



HEALTH AND WELLBEING BOARD

Meeting to be held in The Holbeck, Jenkinson Lawn, Holbeck, Leeds, LS11 9QX on
Wednesday, 11th December, 2019 at 2.00 pm

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

MEMBERSHIP

Councillors

R Charlwood (Chair)
F Venner
A Smart

S Golton

G Latty

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 - NHS England

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 compiled by: Harriet Speight
Governance Services 0113 37 89954

A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
2			WELCOME AND INTRODUCTIONS 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 16 September 2019 as a correct record.

1 - 10

9		PRIORITY 3: STRONG, ENGAGED AND WELL-CONNECTED COMMUNITIES - DEVELOPING OUR LOCAL CARE PARTNERSHIPS To consider the report of the Chief Executive of Leeds Community Healthcare that provides an overview of Local Care Partnerships to Health and Wellbeing Board. The paper will describe why Leeds health and care system is developing Local Care Partnerships, how they fit with other activity in Leeds, and the current stage of development.	11 - 26
10		LEEDS SYSTEM RESILIENCE PLAN 2019/20 To consider the report of the System Resilience Assurance Board (SRAB) that provides assurance to the Leeds Health and Wellbeing Board that the Leeds health and care system continue to work together to improve the resilience of service delivery.	27 - 156
11		DEVELOPING OUR APPROACH TO IMPROVING HEALTH AND WELLBEING ACROSS LEEDS AND WEST YORKSHIRE AND HARROGATE HEALTH AND CARE PARTNERSHIP 11.1 Draft Leeds Health and Care Plan To consider the report of the Head of the Leeds Health and Care Plan that provides the final draft Leeds Plan summary on a page for approval as well as outlining the progress to date. 11.2 Draft WYH Health & Care 5 Year Strategy To consider the report of the West Yorkshire and Harrogate Health and Care Partnership that presents a further draft of the narrative of the West Yorkshire and Harrogate Health and Care Partnership Five Year Strategy.	157 - 328

12		FOR INFORMATION: LEEDS HEALTH AND CARE QUARTERLY FINANCIAL REPORTING To note, for information, the report of the Leeds Health and Care Partnership Executive Group (PEG) that provides a brief overview of the financial positions of the health and care organisations in Leeds, brought together to provide a single citywide quarterly financial report (Appendix 1). This report is for the period ending months ending September 2019.	329 - 338
13		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 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 carers, women in Leeds, and the draft Mental Health Strategy. ANY OTHER BUSINESS	339 - 346
15		DATE AND TIME OF NEXT MEETING The next meeting will take place on Thursday 20th February 2020 at 12:30 p.m.	

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

MONDAY, 16TH SEPTEMBER, 2019

PRESENT: Councillor R Charlwood in the Chair

Councillors G Latty, A Smart and 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

Directors of Leeds City Council

Victoria Eaton – Deputy Director of Public Health

Cath Roff – Director of Adults and Health

Sue Rumbold – Chief Officer, Children and Families

Third Sector Representative

Ruth Kettle – Community Links

Representative 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 Philip Wood - Leeds Teaching Hospitals NHS Trust

Thea Stein - Leeds Community Healthcare NHS Trust

Safer Leeds Joint Representative

Paul Money - Chief Officer, Safer Leeds

Representative of Leeds GP Confederation

Jim Barwick – Chief Executive of Leeds GP Confederation

12 Welcome and introductions

The Chair welcomed all present and brief introductions were made.

The Chair encouraged Members and public present to attend the next Big Leeds Chat event due to take place at Kirkgate Market on 7th November 2019, to have their say on the development of health plans and strategies in the city.

The Chair also noted the publication of the latest Suicide Audit in Leeds, which echoed finding from previous years that those living in the most deprived areas of Leeds, particularly middle-aged men, are most at risk of dying through suicide.

Draft minutes to be approved at the meeting
to be held on Wednesday, 11th December, 2019

13 Appeals against refusal of inspection of documents

There were no appeals.

14 Exempt Information - Possible Exclusion of the Press and Public

There were no exempt items.

15 Late Items

There were no formal late items. However, the following supplementary information was distributed to Members after agenda publication:

- Item 12.2 Appendix 1 (Draft Leeds Health and Care Plan 2019 – 2024)
- Item 14 Appendix 1 (Draft Better Care Fund Plan 2019/20)

16 Declarations of Disclosable Pecuniary Interests

There were no declarations of disclosable pecuniary interests.

17 Apologies for Absence

Apologies for absence were received from Councillor Golton, Alison Lowe, Ian Cameron, Steve Walker, Julian Hartley and Anthony Kealy.

Ruth Kettle, Victoria Eaton, Sue Rumbold and Dr Philip Wood were in attendance at the meeting as substitutes.

18 Open Forum

Tom Fellows, Head of NHS relations at Nuffield Health, informed the Board of the not-for-profit programmes run by invited Members of the Board to contact him following the meeting on matters. Specific programmes included wellbeing provision in schools and support groups for children and young people with cystic fibrosis.

Dr John Puntis, Leeds Keep our NHS Public, raised some concerns regarding the West Yorkshire and Harrogate Five Year Strategy for Health and Care, specifically in relation to the national context of funding arrangements including the impact of Private Finance Initiative (PFI) on NHS hospital trusts and restrictions to patient access. The Chair recognised the potential for the digital exclusion to contribute to health inequalities and highlighted the positive work occurring through a number of programmes in Leeds including the 100% Digital Leeds movement. The Chair also highlighted the importance of better understanding the local implications of PFI in Leeds and regionally. Furthermore, the Chair informed Dr Puntis of the opportunity to engage with the West Yorkshire and Harrogate Five Year Strategy for Health and Care and to provide feedback via the West Yorkshire Partnership website.

19 Minutes

RESOLVED – That the minutes of the meeting held 14 June 2019 be approved as an accurate record, subject to the inclusion of attendance details.

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

The Leeds Palliative Care Network submitted a report that provided an overview of the work of the network, including the Dying Matters programme.

The following was appended to the report:

- Leeds Palliative and End of Life Care Framework for Adults
- Leeds Palliative and End of Life Care Draft Outcomes Framework

The following were in attendance:

- Dr Mike Stockton, Chair of the Leeds Palliative Care Network
- Lucy Jackson, Chief Officer, Public Health, Leeds City Council
- Diane Boyne, Leeds Palliative Care Network Manager at St. Gemma's Hospice

Members were provided with a presentation, which highlighted the following:

- Access issues, in Leeds and nationally;
- Key milestones in 2018/19;
- Draft outcomes and priorities for the future.

Members discussed a number of matters, including:

- Opportunity to strengthen the framework through an all age approach, to include children and young people and challenges around transitions and engaging them on talking about palliative care and end of life as key influences in their homes and communities;
- The need for consideration of economic impact in line with the identified projections for future need;
- The need for better integration between hospitals and hospices to ensure early identification of need and a focus on 'Leeds Left Shift' in the framework;
- Support for the think family approach around palliative and end of life care particularly in relation to carers and bereavement services;
- The need for consideration of how Leeds can better resource community palliative care in line with the Leeds Left Shift, which is currently significantly dependent on the third sector explored through the Integrated Commissioning Executive (ICE).
- The need for consideration of how the city provides care at home utilising frontline staff through a more holistic approach to care.

- The importance of better understanding and addressing why lower proportions of mixed 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.
- The importance of better understanding and addressing the linkages of areas experiencing higher levels of deprivation that have a lower proportion of people dying in their preferred place of death.
- The need for the health and care system to challenge itself in reducing the inequality gaps highlighted in the Health Needs Assessment.
- Suggestions for further consideration of the quality of life of those living in poverty and who are homeless in relation to palliative and end of life care. Representatives present sought more support with data blockages, to enable them to identify the needs are different populations. The Chair suggested that a session be held focused on reducing inequalities in end of life care.

RESOLVED –

- a) To note the breadth of work driven by the Leeds Palliative Care Network including the work of the Dying Matters Partnership;
- b) To note the Board's recognition of people receiving palliative care and those at end of life as a key priority population in city plans;
- c) To note the Board's comments on the draft population level outcomes for people at end of life and draft Leeds Palliative and End of Life Framework.

21 Leeds Carers Partnership Strategy

The Leeds Carers Partnership submitted a report that presented a new draft Leeds Carers Partnership Strategy, including details of how the strategy will help deliver the Leeds Health and Wellbeing Strategy and Leeds Health and Care Plan.

The following was appended to the report:

- Draft Leeds Carers Partnership Strategy Plan on a Page
- Draft Leeds Carers Partnership Strategy

The following were in attendance:

- Val Hewison, Chief Executive of Carers Leeds
- James Woodhead, Head of Commissioning for Adults and Health, Leeds City Council
- Martin Earnshaw, Head of Primary Care (Proactive Care), NHS Leeds CCG

The Head of Commissioning (Adults and Health) introduced proposed interactive strategy and five key priority areas, as well as proposals for consultation. The Chief Executive of Carers Leeds noted the importance of a

meaningful strategy for carers, which gives them confidence that actions will be fulfilled.

Members discussed a number of matters, including:

- The need for the strategy to be fully aligned to the Young Carers Strategy, to ensure that all carers are supported consistently throughout their lives;
- Support for the interactive format as a more accessible form of engagement with communities;
- Opportunity for the strategy to be linked to the Inclusive Growth, recognising the importance of supporting carers in the workplace and economic health and wellbeing;
- The development of the additional incentive scheme for GP practices to become involved. Jim Barwick, the GP Confederation representative, noted that they would like to join the partnership, and would make contact.
- Opportunity for the strategy to challenge the health and care system to address longstanding issues and holding each other to account for actions, pledges and performance. In particular, working with our wider workforce to create a cultural change in health and care in Leeds around carers.
- Importance of putting carers' voices and experiences at the heart of the strategy and in how the strategy measures progress.

RESOLVED –

- a) To note the progress made by the Leeds Carers Partnership in developing the draft strategy;
- b) To note Members comments on the development of the strategy, including the public engagement proposal.

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

The Director of Operational Delivery (NHS Leeds CCG) and the Director of Children and Families (Leeds City Council) submitted a joint report that provided 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.

The following was appended to the report:

- Future in Mind: Leeds Local Transformation Plan for children and young people's mental health and wellbeing – Draft Annual Refresh October 2019

Jane Mischenko, Lead Commissioner for Children & Maternity Services at NHS Leeds CCG, introduced the report, highlighting the prevalence of mental health problems amongst children and young people, particularly in areas of high deprivation, and the projections for rapid growth in coming years.

Members discussed a number of matters, including:

- The success of the MindMate programme in schools, but equally the need to address support for schools in relation to managing exclusions and off-rolling;
- The challenge of investment into services, and the need to continue to commit to delivering a Leeds Left Shift and effectively using additional funding outlined in the NHS Long Term Plan. Particularly actions to mitigate the risk of a projected rise in numbers of children experiencing poor mental health due to demographic challenges and the higher proportion of increasing numbers of children and young people occurring in areas experiencing the highest levels of deprivation in Leeds where they are more likely to experience Adverse Childhood Experiences (ACEs).

RESOLVED –

- a) To endorse the refreshed Leeds Local Transformation Plan for publication before 31 October;
- b) To note the Board's recognition of the achievements over the last 4 years;
- c) To note the Board's recognition of the strength of the child and young person's voice, in particular the impact of the MindMate Ambassadors;
- d) To note the breadth and connection between partners and practitioners across the system and thank them for their continued commitment;
- e) To note the Board's recognition of the strong contribution this strategy and plan delivers to the core prevention agenda of the city;
- f) To note the Board's recognition of further work 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)

23 Our approach to improving health and wellbeing across Leeds and West Yorkshire and Harrogate

12.1 Leeds Health and Care Plan: Continuing the Conversation

The Head of the Leeds Health and Care Plan (Health Partnerships) submitted a report that provided an overview of the review of the Leeds Plan and the significant engagement to date which has supported its development.

The following was appended to the report

- Leeds Health and Care Plan 2019 – 2024 Improving health: transforming the system, Working Draft Version 9

The Head of Leeds Plan introduced the report, highlighting the set of qualities and behaviours set out in the report and the city ambitions. Members were informed that an action plan was currently being developed.

Members discussed a number of matters, including:

- The need to further engage front line staff around the culture change envisaged;
- The need to clarify and define what is meant by a whole system 'left shift' in Leeds for future documents.

RESOLVED –

- a) To note the engagement and progress to date in developing a draft Leeds Plan;
- b) To note the Board's comments in relation to the draft Leeds Plan.

12.2 Development of the WYH 5 Year Strategy for Health and Care

The West Yorkshire and Harrogate Health and Care Partnership submitted a report that presented a draft of the narrative of the Five Year Strategy and the process for further developing and refining it.

The following was appended to the report

- Draft Five Year Strategic Plan

The following were in attendance:

- Ian Holmes, Director for West Yorkshire and Harrogate Health and Care Partnership
- Rachael Loftus, Head of Regional Health Partnerships

The Director introduced the report and the Five Year Strategic Plan, highlighting the opportunity to engage with the Board at the earliest opportunity along with the planning timetable leading up to implementation.

Members discussed a number of matters, including:

- Support for the overall approach, specifically the improved references to tackling health inequalities in all programmes at West Yorkshire and Harrogate level and having a greater focus on the conditions needed for health and working with wider partners.

- Support for the integration and recognition of oral health in primary care within the draft plan and the need for similar consideration within the Leeds Plan.
- The Chair also queried whether any of the unspent dentistry budget from the national Specialist Commissioning budget could be potentially re-invested locally on in-school dentist provision, as opposed to being returned to central government. An update would be provided to the Chair in due course on this matter.
- Concerns around the direction of travel being suggested nationally to rationalise the number of CCGs to one per Integrated Care System, which Members felt would not be appropriate for West Yorkshire and Harrogate given the large geography of the partnership. The Director responded that a strong message has been sent back to NHSE/I from the WYH Partnership that a single CCG would not be suitable.

RESOLVED –

- a) To note the timescale and process for the further refinement and sign-off of the strategy;
- b) To note the Board's comments and feedback on the draft 5 Year Strategy.

24 Update on CQC Leeds System Review Action Plan

The Lead for CQC System Review & Leeds CQC System Review Task and Finish Group submitted a report that provided a summary of the progressions of the Board's action plan made to date.

The following was appended to the report

- CQC Leeds System Review Action Plan

The following were in attendance:

- Paul Bollom, Head of Leeds Plan
- Emma Geary, Project Officer, Health Partnerships

The Head of Leeds Plan introduced the report, explaining that the self-judged action plan was developed following a Local System Review (LSR) of Leeds carried out by the Care Quality Commission (CQC).

Members discussed a number of matters, including:

- Members welcomed the progress made, particularly in relation to 'How Does it Feel for me?' group;
- The need for some of the actions to be integrated into the Leeds Plan ensuring that a positive difference has been made to the health and care system as a result of completed actions and continued focus.

- Cath Roff provided an overview of Action 5: development of a one' system suite of measures dashboard / scorecard as action lead, which will be brought to the Board at a future meeting.

RESOLVED – To note the Board's comments and feedback.

25 Draft Leeds Better Care Fund Plan 2019/20

The Chief Officer of Adults & Health (Leeds City Council) and the Director of Operational Delivery (NHS Leeds CCG) submitted a report that sought approval of the draft Leeds BCF Plan 2019/20.

The following was appended to the report:

- Draft Leeds Better Care Fund Plan 2019/20

The following were in attendance:

- Steve Hume, Chief Officer for Resources and Housing, Leeds City Council

The Chief Officer introduced the report, noting the continued financial challenge associated with mental health residential placements. Members were advised that there was still opportunity for comments to be incorporated into the plan if Members wished to submit comments following the meeting.

RESOLVED – To agree the draft Leeds Better Care Fund Plan 2019/20.

26 For information: Leeds Drugs & Alcohol Strategy & Action Plan 2019-24

The Board received, 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.

RESOLVED – To note the contents of the report.

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

The Board received, 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.

RESOLVED – To note the contents of the report.

28 Any Other Business

No matters were raised on this occasion.

29 Date and Time of Next Meeting

Wednesday 11th December 2019 at 2 pm.

The meeting ended at 4:40 pm

Leeds Health and Wellbeing Board



Report author: Kim Adams (Head of LCP Development)

Report of: Thea Stein (Chief Executive, Leeds Community Healthcare and SRO, LCP Development)

Report to: Leeds Health and Wellbeing Board

Date: 11 December 2019

Subject: Priority 3: Strong, engaged and well-connected communities – Developing our Local Care Partnerships

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

- Local Care Partnerships is the term adopted in Leeds to describe a model of joined-up working across health and care with teams delivering 'local care for local people' 'working in and for' local communities.
- Leeds has 19 Local Care Partnerships, providing coverage across Leeds. They bring together health and care leaders from the local area to plan and deliver support services for the local population.
- Local Care Partnerships are a new initiative but based on previously established relationships in many areas. This means that different partnerships are at different stages of maturity.
- The ambition for Local Care Partnerships is to develop a broad partnership of local leaders that goes beyond providers of health and care services, enabling leaders to work together with local people to address the wider determinants of health.

- Population Health Management, a method of using local data to target interventions at people who would benefit most, is being used to test out how local solutions can be developed and delivered by Local Care Partnerships, with an initial focus on achieving the outcomes set for people living with frailty. Interventions are multi-disciplinary and include the Third Sector as a key delivery partner.

Recommendations

The Health and Wellbeing Board is asked to:

- Note the work being undertaken to develop Local Care Partnerships.
- Understand that success is dependent on strong relationships fostered through working together on shared priorities with appropriate support to make this happen.
- Support the principle of prioritising time to foster the right culture to make lasting change happen.

1 Purpose of this report

- 1.1 The purpose of this report is to provide an overview of Local Care Partnerships to Health and Wellbeing Board. The paper will describe why Leeds health and care system is developing Local Care Partnerships, how they fit with other activity in Leeds, and the current stage of development.

2 Background information

- 2.1 **Local Care Partnerships** is the term adopted in Leeds to describe a model of joined-up working with teams delivering 'local health, wellbeing and care for local people' 'working in and for' local communities. Each Local Care Partnership has a board which meets approximately monthly. Make-up of the board differs from one Local Care Partnership to another, but typically includes representatives from all statutory health and care providers, local councillor, public health and third sector. Many have housing and community pharmacy and some have representative(s) from the local community.
- 2.2 Local Care Partnerships build on a history of joined up working between primary care, community healthcare services and Adult Social Care which resulted in the formation of Neighbourhood Teams. They also build on collaborative working across a range of partners in Children's services including Children and Family Hubs and school clusters. Neighbourhood Teams sought to improve care delivery by bringing together providers of health and care services in an integrated team. Local Care Partnerships aspire to improve upon this model by:
- being inclusive of all ages
 - putting people at the heart of the Local Care Partnership – ensuring support and services are appropriate to the population by working with local people
 - promoting a culture which builds on the strengths of individuals and assets of locally communities
 - bringing together leaders from statutory health and care services with Third Sector and community groups, housing, employment, planners, elected representatives and local people to address wider determinants of health inequality
 - planning together how available resources can best be used to meet local need
- 2.3 Local Care Partnerships differ from Neighbourhood Teams in that, whilst they are concerned with ensuring that care and support is joined up, they also have a broader remit in addressing health inequalities and tackling the wider determinants of health. In this way they have a key role in delivery of both the Leeds Health and Wellbeing Strategy and the Leeds Health and Care Plan.
- 2.4 Local Care Partnerships are being developed at a time when there is a lot of other change being progressed across the city. Some of this is locally driven through the Leeds Health and Care Plan whilst other change is nationally mandated. Local Care Partnership development needs to integrate with all of this change. However, there are two specific developments that are central to the development

of Local Care Partnerships – establishment of Primary Care Networks and the use of Population Health Management.

- 2.5 **Primary Care Networks** sit as a key strand of the national NHS Long Term Plan. This describes a model of multidisciplinary integration. Primary Care Networks are described as expanded primary care teams based on neighbouring GP practices that work together with integrated community health services; typically covering 30-50,000 population.
- 2.6 These expanded community multidisciplinary locality-based teams comprise of a range of staff such as GPs, pharmacists, district nurses, community geriatricians, dementia workers and allied health professionals (AHPs) such as physiotherapists and social prescribing link workers, working in partnership with social care and the Third Sector. The ambition is to deliver fully integrated community-based health care for the first time since the NHS was created.
- 2.7 In Leeds, we recognise the impact that delivering in this way would have on the way people access and experience care outside of hospital. We have been working with locality based networks of general practice for some time. Primary Care Networks formalise the established collaborations between local GP practices across 19 geographical localities; together with work already being progressed to integrate community and primary care services. Primary Care Networks are central to the vision of Local Care Partnerships but do not replace them. Local Care Partnerships seek to actively engage as partners, services which do not deliver care services but are well placed to have a positive impact on the wellbeing of local people. In this way their remit expands beyond that of the Primary Care Network supporting delivery of our Leeds Health and Wellbeing Strategy.
- 2.8 There are 19 Primary Care Networks and Local Care Partnerships mirror this footprint. However, in practice, a number of Primary Care Networks meet together as Local Care Partnerships so the number of Local Care Partnership meetings is currently 14.
- 2.9 **Population Health Management** is described as a collective understanding, across organisations, of the needs and behaviours of the defined population they are responsible for. It uses data to understand where the greatest opportunities to improve health outcomes, value and patient experience can be made; and then using available resources to plan, design and deliver proactive, person centred care solutions to achieve better outcomes for the defined population. Population Health Management focuses on the widest description of health and wellbeing incorporating physical and mental health outcomes, social determinants and looks to reduce health inequalities across a population.
- 2.10 There are five overall aims of Population Health Management:
- Improve the health and wellbeing of each of the population segments
 - Enhance experience of care and support
 - Reduce per capita cost of care and improve productivity
 - Increase the wellbeing and engagement of the workforce
 - Address health and care inequalities

- 2.11 In Leeds, the Population Health Management approach is being tested within Local Care Partnerships on a 'frailty' cohort. Frailty was chosen as the city has a combined data set (drawing from a range of health and care providers) and model of good practice for working with this cohort. Four Local Care Partnerships embarked upon this approach to test new ways of working at the start of the year. Seven 'wave two' sites commenced in October and the remaining Local Care Partnerships will join the programme early next year. Population Health Management is one of the transformational changes in the NHS Long Term Plan and all Primary Care Networks need to develop their capabilities around this.

3 Main issues

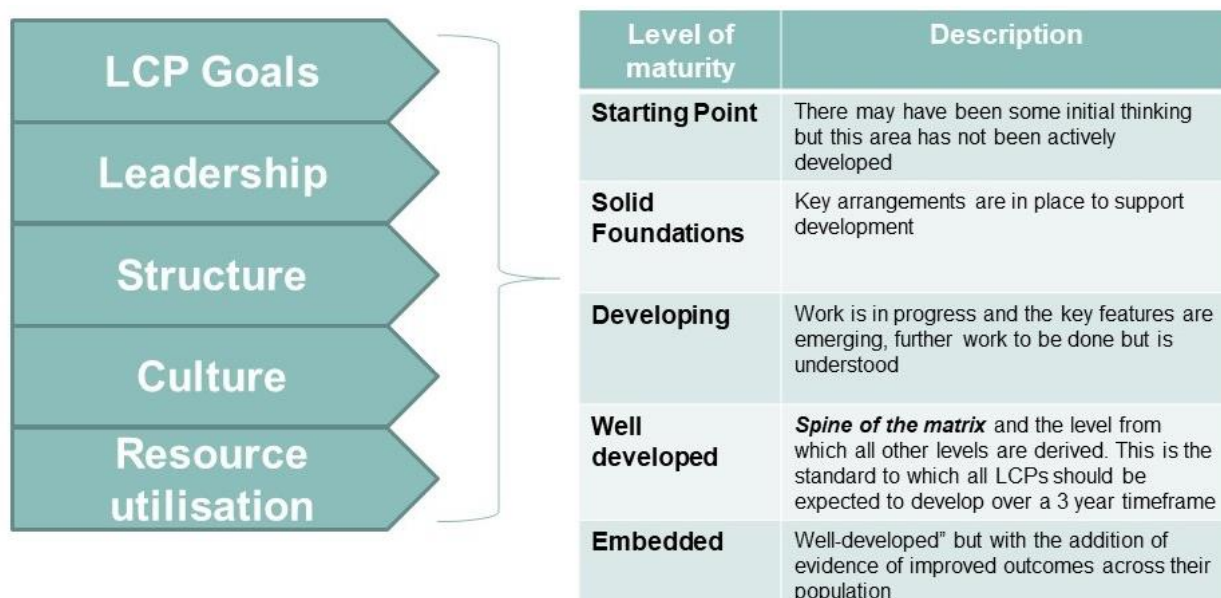
- 3.1 Whilst the term Local Care Partnership is relatively new, the concept of developing multi-disciplinary leadership teams to address health and social care priorities has been in place in parts of Leeds for a number of years. When Leeds operated with three Clinical Commissioning Groups (CCGs), West Leeds CCG supported the development of Community Wellbeing Leadership Teams. These brought together at a neighbourhood level NHS and Social Care managers with GPs, practice nurses and practice managers to form a 'core' leadership team. These local leaders were joined by the Third Sector, Leeds City Council managers from across other directorates and elected member representatives. At the same time GP practices within Harehills, Richmond Hill & Burmantofts and Chapeltown brought together a broad range of partners working in the Chapeltown Neighbourhood Team area to build relationships and foster a culture of one workforce with shared priorities.
- 3.2 These forerunners of Local Care Partnerships helped to strengthen local relationships, build understanding of one another's roles and start to tackle local problems together. They also highlighted some of the challenges of trying to work differently at a local level with multiple services each with their own priorities to deliver. A strategic approach to establishing Local Care Partnerships ensures each partnership is supported to work collaboratively, that issues that cannot be resolved locally can be escalated, and that success can be shared widely so that Local Care Partnerships can learn from one another.
- 3.3 Developing the Local Care Partnership Model. A dedicated programme, funded by the Integrated Care System arrangements for West Yorkshire has been provided for two years (up until 31 January 2021) to accelerate the development of Local Care Partnerships across Leeds. The programme is hosted by Leeds Community Healthcare NHS Trust on behalf of health and care partners across the city. Thea Stein (Chief Executive, Leeds Community Healthcare) is the Senior Responsible Officer (SRO) for Local Care Partnerships. A programme team drawn from the Third Sector, Leeds City Council and NHS organisations is now in place to support local development.
- 3.4 A programme board, chaired by Thea Stein as SRO, provides programme governance. Through the SRO this board reports to the Leeds Health and Care Partnership Executive Group and the Leeds Health and Wellbeing Board. All health and care partners in Leeds are represented at the programme board including the Third Sector through Forum Central and citizen voice through Healthwatch Leeds. Programme board members are tasked with considering

changes needed within their own organisations to enable a systems approach to local working. Organisations are expected to explore collaborative ways of working and sharing of resource where it is identified that this best meets the needs of the local population.

3.5 Success of Local Care Partnerships relies heavily on forging strong relationships and developing a culture which supports new ways of working. There is good international evidence that this sort of way of working has impact and does work but it takes time and determination. In first year of the programme the LCP Development Team have been tasked with:

- Baselining the current position of each Local Care Partnership and identifying development support required.
- Supporting Local Care Partnerships to engage with Population Health Management, working with a cohort of local people living with frailty.
- Supporting each Local Care Partnership to progress a locally identified priority.

3.6 Local Care Partnership Maturity Framework. To support initial benchmarking discussions and to track progress of Local Care Partnerships a Maturity Framework has been developed.



3.7 The maturity framework consists of five key elements that together capture the aspects of an effective Local Care Partnership – goals, leadership, structure, culture and resource utilisation. Leadership describes the way in which local leaders interact and work together to define and deliver on shared goals. Structure describes the extent to which local and citywide services and community groups work effectively at a local level to deliver these goals. Culture is further divided into four aspects – community driven, a strengths based approach, evidence based decision making and a focus on making things better (quality improvement).

- 3.8 Each Local Care Partnership is asked to rate their level of maturity for each area of the framework. The model is flexible and changes over time may not be linear. For example, a Local Care Partnership could have spent a lot of time building local relationships and a strong leadership team so may rate themselves as 'well developed' on this dimension but may have spent less time engaging with the local population so may rate themselves as having 'solid foundations' for Community Driven Culture. Below is an example summary from a Local Care Partnership.



- 3.9 Continuing with the example of the LCP which rated themselves as 'well developed' on leadership, a change of local leaders could mean that they would no longer rate themselves at this level as they need to regroup and establish new relationships. In practice, Local Care Partnerships are at very different stages of development to one another. Some have been meeting in one form or another for a number of years and others have just started to meet.
- 3.10 The maturity framework is designed to be a supportive tool that enables development which is responsive to the local context whilst ensuring an element of consistency of approach. It is currently being introduced to Local Care Partnerships and the development team are employing a number of different methods to identify how to make it useful and practical to local teams in considering their development needs.
- 3.11 Population Health Management. As mentioned in para. 2.9, one of the activities which all Local Care Partnerships are being asked to be part of this year is Population Health Management with a focus on people living with frailty.
- 3.12 Each Local Care Partnership followed an intensive 20 week programme to identify – from local population data – a cohort of individuals to work with that will have the biggest value and achieve the outcome of 'what matters to people'. They then worked together to design an intervention to be tested. This programme brought together a group of individuals from NHS, local authority and Third Sector organisations to form a team. The main aim of the programme was to provide local teams with a mechanism for using data specific to their local population to plan services and interventions that provide proactive support to achieve the agreed outcomes.

- 3.13 Four Local Care Partnerships embarked on this programme as part of wave one at the beginning of 2019. Three of these Local Care Partnerships (Seacroft, Woodsley and Pudsey) focused on what good care co-ordination would look like in a cohort of individuals with moderate levels of frailty. The fourth Local Care Partnership (LS25/26) focused on Advanced Care Planning in a cohort with severe levels of frailty. Interventions are currently underway so it is too early to know the impact of these initiatives for local people. Leeds is acting as a national exemplar for this work. However, early case studies report positive experiences for people who were living with frailty but not actively engaged with health and care services.
- 3.14 Initial benefits of participating in this programme have been identified for Local Care Partnerships. All participants reported that the programme brought them closer together as a local team and helped them understand one another's roles. It also helped them to see the potential of working together as a Local Care Partnership across a range of agendas. Designing new approaches enabled multi-disciplinary teams to think differently about how they used collective resources and who might have appropriate skills. Being able to see how the local population compared to the Leeds average also tested assumptions made by health and care teams. This led to teams focusing on members of the local community that they may not otherwise have targeted through a frailty initiative.
- 3.15 The second wave of Local Care Partnerships started on the Population Health Management programme in October with a focus on areas experiencing higher levels of deprivation in Leeds. These Local Care Partnerships are currently using data to identify a 'cohort' to work with and will then design interventions to test. In recognition of the different demographics and taking learning from wave one, the teams taking part this time include a broader range of Third Sector partners and colleagues from Housing and Community Pharmacy.
- 3.16 A number of Local Care Partnerships in wave two have identified as an important outcome that they want the people identified as the 'cohort' to shape the intervention, testing the role of Local Care Partnerships in truly personalised care planning. This will include a focus on an individual's goals and a commitment to looking at wider determinants of health.
- 3.17 Identification of local priorities. In addition to supporting Local Care Partnerships to engage in Population Health Management, the development team have been asked to support partnerships to work on a locally identified priority. The priority could be support to progress work on a local health or wellbeing priority or it could be something relating to the partnership, such as building a local leadership team.
- 3.18 A number of the Local Care Partnerships have been meeting for some time and have already identified health priorities that they want to focus on together. The development team are working with these partnerships to help them translate priorities into tangible goals that they can work on together.
- 3.19 Other LCPs have been focused on relationship building and understanding the assets that are in their local area. Some of these LCPs are in the October intake to the Population Health Management programme. Activity through the summer and in early Autumn focused on ensuring their leadership teams have the right

members and are organised appropriately to support intensive project activity. The development team are supporting these partnerships to look at governance, membership and exploring a model that they believe will work for all partners.

- 3.20 In addition to the activity outlined above there are a number of Leeds priorities that are being piloted in one or two Local Care Partnership areas. The Local Care Partnership leadership team in these areas provides a forum to discuss these initiatives and ensure that they are appropriately tailored to local need.
- 3.21 Elected member involvement in LCPs. Local elected member involvement is key to achieving the aspiration that Local Care Partnerships maintain a focus on improving health and care which is based in local communities. Elected members' roles in Local Care Partnerships will develop as Local Care Partnerships mature but will include help in shaping and influencing local services to address local needs in addition to city priorities. It is envisaged that elected members may use their wider links and influence to improve the wider determinants of health and wellbeing.
- 3.22 Planned activity around Local Care Partnership development. Recognising that each Local Care Partnership is unique, it is expected that partnerships will develop at different rates. Priority will be given to supporting Local Care Partnerships to establish regular meetings and develop governance structures that enable shared decision making at a local level.
- 3.23 As partnerships identify local goals the development team will support them in ensuring that goals are shaped into actions and that the right representatives are involved. Health and care services are often organised into services for the adult population and services for children and young people. Local Care Partnerships offer an opportunity to work together on the wider determinants of health that impact on the whole family through a Think Family approach. To work effectively on a shared agenda people need time to establish relationships and understand one another's roles. Therefore another important strand of the work over coming months will be establishment of a shared culture.
- 3.24 It is also important that Local Care Partnerships deliver change, starting to do things differently together for the benefit of local people. Population Health Management provides a mechanism to enable this change. Early feedback from the wave one sites indicate that having a shared focus and shared activity to engage in can support the development of relationships and establishment of a shared culture. For this reason a key aspect of the planned activity over the coming six to nine months will be support to this programme.

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

- 4.1.1 There is a long history of working collaboratively together across health and care services in Leeds. The aspiration within Local Care Partnerships is to build a broader partnership encompassing partners that are not directly involved in health and care provision but have an important role to play in supporting the broader

health and wellbeing of the local population. At the same time there is also a desire to ensure that local people are at the heart of planning for local services.

- 4.1.2 There is a lot of good practice that can be built upon to achieve this aspiration but it must also be recognised that some Local Care Partnerships are relatively new and need some time to establish relationships across health and care providers and to understand local priorities. Whether trying to engage new partners, or involving local residents, the Local Care Partnership needs a clear identity and a solid understanding of their role locally. There is a significant amount of work needed from all partners if we are to achieve this goal. However, there is also real enthusiasm to see this become a reality.
- 4.1.3 During Big Leeds Chat week the Local Care Partnership Development team supported a number of Local Care Partnerships to organise their own local 'chat'. Using the same questions as the main Big Leeds Chat event this gave local leaders the opportunity to hear the voices of local people and their opinions on health and wellbeing (see appendix). Some Local Care Partnerships have a Patient Participation Group representative working with them as a member of either the board or a working group (such as the Population Health Management group). Others have organised events in their local area to gather opinions before identifying priorities to work on together.
- 4.1.4 Healthwatch Leeds are a member of the Local Care Partnership Programme Board. The Local Care Partnership development team are linking with Healthwatch and other organisations involved in citizen participation to make sure that Local Care Partnerships can take advantage of existing mechanisms for citizen engagement. They are also considering how to make effective use of communication to ensure that all Leeds residents understand what a Local Care Partnership is and how they can engage with their local partnership.

4.2 Equality and diversity / cohesion and integration

- 4.2.1 Local Care Partnerships offer an opportunity to be locally responsive and ensure that people are supported to manage their health and care needs in a way that is appropriate to them. An integrated approach to both planning and delivery of services offers the opportunity for a holistic response to need.
- 4.2.2 At the same time it is recognised that some minority groups are dispersed across Leeds and that for these groups local planning and delivery of services could result in their needs being overlooked. Where it makes sense for service planning and delivery to operate across a broader footprint this would continue. For support which should be planned and delivered at a local level there are a number of ways to support equitable delivery. Firstly, personalised care planning puts the individual at the heart of their support planning. Secondly, the move to local planning does not negate the need for impact assessments ahead of any major change. Finally, the central development team can support Local Care Partnerships to engage with minority groups. In addition there is the opportunity to roll out good practice across all Local Care Partnerships with one setting a standard and others benefitting from the learning.

4.3 Resources and value for money

- 4.3.1 Resource utilisation is one of the five elements of the LCP maturity framework with an aspiration that partner organisations plan together to remove duplication and identify appropriate resource to meet the needs of the local population.

4.4 Legal Implications, access to information and call In

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

4.5 Risk management

- 4.5.1 To ensure that all citizens of Leeds can benefit from Local Care Partnerships a dedicated programme resource has been employed to support each Local Care Partnership's development. The LCP Programme Board has been established with partner representation from all sectors of the health and care system to provide oversight, manage risks and ensure timely progress. The Local Care Partnership Programme governance structures are linked to the Health and Care Partnership Executive Group and the Health and Wellbeing Board.

5 Conclusions

- 5.1 Whilst Local Care Partnerships have been discussed for a while, they remain a new concept in parts of Leeds. In areas which have a history of partnership working some partnerships are well embedded. However, changes in key local leadership positions mean that others are now re-forming relationships and reviewing priorities. A small development team has been established to work with Local Care Partnerships, assessing the development needs of each and supporting them to take forward priorities.
- 5.2 At the same time the Local Care Partnerships will be supported to broaden their membership so that they can deliver on priorities that benefit people of all ages and they can begin to address some of the wider determinants of health and wellbeing.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Note the work being undertaken to develop Local Care Partnerships.
- Understand that success is dependent on strong relationships fostered through working together on shared priorities with appropriate support to make this happen.
- Support the principle of prioritising time to foster the right culture to make lasting change happen.

7 Background documents

None.

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Implementing the Leeds Health and Wellbeing Strategy 2016-21

How does this help reduce health inequalities in Leeds?

Planning at a very local level helps draw in local knowledge (including the voices of local people) to understand the particular challenges that communities face. Expanding partnerships to include local community groups, housing, employment services and a range of supports that are not always part of health and care planning allows for a broader focus on the issues that impact on an individual's health. Use of a data informed approach such as population health management allows teams to identify where they are outliers and to focus targeted initiatives on tackling these issues.

How does this help create a high quality health and care system?

Local Care Partnerships supports across the whole of the transformation agenda as described in the Leeds Health and Care Plan. Initiatives tested at a local level are measured for impact. Strengthening of local relationships improves awareness of all professionals of one another's services and allows for a more supported transition for those that use multiple services. Local people are seen as partners in their health.

How does this help to have a financially sustainable health and care system?

Third sector are an equal strategic partner and their role is valued. Local Care Partnerships are asked to look at different ways of working and opportunities to use resources differently to achieve positive outcomes for local people. Population Health Management encourages a proactive approach – reaching people earlier and intervening to slow and halt disease progression. A strengths and assets based approach is applied to avoid 'over-provision' of services and unintentional stripping of confidence and independence.

Future challenges or opportunities

It should be recognised that Local Care Partnerships are still in early stages of maturity. Their success is dependent on building of strong relationships and a change in culture but also the building of a shared culture. The ambition for partnerships is that the voice of the citizen is central to the work of the partnership and that everyone working in an area has an understanding of the local community and their strengths and assets. This takes both time and the recognition that many frontline staff are under immense pressure in their day job providing essential services. To meet challenges and achieve this ambition requires all partners to supportively challenge but to balance this with encouragement, enthusiasm and energy.

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	
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

Appendix: Case Study – Local Big Leeds Chat

Morley and District Big Leeds Chat



In the first week of November, the Big Leeds Chat took place in Kirkgate Market. This is an event where leaders from the health and care system spend time chatting to members of the public who are visiting Kirkgate Market. Some Local Care Partnerships took this opportunity to organise a local 'chat'. This provided an opportunity for members of the partnership to engage with the people living in their area to find out what matters most to them about health and wellbeing.

This case study aims to capture the partnership working within the Morley and Districts LCP during their recent delivery of a local 'Big Leeds Chat'.

Background: During the Morley and District Local Care Partnership meeting (09 Oct) members of the Local Care Partnership development team introduced the community engagement initiative led by Healthwatch Leeds to take the Big Leeds Chat into local communities and ask people; what they love about where they live; what they do to keep healthy; what change would they like to see to make Leeds the best place for health and wellbeing.

Objectives: This Local Care Partnership has been spending time building relationships and understanding one another's roles and services but did not have a focused project they were working on together. They were hesitant to embark on a major project as they will be part in a frailty project (as part of the Population Health Management work) early in 2020. The partnership were really enthused about the potential of delivering a local Big Leeds Chat in Morley for two primary reasons: to find out what is important to the local community that the partnership serves; to build working relationships and a sense of identity in preparation for the frailty project.

What happened: In total, 12 partners from the Local Care Partnership (Primary Care, Adult Social Care, Community nursing, Community Pharmacists, GP pharmacist, Third Sector organisations), and two members of the Local Care Partnership Development team took to the streets of Morley alongside friends and colleagues from Healthwatch Leeds (06 Nov 2019). Photo on the previous of the start with more members arriving as the day went on.

Reflections: One of the objectives set by the partnership was to build working relationships and a sense of partnership identity in anticipation of the frailty work. The Local Care Partnership development team (in between having conversations with the people of Morley) saw partners from different organisations mixing, conversing, planning, laughing, joking, hugging (it was a particularly cold day). There was a real buzz about the time spent together, as well as some reflective moments following some sombre conversations with members of the public.

As well as the connections between partners themselves, the afternoon served to forge connections and relationships between the Local Care Partnership development team members and the Morley Local Care Partnership, adding an unintended outcome of the afternoon. This is a great example of "not everything that counts can be counted". We cannot quantify the connections made, but we believe this project will stand members in great stead for 2020. Healthwatch will be supplying the Local Care Partnership with the local 'themes' that came out of the conversations with members of the public in Morley. It is hoped that this will be ready to be delivered to the partnership in January and will form part the partnership's work to make sure they are aware of what matters to the community.

