age well	X
Strong, engaged and well-connected communities	X
Housing and the environment enable all people of Leeds to be healthy	
A strong economy with quality, local jobs	
Get more people, more physically active, more often	
Maximise the benefits of information and technology	X
A stronger focus on prevention	X
Support self-care, with more people managing their own conditions	X
Promote mental and physical health equally	X
A valued, well trained and supported workforce	
The best care, in the right place, at the right time	X

This page is intentionally left blank

Leeds Health and Wellbeing Board

Report author: Vic Clarke-Dunn

Report of: Director of Public Health

Report to: Leeds Health and Wellbeing Board

Date: 16th September 2019

Subject: Leeds Drug & Alcohol Strategy & Action Plan 2019-2024

Are specific geographical areas affected? If relevant, name(s) of area(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, access to information procedure rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

- The Leeds Drug and Alcohol Strategy and Action Plan 2019-2024 sets out the city's ambition to address drug and alcohol misuse over the next five years. The strategy has been refreshed in line with changes to national policy and to respond to evolving local challenges and needs.
- The Drug and Alcohol Board agreed the draft strategy on 22nd July 2019 and, subject to endorsement from Executive Board, will look to publish later in the year.
- The governance arrangements have been reviewed and a new framework is proposed to ensure oversight of the delivery of the new strategy and action plan, and connections to other key strategies and partnerships.

Recommendations

The Health and Wellbeing Board is asked to:

- Note the Leeds Drug and Alcohol Strategy and Action Plan 2019-24.
- Note the proposed governance arrangements for the strategy and connections made to key partnerships, including Safer Leeds and the Children and Families Trust Board.

1 Purpose of this report

1.1 The purpose of this report is to present the updated Leeds Drug & Alcohol Strategy and Action Plan 2019-2024 (see Appendix 2).

1.2 The strategy and action plan set out the city's ambition to address drug and alcohol misuse over the next five years, with the overarching principle that "Leeds is a compassionate city that works with individuals, families and communities to address drug and alcohol misuse" and supports the Leeds Health and Wellbeing Strategy and Safer Leeds Strategy.

1.3 As part of the development of the strategy and action plan, refreshed governance arrangements are also outlined which ensure effective oversight and connection to other key strategies and partnerships such as the Safer Leeds Strategy and the Children and Young People's Plan (see Appendix 1 - Drug & Alcohol Board Terms of Reference).

2 Background information

2.1 Leeds Drug and Alcohol strategies and action plans have always aligned with changes to national policy and responded to evolving local challenges and needs.

2.2 The national Drug Strategy 2010: Reducing demand, restricting supply, building recovery: Supporting people to live a drug free life (HM Government, 2010), set out the Government's response to drugs misuse and drug addiction, encompassing activity across three themes: reducing demand; restricting supply; and building recovery in communities. It had two overarching aims:

- reducing illicit and other harmful drug use; and
- increasing the numbers recovering from their dependence

2.3 The previous Leeds Drug and Alcohol Strategy and Action Plan was developed in 2016 and set out the local strategy for 2016-2018 to respond to the national 2010 drug strategy with a focus on four main areas. These were:

- People choose not to misuse drugs and/or alcohol
- More people to recover from their drug and alcohol misuse and the harms it can cause
- Fewer children, young people and families are affected by drug and alcohol misuse
- Fewer people experience crime and disorder related to the misuse of drugs and alcohol

2.4 The Government released a new drug strategy in 2017, which maintained its two overarching aims and three themes from the 2010 strategy alongside the introduction of a fourth: Global Action - leading and driving action on a global scale.

2.5 The national alcohol strategy has not been updated since 2012 but has also informed the development of the Leeds Drug and Alcohol Strategy, ensuring that actions were developed across health and social care, and linking to the night-time economy and criminal justice partners.

2.6 The government is currently undertaking a major independent review of drug misuse. Looking at a wide range of issues, including the system of support and enforcement around drug misuse, to inform thinking about what more can be done to tackle drug harms. The governance in place to deliver the local strategy and action plan will ensure we input into, and keep up to date with the developments of the national review and action plan, any other national government recommendations, and update local plans where appropriate.

2.7 There are strong connections between drugs and alcohol and crime and community safety. Consequently, the strategy has been reviewed jointly between Public Health and Safer Leeds. The Drug and Alcohol Strategy is also informed by and referenced in the Safer Leeds Strategy.

2.8 With the establishment of the Street Support team and presenting issues with drugs and alcohol for the majority of street users, increased connectivity around prevention, intervention and recovery has been incorporated into operational delivery. This includes enhanced pathways into treatment for street users with substance misuse issues, and better links into accommodation (including emergency, supported or sustained tenancies).

2.9 The 2017/2018 Annual Report of the Director of Public Health, entitled “Nobody Left Behind”, contained a focus on the decline in life expectancy in women and the static life expectancy in men and the reasons for this. Two of the significant causes for the disappointing life expectancy figures were cited as a rise in deaths in women from alcohol-related liver disease and a rise in deaths in men from drug-related overdoses. The new Leeds Drug and Alcohol Strategy therefore contains responses to these issues.

2.10 The Leeds Drug and Alcohol Strategy and Action Plan 2019-2024 is clearly aligned with national strategy and responds to children, young people and families, with a section dedicated to reducing the impact of harm from drugs and alcohol on children, young people and families. In addition, a section has been included on responding to emerging drug and alcohol issues in the city.

The Leeds Drug and Alcohol Strategy and Action Plan 2019-2024 retains a strong emphasis on prevention, treatment and recovery, including strength and asset based approaches.

3 Main issues

3.1 The refreshed Leeds Drug and Alcohol Strategy and Action Plan contains five main outcomes for delivery:

- Fewer people misuse drugs and/or alcohol and where people do use they make better, safer and informed choices

- Increase in the proportion of people recovering from drug and/or alcohol misuse

- Reduce crime and disorder associated with drug and/or alcohol misuse

- Reduce impact of harm from drugs and alcohol on children, young people and families

- Addressing specific emerging issues

3.2 The strategy has been developed to be delivered over 5 years to allow for better future planning. The action plan supporting the strategy will be a living document, with quarterly reporting built in, and will be reviewed and refreshed on an annual basis.

3.3 The strategy has specific action plans for each of the 5 outcomes. Each action plan contains an element of core business and a section that is the focus for the coming year that will have a higher amount of input. The final section - future ambition and innovation - acknowledges that this is a long term strategy and ensures we have sight of actions we are not delivering on now but may want to deliver within the lifetime of the strategy.

3.4 The strategy and action plan has also built in mechanisms to respond to the annual Report of the Director of Public Health, as needed.

3.5 To oversee the delivery of the strategy, and ensure stronger connections to other key agendas, a new governance framework has been developed. There has been a well-established Drug and Alcohol Board in Leeds for a number of years, with good attendance from a wide range of partners, which maintained ownership of the strategy, but it was acknowledged that reporting mechanisms and connections across strategic partnerships could be improved.

3.6 Membership of the board has been refreshed to ensure the right representation across all the partners. Membership of the board includes:

Public Health, Safer Leeds, Adults and Health, West Yorkshire Police, Leeds Clinical Commissioning Group, Leeds Teaching Hospitals Trust, Leeds and York Partnership Foundation Trust, Children and Families, National Probation Service, Community Rehabilitation Company, St. Anne's Community Services, Forward Leeds, NHS England and HMPPS Yorkshire Prisons

3.7 As well as having named individuals responsible for the delivery of the actions in the plan, the actions are also allocated to a particular sub group for oversight. Sub groups will be expected to report to the board by exception on a quarterly basis.

3.8 In addition to the board, the governance framework establishes a wider group of individuals to convene twice a year as a network to have discussions about drug and alcohol use in the city and input into the action plans.

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

4.1.1 An extensive programme of co-production and consultation has informed the new strategy. This has involved partners and representatives from a range of stakeholders, including Leeds City Council; West Yorkshire Police; National Probation Trust; Leeds Clinical Commissioning Group, Leeds Teaching Hospitals Trust, West Yorkshire Community Rehabilitation Company; HM Prison Service and the voluntary and community sector, including service providers and service users

4.1.2 Drafts of the strategy and action plan have gone to lead members for Adults and Health, Communities and Environments and Children and Families, as well as the Safer Leeds Executive and the Leeds Children and Families Trust Board

4.2 Equality and diversity / cohesion and integration

4.2.1 The issues relating to drugs and alcohol cut across the whole city and therefore the strategy acknowledges this impact, but has developed the action plan to ensure the strategy meets the needs of all Leeds citizens

4.2.2 The Equality, Diversity, Cohesion and Integration Screening document is attached to this report as an appendix

4.3 Resources and value for money

4.3.1 The strategy and action plan has no specific funding attached to it. However, it does recognise the commissioning of drug and alcohol services and ensures reporting feedback from those mechanisms into the board

4.4 Legal Implications, access to information and call In

4.4.1 This report does not contain any exempt or confidential information

4.5 Risk management

4.5.1 The governance framework that has been put in place will ensure that the strategy and action plan is delivered over the next five years

4.5.2 The five year strategy has been written to give a longer term approach to delivery, with the consideration that the National Drug Strategy is unlikely to be reviewed before then, with the assumption that even if a new national strategy for drugs or alcohol is released it is unlikely to contain any major changes to legislation

4.5.3 If significant changes are made nationally to drug legislation, then the city has a robust governance framework in place to respond to these changes

5 Conclusions

5.1 The Leeds Drug and Alcohol Strategy and Action Plan 2019-2024 sets out the city approach to address drug and alcohol misuse over the next five years. The

governance arrangements have been reviewed and a new framework is proposed to ensure oversight of the delivery of the new strategy and connections to other key strategies and partnerships.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Note the Leeds Drug and Alcohol Strategy and Action Plan 2019-24.
- Note the proposed governance arrangements for the strategy and connections made to key partnerships, including Safer Leeds and the Children and Families Trust Board.

7 Background documents

7.1 None.

THIS PAGE IS LEFT INTENTIONALLY BLANK

How does this help reduce health inequalities in Leeds?
Action on the priorities contained within the Drug and Alcohol Strategy will contribute to tackling health inequalities. People who experience socio-economic disadvantage disproportionately also experience problematic drug and alcohol use and are more likely to have poorer outcomes.

How does this help create a high quality health and care system?
A key aim of this strategy is that HWB partners, commissioners, providers, the health and care workforce and those seeking recovery from drug or alcohol use work together to ensure that drug and alcohol services make the best use of resources to deliver the highest possible standard of care across the health and care system

How does this help to have a financially sustainable health and care system?
Drug and alcohol misuse is a significant cost to the health and care system and society as a whole. Investment in and work to reduce drug and alcohol misuse can impact on these costs. For example it is estimated that for every £1 spent on drug treatment there is a return on investment of £4 which increases to £21 over 10 years. For alcohol treatment this figure is £3 increasing to £26 over 10 years

Future challenges or opportunities
The challenges going forward for HWB partners and for service users themselves include the increase in drug related deaths (particularly amongst users outside the treatment system), increased misuse of prescription drugs, increased alcohol related liver disease in women and the poor physical health of long term opioid users. However, the evidence is clear that treatment affords individuals and communities many benefits. Continued investment in treatment and in ensuring services are fully integrated with other healthcare and social services will save the city money and help to address health inequality

Priorities of the Leeds Health and Wellbeing Strategy 2016-21	
A Child Friendly City and the best start in life	√
An Age Friendly City where people age well	√
Strong, engaged and well-connected communities	
Housing and the environment enable all people of Leeds to be healthy	
A strong economy with quality, local jobs	
Get more people, more physically active, more often	
Maximise the benefits of information and technology	
A stronger focus on prevention	√
Support self-care, with more people managing their own conditions	
Promote mental and physical health equally	
A valued, well trained and supported workforce	√
The best care, in the right place, at the right time	√

TERMS OF REFERENCE:

Drug and Alcohol Board

Version:	0.10
Date:	June 2019
Latest version received by:	D&A Board
Date received:	22.07.19
Ratified by:	D&A Board
Date ratified:	22.07.19
Name of author:	Vic Clarke-Dunn
Name of responsible committee:	Drug and Alcohol Board
Review date:	July 2020
Target audience:	Public

1. Purpose

1.1 The purpose of the Drug and Alcohol Board is to provide strategic leadership and ensure effective partnership work to deliver a city-wide Drug and Alcohol Strategy and Action Plan to achieve the following vision:

Leeds is a compassionate city that works with individuals, families and communities to address drug and alcohol misuse.