Why it matters: The Big Leeds Chat helped to make the Local Care Partnership leadership team visible to the public. Partners engage with the public within their day job all of the time but this gave people the chance to have a different type of conversation outside of organisational silos. In the early stages of development a Local Care Partnership can be seen as a meeting that happens once a month rather than the mechanism by which we deliver joined up support to meet the needs of local people. Events like this make the connection back to the community and solidify relationships of equity across partners, encouraging everyone within the partnership to voice their opinions and put people at the centre.

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Leeds Health and Wellbeing Board



Report author: Sue Robins

Report of: System Resilience Assurance Board (SRAB)

Report to: Leeds Health and Wellbeing Board

Date: 11 December 2019

Subject: Leeds System Resilience 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 To ensure we continue to deliver quality, safe and responsive services the Leeds system needs to be equipped, prepared and coordinated to respond quickly and appropriately to any change in demand or circumstances. It also requires us to develop a strategy to transform our system for the future and deliver the NHS Long Term Plan.
- 2 As stated in the NHS Long Term Plan, 2019/20 is seen as a transitional year giving us time to work in partnership to begin to shape our local implementation of the NHS Long Term Plan for our population. In Leeds, we continue to build on the progress we have made in previous years and developed an overarching system resilience plan that supports us to navigate the complexities of the unplanned health and care landscape and demonstrate how the system will continue to meet the needs of the population from an operational and strategic perspectives.
- 3 The plan describes the collective system vision, aims, objectives and priorities to achieve improved services and outcomes for our population and highlights the importance of their alignment in delivering real change in line with the Leeds Health and Wellbeing Strategy and Leeds Health and Care Plan.

Recommendations

The Health and Wellbeing Board is asked to:

- Note the positive work across the Leeds system over the last year to improve system resilience.
- Be assured that comprehensive plans for escalation are in place based upon good governance and communication between system partners.

1 Purpose of this report

- 1.1 The purpose of this report is to provide assurance to the Leeds Health and Wellbeing Board that the Leeds health and care system continue to work together to improve the resilience of service delivery.

2 Background

- 2.1 To ensure we continue to deliver quality, safe and responsive services the Leeds system needs to be equipped, prepared and coordinated to respond quickly and appropriately to any change in demand or circumstances. It also requires us to develop a strategy to transform our system for the future and deliver the NHS Long Term Plan.
- 2.2 Each year the system partners work to develop a Leeds System Resilience Plan (previously known as the winter plan). The Leeds System Resilience Plan is governed under the System Resilience Assurance Board (SRAB), which is attended by all senior system partners. It has recently had its terms of reference refreshed and an Operational System Resilience Partnership Board established to oversee all the actions. Attendance at both groups is excellent and there is a high level of interest and energy from all system partners in the resilience and winter planning activity undertaken working together as 'Team Leeds'.
- 2.3 In developing the Leeds System Resilience Plan for 2019/20 (Appendix 1), we undertook a review of last winter in Leeds and found the following:
- Overall the system agreed that we had a much improved winter in 2018/19 compared to 2017/18 with milder weather and low levels of flu presentations.
 - Emergency Care Standard (A&E delivery 4 hour standard) in April 2019 was 4.7% higher when compared to April 2018 despite a 6.4% average increase in attendances.
 - Planned cancellation of all electives resulted in more elective activity overall.
 - At times of pressure high patient acuity, especially respiratory illness, was a considerable factor.
 - Community investment and pathway improvements will support both attendances avoidance and reduce non-elective admissions improving outcomes and experience.
 - Discharge processes and outcomes have seen an improvement, but these can be further developed starting with a review of the Leeds Integrated Discharge Service (LIDS).
 - Our approach to planning, managing pressure and working together supported positive behaviours building on existing relationships across the system. The Operational winter group was a key vehicle in enabling this and in promoting the benefits of system co-operation.
- 2.4 The outputs from the evaluation have been used to inform the system priorities for 2019/20

3 Main issues

- 3.1 The Leeds System Resilience Plan (LSRP) has three components listed below which describe the elements of a well-functioning system which balances strategic ambition with effective operational delivery.
- Planning and priorities 2019/20
 - Escalation and incident management
 - Transformational plans
- 3.2 Within the plan our narrative to describe these components in detail is through a set of collective actions, initiatives and or projects based on the outcomes of our winter evaluation, system diagnostic exercises and our response the NHS long Term plan. We acknowledge that this can only be achieved by working as a system with strong leadership, commitment to support changes in culture and behaviour and an adopting an integrated approach to service delivery with clear jointly owned governance processes.
- 3.3 Urgent and emergency health and care services continue to be at the forefront of the NHS and citywide priorities due to the fall in national performance of the 4 hour Emergency Care Standard and the demands of an ageing population.
- 3.4 As stated in the NHS Long Term Plan, 2019/20 is seen as a transitional year giving us time to work in partnership to begin to shape our local implementation of the long term plan for our population. Our approach to develop an overarching system resilience plan will support us navigate the complexities of the unplanned health and care landscape and demonstrate how the system will continue to meet the needs of the population from operational and strategic perspectives.
- 3.5 In line with the Leeds Health and Wellbeing Strategy and Leeds Health and Care Plan, over the next five years the need for non-elective acute hospital beds will be determined by continuing pressures from an ageing population balanced against achieving a left shift in the provision of care. We will achieve the left shift through implementing a proactive care approach, embedding the 'Home First' philosophy; developing community capacity and ensuring process are in place to achieve effective discharge from hospital.
- 3.6 It is vital that we continue to learn from our operational behaviour and activities to develop our longer term vision and inform our strategic decision making. Leeds has been fortunate to undertake a number of reviews and diagnostics in the last year across our system to support our strategic thinking and identify opportunities for improvement over the next 12-18 months. We have used the outcomes from these exercises and the winter 2018/19 evaluation to refresh the Leeds System Resilience Plan for 2019/20.
- 3.7 The aims of the Leeds System Resilience Plan is to:
- We will provide an equitable and fully integrated urgent and emergency care service for people with physical, mental health or social care needs, across Leeds.

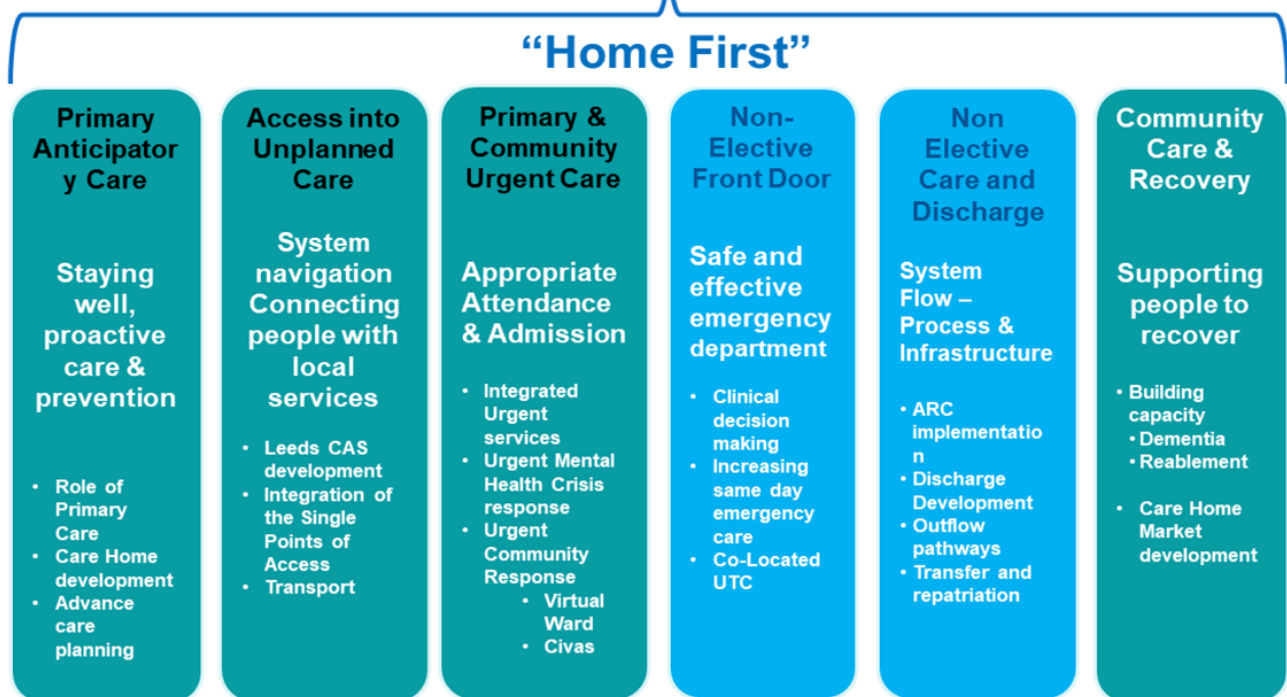
- At every point in the persons' journey we will consider 'home first'.
- We will harness technology so that the people of Leeds only tell their story once and get the best outcome for them.
- We will remove steps that do not add value to the patient or people of Leeds.

3.8 Our priorities for 2019-2021 focuses on the following enabled by predictive system modelling, robust surge & escalation processes, making best use of technology and a well-supported workforce:

- Role of Primary Care in the Urgent Care System
- Connecting people quickly with local services
- Appropriate attendance /admission across the system
- Mental Health Crisis response and Dementia care
- Safe and effective Emergency Department
- System Flow – Process, Infrastructure and capacity

3.9 Our priorities for this winter are:

System Resilience Priority Work Streams 2019-20



3.10 We recognise that strong communication and engagement approach is essential component of delivering the Leeds System Resilience Plan. As part of this, we will continue to work in partnership to run health awareness, signposting and direct action campaigns as below:

- We will engage with local citizens and health and care professionals to develop a significant behaviour and culture change programme. This will be

through a 'Home First' approach, which is about educating and supporting people to leave hospital as soon as they are medically fit as well as proactively supporting people so they get well at home rather than getting admitted to hospital where safe and appropriate to do so.

- Where appropriate, we will also support NHS England and NHS Improvement's 'Where Best Next' campaign targeting acute settings in an effort to reduce long stays
- The 'Looking out for our neighbours' campaign will be running again over winter to get people to look out for those around them (www.ourneighbours.org.uk)
- With over 1600 messages received last winter and regular positive media coverage we'll be running the Big Thank you campaign again (www.bigthankyouleeds.co.uk).
- We have a number of campaigns running that help further and higher education students make the right healthcare choices. This includes No Regrets that promotes safer drinking (www.noregretsleeds.co.uk) and Feel Better that encourages use of pharmacies and NHS 111 (www.feelbetterleeds.org.uk).
- We're currently considering options for a mass mailout to promote NHS 111, pharmacies and extended GP opening hours as well as actions that support the 'left shift' approach.

3.11 Our proactive communications approach includes the following:

- A year round social media calendar with messages adapted to meet seasonal needs (e.g. flu vaccine, summer health advice, etc.).
- Planning ahead for bank holidays with advice issued on social media, through local media and internal communication channels.
- Regular reprint of fridge magnets with advice for parents and carers of children aged 0-5, distributed to health and care settings.
- Promotion of national Help Us Help You campaign.
- Reprint of information leaflets and social media advertising targeting members of the Eastern European community backed up by a dedicated website www.healthinleeds.org.uk.
- Proactive messaging ahead of extreme weather to help people plan ahead, this is often supported by paid for social media advertising
- Providing communication resources and advice for GP practices including a web portal with information resources <https://www.leedscg.nhs.uk/help-us-help-you-comms-resources/>.

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

- 4.1.1 We recognise that strong communication and engagement approach is essential component of delivering the Leeds System Resilience Plan, which is why we have a dedicated communications plan and a citywide winter / system resilience communications group.

4.2 Equality and diversity / cohesion and integration

- 4.2.1 The Leeds System Resilience Plan covers all areas and citizens of Leeds. It strives to deliver cohesive services and demonstrates real organisational and service integration.

4.3 Resources and value for money

- 4.3.1 A robust governance approach for the Leeds System Resilience Plan supports a focus and clarity around the roles and responsibilities of system leaders across our system. This includes clear lines of accountability and an overall system commitment to work in an integrated way to deliver care maximising resources and making best use of the 'Leeds £'. Though the West Yorkshire Integrated Care System (ICS), Leeds will be has been allocated £775.000 to invest in winter initiatives. Priority Projects have been agreed by SRAB in August 2019 and in turn by the ICS Urgent and Emergency Care Board. We are now in the process of working with the projects leads to identify the required resources including workforce. Leeds proposed projects are:

- Social Workers to support the Discharge 2 Assess pathway
- Development of the Community IV antibiotic service
- Expansion of the Primary care advice line function within LTHT
- Community Dementia capacity

- 4.3.2 There will also be a continued focus on new ways of working across organisations to maximise existing investment, capacity and ensure resources are used effectively and efficiently to support the delivery of quality services for our population.

- 4.3.3 Due to the Aligned Incentive Contract (AIC) the CCG and LTHT have agreed a financial envelope based on previous years costs with CCG setting aside a budget for winter pressures. In the event of activity and/or demand significantly above expected levels the health and care system will take joint responsibility and develop mitigation plans. Demand levels will be monitored through the System Resilience Assurance Board and within the CCG and LTHT.

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 The Leeds System Resilience Plan has a risk assessment that is proactively managed through the System Resilience Assurance Board. NHS Leeds CCG holds a risk register, which includes system resilience and is presented at each CCG Quality and Performance Committee and Governing Body through a Governing Body Assurance Framework.

5 Conclusions

- 5.5.1 In conclusion, the Leeds System Resilience Plan seeks to provide a high level of assurance that there is agreed system wide initiatives in place that address both the short and long term priorities within the unplanned health and care services across Leeds. In addition the plan demonstrates that we have clear escalation processes in place for the management of surges and incidents that place additional pressure on our system and the resilience of services. We can also demonstrate clear cross organisation governance arrangements, and a comprehensive communications plan.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Note the positive work across the Leeds system over the last year to improve Leeds system resilience
- Be assured that comprehensive plans for escalation are in place based upon good governance and communication between system partners.

7 Background documents

- 7.1 None.

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How does this help reduce health inequalities in Leeds?

By supporting good access into services for those in urgent need, plus consistent communications to the public to help them make correct choices in accessing services to have their needs met.

How does this help create a high quality health and care system?

Through coordinated service provision and integration across partners.

How does this help to have a financially sustainable health and care system?

People access the right level of service at the right time, be that Primary care, ringing 11 or 99 or presenting at a walk in centre or A&E.

Future challenges or opportunities

The future potential challenges are identified in the risk register (e.g. flu epidemic, severe winter weather, etc.).

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	X
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

Leeds System Resilience

Terms of Reference 2019/21

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 - Highlight / Flash Report

Introduction

The governance relating to the unplanned health and care system has developed over the last 5 years through a combination of national mandates and guidance, continued pressure and unachieved performance targets and the recognition of collaboration and integration to improve services for the people of Leeds. As a result there appears to be a number of meeting forums that have similar agenda with the same attendees.

Due to the publication of the NHS Long Term Plan and the Leeds Plan refresh there was an excellent opportunity for Leeds to review governance and priorities related to the unplanned health and care agenda. A survey gathered the views of representatives, full results of the survey Can be found in appendix 1.

Key findings of the review were:

- There was duplication across the various groups
- A stronger focus on the priorities would result by reducing the number of meetings
- Strong recognition that both a strategic and operational focus is required but that this could be more clearly defined within the Terms of Reference (TOR)
- Representation within the groups needs to be clearer with organisational commitment and accountability.
- The new structure, TOR and priorities need to reflect the whole system pathway

Recommendations were presented to the SRAB for consideration, these included:

- Review the TOR across all groups including purpose, aims, objectives and outputs
- Define clear structure of accountability
- Gain representation commitment from all organisations
- Create a smaller more focussed group for SRAB
- Ensure priorities reflect system inclusivity and focus on the whole pathway e.g community care/999
- Agree new processes for managing the work plan priorities for updating on work streams instead of highlight reports
- Propose new governance structure –June 2019
- Agree system priorities August 2019

System Resilience Governance

This document sets out the approach for implementing robust system resilience governance across the Leeds health and care agenda based on the recommendations.

National guidance dictated in June 2014 the urgent care groups would evolve into System Resilience Groups (SRG) with accountability for System Resilience across the Health and Social Care Economy, these later evolved into the A&E Delivery Boards in 2017. Leeds took the opportunity at this point to create the Leeds System Resilience Assurance Board (SRAB) incorporating the A&E delivery board national mandate. The rationale for this was to maintain a whole system approach from across the health and care economy and recognize the importance all organisations play in the delivery of an effective A&E and system flow.

To ensure we continue to deliver quality, safe and responsive services the Leeds system needs to be equipped, prepared and coordinated to respond quickly and appropriately to any change in demand or circumstances. It also requires us to develop a strategy to transform our system for the future and deliver The NHS Long Term Plan.

Our approach to address the complexities of the landscape is to develop an overarching system resilience plan, detailing the method to our planning; and demonstrates how the system will continue to meet the needs of the population from operational and strategic perspectives.

We acknowledge that this can only be achieved by working as a system with strong leadership, commitment to support changes in culture and behaviour and an integrated approach to service delivery with clear jointly owned governance processes.

System Resilience governance will oversee the Unplanned Health and care system seeking assurance regarding the quality, delivery, improvement and development of all services associated with delivering effective system flow across the Leeds health and care system. Partners from the health and care system will come together to inform the development of the system wide system resilience plan and hold each other to account for the delivery of the elements within the plan that underpin the sustainable provision of services to the population.

System Resilience governance recognises overlaps with other strategies, partnerships, boards and delivery groups. An aim of attached governance structure will be to ensure that there is oversight of any interdependencies to provide system assurance and support where required. System Resilience arrangements do not supersede accountabilities between organisations their respective regulators and or commissioners.

Principles for Joint Working

The focus of the governance is system wide accountability, collaboration and partnership working to ensure we create a culture for change to improve the outcomes for our population.

Across the spectrum of boards and groups all parties have been asked to agree act in accordance with the principles below:

- Act in the best interests of our population
- At all times act in good faith towards each other
- Collaborate and co-operate to work towards delivering a high quality resilient health and care system, including
 - identify solutions,
 - eliminate duplication,
 - mitigate risk and
 - maximise efficiencies
- Hold each other to account of actions to maintain pace and progression
- Act in a timely manner and recognise that some actions and decisions are time-critical and require an immediate response
- Share information, data, experience, materials and skills to learn from each other and develop effective working practices
- Be proactive maintaining a positive outlook
- Recognise the role and contribution of individual organisations with regards system wide delivery
- Work towards delivering the Leeds Health and Well-being Strategy
- Ensure effectiveness, productivity and seek best value for the Leeds Pound

Terms of Reference and Reporting

System Resilience Assurance Board

A monthly report will be provided to SRAB along with the Dashboard to demonstrate progress and highlight risk and issues.

System Resilience Partnership Board

Projects will be reporting on a bi-monthly basis

Steering Groups and Task and Finish Groups

- **Terms of Reference**

To ensure a consistent approach to governance all of the identified projects leads will be required to complete the terms of reference template (page 19) to highlight the following for the group:

- Purpose
- Activities
- Outputs of the group
- Scope
- Membership

- **Reporting**

In addition all project leads will be responsible for submitting a highlight/flash report (Page 20) re progress and escalating any issues and risks. Reporting will be on a bi monthly timetable to the System Resilience Partnership Group for focused discussion and ensure pace and provide a mechanisms to hold each other to account for system delivery and development

- **Metrics**

All projects will be required to develop output measures included SPC charts where appropriate to demonstrate impact.

Meeting and reporting structure/timetable

A full timetable will be established for the following meetings:-

OWG

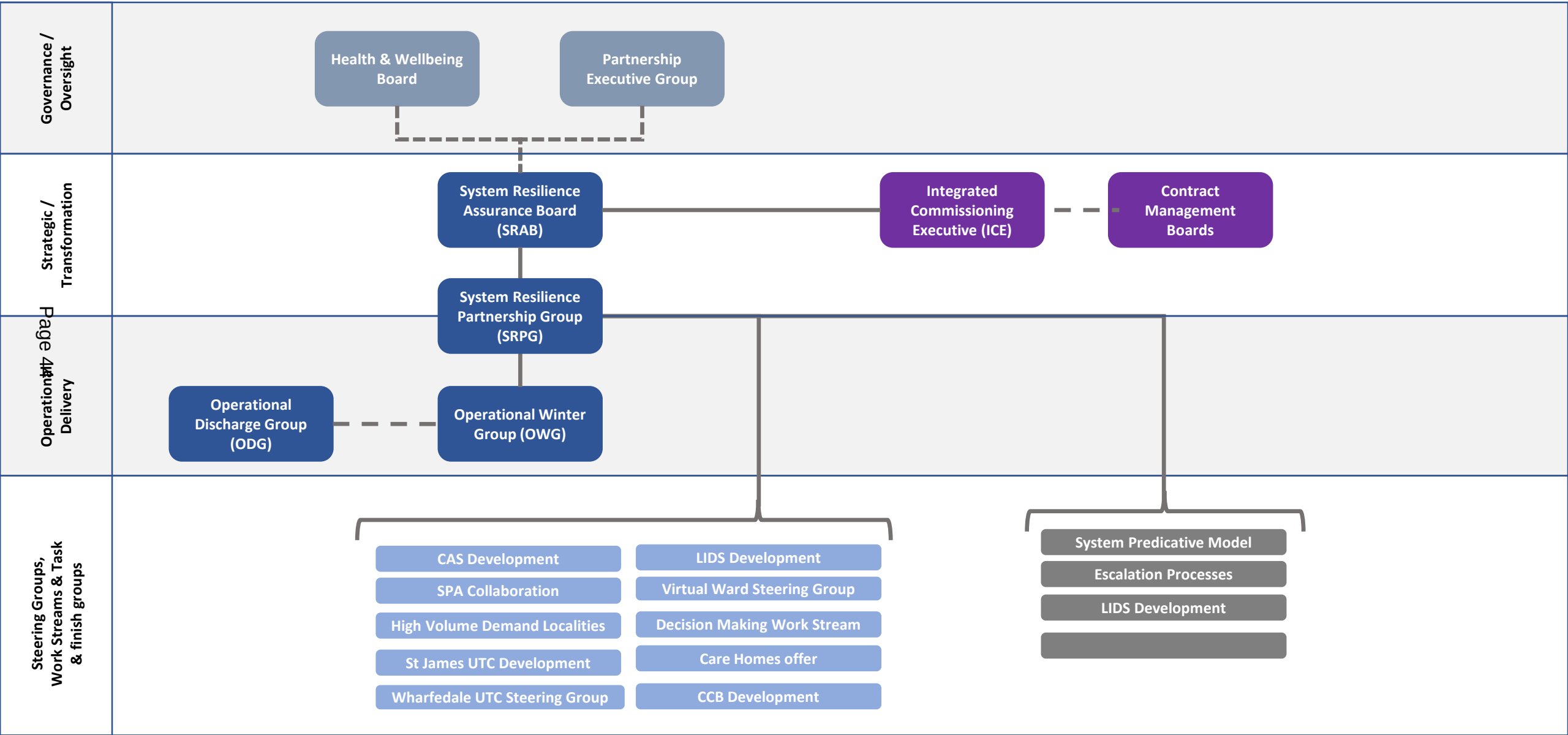
SRPG (ORG)

SRAB

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In addition we will provide bi-monthly reporting timetable.

System Resilience Structure



System Resilience Partnership Group (SRPG)

Purpose

- To deliver system resilience ensuring patient safety, quality of care and experience
- Creating the culture to facilitate system working through strong leadership, collaborative and co-operative partnerships
- To ensure the system delivers key national policy and operational targets/performance
- Members to be the voice of their organisation and ensure dissemination of information
- Identifying service development and service improvement opportunities
- Implement SRAB mandates
- Manage system risks and mitigations
- Monitor projects and task and finish groups across the system to ensure successful delivery holding each other to account
- Place for system escalation to unlock operational/strategic issues
- Oversee interdependencies of effective resilience and system flow
- Produce & monitor the SRAB dashboard

Membership

- System Partner Senior Executives:
- CCG – Chair
 - LTHT
 - NHSE
 - LYPFT
 - Health Watch
 - LCD
 - OPCare
 - LCC – Deputy Chair
 - Public Health
 - LCH
 - YAS
 - 3rd Sector
 - GP Confederation

Activities

- Maintain an overview of the operational and strategic system delivery through monthly reporting and deep dives
- Adopt a working/task and finish group approach ensure effective use of the meeting and deliver targeted solutions
- Working collaboratively across the Health and Care System, to support the system wide approach to the delivery of all local and national targets (e.g. ECS)
- Unblock any issues, monitor outcomes and suggest improvements on reported projects
- Make recommendations to SRAB on areas of future developments to support system resilience
- Implement, manage and monitor escalation processes, actions and outcomes to ensure effective system management at times of surge and or incidents.
- Sharing best practice and learning from both local and national experiences.
- Interrogate the data to inform decision making

Interdependencies

- System wide participation
- Monthly reporting of flash reports and deep dives
- SRPG Task & Finish Group activity
- Effective management of the Operational Winter group
- System wide strategies
- NHSE/I requirements

Quoracy & Administration

- All partners to be represented
- Supported and chaired by CCG Unplanned Care Team
- Agenda item call 2 weeks prior to meeting
- Agenda to be circulated 1 week before meetings

Outputs

- Strategic and operational system management as set out in the System Resilience Plan
- Managed projects with robust reporting and monitoring of improvement
- Environment with strong accountability for delivery of the system
- Identifying blockages, barriers, issues and risks to delivery of the System Resilience plan
- Promotion of system openness and transparency
- Bi-monthly reports to SRAB, providing recommendations, issues and risks.

Accountability & Reporting

- Report to the Leeds System Resilience Assurance Board
- Provide monthly highlight reports to SRAB on task and finish groups and system projects
- System Accountability to deliver the System Resilience Plan
- Ensure links to the Emergency Planning forums for Leeds.

Meeting Frequency

Monthly

Approval & Review

dd/mm/yyyy & dd/mm/yyyy

Operational Winter Group (OWG)

Purpose	Activities	Outputs
- Facilitate system working through strong leadership, collaborative and co-operative partnerships - Ensure the operational delivery of resilient services across Leeds, to maintain effective System flow and promote patient safety and quality of care - Seek solutions to barriers effecting system flow - Plan for future seasonal pressures across health and care economy - Ensure an effective response to seasonal pressures though the OPEL, EPRR and mutual aid - Ensure clear system level communication	- Hold an overview of operational system delivery - Develop year round capacity/demand model - Share and assess recent operational challenges (7-14 days) - Collate demand forecasts (7-21 days) and longer predictive analysis to allow the implementation of collective solutions - Identify blockages for system delivery, acting as a point of escalation for operational teams - Seek practical solutions to operational challenges - Agree and implement actions to mitigate predicted peaks in demand - Provide a local Winter Room function aligned to NHS England Improvement - co-ordinating, monitoring and reporting performance and pressures - Agree operational communications messages - Provide a narrative for NHSE/I during national winter reporting period	- Escalate recommendations to SRPG - Provide a summary of recent operation performance - Agree system activity to mitigate pressures - Provide assurance of future system resilience for coming weeks - Share situational awareness of ongoing organisational priorities - Provide feedback to the system of identified pressures - Provide consistent messages at times of escalation and pressure - Co-ordinated response to the NHSE/I
Membership	Interdependencies	Accountability & Reporting
Operational Managers form across System partners: - Age UK - CCG (Unplanned Care and Neighbourhood Commissioning) - LCC (Commissioning and Adult Social Care) - LCD - LCH - LTHT - LYPFT - GP Confed - OPC (OMG) - YAS All representatives to act as a point of contact within their respective organisations for all actions and updates to the group.	- System wide support and participate required - Task & Finish Group activity from SRPG (ORG) undertaking short-medium term projects	Monthly reporting to SRPG (ORG) - Highlight any predicted increases in demand and planned mitigations - Escalate any matters/barriers that require a higher level of decision making
	Quoracy & Administration	Meeting Frequency
	CCG Commissioner & Relevant Provider Representatives	Apr-Sept Bi-weekly Oct-Mar - Weekly
		Approval & Review
		30/07/2019 (proposed content v2) & 01/06/2020

Leeds Clinical Assessment Service Steering Group

Purpose

- Develop a Local Clinical Assessment service for the Leeds Health and Care System CAS
- Monitor progress , impact and benefits
- Use the learning to inform future development
- Deliver integration across the system e.g. 111/999/LCD/PC
- Contribute to the National 50% clinical assessment target
- Contribute to the national 40% direct booking targets

Activities

- To discuss delivery and performance of the current service
- To test new approaches to build upon the pilot
- To evaluate all approaches
- To make links with relevant services
- Continue to test and develop the Leeds
- Engagement with local providers

Outputs

- Phase 2 evaluation report
- Monthly monitoring of the service
- Mini evaluations of new approaches built into the service
- Agreement of Phase 3 scope
- Evidence based future commissioning plans
- Proof of concept
- System benefits realisation

Accountability & Reporting

- Monthly. TBD once scope of Phase 2 agreed
- System Resilience Partnership Group/SRAB

Interdependencies

Clinical advice target
Direct booking target
'Talk before you walk'
NHS 10 Year Plan
LCD infrastructure
Leeds Digital Strategy

Administration

Meeting frequency- Monthly
Approval date
Review date
Quoracy –

Membership

- Representation from:
- CCG: unplanned care commissioner, finance rep, contracting rep, business intelligence rep, quality rep, health evaluation rep
- LCD
- GP Confederation
- Directory of Services
- NHS 111
- Membership to be expanded as project develops

Project scope

Escalation Task & Finish Group

Overall RAG
Project implementation

Objectives To continue to develop escalation processes, improving the use of OPEL reporting , further reviewing mutual aid and maximising use of UEC-Raidr application

Start date End Date

21/05/19 03/10/19

Milestones	Planned completion date	Actual completion date	Current Progress, Status or Comments	RAG Green = On track Amber = Behind schedule Red = Not progressing
Identify appropriate group membership	06/06/19	tbc	21/05/19 All provider organisations asked to identify suitable representative – follow-up conversation required for LTHT, LYPFT and LCH re membership and objectives	
Agree group objectives & frequency	27/06/19	tbc	07/06/19 Objectives agreed - review OPEL reports, consider mutual aid and look to maximise use of UEC-Raidr. Proposed to extend future OWG to accommodate future meetings	
Evaluate current OPEL processes	25/07/19	tbc	07/06/19 YAS, OMG, LCD and CCG asked to consider existing reports and how these could better inform the system of pressures	
Review and agree mutual aid	22/08/19	tbc		
Hold UEC-Raidr feedback/workshop	19/09/19	tbc		
Create system guidance / policy	03/10/19	tbc		
Create plan for development of UEC-Raidr application	03/10/19	tbc		

Risk to Objective / Issues	Recommended Action / Control	Progress	Impact 1 = Insignificant 2 = Minor 3 = Moderate 4 = Major 5 = Catastrophic	Probability 1 = Rare 2 = Unlikely 3 = Possible 4 = Likely 5 = Almost certain	Status Impact x Probability Green = 1-5 Amber = 6-15 Red = 15+
Limitations of current UEC-Raidr application	Early and continuous engagement with NECS regarding potential requirements	10/06/19 NECS included in T&F group membership and separate weekly calls also taking place	2	1	
Inclusion and availability of all group members and data to fulfil commitments of group	Activity intentionally linked to current system operating procedures so as to minimise additional task Support of OWG/SRPG representatives expertise and knowledge	10/06/19 Group membership sought based on most appropriate personnel Contribution of PC and ASC still to be agreed as neither currently provide OPEL data	4	3	

Work Stream Title

Overall RAG
Project Impact



Up Coming Items of note

- NECS planning to facilitate a workshop for system partners specifically on UEC-Raidr application

Key accomplishments

- Weekly calls re-established with NECS
- First meeting held to discuss proposed objectives held at WIRA 07/06/19 – positive engagement from those present

Metrics – demonstrating Impact

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EXAMPLE

Impact contribution

What system metric the projects contribute too achieving

Templates

The following 3 slides are templates

Terms Of Reference – Meeting / Steering Group

Purpose	Activities	Outputs
		Accountability & Reporting
Membership	Project scope	Interdependencies
		Administration
		Meeting frequency- Approval date Review date Quoracy –

Work Stream / Task & Finish Group Title

Overall RAG project implementation

Project Aim/s	What are you trying to achieve	Start date	End Date

Milestones	Planned completion date	Actual completion date	Current Progress, Status or Comments	RAG Green = On track Amber = Behind schedule Red = Not progressing
1. Project milstones	dd/mm/yy	dd/mm/yy	Date last updated	
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Risks (R) and Issues (I)		Recommended Action / Control	Progress	Impact 1 = Insignificant 2 = Minor 3 = Moderate 4 = Major 5 = Catastrophic	Probability 1 = Rare 2 = Unlikely 3 = Possible 4 = Likely 5 Almost certain	Status Impact x Probability Green = 1-5 Amber = 6-15 Red = 15+
R						

Work Stream Title

Overall RAG
Project Impact



Up Coming Items of note

Key accomplishments

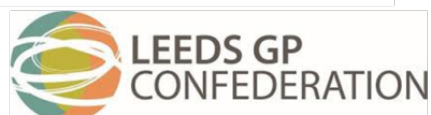
Metrics- demonstrating Impact

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Impact contribution

What system metric the projects contribute too achieving

Leeds System Resilience Winter 2018-19 Evaluation



Document Maintenance

Title	Winter 2018/2019 Review
Author	NHS Leeds CCG – Unplanned Care
Version / Date	1.0 14/05/2019 – Initial draft 2.0 28/05/2019 – draft 3.0 18/06/2019 – inclusion of ECS performance 4.0 27/08/2019 – final

Acknowledgements

This report has been informed by feedback from across the Leeds Health and Care system, and the regional NHSE Winter Review.

All system partners in Leeds should be thanked for their support shown to one another throughout winter, during which positive and productive time was spent in the Operational Winter Group and other forums to contribute to the management of winter pressures.

1. Introduction

Seasonal variations on demand occur year round in many sectors and winter is widely regarded as the time of the most sustained and significant pressure on health and care systems; nationally A&E attendance numbers increase, seasonal infections such as flu are more common, and colder weather can make specific population groups more vulnerable to serious illness.

Consequently each year, every health and care provider, and system formulates plans to better manage this demand, with the aim to make improvements year on year.

This report provides a outcomes of the evaluation of winter planning, performance within in the Leeds Health and Care System 2018/2019.

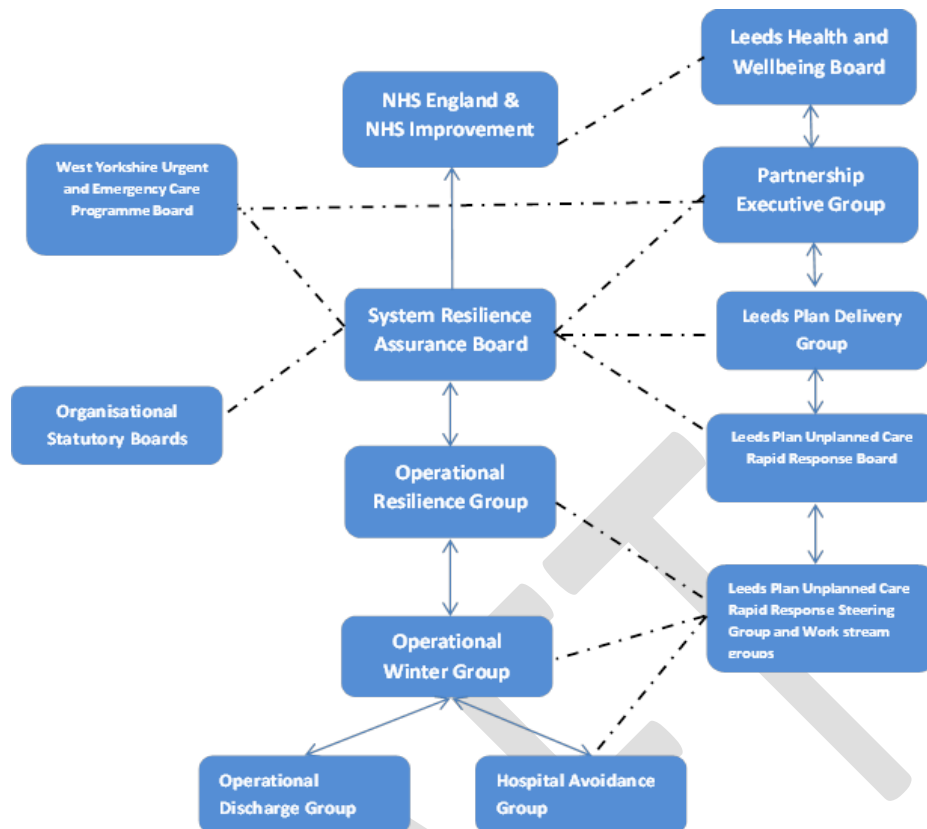
The report reflects on the experiences of last winter, the governance, what worked well and areas for further development.

The Leeds system includes a range of providers and commissioners across health and social care. For the context of this report experiences from those provider-organisations directly involved in the system resilience governance and operational delivery groups have been included, however it is acknowledged that many more specific individuals, providers and organisations in the city continue to work towards Leeds's shared health and care values. Specific contributors to this review include:

- One Primary Care (One Medical Group)
- Leeds and York Partnership NHS Foundation Trust
- Leeds GP Confederation
- Leeds City Council
- Leeds Community Healthcare NHS Trust
- The Leeds Teaching Hospitals NHS Trust
- Age UK (Leeds)
- Local Care Direct
- Yorkshire Ambulance Service NHS Trust
- Leeds Clinical Commissioning Group
- NHSE England – Yorkshire and the Humber

2. Governance Structure 2018/19

The following diagram shows the governance structure supporting the system resilience agenda in Leeds. This has subsequently been reviewed as it was felt that there was considerable duplication which it was felt lead to confusion and a lack of focus. The new governance structure in can be found in Appendix X. of the System Resilience Plan 2019/20.



2.1 Operational Winter Group

It is important to refer to the Operational Winter Group (OWG) and its importance in managing relationships over the winter.

Starting in October 2018, the OWG was a new element within the governance structure. Meeting weekly the remit of this group was to review recent past activity, consider future demand, surges & challenges and agree and enact action across the system in response.

Representatives of the OWG under the system resilience governance structure were drawn from across the system to:

- Promote successful collaboration, communication, and partnership working across the health and care system in Leeds by:
 - Recognising each other's challenges and constraints
 - Recognising system interdependencies and opportunities
 - Promote system openness and transparency
 - Creating a culture of supportiveness and a *no blame* culture
 - Communicating weekly with the system, successes, impact, difficulties etc. through 3 key messages.
- Provide focused management for the delivery of resilient services, across the Leeds health and care system with an agreed time period through:
 - Driving the identified system culture and behaviour change

- Using data to drive decision making
- Identifying themes, developments and improvements
- Identifying predicted pressures and system blockers
- Developing and implementing system wide management tools
- Considering and recognising the consequences, including any unintended consequences
- Seeking solutions to address and deliver the opportunities and unblock barriers
- Developing the capability for the system recovery
- Take an overview of the management of system risk aligned to the system decision management tool to make recommendations to SRAB when required.
- Report to Operational Resilience Group:
 - Areas for improvement and opportunity
 - System impact
 - Escalate barriers, issues and risks
 - Identify future developments to support the system from both an operational and strategic perspectives.

3. System Winter 2018/19 Planning

The principles of the Leeds Resilience Plan are clear with high-quality and patient safety paramount. Through robust planning and collaboration the planned winter 2018/19 interventions below supported improved system delivery and improved outcomes for people.

- Weekly operational system meeting with senior managers sharing timely data - the impact of this weekly senior meeting is felt to have been significant.
- Operational Discharge Group at LTHT meeting 3 times a week to manage individual patients
- Sign off and implementation of the Transfer of Care policy.
- Planned opening of additional capacity/ beds within LTHT
- Flu, *point of care testing* in A&E to support management of diagnosed patients
- Discharge Transport booking times extended
- Community Care Bed flexibility in terms of criteria, times and quality of admissions
- Care home manager invited into the hospital to maximise use of beds in care homes, previously difficult to fill.
- Recruiting Trusted Assessor for the Care Home market
- Additional social workers to support additional winter beds (community and acute) to support maintained flow
- Urgent Treatment Centre (UTC) designation at St George's Middleton expanding capacity and providing direct bookable appointments from NHS111

- 100% population coverage for GP extended access
- Age UK collect and deliver medicines to further support patient discharge
- Additional staff deployed to meet increased demand at the Walk-in-Centre
- Enhanced streaming within the LGI GP streaming service in A&E to increase flow through the service
- Community services continue to support increases in referrals in additional pathways including respiratory, CIVAS and stroke
- Leeds hospices undertaking in reach to LTHT
- System wide mutual aid actions agreed and signed off
- Improved system relationships and understanding of services
- Weekly update to the system with a focus on front line staff to ensure good communication and provide feedback

3.1 NHS England Exception Reporting

To ensure a national view of performance regional winter rooms have been in operation 7 days a week to gather information from systems. The Leeds system had robust processes in place to ensure that we complied with the requirements of exception reporting 7 days a week during the reporting periods. Reporting 2018/19 consisted of the following elements:

1. NHS England's weekly call for systems to report their performance, pressures and recovery/supporting actions, CCGs represent their system. To ensure we are able to provide timely information, the Operational Winter Group discusses each week the local pressures and actions taken to provide an overview which is further informed by a call immediately prior to the NHS call between LTHT and the CCG, with other partners included by exception.
2. Relates to assurance reporting to NHSE by way of a daily assurance return, should one of five trigger criteria be met. On days when a specific trigger is met, ongoing actions within the acute hospital are shared by the A/DOP for escalations (that day) or the on call general manager (weekends and bank holidays). The CCG is responsible for collating and submitting the assurance return detailing the steps taken both short and long term by the system to recover the position and support performance improvement and recovery, either via the unplanned Care Team or the CCG on call manager (weekends and bank holidays).

There are triggers in place that necessitate exception reporting each day from October to March and on all bank holidays:

- A&E standard at or below 80% or a deterioration of more than 10% from the previous day,
- Any 12 hour trolley breaches,

- More than 5 Ambulance delays greater than 60 minutes,
- Increase in beds closed due to D&V by 20 beds from one day to the next,
- Other significant event e.g. disruption due to a catastrophic event or loss of infrastructure where the flow of ED is disrupted, major patient safety issues, developing situations where national briefing and preparedness would be of help to the system

4. Performance

4.1 Key issues from Yorkshire & Humber Region

Understanding the wider system/regional position helps us bench mark our position and provides the opportunity for us to learn from good practice of other systems. NHS England conducted a *mini* winter review using feedback from individual systems and observations through the winter reporting period.

The following regional themes were identified:

- Milder weather than 2017/2018 reducing the impact of travel disruption and school closures on Leeds staff, as well as potentially reduced minor injuries and cold-weather related illness presentations
- Seasonal Flu and D&V not above expected levels – and also much reduced from last year.
- Ambulance conveyance to/from care homes has not been reported as a pressure of this winter
- Some systems have experienced handover delays, although not significantly so in Leeds
- High patient acuity, especially respiratory disease been a feature throughout winter and this has been evident in A&E presentations at times of pressure
- A&E attendances are reported up year on year, although Leeds noted no increase in admission conversion rates

4.2 Leeds Health and Care System

Our improved position over winter has been attributed to:

- improved operational response
- predictive bed modelling
- planned reduction in elective operations resulting in less cancellations but overall a greater number of operations than in previous years)
- a milder weather (reducing the risk to vulnerable populations groups)
- lower number of people suffering from flu

Nationally, the Emergency Care Standard is used as a key metric of establishing the performance of a health and care system. Since November 2018, a month on month trend of improvement has been reported in the ECS when compared to equivalent months last year – notably March this year was 18.52% up on 2018.

In 2018/2019, 8,554 additional attendances were reported when compared to 2017/2018, representing an increase of 3.58% (and above the 2% anticipated growth in Leeds).

Following winter, and specifically in April 2019, the ECS was 4.7% improved on April 2018, whilst a 6.4% increase in attendances was reported in the same period (an additional 1237 patient).

Exception reporting in Leeds and weekly regional conference calls described consistent themes and challenges throughout the winter months:

- Patient acuity frequently combined with respiratory issues
- Surges in attendances in the evenings and at weekends
- High paediatric presentation numbers were a national trend

By November A&E attendances started to increase with notably high weekend demand. This was also seen in the Walk in Centre where weekend attendances often approached 200. Nationally paediatric attendances were high and this was also the case in Leeds. As a major trauma centre the demand for critical care capacity remained pressured over winter.

In January, the flow through community care beds was at its highest resulting in a lower than expected bed occupancy level allowing widening of the acceptance criteria. However, this increased flow into the beds did highlight challenges in the current discharge processes between the homes and the hospital.

National changes to NHS pathways and 111 algorithms posed a significant challenge to the Out of hours GP service, with a marked increase in people requiring contact within 1 hour. The Leeds Clinical Assessment Service pilot supported this increase for Leeds maximising GP extended access appointments. As in previous years bank holidays saw the greatest reported pressure in these services.

St Georges became a designated Urgent Treatment Centre (UTC) in December 2018. Activity naturally increased at the Centre due to the additional minor illness service offer, as well as the traditional minor injury and GP Out of Hours service. The GP Out of Hours service saw a marked increase in activity which still remains a challenge to service delivery due to the national introduction of an additional disposition code for the NHS 111 service which specifies patients need to 'speak to' a GP within 1 hour.

Neighbourhood teams operated consistently over the winter and managed spikes in demand through their own internal business continuity plans. There were many

discussions regarding attendance/admission avoidance opportunities within our community services and it was agreed that this will be a priority for 2019/20.

Mental health services proved a challenging area for Leeds with high bed occupancy rates leading to high levels of out of area placements. These were at their highest at the beginning and then at the end of the winter period.

4.3 Escalations

In previous winters, sitrep calls were held daily. During this winter, on only 3 occasions was it deemed necessary to call a system-wide Sitrep call – on occasion subsequent pre-arranged calls were held to update on outstanding agreed actions. These calls were as a result of significant pressure within LTHT. All partners' participated and discussions lead to a number of solutions including:

- An offer to increase the capacity of the co-located streaming GP in A&E) if required
- All care home providers asked to accept admissions beyond 5pm
- Patients close to existing referral criteria to be identified for case by case review with a view to enable discharge
- Comms message to general practice, promoting the use of PCAL and sharing awareness of acute pressure in the hospitals
- CCB providers were asked to accept patients later in the day, as well as working with a wider inclusion criteria
- In reach by Neighbourhood Teams to also focus on patients identified suitable for discharge into their service.
- LCD staff, including care navigators, were to monitor demand from elderly patients and any others recent discharged to support avoiding re-admission
- SPUR staff were asked to escalate any referrals to the Ops Centre

All additional new actions were monitored and where beneficial will be included into a revised mutual aid suite.

Feedback from all partners stated that the OWG was a more effective way of managing escalations, and had improved relationships across the system.

4.4 Communications

Our proactive approach to internal and external communications resulted in the following:

- Sustained positive media coverage including a week long double-page feature in the Yorkshire Evening Post running from Saturday to Friday during the first week of December as well as regular press coverage of a range of our activities and campaigns designed to respond to system pressures

- Regular updates shared internally reflecting work of the OWG and sharing details of services that could help staff such as reablement (SkILS) and Home Plus (Leeds)
- Two effectively evaluated campaigns that avoided the '*don't come to A&E*' message that has typified recent approaches. *The Big Thank You* saw over 1600 messages posted and support from a range of citywide partners. The *Looking out for Our Neighbours* campaign has seen 3 in 4 people engaged with the campaign doing something new to help one of their neighbours. Both campaigns received regular media coverage
- Regular briefings were shared with Cllr Charlwood and other elected members as appropriate
- Proactive social media advertising ahead of extreme weather events and bank holiday periods
- A resource page was set up for primary care colleagues and shared with third sector partners as well, including social media plans, posters, leaflets and other resources to help people prepare for winter and beyond
- A joined up approach that ensured consistent messages around prevention including the *flu jab*, *Winter Friends* programme and *Keeping warm, Keeping well* as well as series of films produced by Leeds TV

5. System Evaluation process

The NHS England regional team (Yorkshire and the Humber) created a written review based upon findings from a questionnaire to local systems along with the outcomes of regional focused exception reporting. This approach provided a mechanism to share examples of '*what worked well*' across systems.

The Leeds system conducted a workshop; this provided all organisations the opportunity to share their challenges to inform system wide future planning. All organisations presented '*what worked well*' for them and the system from their perspective, along with '*lessons learned*' and suggested '*priorities for winter 19/20*'. Hearing about each other organisation's challenges proved invaluable to all partners and positively supported the strengthening of relationships across the system.

Subsequent exercises were focussed on themes from these presentations and informed a local evaluation and action plan that a number of task and finish groups are to progress in preparation and readiness of next winter.

5.1 What Worked Well

From the presentations it was clear that the foundations for improvement are well established;

- Relationships between operational leads are in place so as to facilitate cross-organisational discussions

- Those individuals routinely demonstrate positive behaviours including an understanding and acceptance of each other's challenges and limitations
- There was good accountability for actions taken during times of escalation
- Transparency in terms of data sharing and any specific limitations was evident
- The Operational Winter Group was thought to be a positive and improved model for regular management of system activity over winter
- A deeper mutual understanding of services helped to dispel myths regarding service provision and operating procedures

A key point of this winter was the improved use of data. LTHT created a demand and capacity model to inform their own operational plans but this proved to be a useful tool to timeline opportunities for system interventions.

System mutual aid, in terms of reactive system sitrep calls was significantly reduced this year, with opportunities for proactive solutions at the forefront of discussions.

Significant performance milestones were achieved this winter;

- No patients have been cared for in non-designated areas (NDA) throughout winter (and in actuality since May 2018)
- A&E performance, in terms of the Emergency Care Standard was improved
- Despite reducing the number of planned elective operations over winter, more operations were undertaken overall. There was also a reduction in the number of days when all operations had to be cancelled
- Patient flow into and out of the Community Care Beds was markedly improved, allowing for a broader use across more patient cohorts

5.2 Areas for Further Development in 2018/19

A number of areas offering potential opportunities for improvement have been highlighted:

- Continue to develop improved discharge process to reduce the numbers of patients in surge beds
- Dementia (complex) bed capacity in the independent sector resulting in delays in discharge for people with dementia and complex needs in both in both LYPFT and LTHT
- Maximise Transfer / discharge to assess pathway
- Increase referral rates to community services – Neighbourhood Teams and Reablement
- Improved access and capability of the Leeds Care Record (allowing more health professionals 'write' privileges)
- Development of local DoS to better inform operational staff of available services and operating hours

- A focus on pathway development crossing organisations and specifically on the interfaces between organisations to improve patient flow
- A greater adoption of a shared education and culture by further embedding '*Home First*' and the consideration of sharing staff training programs (across organisations)
- Review of Leeds Integrated Discharge service (LIDs)
- Maximise the Community Care Beds to reduce reliance of the surge wards in LTHT
- Greater participation of Primary Care (including Pharmacy) and wider 3rd Sector inclusion across system meetings. Initial progress has been made this year with the direct inclusion of LCC Housing in discharge discussions
- Continued improved data use, such as a system-wide data planning tool and the UEC-Raidr tool

5.3 Winter Evaluation Actions

The outcomes of the evaluation session below have been progressed in preparation for winter 19/20.

Review current escalation processes – test plans
Develop proactive year round modelling / planning (capacity demand and staffing)
Dementia capacity in the community
Evaluate LIDs service
Review discharge pathways/processes into Community Care Beds
Identify hot spots for urgent care activity across the city

The outputs from these actions will be used to inform the system priorities for 2019/20 forming part of the LSRP 2019/20.

In addition to the system wide review, all partners are in the process of conducting internal organisational winter reviews to identify areas of learning and evidence key actions for 2019/20. Each organisation including the CCG has clear internal governance processes for the sign off of their individual winter plans.

Milder weather reduced the impact of disruption to staff, and potentially cold weather related presentations within urgent care settings. That said, at times of pressure,.

6. Conclusion

Overall the system agreed that we had a much improved winter in 2018/19 compared to 2017/18 with milder weather and low levels of flu presentations. ECS in April 2019 was 4.7% higher when compared to April 2018 despite a 6.4% average increase in attendances and the planned cancellation of all electives resulted in more elective activity overall.

At times of pressure high patient acuity especially respiratory illness was a considerable factor. Community investment and pathway improvements to support both avoidable attendances and reduce non-elective admissions would improve outcomes and experience.

Discharge processes and outcomes have seen an improvement but these can be further developed starting with a review of the LIDS team.

Our approach to planning, managing pressure and working together supported positive behaviours building on existing relationships across the system. The OWG was a key vehicle in enabling this and in promoting the benefits of system co-operation.

Winter resilience 2018-2019 communications plan DRAFT V.2

1. Introduction

The NHS is under considerable pressure across all areas. However this pressure is keenly felt within urgent and emergency care services throughout the year with a significant rise in activity expected over the winter months. Data shows that the 'winter pressures' experienced by urgent and emergency care units is a year round issue with spikes experienced throughout any given year however the media tends to highlight activity during the winter period. This results in further pressure on system partners from a range of stakeholders. Winter 2017-2018 saw exceptional pressures experienced by the whole health and care system and this year is expected to be just as tough, if not tougher. This communications plan, which is to be regularly updated, has been designed to show how system partners can provide mutual support and clear messages throughout the winter to provide reassurance to the public while also recognising the hard work of all those working to support local citizens.

To combat this the Leeds health and care system has robust operational plans in place to deal with increased demand. Evidence suggests that some of the pressure on the system could be reduced by patients making appropriate use of all services available to them should they fall ill or get injured. "While A&E is the right place for many of these patients, estimates quantifying the size of non-urgent A&E demand (patients who could be better treated elsewhere) vary from 20% to 40% of all attendances", (source: Department of Health). In addition it is recognised that the pressures on the system from delayed discharges, due to a number of reasons including patient choice, has a significant impact on performance (King's Fund, 2018).

In Leeds we are now working together to see how all system partners can support communication activity that encourages people to self-care where appropriate, use alternatives to A&E and look out for vulnerable neighbours. We are following the principles of the national 'Help us help you' campaign with communication messages and activities based around preparedness, prevention and performance and the idea of developing a reciprocal relationship with people.

We also need to recognise and ensure we acknowledge the hard work that all health and care professionals, community and voluntary groups and carers/unpaid carers do. This is reflected in our planned activity for this winter and beyond. As a system we recognise the issues we are faced with are not unique to Leeds therefore we will support and share regional and national communication resources.

2. Aims of the plan

The overarching aim of the plan is to demonstrate how the system is gearing up for winter, what we'll deliver, what our actions will be, recognising the efforts of all those supporting local citizens and maintaining confidence in services.

More specifically the plan will aim:

- To demonstrate how Leeds has prepared for winter, continue to provide assurance that we are doing all we can despite the pressures faced
- To raise awareness of how local citizens can access the most appropriate services to keep themselves or their loved ones well
- To encourage people to do all they can to stay well such as having their flu jab, self care at home, completing courses of antibiotics, looking out for vulnerable neighbours etc.
- To maintain staff morale and encourage greater recognition of their efforts

3. Key messages

With such a broad range of audiences the key messages need to be tailored accordingly depending on who we are communicating to, how we are communicating with them and what we expect them to think or do differently. The overarching key messages are below however these have been further broken down by audience profile.

- At the first signs of illness speak to your local pharmacist
- GPs are now open longer so if it is an illness that won't go away, arrange an appointment with your GP including evenings or weekends
- 'Talk before you walk' – ring NHS 111 if you feel unwell but don't think it's an emergency
- Keep an eye out for vulnerable neighbours / be a winter friend
- Take preventative action such as getting the flu jab, wearing appropriate clothing, taking medication / ordering enough medication to cover holiday, preparing for spells of cold and/or icy weather and having a well stocked medicines cabinet

The key messages should look to address one of the following areas of advice:

- Prevention – to reduce the risks of falling ill in the first instance or to support others to stay well (eg be a winter hero or a winter friend if you're a frontline worker/actively engaged community volunteer)
- Self care – to be able to look after yourself using over the counter medicines or items that can be found in first aid kits
- Appropriate use of services – considering the right service to support you

4. Additional messages by audience

Staff and carers/unpaid carers

- Thank you for everything that you do to help citizens in Leeds
- We recognise the pressures you all face and are doing all we can to support you
- The system is ready for winter and we recognise your ongoing support
- Don't forget to have your free flu jab

Parents and carers of children aged 0 - 5

- If you're pregnant get the flu jab
- Ensure your child is protected against flu
- If your child is unwell ring NHS 111 or speak to a pharmacist or GP
- Ring 999 or go to A&E in any emergency

Parents and carers of children aged 5-11

- If your child is eligible for a free jab, make sure they are protected
- If your child has asthma please ensure they have their inhaler with them at all times
- If your child has any respiratory conditions please ensure they are dressed appropriately especially during colder weather
- Hand washing is the single most effective way to prevent the spread of infections
- If your child has the winter vomiting bug keep them off school for 48 hours

Children aged 11 – 18 (as well as parent's carers)

- If your doctor has asked you to get a flu jab it means you need it
- Some people need to take extra care in cold weather, make sure you wrap up warm as well as looking out for any older relatives
- There can be lots of things that stress you out or make you anxious as you grow older, you can get some great advice from www.mindmate.org.uk NB targeted comms and resourcing for Mindmate sits outside this plan

Higher education students

- Not feeling great? Go visit your local pharmacy
- If your doctor has asked you to get a flu jab it means you need it
- Being away from home can be tough if you need advice on staying mentally well visit www.mindwell-leeds.org.uk or speak to your university's counselling service NB targeted comms and resourcing for Mindmate sits outside this plan
- Have you or someone you know been helped out by a winter hero last year, why not say thank you to them?

Working age adults

- Keep a well stocked medicine cabinet and self care for common conditions
- Your GP is now open for longer so you could get an appointment on an evening or at the weekend
- Reduce the risk of infections by practicing good hand hygiene, finishing your course of antibiotics and staying at home when you're feeling sick
- Keep an eye out for any vulnerable neighbours
- If a family member is in hospital, could you help them at their usual residence as it would be better for them

People with a long-term condition

- Get your flu jab as you need it
- Ensure you take any medication as advised and have this reviewed regularly at least once every six months
- Keep warm, keep well
- Stay active as much as possible

Older people

- Get your flu jab as you need it
- Keep warm, keep well
- Have you ordered your repeat prescription especially over any holiday periods
- Being at your usual home is the best place for you
- Get up and keep moving – staying active is best for you
- Hospital is not the best place for you, we'll aim to get you home as soon as we can and we'll need your support to do this
- Home being "safe, suitable and warm linked to the core message of Care & Repair's Home Plus service <https://care-repair-leeds.org.uk/news/home-plus-leeds/>

New migrants

- Know where to go to help when you fall ill or get injured
- Register with a GP
- Call NHS 111 – ask for an interpreter if you need one
- Only use A&E in an emergency

5. Support from system partners

We have established a winter /system resilience communications group which has started meeting on a monthly basis since August 2018 with representatives from NHS Leeds CCG, the city's three NHS provider trusts, Leeds City Council, Healthwatch Leeds, One Medical Group, Forum Central / Leeds Older People's Forum as well as service managers and members of the operational resilience group.

6. Membership of the winter / system resilience communications group

Members of the citywide communications group are listed below, these are based on nominated leads suggested by members of the operational resilience group as well as additional membership from third sector partners and Healthwatch Leeds. The group meets on a monthly basis with notes and actions shared after the meeting.

Core members of the group

Organisation	Contact name	Nominated by respective ORG rep	Comms highlight report expected by System Resilience Assurance Board	Winter comms plan received – as of 1 November 2018
NHS Leeds CCG	Shak Rafiq Communications Manager (chair of the group)	✓	✓	✓
Forum Central / Leeds Older People's Forum	Rachel Koivunen Sean Tunnickliffe	n/a	n/a	n/a
Healthwatch Leeds	Dex Hannon	n/a	n/a	n/a
Leeds City Council	Sara Hyman	✓	✓	Wider flu plan only and overview of core messages
Leeds Community Healthcare NHS Trust	Jayne Murphy	✓	✓	
Leeds Teaching Hospitals NHS Trust	Rachel Warburton Ross Langford	✓	✓	✓

Leeds and York Partnership NHS Foundation Trust	Oliver Tipper	✓	✓	Received update on how Trust will support wider comms campaigns not specific comms plan for the organisation
One Medical Group	Rebecca Chege	n/a	n/a	n/a
	Shaun Major-Preece			
Yorkshire Ambulance Service NHS Trust	Elaine Gibson	n/a	n/a	n/a

Also in attendance as required – colleagues from public health (Leeds City Council), an operational representative from ORG, NHS commissioners, project manager for urgent and emergency care for the West Yorkshire and Harrogate Health and Care Partnership and Adrian Winterburn from the Leeds Health Partnerships team

7. Evaluation

Each individual organisation will be responsible for the recording and measurement of its own communications activity, including the following:

- Social media engagement
- Media releases and statements issued / media enquiries received / media coverage received
- Reach of any advertising booked

In addition, this will be compared against standard performance figures for health and social care services throughout winter, for example, public and staff uptake on the flu vaccine. Figures will be submitted to the NHS Leeds CCG Communications Team by all partners involved in this plan, to be collated and submitted to the System Resilience Assurance Board.

Evaluation for the campaigns planned will be undertaken either by the appointed creative agency or by NHS Leeds CCG's communications team.

8. Available resources

- All partners are advised to sign up and download national resources from the Public Health England Campaign Resource Centre: <https://campaignresources.phe.gov.uk/resources/campaigns> **resources are only posted out centrally to GP practices and pharmacies. Community packs are available to order**
- Fridge magnet for parents and carers of children aged 0-5 **Currently out of stock, no reprint planned unless sufficient interest**
- Information for people from Czech Republic, Lithuania, Poland and Romania: www.healthinleeds.org.uk **Only a small supply of leaflets remaining, reprint will only take place if sufficient interest**
- Feel Better Leeds campaign aimed at students to encourage them to use pharmacies for common conditions: www.feelbetterleeds.org.uk includes printed resources such as the Little Book of Feel Better and pharmacy map **Resources available to order from NHS Leeds CCG**
- Seriously resistant antibiotic awareness campaign www.seriouslyresistant.com – campaign now being replicated by NHS Wales **Resources available to order from NHS Leeds CCG including selfie frame, posters, pledge cards**
- Self care resources developed in Leeds including videos featuring a range of healthcare professionals: www.leedscg.nhs.uk/health/healthy-living/selfcare/ with additional resources available from the Self Care Forum: www.selfcareforum.org/
- Information for new migrants to Leeds <https://newtoleeds.org/>
- Leeds version of the former stay well this winter campaign: <http://www.leedsth.nhs.uk/stay-well>

9. Risks and issues

There are a number of risks and issues that need to be considered when delivering our communications plan.

- Lack of sufficient awareness = no significant change in behaviour or attitude from patients
- Significant increase in people with winter related illnesses that require support within hospital which cannot be influenced by communication messages
- Severe wintry pressure increasing numbers of injuries and limited impact of comms when people are required to travel / walk such as attending work
- Lack of engagement and support from all partners due to other operational issues taking a precedent
- Risk of big thank you campaign also encouraging a relatively small number of people to provide negative feedback on their experience
- Information overload and general apathy

Action plan

NB Column highlighted in pink highlights expected pressure points at Leeds Teaching Hospitals NHS Trust

	1 Oct	8 Oct	15 Oct	22 Oct	29 Oct	5 Nov	12 Nov (expected pressure point)	19 Nov	26 Nov (expected pressure point)	3 Dec	10 Dec	17 & 24 Dec
National campaigns	Help us help you – know what to do (promote NHS 111)	Help us help you stay well this winter – flu vaccine Help us help you – know what to do (promote NHS 111)	Help us help you stay well this winter – flu vaccine Help us help you – know what to do (promote NHS 111)	Help us help you stay well this winter – flu vaccine Help us help you – know what to do (promote NHS 111) Keep antibiotics working	Help us help you stay well this winter – flu vaccine Help us help you – know what to do (promote NHS 111)	Help us help you stay well this winter – flu vaccine Help us help you – know what to do (promote NHS 111)	*launch* Help us help you before it gets worse – first signs see your pharmacy *launch* Self care week ‘choose self care for life’	Help us help you before it gets worse – first signs see your pharmacy	Help us help you before it gets worse – first signs see your pharmacy	Help us help you stay well this winter – your GP practice is open for longer	Help us help you stay well this winter – your GP practice is open for longer	Help us help you stay well this winter – your GP practice is open for longer
Regional campaign									Insight work for ‘Neighbourliness’ campaign from West Yorkshire and Harrogate Health and Care Partnership Dates still TBC and will begin with some targeted pilot activity before wider roll out	Insight work for ‘Neighbourliness’ campaign from West Yorkshire and Harrogate Health and Care Partnership Dates still TBC and will begin with some targeted pilot activity before wider roll out	Insight work for ‘Neighbourliness’ campaign from West Yorkshire and Harrogate Health and Care Partnership Dates still TBC and will begin with some targeted pilot activity before wider roll out	Insight work for ‘Neighbourliness’ campaign from West Yorkshire and Harrogate Health and Care Partnership Dates still TBC and will begin with some targeted pilot activity before wider roll out

Local campaigns	Flu vaccination campaign – led by Leeds City Council	Flu vaccination campaign – led by Leeds City Council *soft launch* Winter Friends – led by Leeds City Council	Flu vaccination campaign – led by Leeds City Council Winter Friends – led by Leeds City Council	Flu vaccination campaign – led by Leeds City Council Winter Friends – led by Leeds City Council	Flu vaccination campaign – led by Leeds City Council	*launch* Feel better campaign encouraging students to visit their pharmacy – led by NHS Leeds CCG Winter Friends – led by Leeds City Council **communication resources expected to be shared with partners during this week** Flu vaccination campaign – led by Leeds City Council	*launch* Seriously resistant antibiotics awareness campaign – led by NHS Leeds CCG & Leeds City Council Feel better campaign encouraging students to visit their pharmacy – led by NHS Leeds CCG Flu vaccination campaign – led by Leeds City Council Winter Friends – led by Leeds City Council	Seriously resistant antibiotics awareness campaign – led by NHS Leeds CCG & Leeds City Council Feel better campaign encouraging students to visit their pharmacy – led by NHS Leeds CCG Flu vaccination campaign – led by Leeds City Council Winter Friends – led by Leeds City Council	*launch* malnutrition campaign ‘where’s your next hot meal coming from’ – led by Leeds City Council Seriously resistant antibiotics awareness campaign – led by NHS Leeds CCG & Leeds City Council Feel better campaign encouraging students to visit their pharmacy – led by NHS Leeds CCG Flu vaccination campaign – led by Leeds City Council Winter Friends – led by Leeds City Council	*expected launch* The big thank you and be a winter hero campaign – system wide campaign co-ordinated by the winter/system resilience comms group *launch* Extended access to GP appointments – led by NHS Leeds CCG malnutrition campaign ‘where’s your next hot meal coming from’ – led by Leeds City Council The big thank you and be a winter hero campaign – system wide campaign co-ordinated by the winter/system resilience comms group Seriously	*launch* Mental health awareness campaign with Teen Connect aimed at younger people – led by NHS Leeds CCG and Leeds Survivor Leeds Crisis Service *launch* Home first campaign to reflect agreed partnership approach around discharging patients Extended access to GP appointments – led by NHS Leeds CCG malnutrition campaign ‘where’s your next hot meal coming from’ – led by Leeds City Council The big thank you and be a winter hero campaign – system wide campaign co-ordinated by the winter/system resilience comms group Seriously resistant antibiotics	Mental health awareness campaign with Teen Connect aimed at younger people – led by NHS Leeds CCG and Leeds Survivor Leeds Crisis Service Extended access to GP appointments – led by NHS Leeds CCG malnutrition campaign ‘where’s your next hot meal coming from’ – led by Leeds City Council The big thank you and be a winter hero campaign – system wide campaign co-ordinated by the winter/system resilience comms group Seriously resistant antibiotics

										resistant antibiotics awareness campaign – led by NHS Leeds CCG & Leeds City Council	awareness campaign – led by NHS Leeds CCG & Leeds City Council	awareness campaign – led by NHS Leeds CCG & Leeds City Council
										Flu vaccination campaign – led by Leeds City Council	Flu vaccination campaign – led by Leeds City Council	Flu vaccination campaign – led by Leeds City Council
										Flu vaccination campaign – led by Leeds City Council	Winter Friends – led by Leeds City Council	Winter Friends – led by Leeds City Council
										Winter Friends – led by Leeds City Council		
Briefings for elected members and senior leaders (eg Health and Wellbeing Board, Scrutiny, Partnership Executive Group)							Briefing paper outlining how Leeds is prepared for winter (and beyond) – dependent on information received from ORG members		Briefing on big thank you campaign and an opportunity to get involved – to summarise other campaign activity to date			
Media			Meet with Joseph Keith (Yorkshire Post/Evening Post) to discuss running a series on Leeds system getting ready for winter	Public health message around getting ready for winter if you have a respiratory condition – Leeds City Council (or NHS Leeds CCG if prefer a GP to front)	Update on flu jab uptake among staff from providers as national directive is 100% take up? Feel Better campaign to be launched – NHS Leeds CCG	Relaunch of seriously resistant antibiotics awareness campaign next week – possible photocall at Gledhow Wing Self care week takes place following week message from local GP – NHS Leeds CCG		Big thank you campaign launch – possibly film Cllr Charlwood and/or clinicians and / or a carer – NHS Leeds CCG or Leeds Plan team. Possibility of partnering with Yorkshire Evening Post to make this a #TeamLeeds effort Reminder about how pharmacists can help you this winter – NHS		Run YEP feature (to begin on 1 December) on winter preparedness as eg frailty unit, LIDS team, rotational paramedics, paediatric consultants working with Pudsey GP practices, community initiatives etc – led by NHS Leeds CCG/LTHT as	Christmas and new year reminder about repeat prescriptions, opening hours of services etc – NHS Leeds CCG Say no to noro – highlighting concerns around winter vomiting bug and what you should do – LTHT or NHS Leeds CCG?	What to do if the festive period affects you emotionally eg loneliness, stress etc – LYPFT or NHS Leeds CCG?

								Leeds CCG		well as partners Reminder that your GP practice is open for longer – NHS Leeds CCG		
Social media	NHS 111 information available from Public Health England Campaign Resource Centre End of paid for social media campaign targeting Leeds' Eastern European communities – NHS Leeds CCG	Flu vaccination information available from Public Health England Campaign Resource Centre Social media opportunities through NHS Employers #jabathon and #fridayflufacts	NHS Leeds CCG to share social media plan however this will be revised and additional content will be provided throughout winter where appropriate as highlighted in this action plan	Keep antibiotics working social media plan available from Public Health England Campaign Resource Centre please use Seriously Resistant campaign social media plan from w/c 12 November	Feel better campaign social media plan – specifically targeted at students (may include some paid for ads)	Seriously resistant campaign social media plan to be shared – NHS Leeds CCG	Seriously resistant social media from event at Gledhow Wing with LTHT Self Care week social media plan – shared by NHS Leeds CCG Big thank you social media plan – co-ordinated by NHS Leeds CCG on behalf of partners First signs see your pharmacy information available from Public Health England Campaign Resource Centre		NHS Leeds CCG to provide social media plan to promote localised info on extended access to GP practices	Extended access to GP information available from Public Health England Campaign Resource Centre use in conjunction with local social media plan	Reminder about repeat prescriptions/ bank holiday preparedness	
Websites		Flu information on Leeds City Council website Winter Friends pack available from Leeds City Council website	Share NHS Leeds CCG pages on accessing the right service at the right time		LTHT to show live waiting times for A&E, minor injury unit and walk-in centre?	Feel better campaign website re-promoted	Seriously resistant campaign website to be promoted internally/externally	Big thank you campaign microsite available – co-ordinated by NHS Leeds CCG on behalf of partners		Extended access to GP practices information to be made available – NHS Leeds CCG Opening times of GP practices and		

										information on hub appointments on GP practice websites – led by GP Confederation		
Internal comms This does not include organisational specific messages / campaigns such as staff flu uptake			Weekly message to primary care staff through GP bulletin – flu, respiratory etc	Weekly message to primary care staff through GP bulletin – flu, respiratory etc Weekly update from operational winter group – tailored accordingly by all partners	Reminder to sign up to Winter Friends scheme Weekly message to primary care staff through GP bulletin – flu, respiratory etc Weekly update from operational winter group – tailored accordingly by all partners	Weekly message to primary care staff through GP bulletin – flu, respiratory etc Weekly update from operational winter group – tailored accordingly by all partners	Launch of seriously resistant campaign Weekly message to primary care staff through GP bulletin – flu, respiratory etc Weekly update from operational winter group – tailored accordingly by all partners	Weekly message to primary care staff through GP bulletin – flu, respiratory etc Weekly update from operational winter group – tailored accordingly by all partners	Launch of the big thank you Launch of malnutrition campaign Weekly message to primary care staff through GP bulletin – flu, respiratory etc Weekly update from operational winter group – tailored accordingly by all partners	Message to remind colleagues GPs are open for longer Share any messages received from the big thank you to date Weekly message to primary care staff through GP bulletin – flu, respiratory etc Weekly update from operational winter group – tailored accordingly by all partners	Weekly message to primary care staff through GP bulletin – flu, respiratory etc Weekly update from operational winter group – tailored accordingly by all partners	Weekly message to primary care staff through GP bulletin – flu, respiratory etc Weekly update from operational winter group – tailored accordingly by all partners

Action plan January – March 2019

	31 December	7 Jan	14 Jan	21 Jan	28 Jan	4 Feb	11 Feb	18 Feb	25 Feb	4 Mar	11 Mar	18 Mar	25 Mar
National campaigns	TBC Help us help you – know what to do (promote NHS 111 online)	TBC Help us help you – know what to do (promote NHS 111 online)	TBC Help us help you – know what to do (promote NHS 111 online)	TBC Help us help you – know what to do (promote NHS 111 online)	TBC Help us help you – know what to do (promote NHS 111 online)	Help us help you before it gets worse – see your pharmacist	Help us help you before it gets worse – see your pharmacist	Help us help you before it gets worse – see your pharmacist	Help us help you before it gets worse – see your pharmacist	Help us help you before it gets worse – see your pharmacist	Help us help you before it gets worse – see your pharmacist		
Regional campaign	‘Neighbourliness’ campaign from West Yorkshire and Harrogate Health and Care Partnership	‘Neighbourliness’ campaign from West Yorkshire and Harrogate Health and Care Partnership	‘Neighbourliness’ campaign from West Yorkshire and Harrogate Health and Care Partnership	‘Neighbourliness’ campaign from West Yorkshire and Harrogate Health and Care Partnership	‘Neighbourliness’ campaign from West Yorkshire and Harrogate Health and Care Partnership	‘Neighbourliness’ campaign from West Yorkshire and Harrogate Health and Care Partnership	‘Neighbourliness’ campaign from West Yorkshire and Harrogate Health and Care Partnership	‘Neighbourliness’ campaign from West Yorkshire and Harrogate Health and Care Partnership	‘Neighbourliness’ campaign from West Yorkshire and Harrogate Health and Care Partnership	‘Neighbourliness’ campaign from West Yorkshire and Harrogate Health and Care Partnership	‘Neighbourliness’ campaign from West Yorkshire and Harrogate Health and Care Partnership	‘Neighbourliness’ campaign from West Yorkshire and Harrogate Health and Care Partnership	‘Neighbourliness’ campaign from West Yorkshire and Harrogate Health and Care Partnership
Local campaigns	The big thank you and be a winter hero campaign – Seriously resistant antibiotics awareness campaign	The big thank you and be a winter hero campaign Seriously resistant antibiotics awareness campaign	*possible launch* Leeds version of regional ‘neighbourliness’ campaign building on Winter Friends The big thank you and be a winter hero campaign The big thank you and be a winter hero campaign – Seriously resistant antibiotics awareness campaign	Leeds version of regional ‘neighbourliness’ campaign building on Winter Friends The big thank you and be a winter hero campaign Seriously resistant antibiotics awareness campaign	Leeds version of regional ‘neighbourliness’ campaign building on Winter Friends The big thank you and be a winter hero campaign Seriously resistant antibiotics awareness campaign	*launch* End PJ paralysis campaign as part of ‘Home first / why not home, why not today’ initiative – LTHT / NHS Leeds CCG / Leeds City Council? Seriously resistant antibiotics awareness campaign	End PJ paralysis campaign as part of ‘Home first / why not home, why not today’ initiative	End PJ paralysis campaign as part of ‘Home first / why not home, why not today’ initiative	End PJ paralysis campaign as part of ‘Home first / why not home, why not today’ initiative	End PJ paralysis campaign as part of ‘Home first / why not home, why not today’ initiative	End PJ paralysis campaign as part of ‘Home first / why not home, why not today’ initiative	End PJ paralysis campaign as part of ‘Home first / why not home, why not today’ initiative	End PJ paralysis campaign as part of ‘Home first / why not home, why not today’ initiative
Briefings for elected members and senior leaders	Briefing on Leeds ‘neighbourliness’ campaign and		Briefing paper outlining how Leeds is responding to		Briefing on PJ paralysis campaign and links to home								

(eg Health and Wellbeing Board, Scrutiny, Partnership Executive Group)	an opportunity to get involved		system pressures including info on any pre-planned changes to elective appointments		first strategy								
Media		YEP week long feature on 'changing face of primary care/ your local GP practice' – NHS Leeds CCG Launch of Leeds neighbourliness campaign	Highlight any winter heroes either from big thank you campaign or those identified by partners		Launch of end PJ paralysis campaign		Reminder of role of pharmacists as trained medical professionals		Reminder of extended GP access				
Social media	Facing up to the new year including advice on staying mentally well as well as lifestyle info	CCG to reissue social media plan to include any additional content from national campaigns			Social media plan for end PJ paralysis campaign								
Websites					Content for websites for end PJ paralysis campaign								
Internal comms This does not include organisational specific messages / campaigns such as staff flu uptake	Launch of regional neighbourliness campaign Weekly message to primary care staff through GP bulletin – flu, respiratory etc Weekly update from operational winter group – tailored	Launch of Leeds 'neighbourliness' campaign Weekly message to primary care staff through GP bulletin – flu, respiratory etc Weekly update from operational winter group – tailored accordingly by all partners	Weekly message to primary care staff through GP bulletin – flu, respiratory etc Weekly update from operational winter group – tailored accordingly by all partners	Weekly message to primary care staff through GP bulletin – flu, respiratory etc Weekly update from operational winter group – tailored accordingly by all partners	Info on end PJ paralysis campaign Weekly message to primary care staff through GP bulletin – flu, respiratory etc Weekly update from operational winter group – tailored	Messages to wrap up big thank you campaign including one from Cllr Charlwood? Weekly message to primary care staff through GP bulletin – flu, respiratory etc Weekly update from operational winter group – tailored accordingly by all partners	Weekly message to primary care staff through GP bulletin – flu, respiratory etc Weekly update from operational winter group – tailored accordingly by all partners	Weekly message to primary care staff through GP bulletin – flu, respiratory etc Weekly update from operational winter group – tailored accordingly by all partners	Weekly message to primary care staff through GP bulletin – flu, respiratory etc Weekly update from operational winter group – tailored accordingly by all partners	Weekly message to primary care staff through GP bulletin – flu, respiratory etc Weekly update from operational winter group – tailored accordingly by all partners	Weekly message to primary care staff through GP bulletin – flu, respiratory etc Weekly update from operational winter group – tailored accordingly by all partners	Weekly message to primary care staff through GP bulletin – flu, respiratory etc Weekly update from operational winter group – tailored accordingly by all partners	Weekly message to primary care staff through GP bulletin – flu, respiratory etc Weekly update from operational winter group – tailored accordingly by all partners

	accordingly by all partners				accordingly by all partners								

Leeds System Resilience Plan 2019 – 2020 Risks Register

The high level risks and mitigating actions to support the delivery of a resilient health and care system in 2018/19 are identified within 2 areas:

- Variable risks are those which we cannot fully predict but where we can put mitigating plans in place.
- Impact risks are those we have assessed and highlighted the probabilities and consequences of the risk.