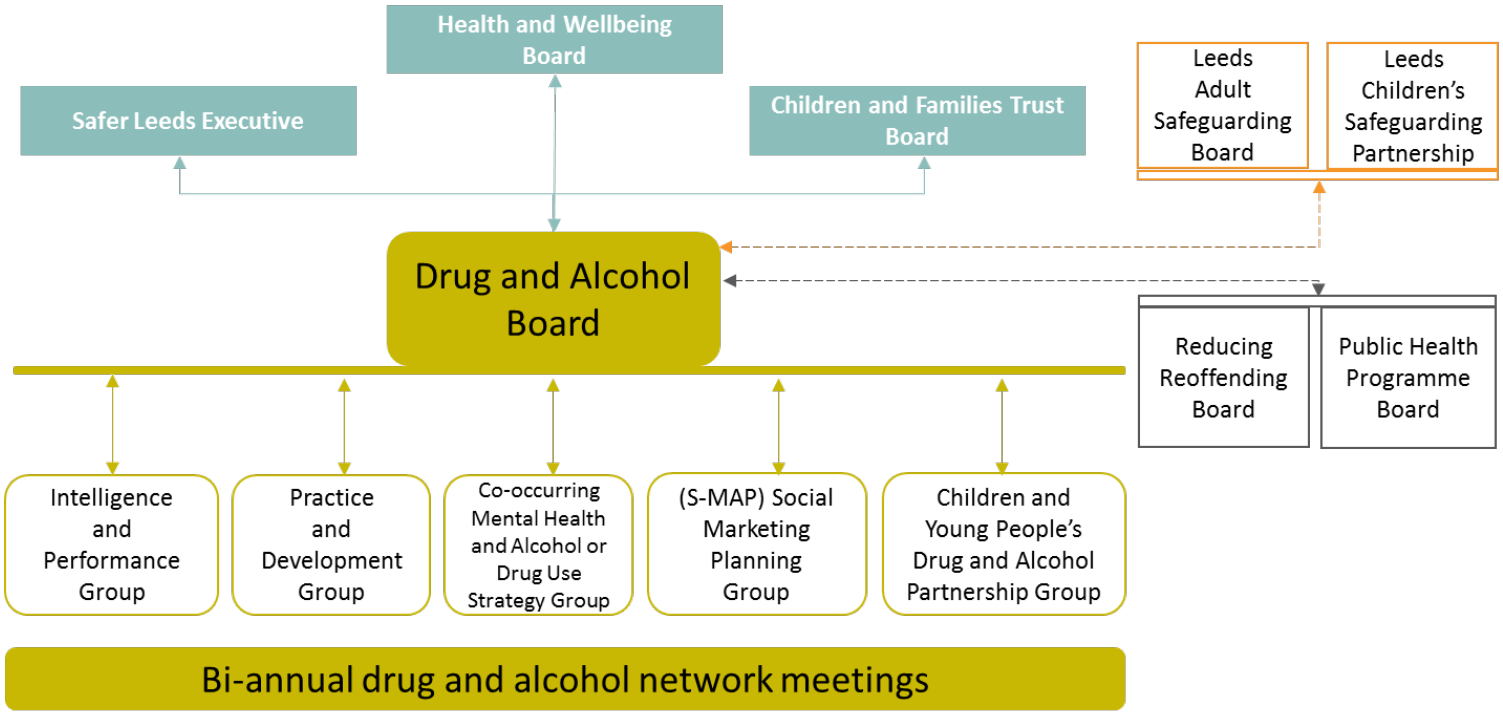
1.2 Outcomes from the Drug and Alcohol Board will inform subsequent required reports and provide assurance to the Safer Leeds Executive, the Health and Wellbeing Board and the Children's Board on strategies in place to deliver the Drug and Alcohol Strategy and Action Plan.

2. Summary of the Drug and Alcohol Board priorities

- Have oversight on delivering outcomes on the Drug and Alcohol system in Leeds, setting the direction of travel and keeping the strategy alive
- Identify exceptions, issues, risks and items for escalation to the Safer Leeds Executive, the Health and Wellbeing Board and the Children and Families Trust Board
- Ensure that alcohol and drug related needs and priorities are identified across Leeds
- Promote integration and partnership working to deliver service changes and priorities
- Raise awareness of, and tackle, drugs and alcohol harm across all the partnership structures
- Develop an effective governance framework to develop, implement and monitor the drug and alcohol strategy and deliver the accompanying action plan
- Oversee the reporting of progress on the action plan towards meeting the targets
- Monitor progress of the plan, raising issues and risks to delivery through the governance structure
- Use the best available evidence, data and intelligence to inform citywide decisions on drug and alcohol misuse actions and ensure effective use of resources
- Annually review the action plan, acknowledging what has been achieved, and review and set actions for the following year(s)
- Be aware of new and emerging issues and establish mechanisms to be able to quickly and effectively respond and make plans

- Encourage innovation and seek additional funding opportunities through business, private enterprise and academia
- Influence local, regional and national government policy that affects drugs and alcohol harm in Leeds
- Influence and inform investments and commissioning around drugs and alcohol

3. Reporting arrangements:



3.1 Purpose of the reporting groups

3.2 Intelligence and Performance Group

- The Intelligence and Performance Group of the Drug and Alcohol Board is established to provide the most accurate and up to date intelligence to support the delivery of the Drug and Alcohol Strategy and Action Plan

3.3 Practice and Development Group

- The Practice and Development group of the Drug and Alcohol Board is established to ensure best practice is delivered in drug and alcohol services, and that robust systems are in place to support the delivery of the Drug and Alcohol Strategy and Action Plan

3.4 Co-occurring Mental Health and Alcohol or Drug Use (COMHAD) Strategy Group

- The COMHAD Strategy Group is established to provide city wide strategic direction to ensure the development and delivery of excellent practice in working with services users with co-existing substance misuse and mental health problems. It

will report to both the Mental Health Partnership Board and the Drug & Alcohol Board

3.5 Drug and Alcohol Social Marketing Planning (S-MAP) Group

- The Drug and Alcohol Social Marketing Planning (S-MAP) Group of the Drug and Alcohol Board is established to provide the campaigns and promotional activity to support the delivery of the Drug and Alcohol Strategy and Action Plan

3.6 Children & Young people's Drug & Alcohol Partnership Group

- The Children & Young people's Drug & Alcohol Partnership Group of the Drug and Alcohol Board is established to provide oversight and delivery of the areas of the strategy and action plan that relate to children and young people

3.7 Reducing Reoffending Board

- The Reducing Reoffending Board (ROB) has a remit wider than that of drugs and alcohol and reports to the Safer Leeds Executive. All items considered by the ROB that relate to the Drug and Alcohol Strategy and Action Plan will be brought to the Drug and Alcohol Board

3.8 Public Health Programme Board

- The Public Health Programme Board (PHPB) has a remit wider than that of drugs and alcohol and reports to the Public Health Leadership Team. All items considered by the PHPB that relate to the Drug and Alcohol Strategy and Action Plan will be brought to the Drug and Alcohol Board

4. Membership, roles and responsibilities

4.1 The following constitutes core membership:

Role	From
Consultant in Public Health (Chair)	LCC Public Health
Head of Safeguarding and Partnership Development (Deputy chair)	LCC Safer Leeds
Health Improvement Principal Drug and Alcohol Lead	LCC Public Health
Lead Commissioner for Drug and Alcohol Services	LCC Adults and Health
Police Superintendent Partnerships	West Yorkshire Police
CCG Safeguarding Lead	CCG
Deputy Director of Nursing	LYPFT
Consultant Hepatologist	LTHT
Chief Officer Children's Social Work	Children's Social Work Services
Head of Service Adult Social Work	Adult Social Work
Assistant Chief Probation Officer	NPS
Director of Operations	CRC
Operational Lead – Commissioned Services	St. Anne's Community Services

Operational Lead – Commissioned Services	Forward Leeds
Chair of Children and Young People's Drug and Alcohol Partnership Group	LCC
Head of Health and Justice (Yorkshire and Humber)	NHS England & NHS Improvement
West Yorkshire Reducing Reoffending Lead	Office of the Police and Crime Commissioner

4.2 Named deputies, with delegated decision making responsibility, may attend on behalf of core members.

4.3 The following constitutes co-opted Drug and Alcohol Board membership. Co-opting a member into the meeting will be a two-way process to ensure co-opted members:

- are invited by Core Members when relevant to provide specialist input to the group
- can opt themselves into the meeting when indicated, to provide information on learning and actions relevant to the purpose of the Drug and Alcohol Board

5. Quorate and attendance

5.1 The Chair will be present at all meetings and in circumstances where the Chair cannot attend the Deputy Chair will provide representation.

5.2 A quorum will require the Chair (or Deputy Chair) plus 5 other group members to be present. This must include representation from Safer Leeds, Commissioners, West Yorkshire Police, Public Health and Commissioned Services.

5.3 In the event that Drug and Alcohol Board is not quorate the meeting will be postponed at the discretion of the Chair; and in the absence of quorum no decisions will be made.

5.4 The Chair may act on or call extra-ordinary meetings to deal with urgent matters arising either at or in between meetings of the Drug and Alcohol Board.

5.5 Apologies must be given in cases of non-attendance

5.6 Additional requests for attendance may be made where indicated e.g. to provide expert input of relevance

5.7 Any issues regarding the meeting and quorum will be escalated to the Health and Wellbeing Board, Safer Leeds Executive or Children and Families Trust Board as appropriate

6. Frequency of meetings

6.1 Meetings will be held quarterly, to coincide with the relevant executive boards where possible, and annual reporting cycles

6.2 Meeting times, dates and venues for the following year will be identified at the end of each year in order to maximise attendance

7. Resources

7.1 Administrative support for the Drug and Alcohol Board will be provided by LCC Public Health

7.2 Requests for agenda items will be made a minimum of 14 days before the next meeting

7.3 The agenda and papers will be prepared and circulated a minimum of 7 days before the meeting

7.4 An accurate record of discussions, decisions, actions and learning will be made at each meeting

7.5 An action log will be updated following review at each business meeting

7.6 Minutes of the meeting and the updated action log will be produced and approved within 14 days of the meeting held

8. Work plan and reporting arrangements

8.1 The Drug and Alcohol Board will have an annual work plan based on the Drug and Alcohol Strategy and Action Plan that will be shared with all core members and set by the Drug and Alcohol Board. The work plan will be reviewed at the first meeting of the fiscal year.

8.2 The Drug and Alcohol Board will report to the Safer Leeds Executive, Health and Wellbeing Board and Children and Families Trust Board on a quarterly basis by exception.

9. Document management

9.1 These Terms of Reference (ToR) have been produced in consultation with the Drug and Alcohol Board Chair and Core members.

9.2 These ToR will be reviewed on an annual basis at the first business meeting of the fiscal year.

Leeds

Drug and Alcohol Strategy and Action Plan

2019 – 2024

Leeds is a compassionate city that works with individuals, families and communities to address drug and alcohol misuse.

Our vision supports the wider vision for Leeds - that, by 2030, Leeds will be locally and nationally recognised as the best city in the UK - driving forward change by working effectively with our partners, stakeholders and service users.

This document describes our plans for addressing drug and alcohol misuse in Leeds. Informed by the ambitions and challenges of the Government's latest Drug and Alcohol Strategies, as well as our local ambitions to deliver the Safer Leeds Community Safety Strategy, the Leeds Health and Wellbeing Strategy, Best Council Plan and The Leeds Health and Care Plan, we have worked collaboratively to agree our vision, and the priorities and actions to achieve agreed outcomes.

The success of this strategy will also contribute to achieving our City Priorities including ensuring that Leeds is the best city for Health and Wellbeing; a Child-Friendly City and contributes to Safe, Strong Communities.

Our strategy and action plan covers children, young people and adults and takes account of an individual's life course.

Why have a Drug and Alcohol Strategy?

Drug and alcohol misuse affects a large number of people, not just those who misuse drugs and alcohol but also their families, loved ones, carers, wider communities, services and businesses.

The consequences of drug and alcohol misuse for people and society are wide ranging and can be long lasting. Our vision is that Leeds is a compassionate city that works with individuals, families and communities affected by drug and alcohol use to help them to make better and informed choices, and lead healthier, safer and happier lives. An important element of the strategy is around minimising drug and alcohol misuse, in order to reduce harm and prevent associated problems from escalating.
In October 2018, the government announced that there would be a major independent review of drug misuse. Looking at a wide range of issues, including the system of support and enforcement around drug misuse, to inform thinking about what more can be done to tackle drug harms. The Review will seek to discover as much as possible about who drug users are, what they are taking and how often, so that law enforcement agencies can target and prevent the drug-related causes of violent crime effectively. The Review will also look at the health and social harms associated with drug use, identifying evidence-based approaches to preventing and reducing drug use, as well as highlight any gaps in the evidence about what works.