The high level risks RAG rating pre and post mitigation 1st **September 2019** are as follows:

	Variable risks	RAG rating pre mitigation	Mitigating Actions 2017/18	Rag rating post mitigation
1	Surges in demand from patients accessing services that may not always be appropriate to their needs	16	• Communications campaign. • New specification for the regional 111 service 100% • Extended access in Primary Care core services • Development of urgent treatment centres, • Integrating current services walk-in centre/Gp streaming	12
2	Surges in demand due to the ageing population and increased presenting levels of acuity resulting in significant pressure on services to deliver high quality safe services and maintain system flow	20	• Additional front of house services GP in A&E, Frailty, rapid assessment unit, Point of care flu testing Ambulatory care pathways, focused admission avoidance and discharge processes • Frailty strategy • Virtual ward development • Care home action plan • Workforce development group • System approach to escalation and development of robust mutual aid actions • Joint capacity planning, testing scenarios to inform mitigating actions interventions • Development of Primary Care networks and Local Care Partnerships	16

			- Extended GP services evening and weekend - Establishing urgent treatment centres, - Integrating current services walk-in centre/GP streaming - Expansion of PCAL - Integration of PCAL by YAS, spur	
3	Disruption in service delivery and system management due to adverse weather conditions resulting in limited system capacity to manage demand	10	- Adverse weather plans - Organisations' Business Continuity plans - Tested system escalation plans - Mutual aid agreements - Community network volunteers e.g. 4x4 capabilities	6
4	Insufficient system capacity to manage the additional demand and compromised service delivery as a result of health effects from Flu or infection outbreaks resulting in compromised workforce and services	12	- Outbreak plans - Flu immunisation campaign - Staff immunisation plans - Organisations' Business Continuity plans - Tested system escalation plans - Mutual aid agreements	6
5	Lack of system commitment to develop new ways of working/thinking/culture resulting in limited impact in proposed initiatives	8	- Strong System Leadership- SRAB, PEG, HWB - Commitment to deliver the Leeds System Resilience Plan - One version of the truth/system vision - Leeds Health and Care Plan - System escalation and mutual aid approach - Provider partnership collaborative and Local Care Partnership development - Integration Care System approach - Engagement with Newton Europe and adoption of the recommendations - IT developments, Leeds Care Record, Telehealth approach	4

6	Availability of a skilled workforce across the system due to limited national workforce and changing political landscape resulting in challenges to deliver robust high quality and safe services for our population	16	• System workforce group- Leeds approach to recruitment • Organisations' internal staff management and recruitment plans • Robust recruitment and retention practices within all organisations • Established banks to share experienced staff	12
7	Inability of our workforce to flex skills and capabilities internally and across organisations resulting in limited opportunities to deploy a flexible and shared workforce	12	• System workforce group- Leeds approach to recruitment • Established banks to share experienced staff • Integrated service delivery- LIDS, EDAT, Frailty, A&E streaming, Urgent treatment centres	8
8	There is a risk of Industrial Action (IA) due to any arising political situation that will result in disruption to normal service delivery across the Health and Social Care Economy. E.G Clinical staff disputes, Fuel shortages	8	• All organisations test and activate internal and business continuity plans to mitigate against the impact and improve contingency plans • Manage communications across the system and work with colleagues to ensure consistent messages	8
9	Inability to respond to a major incident through a command and control approach due to insufficient agreed process and procedures resulting in an un-coordinated response	10	• Leeds system EPRR compliance • Robust Business Continuity and major incident plans • Participation in local and regional system resilience forum • Ongoing resilience exercises • Robust escalation and On Call systems across the system • Communication plans • Robust command and control structure NHS England lead • Consistent processes through both escalation and incident management	5

	System Impact Risks	RAG rating pre mitigation	Mitigating Actions 2017/18	Rag rating post mitigation
10	Disruption to the Leeds health and care system due to Britain's exit from the EU	16	- NHS England central management - Regional LHRP and LRF governance - System Task and finish group - Individual organisational assessment and risk assessments - Robust system wide business continuity plans	12
11	Compromised patient flow and service delivery due to excess demand, staff availability or an incident resulting increased pressure to deliver high quality safe services for our population and increased Mental Health out of area placements	20	- Organisational surge and capacity plans - Organisational quality and safety plans - System Escalation and mutual aid plans - Business Continuity and incident management	12
12	There is a risk to system flow due to the balance of service delivery between admission avoidance and discharge due to the increased demand from all points of referral into community nursing services.	16	- Leeds Community Healthcare surge and capacity plans - Leeds Community Healthcare quality and safety plans - System Escalation and mutual aid plans - Cross organisational Joint working - Newton Europe identified opportunities front and back door	12
13	Ability to meet system wide national performance targets due to system challenges in delivering system flow and insufficient system management and prioritisation of services	20	- Organisational surge and capacity plans - System Escalation and mutual aid plans - System agreement for the prioritisation of services - Regional agreement regarding the management of repatriations and critical care capacity	16

14	Ability to maintain an agreed level of planned activity across service providers due to system challenges in delivering system flow resulting lack of capacity to deliver planned activity	20	• Organisational surge and capacity plans • System Escalation and mutual aid plans • Planned suspension of routine elective over historical times of pressure • System agreement for the prioritisation of services-decision management tool • Regional agreement regarding the management of repatriations and critical care capacity	16
15	There is a risk that we do not realise the opportunity to achieve the left shift in the provision of care.	16	• CCG community strategy • 5 year demand and capacity modelling • Trajectory to reduce super stranded patients • Plans to close the Villa care wards within LTHT • Newton Europe actions to further develop attendance and admission avoidance pathways	12
16	Our ability to balance and share clinical risk across the system to manage the most vulnerable and needy people	20	• Organisational surge and capacity plans • Organisational quality and safety plans • System Escalation and mutual aid plans • System agreement for the prioritisation of services-decision management tool • Regional agreement regarding the management of repatriations and critical care capacity	16
17	There is a risk increased patient flows into Leeds acute trust, increasing demand and impacting on the quality and safety of services across the system. This is due to the of the proposed regional acute trust changes which will result in reconfiguration/closure of various services including A&E which will in turn result in increased demand flowing towards Leeds service.	12	• Partnership working and collaboration through the following regional forums ◦ West Yorkshire ICS ◦ West Yorkshire Acute Trust Group ◦ West Yorkshire Urgent and Emergency Care Network	8

18	Loss of financial allocation/incentives associated with the achievement of system and national targets	8	Robust monitoring and escalation to track progress	6
	Risk to the Leeds system's reputation due to our inability to provide assurance and evidence of our actions	8	Documented evidence of our actions and decisions associated with the execution of our: - Organisational surge and capacity plans - Organisational quality and safety plans - System Escalation and mutual aid plans - System agreement for the prioritisation of services - System Agreement for the management of risk - Robust commissioning and contracting practices - EPRR compliance – self assessment levels - EU Exit individual and system wide plans	4

	Consequence (initial)				
Likelihood (initial)	Insignificant	Minor	Moderate	Major	Catastrophic
Expected to occur at least daily. More likely to occur than not.	 5 Low Priority	 10 Medium Priority	 15 Medium Priority	 20 Very High Priority	 25 Very High Priority
Expected to occur at least weekly. Likely to occur.	 4 Low Priority	 8 Medium Priority	 12 Medium Priority	 16 Very High Priority	 20 Very High Priority
Expected to occur at least monthly. Reasonable chance of occurring.	 3 Low Priority	 6 Medium Priority	 9 Medium Priority	 12 Medium Priority	 15 Very High Priority
Expected to occur at least annually. Unlikely to occur.	 2 Low Priority	 4 Low Priority	 6 Medium Priority	 8 Medium Priority	 10 Medium Priority
Not expected to occur for years. Will occur in exceptional circumstances.	 1 Low Priority	 2 Low Priority	 3 Low Priority	 4 Low Priority	 5 Low Priority
	Rating (initial): Risk level (initial):				

LEEDS SYSTEM RESILIENCE PLAN 2019-20

Leeds System Resilience Plan 2018/19

Document Name:	Leeds System Resilience Plan 2019-20
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Agreed / Ratified :	
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Control

This a controlled document maintained by the Unplanned Care Team within Leeds Clinical Commissioning Group (CCG) on behalf of the Leeds System Resilience Assurance Board.

Distribution

An electronic version of this plan is distributed to all members of the Leeds System Resilience Assurance Board and partners across associated organisations.

Organisations involved in developing the plan

The contribution by members of the Leeds health and Care system:

Leeds Clinical Commissioning Group [CCG]

Leeds Teaching Hospital Trust [LTHT]

Leeds City Council - Adult Social Care [ASC]

Leeds Community Healthcare Trust [LCH]

Leeds and York Partnership Foundation Trust [LYPFT]

Yorkshire Ambulance Service [YAS] – 111 and 999

Local Care Direct [LCD]

One Primary Care (OPC)

Leeds Confederation

Leeds City Council – Emergency Planning

Leeds City Council – Public Health

NHS England – Area Team

Third Sector Providers

Health watch

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To ensure we continue to deliver quality, safe and responsive services the Leeds system needs to be equipped, prepared and coordinated to respond quickly and appropriately to any change in demand or circumstances. It also requires us to develop a strategy to transform our system for the future and deliver The NHS Long Term Plan.

As stated in the long term plan 2019/20 is seen as a transitional year giving us time to work in partnership to begin to shape our local implementation of the long term plan for our population. Our approach to develop an overarching system resilience plan will support us navigate the complexities of the unplanned health and care landscape and demonstrate how the system will continue to meet the needs of the population from operational and strategic perspectives.

The plan describes the collective system vision, aims, objectives and priorities to achieve improved services and outcomes for our population and highlights the importance of their alignment in delivering real change.

The Leeds System Resilience Plan (LSRP) has three components listed below which describe the elements of a well-functioning system which balances strategic ambition with effective operational delivery.

- Planning and priorities 2019/20
- Escalation and incident management
- Transformational plans

Within the plan our narrative to describe these components in detail is through a set of collective actions, initiatives and or projects based on the outcomes of our winter evaluation, system diagnostic exercises and our response the NHS long Term plan. We acknowledge that this can only be achieved by working as a system with strong leadership, commitment to support changes in culture and behaviour and an adopting an integrated approach to service delivery with clear jointly owned governance processes. The Governance refresh supports a more focused approach and clarifies the roles and responsibilities of system leaders across our system with clear lines of accountability and an overall system commitment to work in an integrated way to deliver care and maximise resources.

In conclusion our plan seeks to provide a high level of assurance that there is agreed system wide initiatives in place that address both the short and long term priorities within the unplanned health and care services across Leeds. In addition the plan demonstrates that we have with clear escalation processes in place for the management of surges and incidents that place additional pressure on our system and the resilience of services.

1.1 Introduction - Leeds System Resilience Plan 2019/20

Urgent and emergency health and care services continue to be at the forefront of the NHS priorities due to the fall in national performance of the 4 hour Emergency Care Standard (ECS) and the demands of an ageing population.

To ensure we continue to deliver quality, safe and responsive services the Leeds system needs to be equipped, prepared and coordinated to respond quickly and appropriately to any change in demand or circumstances. It also requires us to develop a strategy to transform our system for the future and deliver The NHS Long Term Plan.

As stated in the long term plan 2019/20 is seen as a transitional year giving us time to work in partnership to begin to shape our local implementation of the long term plan for our population. Our approach to develop an overarching system resilience plan will support us navigate the complexities of the unplanned health and care landscape and demonstrate how the system will continue to meet the needs of the population from operational and strategic perspectives.

Over the next five years, the need for non-elective acute hospital beds will be determined by continuing pressures from an ageing population balanced against achieving a left shift in the provision of care. We will achieve the left shift through implementing a proactive care approach, embedding the 'Home First' philosophy; developing community capacity and ensuring processes are in place to achieve effective discharge from hospital.

It is vital that we continue to learn from our operational behaviour and activities to develop our longer term vision and inform our strategic decision making. Leeds has been fortunate to undertake a number of reviews and diagnostics (MADE, CQC and Newton Europe) across our system to support our strategic thinking and identify opportunities for improvement over the next 12-18 months. We have used the outcomes from these exercises and the winter 2018/19 evaluation to refresh the Leeds System Resilience Plan (LSRP) for 2019/20.

Through this plan we will demonstrate:

- Alignment with the Long Term Plan
- Collective accountability for the challenges faced by our system in relation to urgent and emergency care services
- Delivery of quality care and effective care across our system
- Robust management of predicted and unpredicted surges in demand through normal variation or as a result of an incident.
- Continuing to deliver improvement throughout 2019/20 building on our learning of operational and behavioural changes
- Commitment of clear and agreed vision for the further transformation of the Unplanned Health and Care landscape in Leeds

The Leeds System Resilience Plan (LSRP) has three components listed below which describe the elements of a well-functioning system which balances strategic ambition with effective operational delivery.

- Planning and priorities 2019/20
- Escalation and incident management
- Transformational plans

The plan acknowledges that Britain's planned exit from the EU poses additional challenges for the NHS and comes at a time of historical pressure 13 October as the system enters winter. Section 4.6 provides an overview of how the system lead by NHS England is preparing for Britain's exit.

1.2 System Resilience Vision

The Leeds System Assurance Board (SRAB) understands the importance of a vision to inspire individuals and organisations to commit action. SRAB will use their vision a practical guide for agreeing priorities, setting objectives making decisions, creating plans, and coordinating and evaluating the work streams and projects.

The Leeds System Resilience Vision

By working together our services will be high quality, easy to access and understand to ensure all people receive the right advice, care and support in the right place, first time as close to

The vision will support integration across organisations keeping groups focused, especially with complex projects and in challenging times.

To ensure that we deliver our visions it was important to agree set of aims to achieve our vision along with a set of aligned relevant and measurable objectives.

1.3 Leeds System Resilience Aims

- We will provide an equitable and fully integrated urgent and emergency care service for people with physical, mental health or social care needs, across Leeds.
- At every point in the persons journey we will consider 'home first'.
- We will harness technology so that the people of Leeds only tell their story once and get the best outcome for them.
- We will remove steps that do not add value to the patient or people of Leeds.

1.4 Leeds System Resilience Objectives - a measurable result that a group aims to achieve

The following objectives are based on national performance measures for the Leeds health and care economy. It is the aim of the Leeds System Resilience Assurance Board to ensure that all of the winter, operational and strategic initiatives governed through the governance; detailed in section 2 will contribute to these measures to improve the overall system position supporting improve outcomes for the population.

- Model the opportunity and impact of a left shift in the provision of care and support by **March 2020**
- Implement Leeds Clinical Advice/Assessment Service (CAS)
 - Increase the percentage of people triaged by NHS 111 that are booked into a face-to-face appointment, where this is needed, to greater than **40% by 31st March 2020**.
 - Maintain a **50%+** proportion of NHS 111 calls receiving clinical assessment
- Deliver the Leeds System Emergency Care Standard – **93.3% by March 2020**
- Reduce Non-Elective Admissions by ?
 - From Care Homes
 - Increasing same day emergency care
- Reduce the length of stay for those admitted to an acute hospital bed
 - Reduce people in an acute bed more than 21 days to **319 by March 2020**
 - Reduce people in an acute bed more than 7 days to ?
- Reduce Mental Health out of area placements **to zero by 2021**
- Reduce Delayed Transfer of Care
 - LTHT
 - LYPFT
- Increase number of people receiving reablement?
- Reduce the number of people entering into long term care?

The specific trajectories and timescales for each of the system metrics will be worked through by the System Resilience Partnership Group (SRPG). The SRPG will be accountable for ensuring that all initiatives/projects that support the delivery the identified priorities, below, contribute to the overall performance.

In addition as the details of work plan are developed the SPRG will focus on collectively creating outcomes measures for the priorities that demonstrate measurable improved population outcomes to show what will different for people using our services and to ensure alignment with the future direction of commissioning.

1.5 System Resilience Priorities 2019-2021

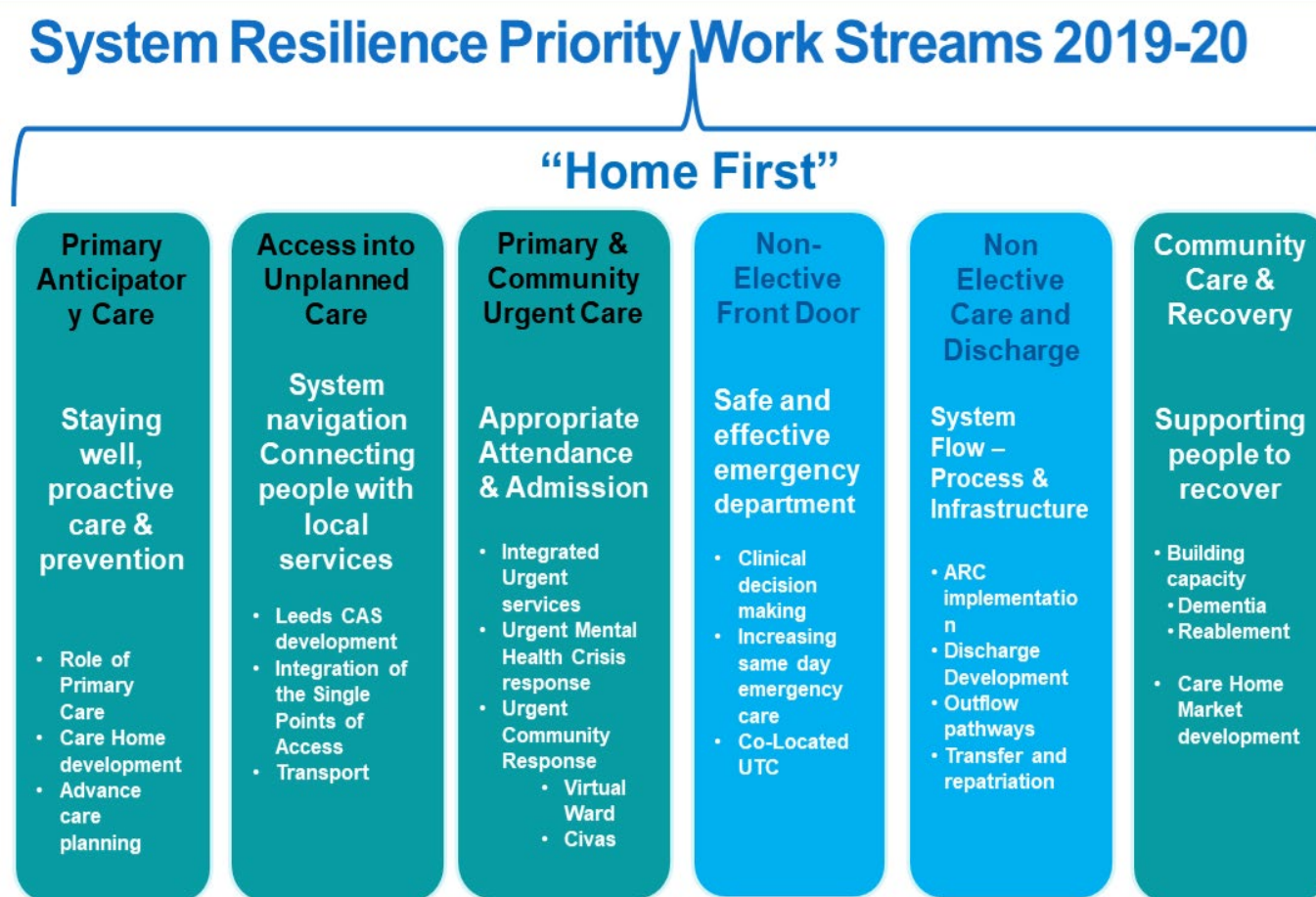
- Role of Primary Care in the Urgent Care System
- Connecting people quickly with local services
- Appropriate Attendance /Admission across the system
- Mental Health Crisis response and Dementia care
- Safe and effective Emergency Department
- System Flow – Process, Infrastructure and capacity

Enablers

- System modelling – predictive
- Surge & Escalation
- Technology
- Workforce

With a new focused approach the SRAB will be responsible for setting the strategic direction and seeking assurance from the SRPG on the effectiveness and pace of their work to address the agreed priorities. The SRPG will be accountable for the delivery of the actions, initiatives and or projects within the priorities as shown in Diagram 1, ensuring that they balance both the strategic ambitions and daily operational delivery across the health and care system retaining a focus on pressured times such as winter.

Diagram 1



Section 3.3.2 provides further details of the some of the work streams

We acknowledge that this can only be achieved by working as a system with strong leadership, commitment to support changes in culture and behaviour and an adopting an integrated approach to service delivery with clear jointly owned governance processes.

2. Governance and leadership

A resilient health and care system is equally reliant on all partner organisations being able to deliver their care elements safely. Each organisation has individual strategic, winter and service development plans, along with business continuity and major incident plans monitored through their own boards and contracts.

2.1 Governance

The governance of the essential cross organisational, development, communication and collaboration is harder to define. The governance relating to the unplanned health and care system has developed over the last 5 years and has seen a number of reiterations due to continued pressures, system reviews and national guidance. Due to the publication of the NHS Long Term Plan and the Leeds Plan refresh it was felt that it was an excellent opportunity for Leeds to review governance and priorities related to ensure our system is resilient and we are committed to transform the unplanned health and care landscape.

A survey gathered the views of representatives across the various groups currently aligned to the SRAB. Key findings and recommendations below

Key findings:

- There was duplication across the various groups
- A stronger focus on the priorities would result by reducing the number of meetings
- Strong recognition that both a strategic and operational focus is required but that this could be more clearly defined within the Terms of Reference (TOR)
- Representation within the groups needs to be clearer with organisational commitment and accountability.

- The new structure, TOR and priorities need to reflect the whole system pathway

Recommendations were presented to the SRAB for consideration, these included:

- Review the TOR across all groups including purpose, aims, objectives and outputs
- Define clear structure of accountability
- Gain representation commitment from all organisations
- Create a smaller more focussed group for SRAB
- Ensure priorities reflect system inclusivity and focus on the whole pathway
- Agree new processes for managing the work plan priorities for updating on work streams instead of highlight reports
- Propose new governance structure –July 2019
- Agree system priorities August/September 2019

A revised governance structure was agreed by SRAB August 2019.

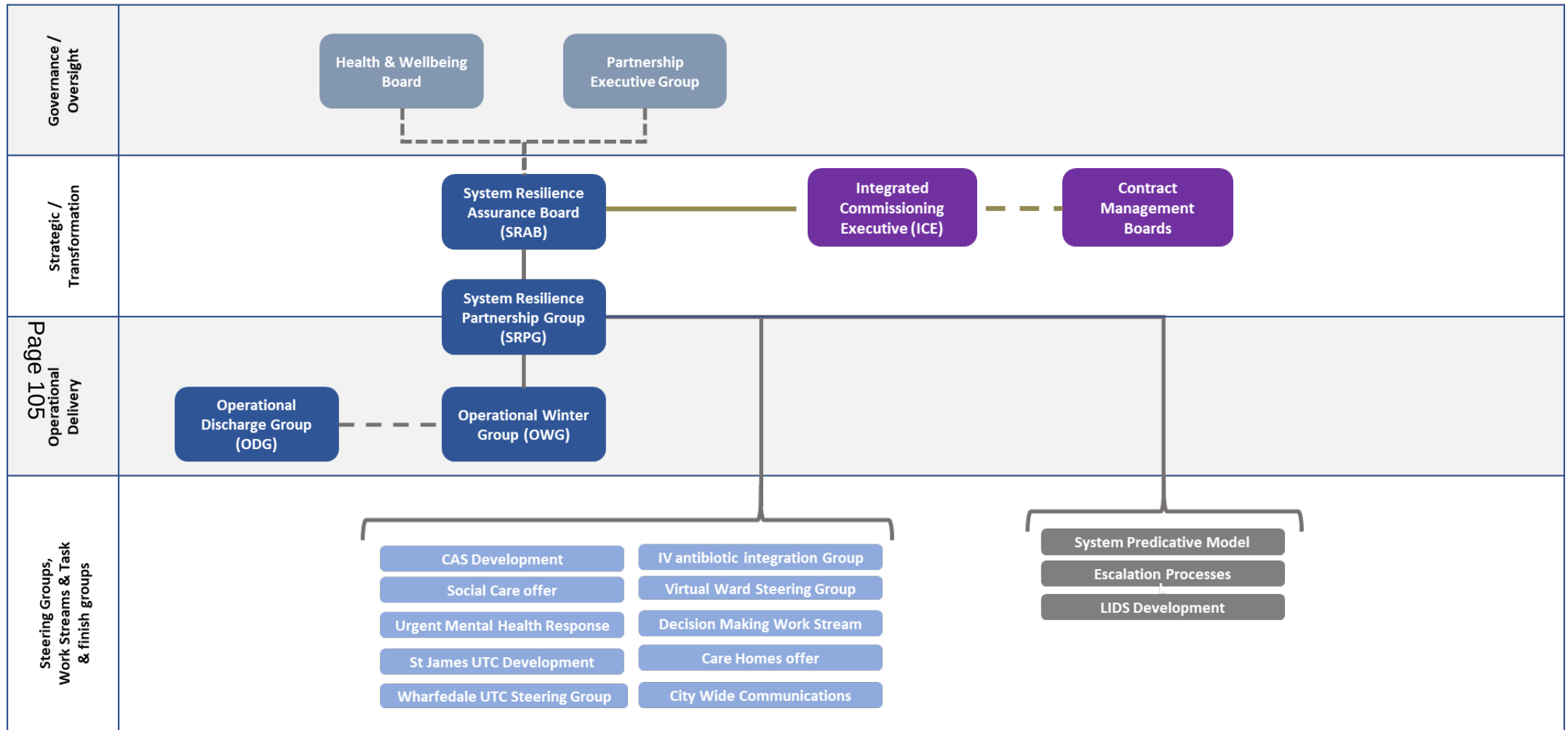
Full revised Terms of Reference for the three main groups; SRAB, System Resilience Partnership Board (SRPB) and Operational Winter Group (OWG) are within Appendix 1.

2.2 Project Management and reporting

The SRPG will be accountable in maintaining the overview of the operational and strategic system delivery via a robust reporting structure.

To ensure a consistent approach all of the identified projects leads will be required to complete the terms of reference template (Appendix 1) which will act as a Project Initiation Document defines the purpose, actives, outputs, scope and membership of the group. All projects will be required to report to the SRPG on a bi-monthly though the highlight report template.

Diagram 2. Leeds System Resilience Governance Structure



2.3 Leeds System Winter Plan Time line

Table 1 set out the key activities the Leeds system has conducted and the various groups, boards and forums who have been engaged with in developing and approving the LSRP

Table 1

Date	Activities	Comments
09/05/2019	Organisational winter Evaluation	Priorities identified for development summer 2019
16/05/2019	Newton Europe diagnostic – Discharge Re Audit/Front door diagnostic	Work commenced
20/06/2019	Review of SRAB Governance & winter findings	Survey and report completed recommendations to SRAB
11/07/2019	Newton Europe summit	Well attended by system
11/07/2019	Board to Board winter presentation	Joint presentation LTHT/CCG
18/07/2019	SRAB reflection on Newton Europe findings	Emerging priorities
15/08/2019	SRAB sign off Governance	Governance agreed
05/09/2019	North of England EU Exit Workshop	
12/09/2019	SRAB sign off priorities and comments for draft System Resilience Plan	Amendments made
03/10/2019	Operational Winter Group commences weekly meetings	
21/10/2019	National EU Exit reporting commences	
17/10/2018	SRAB Meeting-sign off Leeds System Winter Plan – including EPRR compliance statements	
30/10/2019	Winter plan scenario testing	
22/11/2019	Scrutiny Board – winter plans	

13/11/2019	Leeds System Resilience Plan to Quality and Performance committee – including EPRR	
27/11/2019	Leeds System Resilience Plan to CCG Governing Body - including EPRR	

2.4 Leeds Cross-System Winter Operations Team

Table 2 below identifies the members the Leeds system winter leads. All those nominated hold senior positions, have the authority to commit resources and make immediate decisions that impact on the resilience and effectiveness of our system.

Table 2 Winter Operational Leads

Organisation	Lead	Title	Deputy	Title
Leeds Teaching Hospital Trust	Clare Smith	Chief Operating Officer	Sajid Azeb	Interim Director of Operations
NHS Leeds CCG	Sue Robins	Director of Operational Delivery	Debra Taylor-Tate	Head of Unplanned Care
Leeds City Council	Shona McFarlane	Deputy Director Social Work and Social Care services	Nigel Parr	Head of Safeguarding and Quality
Leeds Community Healthcare Trust	Sam Prince	Executive Director of Operations	Megan Rowlands	General Manager – Adult Business Unit
Leeds and York Partnership Foundation Trust	Joanna Forster-Adams	Chief Operating Officer	Andy Weir	Deputy Chief Operating Officer
Leeds GP Con-Federation	Gaynor Connor	Director of Transformation	Wendy Pearson	Director of delivery
Yorkshire Ambulance Service	Catherine Bange	Regional General Manager	John McSorley	Divisional Commander

Local Care Direct	Andrew Nutter	Chief Operating Officer	Wendy Pearson	Director of Delivery
One Primary Care	Shaun Major-Preece	Assoc. Director of Operations and Performance	Rebecca Chege	Clinical Lead
Age UK	Iain Anderson	Chief Executive	Jess Inglis	Operations Director

Winter Leads will also be required to participate in co-ordinated system wide Sitrep calls over the winter period when the system is experiencing significant pressure. In addition all lead on major work streams within our recovery plan.

3

Planning and priorities

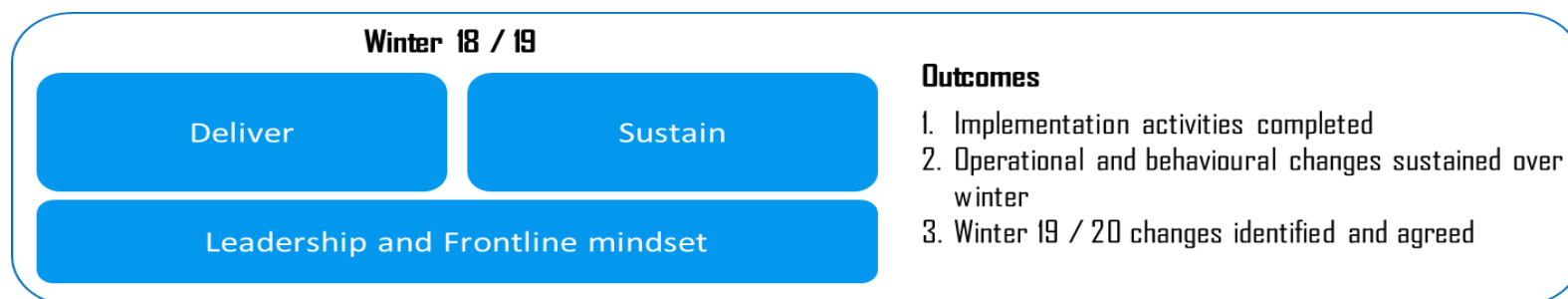
In preparation for winter 2018/19 Leeds had a comprehensive action plan based the opportunity identified through the Perfect Week (Oct 17) and Multi Agency Discharge Event (MADE Feb 18) and the Newton Europe diagnostic June 2018.

The action plan demonstrated the systems commitment to continuous improvement through agreed work streams to improve people's outcomes and experience and achieve national performance standards. The central tenant of the plan remained 'home first' as a consideration for every patient to keep people in their own homes, promote self-care and independence. Work streams included:

- Discharge decision making
- Stroke pathway- integration acute and community services
- Social work assessments
- Mental health continuing care funding
- Care Home trusted assessors
- Mental health support for care homes

It was agree by SRAB that we needed to keep focused on the outcomes as identified in diagram 1 to improve our position over winter 2018/19 and realise the opportunities presented by Newton Europe.

Diagram 1



3.1 Winter 2018/19 evaluation

To support the action plan the system also committed to make changes in the operational management of winter, introducing a weekly winter operational group to manage the day to day pressures in the system

A full report of winter 2018/19 can be found in Appendix 2. This report covers:

- System winter planning 2018/19
- Performance
- Evaluation process and outcomes

Key findings include:

- Overall the system agreed that we had a much improved winter in 2018/19 compared to 2017/18 with milder weather and low levels of flu presentations.
- ECS in April 2019 was 4.7% higher when compared to April 2018 despite a 6.4% average increase in attendances.
- Planned cancellation of all electives resulted in more elective activity overall.
- At times of pressure high patient acuity especially respiratory illness was a considerable factor
- Community investment and pathway improvements will support both attendances avoidance and reduce non-elective admissions improving outcomes and experience.
- Discharge processes and outcomes have seen an improvement but these can be further developed starting with a review of the LIDS team.
- Our approach to planning, managing pressure and working together supported positive behaviours building on existing relationships across the system. The OWG was a key vehicle in enabling this and in promoting the benefits of system co-operation.

The outputs from the evaluation have been used to inform the system priorities for 2019/20 forming part of the LSRP 2019/20

3.2 Newton Europe diagnostics 2019

It was evident from our collective winter position that we were making progress in a number areas of opportunity identified in the 2018 Newton Europe diagnostic.

- Average length of stay for those on the Stroke Pathway reduced by 45% from 34 days to 18 days
- No longer any patients waiting for a decision on Mental Health Funding
- 25% increase in the number of patients discharged before 4pm on pilot acute wards
- Increased pace of social work assessments, with 1.5 fewer days spent on referral and allocation processes

In addition we have seen progress within the system leadership and mind-set, diagram 2. From a lower starting position our leadership has seen more growth across all of the domains and demonstrates the system commitment to the vision. For 2019/20 we aim to translate this through to our frontline staff where we need to develop capability and improve our set up if we are to progress further.

Diagram 2

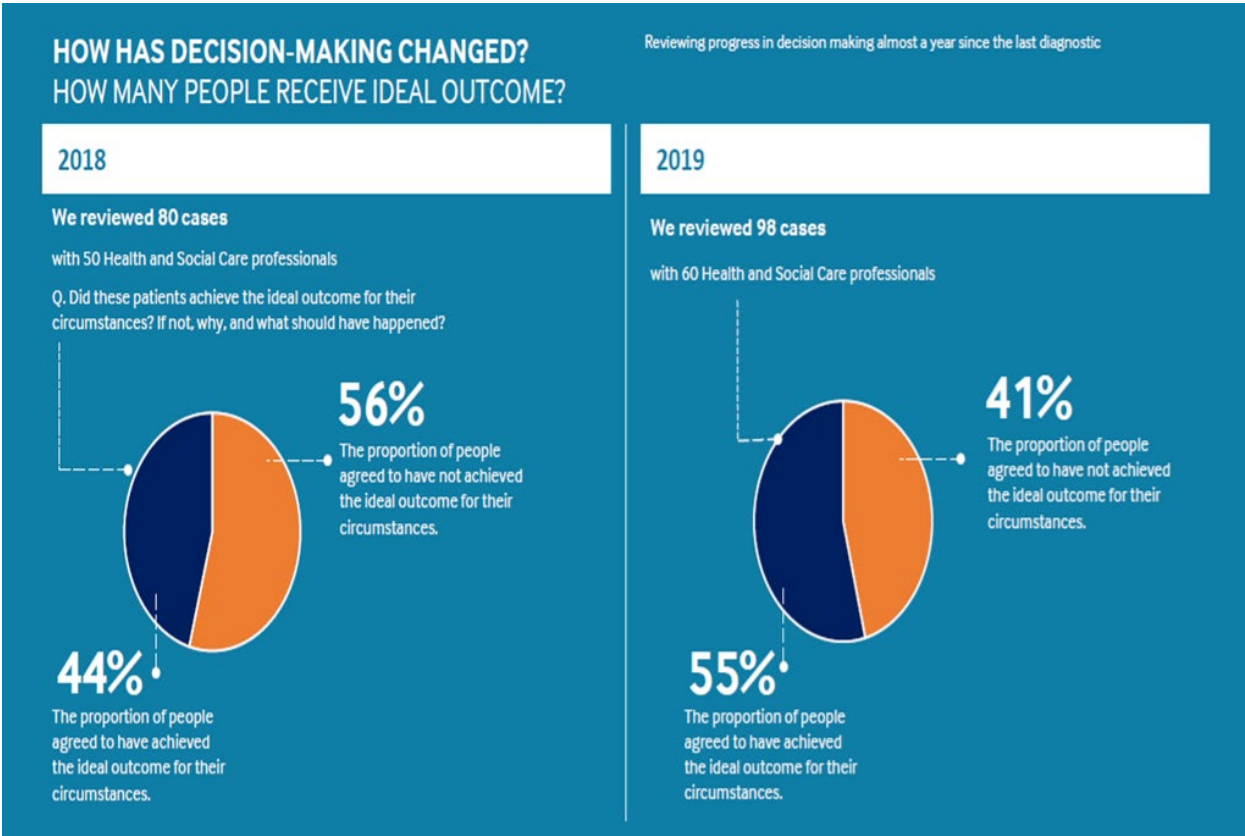


3.2.1 Newton Europe back door re-audit

To ensure we understand our progress and identify further opportunities Newton Europe agreed to re-audit the discharge decision making across our system. As the key areas for improving discharge, ensuring the optimal outcome for people and supporting effective outflow from the hospital this was a priority for the system.

The audit showed that we had made a slight progress in achieving the ideal outcome for people on discharge by 15%, diagram 2. Though there is further scope to reduce the variation in decision making. This will ensure that at discharge the best decisions to maximise peoples independence are consistently made and the opportunities for the system are realised during 2019-20.

Diagram 3



3.2.2 Newton Europe front door diagnostic

Newton Europe provided the SRAB with a version of the truth regarding the issues associated with discharge across the system. It was decided that conduct a similar diagnostic at the front door of LTHT would once again provide valuable insight into our system.

Newton Europe seeks to answer the following questions:

How can we better utilise primary, urgent & community services to avoid unnecessary A&E attendance & acute ward admission?

Outcomes of the exercise indicated:

Admissions

- 28% of admissions were avoidable with services **currently** in the Leeds System
- Average length of stay for the avoidable admissions was 4.5 days
- Key reasons for the admissions
 - Clinical decision making
 - None or perceived no access into alternative services e.g. variation in referrals to neighbourhood teams
 - Knowledge of alternative services perceived criteria/capacity of services e.g. Community IV antibiotic service

A&E Attendances

- 42% of people could have used an alternate pathway instead of attending the A&E
 - 14% of the 42% attended on the advice of a professional
 - 65% referred by a GP – 60% of these could have gone via PCAL negating the need to attend A&E
 - 20% referred by 111
 - 10% referred by a UTC
 - 28% of the 42% was patient choice
 - 55% of those who chose A&E could have been treated in an UTC or Walk-in-centre
 - 40% of those who chose A&E were treated in the GP stream and there could have attended a GP surgery

Diagram 4 shows a summary of the opportunity identified by the Newton Europe re-audit and the front diagnostic.

Diagram 4

2019 DIAGNOSTIC SUMMARY OF FINDINGS			
	THE OPPORTUNITY	THE CHALLENGE	SCALE OF CHANGE
Admission Avoidance	6,700 AVOIDABLE ACUTE ADMISSIONS PER YEAR	CAPACITY REQUIRED FOR 50 ADDITIONAL NEIGHBOURHOOD TEAMS VISITS IN THE EVENING PER WEEK	750 STAFF TO ENGAGE IN CO-DESIGN & CHANGE
Attendance Avoidance	13,000 AVOIDABLE ACUTE ATTENDANCES PER YEAR	90,000 SELF-REFERRED ATTENDANCES TO A&E ANNUALLY	100+ GP PRACTICES LISTED ACROSS LEEDS
Discharge Decision Making	800 PATIENTS COULD BE CARED FOR IN A BETTER SETTING PER YEAR	MINIMAL MEASURABLE CHANGE IN METRICS SINCE 2018	5000+ ACUTE & COMMUNITY STAFF TO ENGAGE IN CO- DESIGN AND CHANGE

It is evident from the findings above that there are significant opportunities for improvement across all aspects of our unplanned care system. Realising these opportunities would support the left shift in the provision of care and improve outcomes for the population.

3.3 Leeds System priorities

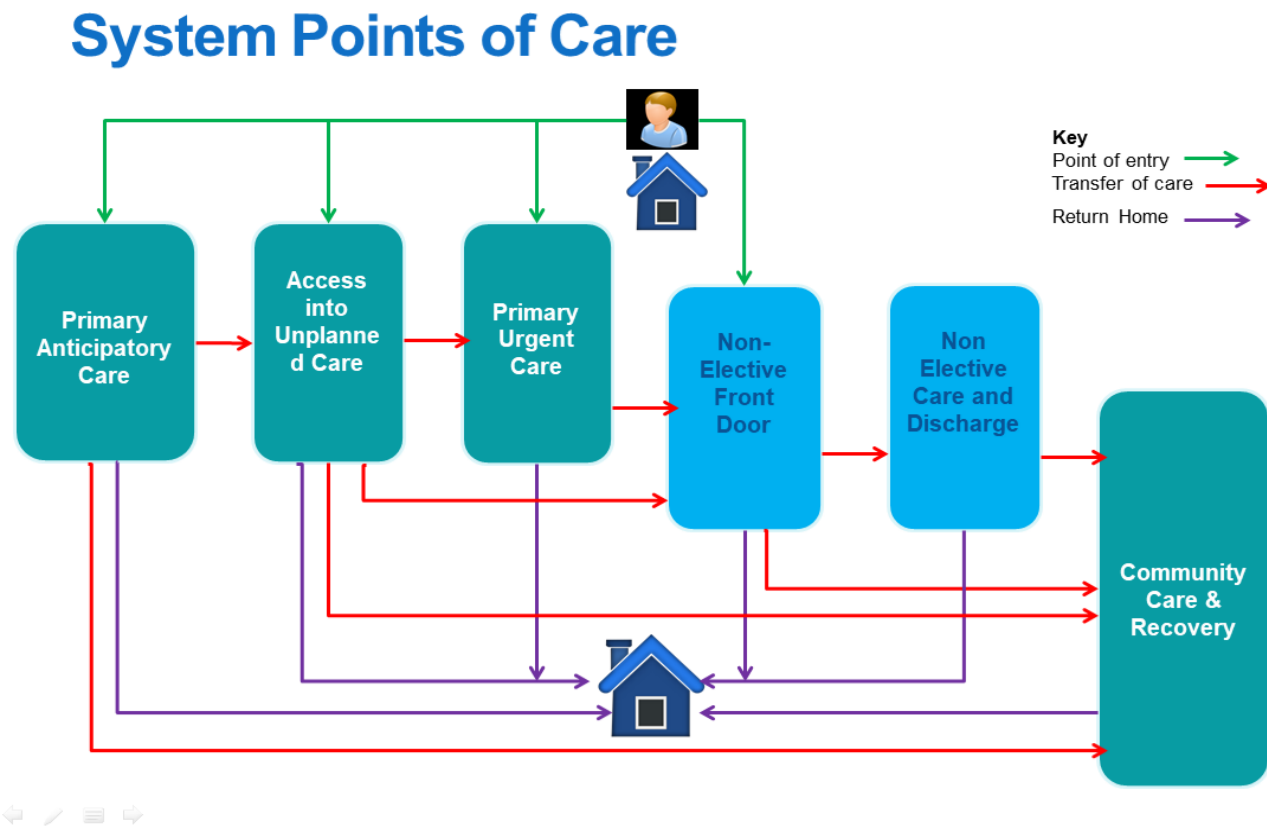
Following the outputs from both Newton Europe diagnostics, the winter review and the NHS Long Term Plan, SRAB has reviewed the priority work streams for 2019/20.

Feedback from the governance review highlighted the need for to focus across the whole pathway of unplanned care. The system points of care diagram 5 form the 6 key areas of the pathway across the system. The priority work streams span all points of care to ensure our plans reflect the full scope of the opportunities available to achieve the left shift and deliver the aims of the long term plan.

3.3.1 System pathway

Diagram 5, illustrates the points of care and the complexities across the unplanned care system.

Diagram 5

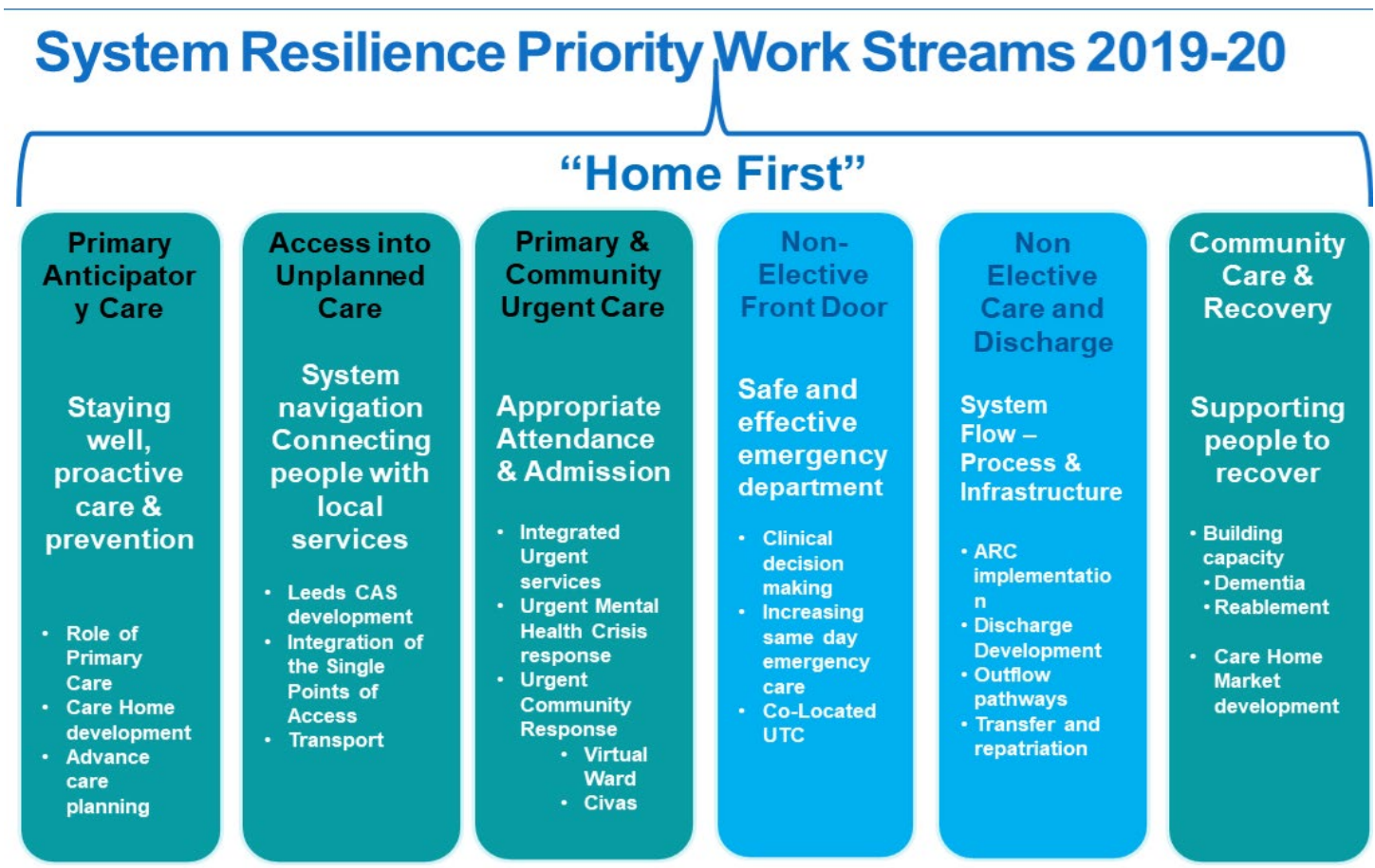


3.3.2 System priority work streams

The work streams identified in diagram 6 support the delivery of the priorities for 2019/21. Many of the work streams are established and are clear regarding their aims and governance. Pulling these work streams into the SRAB governance will ensure pace, a renewed focus holding system partners accountable for delivery.

Key to our success will be monitoring progress to understand the impact of the work streams and the collective impact on the system and performance. Each work stream will be required to demonstrate how their project maps to the vision and aims supports overall system performance and the left shift .

Diagram 6



The next section describes a number of the work stream in more detail.

Primary Anticipatory Care – staying well, proactive care and prevention

➤ Care Home developments

The quality and the sustainability of older people's care home provision remain key issues both nationally and locally, and the Council and the CCG have a key role to play in supporting care homes to continuously improve the quality of care delivered and to remain viable to ensure there is sufficient capacity to meet needs. The governance of the various projects and work streams have been brought together through the establishment of the Integrated Care Homes Oversight Board.

The main aim of the plan through various initiatives and programmes is to support the reduction of avoidable hospital attendances and admissions and ensure processes are in place to support effective timely discharges. There is a continued focus on people with complex needs and/or challenging behaviours relating to their dementia delayed in wards at LTHT and at The Mount at LYPFT and who are experiencing excessive lengths of stay because they are awaiting a suitable care home placement.

To address we have extended LYPFT Care Homes Liaison support to provide additional clinical input, including access to out of hour's psychiatric services to care homes where they were willing and able to offer a placement to a person exhibiting challenging behaviours relating to their dementia. Also there has been additional funding available for transitional payments to care homes for up to 6 weeks for additional staffing when a person with complex needs/challenging behaviours are admitted to their care home.

Our highest group of DTOCS in Leeds is for dementia patients, many of whom present with challenging behaviour. In discussion with Leeds city council we are in the planning stages for the re conversion of a number of community care beds along with other facilities to provide an intermediate tier offer for these patients. These would not be a step down facility but a medium term units where patients can be fully assessed and supported towards long term care options. This could be up to 30 beds which would start to free up capacity in both LTPFT and LTHT and improve outcomes for this population.

Other initiatives include:

- The 'Red Bag' initiative
- Telemedicine scheme - trialled in 14 care homes, now extended to 30 homes
- React to Red Skin campaign
- Enhanced care home scheme – Aging Well Model (Long Term Plan)

- Care home capacity tracker
- Enhanced Surveillance tool and joint protocol for addressing safeguarding and risk escalation
- 'Delivering Effective Social Care with LGBT People' RIPFA (Research In Practice for Adults)
- Dementia mapping
- The Living Lab Project – initiative led by the Leeds Care Association – a collaboration between care homes and the Universities of Leeds and Maastricht, to improve quality and to nurture and support learning cultures in care homes
- Digital connectivity - enhancing the use of technology in care homes to improve service provision including:
 - the Social Care Digital Innovation Programme
 - support to care homes to complete the Data Security and Protection toolkit
 - support to care homes to access the Leeds Care Record and an NHS.net email address
- Workforce
 - registered managers network, activities co-ordinators network
 - a joint health and care annual awards ceremony for care home staff
 - supporting the nursing workforce in nursing homes/Leeds Teaching Care Homes

During 2019/20 we will continue to work in partnership with care home providers/registered managers to raise the standards of care and to achieve a 'Good' CQC rating throughout our care homes in Leeds. In addition we know we need to secure further capacity for nursing care and particularly for high quality specialist dementia care home provision through market facilitation and development.

System navigation- connecting people to local services

To support people to navigate the system and access the optimal service by embedding multidisciplinary Clinical Assessment Services (CAS) that will integrate with NHS 111, mental health, ambulance dispatch, acute, community and primary care services and social care. Section 5.2.2 provide more detail regarding our long term plans to develop a Leeds CAS

There are 4 main areas for development within this work stream during In 2019/21:

- Continue testing the integration with 111 and a local Leeds CAS
- Expansion of pathway development within the Primary Care Advice line (PCAL), within LTHT)
- Integrating the Single points of access across the city

- National Pilot site - Clinical Assessment Services Supported Discharge
- Accelerator site for Urgent Community Response

➤ **Leeds Local CAS**

Due to the size of the city, it was felt that Leeds would benefit from developing its own local CAS. The local CAS will supplement the Core CAS function. It will offer clinical advice from a varied health and care clinical skill mix to the population. This will support the move towards increasing the volume of clinical advice given to people by health and care professionals over the telephone, reducing the volume of activity going into face to face appointments. For those individuals who do require a face to face appointment, the CAS will direct book an appointment the individual into the right service, within the right timescales depending upon the clinical need of the individual support the national targets within the Long term plan and our system objectives.

The proof of concept of implementing a local CAS has been tested; with the pilot successfully evidencing clinical advice was the outcome for 50% of the calls coming in to the CAS. 30% of calls requiring a face to face appointment were seen in the GP Out of Hours service, and the remaining 20% of calls requiring a face to face appointment had appointments booked back at their own registered general practice. The data from the testing the proof of concept supports:

- The ability to give clinical advice, supporting the national ambition;
- A reduction of face to face appointments within the system;
- Direct booking in service for onward care/assessment
- The left shift model of service delivery;
- Positive collaboration and system working between providers and commissioners;

The ambition is to utilise a phased approach to gradually build up and test new elements within the local CAS function. The development will be based on the findings from continuous learning and formal evaluation. This development will continue over the upcoming 5 year period. This supports the NHS 10 Year Plan as by 2023 the local CAS will have been developed to include the function of discharge.

➤ **Primary Care Advice line**

Set up over 10 years ago PCAL has support General Practice in the management of people requiring acute assessment/care negating the need for them to go to A&E. The service has developed over the years and is now a fundamental part of managing acute flow into LTH. The Newton Europe diagnostic highlighted the need for the service to be expanded in terms of capacity and pathways to maximise its potential in reducing A&E attendances, avoidable admissions and improving peoples experience and outcomes. Funding to support the required capacity has been identified within the Leeds winter ICS allocation.

Priorities for the PCAL service during 2-019/20 include:

- Balance demand and capacity
- Embed the Ambulance pathway to ensure people are taken directly to an appropriate assessment unit where appropriate
- Consultation with geriatrician to direct people to the frailty unit and the virtual wards as they develop
- Re launch PCAL across the system
- Integration with Single Point of Urgent Referral (SPUR)PCAL to direct people to Neighbourhood Teams and Community Care beds

➤ **Integrating Single Points of Access**

Leeds, there exist multiple single points of access. Some of which are available to the public, some to health and care professionals, and some which are available to both. Evidence suggests people and professionals use the single points of access that they are most familiar with, and perhaps are not aware off other offers, which may better suit the presenting needs.

There is an opportunity to converge all the single points of access to generate a truly single, multi-disciplinary clinical skill mix offer, to both the public and professionals, to give clinical advice and when necessary to book people into the right service within the unplanned care system. Scoping of the opportunity is completed and full work plan is in development.

➤ **Clinical Assessment Services Supported Discharge**

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. Leeds has expressed an interest in becoming a pilot site for supported discharge with a focus on acute care alongside establishing good practice within the acute setting for when discharge support is started. This will support the development of the CAS function as well as the Non elective care and discharge -decision-making works stream. We are waiting to hear from NHS England as to whether or not we have been successful.

Primary and community urgent care – appropriate attendance and admissions

➤ **Urgent Mental Health response**

The Independent Mental Health Taskforce Five Year Forward View (February 2016) made it clear that improving access to high-quality mental health care must become a national priority. Locally it is also recognised that there is a growing need for urgent mental healthcare services in Leeds to support people to access care.

A mental health crisis is defined as a situation that the person or anyone else believes requires immediate support, assistance and care from an urgent and emergency mental health service.

Improving access, pathways and care for people in crisis will involve all partners including the third sector and service users to work in collaboration. We will work to improve blue light and community based crisis response, ensure Children's and Adolescent Mental Health services (CAMHS) services are developed. This will include development of pathways e.g. street triage that provide an alternative to the Emergency Department (ED) and provide a more appropriate care for patients seven days a week.

Key commitments during 2019/20 aligned to the long term plan:

1. Ensure that anyone experiencing mental health crisis can call NHS 111 and access 24/7 age-appropriate mental health community support.
2. Continue ambition to ensure that all adult and older adult community crisis resolution and home treatment services are resourced and operating with high fidelity by 20/21

3. Ensure that by 2023/24, 70% of Mental Health Liaison services in acute hospitals meet the 'core 24' standard for adults and older adults, working towards 100% coverage thereafter.
4. All children and young people will have access to 24/7 crisis, liaison and home treatment services by 2023/24
5. Increase provision of non-medical alternatives to A&E such as crisis cafes and sanctuaries that can better meet needs for many people experiencing crisis.
6. Increase alternatives to inpatient admission in acute mental health pathways, such as crisis houses and acute day services.
7. Improve ambulance response to mental health crisis by introducing mental health transport vehicles (subject to future capital funding settlement), introducing mental health professionals in 111/999 control rooms; and building the mental health competency of ambulance staff.
8. Specific waiting time's targets for emergency mental health services will for the first time take effect from 2020 (Part of wider clinical review of Standards)
9. Improve the therapeutic offer on inpatient wards, e.g. more psychologists and occupational therapy

A new group is being established to oversee this work to ensure links with both the Mental Health and Children and Adolescence strategies.

Urgent Community Response

➤ Neighbourhood teams

Across Leeds there are 13 Neighbourhood teams delivering health and care services to their communities. The Newton Europe diagnostic showed that 17% of admissions could have avoided by referring to the NT as an alternative. All identified patients were over 65 years old and 75% were admitted between 18:00 & 23:00.

Diagram's 7 and 8

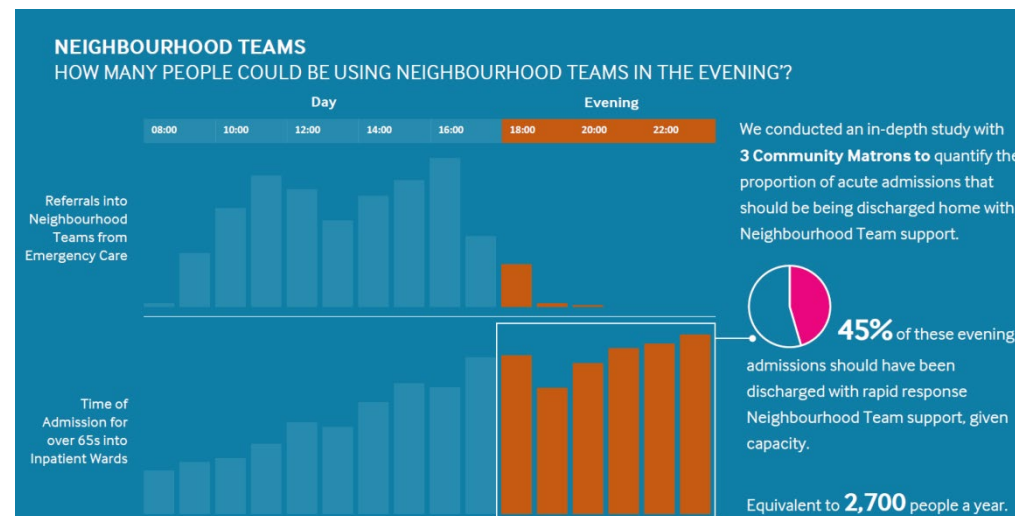


Diagram 7, shows neighbourhood teams referral pattern vs A&E admissions. Following an in depth study with 3 Community Matrons 45% of evening (6pm-12am) acute admissions could have been discharged home with Neighbourhood Team support. This has the potential to effect 2,700 people per year by returning home with support requiring an additional 50 NT visits per week.

To understand the full scope of the opportunity to maximise NT we also looked at how many people could have been supported during the day. It showed that 14% of admissions between 8am-6pm could have been discharged with support. 600 people a year.

The total opportunity equates to 3.300 people avoiding admission to an acute bed receiving care in their own home.

Understanding the variation across the NT along with developing a 27/4 model that would increase the capacity of the teams to start to realise the left shift in care is be a priority for LCH as they develop their response to the national implementation of the Aging Well Model. This will see Community Rapid response service responding within 2 hours and the reablement offer (Leeds City Council) within 4 hours.

➤ **Virtual Wards**

The development of a city wide Virtual Ward across multiple specialities including respiratory and frailty is key in the development of Neighbourhood Teams in increasing the community rapid response offer and supporting the left shift.

The ambition within Leeds is to develop a multidisciplinary Virtual Ward which will be a collaborative service between LTHT and LCH and the Confederation to provide coordinated rapid care to people in their home who are experiencing an acute medical episode. This rapid care involves providing responsive specialist assessment (including medication review), monitoring, investigations, treatment, support and education for people and their carers by the most appropriate specialised team.

It will ensure people's needs are safely met within the community without requiring a hospital attendance/admission where appropriate. A phased implementation has been agreed which sees avoiding hospital based care as the initial focus with the service supporting earlier discharge in phase 2 expected in Q1 of 2020/21.

The virtual ward projects have been funded through system transformation monies.

➤ **The Community IV Antibiotics Scheme**

Newton Europe diagnostic showed that 7% of admissions for those 65 and over could be avoided through using the Community IV Antibiotics Scheme (CIVAS).. CIVAS is a community based service that is delivered jointly by Leeds Community Healthcare (LCH) and LTHT. The aim of the service is to support discharge from hospital; Emergency Department (ED) and inpatient wards at the earliest possible opportunity by providing IV antibiotic therapy in a community/outpatient setting to prevent either admission or extended length of stay. The service is delivered in both people's homes and community hub clinics by a multi-disciplinary team consisting of staff and senior nurses, LTHT clinical nurse specialists, pharmacists, and Infectious Diseases Specialists.

By developing the service and increasing the capacity to manage up to 75 cases at any one time there is the opportunity to avoid 1,500 admissions. Priorities for the service in 2019/20 include:

- integration of the service across LCH and LTHT
- provision of IV Diuretics, and Line Care
- Implement Cellulitis Pathway
- Rebranding of the service - CIVAS as this implies only IV Antibiotics can be provided as is therefore misleading to referring clinicians.

Safe and effective emergency departments

➤ A&E decision making/triage

Clinical decision making within an ED can vary due to a number of factors, Newton Europe identified an opportunity for the Leeds system to avoid up to 2,700 admissions through education of ED staff of alternative services in the community. The system is currently working though how this can best be achieved through a number of initiatives including:

- Focus on developing/improving mind-set and behaviours of front line staff
- Shadowing of staff across roles/teams ie. neighbourhood team/community to gain more knowledge about the services
- Education to improve confidence and knowledge of the services to support decision making
- Key educational messages for the system
- Maximise technology to support decision making- CAILTEC, DOS
- Improved data sharing to inform decisions and understand behaviour
- Tools to support care navigation - local DOS

➤ CAILTEC

Leeds is currently working with partners CAILTEC is an innovative technology solution to harness digital power to transform and integrate high quality patient care. It looks to find a way to accelerate education and skills retention of clinicians by studying opportunities to create technical integrations between systems to increase the quality of data across the emergency care's patient journey.

➤ **Co-located Urgent Treatment Centres**

In 2019/20 we will confirm the plans for the development of our first co-located UTC within the LTHT footprint. There will be a single entry point for all people who walk-into the hospital with an urgent need. All people will be triaged and then streamed to the most appropriate services for their presenting needs, these include:

- UTC
- Champion for signposting/booking into alternative more appropriate services
- Assessment area/unit
- Emergency Department

This will enable the right skills and capabilities in the right place ensuring those with the most life threatening conditions have the best chance of survival.

Non Elective Care and Discharge - System Flow, Process & Infrastructure

The Decision making work stream has been established for a year now and has been making progress in the decisions for people leaving the acute trust who require further care or support. Though it is acknowledged that there is still scope for improvement to ensure people receive the ideal outcome for their circumstances. The group is in the process of reviewing progress and scoping further opportunities.

Three further areas of development have been proposed for 2019/20:

- Achieving Reliable Care (ARC) to reduce LOS and bring about real behavioural and cultural change on our wards.
- Implement the outputs of the Leeds Integrated Discharge Service
- Implement the Discharge to Assess pathway for community care beds

All of these initiatives will be supported through winter monies to ensure resources are available to progress further and impact the system this winter.

Community Care & Recovery- Supporting people to recover

A fundamental aspect to effective discharge from hospital is to ensure that community services have sufficient capacity and support to ensure people return as quickly as possible to the most appropriate place for their care.

Within section Primary and community care urgent response, we refer to work within the NT, including social care and the wider Local Care Partnerships that will support attendance and admission avoidance which also support people discharges from hospital.

In discussions with Leeds City Council we are scoping the options to expand the reablement service in response to the Aging Well Model supporting attendance and admission avoidance. These discussions will also focus on maximising the service to facilitate discharge and support keeping peoples them in their own home retaining their independent and reducing the system long term placements in response to the Newton Europe findings.

We will continue to ensure the reablement services has sufficient capacity by ensuring it:

- Recruits to establishment
- Maximise time with service users
- Ensure service users spend the right amount of time receiving the service

Addressing all three points will continue to see increased numbers of weekly starts to meet the extra demand and support a shift towards recovery and independence services

System Resilience Communications

Data shows that the ‘winter pressures’ experienced by urgent and emergency care services is a year round issue with various in demand experienced throughout the year, however the media tends to highlight activity during the winter period.

Evidence suggests that some of the pressure on the system could be reduced by patients making appropriate use of all services available to them should they fall ill or get injured. “While A&E is the right place for many of these patients, estimates quantifying the size of non-urgent A&E demand (patients who could be better treated elsewhere) vary from 20% to 40% of all attendances”, (source: Department of Health).

Evidence shows (BMJ, 2016 and RCN, 2016) the A&E 'superbrand' continues to attract patients who could potentially be treated elsewhere. Furthermore evidence shows that when faced with a range of options, patients are confused and default to A&E (NHS England, 2017). More recently the British Social Attitudes Survey (2019) reinforces this and highlights the perception people have that it's difficult to get GP appointments as well as increased trust in hospital-based doctors over other clinicians.

Our communications activities are year round designed to provide a consistent set of messages that highlight alternative support available as well as placing an onus on self-care and prevention, where appropriate.

In Leeds we are now working together to see how all system partners can support communication activity that encourages people to self-care where appropriate, use alternatives to A&E and look out for vulnerable neighbours. We are following the principles of the national 'Help us help you' campaign with communication messages and activities based around preparedness, prevention and performance and the idea of developing a reciprocal relationship with people.

➤ **Our focus**

Throughout this year and as we head into winter we have concentrated our communications effort on the following.

- Ensuring people are aware of the alternatives to A&E for non-emergency care. We've particularly focused on developing the 'Talk before you walk' concept to encourage people to call NHS 111 when they're feeling unwell but it's not an emergency.
- In line with national campaigns we have also highlighted the support people have available from pharmacies including a concerted effort to demonstrate that they are skilled healthcare professionals.
- We know that not everyone is aware that GP practices are open on evenings and weekends, this is something we've continued to promote so that every available appointment is taken up.
- Providing year round seasonal advice such as a summer health campaign, with a particular push on ensuring people stay hydrated.
- Strong internal communications so that system partners are aware of the work we're doing in Leeds.
- Linked to the above we ran the Big Thank You campaign that encouraged people in Leeds to say a message of thanks to anyone who helps them through winter (and beyond) which supported positive messaging for internal colleagues.

- We've played a key role in developing the first every regional campaign by the West Yorkshire and Harrogate Health and Care Partnership. 'looking out for our neighbours' was launched in March and has recently been evaluated, with results showing a positive impact among those who had seen the campaign.

➤ **Priorities for this winter**

We will continue to work in partnership to run health awareness, signposting and direct action campaigns as below:

- We will engage with local citizens and health and care professionals to develop a significant behaviour and culture change programme. The current working title is 'Home First'. Home First is about educating and supporting people to leave hospital as soon as they are medically fit to do so as well as proactively supporting people so they get well at home rather than getting admitted to hospital. We'll also, where appropriate, support NHS England and NHS Improvement's 'Where Best Next' campaign targeting acute settings in an effort to reduce long stays
- The 'Looking out for our neighbours' campaign will be running again over winter to get people to look out for those around them (www.ourneighbours.org.uk)
- With over 1600 messages received last winter and regular positive media coverage we'll be running the Big Thank you campaign again (www.bigthankyouleeds.co.uk).
- We have a number of campaigns running that help further and higher education students make the right healthcare choices. This includes No Regrets that promotes safer drinking (www.noregretsleeds.co.uk) and Feel Better that encourages use of pharmacies and NHS 111 (www.feelbetterleeds.org.uk).
- We're currently considering options for a mass mailout to promote NHS 111, pharmacies and extended GP opening hours as well as actions that support the 'left shift' approach.

➤ **Activity and resources**

Our proactive approach includes the below:

- A year round social media calendar with messages adapted to meet seasonal needs eg flu vaccine, summer health advice etc

- Planning ahead for bank holidays with advice issued on social media, through local media and internal communication channels
- Regular reprint of fridge magnets with advice for parents and carers of children aged 0-5, distributed to health and care settings
- Promotion of national Help Us Help You campaign
- Reprint of information leaflets and social media advertising targeting members of the Eastern European community backed up by a dedicated website www.healthinleeds.org.uk
- Proactive messaging ahead of extreme weather to help people plan ahead, this is often supported by paid for social media advertising
- Providing communication resources and advice for GP practices this includes a web portal with information resources <https://www.leedsccg.nhs.uk/help-us-help-you-comms-resources/>

➤ **Communications plan**

The communications plan for this winter will broadly follow the same approach as the one for 2018-2019 (appendix 3).

The current plan is being discussed by the citywide communications group and will be signed off by SRAB

Assess the opportunity of the left shift- capacity and demand

It is vital that as we start to develop work streams and projects to achieve the left shift in the provision of care by increasing primary care and community capacity, that we start to understand the potential shift of activity and associated financial flows that will be required.

In response to the Long Term Plan Implementation Framework we are required to submit a strategic planning tool to NHS England in September 2019. This submission will show our long term acute activity assumptions and strategic financial investments by sector across our system, supported by our workforce assumptions. The plan will be signed off by both the CCG and providers. It is

important to mention that this brings potentially £27m into the West Yorkshire system. We are awaiting confirmation of Leeds allocation and guidance on how this will be spent.

This will be the start of developing a detailed model which includes but is not limited to:

- Population Health Management
- Newton Europe outputs and opportunities
- Current contracts
- Development of Primary Care Networks
- Financial investment plans

3.3 Investment

Realising the opportunities identified within the plan will require a shift in investment over the next 2-5 years. The systems response to the long term plan implementation framework will start to provide an overview both commissioners and providers investment strategies. The development of one version of the truth regarding the future system demand, capacity and the left shift opportunity by March 2020 will be key in further informing the investments and detailing plans, business cases and financial risks.

➤ Winter 2019/20 investment

Though the West Yorkshire Integrated Care System (ICS), Leeds will be has been allocated £775.000 to invest in winter initiatives. Priority Project has been agreed by SRAB August 2019 and in turn by the ICS Urgent and Emergency Care Board. We are now in the process of working with the projects leads to identify the required resources including workforce.

Leeds proposed projects are:

- Social Workers to support the Discharge 2 Assess pathway
- Development of the CIVS service
- Expansion of the PCAL function within LTHT
- Community Dementia capacity

Though the ICS allocation will support a number of 2019/20 priority projects the resilience of our system especially at times of pressure depends on our commitment to work in an integrated way. There will be a continued focus on new ways of working across organisations to maximise existing investment, capacity and ensure resources are used effectively and efficiently to support the delivery of quality services for our population.

Due to the Aligned Incentive Contract (AIC) the CCG and LTHT have agreed a financial envelope through the based on previous years costs with CCG setting aside a budget for winter pressures. In the event of activity and/or demand significantly above expected levels the System will take joint responsibility and develop mitigation plans within agreed cost envelopes. The CCG and LTHT will monitor demand levels within the unplanned working group and System Resilience Assurance Board. The CCG has plans protecting LTHT against the loss of elective capacity from increased non-elective demand especially with the intent to suspend some elective activity in January 2019.

3.4 Risks

The high level risks and mitigating actions to support the delivery of a resilient health and care system in 2018/19 are identified within 2 areas:

- Variable risks are those which we cannot predict but where we can put mitigating plans in place, 9 high level risks have been identified.
- Impact risks are those we have assessed and highlighted the probabilities and consequences of the risk, 8 high level risks have been identified

The high level risks have been RAG rated pre and post the agreed mitigating actions, the full risk register for the LSRP are included in Appendix 4.

3.5 Public Health - Leeds City Council

The Leeds Local Authority Public Health contribution focuses on preventative and preparedness health measures and is informed by the PHE Cold Weather and Heatwave plans for England (2018). LCC Public Health are leading a number of key programmes to ensure vulnerable people are protected from the adverse effects of cold and hot temperatures. Public health are working to optimise the role of the Council to address priorities including promoting key messages through Council services, working with commissioned services to prioritise programmes with service users, and ensuring that Elected members are briefed on key messages and issues.

Public Health priorities:

- Infection prevention and control; improving flu vaccine uptake in target groups, increasing community staff skills, knowledge and competencies through the delivery of infection prevention training; outbreak planning and management across the community
- Mitigate the impact of the negative effects of cold and heat on vulnerable people; commissioning of winter warmth services including winter friends programme, providing vulnerable people with high impact interventions to keep people well during cold and hot periods, delivery of small grants schemes for community groups and others.
- Living with Frailty; delivery of programmes, including the commissioning of the Home Plus, to support people living with frailty focusing on falls, malnutrition and support for independent living

4

Escalation and Incident Management

Variation in the demands across a health and care economy is normal and occurs throughout the year though experience informs us that winter months pose significant challenges. To ensure we continue to deliver quality, safe and responsive services Leeds needs to be equipped, prepared and coordinated to respond quickly and appropriately to any change in demand or circumstances as well as develop a strategy to transform our system for the future.

4.1 Escalation and Mutual Aid

Operational Pressures Escalation Levels (OPEL) NHS England Mandated framework for all NHS health organisations aims to provide consistency in the reporting and managing escalating situation across system both locally and nationally.

It was evident during the winter of 2017/18 at times of extreme pressure the system veered away from agreed processes and our mutual aid was not sufficiently defined to support de-escalation and recovery. With clear processes, robust mutual aid agreements; including the Decision Management tool (Appendix X) and the establishment of the weekly OWG we entered winter 2018/19 in an improved position. All partners were clear on their roles and responsibilities and there was the assurance that these were aligned to organisational on call procedures and national reporting requirements. With only the need for 3 Sitrep call over the 2018/19 winter we will be building on the foundations of this success as we plan for 2019/20.

All organisations in 17/18 developed a Decision Management Tool which provided a risk assessed model to identify contingency actions that we would need to take if our system reached OPEL 4. The tool focuses predominately what services could be suspended and resources re-deployed to manage the incident and support recovery. This was further developed in 2018/19 and will be reviewed as part of the 2019/20 LOPEL refresh.

We are in the process of refreshing the Leeds Operational Pressures Escalation Levels (LOPEL) for 2019/20 to ensure it is reflective of operational activities and behaviours. The refresh will focus on the agreed objectives carried forward from last winter below:

- Confirm governance arrangements for winter – winter room, patient level operational groups
- Mutual understanding of the parameters of the OPEL Levels and how they work within Leeds to ensure they reflect and meet local changing needs
- Review and align organisational triggers to OPEL to ensure consistency in the interpretation
- Internal actions to be taken to ensure/support de-escalation
- Joint planning to support the prediction of flow issues and delays
- Complete an analysis of mutual aid across the system to identify develop and agree tangible and realistic actions based on the Leeds system principles
- Agree daily the reporting format, analysis and sharing information including primary care
- Refine our approach to the timely management of the system; command and control to address operational challenges and promoting a recovering system (SiTRep calls, winter room)
- Agreeing our approach, processes and escalation to executive level command
- Review of organisational decision management tool to inform system management and actions at OPEL 4/critical, major incident
- Review all On call arrangements and ensure alignment and communication is clear and understood, including exception reporting process during winter, further on –call training
- Desk top exercise to test process and mutual aid in an escalating scenario, to include adverse weather and flu
- Align predictive and responsive communications to OPEL levels to develop consistent and targeted messages to staff and the public
- Implement a structured approach which drives and supports assurance of organisational compliance with the 2019/20 Emergency, Preparedness, Resilience and Response

4.2 Leeds Escalation principles

Clinical quality and safety are the top priority in the delivery all health and care services. During the periods of intense pressure in Leeds we have maintained zero twelve hour trolley breaches and people in non-designated bed areas since May 2018.

The principles below were agreed in 2018/19 and will be carried forward for this year's plan. These principles underpin our plans and ensure we have a shared approach to deliver quality and safety for our population with clear outcomes.

- The Leeds health and care system provides consistently high quality and safe care, across all seven days of the week
- Zero tolerance of 12 hour trolley breaches
- Non patient cared for in a non-designated hospital areas
- No cancellation of elective surgery within 48 hours
- Services have a set of standard response times and categories for prioritisation
- Clinical standards are clear and articulated through assessment, intervention and discharge pathways
- Patients will not wait longer than 15 minutes in ambulances before handover at ED
- Clear infection control protocols are in place including the transfer of people on to or returning to alternative services
- Capacity is managed within organisations and as a coordinated system across the health and social care economy.
- No action that would undermine the ability of any other part of the system to manage their core business will be taken by one constituent part of the system without prior discussion.
- Should an organisation take action which results in unintended consequences for another/others they will, as soon as if practical and practicable, rectify that action
- As far as possible, the clinical priority of patients, across all care groups and categories of service (i.e. between emergencies and electives) will be the key determinant of when and where patients are treated and cared for. E.g. this may mean that some patients who have self-referred as an urgent are given lower clinical priority than urgent elective patients.

- No action will undermine or question the clinical judgement of practitioners but will however aim to decrease escalation by sign posting patients to less congested services where acceptable clinical alternatives are available.
- Managing patients at a time of increased escalation will require accepting and managing additional risk across organisations, as individual decisions on patient's care are taken, and competing pressures/targets are prioritised.
- Services should be maintained for as long as is practicable in times of increased escalation and organisations will work to recovering suspended services as soon as possible.
- Decision-making and actions in response to escalation alert will be within appropriate timescales.
- De-escalation will be agreed by all partners.

All of our developments need to be flexible to allow an effective response to a whole spectrum of incidents and events that may create a surge in demand or disrupt the normal delivery/flow of services for health and care services, irrespective of situation, duration, scale and type.

4.3 Provider clinical escalation plans

All providers annually review their internal clinical escalation plans which outline their organisational response to managing clinical safety and quality during times of escalation. These are tailored to reflect organisations key priorities, scale of business and are based on continuous learning to provide insight to target interventions when they face further quality, safety and performance challenges

The plans include; but are not exclusive how organisations will manage:

- daily operational process including
 - management of OPEL triggers and action plans
 - weekly quality meetings
 - weekly executive meeting chaired by the CEO
 - escalation process in place for workforce shortfalls

- cessation of non-essential training and development
 - re-deployment of staff to manage pressure areas
 - transfer of clinical staff in non-clinical roles to support patient areas.
 - daily duty response to care homes
- operational silver command response
- approach to Joint Decision Making (JDM)
- implementation of Full Capacity Protocols
 - trolley wait escalation
 - organisational balancing of clinical risk
 - the use of use of flexible labour
 - agreed process of workforce mutual aid across our internal teams
 - elective care activity and the cancellation of routine elective requiring inpatient stay
 - staff flu vaccination programme
 - comprised capacity and flow due to infection and the management of outbreaks
 - prioritisation of services to manage risk and redeploy resources through Decision Management Tools
 - response to increasing demand
- additional winter / flex beds
- conversion of 5 day wards in to 7 day capacity
- additional evening / weekend cover secured via on-call Psychiatry
- medically supervised bays for ambulance conveyances
- additional workforce at times of key pressure to support operational flow
 - implementation of robust audit processes to assure plan effectiveness and identify further opportunities

4.4 NHS England Exception Reporting

To ensure a national view of performance regional winter rooms have been in operation 7 days a week to gather information from systems. The Leeds system has robust processes in place to ensure that we comply with the requirements of exception reporting 7 days a week during the reporting periods. Reporting consists of the following elements:

1. NHS England's weekly call for systems to report their performance, pressures and recovery/supporting actions, CCGs represent their system. To ensure we are able to provide timely information, the Operational Winter Group discusses each week the local pressures and actions taken to provide an overview which is further informed by a call immediately prior to the NHS call between LTHT and the CCG, with other partners included by exception.
2. Relates to assurance reporting to NHSE by way of a daily assurance return, should one of five trigger criteria be met. On days when a specific trigger is met, ongoing actions within the acute hospital are shared by the A/DOP for escalations (that day) or the on call general manager (weekends and bank holidays). The CCG is responsible for collating and submitting the assurance return detailing the steps taken both short and long term by the system to recover the position and support performance improvement and recovery, either via the unplanned Care Team or the CCG on call manager (weekends and bank holidays).

There are triggers in place that necessitate exception reporting each day from October to March and on all bank holidays:

- A&E standard at or below 80% or a deterioration of more than 10% from the previous day,
- Any 12 hour trolley breaches,
- More than 5 Ambulance delays greater than 60 minutes,
- Increase in beds closed due to D&V by 20 beds from one day to the next,
- Other significant event e.g. disruption due to a catastrophic event or loss of infrastructure where the flow of ED is disrupted, major patient safety issues, developing situations where national briefing and preparedness would be of help to the system

4.5 Emergency, Preparedness Resilience and Response

All NHS organisations have a statutory responsibility to ensure they are properly prepared to deal with an incident or emergency. There are well-defined core standards for Emergency Preparedness, Resilience and Response (EPRR) across NHS organisations. All NHS organisations are responsible for the achievement, maintenance and monitoring of the standards, and are accountable to NHS England through the Local Health Resilience Partnership Board (LHRP).

4.5.1 Emergency, Preparedness Resilience and Response standards

The EPRR standards are used to inform and direct our approach to escalation management along with the OPEL framework. The detailed standards seek assurance on all levels of planning, guidance and preparedness on information sharing, command and control arrangements, responsibilities and mutual aid arrangements to enable prompt recovery from disruptions. Business continuity plans are a key part of EPRR planning including the regular testing.

Emergency Preparedness Resilience and Response – Responder Categories

The Civil Contingencies Act (2004) specifies that responders will be either:

- Category 1 (primary responders), or
- Category 2 responders (supporting agencies).

Category 1 responders for health are those organisations at the core of emergency response:

- Department of Health on behalf of Secretary of State for Health
- Public Health England
- NHS England
- Local authorities (inc. Directors of Public Health)
- Acute service providers
- Ambulance service providers

Category 2, responders are critical players in emergency preparedness, resilience and response and will work closely with other category 1 and category 2 responders. The following are considered to be category 2 responders for health:

- Clinical Commissioning Groups (CCGs)
- NHS Property Services.

All NHS providers will complete a self-assessment across a number of domains. The standards are reviewed and updated annually as lessons are identified following incidents or testing, or changes made to legislation or guidance. The 2019/20 standards remain the same as 2018/19; 68 individual standards under 10 domains below which range from command and control to evacuation.

Organisations will be assessed as either Full, substantial, partial or noncompliance based on their response to the standards that their organisation is required to assess against. As Category 2 Responders CCGs are required to self-assess against 43 individual standards, these sit within the 10 domains. By comparison acute providers have to assess against 64 individual standards.

The ten domains are:

- Governance
- Duty to Risk Assess
- Duty to Maintain Plans
- Command and Control
- Training and Exercising
- Response
- Warning and Informing
- Cooperation
- Business Continuity
- CBRN

The submission date is 31st October; SRAB will receive provider's assessment outcomes and develop an approach to address any areas for development especially where themes are evident.

4.5.2 2019/20 EPRR Assurance Deep Dive

Each year NHS England uses the core standards assurance process to undertake a 'deep dive' look at a specific topic relating to EPRR. Previous deep dive topics include Command and Control, Pandemic Influenza, Business Continuity and Governance. Deep dive results are not included in the overall organisational compliance rating and are therefore reported separately. In 2019/20 the

deep dive topic is Severe Weather and Climate Adaptation. Severe Weather would clearly have a system impact, and quickly invoke escalation management processes. Climate Adaptation and Sustainability are city priorities and for these reasons there was support to review this deep dive area in partnership with health providers and the local authority.

4.6 EU Exit Preparations

The Department of Health and Social Care (DHSC) is leading the response to EU Exit across the health and care sector. The application of national guidance is mandatory including all communication, planning and the assessment of risk. Professor Keith Willetts is leading NHS England response to the exit from the EU which focuses on the following key areas as identified by DHSC:

- Interruption to the supply of medicines and vaccines;
- Interruption to the supply of medical devices and clinical consumables;
- Interruption to the supply of non-clinical consumables, goods and services;
- Availability of workforce;
- Changes to reciprocal healthcare arrangements;
- Continuation of research and clinical trials; and
- Interruption to data sharing, processing and access.

Nationally we are being told to expect to begin assuring local preparations in September. This assurance process will cover similar ground as previous exercises, including your plans, systems and contingency arrangements for key areas such as operational readiness, communication, continuity of supply, workforce, clinical trials, data, finance and health demand. Further clarification will be provided at the national workshop for the north of England September 5.

The NHS in Leeds and Leeds City Council are working together on citywide plans to prepare, plan and respond to any impact related to EU Exit. A city wide steering group chaired by Dr Ian Cameron; Director of Public Health was established to ensure a collective and consistent response across the city. It was agreed that the remit of the group was to:

- gain assurance of individual organisations plans.
- focus on themes that effective all organisations, identified as

- Medicine and equipment
- Staff
- Fuel disruption
- Communication
- collective test our continuity plans at a system level

Table 3 shows the Senior Responsible Officers across the Leeds NHS organisations.

Table 3

Organisation	Lead	Title
Leeds Teaching Hospital Trust	Clare Smith	Chief Operating Officer
NHS Leeds CCG	Sue Robins	Director of Operational Delivery
Leeds City Council	Ian Cameron	Director of Public Health
Leeds Community Healthcare Trust	Sam Prince	Executive Director of Operations
Leeds and York Partnership Foundation Trust	Sara Munro	CEO
Leeds GP Con-Federation	Jim Barwick	Chief Executive
Yorkshire Ambulance Service	Steve Page	Deputy Chief Executive & Executive Director of Quality,
Local Care Direct	Andrew Nutter	Chief Operating Officer

In addition Leeds City Council has an EU Exit 'no deal' Strategic City Recovery Plan that demonstrates strong links with partner organisations across the city. The plan focuses on the following key areas:

- Infrastructure and Supplies impact
- Business and Economic impact
- Community impact
- Council impact
- Media, Communications and Public Affairs

As the new exit date of October 31 approaches all groups have been re-established to assess the current status and progress planning. National guidance asks all organisations progress the following mandated actions in preparation for national messages expected early in September.