The Review will be held in two parts, with part one focusing on:
i. The demographics of drug use. This will look at demand, including who uses which types of drugs, together with patterns of, and motivations for, use; and
ii. The drugs market. This will look at supply into and within the UK and how criminals meet the demand of users.

The scope of the second part will be determined once the first part has reported, this is expected by summer 2019.
This is supported by the government's appointment of a Drug Recovery Champion, who will help drive forward the aims of the government's Drug Strategy and Serious Violence Strategy and work with ministers to agree an annual delivery plan for drug recovery. They will also support collaboration between partners such as local authorities, housing groups and criminal justice agencies at national and local levels, offering advice on best practice in relation to treatment and recovery.

The governance in place to deliver the local strategy and action plan will ensure we input into, and keep up to date with the developments of the national review and action plan, any other national government recommendations, and update local plans where appropriate.

How are we going to achieve the vision?

- Whilst the aim is to prevent or reduce drug and alcohol misuse, it is recognised that some people are unable or unwilling to stop using drugs and/or alcohol. Therefore, a harm reduction approach will also be taken, which aims to reduce the harms associated with the use of drugs and alcohol. This very much fits with the ambition to be a compassionate city.

- The Leeds Drug and Alcohol Strategy and Action Plan feeds into the Leeds Best Council Plan. Therefore, it impacts on, and is influenced by, a number of different council strategies and plans including, but not limited to:
    - Leeds Health and Wellbeing Strategy
    - Leeds Health and Care Plan
    - Leeds Community Safety Strategy
    - Leeds Reducing Reoffending Strategy
    - Leeds Inclusive Growth Strategy
    - Leeds Housing Strategy
    - Leeds Mental Health Strategy
    - Leeds Children and Young People's Plan
    - Leeds Best Start Plan
    - Future in Mind: Leeds (a strategy to improve the social, emotional, mental health and wellbeing of children and young people aged 0-25 years)
    - Leeds Maternity Strategy
    - Leeds City Council Equality Improvement Priorities
    - Leeds Better Lives Strategy
    - West Yorkshire and Harrogate Health and Care Partnership Plan.

- An effective governance framework will be developed to monitor the drug and alcohol strategy and deliver the accompanying action plan.

- We acknowledge the importance of close working with NHS partners to deliver this strategy and reflect the NHS Forward Plan, which encourages the NHS to do more around the prevention agenda. We will also engage with Primary Care Networks and Local Care Partnerships across the city to ensure that primary care play their part.

- The importance of our third sector partners who contribute to the drug and alcohol agenda is recognised and highly valued; ensuring partnership working is effective, developing a shared citywide approach to addressing the challenges caused by drug and alcohol misuse, resulting in services that are better integrated, including mental and physical health, criminal justice, housing, and employment and skills.

- We recognise the work being done across West Yorkshire and the wider region and how what we do in Leeds fits into this, as well as where we can work collaboratively with partners in other areas. In addition, the priorities outlined within the West

Yorkshire and Harrogate Health and Care Partnership Plan align well with the drug and alcohol agenda and this provides a valuable platform for partnership building.

In order to deliver this strategy we will also ensure that we:

- Work in partnership and co-produce with service users
- Work with vulnerable people, including families and those who are not currently accessing services, to direct help to those who need it most in order to better understand and meet their needs
- Use the best available evidence, data and intelligence to inform citywide decisions on drug and alcohol misuse and ensure resources are allocated effectively
- Review the action plan annually to take stock of what we have achieved and review and set actions for the following year(s)
- Work restoratively, using a 'Think Family' approach and to remain alert to current and emerging safeguarding issues
- Are aware of new and emerging issues and establish mechanisms to be able to quickly and effectively respond
- Respond to any recommendations relating to drugs and alcohol made in the Director of Public Health's annual report
- Encourage innovation and the use of new technologies
- Seek additional funding opportunities through business, private enterprise and academia to support the drug and alcohol agenda

What we know in Leeds:

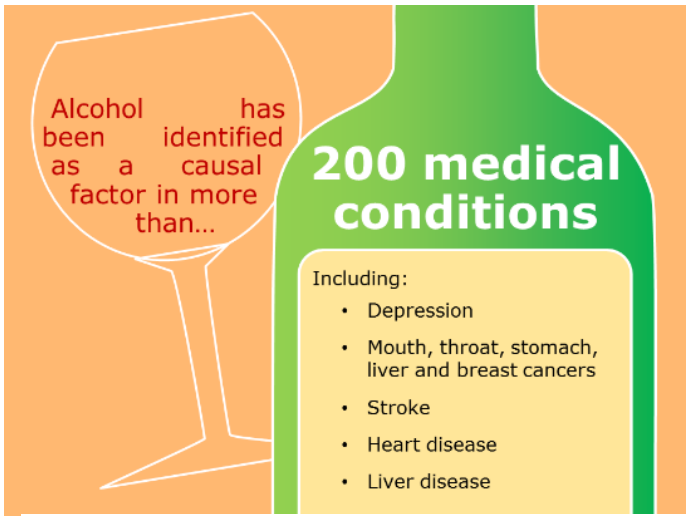
- Drug and alcohol problems are becoming increasingly complex. For example, there are more cases of poly-drug use, people often have co-occurring conditions such as mental health issues alongside their addiction and greater numbers of people addicted are to prescribed and over-the-counter medicines
- In addition to the above, people who misuse drugs or alcohol are at an increased risk of physical and mental health issues and social issues, such as insecure housing, unemployment and involvement in crime
- Children can suffer significantly where there is antenatal and parental drug and/or alcohol misuse, resulting in long term health problems into adulthood
- Of children in Leeds coming into care, a significant number are from families where the parents misuse drugs and/or alcohol
- Self-reporting of drug and alcohol use by children shows usage has dropped over the past few years
- There is an increase in numbers and visibility of vulnerable people involved in street based activities, including people who are rough sleeping, begging and street based sex working, who have complex needs and require intensive support
- Synthetic Cannabinoid Receptor Agonists – SCRAs (which includes 'spice') are increasingly used in specific populations, including prisoners, rough sleepers and vulnerable young people, and despite the change in law, are having a negative impact across the city, with significant issues occurring in prisons and parts of the city centre
- We have an ageing cohort of heroin users who have been using for many years and consequently have many physical health issues, such as liver and kidney disease
- A new cohort of younger (18-25 year olds) heroin users has recently been identified, many of whom are new drug users (which increases the risk of harm)
- Misuse of prescription and over the counter drugs is an increasing concern and is often a factor in drug-related deaths
- There has been a national rise in drug related deaths and locally we have seen a larger proportion of men dying prematurely from drug and alcohol misuse, particularly in deprived areas
- There has been a significant increase in the number of women dying, and at a younger age, because of their alcohol misuse in Leeds
- Drug litter such as syringes, needles and foil is a growing issue across the city
- A considerable amount of crime, including serious organised crime, is linked to drugs and alcohol
- An increasing amount of drugs are purchased over the internet, including on the "Dark Web"
- Leeds has a growing and vibrant nightlife and an availability of cheap alcohol, which impacts upon drinking behaviours
- LGBT+ communities are disproportionately impacted by drug and alcohol abuse, driven by experiences of social marginalisation, discrimination and prejudice.

What are we going to do?

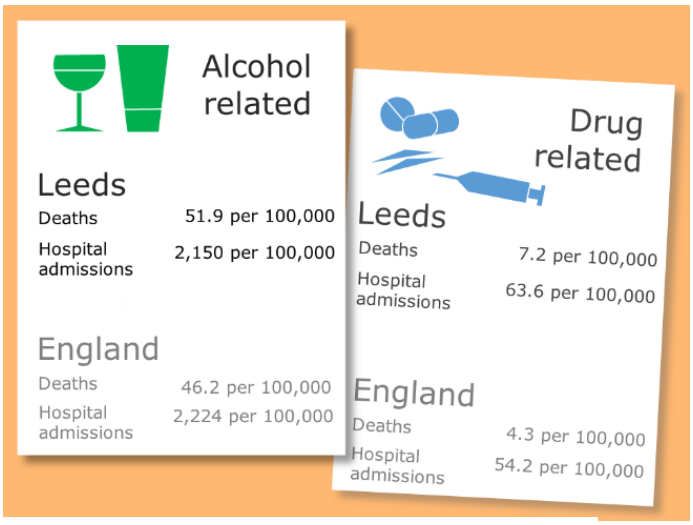
We have set out 5 key outcomes supported by an action plan:

1. Fewer people misuse drugs and/or alcohol and where people do so they make better, safer and informed choices

We will ensure people understand the potential harms of drugs and alcohol, and that they have the knowledge and options available to them to make better, safer and informed choices, giving everyone opportunities to lead fulfilling lives. We will work to ensure that we 'Think Family' and are better able to identify and support vulnerable individuals and families affected by drug or alcohol misuse. We will ensure we recognise and act on key points where people are considered most vulnerable to harm, such as people leaving custody. We will do this by focussing on the following sub outcomes:



Medical conditions where alcohol has been identified as a causal factor (Public Health England, 2018)



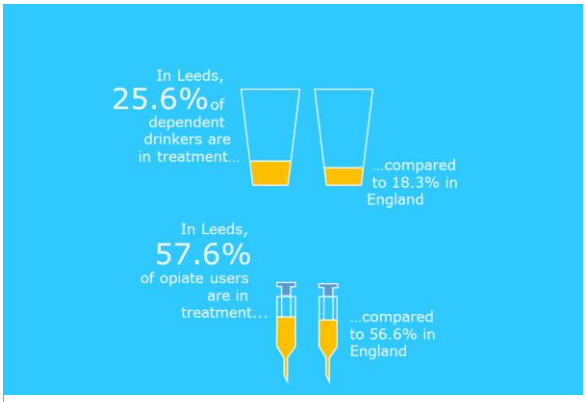
Alcohol and drug-related deaths and hospital admissions in Leeds, compared to the national rate, per 100,000 (Public Health England, 2018)

Outcome 1.1 – Increase public awareness of issues relating to drugs and alcohol
Outcome 1.2 - Increase the safety of all our communities by reducing the amount of drug-litter on our streets and improving use of pharmacy based needle exchange services
Outcome 1.3 – Ensure the availability of high quality harm reduction services

2. Increase in the proportion of people recovering from drug and/or alcohol misuse

Drug and alcohol treatment is effective in improving health and saving lives. We will ensure services continuously improve and are informed by, and responsive to, the needs of those who misuse drugs and alcohol. We will provide clear and easy routes into treatment and services that support recovery and address people's individual needs, including mental and physical health, housing, and employment and skills. We will prioritise vulnerable groups for treatment including people who are homeless, rough sleeping, sex working, leaving prison, and parents and families who need more support and flexibility to access services. We will do this by focussing on the following sub outcomes:

Social return on investment of drug and alcohol treatment (Public Health England, 2018)



Percentage of dependent drinkers and opiate users in treatment in Leeds, compared to the national average (Public Health England, 2019)

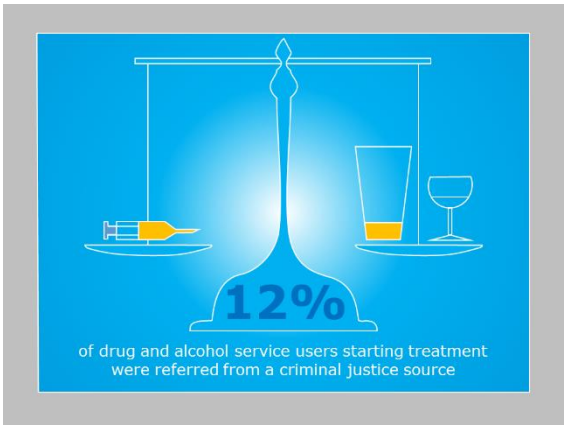
Outcome 2.1 – Ensure treatment services are effective, of high quality and are easily accessible
Outcome 2.2 – Ensure that there are pathways and services in place to support drug and alcohol users to access the support they need for issues linked to their drug and alcohol use
Outcome 2.3 – Leeds provides a wide and varied number of options to promote and support recovery

3. Reduce crime and disorder associated with drug and/or alcohol misuse

A significant amount of crime in the city is linked to drug and alcohol misuse, either through people committing crime to fund drug and alcohol use, or through behaviours associated with the use of drugs and alcohol, e.g. street drinking and street drug use. Leeds has three prisons within its boundary and a women's feeder prison just outside. We will work across the prisons, police and probation to ensure offenders with drug and alcohol misuse issues have clear routes into services and opportunities for effective rehabilitation.

Working with partner agencies, we will influence the night time economy and reduce drug and alcohol harm. We will also work with relevant criminal justice agencies to disrupt and reduce the impact of organised crime groups and reduce the inappropriate availability of drugs and alcohol.

We will ensure that we protect children and young people from being exploited by addressing the impact of drugs and alcohol on Child Sexual Exploitation (CSE)/Child Criminal Exploitation (CCE) including across county lines. We will also improve our understanding of links between youth violence and drugs and alcohol and develop our responses accordingly.



Percentage of drug and alcohol service users starting treatment who were referred from a criminal justice source (Public Health England, 2019)

With well evidenced links to drug and alcohol use, domestic violence and abuse is a priority for many partnerships. We will ensure that these links are embedded within the action plan.

We will do this by focussing on the following sub outcomes:

Percentage of known organised crime groups who are associated with illicit drug supply, in Leeds (Leeds City Council, 2019)

Outcome 3.1 – Reduce offending and antisocial behaviour associated with drug and alcohol use and improve outcomes for drug and alcohol offenders

Outcome 3.2 – Reduce the inappropriate availability of illicit drugs and alcohol

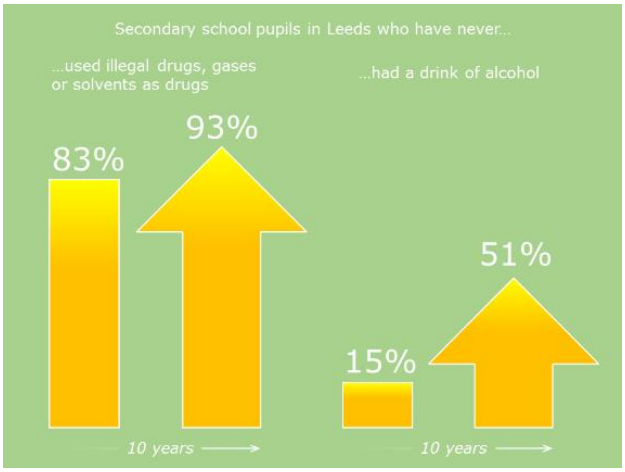
Outcome 3.3 – Ensure services are in place to tackle domestic violence and abuse linked to drugs and alcohol

4. Reduce impact of harm from drugs and alcohol on children, young people and families

Leeds wants to be the best city for children and young people to grow up. We want to ensure that we protect children and young people from the harmful effects of substance misuse and aim to achieve this by an effective prevent and treatment approach that is bespoke to children's and young people's needs. We recognise that a number of children and young people have had adverse childhood experiences (ACEs), caused by parental/carer substance misuse and we aim to reduce this number by supporting their parents and carers to address their substance misuse. We know that the vast majority of young people in Leeds do not have any issues with substances.

Potential financial benefit from investment in young people's drug and alcohol interventions (Public Health England, 2018)

However there are a small minority that need this additional support. We will do this by focussing on the following sub outcomes:



Percentage of secondary school pupils in Leeds who have never used illegal drugs, gases or solvents as drugs, or had a drink of alcohol – 2017/18 compared to 2007/08 (Leeds City Council, 2018)

Outcome 4.1 – Make sure children and young people are informed about the potential harms of drugs and alcohol
Outcome 4.2 Protect children and young people and prevent harm by supporting parents / carers into effective treatment
Outcome 4.3 – Protect children and young people; including addressing the impact of drugs and alcohol on Child Sexual Exploitation (CSE)/Child Criminal Exploitation (CCE)/domestic violence and abuse (DVA)
Outcome 4.4 – Ensure children and young people are supported to access services for their drug and/or alcohol use

5. Addressing specific emerging issues

Drug and alcohol misuse is an ever changing landscape, requiring systems, mechanisms and structures in place to respond quickly and effectively to new and emerging issues. A section of the action plan will focus on these specific issues and processes for responding to them. We will ensure that the complexity and vulnerability around drugs and alcohol is on the agenda of safeguarding boards, encouraging collaborative work across the wide range of agencies and services throughout the city.

How will we check on progress?

The Drug and Alcohol Board is a partnership of Public Health, Safer Leeds, the NHS, Police, Prisons, Probation, Adults and Health, Children's Services and the third sector. The board has developed the strategy and action plan in consultation with a wide range of partners, providers and service users. This Board will set key performance indicators and oversee and drive the delivery of the action plan.

Members of the board will be responsible for different areas of the action plan and will be accountable to the Board for the delivery of that area.

A regular update will be provided to the Board on the progress of the action plan, against key performance indicators, which will be refreshed annually by the board.

The Board will report on the progress towards achieving strategic outcomes to the Health and Wellbeing Board. Progress on priorities to reduce the impact of drugs and alcohol on crime and disorder will also be reported to the Safer Leeds Executive. Progress on priorities for children and young people will be reported to the Children and Families Trust Board.

Appendices:

1. Achievements over the last year
2. Performance and intelligence to support the strategy and action plan
3. Governance structure
4. Action plan
5. Plan on a page

Appendix 1

Achievements over the last year (2018-2019):

This appendix will be updated on an annual basis following the review of the action plan to highlight the achievements over the previous year.

Much has changed in Leeds since the last Drug and Alcohol Strategy. Forward Leeds was commissioned in 2015 to provide an integrated prevention, treatment and recovery service to support people with drug and / or alcohol issues. The service is provided by a consortium of four organisations, led by Humankind, and delivered from three hubs (in Armley, Seacroft and Kirkgate), as well as in primary care settings. It provides tailored support to around 3,500 individuals at any one time. The integrated service includes:

- Early intervention and prevention
- Harm reduction (including needle exchange)
- Recovery co-ordination
- Access into community and residential detox
- Support for families
- Young people's services
- Specialist services for those who have additional complex needs e.g. mental health or pregnancy
- Supporting a dedicated and thriving recovery community.

Forward Leeds have recently developed and introduced a number of specialist services, in order to respond to local need, including:

- Actively working with BASIS Yorkshire and the Joanna Project, to provide enhanced support for women involved in sex work, who require treatment for their drug and alcohol use, with a dedicated recovery co-ordinator in each hub
- A new service for 'entrenched users', called *Positive Challenge* – an approach that seeks to address the needs of service users who are five years or more in treatment, who are recognised as needing dedicated support through the Recovery Co-ordinators and the prescribing team
- Improved pathways for 18-24 year olds, with those defined as vulnerable (e.g. care leavers) now seen by the Young People team, to utilise their expertise with this client group
- A refocus of the Dual Diagnosis team to work with service users who are experiencing or have experienced suicidality, trauma, personality disorder and psychosis
- The development of a community-based reduction and medically assisted detoxification programme for Synthetic Cannabinoid Receptor Agonists (e.g. "spice")
- The development of specific referral pathways from hospital into treatment for young people aged 16-17.

Ultimately, the aim is for Leeds to be one of the best performing cities in the country, something it is on its way to achieving. Outcomes for people affected by alcohol and non-opiate substances are better than they have ever been in Leeds and the ambition is to achieve the same for opiate users.

To complement this work, the Drug and Alcohol Social Marketing Planning Group (S-MAP), have delivered a number of citywide drug and alcohol campaigns over the last year, including:

- Guides to Synthetic Cannabinoid Receptor Agonists (e.g. "spice") produced for both professionals/ businesses/ the public, and those who use/might use SCRAs. This was supplemented by a series of *Want to Know More About* training sessions in partnership with the Public Health Resource Centre
- The *No Regrets* campaign – a website and social media-based responsible drinking campaign, aimed at 18-25 year olds
- Show cannabis some respect campaign, aimed at Leeds school children
- A series of events held across the city, where people could pledge a positive change to their drinking, as part of 2018's Alcohol Awareness Week.

In addition, a wide range of health (including primary care, secondary care and the third sector), criminal justice (including the police, prisons and probation) and community safety partners, and children's services across the city have worked collaboratively to address a wide range of drug and alcohol-related issues, including:

- Using the Leeds Alcohol Licensing Data Matrix, to inform the alcohol licensing process
- Providing free drug and alcohol awareness training, aimed at the night time economy and those who work in the bars, pubs and clubs in the city whether behind the bar or working on the door in a security role. This training is also open to partners including security firms who work across all the main shopping arcades in the city
- Training hospital staff in the delivery of Identification and Brief Advice (IBA) to those with alcohol issues
- Delivering drug and alcohol programmes in schools
- Developing an alcohol education tool
- City wide distribution of naloxone to those at risk of overdose
- Early identification and treatment of those with alcohol-related liver disease, as part of a Community Hepatology Programme in partnership with primary care
- Identifying hard to reach drug and alcohol using populations, with street outreach teams operating in the city centre alongside a newly established Street Support team – an integrated, multidisciplinary team who work to ensure those with the highest levels of need receive bespoke support
- Responding to discarded needles/ drug paraphernalia issues, including the introduction of a new enhanced needle waste service and the installation of a number of needle bins across the city.

The Leeds Drug and Alcohol Strategy and Action Plan will build on what has already been achieved and provide clear focus and direction to further develop the city's response to drug and alcohol issues.

Appendix 2

Key Performance Indicators:

Key Outcomes 1: Fewer people misuse drugs and/or alcohol and where people do so they make better, safer and informed choices

- Decrease in prevalence of opiate and / or crack users
- Decrease in prevalence of dependent drinkers
- Increase in pharmacy needle returns

Key Outcome 2: Increase in the proportion of people recovering from drug and/or alcohol misuse

- Increase in successful completions of drug treatment
- Increase in Hep C testing and referrals into treatment

Key Outcome 3: Reduce crime and disorder associated with drug and/or alcohol misuse

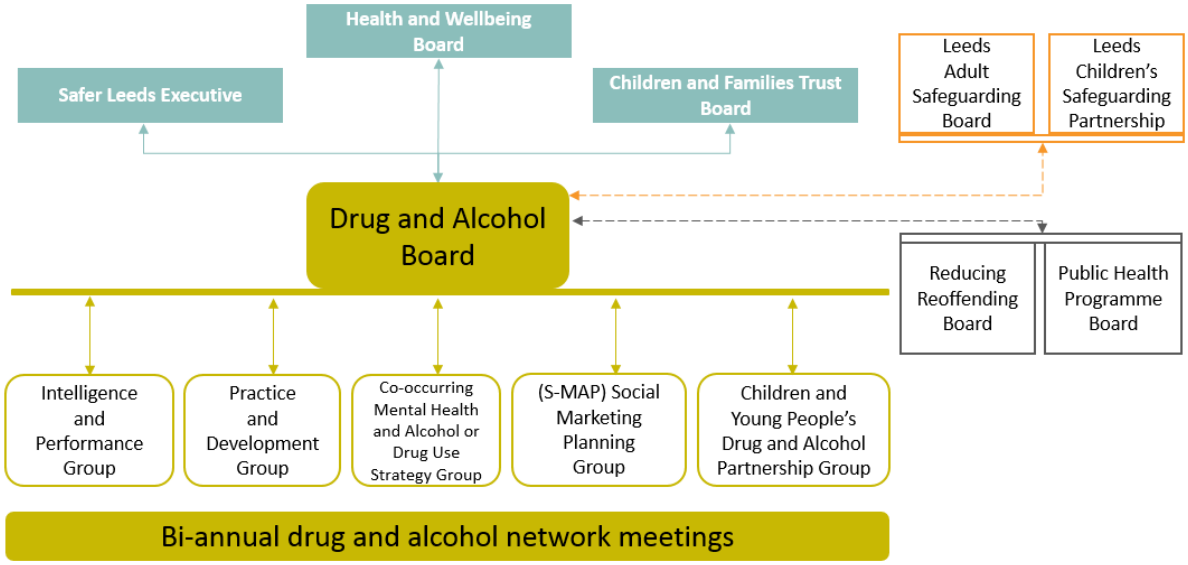
- Increase in successful completions as a proportion of all Criminal Justice clients in treatment
- Reduce violent crime involved with alcohol consumption
- Reduce A&E assault admissions with alcohol involved
- Increase positive outcomes for drug offences

Key Outcome 4: Reduce impact of harm from drugs and alcohol on children, young people and families

- Increase in secondary school pupils who have never had a drink of alcohol
- Decrease in secondary school pupils who have ever used illegal drugs, gases and solvents as drugs
- Decrease in children and families where drugs or alcohol was main reason for issuing care proceedings

Appendix 3

Governance structure:



The purpose of the Drug and Alcohol Board is to provide strategic leadership and ensure effective partnership work to deliver a city-wide Drug and Alcohol Strategy and Action Plan to achieve the following vision:

- *Leeds is a compassionate city that works with individuals, families and communities to address drug and alcohol misuse.*

It is supported by:

- Intelligence and Performance Group

The Intelligence and Performance Group of the Drug and Alcohol Board is established to provide the most accurate and up to date intelligence to support the delivery of the Drug and Alcohol Strategy and Action Plan

- Practice and Development Group

The Practice and Development group of the Drug and Alcohol Board is established to ensure best practice is delivered in drug and alcohol services, and that robust systems are in place to support the delivery of the Drug and Alcohol Strategy and Action Plan

- Co-occurring Mental Health and Alcohol or Drug Use (COMHAD) Strategy Group

The COMHAD Strategy Group is established to provide city wide strategic direction to ensure the development and delivery of excellent practice in working with services users with co-existing substance misuse and mental health problems. It will report to both the Mental Health Partnership Board and the Drug & Alcohol Board

- Drug and Alcohol Social Marketing Planning (S-MAP) Group

The Drug and Alcohol Social Marketing Planning (S-MAP) Group of the Drug and Alcohol Board is established to provide campaigns and promotional activity to support the delivery of the Drug and Alcohol Strategy and Action Plan

- Children & Young people's Drug & Alcohol Partnership Group

The Children & Young People's Drug & Alcohol Partnership Group of the Drug and Alcohol Board is established to provide oversight and delivery of the areas of the strategy and action plan that relate to children and young people

- Reducing Reoffending Board

The Reducing Reoffending Board (ROB) has a remit wider than that of drugs and alcohol and reports to the Safer Leeds Executive. All items considered by the ROB that relate to the Drug and Alcohol Strategy and Action Plan will be brought to the Drug and Alcohol Board

- Public Health Programme Board

The Public Health Programme Board (PHPB) has a remit wider than that of drugs and alcohol and reports to the Public Health Leadership Team. All items considered by the PHPB that relate to the Drug and Alcohol Strategy and Action Plan will be brought to the Drug and Alcohol Board

Appendix 4

Our vision and priorities action plan:

Leeds is a compassionate city that works with individuals, families and communities to address issues caused by the misuse of drugs and alcohol.

Although the strategy outlines our strategic objectives for the next five years, it is through the Action Plan where detailed progress and updates will be formally reported and regularly reviewed by the Drug and Alcohol Board. There is an expectation that the document will be added to, or actions altered to best meet any changes occurring in the city in relation to the drug and alcohol agenda. Therefore a more detailed working action plan will be maintained alongside the one outlined in this appendix.

Outcome 1 – fewer people misuse drugs and / or alcohol and where people do use they make better, safer and informed choices

We will ensure people understand the potential harms of drugs and alcohol, and that they have the knowledge and options available to them to make better, safer and informed choices, giving everyone opportunities to lead fulfilling lives. We will work to ensure that we 'Think Family' and are better able to identify and support vulnerable individuals and families affected by drug or alcohol misuse. We will ensure we recognise and act on key points where people are considered most vulnerable to harm, such as people leaving custody.

No.	Action	Target / Product	Group / Board
Outcome 1.1 – Increase public awareness of issues relating to drugs and alcohol			
Core business			
i.	Plan, develop and deliver marketing campaigns and promotional activity, through the Drug & Alcohol Social Marketing Planning (S-MAP) Group, that are effective and responsive to need and changes in drug and alcohol use	Deliver a range of marketing campaigns and promotional activity, including: • Annual (including national) campaigns • Seasonal campaigns • Campaigns targeted at specific populations • Ad hoc campaigns and promotional activity, as required Measured by reviewing website clicks, evaluations and calls to Forward Leeds Single Point Of Contact phone number following campaign activity.	S-MAP Group

ii.	Continue to promote prevention & harm reduction, through public engagement activities	Monitored through commissioners contract management processes	Public Health Programme Board
Focus for this year 2019-2020			
Outcome 1.2 - Increase the safety of all our communities by reducing the amount of drug-litter on our streets and improving use of pharmacy based needle exchange services			
Core business			
i.	Explore ways to prevent needles being discarded in the city	Monitor the six needle bins that were installed in 2018, and evaluate after one year. Implement recommendations	Practice and Development Group
ii.	Work with the Cleaner Neighbourhoods Team and Forward Leeds to develop the new Enhanced Needle Waste Service	Monitor, evaluate and establish a baseline for the Enhanced Needle Waste Service	Practice and Development Group
iii.	Work with LCC contracted pharmacy needle exchange services to improve the service that they provide	Increase the return rate of needles to pharmacies to 70% during 2019/20	Practice and Development Group
Focus for this year 2019-2020			
iv.	Increase engagement of people using pharmacy needle exchanges into services via new role in Forward Leeds of Assertive Needle Waste Worker	Baseline data and review 6 monthly	Practice and Development Group
Outcome 1.3 – Ensure the availability of high quality harm reduction services			
Core business			
i.	Every member of Forward Leeds staff are trained to deliver Identification and Brief Advice	All staff are trained and learning reflected in practice Monitored through commissioners contract management processes	Public Health Programme Board
ii.	Capture harm reduction activity, including information around equipment, support and	Monitored through commissioners contract management processes	Public Health Programme Board

	advice, and referrals for other interventions		
iii.	Continue naloxone distribution and ensure all relevant Forward Leeds staff are trained on its use	Monitor use and administration, and training	Practice and Development Group
iv.	Ensure services are trauma informed and aware of gender specific needs	Use of 'systems change' trauma toolkit	Practice and Development Group
v.	Use the alcohol licencing data matrix to support licencing decisions	Monitor, review use and update data annually	Public Health Programme Board
Focus for this year 2019-2020			
vi.	Improve information and intelligence about drug related deaths, to better service provision	Develop a system for reporting drug related deaths, that builds on the current (deaths in service) system and feedback lessons learned to local services	Practice and Development Group
vii.	Improve the drug alerts system, to better inform drug users and services	Develop a system for responding to drug alerts, that builds on the current system, based on the latest PHE guidelines	Practice and Development Group
viii.	Increase the number of Audit C screenings completed	Increase the number of Audit C screenings completed by GP services 'ever' (50%) and 'in the last 12 months' (15%) Establish a baseline in relation to Audit C screenings completed in hospitals through the risky behaviours CQUIN	Practice and Development Group
ix.	Engage with GPs around the issue of over prescribing, and addiction to, medicines	Practice development session held with Shared Care GPs and Primary Care Extended Service GPs	Practice and Development Group
x.	Recruit to a post, in Forward Leeds, that has a specific focus on naloxone	Roll out existing naloxone plan, including the training of non-drug specific services	Practice and Development Group
xi.	Train staff of licensed premises in drug and alcohol awareness	Monitor attendance at bi-monthly training sessions and evaluate the	Public Health Programme Board

	and responding to drug and alcohol related issues	programme in partnership with the Licensing Enforcement Group	
xii.	Train Leeds City Council Licensing Committee and all elected members in alcohol related harm	Monitor attendance at sessions and evaluate the programme	Public Health Programme Board
xiii.	Forward Leeds undertake research into people engaged in needle exchange but not structured treatment	Better understanding of people not in treatment	Practice and Development Group
xiv.	Extend Forward Leeds outreach in relation to harm reduction interventions, alongside understanding access issues for women	New outreach hours implemented	Practice and Development Group
Future ambition and innovation			
a.	Training & tracking Identification and Brief Advice delivery and outcomes achieved		
b.	All appropriate police officers in Leeds to carry naloxone and be trained in its use		
c.	Engage with the CCG around addiction to prescribed medicines		
d.	Host the Harm Reduction conference in Leeds		

Outcome 2 – Increase in the proportion of people recovering from drug and / or alcohol misuse

Drug and alcohol treatment is effective in improving health and saving lives. We will ensure services continuously improve and are informed by, and responsive to, the needs of those who misuse drugs and alcohol. We will provide clear and easy routes into treatment and services that support recovery and address people's needs, including mental and physical health, housing, and employment and skills. We will prioritise vulnerable groups for treatment including people who are homeless, rough sleeping, sex working, leaving custody, and parents and families who need more support and flexibility to access services.

No.	Action	Target / product	Board / Group
Outcome 2.1 – Ensure treatment services are effective, of high quality and are easily accessible			
Core business			
i.	Maintain effective treatment outcomes, including engagement with drug and	Improve drug and alcohol treatment summary ranks (against similar local authorities), on the	Public Health Programme Board

	alcohol treatment, for those who need it	(Public Health England) Public Health Dashboard %age of successful completions (split via substance type). Ambition for treatment services are to be consistently above the national average %age of successful completions (split via substance type) who do not represent (Public Health Outcome Framework 2.15) Leeds to be the best performing English core city	
ii.	Maintain the maximum number of dependent drinkers successfully going through detox and/or rehabilitation	Monitored through commissioners contract management processes	Practice and Development Group
iii.	Maintain relevant and effective referrals from Forward Leeds into St. Anne's residential rehabilitation and alcohol detox	Monitored through commissioners contract management processes	Public Health Programme Board
iv.	Make most effective use of budget for out of area residential detox and rehabilitation	Monitor and review spend	Practice and Development Group
v.	Forward Leeds to use a fast track approach for anyone identified through the street support team or sex work outreach, to ensure they can get into and remain in treatment without barriers	Maintenance of a fast track approach, that meets the needs of street users and street sex workers	Practice and Development Group
Focus for 2019-20			
vi.	Plan for West Yorkshire – Finding Independence (WY-FI) service stopping	All service users engaged with WY-FI are supported into other services	Practice and Development Group
vii.	Drug and Alcohol Social Marketing Planning (S-MAP) Group Plan, develop and deliver marketing campaigns and	Deliver a range of marketing campaigns and promotional activity, including: • promotion of treatment and recovery services	S-MAP

	promotional activity that are effective and responsive to need and changes in drug and alcohol use.	• promotion of Hep C treatment (measured by numbers tested and referred into hepatology at LTHT	
viii.	Process map and implement a robust pathway for people leaving out of area rehab and returning to Leeds	More people leaving out of area rehab returning to Leeds with appropriate housing on return	Practice and Development Group
ix.	Review access to supervised consumption to ensure pharmacy services are accessible and responsive to individual needs, including sex workers, homeless, Gypsy and Travellers and other vulnerable groups	Conduct review and implement recommendations	Practice and Development Group
x.	Increase the number of people accessing Forward Leeds hubs who are tested for Hepatitis C	15 staff trained on Dried Blood Spot testing 80% of new clients tested via DBST	Practice and Development Group
xi.	Undertake city-wide workforce skills audit of people who come into contact with drug and alcohol users	Audit and training needs assessment completed with recommendations made for improvement as required	Public Health Programme Board
xii.	Percentage of inpatients in LTHT who are screened for alcohol use	50%	Public Health Programme Board
xiii.	Percentage of screened patients in LTHT who drink alcohol above lower-risk levels given brief advice.	80%	Public Health Programme Board
xiv.	Percentage of screened patients in LTHT who drink alcohol at possible dependant levels offered a specialist referral.	80%	Public Health Programme Board
xv.	Effectively manage impact of Preventing Ill Health by Risky Behaviours CQUIN on commissioned services	Agree referral targets from LTHT and monitor progress	Public Health Programme Board
xvi.	Forward Leeds to develop a training programme ensuring all	All staff have undertaken trauma informed training	Practice and Development Group

	staff are trauma informed trained		
xvii.	Roll out new training: • low-level mental health training for all Forward Leeds staff • drug and alcohol training in all sex work services	All 95 frontline drug and alcohol workers trained in low-level mental health All sex work services trained drug and alcohol issues	Practice and Development Group
xviii.	Forward Leeds to work collaboratively with GPs to ensure they have a better understanding of addiction to prescribed medication and refer appropriately	Practice development session held with Shared Care GPs and PSC GPs	Practice and Development Group
Outcome 2.2 – Ensure that there are pathways and services in place to support drug and alcohol users to access support they need for issues linked to their drug and alcohol use			
Core business			
i.	Maintain appropriate treatment pathways for those who test positive for Hepatitis C in all Forward Leeds hubs	80% of those tested access and complete hepatitis C treatment	Practice and Development Group
ii.	Develop a dual diagnosis work plan that addresses the needs of those with coexisting drug and/or alcohol with mental health issues, including trauma.	Improve how drug and alcohol treatment services work with mental services	Dual Diagnosis Strategy Group
Focus for 2019-20			
iii.	Conduct an audit of provision for those with coexisting drug and/or alcohol with mental health issues, including trauma specific needs of women accessing services	Produce a report, through the Dual Diagnosis Strategy Group, that highlights good practice and gaps in service provision, and make recommendations for improvement	Dual Diagnosis Strategy Group
iv.	St. James's Hospital to work in collaboration with GP services and Forward Leeds to identify and treat those at risk of Alcohol-related liver disease	Monitor and review progress and establish baseline data	Practice and Development Group
v.	Strengthen pathways for LGBT+ clients between drug and alcohol treatment services and	Pathways developed with sexual health services	Practice and Development Group