Nationally mandated actions August 2019

- Complete the mitigation of any issues identified in the previous assurance processes
- Make sure your EU Exit team is in place. This should include, Advising your Board that the EU exit response is being stood up for leaving the EU on 31 October
- Having an EU Exit SRO in place, with supporting EU Exit team, and full management and oversight of the organisation's Single Point Of Contact (SPOC) email for EU exit communications
- Having relevant subject matter experts available for critical areas including supply/ procurement, pharmacy, logistics, estates and facilities, workforce, data
- Reinstating on-call arrangements, and ensuring on-call directors understand what is required of them and the escalation routes for problems
- Ensure your business continuity plans are up-to-date and tested, including winter and flu plans
- Make sure you are engaged with local system preparations around EU exit through Local Health Resilience Partnerships and Local Resilience Forums, and have agreed to link with partner agencies including local authority, CCG and provider colleagues to collaboratively manage and address issues.

- Re-familiarise your teams with details of the EU exit operational guidance from 21 December 2018 bearing in mind some aspects of this may have been supplemented or may be updated in the coming weeks
- Register to attend the regional EU Exit workshops in September, where you will be updated on the operational guidance and planning context, including the key changes since April.
- Revisit your organisation's contract and supplier assurance process including 'walk the floor' checks, to include smaller and/or niche local suppliers not covered by national assurance exercises (this applies to both CCGs and providers)
- Ensure you communicate with healthcare professionals and patients using the available information on the GOV.UK, NHS England and Improvement websites and NHS Choices.

We are informed that we should expect regular situation reporting to start from 21 October. All organisations in Leeds have plans in place for completing the reporting as required.

5.1 Transforming Leeds Unplanned Health and Care System

The NHS Long Term Plan details the strategic direction for the NHS over the next ten years. The plan highlights the challenges facing the NHS including staff shortages, growing demand and an aging population. With a focus on changing the way we do things to tackle these challenges the plan aims to give people more control over their own health and care whilst preventing illness and tackling health inequalities.

With emphasis on integrated care the long term plan is a framework not a blueprint giving local systems the flexibility to develop their response to meet the local needs and priorities of their populations. Through Integrated Care Systems (ICS) Leeds commissioners will make shared decisions with providers on population health, service redesign and implementation of the Long Term Plan.

The Long Term Plan sets out actions to ensure patients get the care they need, fast, and to relieve pressure on emergency departments. This will be achieved by developing and investing in primary and community services such as urgent treatment centres. For people requiring hospital care there is a drive for these to be treated through 'same day emergency care' without need for an overnight stay where appropriate. It is hoped that by implementing this model that the proportion of acute admissions typically discharged on day of attendance from a fifth to a third. Building on previous successes in improving outcomes for major trauma, stroke and other critical illnesses conditions, new clinical standards will ensure patients with the most serious emergencies get the best possible care. And though our continued partnership with local council's further action to support people to return home and retain their independence where possible will support reducing delayed hospital discharges.

5.2 The system pathway of care

The six areas referred to in section 3 also support the development of our strategic transformational plans.

5.2.1 Anticipatory Primary care

The development of Primary Care Networks and Local Care Partnerships are key in delivering efficient and effective urgent and emergency care services. Primary care networks build on the core of current primary care services and enable greater provision of proactive, personalised, coordinated and more integrated health and social care. As they develop we will work with them to ensure links to all urgent and emergency services and maximise any opportunities to integrate services.

The UTC's are a great example of how can deliver the national mandate and support local people through the integration of services. We will build on this as we develop further services across the system.

5.2.2 Access into Unplanned Health and Care Services

Nationally and locally, it is recognised that there are too many entry points into the unplanned care system. This makes it confusing for people to know where to go when they feel they have an unplanned care need. The vast majority of unplanned care services offer walk in options. People therefore tend to present to the service they are most familiar with, as opposed to presenting at the service that may best meet the person's health and care needs. Health and care professionals equally report understanding the unplanned care landscape is difficult and complex to navigate.

In Leeds, multiple single points of access exist. Some of which are available to the public, some to health and care professionals, and some which are available to both. There is an opportunity to converge all the single points of access to generate a truly single, multi-disciplinary clinical skill mix offer, to both the public and professionals, to give clinical advice and when necessary to book people into the right service within the unplanned care system. This will allow unplanned care to move back into planned care at the earliest opportunity.

The newly commissioned NHS 111 Integrated Urgent Care (IUC) service allows for greater synergies between the urgent (NHS 111) and emergency (999) services which supports the aim of the access work stream as regards to making access to urgent and emergency care more seamless.

Planned and unplanned (emergency 999) Patient Transport Services (PTS) is recognised as a key enabler for the delivery of the access work stream ensuring the needs of patients can be met within various healthcare settings. Robust planned and unplanned transport services will ensure that people are able to access emergency care, present at urgent unplanned appointments and attend planned appointments anywhere within the health and care system.

The development of transport services programme will seek to improve the National Ambulance Response Programme (ARP) targets, create a hybrid service model between emergency and planned transport and improve access and integration between health and care transportation.

5.2.3 Primary and Community Urgent Care

A clear driver in the establishment of UTC's is to standardise the offer the public can expect from unplanned care services including for primary urgent care. People tell us, locally and nationally 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, numerous General Practices offer differing appointment systems and varied offers of core and extended services.

The recent publication of the *NHS Long Term Plan* (2019)¹ and the NHS Operational Planning and Contracting Guidance 2019/20 (2019)² specifies that commissioners should continue to redesign urgent care services outside of A&E, aiming to designate the majority of UTCs by December 2019. The guidance states UTCs should meet the previously published standards and ensure that they operate effectively as part of a network of services including primary care, integrated urgent care, ambulance services and A&E.

The aim of delivering standardised UTC's are to:

- simplify the system and access to services that meet people's needs, making the right choice the easiest choice
- improve people's experience of health and care services
- integrate services across the health and care system
- reduce attendance within Emergency Departments

¹ <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf>

² <https://www.england.nhs.uk/wp-content/uploads/2018/12/nhs-operational-planning-and-contracting-guidance.pdf>

- reduce conveyance to Emergency Departments
- support effective system flow,
- ensure Emergency Departments have the dedicated resources for higher acuity and specialised services
- support the improvement of the Emergency Care Standard
- achieve a left shift in the delivery of care closer to home
- increase access to diagnostics in the community

A fundamental requirement to achieve a network approach for the UTC's is for the providers to work in strong collaboration with one another at each UTC location, with services to be integrated where required. This strong, positive collaboration approach was implemented at the St Georges Centre UTC development and was a critical factor in the success of the UTC achieving designation status.

Opportunities are presented within the UTC mandate to support the development of 24/7 urgent primary care and ensuring that people receive care as close to their place of residence as possible. This will include the review of how we commission GP Out of Hours service in the future, either at place or ICS level. The review will explore the different elements of the current contract to maximise the future opportunities and economies of scale. These elements are:

- Infrastructure to manage the calls across the 111 regional, sub-regional and local levels
- Delivery of GP Out of Hours service

The review of GP Out of Hours will explore what rapid response may be required to support keeping people at their own home, and by what skill mix of health and care professionals. Both the UTC and GP Out of Hours offer will be further supported and complemented by the evolution of Primary Care Networks and Local Care Partnerships.

As Primary Care Networks and Local Care Partnerships develop and integrate, we will need to be clear regards how they link with the UTC's to develop clear pathways and where appropriate, additional services for their respective populations. This will provide an ideal opportunity to put more formal arrangements in place around integrated urgent primary care.

One of the national ambitions for UTC's is to reduce activity at the Emergency Departments to support the achievement of the 4 hour ECS performance target across the system. It is recognised in Leeds that due to pre-existing urgent care services (MIU's Walk-in-centre) this is not Leeds prime driver for implementation. The main driver for UTC's will be to standardise the service offer to reduce confusion for the public and support the delivery of 24/7 primary care at both a place based and primary care level.

5.2.4 Non-Elective Front Door

Efficient acute hospital flow encompasses quickly, proficiently, and effectively meeting the demand for care at both the front and back ends of the hospital. It involves effective coordination of patient care, moving the patient through pathways safely, to achieve the best possible outcomes. Poorly managed patient flow at hospitals front door can lead to adverse health outcomes, including increased re-admissions, longer length of stays and adverse mortality rates.

The non-elective front door work stream is broken down into the following:

Hospital handovers

The amount of ambulance to hospital handover delays across Leeds will be reduced and the handover process will be improved. The handover of clinical information about the patient from ambulance staff to the hospital is potentially a critical point in a persons unplanned care journey. Any information that isn't passed over effectively could result in sub-optimal patient experience through effecting the actions taken once the person hits hospital.

Attendance Avoidance

- We will reduce the number of attendances at hospital through identifying and supporting schemes across the system which facilitate the shift left and lead to more patients accessing community alternatives for unplanned care episodes.

Admission Avoidance

- Avoidable admissions will be reduced through a number of schemes including:
 - improving access to PCAL for front line staff
 - Improving acute frailty services to ensure patients are assessed treated and supported by Multi-Disciplinary teams in A&E and acute receiving units with people receiving rapid assessment.

- Concentrating on admission avoidance pathways from care homes – “Analysis suggests that over a third of hospital admissions from care homes are avoidable”.³
- We will also implement the recommendations of the NHS clinical standards review for those patients with the most serious illness and injury to ensure they receive the best possible care in the shortest timeframe. This includes patients who come to A&E following a:
 - Stroke,
 - Heart attack
 - Severe asthma attack
 - Major trauma
 - Sepsis.

Same Day Emergency Care (SDEC) and Ambulatory Care

Same Day Emergency Care ensures that people presenting in hospital in an unplanned car with certain conditions can be rapidly assessed, diagnosed and where appropriate and safe to do so, treated without being admitted to a ward. People are then able to go home to their place of residence on the same day. Assessment areas and ambulatory care hubs will be utilised to reduce the number of people with short stay admissions to ensure more are discharged on the same day.

More effective management of patients who attend the hospital who would have previously attended ED and been admitted will support better outcomes for people. For the system, over time, it is assumed that we will be able to reassess the capacity required for non-elective admissions and ultimately reduce non elective demand on the LTHT bed base. This will also support the achievement of ECS target through more appropriate management of patients at the front door and ultimately support the achievement of planned care targets e.g. 18 weeks.

Co-Located UTCs

These will contribute to the improved flow of the hospital ensuring that people who present with an urgent primary care need will be streamed effectively into the UTC to ensure they get the most effective care for their needs. This will mean that the Emergency Department will be freed up to care for those patients with a true emergency need.

³ <https://www.gov.uk/government/news/record-nhs-funding-to-give-patients-a-better-alternative-to-hospital>

The UTC will treat most injuries or illnesses that are urgent but not life threatening e.g. sprains and strains, broken bones, minor burns and bites and stings. The co-located UTC will provide an initial assessment and treatment of patients and reduce the need for an admission.

5.2.5 Non-elective care and discharge

Hospital Discharge

The Leeds Health and Care system will work in partnership to ensure discharge is effectively planned from the day of arrival into hospital to ensure people receive the most optimal outcomes for their care. There is currently a disparity in where people are currently discharged to and where would provide the best outcome for their discharge. We aim to ensure that this is addressed with the right choice for the patient also being the easiest choice. In order to improve hospital discharge we will:

- Continue to implement initiatives which help to optimise discharge and make it timelier.
- work to ensure that people get the most efficient pathway through and out of the hospital
- increase the number of patients who are discharged to the most optimal discharge pathway for their care as described in the Newton Europe findings contributing to the left shift in patient care.
- look to improve Length of Stay (LOS), Delayed Transfer of Care (DTC) and reduce the number of ward moves. We will also look to increase the number of people who are given an estimated date of discharge (EDD) on the day of arrival.
- look to reduce the year round reliance on the medically fit for discharge wards run by villa care ensuring alternatives in the community are identified and available
- Improving discharge processes contributes to all previously outlined system benefits.

5.2.6 Community care and recovery

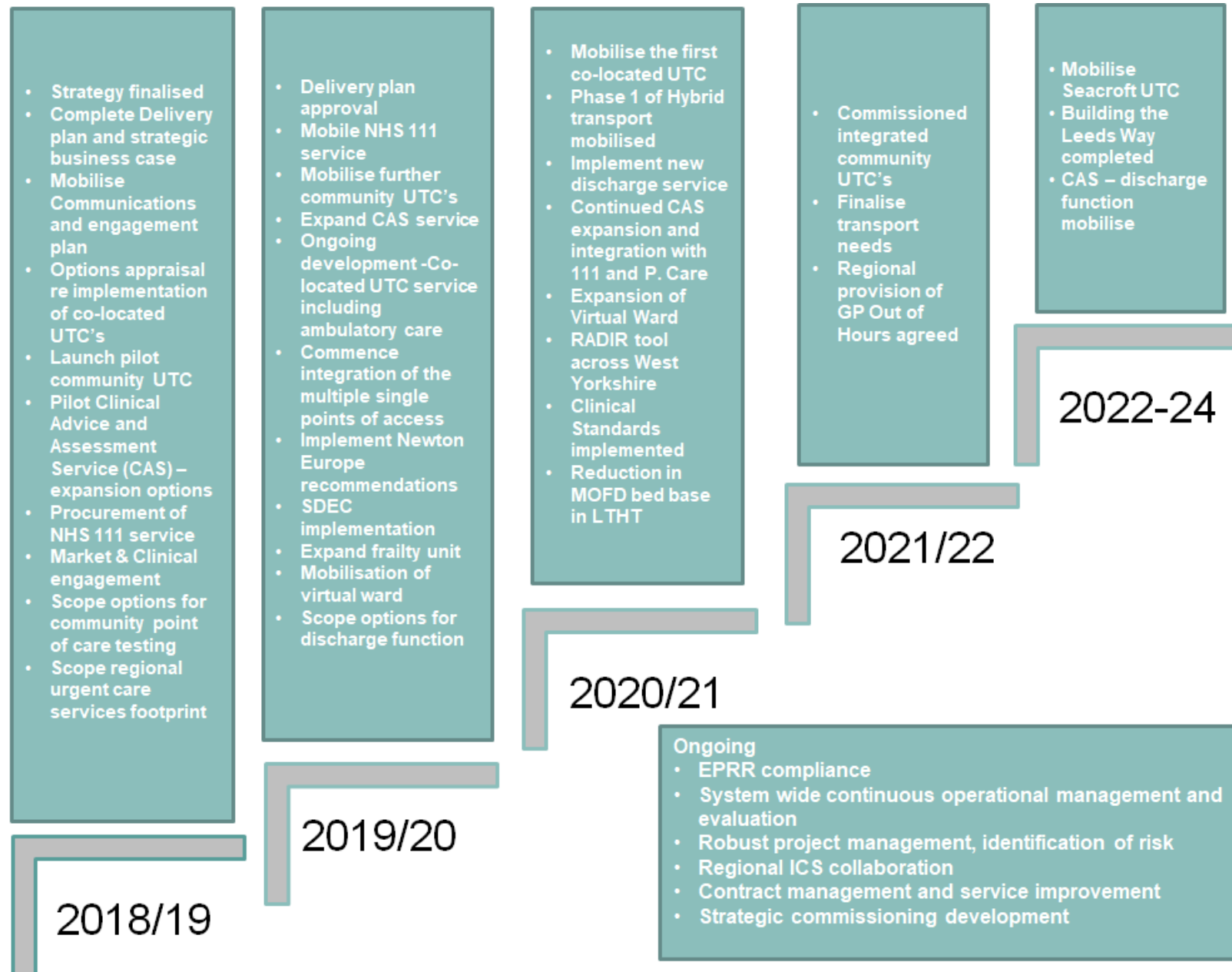
A fundamental aspect to effective discharge from hospital is to ensure that services in the community are able to efficiently support the shift left and get patients back out of hospital as quickly as possible to the most appropriate place for their care.

Discharge not only has to be planned effectively in hospital but also post discharge, to ensure that patients receive the best care and support possible. Effective care in the community can stem the flow of readmissions, decrease future care use and improve long term health outcomes for patients. In order to improve post hospital discharge we will:

- Expand and improve the range of flexible and responsive health and care services to support the left shift
- Ensure more people are being discharged to the most appropriate place for their care as measured by the Newton Europe audit.
- Engage the voluntary and third sector more in effective post hospital care and recovery
- Develop a range of care options and pathways for different levels of required support
- Increase the number of patients going home with reablement
- Use population health management to be proactive in a person's care following discharge from hospital and ensure they get appropriate reviews and follow ups.

Diagram 9 show the strategic milestones for the development and commissioning of the Urgent and Emergency care system in Leeds for the next 5 years.

Diagram 9



Through the LSRP the overarching system aim is to demonstrate that we improve the outcomes for our population especially at a time of significant pressure.

As we strive to retain people's health and wellbeing and maintain their independence we know that this will require new ways of working and an aim to shift the provision of care from the acute trust into the community close to people's home.

Leeds continues to take collaborative and proactive approach to planning for those predictable, unpredictable and longer term challenges that face our health and care system as well as our longer term strategic plans to transform our system.

Our plan seeks to provide a high level of assurance that there is agreed system wide initiatives in place that address both the short and long term priorities within the unplanned health and care services across Leeds.

There are clear lines of accountability and governance and an overall system commitment to work in an integrated way to deliver care and maximise resources.

We will ensure that we have identified measurable objectives in place to demonstrate the impact our changes are having for the people that access our services their families and carers as well as to our system and the people that work within it.

Glossary

CCG	Clinical commissioning Group
DTOC	Delayed Transfer of Care
ED	Emergency Department
ECS	Emergency Care Standard
EDAT	Emergency Duty Assessment Team
EMI	Elderly Mentally Infirm
EPRR	Emergency Preparedness Resilience & Response
HWBB	Health and Wellbeing Board
LCC	Leeds City Council
LHRP	Local Health Resilience Partnership Board
LCH	Leeds Community Healthcare
LSRP	Leeds System Recovery Plan
LSWP	Leeds System Winter Plan
LTHT	Leeds Teaching Hospitals Trust
LYPFT	Leeds & York partnership Foundation Trust
LIDS	Leeds Integrated Discharge Service
SRPG (ORG)	System Resilience Partnership Group
OPEL	Operational Resilience Escalation Level
PEG	Partnership Executive Group
STP	Sustainability and Transformation Plan
SiTREP	Situation Report
SRAB	System Resilience Assurance Board
UHCS	Unplanned Health and Care Strategy
UTC	Urgent Treatment Centre

Appendices

Appendix 1	Leeds System Resilience Governance
Appendix 2	2018/19 Review
Appendix 3	System Resilience Communications Plan
Appendix 4	System Resilience Risk Register

Leeds Health and Wellbeing Board



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

Report to: Leeds Health and Wellbeing Board

Date: 11th December 2019

Subject: Leeds Health and Care Plan (2020 – 2023)

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 purpose of this paper is to provide the Leeds Health and Wellbeing Board with an outline summary of the successes of the first iteration of the Leeds Health and Care Plan (Leeds Plan). It also describes the process of developing the revised Plan and presents the final draft of the Summary on a Page for the Board to sign-off.
2. This follows a number of previous Health and Wellbeing Board sessions, particularly the September Board that reviewed and provided feedback on the draft narrative and confirmed the key areas of focus for the refreshed Plan.
3. The Leeds Health and Care Plan is the description of what it envisages health and care will look like in the future and how it will contribute to the delivery of the Leeds Health and Wellbeing Strategy 2016-2021.
4. This paper also describes proposed governance and a communications and engagement plan.

Recommendations

The Health and Wellbeing Board is asked to:

- Note the progress and successes of the Leeds Plan to date (section 3.1).
- Confirm that the Leeds Plan summary reflects the priorities that the Board previously agreed (16 September 2019) should be given additional focus (section 3.2.2).
- Identify actions that each partner will take to deliver the refreshed Leeds Plan.
- Support the development of a system-wide approach to communications and engagement (section 3.4).

1 Purpose of this report

- 1.1 It was agreed at Health and Wellbeing Board (28 Feb 19) that the Leeds Plan should be reviewed and refreshed. The purpose of this report is to respond to this request and provide the final draft Leeds Plan summary on a page for approval as well as outlining the progress to date.
- 1.2 This paper also outlines governance for overseeing the delivery of the Leeds Plan and describes the proposed approach to engagement and communication.

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 how we will achieve that.
- 2.2 Our Leeds Plan is a declaration of what our health and care system will do to help realise the ambitions of the Leeds Health and Wellbeing Strategy. It clearly states our goals and how we'll get there by working with people, communities and as a partnership. It is owned by the Health and Wellbeing Board (HWB) with delivery delegated to the Partnership Executive Group (PEG) and relevant subgroups.
- 2.3 The refreshed Leeds Plan aims to build on what we have done well and respond to the changing local, regional and national context as highlighted in previous papers to the Board. The Board through 2019 has provided a strong steer to the shaping of the refreshed Leeds Plan at formal board meetings on 28th February and 14th June, Board to Board workshops in March and July. At the public Board meeting on 16th September the Board reviewed and provided feedback on the draft narrative to support the plan and confirmed the key areas of focus for the refreshed Plan.
- 2.4 The refresh is 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 Success of the Leeds Plan

To date we have achieved many successes. The following covers strategic and operational successes as well as tangible improvements in outcomes for people.

3.1.1 Strategic successes

Aspect	Successes
People at the heart of what we do	Fundamental shift in language and perception from 'patients' and 'service users' (consumers of health and care) to people as active leaders and participants in their own, their families and their community health and wellbeing. We have developed the Big Leeds Chat as an approach and brand of starting with and listening to what matters most to people and what helps keep them well. For the first time we are collectively listening to people's journey of care as a whole through our 'how does it feel for me?' approach. There is greater understanding of 'think family' as an approach which recognises that children and adults lives are connected together through family relationships.
Co-production	Leeds Plan is both our programme of change as well as our ongoing conversation with citizens and staff. For the first time in health and care in Leeds we have a transformation plan that is recognised as being by citizens, staff, elected members and partners from across the health and care sector. It has set the foundations for an ongoing conversation with citizens, staff and those that make decisions about how health and care services need to change to ensure our health and care services are person-centred, sustainable and fit for the future.
Strong community model	We have broadened our previous neighbourhood health and social care model to a much broader community model which includes GPs, housing, elected members, citizens, mental health and the 3rd sector via Local Care Partnerships, Harnessing the Power of Communities and stronger third sector links, for example to Leeds Community Foundation.
Democratic leadership	Leeds plan has been a revolution in how elected members and democratic voice can support more effective local services in the context of wider determinants of health.

Aspect	Successes
Leading the way in person, family and community centred approaches	Our approach in Leeds has significantly influenced regional and national policy, strategies and approaches for example: our approach to working with the third sector as equal strategic partners; national Population Health Management approach; Strength Based Social Care; national extension of the Family Valued programme; system leadership; the NHS People Plan; West Yorkshire and Harrogate Integrated Care System strategy; and the development of an all age working including a specific children's programme at the WY&H ICS level.
Quality judgements	Leeds has been assessed to be operating at high standards across care homes, GPs, NHS providers, Council services and the CCG. This was also recognised as a strength and good practice by the CQC Local System Review in 2018.
Whole system approach	In addition to people's voice at the heart of our approach, we have broadened our health and care partnership approach to include the 3 rd sector, academia, Healthwatch, businesses, primary care, a refreshed Clinical Senate. Work underway to broaden this even further with care homes.
Leeds £	One of our Leeds Plan approaches commits us to making best use of the Leeds £, by working together across health, care and community organisations to focus resources and prioritise those areas where we can make the biggest difference in outcomes for people. Regular system publication of partnership financial position and a radical shift from a projected deficit to maintained financial balance across partners.
Established core central joint partnership resources	We developed jointly funded policy, project and enabler resources which have accelerated system working. This has included a partnership employment model which includes risk share. This has facilitated the development of the LCP Development Team, Academy Team and Citywide Digital Team.
Clarity of purpose and a common direction of travel	The Leeds Plan clearly states our ambitions, our approach and our actions to guide what we do locally and ensures we have a strong story to tell regionally and nationally. It sets out the transformational actions we will work on together, to make significant and lasting change in Leeds. This connected narrative with a strong focus centred around people and improving the health and wellbeing of people who face the greatest inequalities has inspired and reinvigorated a sense of purpose.

Aspect	Successes
Building relationships across organisational boundaries and being system leaders ‘from any seat’	The Leeds Plan is helping to build the culture and conditions required to make significant improvements in the way we deliver health and care. By developing greater partnership working beyond organisational boundaries, as ‘Team Leeds’, it has significantly strengthened our relationships and allowed us to take bold steps to move the system further and faster towards our ambitions.
Joint enabler system strategies and priorities agreed	We now have an agreed: Communities Estates Strategy principles; Citywide Workforce Strategy; Citywide Digital Strategy; Innovation Strategy; Frailty Strategy; Citywide Mental Health Strategy and Carers Strategy.
Citywide approaches to working with people and staff	We have developed and signed-up to the Better Conversations, Home First; Think Family.
Systems leadership	We have developed a programme of system leadership development including a two day programme, half day module which has been rolled out to all partners including universities and shadow Board programmes. These have helped develop system leaders across the partnership.
Wider determinants of good health and wellbeing	Raised awareness and understanding of how wider determinants are connected and influence good health and wellbeing through closer alignment with the Inclusive Growth Strategy, Climate Emergency, Industrial Strategy, work in Priority Neighbourhoods and arts and culture. As a result health and care partners are increasingly active agents in these agendas.
Raised profile of Leeds on a national and international stage	Worked with national partners to design and deliver a number of high profile visits and conferences, positioning Leeds as a Best City for Health and Wellbeing and bringing learning from other areas to the city. These include The King’s Fund ‘Community Is the Best Medicine’ where we shared our strategic narrative for ‘wellbeing starts with people: a whole city approach to creating strong, resilient and healthy communities in Leeds’ and heard from a number of exciting community-based projects making a difference to people’s lives in Leeds. Hosted national visits from Ministerial and NHS leads for Digital, Workforce and NHS X. We have also hosted visits from international health and care systems including China, India and Korea.

3.1.2 **System-wide operational successes**

Some of the operational highlights include:

- Data released by Public Health England shows that smoking rates in Leeds are continuing to fall and are now at the lowest in West Yorkshire.
- The work of the Best Start programme and Children and Young People's Plan has led to Leeds bucking the trend in child obesity rates among four and five year olds. Leeds is the only English City to achieve this. The drop in obesity has been seen primarily among the most disadvantaged areas in the city. In general obesity levels fell from 9.4% to 8.8% in reception age children with levels falling from 11.5% to 10.5% in the most deprived areas.
- 2018/19 winter not a single patient was cared for in a non-designated area - this is where someone is being treated in a space that's not dedicated for patient care.
- We also made significant strides in 2018/19 winter in reducing delayed transfers of care so that patients aren't staying longer than they need to within a hospital based setting. This fits in with our 'Home First' ethos which means that people will be supported to remain or return quickly to their own beds, and their own home (including a care home if that is their usual place of residence) wherever possible.

3.1.3 **Programme and enabler successes**

The Plan to date has four programmes and a set of enablers to organise delivery. Successes highlighted below are shown against these current programme and enablers.

3.1.4 **Prevention at scale – “Living a healthy life to keep myself well”**

Successes under this programme include:

Initiative	Successes
Better Together The programme focusses on the issues that lead to poor health, such as social isolation, and use a community development approach to work with individuals, groups and communities to help them improve their situation and live longer, healthier lives.	Outreach work has engaged over 18,000 people from the 10% most deprived communities into community groups and programmes to improve general health and wellbeing.
‘One You Leeds’ (OYL) OYL is designed to support Leeds residents to start and maintain a healthy lifestyle. It has a key aim to support the ethos of ‘improving the health of the poorest the fastest’. There is a specific aim around increasing access by specific target populations (eg. people living in deprived Leeds, people at risk of long term conditions, pregnant women and emerging migrant populations).	OYL continues to achieve high levels of referrals into the service.
Alcohol Programme This programme aims to continue to reduce harm from alcohol through: • promoting safe alcohol consumption as the norm • reducing access to alcohol by young people and providing; and • Promoting alternative routes to behaviour change for those people who would prefer to self-help.	There has been a significant amount of activity over the last year aimed at alcohol awareness, including; The ‘No Regrets’ campaign, an online responsible drinking campaign aimed at 18-25 year olds. Forward Leeds holding a series of events across the city, where people were able to make positive pledges to change their drinking behaviour. There has also been a focus on secondary prevention for people who may be attending health services for a condition and present an opportunity to discuss smoking and alcohol use. For example, the Nursing Specialist Assessment ‘e-form’ is now live on all inpatient wards throughout Leeds Teaching Hospitals NHS Trust (LTHT). This means alcohol and tobacco screening is now being undertaken as part of every inpatient’s admission into the hospital as they come onto the wards.

Initiative	Successes
Tobacco Programme This programme aims to continue to reduce the harm from tobacco through promoting smoke free as the norm, reducing access to tobacco by young people and providing and promoting alternative routes to behaviour change for those people who would prefer to self-help.	Smoking prevalence across the city is now at an all-time low of 16.7%. Progress continues to be made towards the aim to create a smoke free generation, with over 35,000 less smokers in Leeds than there were in 2011. Data released by Public Health England shows that smoking rates in Leeds are continuing to fall and are now at the lowest in West Yorkshire.
Best Start The programme has a key aim to give every child the best start in life, specifically the crucial period from conception to the age of 2.	Food and activity for a Healthy Pregnancy sessions have been made available for pregnant women with a BMI over 25 (and their partners). The sessions use the HENRY strengths based approach – building on participant’s current knowledge and begins with an activity looking at what they think a healthy pregnancy looks like. The work of the Best Start programme has led to Leeds being the first city in the UK to report a drop in childhood obesity. There is also a lot of ongoing work with the maternity voices group, ongoing engagement with young people and their families. There has been a focus on mental health, and support for breastfeeding.

3.1.5 **Self-Management and Proactive Care - “Health and care services working with me in my community”**

Successes under this programme include:

Initiative	Successes
Better conversations Better conversations is a culture change programme moving the conversation between worker and citizen from a paternalistic dynamic where the worker is viewed as the 'expert' and has a role to 'fix' the citizen, towards an equal partnership where the worker looks to enable the citizen	Over 1200 attendees from 52 different health and care organisations across the city including both the statutory and third sector. Specific skills sessions have taken place for Seacroft and Crossgates LCPs. Intention is to roll out LCP-wide. 89% of attendees agreed or strongly agreed that they will use the skills practiced in their role.
The Diabetes Structured Education Programme To improve uptake for Type 2 Diabetes education courses with an emphasis on targeted groups (men over 40 and BME) with the overall outcome that people feel well supported and confident to manage their condition. Self-Management support is now part of the ICS Universal Personalised care plan programme detailed by NHS England (NHSE).	Diabetes education sessions have increased from 33 to 125 per annum. 100% of people reporting an improved confidence to manage their condition after the course. Targeted groups: Men over 40 years (52% of attendees), deprived areas (62%) and people from BAME groups (51%).
National Diabetes Prevention Programme (NNDP) The programme aims to help people reduce their risk of developing Type 2 diabetes, by offering them a referral to an intensive lifestyle intervention programme (diet, weight loss and physical activity).	Between April 1 2018 and March 31 2019 5,542 people have been referred for the National Diabetes Prevention Programme (NNDP).
Breathe Easy The project aims to develop an integrated network of respiratory peer support groups in Leeds which will result in higher quality and more consistency in terms of how patients with COPD manage their condition.	The 10 Breathe Easy groups in Leeds in Bramley, Middleton, Gipton, Hunslet, Yeadon, Beeston, Allerton Bywater, Harehills, Richmond Hill and Osmondthorpe. All groups are now operating from low/no cost venues and the numbers attending are growing. This project has led to a wider programme of developing peer support networks with people with long term conditions.

Initiative	Successes
Collaborative Care Support Planning (CCSP) CCSP annual reviews form a collaborative discussion between professional and person, focusing on “what is important to the person” enabling person centered goals to be agreed to support people to self-manage their condition.	There have been 85,859 CCSP Annual reviews performed in Leeds between April 1st 2018 and March 31st 2019. This programme is part of the ICS Universal Personalised care plan programme as detailed by NHSE. Leeds has been recognised by the ICS and NHSE as meeting the quality markers for personalised care planning.
Social Prescribing Social Prescribing offers activity, social and cultural interventions in communities as an alternative to or adjunct to medical intervention.	The city is on track to meet the target of 5,000 referrals for 2019/20. Following reprocurement by the CCG there will now be one provider (a consortia) covering the whole of the city, ensuring that all LCPs have social prescribers.
Virtual Respiratory Ward Leeds Community Healthcare NHS Trust's virtual respiratory ward was expanded to cover Armley to help patients with long-standing respiratory conditions.	The virtual respiratory ward is designed to help those with Chronic Obstructive Respiratory Disease (COPD) exacerbations avoid being admitted to hospital and support earlier discharges for those that have been admitted.
Frailty Unit A multi-disciplinary team work on the unit providing medical and holistic care for patients over the age of 80, or from 65 if they have particular frailty needs. The Frailty Unit is set away from the main emergency department, so it's a lot quieter and a much better environment for our older patients to be while they're being assessed.	In a sample of nine months the frailty unit at St James's Hospital has prevented 951 admissions which equates to around 1902 bed days.

3.1.6 Optimising Secondary Care - “Go to a hospital only when I need to”

Recent successes under this programme include:

Project and Description	Successes
Cancer Programme The objective of the programme is to achieve the best in cancer care for the people of Leeds. The programme is centred around four areas of focus: • Prevention awareness and screening • Early diagnosis • Living with and beyond cancer • High quality modern services	Over 1000 additional people have completed a bowel screening test since April 2018 after being contacted by practice champions. The Accelerate Coordinate Evaluate (ACE) pilot pathway is for patients with non-specific but concerning symptoms has now been mainstreamed and the 1000th patient has just recently been referred on this pathway. Early evaluation indicates ACE provides faster diagnosis and clarity to patients and physicians, improves diagnostic findings of other significant but non-cancer conditions and as equally or more cost effective than previous approaches.
Care Navigation Leeds and York NHS Partnership Foundation Trust (LYPFT) have appointed a nurse as a Care Navigator role based at The Mount. She attends operational delayed discharge forums at Leeds Teaching Hospital Trust (LTH) to co-ordinate arrangements for people with complex needs in dementia, regardless of hospital setting.	The role has become a valued member of the LTH Operational Discharge Group, ensuring people are referred to the LYPFT Enhanced Care Homes Team. The role works in partnership with commissioners to invite interested providers to discuss individual needs, develop the care home market and support individuals to leave hospital.
Enhanced Care Home Team The initiative aims to reduce avoidable delays that older people with complex dementia needs face when being placed from hospital beds to suitable long-term care home placement. They do this through proactively pursuing care home placement options as well as then providing care homes with rapid access to intensive short term input/care.	Between July and December 2018, successfully placed 42 service users to care homes who otherwise would have been in hospital for longer. This service has now received recurrent funding.
Medicines and Consumables The objective of this programme is for patients to receive the medicines that are the best value for them and for Leeds.	Significant progress has been made in making the best use of the Leeds pound whilst improving service in the following areas; • Stoma care • Oral nutritional supplements • Silk Garments • Wound Dressings

3.1.7 Urgent Care and Rapid Response - “I get rapid help when needed to allow me to return to managing my own health in a planned way”

Recent successes under this programme include:

Project and Description	Successes
Urgent Treatment Centres (UTC) This programme will develop UTCs across the city. UTC's offer urgent primary care for minor injury and minor illness. The proposal is to develop five UTC's in Leeds. Three UTC's will be in the community (St Georges, Middleton, Wharfedale, Otley and potentially in Seacroft) and two will be co-located at the A&E departments (St James University Hospital and Leeds General Infirmary)	The St Georges Centre in Middleton, South Leeds was formally designated as an UTC in December 2018 by NHS England. A formal 12 week public engagement programme which sought views on the proposals for UTC's in Leeds was undertaken during May 2019. The development of Urgent Treatment Centres are underway at the Wharfedale site and at St James's Hospital.
Clinical Assessment Service (CAS) This project aims to provide a Clinical Assessment Service for the Leeds population. People who ring NHS 111 will receive a clinical assessment over the telephone, reducing the number of people who need to receive a face to face appointment. The ambition is for all single points of access to link into the CAS, and for the CAS to book appointments into services when a face to face appointment is required. This will standardise and simplify access into health and care services	The 6 month pilot has been evaluated. Findings show that 50% of all calls to the Leeds CAS were dealt with over the phone. The learning from the pilot is helping to inform how the service can expand for Phase 2.
High Intensity Users Project The service provides tailored support to people who attend A&E frequently to address underlying social, medical and mental health issues and supporting them to access the services they most need rather than A&E.	Emergency Department attendances and ambulance conveyances were reduced by 53% over the 12 months for the 72 people the service worked with in the last year.
Yorkshire Ambulance Service (YAS) YAS are now able to refer patients directly into the Leeds Frailty Unit at St James's hospital. This means patients may bypass a potentially delaying and stressful period in the hospital Emergency Department.	The project allows ambulances to take people straight to the most appropriate place for their care giving them the best chance of avoiding admission.

3.1.8 **Collective resource areas that enable transformation**

3.1.9 **Estates successes include:**

- Closer working with LCC Planning officers on ensuring sustainable community health provision in light of housing growth. This will entail outlining actual and target figures in Site Allocations Plans.
- Focused work on priority neighbourhoods, linking closely with the Neighbourhood Improvement Programme and LCC Localities team, as well as the third sector and private sector (for example Arup, the engineering and design firm).
- Master planning with Regeneration and Communities officers to deliver significant recalibration of community, commercial and housing offer in Lincoln Green.
- Commitment from LCC Planning to work in partnership on embedding health and wellbeing into policy and process of determining planning applications.
- Asset mapping tool developed, providing contextual information on LCPs/PCNs and housing growth.

3.1.10 **Digital successes include:**

- Introduced significant shared IT services between LCC, CCG, LCH and GP Practices.
- Added children's data in to the Leeds Care Record.
- Introduced a new way of sharing child protection information between urgent and emergency care services and social care.
- Increased the number of GP Practices taking appointment bookings directly from the 111 service.

3.1.11 **Workforce successes include:**

- 130 people from Lincoln Green, Burmantofts and Richmond Hill and surrounding areas attended recruitment events held in the local community in April. All attendees signed up for courses or interviews and 3 nurses from overseas are joining Leeds Teaching Hospitals Trust.
 - 28 people given jobs at LTHT, 23 of these are within the Estates and Facilities Team, portering and ward housekeeper roles
 - 5 are now part of the nursing workforce and will be doing retraining qualifications that will eventually transition them into the LTHT nursing staff

- 7 people live in Priority Neighbourhoods – 6 Lincoln Green and 1 Clifton and the Nowells
- 16 are from Burmantofts and Richmond Hill and 7 live in Gipton and Harehills.
- Around 500 of the Leeds 'One Workforce' have already attended the two day System Leadership Programme
- The first Leeds wide Health and Care Careers and Recruitment Event was held on 14 May 2019.
- The Academy team has received significant support from the 2 workforce managers hosted in the Health Partnerships Team.

3.1.12 Communications and engagement successes include:

- Big Leeds Chat – one system, one engagement, bringing senior decision-makers to hear from the people of Leeds, impacted the priorities of the Leeds H&C Plan.
- Commitment to a partnership communications, engagement and marketing strategy.
- Promotional launch of the Health and Care Academy, including supporting the Washington DC trip.
- Winter communications – coordinated approach across all partners
- Get Set Leeds – Brand development and launch.
- Partnership based newsletter and co-ordinated press releases on a number of issues from helping publicising Kings Fund events to supporting the Care Quality Commission and international visits.
- Leeds Digital Festival – supporting healthcare events

3.2 Refreshing the Leeds Plan

In order to refresh the Leeds Plan the partnership took stock of what we have achieved to date, agreed what we wanted to achieve out of the refresh process and agreed which aspects we felt we wanted to give extra attention to as a partnership.

3.2.1 Engagement undertaken

As highlighted at the Board 16th September 2019, significant engagement has supported the development of the refreshed Leeds Health and Care Plan.

To develop the refreshed Leeds Plan we have collaborated with partners across the city regularly through a number of mechanisms. These include:

- Scrutiny Board discussions (September 2018 and April 2019)
- Community Committees (June 2019)
- GP Confederation Executive Group (September 2019)
- Leeds City Council Commissioning Managers Meeting (September 2019)
- Leeds CCG Governing Body (September 2019)
- Leeds Teaching Hospitals Trust Executive meeting (October 2019)
- Leeds Community Healthcare Executive Group (October 2019)
- Leeds and York Partnership NHS Foundation Trust Board (October 2019)
- Palliative Care and End of Life Board (October 2019)
- Big Leeds Chat (November 2019)
- Palliative Care and End of Life Network (November 2019)
- Strategic Estates Board (November 2019)
- Strategic Workforce Board (November 2019)

Ongoing conversations at:

- Partnership Executive Group (PEG)
- Integrated Commissioning Executive (ICE)
- Leeds Plan Delivery Group (LPDG)
- Discussions at 3rd sector leadership groups
- A series of partnership wide workshops

3.2.2 **Key themes that emerged**

In Leeds we start with the voices of local people which are at the heart of the future of health and care. The views of local people have helped inform the refreshed Leeds Plan.

In developing the refreshed Leeds Health and Care Plan, we used the key findings of some of our most recent engagement across the city, including the findings of the Big Leeds Chat event in 2018, engagement on the NHS Long Term Plan, and engagement as part of a 2019 scrutiny inquiry into whether Leeds is a child friendly city.

It should be noted the following summary does not aim to outline how we have used all of the engagement insight that we have collected in the city, but just the headline feedback that has impacted the Leeds Health and Care Plan.