	others providing support around risky behaviours		
vi.	Identify people with Hepatitis C through pharmacies for onward referral into hepatitis C treatment, by exploring the feasibility of hepatitis C testing in pharmacy needle exchanges	Increase the number of people getting tested for hepatitis C in pharmacies and, where testing positive, referred into treatment	Practice and Development Group
Outcome 2.3 – Leeds provides a wide and varied number of options to promote and support recovery			
Core business			
i.	Ensure the drug and alcohol recovery offer in Leeds is joined up, responsive and shares good practice	Regular meetings held with all the recovery service leads to ensure timetables, and events are complementary	Practice and Development Group
ii	Leeds will continue to support a diverse and thriving recovery community, with a range of opportunities for involvement	Annual recovery graduation events Events including but not limited to 'open mic 'nights and theatre performances	Practice and Development Group
iii.	5- ways Recovery Academy to have strong links with community learning providers including: The Cardigan Centre, Norton Web, Swarthmore and lifelong learning @Leeds Uni	80 people enter either further education, employment or structured volunteering	Practice and Development Group
iv.	Continue to support the Recovery Wrx website	Leeds provides regular web content for the site	Practice and Development Group
Focus for 2019-20			
v.	Ensure ongoing support in recovery for women involved with Children's Services	Set up peer support at 5 Ways with links across to all recovery services	Practice and Development Group
vi.	5 Ways provides a wide range of non-accredited courses	Minimum of 6 people complete each course Drama course performs Macbeth at the Leeds Playhouse, if funding is secured	Practice and Development Group
vii.	Widen Recovery Wrx roadshows to include input from all Leeds recovery services	Monitor number of people involved and roadshows delivered	Practice and Development Group

viii.	Submit application to host the Recovery Walk in Leeds	Application successful	Practice and Development Group
ix.	Increase the number of opiate and crack users, who have completed treatment, involved in the recovery community offering taster sessions, from Forward Leeds hubs that are opiate focussed	Specific opiate and crack support groups set up	Practice and Development Group
x.	Increase the number of women in recovery	Monitor percentage increase	Practice and Development Group
xi.	Support ex-users in the community, by exploring linking those in recovery with local businesses and work opportunities in their communities	Increase the number of people in recovery accessing employment in their community	Practice and Development Group
xii.	Develop a pack for all recovery services to be used to promote what is available in Leeds	Recovery services promoted every month at the FL hubs	Practice and Development Group
Future ambition / innovation			
a.	Explore opportunities to provide a Leeds residential drug detox and rehabilitation centre with recognition of need for gender specific services		
b.	Leeds hosts the annual national Recovery Walk		
c.	Better understanding impact of e.g. CQUINs on the treatment systems		
d.	Identify and treat all individuals with Hepatitis C - Eradicate Hepatitis C in Leeds by 2025 – in line with the NHS national target		
e.	Forward Leeds to develop the medical alcohol detox route and treatment pathway with hospitals		
f.	Explore how mainstream mental health services can ring-fence some time to be in drug and alcohol services		

Outcome 3 – Reduced crime and disorder associated with drug and/or alcohol misuse

A significant amount of crime in the city is linked to drug and alcohol misuse, either through people committing crime to fund drug and alcohol use, or through behaviours associated with the use of drugs and alcohol, e.g. street drinking and street drug use. Leeds has three prisons within its boundary and a women's feeder prison just outside. We will work across the prisons, police and probation to ensure offenders with drug and alcohol misuse issues have clear routes into services and opportunities for effective rehabilitation.

Working with partner agencies, we will influence the night time economy and reduce drug and alcohol harm. We will also work with relevant criminal justice agencies to disrupt and reduce the impact of organised crime groups and reduce the inappropriate availability of drugs and alcohol.

We will ensure that we protect children and young people from being exploited by addressing the impact of drugs and alcohol on Child Sexual Exploitation (CSE)/Child Criminal Exploitation (CCE) including across county lines. We will also improve our understanding of links between youth violence and drugs and alcohol and develop our responses accordingly.

With well evidenced links to drug and alcohol use, domestic violence and abuse is a priority for many partnerships. We will ensure that these links are embedded within the action plan.

No.	Action	Target / Product	Board / Group
Outcome 3.1 – Reduce offending and antisocial behaviour associated with drug and alcohol use and improve outcomes for drug and alcohol offenders			
Core business			
i.	Improve drug and alcohol treatment outcomes for offenders	Increase proportion of criminal justice service users who successfully complete treatment Monitored through contract management processes	Public Health Programme Board
ii.	Reduce reoffending rates following Drugs Intervention Programme	Monitored through contract management processes	Public Health Programme Board
iii.	Reduce offending behaviour in people leaving drug and alcohol treatment	Monitored through contract management processes	Public Health Programme Board
iv.	Continue to use out of court disposals for substance misuse with positive requirements	Maintain referrals to TWP for women and CGL/Humankind for men	Reducing Reoffending Board
v.	Ensure that women involved in street sex work, and identified as at risk of offending, are offered diversionary pathways alongside drug and alcohol and mental health treatment	Initial meeting with police and CPS to be widened to other partners	Practice and Development group
vi.	Where people stop using substances in prison, continue the recovery pathway for 'support only' from HMP Leeds, HMP Newhall and HMP	Monitor members accessing 5 Ways, engagement with provision and the impact on re-offending rates	Practice and Development group

	Wealstun, with 5 Ways Recovery Academy		
vii.	Introduce Conditional Cautions for low level SCRAs use	Increase the number of people using SCRAs referred for three sessions of treatment, as an alternative to prosecution	Reducing Reoffending Board
viii.	Continue drug testing for SCRAs in prison	Increase percentage rate in testing of those identified as using Increase in the number of those testing positive receiving treatment Monitor and review test results	Practice and Development group
ix.	Introduce drug testing on SCRAs seized by the police	Liaise with Manchester police Disseminate findings to increase knowledge of SCRAs and there use	Reducing Reoffending Board
Focus for this year 2019-2020			
x.	Improve Drug Rehabilitation Requirement breach process	Number of appropriate DDR breach sanctions increases	Practice and Development group
xi.	Increase drug testing and cell intervention	More people identified with a positive drug test referred to intervention services	Practice and Development group
xii.	Review the treatment process for offenders specifically around short-term sentence prison release and Friday court releases	Report findings and make recommendations to improve services for this population	Practice and Development group
xiii.	Undertake a thematic review of offenders with dual diagnosis with particular reference to trauma	Use of systems change trauma toolkit Make recommendations for service improvement and implement changes.	Dual Diagnosis Strategy group
xiv.	Test and evaluate where to use peer mentors from substance use and offending across the city	Report produced	Practice and Development group
xv.	Review drug and alcohol training for ASB officers	New programme of drug and alcohol training implemented	Practice and Development group
xvi.	Where ASB and drug or alcohol use is identified, and the person gives consent, a referral to Forward Leeds is made	All referrals made	Practice and Development group

xvii.	Work with prison drug and alcohol strategy managers to develop a city approach for support to people moving in and out of prison	Processes developed and agreed	Reducing Reoffending Board
	Work with the Youth Violence Strategic Group to better understand the links between youth violence and drugs and alcohol.	Undertake analysis and produce recommendations.	Youth Violence Strategic Group
Outcome 3.2 – Reduce the inappropriate availability of drugs and alcohol			
Core business			
i.	Continue to undertake licensing compliance visits	Problem premises and compliance visits will be identified and carried out, via the Licensing Enforcement Group (LEG) Continuation of the licensing scores programme through the LEG and to encourage 'problem premises' to engage with the LEG organisations	Practice and Development group
ii.	Support the work of the Purple Flag Working Group and contribute to actions around the night time economy, including delivery of safeguarding and free drug and alcohol training to licenced premises	Retain Purple flag status	Practice and Development group
Focus for this year 2019-2020			
iii.	Engage with the courts/sentencers to ensure they are aware of how drugs get into prisons e.g. through individuals deliberately getting short sentences to act as "drug mules", and improve awareness of DRR/community orders	Increase in the use of community orders / DRRs as an alternative to custodial sentences, where appropriate	Reducing Reoffending Board
iv.	Deliver SCRAs awareness training to magistrates	20 trained	Reducing Reoffending Board

v.	Roll out of partner intel sharing portal to ensure a consistent approach to reporting	Increase in intelligence to police on drug issues coming from partners agencies	Reducing Reoffending Board
vi.	Host prison tours for magistrates	At least 1 tour per prison within the year	Reducing Reoffending Board
vii.	New police recruits to visit prisons with a focus on the impact of drugs and alcohol	Visits built into the training programme	Reducing Reoffending Board
viii.	New police recruits and magistrates to visit treatment services	Develop visit programme	Reducing Reoffending Board
ix.	Target high risk, high harm drug and alcohol related Organised Crime Groups (OCG) with disruption tactics	Reduced number of active OCGs	Reducing Reoffending Board
x.	Develop a de-escalation approach to alcohol and drug related violent disorder at night	Manage regular night time economy at an 'events' level	Reducing Reoffending Board
Outcome 3.3 – Ensure services are in place to tackle domestic violence and abuse linked to drugs and alcohol			
Core business			
i.	Continue to develop joint work with Leeds Domestic Violence Service (LDVS), when responding to victims of domestic violence where drugs and/or alcohol is involved	Monitored through contract management arrangements	Public Health Programme Board
ii.	Provide specialist drug and alcohol support to those experiencing domestic violence	Specific role within Forward Leeds	Public Health Programme Board
Focus for this year 2019-2020			
iii.	Implement any recommendations involving drugs or alcohol identified through the Front Door Safeguarding Hub review	All changes implemented	Drug and Alcohol Board
iv.	Forward Leeds to deliver the Relationships and Recovery group, working with perpetrators of domestic violence with drug and alcohol issues	Referrals and outcomes based lined	Practice and Development group

Future ambition and innovation	
a.	Explore use of the Reducing Re-offending Analysis Tool (RRAT) to understand offenders with drug and alcohol flags
b.	Conduct research to get a better understanding of the first few days following release from prison, identify gaps in provision, and make recommendations for improvement

Outcome 4 – Reduce impact of harm from drugs and alcohol on Children, Young People and families

Leeds wants to be the best city for Children and Young People to grow up. We want to ensure that we protect Young People from the harmful effects of substance misuse and aim to achieve this by an effective prevent and treatment approach that bespoke to Young People's needs. We recognise that a number of Children and Young People experience adverse childhood experiences (ACEs) caused by parental/carer substance misuse and we aim to reduce this number by supporting their parents and carers to address their substance misuse. We know that the vast majority of Young People in Leeds do not have any issues with substances however there are a small minority that need this additional support.

	Action	**Target / Product**	**Board / Group**
Outcome 4.1 – Make sure children and young people are informed about the potential harms of drugs and alcohol			
Core business			
i.	Health & Wellbeing service to continue to support schools to deliver drug & alcohol education and in reviewing and updating drug & alcohol education and incidents policies	Monitor delivery and review in line with development of working group	Children and Young People's Group
ii.	Deliver drug and alcohol targeted education to vulnerable groups. Vulnerable groups currently include Looked After Children (CLA), those at risk of or experiencing DVA, CSE, CCE; at risk of exclusion or most at risk of using drugs and alcohol, also service to consider working with community and youth groups to identify opportunities to engage cohorts of other young people	To deliver 50 sessions to Pupil Referral Units, alternative education providers and children's homes, and vulnerable groups in mainstream schools	Children and Young People's Group
iii.	Develop a drug and alcohol input, for Safer School Officers to deliver in schools	Monitor the delivery of drug and alcohol input in schools throughout Leeds	Children and Young People's Group

Focus for this year 2019-2020			
iv.	Undertake audit of drug and alcohol targeted early intervention and prevention work with vulnerable groups	Implement recommendations from audit to improve early intervention and prevention services	Children and Young People's Group
v.	Set up a working group to review and develop drug and alcohol education in schools including, incorporating mandatory health education from September 2020 into drug and alcohol schools delivery plan	Group set up to develop content and increase the quality and uniformity of drug and alcohol education for under 18 year olds and explore the development of a commissioned resource	Children and Young People's Group
vi.	Train the children and young people workforce around cannabis, specifically those providing 1-1 support, including family support workers, learning mentors and foster carers	100 people trained to provide cannabis advice and information to young people	Children and Young People's Group
vii.	S-MAP group to deliver specific campaigns during this year	Campaigns this year to include: • Cannabis awareness for young people • 2 alcohol campaigns, focussed on under 18 year olds and 18-25 year olds	S-MAP Group
Outcome 4.2 Protect children and young people and prevent harm by supporting parents / carers into effective treatment			
Core business			
i.	Ensure staff in contact with families where parental drug and/or alcohol use is identified are skilled in addressing the issues and can offer support to the children and parents/carers, as necessary	To have a robust identification process for children's services with clear referral pathways into support services. Develop stronger links with Children's Social Work, Health Visitors, Forward Leeds and Willows Young Carers	Children and Young People's Group
ii.	Review the report that was set up for the D&A board which highlights the number of cases going through the decision and review board	Reduced number of children coming into care, through the family court	Practice and Development Group & Children and Young People's Group

	Establish a baseline Review process for parents identified as D&A users fast-tracked into adult treatment with an enhanced offer to make sustainable changes. Services share best practice on working with families going through the care proceedings process		
iii.	Undertake an annual audit of clients in Forward Leeds who have children living with them	Audit informs ongoing work to support children living with parents/carers who use drugs or alcohol	Practice and Development Group
iv.	Forward Leeds refer families to their 'family plus' service	Increase in number of families seen in the service to prevent them moving into social care	Practice and Development Group
Focus for this year 2019-2020			
v.	Reduce the number of children of adults with drug and alcohol issues taken into care by fast tracking and retaining parents/carers into treatment	Parents are seen quickly in treatment services and staff are trained within the think family model and ensure they offer a 'you and your family' approach to parents or anyone with children living in their household to ensure better treatment outcomes	Practice and Development Group
vi.	Increase identification of, and support to, children who have parents/carers identified as having drug and alcohol issues	Explore how information on looking out for signs/symptoms, and basic needs being met, can be provided to the wider workforce	Children and Young People's Group
vii.	Work with partner services to look at ongoing provision of the FDAC service from 2020	FDAC court continues past March 2020	Children and Young People's Group
Outcome 4.3 – Protect children and young people; including addressing the impact of drugs and alcohol on Child Sexual Exploitation (CSE)/Child Criminal Exploitation (CCE)/domestic violence and abuse (DVA)			
Core business			
i.	Continue to use the screening matrix for existing child exploitation pathways	Risk and vulnerability plans in place	Children and Young People's Group

ii.	Refer all cases that have gone through a Multi-Agency Risk Assessment Conference/Front Door Safeguarding Hub with children where drugs or alcohol are involved are fast-tracked to the Young Peoples team at Forward Leeds	All cases referred	Children and Young People's Group & Practice and Development Group
iii.	Ensure young people who are using drugs and/or alcohol, and experiencing domestic violence and abuse (or are at risk of domestic violence and abuse), can access appropriate support from Forward Leeds and Leeds Domestic Violence Service (LDVS)	Clear pathways developed with LDVS Forward Leeds. Establish Forward Leeds Young People's team representation at relevant forums where young people are discussed	Children and Young People's Group
Focus for this year 2019-2020			
iv.	Screening matrix developed for all vulnerabilities for young people including CCE	Screening matrix developed	Children and Young People's Group
v.	Police to develop a city wide protocol/guidance to calls of drugs in schools that is disseminated to all police officers and schools	Information developed and disseminated to all schools	Children and Young People's Group
vi.	Ensure effective and priority response to those identified as at risk or subject to CSE/CCE or trafficking	Better pathways in place with police and drug/alcohol service and with services working with CSE/CCE Develop a programme of communications on CCE, including using people with lived experience	Children and Young People's Group
vii.	Conduct test purchasing of alcohol by underage young people	Report findings and make recommendations for future targeted work	Children and Young People's Group
Outcome 4.4 – Ensure Children and Young People are supported to access services for their drug or alcohol use			
Core business			
i.	Monitor the percentage of young people who use alcohol and/or drugs regularly	Monitor and review data relating to drug and alcohol use and education from My Health and My School Survey and make recommendations	Children and Young People's Group

ii.	Maintain all appropriate referrals from schools and Children's services to Forward Leeds when young people are identified with drug/alcohol issues	All appropriate referrals are made and receive the right response	Children and Young People's Group
iii.	All Forward Leeds staff have up to date safeguarding training	Monitored through staff training records	Practice and Development Group
Focus for 2019-20			
iv.	Develop a Children and Young People's social care, children in care and care leavers pathway	Completed pathway for implementation to ensure young people are identified appropriately and referred to service	Children and Young People's Group
v.	Develop a Children and Young People's mental health pathway – "mind mate", CAMHS and Forward Leeds	Complete pathway for implementation to ensure young people are identified appropriately and referred to service	Children and Young People's Group
vi.	Extend drug & alcohol A&E pathway to include 16 and 17 year olds from St. James's and LGI	Existing model in LGI is replicated in St. James's, with appropriate thresholds for referral	Children and Young People's Group
vii.	Ensure any recommendations in the new Young Carers Strategy around drugs and alcohol are implemented	All recommendations implemented	Children and Young People's Group
viii.	Ensure any recommendations in the new "Think Family" protocol around drugs and alcohol are implemented	All recommendations implemented	Children and Young People's Group
ix.	Youth panel YJS and police 1st contact maximise options to divert out, if substance use identified, and referred to Forward Leeds	Deferred prosecution where individuals engage with Forward Leeds Training for Youth Panel members and police around identification and referral pathway. To monitor percentage of young people where a referral is identified, made, and taken up	Children and Young People's Group
x.	Increase referrals into treatment for young people being released from secure settings	More young people released on temporary license prior to release Arrangements in place to meet need prior to release	Children and Young People's Group

Future ambition and innovation	
a.	All schools deliver high quality locally agreed drug and alcohol education
b.	Using My Health My Schools data, understand the use of vapes by young people who have never smoked and develop pathways into treatment
c.	Assess need for preventative work on drink/drug driving/passenger by young people
d.	Families, via care proceedings, all have the opportunity to access a problem solving court model

Outcome 5 – addressing specific emerging issues

Drug and alcohol misuse is an ever changing landscape, requiring systems, mechanisms and structures in place to respond quickly and effectively to new and emerging issues. A section of the action plan will focus on these specific issues and processes for responding to them. We will ensure that the complexity and vulnerability around drugs and alcohol is on the agenda of safeguarding boards, encouraging collaborative work across the wide range of agencies and services throughout the city.

No.	Action	Target / Product	Board / Group
Core business			
i.	Respond to, and meet, identified needs and recommendations highlighted in the Director of Public Health's annual report	Ensure new issues highlighted in the annual report are actioned	Public Health Programme Board
Focus for this year 2019-2020			
ii.	Forward Leeds to continue to develop its community-based reduction and medically assisted detoxification programme for Synthetic Cannabinoid Receptor Agonists ("spice)	Monitor delivery of programme	Practice & Development Group
iii.	Gather and monitor data on ambulance call outs, including to Forward Leeds and the prisons	Establish a working group to analyse data and make recommendations on ways to reduce call outs / improve recording	Intelligence & Performance Group
iv.	Understand drug use in poly drug users	Gather research and intelligence and make recommendations for future action	Intelligence & Performance Group
Future ambition and innovation			
a.	Develop better understanding of steroid use		

Leeds Drug and Alcohol Strategy and Action Plan 2019-2024

Vision:	Leeds is a compassionate city that woks with individuals, families and communities to address drug and alcohol misuse				
Outcomes:	**1. Fewer people misuse drugs and/or alcohol and where people do so they make better, safer and informed choices**	**2. Increase in the proportion of people recovering from drug and/or alcohol misuse**	**3. Reduce crime and disorder associated with drug and/or alcohol misuse**	**4. Reduce impact of harm from drugs and alcohol on children, young people and families**	**5. Addressing specific emerging issues**
To achieve this we will:	1.1 – Increase public awareness of issues relating to drugs and alcohol 1.2 - Increase the safety of all our communities by reducing the amount of drug-litter on our streets and improving use of pharmacy based needle exchange services 1.3 – Ensure the availability of high quality harm reduction services	2.1 – Ensure treatment services are effective, of high quality and are easily accessible 2.2 – Ensure that there are pathways and services in place to support drug and alcohol users to access the support they need for issues linked to their drug and alcohol use 2.3 – Leeds provides a wide and varied number of options to promote and support recovery	3.1 – Reduce offending and antisocial behaviour associated with drug and alcohol use and improve outcomes for drug and alcohol offenders 3.2 – Reduce the inappropriate availability of illicit drugs and alcohol 3.3 – Ensure services are in place to tackle domestic violence and abuse linked to drugs and alcohol	4.1 – Make sure children and young people are informed about the potential harms of drugs and alcohol 4.2 Protect children and prevent harm by supporting parents / carers into effective treatment 4.3 – Protect children and young people; including addressing the impact of drugs and alcohol on Child Sexual Exploitation (CSE)/Child Criminal Exploitation (CCE)/domestic violence and abuse (DVA) 4.4 – Ensure children and young people are supported to access services for their drug and/or alcohol use	Drug and alcohol use is an ever changing landscape, requiring systems, mechanisms and structures in place to respond quickly and effectively to new and emerging issues. A section of the action plan will focus on these specific issues and processes for responding to them. We will ensure that the complexity and vulnerability around drugs and alcohol is on the agenda of safeguarding boards, encouraging collaborative work across the wide range of agencies and services throughout the city
How we will measure success (key performance indicators):	• Decrease in prevalence of opiate and / or crack users • Decrease in prevalence of dependent drinkers • Increase in pharmacy needle returns	• Increase in successful completions of drug treatment • Increase in Hep C testing and referrals into treatment	• Increase in successful completions as a proportion of all Criminal Justice clients in treatment • Reduce violent crime involved with alcohol consumption • Reduce A&E assault admissions with alcohol involved • Increase positive outcomes for drug offences	• Increase in secondary school pupils who have never had a drink of alcohol • Decrease in secondary school pupils who have ever used illegal drugs, gases and solvents as drugs • Decrease in children and families where drugs or alcohol was main reason for issuing care proceedings	

An effective governance framework will monitor the drug and alcohol strategy and deliver the accompanying action plan:

Leeds Health and Wellbeing Board

Report author: Arfan Hussain (Health Partnerships Team)

Report of: Tony Cooke (Chief Officer, Health Partnerships)

Report to: Leeds Health and Wellbeing Board

Date: 16 September 2019

Subject: Connecting the wider partnership work of the Leeds Health and Wellbeing Board

Are specific geographical areas affected? If relevant, name(s) of area(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☒ Yes	☐ No
Is the decision eligible for call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, access to information procedure rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

This report provides a summary of recent activity from workshops and wider system meetings, convened by the Leeds Health and Wellbeing Board (HWB). The report gives an overview of key pieces of work across the Leeds health and care system, including:

- Leeds System Resilience Plan Update: Winter 2018/19 and Next Steps
- Continuing Leeds Story: Partnership, innovation, inclusive growth and the promotion of sustainable health and wellbeing for all of the people of Leeds
- How the city can work better together to enable Leeds to be a child friendly, healthy and caring city for all ages, where people who are the poorest improve their health the fastest through 'Think Family' approach, understanding and working to address the impact of ACEs (Adverse Childhood Conditions) and weaving together the two threads of children, young people and families and older people.

Recommendations

The Health and Wellbeing Board is asked to:

- Note the contents of the report.

1 Purpose of this report

1.1 The purpose of this report is to provide a public account of recent activity from workshops and wider system meetings, convened by the Leeds Health and Wellbeing Board (HWB). It contains an overview of key pieces of work directed by the HWB and led by partners across the Leeds health and care system.

2 Background information

2.1 Leeds Health and Wellbeing Board provides strategic leadership across the priorities of our Leeds Health and Wellbeing Strategy 2016-2021, which is about how we put in place the best conditions in Leeds for people to live fulfilling lives – a healthy city with high quality services. We want Leeds to be the best city for health and wellbeing. A healthy and caring city for all ages, where people who are the poorest improve their health the fastest. This strategy is our blueprint for how we will achieve that.

2.2 National guidance states that: to make a real difference for the people they serve, Health and Wellbeing Boards need to be agents of change[1]. With good governance, the Leeds Health and Wellbeing Board can be a highly effective 'hub' and 'fulcrum' around which things happen.

2.3 This means that the HWB is rightly driving and influencing change outside of the 'hub' of public HWB meetings. In Leeds, there is a wealth and diversity of work that contributes to the delivery of the Strategy.