Promoting good health	
What people told us	Our response
More support is required from the NHS and its partners to make it easier and affordable for people to live healthier lives.	- Integrating prevention into all clinical pathways. - Our estates strategy will provide green spaces, promote active travel and mitigate against air pollution. - Social prescribing services are connecting people to non-medical services and activities in their local area.
Barriers to improving lifestyle choices include a lack of time and motivation, and poor health.	- Better Conversations approach is helping local people use their strengths and assets to make healthy lifestyle changes. - The new physical activity ambition for the city is being co-produced by local people, and changing the conversation on what being active means. - Links in with the wider determinants of health through the Leeds Health and Wellbeing Strategy, and other city-strategies and boards including Inclusive Growth.
Supporting mothers during pregnancy, supporting families with new-born babies, early diagnosis of conditions and support through childhood.	- Best Start is a preventative programme from conception to age 2, aiming to ensure a good start for every baby, with early identification and targeted support for vulnerable families early in the life of the child. - Children's Hubs are bringing organisations together to improve the health and wellbeing of children and families, with more focussed support in areas of highest need. - Maternity Strategy - sets out city action for high quality, safe and personalised maternity services. - Children and Young Peoples Plan - our plan for Leeds to be the best city for Children and Young People to grow up in and to become a child friendly city. - Improved perinatal mental health provision through the Mental Health Strategy. - Think Family approach recognises the impact that adult mental health needs can have on children's health and wellbeing
Better promotion of activities in local communities.	- Social prescribing services are connecting people to non-medical services and activities in their local communities. - Building prevention into our clinical pathways will help health professionals to better signpost people to activities and services in their local communities. - Targeted communication campaigns, co-designed with local people, will strengthen the outcomes of our promotional activity. - A continued commitment to the Leeds Directory, which is used by local people and professionals, and promotes local activities and community groups.

Connected care closer to people in their communities	
What people told us	Our response
People's additional needs and personal circumstances need to be taken account when accessing services.	• Our Better Conversations approach will enable health and care professionals to work with local people to help them better utilise their strengths and assets. • Implementation of personalisation will ensure people with long-term conditions or illnesses receive support that is tailored to their individual needs and wishes. • We are improving the lives of people living with frailty by taking a population outcomes approach and overseeing the implementation of an integrated model which has been developed by providers. This programme includes the implementation of virtual frailty wards. • Our work on patient experiences will help us understand what it feels like to be a patient in our services, including for those with additional needs. • We will continue to use data and insight through our various satisfaction and complaints processes to inform service design.
Digital technologies have an important role to play, but digital services need to be better joined-up and easier to use, and we need to be mindful of digital inclusiveness.	• We continue to be committed to the Leeds Care Record, which enables health and care providers to link people's data, and provider better and safer services and advice. • HELM is the city's personal health record that is currently being developed. It will be tested with a small cohort of users & developed in an iterative way to ensure it is easy for people use. • The city's Smart City approach is committed to achieving a 100% digitally enabled population. • The Leeds Repository will bring together health and care information onto one platform, meaning it will be easier for people and professionals to access. • Digital choices for appointments will be introduced, particularly for GP and outpatients appointments.
Patient-driven and patient-managed care, enabled by more empowered patients.	• Our Population Health Management approach means we will bring together health-related data to identify specific populations which will allow us to prioritise our services to meet their needs and deliver personalised services. • HELM is the city's personal health record which is currently being developed. This will give people greater access to credible health information, data and knowledge, meaning they can better improve their health and manage their health conditions. • Our Better Conversations approach enables health and care professionals to work with local people, to empower them to live healthier lives, and better manager their health conditions.

Connected care closer to people in their communities	
What people told us	Our response
A wider range of professionals from NHS, local authority, private health and social care organisations, and the community and voluntary sector, working closer together to plan and deliver health and care services.	We will continue to develop the 18 Local Care Partnerships across Leeds, which bring together professionals from the health and care sector, third sector, and decision-makers who influence the wider determinants of health. LCPs will enable a more person-centred care model, closer to a person's home.
Access to GP surgeries and specialist services.	- Digital choices for appointments will be introduced, particularly for GP and outpatients appointments. - Specialist services will be a core part of the Local Care Partnerships, meaning these services can better accessed in communities. These services will be based on the needs of the local communities that the LCPs serve. - The Urgent Treatment Centres will provide specialist services for urgent care in communities. - We are developing new services in GP surgeries, such as Cancer screening, meaning people can access these services closer to home. - LCPs, UTCs, and new services in GP surgeries (e.g. cancer screening) will help improve waiting times at hospitals.
Health services to embrace digital technologies.	- Digital choices for appointments will be introduced, particularly for GP and outpatients appointments. - Online booking systems have been introduced at GP surgeries, and these will continue to be promoted. Online bookings will also be explored in other health settings.
There are concerns that moving outpatient appointments into community settings could impact quality of service, particularly when engaging on cancer services.	- Services will be co-produced with people, so that they are person-centred. - Community based services will be subject to risk assessment, and only implemented when appropriate.
People find it confusing which services to use for unplanned care, for example whether to attend Minor Injury Units, A&E Departments, or Walk-In Centres.	- Five Urgent Treatment Centres will be introduced across the city. These will make it easier for people to know where to go for unplanned care. - In implementing the UTCs we will continue to engage with people using the services to better understand their experiences, which will help improve communication within the centres – for example through signage. - Robust referral pathways and communication mechanisms will be implemented, aligning the LCPs and PCNs to the UTCs.

Mentally healthy city for all	
What people told us	Our response
More prevention of mental ill health.	• In our Health and Wellbeing Strategy, one of the key priorities is to promote good physical and mental health equally. This is reflected in our Plan goal of promoting good health, which includes mental health as well as physical health. • Connecting with the Best Start programme and the Future in Mind plan we recognise that getting it right for children benefits the whole population throughout the life course. • We address the wider determinants of mental health targeting communities with the poorest mental health through good accessible information, self-care, peer support and social prescribing. • Targeted support for people from BAME communities to reduce hospital admission for mental health issues.
More investment in community mental health services.	• As part of the Community Mental Health service redesign that is being implemented across the city, home-based treatments are being introduced where it is safe for them. • Developing more community based crisis support services. • Intention to reduce of the numbers of people from BAME backgrounds who are detained under the Mental Health Act. • IAPT services continue to provide valuable mental health services in local communities and have been recommissioned to improve the service offer
Mental Health needs to be given greater attention and focus	• We are currently finalising the Mentally Healthy City Strategy which is a city strategy which all partners have shaped and are signed-up to delivering. • The Leeds Plan is a plan in which both mental and physical health are implied and considered throughout. We also have a set of specific actions to improve mental health services and experiences for specific groups that can experience inequalities in mental health outcomes.
Children's mental health services need to be easier to access.	• Improving the social, emotional, mental health and wellbeing of children and young people is a priority of the Mental Health Strategy. • Think Family approach recognises the impact that adult mental health needs can have on children's health and wellbeing • One of the core passions of the Mental Health Strategy is to increase the numbers of people with mental health needs in education, training and employment
Addressing street drinking, drugs and mental health.	• A new Leeds Drug and Alcohol Strategy has been launched. The new strategy has a number of priorities, including providing better health support for people misusing alcohol and drugs, and reducing crime and disorder as a result of misuse. The Leeds Alcohol and Drug Strategy will help achieve some of the priorities identified in the Leeds Health and Wellbeing Strategy.

Key themes that emerged from partnerships boards / groups include:	
What people told us	Our response
There is a need to describe what the Left Shift is. Need to ensure the Left Shift becomes real action.	The updated plan sets out characteristics of the left shift shared by partners across boards and conversations. The refresh process has invited partners to give initial actions to support a left shift. The refresh recognises the further work required to develop the commissioning and partnership actions to collectively develop a shared approach to a left shift.
Need to be clear what the actions partners will take in response to the plan	The approach has consulted widely with partner leadership groups and meetings including leadership groups to develop and share initial actions in response to the plan by partners.
Commissioning needs to adapt to support the Plan including development of joint commissioning and flexible approaches to support the left shift. Commissioning will need to be adaptive to differences between PCNs	Commissioning wording in plan has been updated to indicating role of joint commissioning Role and terms of reference for Integrated Commissioning Executive are being reviewed and updated to reflect joint commissioning and population health management approaches. Joint commissioning development programme is in place.
We need to ensure a wider understanding of the refreshed Leeds Plan ambitions across staff teams. The Leeds Plan on a page needs to be simple to support wider staff understanding	The Plan on page has been simplified. There is planned test engagement with staff groups which will determine final wording and presentation to maximise staff understanding. There is a communications plan to support dissemination of the Plan.
Needs assurance that Left Shift will not increase waiting times for hospital procedures	Assurance given that there are no planned reductions in funding for hospital based care through Left Shift. Approach will support earlier help and aims to create faster local responses to need.
GP capacity needs increasing if the Left Shift approach is to be effective	The Leeds Plan transformation action for Local Care Partnerships has significant development support already in place. Plans will be further developed and shared on the next stages of support for the NHS Primary Care Network programme. Strategic Workforce programme includes Primary Care group supporting overall needs for primary care services.

Key themes that emerged from partnerships boards / groups include:	
What people told us	Our response
Crucial role of workforce and digital in driving transformation not reflected strongly enough	Plan presentation and wording has been changed to give more prominent status to transformative aspects of workforce, digital and other enabling areas. Supporting strategy for workforce and associated governance has been updated to give greater prominence and leadership to this area.
Make clear the Leeds Plan link to wider determinants of health and wellbeing.	The plan on a page has been changed to make it clearer that it is rooted within the wider Health and Wellbeing Strategy.
Ensure protected characteristics outside BAME are in the plan.	The plan has an overarching requirement to reduce health inequalities in all forms and the wording has been strengthened to emphasise this. Specific actions are underway to improve the recognition, involvement of and leadership by people with a Learning Disability in the plan including development. Workshops and development is planned for early 2020 for HWB and Plan support teams. Supporting plans for workforce include career development for women and BAME to increase mobility into leadership roles.
Need to be clearer how resources flow to support Left Shift – particularly where issues of wider public health or food poverty which are salient to core wellbeing.	The Leeds Plan is set in the context of a strategy to make economic growth in Leeds more inclusive. The strategy includes actions to promote shared investment in health and wellbeing across the wider economy via initiatives such as the Anchors Programme, itself rooted within the Inclusive Growth Strategy. Commissioning will increasingly reflect Leeds Plan priorities.
How does this link to the West Yorkshire and Harrogate Integrated Care System (ICS) and the NHS Long Term Plan?	The Leeds Plan links to the NHS Long Term Plan and is our place based contribution to the WY&H ICS 5 Year Plan.

3.3 Leeds Plan summary on a page

- 3.3.1 Using the learning from the approach to date, the key themes that have emerged from engagement activities and discussions, as well as the successes to date, it is recommended that the refreshed Leeds Plan is organised as described in the proposed Leeds Plan summary on a page (see the follow page).

It is important to understand that the attached summary:

- Has been developed to summarise the key areas of partnership focus
- Sets out the aspirations for health and wellbeing in our city and connects the actions we must take to improve outcomes
- Behind each of the specific actions and approaches exists detailed information, much of which has been presented or discussed with the Health and Wellbeing Board and other strategic or statutory Boards. For example, plans for Local Care Partnerships.
- Is not an exhaustive list of initiatives, changes or areas of work that partners will undertake. These are captured in other documents and will be covered during the production of more detailed Programme Initiation Documents (PIDs) and communications and engagement materials.
- A communications plan has been developed. This outlines how the current summary on a page will be translated into public facing and easy read versions for all staff and citizens.

Our Leeds Health and Care Plan

Informed, developed and delivered together as Team Leeds for all people of all ages: by citizens; carers; elected members; volunteer, community and faith sector; our community health and care service providers; GPs; local authority; hospitals; commissioning; and academic organisations.

Delivering our Leeds Left Shift



A friendly, healthy, compassionate city with a strong economy, where we reduce health inequalities, promote inclusive growth and tackle climate change

Our outcomes

What we want to achieve, contributing to the five outcomes in the Leeds Health and Wellbeing Strategy

1. People will live longer and have healthier lives
2. People will live full, active and independent lives
3. People's quality of life will be improved by access to quality services
4. People will be actively involved in their health and their care
5. People will live in healthy, safe and sustainable communities

Our approach

In everything we do

We start with people – working with people instead of doing things to them or for them, maximising the assets, strengths and skills of Leeds' citizens, carers and workforce.

- Have 'Better Conversations' –equipping the workforce with the skills and confidence to focus on what's strong rather than what's wrong through high support, high challenge, and listening to what matters to people
- 'Think Family' – understand and coordinate support around the unique circumstances adults and children live in and the strengths and resources within the family
- 'Think Home First' – supporting people to remain or return to their home as soon as it is safe to do so

We deliver – prioritising actions over words. Every action focuses on what difference we will make to improving outcomes and quality and making best use of the Leeds £.

- Make decisions based on the outcomes that matter most to people
- Jointly invest and commission proportionately more of our resources in first class primary, community and preventative services whilst ensuring that hospital services are funded to also deliver first class care
- Direct our collective resource towards people, communities and groups who need it the most and those focused on keeping people well

We are Team Leeds – working as if we are one organisation, being kind, taking collective responsibility for and following through on what we have agreed. Difficult issues are put on the table, with a high support, high challenge attitude.

- Unify diverse services through a common culture
- Be system leaders and work across boundaries to simplify what we do
- Individuals and teams will share good practice and do things once

Our collective effort

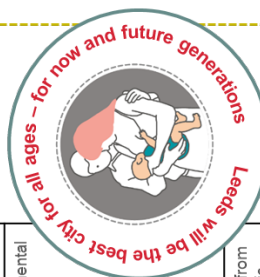
Start, design, work and evaluate with citizens and staff. Listening to people's journeys and experiences of care and using this to drive improvements.

Goals	Promoting good health	Connected care closer to people in their communities	Mentally healthy city for all
Priorities	1. Build prevention into everything we do 2. Get more people, more physically active, more often	3. Embed person centred care through delivering the universal personalised care model and through taking a strengths and asset based approach to working with people and their communities 4. Develop and embed Local Care Partnerships, our integrated community health and care model around GP practices	5. One system of coherent mental health services 6. <<action from BAME MH workshop TBC>>
Measures	Increase the number of people receiving lifestyle advice in primary care including brief advice offered and onward referral to services e.g. smoking, weight management, physical activity and alcohol use <<Moving more measure TBC>>	Safely and appropriately reduce the number of hospital bed days utilised per 100,000 people Increase self-reported wellbeing in communities including that for children, young people, adults and older people	Reduce the number of people from Black, Asian and Minority Ethnic (BAME) backgrounds who are detained under the Mental Health Act Increase recovery rates of children, young people and adults in community settings
How does it feel for me? – listening to people's journey of care			

Helping us get there

We will...

- Recruit people from communities of greatest inequality by providing opportunities for skills and jobs and inspiring the next generation of health and care workforce
- Learn together through our Health and Care Academy, ensuring our workforce is delivering 21st century care
- Prioritise service delivery in our buildings which offer fit for purpose, flexible space in communities into practice on the ground
- Transfer cutting edge research and innovation
- Digitally connect our whole system (information, people, systems) and act on digital opportunities to redesign the way we deliver health and care
- Work with people and staff to develop and evaluate collaborative city campaigns that improve health outcomes for all



Results we want include:

- ← Better health and wellbeing through all stages of life
- ← Greater focus on the whole person, not just on individual health conditions taking into consideration the circumstances in which we are born, grow, live, work and age
- ← Social and medical models of health and wellbeing brought closer together
- ← A shift of resources to protect the vulnerable and reduce inequalities

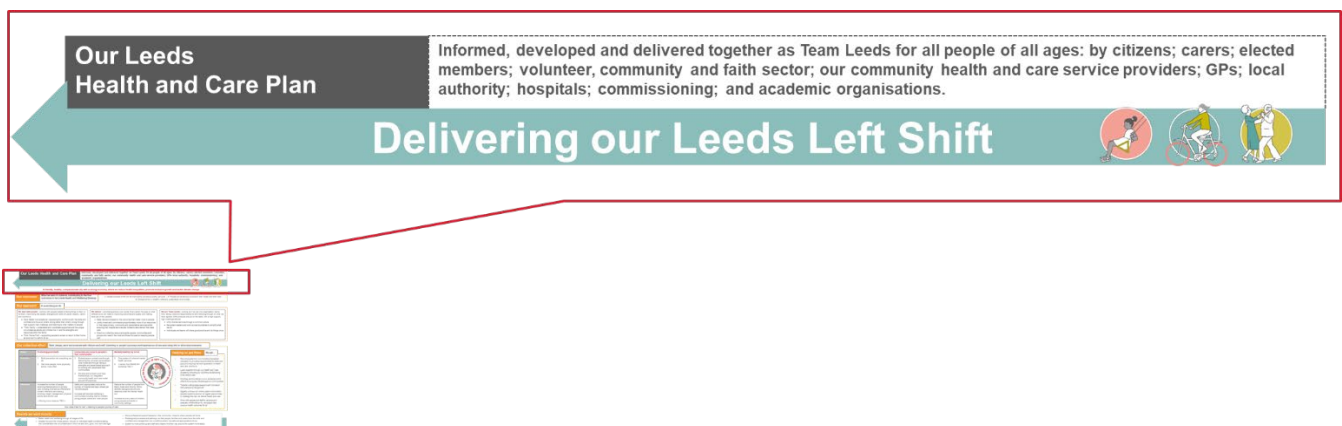
- ← More professional support happens in the community, closer to where people call home
- ← Redesigned processes and pathways so that people, families and carers have the skills and confidence to manage their own conditions where it is safe and appropriate to do so
- ← System is more joined up and staff and citizens find their way around the system more easily
- ← Citizens have greater access to their own data and information
- ← Decisions we take now will benefit our current and future generations

3.3.2 Explaining each component of the Leeds Plan:

3.3.3 The Leeds Plan contributes to delivering the Leeds Health and Wellbeing Strategy. The Plan represents a further shift towards outcome based working – both for the whole population of Leeds and also for populations within Leeds of people with similar needs – such as those living with frailty.



3.3.4 The Leeds Left Shift has proved a helpful concept in uniting the commonly held themes of moving to a more preventative approach that delivers better outcomes, takes the pressure off acute services and moves care closer to people's homes. There are ongoing discussions about the meaning and interpretation of the term and the detail of what it implies for different services.



3.3.5 'Our approach' guides the way we expect all staff to work. Some of the tangible partnership actions that will bring our approaches to life are outlined in the bullets.

Our approach

In everything we do

We start with people – working with people instead of doing things to them or for them, maximising the assets, strengths and skills of Leeds' citizens, carers and workforce.

- Have 'Better Conversations' – equipping the workforce with the skills and confidence to focus on what's strong rather than what's wrong through high support, high challenge, and listening to what matters to people
- 'Think Family' – understand and coordinate support around the unique circumstances adults and children live in and the strengths and resources within the family
- Think 'Home First' – supporting people to remain or return to their home as soon as it is safe to do so

We deliver – prioritising actions over words. Every action focuses on what difference we will make to improving outcomes and quality and making best use of the Leeds £.

- Make decisions based on the outcomes that matter most to people
- Jointly invest and commission proportionately more of our resources in first class primary, community and preventative services whilst ensuring that hospital services are funded to also deliver first class care
- Direct our collective resource towards people, communities and groups who need it the most and those focused on keeping people well

We are Team Leeds – working as if we are one organisation, being kind, taking collective responsibility for and following through on what we have agreed. Difficult issues are put on the table, with a high support, high challenge attitude.

- Unify diverse services through a common culture
- Be system leaders and work across boundaries to simplify what we do
- Individuals and teams will share good practice and do things once

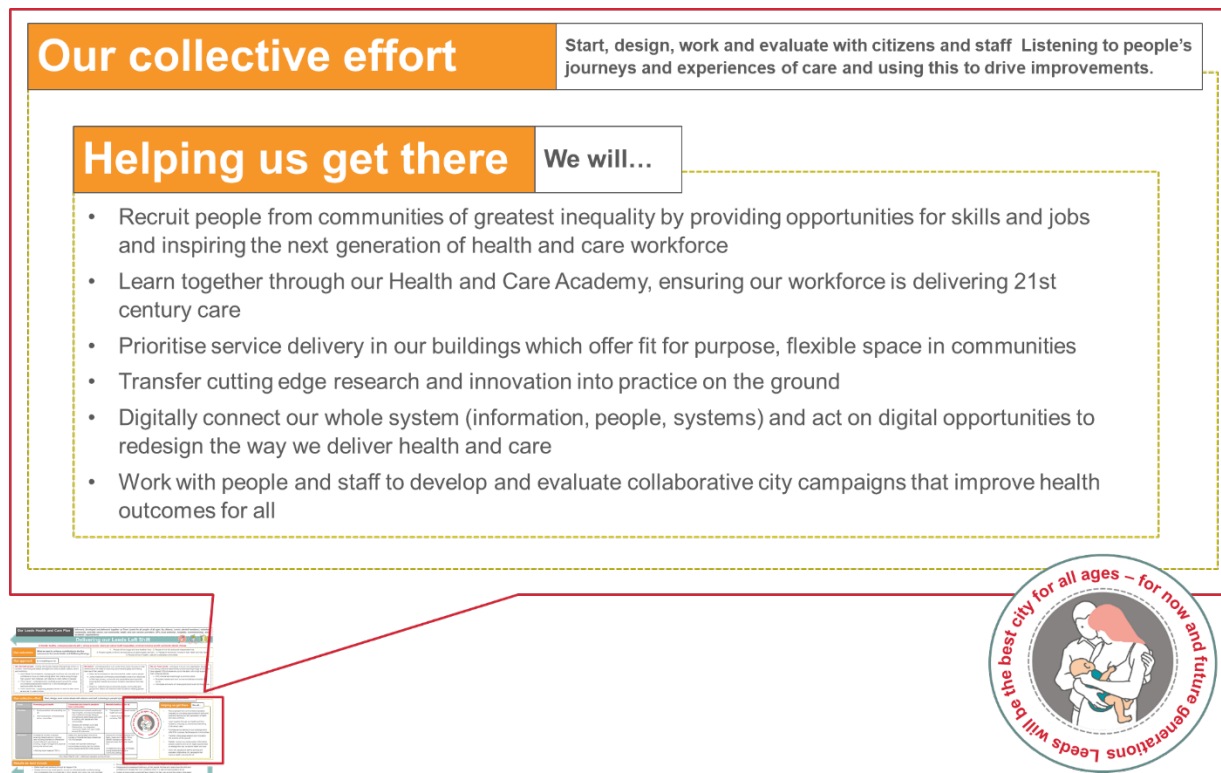


3.3.6 'Our collective effort' outlines three interconnected goals and the transformational actions we will prioritise as a partnership to achieve system wide impact. We will measure our progress on key indicators to tell if we're making a difference.

Our collective effort		Start, design, work and evaluate with citizens and staff. Listening to people's journeys and experiences of care and using this to drive improvements.	
Goals	Promoting good health	Connected care closer to people in their communities	Mentally healthy city for all
Priorities	1. Build prevention into everything we do 2. Get more people, more physically active, more often	3. Embed person centred care through delivering the universal personalised care model and through taking a strengths and asset based approach to working with people and their communities 4. Develop and embed Local Care Partnerships, our integrated community health and care model around GP practices	5. One system of coherent mental health services 6. <<action from BAME MH workshop>>
Measures	Increase the number of people receiving lifestyle advice in primary care including brief advice offered and onward referral to services e.g. smoking, weight management, physical activity and alcohol use <<Moving more measure TBC>>	Safely and appropriately reduce the number of hospital bed days utilised per 100,000 people Increase self reported wellbeing in communities including that for children, young people, adults and older people	Reduced the number of people from Black, Asian and Minority Ethnic (BAME) backgrounds who are detained under the Mental Health Act Increase recovery rates of children, young people and adults in community settings
How does it feel for me? – listening to people's journey of care			



3.3.7 'Our collective effort – helping us get there' outlines some of the key actions that will enable us to deliver sustainable change, by working differently and collectively on; workforce, digital, communications and engagement, innovation and estates.



3.3.8 A summary of results we expect from delivering the Leeds Plan.



3.4 Communications Plan

- 3.4.1 A communications plan will ensure there is a consistent and robust approach to raising awareness and understanding of the Leeds Health and Care Plan. Between December 2019 and February 2020, communication leads from across the system will work together with a local creative agency to develop a series of communication assets for local people and our workforce.
- 3.4.2 The objectives of the communication plan are to:
- Develop further the consistent narrative for the Leeds Health and Care Plan
 - Equip communications teams with the assets they need to promote the Leeds Plan internally and externally
 - Utilise a wide-range of communications tools to promote key messages
 - Ensure our communications is meaningful and audience-specific
 - Ensure we have processes in place to celebrate successes
- 3.4.3 Communications assets will include: a new website, a short animation, slide decks, and some printed materials (such as leaflets and banners). Communication leads will also work on compelling content for social media and traditional print and other local media as part of a public 'launch' of the Plan in March 2020.
- 3.4.4 The following table provides an overview of the different assets that are proposed will be produced.

Asset	Detail
Website	A new partnership website will be developed, which will host information about the Health and Wellbeing Strategy and the Leeds Health and Care Plan. It will be used to demonstrate impact through the use of case studies, provide up-to-date information through a blog and other tools.
Social media	Partners have established social media channels, which will be used to share key messages about the Leeds Plan, and to drive traffic to the website for further information. Infographics and GIFs will be developed to make content on social media more compelling.
Printed materials	Including the plan/summary on a page, the longer narrative, postcards and banners. These will be designed to have a consistent look and feel, and will be used in various settings, including supporting our internal and external communications.
Interactive documents	The plan/summary on a page will be created as an online interactive format, whereby people can click on particular elements of the plan to find further explanation – for example to find more information about workforce priorities.
Case study documents	These will be two-sided documents, each will be dedicated to a particular priority (such as digital), and will briefly outline the ambition for the priority, as well as providing a case study of impact. These will be created as PDFs, and made available on the website, and will be updated with progress on a regular basis.
Slide decks	Slides will be designed, to enable consistent presentation of the Leeds Plan.

Asset	Detail
Animation	A short animation will be developed as an effective way to explain what the Leeds Plan is and what it is aspiring to achieve. This will be made available on the website, and shared through social media.
Internal communications	Communication leads will use existing internal communication channels to cascade messages about the Leeds Plan through their organisations.
Media	We will engage with local media about the new Leeds Health and Care Plan, issuing press releases, and inviting media outlets to interview senior leaders.

3.5 Governance / delivery framework

- 3.5.1 Leeds has a proud history of partnership working as ‘Team Leeds’. Effective governance arrangements are essential to achieving the ambition and driving the collective actions required to deliver the Plan and link to wider strategies and organisational governance.
- 3.5.2 It is proposed that the Leeds Plan should continue to be strategically steered by the Leeds Health and Wellbeing Board with executive functions delivered through the Partnership Executive Group. Rather than adding additional layers of governance it is proposed that current boards/groups are used or repurposed if necessary after conversations with Senior Responsible Officers (SROs).

3.6 Next Steps

- 3.6.1 As with the current Leeds Plan, Programme Initiation Documents will be produced for each transformational initiative during the first quarter of 2020.
- 3.6.2 It is recognised that initiatives within the plan are at different levels of maturity, with some having existing delivery plans and some requiring new delivery plans. The partnership will use tools like Outcome Based Accountability, Logic Models or other relevant approaches to ensure delivery plans clearly describe the intended change, key milestones, timescales and risks. Governance and resource implications will also be factored into the delivery plans.
- 3.6.3 In the appendix is a draft initial high-level key milestones for 2020. This will be developed in more detail alongside the development of the PIDs.

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

- 4.1.1 In Leeds, the voices of local people are at the heart of how we work. We have used the insight collected from a series of consultation and engagement activities including the Big Leeds Chat, consultation on the NHS Long-Term Plan, and mental health engagement carried out by Healthwatch Leeds. We will continue to work in partnership with local people in implementing the changes outlined in the Leeds Plan, with the People’s Voices Group championing robust and high-quality consultation and engagement across the health and care system.

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 demonstrates how we will work together across health, care and community organisations to focus resources where they can make the biggest difference and get the best value for our Leeds Pound.

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 via Partnership Executive Group and the Health and Wellbeing Board as appropriate.

5 Conclusions

- 5.1 The paper outlines the successes of the current plan and how our refreshed Leeds Plan has been shaped by partners and people.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Note the progress and successes of the Leeds Plan to date (section 3.1).
- Confirm that the Leeds Plan summary reflects the priorities that the Board previously agreed (16 September 2019) should be given additional focus (section 3.2.2).
- Identify actions that each partner will take to deliver the refreshed Leeds Plan.
- Support the development of a system-wide approach to communications and engagement (section 3.4).

7 Background documents

- 7.1 None.

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Implementing the Leeds Health and Wellbeing Strategy 2016-21

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?

Leeds Plan provides an agreed basis for transformation & 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

Transformational Initiatives – High Level Milestones - 2020

	January – March 2020			April – June 2020		July – September 2020			October – December 2020	
1. Building prevention into everything we do										
	Identify PCN to undertake the healthy living pilot in	Planning of Healthy Living Services within Pilot Locality including - Workforce and Digital enablers			Implementation of Healthy Living Services within pilot locality					Evaluation and benefit analysis
									Identification of roll out plan - Including within the hospital setting	
2. More people more physically active more often										
	Development of a draft shared vision / ambition for physical activity		Physical activity ambition action planning			Physical activity ambition implementation				
3. Embed the universal model of personalised care										
	Establish Action Plan for Personalised Care			Deliver Priority Workstreams						
4. Develop our integrated community health and care model*				Final wave of LCPs commence Population Health Management	All integrated care services being tested in LCPs	Each LCP progressing 2 priorities – including demonstrating how to tackle the wider determinants of health				
	All LCPS meeting	Cases studies collated outlining benefits of partnership working				Each LCP demonstrate positive movement on maturity framework vs Sep 2019			Exemplar LCPs evidence system thinking and creative use of resources	
5. Mentally Healthy City for all										
	Complete the Mental Health strategy, agree and implement governance arrangements, identify related initiatives to add to Leeds Plan priorities									

* There are outputs from particular projects in the Population Health Management work and in some of the partnership work that the LCPs are beginning to undertake. Some of our key deliverables (fostering effective relationships, supporting culture change) will be captured through the maturity framework but do not lend themselves well to defining as milestones.

Enablers – High Level Milestones - 2020

	January – March 2020			April – June 2020		July – September 2020		October – December 2020	
1. Recruit people from communities of greatest inequality	Leeds Health and Care careers fair	Leeds Apprenticeships fair	Widening nursing pipeline project commences						
	Develop strategy to recruiting people with greatest inequality			Implement strategy to recruiting people with the greatest inequality					
2. Learn together - health and care academy	Delivery of springboard programme 1		Delivery of springboard programme 2				Delivery of springboard programme 3		
		Implement rolling programme of long term conditions training							
		One workforce health and care careers ambassador programme (quarterly)							
		System leadership event		System leadership event		System leadership event			
3. Service delivery in fit for purpose, flexible space	Health engagement in planning process established		Health engagement in planning process implemented and on-going monitoring						
	PCN / LCP engagement to contribute towards Community Estates Strategy				Community Estates Strategy developed and begin delivery				
	Business case Bangladeshi Centre Completed		Vacant space policy Agreed			Lincoln Green Investment Plan Agreed	Bangladeshi Centre refurbishment works		
4. Cutting edge research and Innovation	Enhancing and continuing the conversation with Bradford regarding joint opportunities		Commission work to develop a be better understanding of demographic changes in Leeds						
	Review and adapt LAHP strategy to ensure continued delivery of LCPMH, Academy and Living in Leeds		Develop new shared LAHP priorities that enable the university sector to work closely with LCC, NHS and Third Sector		Work to align health and economic growth priorities, particularly those that develop and grow the health-tech sector				
	Integration of university research priorities and city research priorities								
5. Digitally connect whole system	External advice on digital transformation opportunities and revised roadmap								
	Delivery Leeds Repository – improved search facilities for service and pathway information,				Deliver Leeds Care Record Business Case to 2020				
	Deliver ongoing programme to improve digital within public sector buildings e.g. Council House of the Future								
			70% of care homes with NHSMail and IG compliance		HELM CCSP Care Plan Functionality in place				
6. Work with people and staff to develop campaigns									
	Development of Leeds Health and Care Plan narrative And communication collateral		System wide scoping to identify campaigns		Engagement with local people to gather insight to shape the programme		Campaign Development	Implementation of programme of campaigns	

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Report of: West Yorkshire and Harrogate Health and Care Partnership

Report to: Leeds Health and Wellbeing Board

Date: 11th December 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 has been working throughout the summer and autumn to develop its five year strategy. This 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 Leeds Health and Care Plan.
2. The WY&H 5 Year Strategy and the Leeds Health and Care Plan are designed and developed to work co-operatively together for the benefit of the health and wellbeing of the people of Leeds.
3. A further draft of the 5 year strategy was discussed at the WY&H Partnership Board on the 3rd December, and this document is now being shared with the Leeds Health and Wellbeing Board for consideration.

Recommendations

The Health and Wellbeing Board is asked to:

- Consider and comment on the WYH 5 Year Strategy documents
- Consider and comment on the links between the 5 Year Strategy and the refresh Leeds Plan for Health and Care
- Note the timescale and process for finalisation of the documents following the General Election.

1 Purpose of this report

- 1.1 The purpose of this paper is to present a further draft of the narrative of the West Yorkshire and Harrogate Health and Care Partnership Five Year Strategy.

2 Background information

- 2.1 On 7th January 2019 the [NHS Long Term Plan](#) (LTP) for England was published. This set out the 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.
- 2.2 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 and the [NHS LTP Implementation Framework](#) published in June 2019 set out their expectations on what needs to be included in that.
- 2.3 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.
- 2.4 All partners were clear that it is our strategy and it will reflect our priorities and our way of working. This will include:
- **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.
 - **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.
- 2.5 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.
- 2.6 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 vision to improve the health of the poorest the fastest
- 2.7 The Leeds 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. It is recognised as the key strategic driver for Leeds alongside the Leeds Inclusive Growth Strategy and the development of the new regional Local Industrial Strategy, which will be key to delivering on these ambitions.

- 2.8 Both at citywide 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 spaces, strong communities, decent housing and the kind of inclusive growth that expands employment and opportunity for all. 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.
- 2.9 Getting the 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 On 3rd December the latest versions of the 5 Year Strategy were presented to the WY&H HCP Partnership Board for consideration and comment. The Partnership Board looked at three versions of the Strategy Documents:
- An updated draft of the full document that reflects all feedback from received between June and November (Annex A).
 - A draft, shorter summary document, which draws out the distinctiveness of the places in the partnership and sets out our 10 big ambitions (Annex B).
 - A draft, easy read version of the 5 Year Strategy (Annex C).
- 3.2 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.
- 3.3 The drafts incorporate the updated priorities from each WY&H programme and builds on the existing work of our Partnership to date. It builds on extensive feedback from all partners, including those received from Leeds Health and Wellbeing Board in June and September. The main themes of feedback have been as follows:
- Strengthening the ambition to reduce health inequalities, particularly in relation to improving healthy life expectancy
 - Placing a stronger emphasis on the social determinants of good health, including employment, housing and climate emergency
 - Strengthening references to social care, and the importance of social care in developing integrated support and care for adults and children

- Strengthening the sense of distinctiveness of our West Yorkshire and Harrogate Partnership, including our values, what is important to us and what makes us unique
- Including references and specific shared ambitions for end of life care
- Strengthening the connections between the feedback from public involvement / engagement and the actions we are taking
- Setting some of the ambitions as minimum standards, reflecting that where possible we want to improve beyond these
- Improving the flow and navigation of the document – including web navigation.

3.4 It should be noted, that because of the timing of the general election, the WYH Partnership Board was not asked to formally sign off the strategy. The document will remain in draft until further comments are taken into account and until after the general election. Depending on the outcome of the general election and any subsequent guidance, we will be looking to launch the strategy early in the New Year. The sign off arrangements for this will be developed with WYH Partnership Board members.

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

- 4.1.1 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.
- 4.1.2 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.
- 4.1.3 The combined WY&H Healthwatch groups collated this feedback into an excellent report, published here [WY&H Healthwatch Engagement Report](#), in June 2019 that has been used by all Programmes to cross reference the feedback given by people with the plans we have developed.

4.2 Equality and diversity / cohesion and integration

- 4.2.1 Throughout our draft 5 Year Strategy we have made consistent and explicit reference to our intention to address the unjust health inequalities, lower life expectancy and lower number of years of healthy life experienced by people because of their socio-economic status, their ethnic background, their mental health status, their gender, their age or their sexuality.

- 4.2.2 Our draft 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 Our Draft 5 Year Strategy sets out our ambitions as a region, for improved delivery of health and care as a system – but it does so conscious that the funding to successfully deliver all aspects of the plan is not in place universally – for all outcomes, or for all parts of the system working together - and that we will need to remain active in securing and maximising funding throughout the life of the strategy.

4.4 Legal Implications, access to information and call in

- 4.4.1 At this stage there are no legal, access to information or call in implications for the relating to this report.

4.5 Risk management

- 4.5.1 At this stage there are no significant risk implications for the Leeds Health and Wellbeing Board relating to this report.

5 Conclusions

- 5.1 The draft 5 Year Strategy 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 5 Year Strategy is intended to complement and enhance the work being proposed in the refreshed Leeds Health and Care Plan.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Consider and comment on the 5 Year Strategy documents
- Consider and comment on the links between the 5 Year Strategy and the refreshed Leeds Plan for Health and Care
- Note the timescale and process for finalisation of the documents following the General Election.

7 Background documents

None.

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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 financial 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

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Better health and wellbeing for everyone: Our five year plan





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](#).

You can also find out more about the positive difference our Partnership is making [here](#).

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.

 Watch our thank you film [here](#).

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 and BSL.

There is also an animated film which you can watch [here](#).

You can read our public summary online here. [\(Add link once approved\)](#)

You can get involved in the Partnership’s work by contacting us at:

-  01924 317659
-  westyorkshire.stp@nhs.net
-  www.wyhppartnership.co.uk
-  [@wyhppartnership](https://twitter.com/wyhppartnership)
-  0781 176 6006 (text us!)

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Foreword

Stronger, better, healthier together

Since our Partnership began in 2016, we have worked hard to build the relationships needed to deliver better health and care locally and across West Yorkshire and Harrogate so we can improve people's lives, with them and for them.

We are pleased with the progress we have made. We are confident we have developed the right principles and values to guide us. We are keen to 'join the dots' so when people experience care, advice, support or treatment it feels joined up, is easier to get help and results in better outcomes.

This plan is full of examples of the progress we have made, from brand new hospitals, award winning carers support and jobs for people.

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. This includes working with partners in the wider economy to create good jobs and increase everyone's prosperity with investment in skills, housing, culture and infrastructure.

To have the best chance of achieving this, we need to think and work differently with each other and with our communities.



^ Rob Webster, CEO Partnership Lead.
Photo credit: Yorkshire Post

As a Partnership we are embracing community partners in our conversations and are listening 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 shared purpose. Our Five Year Plan tells the story of how we are going to do this together.



Our campaign '[Looking out for our neighbours](#)' is a great example of how staff, partners and communities are already making a positive difference through a shared commitment and simple acts of kindness. Find out more [here](#).



^ Cliffites, Huddersfield: 'Looking out for our neighbours' campaign



Together, the campaign has already **touched the lives of over 46,000 people**. We are **stronger, better, and healthier when we work together**.



You can read the campaign 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 have the biggest impact when there is shared commitment by all.

We do however, need to get better at talking with people about what they want and need.

Together we want to stop doing things that don't meet people's physical or mental health needs, or make them feel any better. We need to rethink how we can continually improve and free up money to re-invest in our communities, where we know we can be far more effective in preventing people becoming unwell in the first place. There are some great examples in our Plan to show you what we mean by this.

We also want to make sure our staff are able to give their best, develop their talents and make West Yorkshire and Harrogate a great place to live and work.

Our story



The Partnership belongs to us all.

Everyone is valued and we want to ensure equitable opportunities for people living across our area.

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 or isolation that harm our health.



Making the most of every opportunity, we will embrace fully what our Partnership and communities have to offer, including new technology and new ideas, and how these can make a positive difference to what and how we work on them to improve people's lives.

>>



^ Photo credit: Leeds and York Partnership NHS Foundation Trust

>>

Why work together?

We know people's lives are better when organisations who provide health and care work together, particularly at the times when people most need it. We know people's lives are better when we plan for, and invest in, services that support mental and physical health at the same time. We also know that sharing good ways of working makes the money go further, creates the best use of staff expertise and increases the quality of what we all provide.



Most importantly, by working together, we will have the chance to create the conditions so that children get the best start in life and everyone's chance of living a long, healthy life improves.

We are connectors

Our ambition 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 support delivered

by local groups, services delivered in people's own homes or the treatment that is best provided in a hospital.

We also want to make it easier for people to **take action to improve their own health and wellbeing.**



Health and care is more than services

We know that most of what keeps you healthy and well is a wider set of factors than traditional health and care services. This includes the house you live in, how warm it is, whether you feel isolated or alone, whether you experience poverty, the food you eat every day, how mobile and independent you are, whether you have a job and have access to parks and open spaces.

And so, we recognise that if we want to improve everyone's health, we will have to target those factors that cause some people to experience significantly worse health – because of where, or how they live.

We are challenging traditional ways of working so we see the whole needs of people, what factors are causing or exacerbating their ill-health and what will help them to get well and stay well long term.

We truly believe that working with all partners across all sectors, listening to people, asking them what they want and acting on what works for them is a great place to start.