2.4 Given the role of HWBs as a 'fulcrum' across the partnership, this report provides an overview of key pieces of work of the Leeds health and care partnership, which has been progressed through HWB workshops and wider system events.

3 Main issues

Leeds Health and Wellbeing Board: Board to Board Session (11 July 2019)

3.1 The Health and Wellbeing Board convened its third Board to Board session on 11 July 2019. These sessions bring together a larger number of health and care partners (50+) to discuss key strategic topics, share perspectives and progress collective actions to support the delivery of the Leeds Health and Wellbeing Strategy. This approach is unique to Leeds and ensures that everyone is joined up and working towards the same goals for the city and for our citizens.

3.2 In Leeds our health and care system leaders are committed to a city first and organisation second approach at all levels through the following principals of approach:

[1] *Making an impact through good governance – a practical guide for Health and Wellbeing Boards,* Local Government Association (October 2014)

Principles of our approach		
We put people first: We work with people, instead of doing things to them or for them, maximising the assets, strengths and skills of Leeds citizens and our workforce.	**We deliver:** We prioritise actions over words to further enhance Leeds' track record of delivering positive innovation in local public services. Every action focuses on what difference we will make to improving outcomes and quality and making best use of the Leeds £.	**We are team Leeds:** We work as if we are one organisation, taking collective responsibility for and never undermining what is agreed. Difficult issues are put on the table, with a high support, high challenge attitude to personal and organisational relationships.

3.3 At the previous session the following areas were discussed:

Leeds System Resilience Plan Update: Winter 2018/19 and Next Steps

3.4 HWB: Board to Board received an overview of how, as a system, Leeds is in a better position than in previous years with strengthened relationships and the positive impact of the system working together as Team Leeds in improving outcomes for people who are some of the most vulnerable.

3.5 HWB: Board to Board thanked the workforce and frontline staff for their work during this time of pressure and the progress made.

3.6 During HWB: Board to Board discussions, the wider health and care system through their organisations and existing partnership/board groups agreed the following:

- Reiterated it's committed to the updated Leeds System Resilience Plan.
- Ensuring that the voice and experience of people using learning/actions from the CQC Local System Review of Leeds continues to inform the Leeds System Resilience Plan including engagement with the 'How does it feel for me? Quality Group for Leeds'.

Continuing Leeds Story: Partnership, innovation, inclusive growth and the promotion of sustainable health and wellbeing for all of the people of Leeds

3.7 The previous HWB: Board to Board had discussed the need to create some time at all future sessions for moving the system beyond the important short term challenges to better understand the longer term strategic challenges faced by the city. Three years previously Prof. Paul Stanton had been asked to talk to partners about the likely challenges and the strengths of the Leeds health and care system. Following on from this he was asked to conduct an exercise to help 'future proof' the partnership, including reading and commenting on existing strategies and giving steer for how to further strengthen partnership approaches.

3.8 Prof. Stanton delivered a presentation and development session that looked at the national and regional context and the strengths and challenges of Leeds and our opportunities for further progress in challenging times. This covered:

- Culture and characteristics of effective partnerships – how to build on our collaborative strengths.

- Our collective approach to people and communities: Creating a vibrant and healthy Leeds for everyone that strengthens our approach to improve the health of the poorest the fastest.

- Greatest opportunities for long term improvements: Weaving together the two threads of children, young people and families and older people, and creating opportunities for intergenerational work.

- Understanding the risks and opportunities around the demographic bulge in children and young people in deprived areas, coupled with the challenges around frailty, healthy life expectancy and end of life.

- Understanding the importance of work on anchor institutions, workforce, priority neighbourhoods and inclusive growth and aligning the health and economic strategies – in particular as the shape of the economy changes exploring a stronger strategy for innovation, healthtech, SMEs (Small and medium-sized enterprises), third sector and partnering more effectively with businesses.

- Maintaining the focus on integration should the national direction of challenge change 'holding our nerve'.

3.9 HWB: Board to Board agreed for the discussions to be explored further with the outcomes to be discussed at a future HWB meeting and to feed into our future plans and strategies. Prof Stanton will be talking to key people and drafting a report for further discussion which will explore these themes in greater detail.

Children & Families Trust Board and Health and Wellbeing Board Joint Session (15 July 2019)

3.10 Children and Families Trust Board (CFTB) and Health and Wellbeing Board (HWB) had a joint session to collectively explore actions on how the city can work better together to enable Leeds to be a child friendly, healthy and caring city for all ages, where people who are the poorest improve their health the fastest. This included exploring:

- The Well-being of Future Generations (Wales) Act, managing the short term in the context of the long term ("acting today for a better tomorrow") reflects strongly with the approach taken in Leeds. Sophie Howe (Future Generations Commissioner for Wales) joined the session and shared their learning.

- Strengthening joint partnership working across our strategies/boards through shared priorities.

- How a family, however defined, is an asset right across the life course and how we can better "think family" in strategic planning, commissioning, service design and delivery.

- Understanding the impact of Adverse Childhood Experiences for future health outcomes and the importance of early intervention in mitigating these, with a

particular focus on mental health and the impact of adults on children and young people.

- Weaving together the two threads of children, young people and families and older people – which are growing fastest in communities that experience the highest levels of deprivation.

3.11 CFTB and HWB agreed the following actions to be explored further:

- A longer term 'future generations' approach to making Leeds the Best City for Health and Wellbeing for all ages that brings together the strategic drivers of the city of Leeds Health and Wellbeing Strategy, Inclusive Growth Strategy and Climate Change.

- LTHT to attend a future CFTB to discuss Building the Leeds Way: Children's Hospital.

- Development of partnership wide definition of 'Leeds Left Shift' around preventative spend that can be applied by the system in budget processes and planning decisions.

- Improving linkages and collaboration with and between existing locality arrangements (e.g. children's clusters, LCPs/PCNs, and Neighbourhood Networks, etc.).

- 'Think Family' approach embedded across strategic planning, commissioning, service design and delivery and our workforce through practitioner events.

- Working with children and young people from an early age to understand healthy relationships.

- Population Health Management to explore focusing on children & young people for its next cohort.

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

4.1.1 Health and Wellbeing Board has made it a city-wide expectation to involve people in the design and delivery of strategies and services. A key component of the development and delivery of each of the pieces of work for the HWB: Board to Board session is ensuring that consultation, engagement and hearing citizen voice is occurring.

4.2 Equality and diversity / cohesion and integration

4.2.1 Each of the pieces of work highlighted in this report, through the strategic direction of the Health and Wellbeing Board, is aligned to priorities of our Leeds Health and Wellbeing Strategy 2016-2021 and our vision of Leeds being a healthy and caring city for all ages, where people who are the poorest improve their health the fastest.

4.2.2 Any future changes in service provision arising from work will be subject to governance processes within organisations to support equality and diversity.

4.3 Resources and value for money

4.3.1 Each of the pieces of work highlighted in this report evidences how the Leeds health and care system are working collectively with the aim of spending the Leeds £ wisely under the strategic leadership of the HWB. The volume of partnership working is testament to the approach taken – sharing or integrating resources, focusing on outcomes and seeking value for money as part of its long term commitment to financial sustainability.

4.4 Legal Implications, access to information and call In

4.4.1 There are no legal, access to information or call in implications arising from this report.

4.5 Risk management

4.5.1 Risks relating to each piece of work highlighted is managed by relevant organisations and boards/groups as part of their risk management procedures.

5 Conclusions

5.1 In Leeds, there is a wealth and diversity of work and initiatives that contribute to the delivery of the Leeds Health and Wellbeing Strategy 2016-2021 which is a challenge to capture through public HWB alone. This report provides an overview of key pieces of work of the Leeds health and care system, which has been progressed through HWB workshops and events with members.

5.2 Each piece of work highlights the progress being made in the system to deliver against some of our priorities and our vision of Leeds being a healthy and caring city for all ages, where people who are the poorest improve their health the fastest.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Note the contents of the report.

7 Background documents

7.1 None.

THIS PAGE IS LEFT INTENTIONALLY BLANK

How does this help reduce health inequalities in Leeds?
Each of the pieces of work highlighted in this report, through the strategic direction of the Health and Wellbeing Board, is aligned to priorities of our Leeds Health and Wellbeing Strategy 2016-2021 and our vision of Leeds being a healthy and caring city for all ages, where people who are the poorest improve their health the fastest.

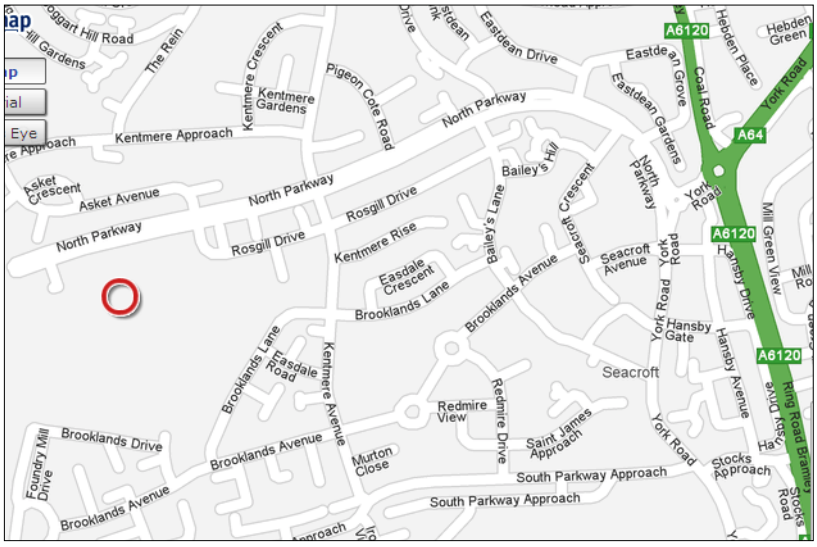
How does this help create a high quality health and care system?
National guidance states that: to make a real difference for the people they serve, Health and Wellbeing Boards need to be agents of change. The Leeds Health and Wellbeing Board is rightly driving and influencing change outside of the 'hub' of public HWB meetings to ensure that the wealth and diversity of work in Leeds contributes to the delivery of the Strategy. The Board is clear in its leadership role in the city and the system, with clear oversight of issues for the health and care system.

How does this help to have a financially sustainable health and care system?
Each of the pieces of work highlighted in this report evidences how the Leeds health and care system are working collectively with the aim of spending the Leeds £ wisely under the strategic leadership of the HWB. The volume of partnership working is testament to the approach taken – sharing or integrating resources, focusing on outcomes and seeking value for money as part of its long term commitment to financial sustainability.

Future challenges or opportunities
In the wealth and diversity of work there is an ongoing opportunity and challenge to ensure that the Board, through its strategic leadership role, contributes to the delivery of the Strategy in a coordinated and joined up way that hears the voices of our citizens and workforce.

Priorities of the Leeds Health and Wellbeing Strategy 2016-21	
A Child Friendly City and the best start in life	X
An Age Friendly City where people age well	X
Strong, engaged and well-connected communities	X
Housing and the environment enable all people of Leeds to be healthy	X
A strong economy with quality, local jobs	X
Get more people, more physically active, more often	
Maximise the benefits of information and technology	X
A stronger focus on prevention	X
Support self-care, with more people managing their own conditions	X
Promote mental and physical health equally	X
A valued, well trained and supported workforce	X
The best care, in the right place, at the right time	X

Bishop Young C of E Academy
Map and Directions



Address Details

Bishops Way
Seacroft
Leeds
LS14 6NU
Phone: 0113 273 9100 E-mail: info@bishopyoungacademy.co.uk

Directions

By car:

Junction 46 M1
A6120 Leeds Ring Road
Continue to Seacroft roundabout (with Britannia Hotel on right).
Turn left at this roundabout. You should now be facing a large Tesco store.
Turn right at the smaller roundabout immediately ahead onto North Parkway dual carriageway.
Proceed to the bottom of the road. It is a dead end but you can turn left at the bottom into Bishops Way. The Academy is signposted ahead of you. Turn left at the roundabout.

By rail/bus:

Train to Leeds main rail station
Take taxi from station (20 minutes)
or
Number 16 bus goes to North Parkway.
Bishops Way is the driveway at the bottom of the road. The Academy is signposted.
or
Train to Leeds main rail station
Take Northern Line train to Crossgates rail station
Take taxi from station (5 minutes)

Please note that 'The Moyes Centre' is located to the right of Bishop Young C of E Academy. Take the righthand exit at the roundabout. Contact reception at the gate on the left to gain entry into the car parking area.

This page is intentionally left blank