Rob Webster,
CEO Lead for West Yorkshire and Harrogate Health and Care Partnership



Our Partnership

Clinical Commissioning Groups (CCGs)

NHS Airedale, Wharfedale and Craven CCG*
NHS Bradford City CCG*
NHS Bradford Districts CCG*
NHS Calderdale CCG
NHS Greater Huddersfield CCG
NHS Harrogate and Rural District CCG
NHS Leeds CCG
NHS North Kirklees CCG
NHS Wakefield CCG



Local councils

City of Bradford Metropolitan District Council
Calderdale Council
Craven District Council
Harrogate Borough Council
Kirklees Council
Leeds City Council
North Yorkshire County Council
Wakefield Council



Care providers

Airedale NHS Foundation Trust
Bradford district Care NHS Foundation Trust
Bradford Teaching Hospitals NHS Foundation Trust
Calderdale and Huddersfield NHS Foundation Trust
Harrogate and District NHS Foundation Trust

Leeds Community Healthcare NHS Trust
Leeds and York Partnership NHS Foundation Trust
Leeds Teaching Hospitals NHS Trust
Locala Community Partnerships
The Mid-Yorkshire Hospitals NHS Trust
South West Yorkshire Partnership NHS Foundation Trust
Tees Esk and Wear Valleys NHS Foundation Trust
Yorkshire Ambulance Service NHS Trust

Others involved

Healthwatch
Health Education England
Leeds City Region Enterprise Partnership
NHS England
NHS Improvement
Public Health England
Universities
West Yorkshire Combined Authority
See page 17 for more partners.

The third sector is made up of voluntary and community organisations, charities, social enterprises, co-operatives, faith based initiatives and other bodies with a not for profit constitution.

**The future plan is to have one NHS Bradford District and Craven, Clinical Commissioning Group from April 2019*

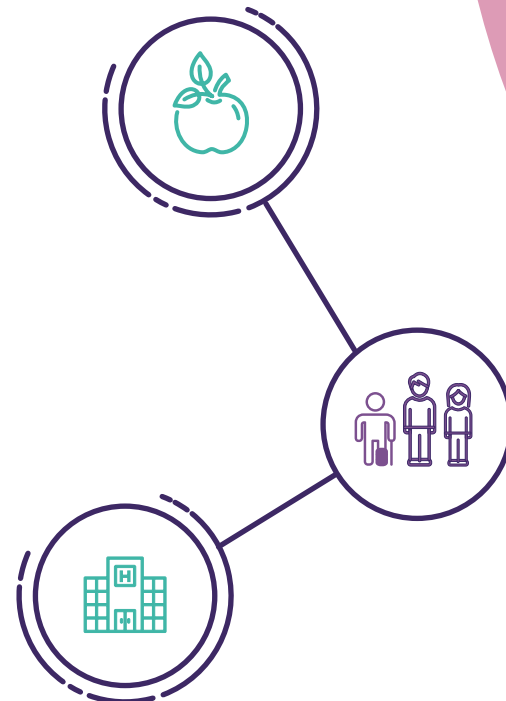
West Yorkshire and Harrogate Health and Care Partnership is made up of six local places:
Bradford district and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield



Our vision

- Places will be healthy; **you will have the best start in life** so you can live and age well and die in the place of their choosing. We will work to make sure you are not disadvantaged by where you live, your background or what you do.
- If you have a long term health condition **you will be offered personalised support to self-care**. This will include peer support, technology and communities of support from people like you.
- If you have multiple health conditions, **you will be in a team with your GP, community care staff and social services working together**. This will involve you, your family and carers, the NHS, social care and community organisations - working on what matters to you.
- If you need hospital care, it will usually mean that your local hospital, which will work closely with others, will give you the best care possible.
- **Local hospitals will be supported by centres of excellence** for services such as cancer, vascular, stroke and complex mental health. They will deliver world class care and push the boundaries of research and innovation.

- All of this will be planned and paid for once between the NHS, your local council and community organisations **working together and removing artificial barriers to care**.
- People and staff will be involved in the design, delivery and assurance of services so that everyone truly owns their healthcare.



In your neighbourhood and community 01

- Your carers will be supported too
- And where safe to do so you will be supported to self-care
- Health and social care will work together to support your social, physical and mental health
- Better use of information and data will be used to organise services around you

You are at the centre of everything we do

You will have the best start in life so you can live and age well.

We will work with you to deal with the issues that affect your health and wellbeing in your communities, whether it's loneliness or learning disability; housing or mental health; childhood obesity or air quality – **together we can make things better with you.**

02 In your local area

- Health and care organisations will work together to tackle inequalities
- We will focus on the conditions for good health including housing and employment

Across West Yorkshire and Harrogate 03

- We will hold each other to account for delivery on our shared issues
- Our hospitals will work together so you have the best treatment possible
- We will make the best use of all the expertise and staff skills available to us for workforce planning
- We will work at scale across the area on wider issues like cancer
- We will share learning and spread good practice



Executive summary



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, NHS 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.



^ Photo credit: Mid Yorkshire Hospitals NHS Trust

As a successful Partnership we expect to deliver on national targets, on people's experience of care, such as accident and emergency, cancer, mental health and operation wait times.

This Plan sets out how we will achieve the ambitions of the NHS Long Term Plan for the **2.7million people** living in West Yorkshire and Harrogate with the money we have available. However, our plan is more than just our response to the NHS Long Term Plan. It is broader in scope, addressing the priorities of local government and third sector partners, as well as the NHS.



It sets out our ambitions on what we have agreed to work together on across the area.



^ Photo credit: Harrogate and District NHS Foundation Trust



Ten of our big ambitions

- 1

We will increase the years of life that people live in good health across West Yorkshire and Harrogate compared to the rest of England. We will reduce the gap in life expectancy between the people living in our most deprived and least deprived communities by 5% by 2024, reducing the gap by six months of life for men and five months of life for women.
- 2

We will achieve a 10% **reduction in the gap in life expectancy between people with mental health, learning disabilities and autism** and the rest of the population by 2024 (approx 220,000 people). Within this we will focus on early support for children and young people.
- 3

We will address the health inequality gap for children living in households with the lowest incomes. This will be central for our approach to improving outcomes by 2024. This will include **halting the trend in childhood obesity**, including those children living in poverty.
- 4

By 2024 we will have increased our **early diagnosis rates for cancer**, ensuring an additional 1,000 people will have the chance of curative treatment.

Our ten ambitions continued...

5

We will **reduce suicide by 10%** across West Yorkshire and Harrogate by 2020/21 and a 75% reduction in targeted areas by 2022.



6



We will achieve at least a **10% reduction in anti-microbial resistance infections** including a 15% reduction in antibiotic usage by 2024.

7



We will achieve a **50% reduction in stillbirths, neonatal deaths, brain injuries** and a reduction in maternal morbidity and mortality by 2025.

8

We will have a **more diverse leadership** that better reflects the broad range of talent in West Yorkshire and Harrogate. Poor experiences in the workplace that are particularly high for Black, Asian and Minority Ethnic (BAME) staff will become a thing of the past.



9

We aspire to become a global leader in responding to **climate emergency** through increased mitigation, investment and culture change throughout our system.



10



We will **strengthen local economic growth** by reducing health inequalities and improving skills, increasing productivity and the earning power of people and the region as a whole.



^ Photo credit: Bradford Teaching Hospitals NHS Foundation Trust



Chapter 1 Introduction

What we cover in this chapter:

- 14 About our Partnership
- 22 How we work
- 27 Working in partnership with people and communities
- 32 Working in partnership with staff



About our Partnership

West Yorkshire and Harrogate is the **third largest health and care partnership in the country**. 2.7 million people live here. We have strong, diverse and vibrant communities.

Collectively, we have a health and care budget of over **£5.5bn**.



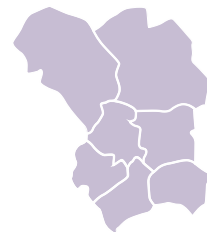
What is an Integrated Care System?

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.**



We work together to improve the health and wellbeing of local people living in our six local places:

- Bradford district and Craven
- Calderdale
- Harrogate
- Kirklees
- Leeds
- Wakefield



The Partnership is not the boss of the partners, it is their servant. This is crucial, as it allows power and energy to remain aligned to statutory accountabilities in our places. 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. We have agreed to work at a West Yorkshire and Harrogate level on the following priority areas of work. Please see below.



Our five year ambitions for these priorities are set out in this plan

Improving population health

- Preventing ill-health
- Health inequalities
- Wider determinants of health and wellbeing, e.g. housing, poverty
- Personalised care



Transforming services

- Primary and community care
- Urgent and emergency care
- Improving planned care and reducing variation
- Hospitals working together



Priority areas for improving outcomes

- Cancer
- Mental health, learning disabilities and autism
- Children and families
- Carers
- Maternity



Supporting work programmes

- Harnessing the power of communities
- Workforce
- Digital
- Capital and estates (buildings)
- Leadership and organisational development
- Partnership commissioning
- Finance
- Innovation and improvement



Partners

The Partnership is made up of many [organisations](#) including the NHS, councils, Healthwatch, charities and voluntary and community organisations who work to provide the best health and care possible to the 2.7million 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 well over 100,000 people and the value that community networks and local support bring to help keep people well and feeling connected.

Throughout this Plan we refer to voluntary and community organisations. It's important to note that we work with charities, social enterprises, the faith sector, community benefit societies and many other community partners. We also work with hundreds of other organisations, including the Police, West Yorkshire Fire and Rescue Service, and independent care providers.



Watch our 'Stronger Together' animated film [here](#).

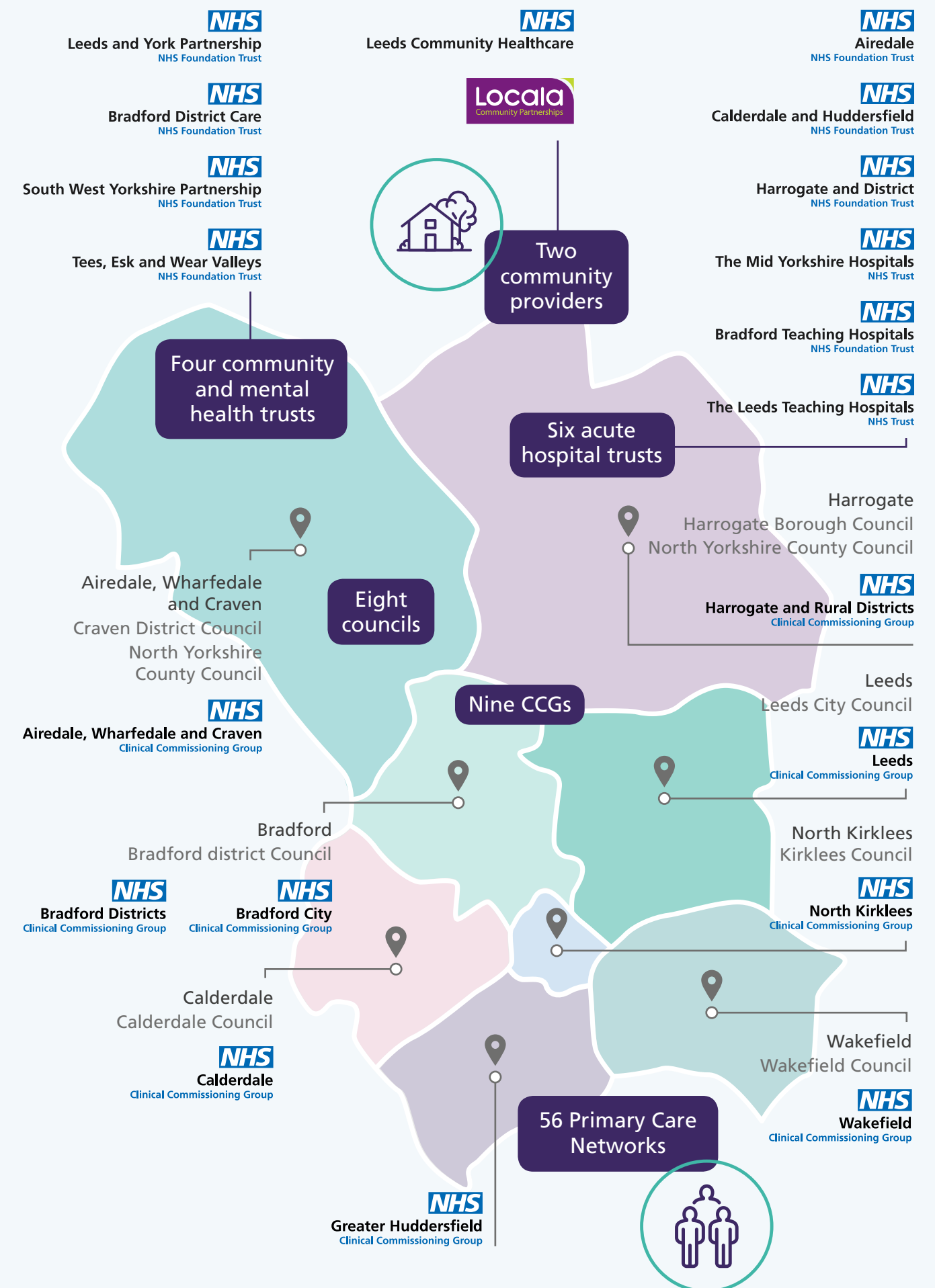
Our health and care landscape

Our councils



- 316 GP practices
- 555 community pharmacies, plus 38 online
- 431 providers of services in people's homes
- More than 611 care homes
- 11 hospices
- Thousands of voluntary and community organisations
- Hundreds of independent care providers

Figures accurate at November 2019.



West Yorkshire and Harrogate Health and Care Partnership is made up of six local places: Bradford district and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield

Agreed to work together
on our finances 



2018



- Developed a programme and training to reduce suicides

West Yorkshire and Harrogate
Health and Care Partnership

Set out our vision
to work with people
so they stay happy
healthy and well

Our next steps to better health and care for everyone

January 2018

Health and Care Research Board

Health and Care Research Board

Published our
**'Next steps to
better health
and care for
everyone'**

£1m invested in
our communities to
tackle loneliness



- Launched the Healthy Hearts project**
 to reduce and prevent heart-related illness

Published **'A healthy place to live, a great place to work'** to help develop and support staff and carers

Rolled out the **'red bag scheme'** to help care home residents when they go in and out of hospital

Hospitals work together



Launched Yorkshire and Humber **Digital Care Record** to improve people's care

Agreed a Memorandum of Understanding (MoU) to strengthen Partnership working



Published our maternity care plan
to give women the right care, in
the right place at the right time

2019



 Partnership Board met for the first time, which brought in elected members, non-executives and lay members into the decision making process

Set up a new community eating disorder service



Funding agreed for new unit to support children and young people with mental ill health



To find out more about the positive difference our Partnership is making, from staying well, to cancer, children and young people's mental health, to award winning support for unpaid carers, to what we are doing to reduce suicide, right through to building new hospitals, visit www.wyhppartnership.co.uk.

Secured the **largest share of national capital investment** totalling £883m for ten schemes

Set up the first **suicide bereavement service** for West Yorkshire and Harrogate ●

Launched career workshops for young carers

Worked with Healthwatch who talked to over **1,800 people** about the NHS Long Term Plan ●

Established a health and care champions network for people with learning disabilities

Managed our
money better
together

Signed a HealthTech Memorandum of Understanding to **reduce health inequalities** and provide more jobs

Launched 'Looking out for our neighbours' community campaign

18

This is our Five Year Plan

This Plan sets out our ambitions for the next five years. It is also a response to the [NHS Long Term Plan](#). 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 inequalities we need to address.

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.

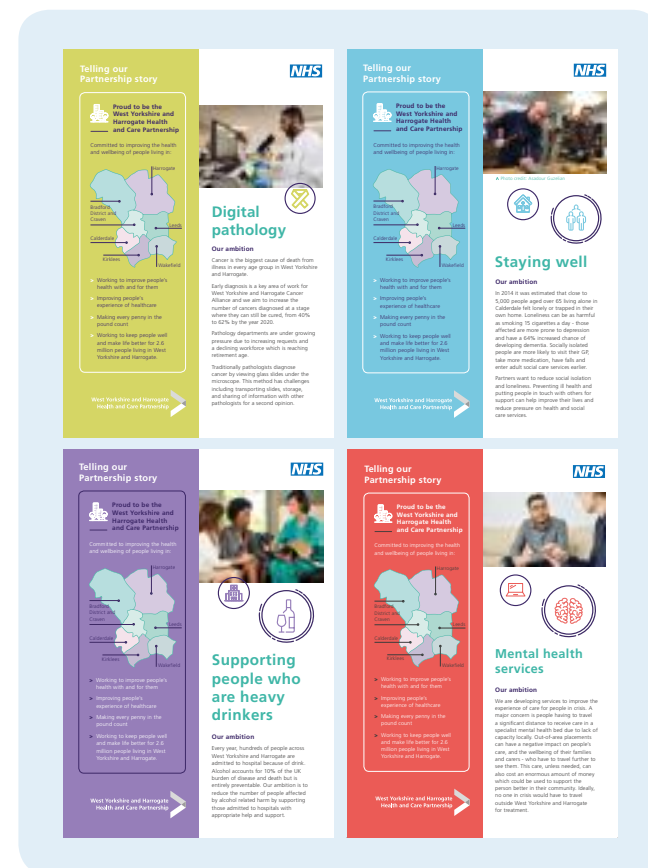
We are treating more people than ever before, providing better services faster, safely and in better environments, as well as supporting more people to live at home independently. Demand for services is growing faster than resources, and we must keep innovating and improving if we are to meet the needs of people to a consistently high standard.



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 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 their own homes, care homes and hospitals.



The current adult social care system is under unprecedented strain. Demand is increasing across all age groups, but there are significant spikes in need in children’s social care, support to prevent family breakdown, adults with learning disabilities and mental illness.

There is also a sharp increase in the number of older people living longer, but unfortunately experiencing a greater number of years in ill health.



The social care system has experienced years of increases in unmet need which has created challenges for the social care market – with a huge number of private and independent sector providers working alongside the statutory care sector. The care market overall has not had the stability it needs to be able to address the substantial workforce shortages now and for the future. There is also evidence that an even greater burden is falling on unpaid carers particularly as other essential wrap-around services such as advice services and housing support workers have been reduced (see page 70).

Our Plan has been developed to this stage in the absence of an anticipated long term funding policy for adult social care. It is likely to evolve further when greater clarity is available.

We want West Yorkshire and Harrogate to be a great place to work and an outstanding place for care; whether in the community, in one of our hospitals or online. Our Partnership [Memorandum of Understanding](#) sets out more clearly how we work together.

Our Partnership is based on the belief that working together and not competing for funding is the only way we can tackle these challenges. We put people, rather than organisations at the heart of all we do. We share our expertise and assets, including staff, buildings and money.

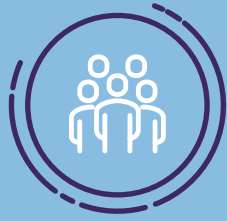


Working together across all sectors at a local level is key to **‘better health and wellbeing for everyone’**.

Case study

Leeds is the first city in the UK to turn the curve in childhood obesity. The change 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 98).





How we work

56 communities, 6 local places, and
one health and care partnership

Joining up services to improve the health and wellbeing in communities

In 56 communities of between 30,000 and 50,000 people across West Yorkshire and Harrogate, GPs, community nurses, social care workers, community organisations, charities, mental health services, pharmacists, advice services and other care providers are working together to provide better joined-up services for people.

Primary Care Networks (PCNs) are a key part of the NHS Long Term Plan, with general practices being a part of a wider network, typically covering 30,000 to 50,000 patients. The networks will provide the structure and funding for services to be developed locally, in response to the needs of people living in their surrounding neighbourhoods. PCNs are important because they will build on strong local partnerships already in place. Working effectively with councils, community organisations, and local elected members in the development of the PCNs is important – they also know what keeps local people healthy and well.



^ Dr Pert
Photo credit: Calderdale Council

Case study

Using creative activities to help people 'Live Well in Calderdale'. This 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.



Case study

Harrogate and Rural Alliance (HARA) brings together primary care, adult community health and social care in Harrogate, Ripon, Knaresborough, Nidderdale and the surrounding areas. It covers a population of 160,000 people. From autumn 2019, integrated community health and adult social care colleagues are working across four teams, wrapped around primary care practices, to prevent ill health and to provide joined up care.

Case study

Nurse Andrea Mann is Clinical Director of the Cross Gates Leeds Primary Care Network (PCN). The PCN is part of the East Leeds Collaborative (made up of three PCNs) with a total population of approximately 95,000. They work together to join up care more effectively to deliver new services.

✓ Leeds Living Well Cafe
Photo credit: James Hardisty



Partnership working at place level



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 which 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.



You can read the local plans for each place [here](#).

Local Health and Wellbeing Boards are responsible for improving outcomes in health, care and wellbeing for their local population and do this by uniting clinical, political and community leaders under a shared vision for their communities.

One of their key roles is to make sure that **preventing ill health is at the heart of everything we do** - 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](#).



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 care 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.

Photo credit: Calderdale and Huddersfield NHS Foundation Trust

Working together across West Yorkshire and Harrogate

We know that in some areas it makes sense to work together across West Yorkshire and Harrogate. We apply three tests for joint working:

- Working at scale to ensure the best possible health outcomes for people
- Sharing good practice across the Partnership
- Working together to tackle complex (or 'wicked') issues.

Working at scale to ensure the best possible health outcomes for people

For some complex services we need to plan and work across West Yorkshire and Harrogate to achieve the 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 72 hours 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 86).



Case study

Working together across West Yorkshire on vascular services.

In 2018, [West Yorkshire Association of Acute Trusts](#) (hospitals working together) agreed it would be better for people needing vascular care if all vascular services in West Yorkshire (except Harrogate, which works 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 units across the area. NHS England are asking people for their views (accurate at November 2019).



Sharing good practice across the Partnership



We have a history of innovation but we need to get better at sharing and spreading these new ways of working. Working better together means we can identify, share and spread good practice across partners and areas. 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 adopted six of them 12 months earlier than expected.

We embrace innovation and encourage the whole system to work together with organisations such as the [Yorkshire & Humber Academic Health Science Network](#) (AHSN), [Leeds Academic Partnership](#) and the health tech sector (see page 152).

Case study

Reducing cardiovascular disease. Atrial Fibrillation (AF) causes devastating strokes every year with one in every 20 sufferers left with a life changing disability. Yorkshire & Humber Academic Health Science Network (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, 1,500 people have been identified across our area 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.



^ Photo credit: Yorkshire & Humber Academic Health and Science Network and Healthwatch



Working together to tackle complex (or 'wicked') issues

We share many common ambitions including a commitment to eliminate preventable health inequalities, remove barriers to accessing care or making sure that everyone has the chance to be healthy. This means having equal access to things we all need, for example 'somewhere to live, someone to love and something to do'. We also share many common challenges including financial pressures, increasing demand and being able to afford, attract and retain the staff we need to deliver our ambitions.

Throughout this Plan you will hear more about these challenges and how we will work together over the next five years to make things better.



Case study

Working together 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 attack and stroke 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.



Working in partnership with people and communities

We know that hospitals and healthcare professionals are not alone in keeping people well. Where people live, their homes, the community environment, family support and the life choices they can make are vital.



Working with people in communities is a crucial part of our Partnership.

The role of voluntary and community organisations (also known as the third sector) is vital, no matter what their size. From the very smallest volunteer-led community group, to the largest not-for-profit organisation, they enable people to take collective action on issues that matter to them. A thriving third sector is vital for our health and care system, as they often have established high levels of trust with people who may have faced multiple barriers when accessing statutory services. They have a strong empathy and knowledge of the people and diverse communities they serve. They are often rooted in that community or work in ways that empower people to bring about their own lasting change.



^ Photo credit: Harrogate and District NHS Foundation Trust



Community anchor institutions

We know that improving health and wellbeing in our communities is about **getting the best out of everyone working together**. This includes local elected members, schools, faith groups, community organisations, local businesses, police, fire and rescue, as well as health and care organisations. There are many more parts of the picture that make up community life.

Case study

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.



^ Photo credit:
Craven District Council

Community conversations

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, and with our diverse communities ensures that we make the right decisions together about our health and care services.

Over the past three years we have published on our website all engagement activity in which we have been involved.



A full list of this activity and reports is available to read [here](#).

These include public assurance groups, patient reference groups, events and community champions. We aim to learn from feedback from all our networks without duplicating effort and cost.

Our Five Year Plan sets out further engagement activities needed to realise our ambitions, including findings from the Healthwatch Report (2019). More information on how you get involved is on page 172.

✓ [Partners in the Wakefield targeted lung health check project](#)



Our engagement and consultation mapping report captures intelligence from activities carried out across West Yorkshire and Harrogate from January 2014 to March 2019. It includes specific mapping exercises, for example on mental health, and details of any issues raised by different groups. This report helps to ensure we don't duplicate people's time and most importantly points us to public conversations that have already taken place in our six local areas and which help to inform our planning.



You can read more [here](#).

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 our Partnership priorities. As well as surveys, Healthwatch coordinated over fifteen focus group sessions 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'**.



You can read the report [here](#).



The findings are important in developing our Five Year Plan and have informed the development of our priorities. You will see other examples of engagement work throughout our Plan. Further community conversations will take place as our programmes of work develop.



We are working with partners to develop a 'health and care champions' network of people with learning disabilities. 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. **Our ambition is for as many people as possible to contribute, influence and co-produce the direction of the Partnership.**



You can find out more by watching this film [here](#).



^ Photo credit: BTM

We have sought guidance on the production of this plan from Inclusion North, an organisation which specialises in supporting people with learning disabilities. They have helped us to identify ten important areas for people with a learning disability or autism. This supports our work to tackle health inequalities (see page 41) and the [Learning Disability Mortality Review \(LeDeR\) Programme](#) (May 2019) which links to our priorities for people with learning disabilities (see page 102). This includes preventing ill health, early identification and treatment of sepsis, cancer screening and health checks.

Case study

More than 80 third sector representatives attended a Partnership event in May 2019. The event raised awareness of the NHS Long Term Plan and how voluntary community organisations could get involved as equal partners.

To find out how you can get involved in the work of the Partnership visit: www.wyhppartnership.co.uk or see page 172.

Working with the voluntary and community sector



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 Health and Wellbeing Boards. This helped tackle loneliness and social exclusion, which has a major impact on people's health and wellbeing.

Community organisations make a tremendous difference. 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 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 to tackle loneliness and isolation.

Kirklees has 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 experiencing depression and unemployment.

>>

Delivered in partnership with Leeds community foundation, Health Impact Grants helped nine community groups to develop and deliver their own innovative solutions – including the 'Friend on a phone' group for older people; the 'Happiness Café' for foodbank users, 'Home Cooking' skills for people with long term mental health problems, or the 'Zine' by men for men on health and mental health. We have also allocated £900,000 this year to voluntary and community organisations to improve person-centred wellbeing across our area.

You can find out more [here](#).



Watch these short films to find out how Julia, Salman, Steve and many others made a positive difference to people in their local neighbourhoods through the 'Looking out for our neighbours' campaign which tackles loneliness and reduces isolation. Watch the films [here](#).



Case study

Building health partnerships.

With the Institute for Voluntary Action Research Building Health Partnerships programme, we have worked with community and voluntary groups to improve the health of people in Calderdale and Wakefield. 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. In Wakefield, the Partnership in collaboration with Wakefield Council's Public Health team, worked with local people and voluntary groups to raise awareness of eye health.



^ Phoenix Project: photo credit Asadour Guzelian



Working in partnership with staff



Our Plan can only be delivered through **working in partnership with staff.**

Page 215

We engage with staff at a Partnership, local place and neighbourhood level, depending on the issue. For example, in Calderdale and Kirklees plans for local changes to hospital services have been informed by both clinical and non-clinical staff. Most engagement with staff takes place through their employing organisations.



^ Photo credit: Leeds Irish Health and Homes

All our 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 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.



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^ Photo credit: WDH



Chapter 2 Improving health and wellbeing for everyone

What we cover in this chapter:

- 34 Improving health and wellbeing for everyone
- 35 Conditions for healthy lives
- 41 Tackling health inequalities
- 45 Preventing ill health
- 49 Population health management
- 51 Personalised care



Improving health and wellbeing for everyone

Improving health and wellbeing is at the heart of the Partnership. We do this by building on the work of local Health and Wellbeing Boards on things which are key to 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 work together to help create the conditions for people to be healthy and to better understand the causes of ill health and wellbeing.

Page 216



^ Photo credit: The Leeds Jamaica Society and Leeds Irish Health and Homes



The factors that keep people healthy are much wider than the impact health and care services have alone. Working with communities allows us to influence the impact which wider factors such as housing, employment, education, social networks and the environment have on people's health.

We will work with our people, our communities and our organisations to seize new opportunities for improving health.



Conditions for healthy lives

Looking at the health and wellbeing of the 2.7million people who live in West Yorkshire and Harrogate gives us a unique opportunity to consider what partners together can do to contribute to people leading healthy lives. Decisions that affect people's health are not taken solely by health and care organisations, but by a much wider set of partners. For example decisions about transport, housing, parks and countryside, community facilities, the economy, public safety or air quality. These all have a causal link to the health of people. It is our ambition to work with all key organisations, sectors and communities.

Good work and fair opportunities

There are links between the economic prosperity of our area and the wellbeing of the people who live here, just as there is a causal interdependence between an individual's economic circumstances and their lifetime health. Some of our area's key economic assets are in the health and care sector.



For example we are home to one in four of all the medtech jobs in the UK.

However, we have a higher rate of people not in work, including people with learning and physical disabilities, who would like to be. For those in work, 25% of the jobs in our region pay below the living wage. One in three people in our workforce has a chronic health condition that can sometimes affect their ability to work, or reduce their ability to work full time or for as many years as they would like before retirement.



Nationally over 600 people a day quit their jobs to care for a loved one – supporting carers is a priority for the Partnership (see page 130).

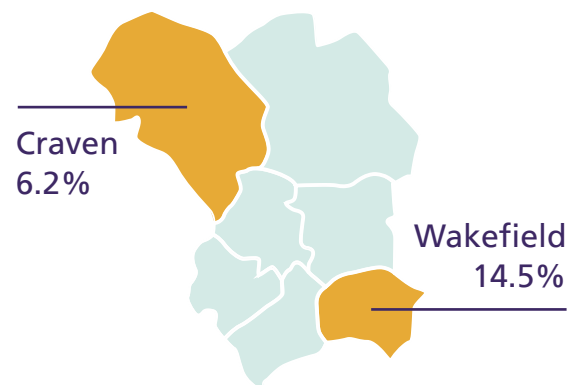


Working with our large organisations can help us understand the role they play as a big employer in promoting good health and contributing towards the local economy. The main causes of long term sickness, musculoskeletal problems and mental ill health, are also the main factors that reduce healthy life expectancy.

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In West Yorkshire and Harrogate 13% of those claiming Employment Support Allowance (ESA) have muscular skeletal conditions as a primary cause. (Please see transforming planned care on page 79).

Long-term health conditions impact on economic inactivity across our area. In West Yorkshire and Harrogate there is a gap of between 6.2% (Craven) and 14.5% (Wakefield) in the employment rates for those people living with a long term health condition and overall employment.



We have a strong relationship with the [West Yorkshire Combined Authority](#) who are working through the [Leeds City Region Local Enterprise Partnership](#) to develop the [Local Industrial Strategy](#). This is a long-term, evidence-based plan to strengthen local economic growth, reduce health inequalities and improve skills, productivity and the earning power of individuals and the region as a whole.

Given the many overlapping ambitions between our five year plan and the Local Industrial Strategy, we are committed to working together to take joint action. For example, we can make a big difference by working together on healthy work places that support and encourage healthy behaviours.

We will work together on skills. Someone's skill level at the age of 18 is the single biggest changeable factor in their life time health; just as we know that our area's prosperity is linked to having people with the right skills across all sectors of the economy. This is especially true of the skills needed in the health and care workforce.



Our homes

A safe, settled home is the cornerstone on which people 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.



^ Photo credit: WDH

Our health and housing working group has been identifying great practice in our local places, in partnership with housing associations, that have proven outcomes.



This has shown that when we work together, it improves people's health.

This includes enabling people to continue living independently or with support in a place they have chosen. This also reduces the need for primary and community care services, prevents hospital admissions, enables timely hospital discharge and prevented re-admissions. Working in this way also promotes rapid recovery from periods of ill health or planned admissions.

We are committed to routinely sharing great practice across all our six places and considering housing as an essential element. There is significant scope for us to work with wider partners to have a greater influence on how houses are designed, adapted and how we are supporting people to live well and independently.

Creating and developing healthy, sustainable places and communities

We have a wealth of natural environments, areas of outstanding beauty, national parks, waterways, dales and parks. But people who live in neighbourhoods already suffering the most economic disadvantage have the fewest opportunities to benefit from outdoor play or recreation.

For people living in urban or built up areas, we know that well maintained and spaces, such as small parks, community gardens or urban trails encourage physical activity.



Through our councils and their relationships with organisations and communities, we can influence and increase the numbers of people improving their physical wellbeing by accessing and interacting with the outdoors.

Connecting people and communities has a huge impact on people's wellbeing – there is strong evidence about the impact of loneliness and isolation on a range of conditions. This is one of the reasons we started the ['Looking out for our neighbours'](#) campaign. Evidence shows that people without strong social connections are more likely to visit their GP, take more medication, have falls and require residential care in later life.



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. 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.

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^ Chris and June, Memory Lane Cafe, Halifax



Case study

"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 Cafe. Memory Lane Cafe has used the campaign to engage the community in conversations around being neighbourly".



Watch this short film to find out more [here](#).

West Yorkshire and Harrogate community infrastructure is made up of community-led activity, of small, medium and large charities and not-for-profit organisations. They are vital to help people get well or stay well.

Case study

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, it encourages local people to stay physically and socially active and stay well, often whilst living with long term health conditions.

^ East Riddleston Walk
Photo credit: Bradford district Care NHS Foundation Trust



Transport

There are obvious links between good public transport and affordable, easy access to health and care facilities for people when they need them. High quality opportunities for active travel, including cycle paths and safe walkways can help reduce road congestion and air pollution whilst saving commuters money and improving people's physical health and wellbeing.

Although mass transport lowers overall carbon emissions, we must be conscious of the carbon emissions made by public transport, which we know businesses are working hard to address. This can be particularly problematic in areas of multiple deprivations where higher rates of existing health conditions can be exacerbated by poor air quality.



Through continued strong relations between the West Yorkshire Combined Authority and our Partnership, over the next five years we aim to:

- Improve public transport access to our health and care facilities, including looking at making this more affordable for people with ongoing treatment
- Continue to work together to improve the quality and availability of active travel options across the region
- Continue to work together to reduce the carbon emissions and harm this causes
- Encourage people to use public transport to reduce carbon emissions and work with operators and the Combined Authority to ensure emissions are reduced to a minimum.

Climate emergency



The climate emergency is a global threat. We believe that we can make immediate changes that could be simple, significant and sustained.

We can improve population health at the same time as making climate friendly choices, such as improving walkways, promoting active travel to offset reliance on cars or investing in local food growing.

We aspire to become a global leader in responding to climate emergency through mitigation: reducing carbon through our buildings, our supply chains, how we travel and how we use digital technologies; as well as through investment: encouraging innovation, rethinking and developing climate friendly products and practices throughout our health and care system.

The Leeds City Region is committed to being a zero carbon economy and is building a coalition of partners to accelerate this. They are investing in projects that will contribute to faster economic growth, lower household and business energy costs and create more skilled jobs. They see the health and care sector as a key partner in achieving this vision.

We will promote our collective responsibility to reduce our carbon footprint. We can do this by reducing unnecessary single-use plastics in hospitals or care homes, reducing transport costs and carbon emissions by smarter use of technology in primary and secondary care, exploring overall waste in medicines and medical equipment through investing in the development of alternative, lower carbon options.

Unfortunately we may have to increase our preparedness to deal with the direct impact of climate change on health conditions in the UK, including projected increases in morbidity due to air pollution, higher temperatures and extreme weather events.

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We will see the most sustained and long term improvements on people's health and wellbeing if we focus greater efforts on the factors that determine health. So, with our regional partners we will:

Increase good work that supports good health:

- By improving equal access to employment for people living with long term physical and mental health conditions
- As employers, committing to providing healthy workplaces that promote physical activity, active travel and good mental health
- Actively supporting equal access to good jobs in the health and care sector for people from poorer socio economic backgrounds.

Increase good housing that supports good health:

- Ensure that great practice in health and housing is routinely shared across our partnership, and support opportunities for investment to integrate this wherever possible. Read more about the work being done in the West Yorkshire and Harrogate Best Practice Health and Housing Report
- Work on ensuring that lifetime health is being designed into future housing plans.

Mitigate the impact of climate change:

- Working with organisations across the system to maximise their contribution to tackling climate change through their buildings, supply chains, travel options and digital capacity
- Increasing green infrastructure to improve air quality through clean transport, more green space and making active travel easier.

Increase personal and community safety:

- Working with the West Yorkshire Violence Reduction Unit to support a whole system approach to prevention with a focus on children and young people and support for victims of violent crime in hospital settings.

Increase healthy transport:

- Improving transport access to health and care facilities, including making this more affordable for people with ongoing treatment
- Improving the quality and availability of active travel across the region
- Reducing the carbon emissions that cause harm and work together for better air quality.

Improve community facilities and access:

- We will support Primary Care Networks (see page 58) to make the links with wider services, including debt advice, housing, benefit support, councillors and employment.
- We will work with Primary and Community Care, Personalised Care and the Harnessing the Power of Communities Programme to ensure that we are investing appropriately in communities, maximising assets and supporting community-led health initiatives.

Our five year ambitions

- Increase the number of staff who travel to work by active travel or public transport
- We will support inclusive economic growth through working with regional partners and maximising the impact of health and care organisations as anchor institutions.



Tackling health inequalities

Health inequalities are the avoidable and unjust differences between people or groups due to social, geographical 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 occupations is higher than people in other occupations; people living with learning disabilities and/or mental health conditions are more likely to die prematurely.

✓ Photo credit: Leeds Community Foundation



We will address some of the preventable differences that contribute towards inequalities. We will consider differences in risk factors for ill health, early diagnosis and screening and access to effective support for people living with long term conditions.

People in West Yorkshire and Harrogate have a **shorter average life expectancy than the rest of England**. Males' lives are on average one year shorter than the England average and females almost 10 months shorter.



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Case study

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.

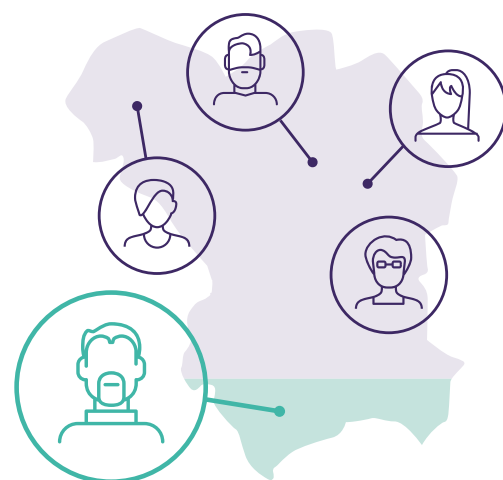
Bradford 'Reducing Inequalities in City'.

The funding formula for clinical commissioning groups changed this year to give additional weight to inequality (particularly where people die before age 75). Using this money Bradford has established a multi-agency programme to test what works (evaluated by Born in Bradford), making a difference to people in inner city Bradford and spreading the learning on what works for everyone's benefit.

Life expectancy varies between our six local places and also within our neighbourhoods. 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, has the highest proportion of the population living with socio-economic deprivation.

People living in more deprived areas have a lower average life expectancy than those living in less deprived areas. **Around a fifth of the population of West Yorkshire and Harrogate live in the most deprived 10% of areas in England.** There is a gap of just over ten years in life expectancy for males and nearly eight and a half years for females between people who live in the 10% most and 10% least deprived areas of West Yorkshire and Harrogate.



People living in areas with the most disadvantages are more likely to have a long term illness or disability and to have been diagnosed with stroke or lung cancer than others. They are also more likely to be living with risk factors



for disease such as higher smoking rates and levels of childhood obesity.

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.

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. Cancer screening and equal access to high quality care, prescribing the right medications for people living with heart conditions can make a real difference to people's lives.

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 two 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** (for example back and neck pain) 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.

To contribute towards a reduction in health 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 we need to engage with and change our approaches to improve their health outcomes
- Work with specific population groups about planning and priorities. We will start with population groups we know to be greatly affected by inequalities in health; those living in poverty; people living with learning disabilities, those living with serious mental illness, unpaid carers, veterans, and those in contact with the justice system, ethnic minority groups and homeless people
- Work to understand the impact of living in a rural or remote area on access to services and on health outcomes
- Be informed by the expertise of people with lived experience, for example those with learning disabilities.

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Our five year ambitions:

- We will increase the years of life that people live in good health across WY&H compared to the rest of England. We will reduce the gap in life expectancy between the 10% of people living in our most deprived and least deprived communities by 5% by 2024, reducing the gap by 6 months of life for men and 5 months of life for women.
- 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 meet 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 engaged with different population groups and have a better understanding of the action we can take to reduce inequalities. This will involve working with community and voluntary organisations.



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. Watch the short film [here](#).

Case study

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'.

▼ Phoenix Shed.
Photo credit: Asadour Guzelian



Preventing ill health

Our approach to prevention will take a life course approach to the factors that impact on ill health. We will reduce the factors that contribute towards ill health (primary prevention), increase earlier detection and diagnosis of disease (secondary prevention) and support people living with long term conditions (tertiary prevention).

Primary prevention: Reducing risk factors which contribute towards ill health and promoting what keeps people well.

In October 2016, we set out three ambitions for preventing ill health; to reduce smoking, reduce alcohol related hospital admissions and reduce the number of people at higher risk of diabetes developing the condition. Since then we have:



Reduced the number of people who smoke in West Yorkshire and Harrogate by **23,000**.



Reduced emergency hospital admissions for alcohol related conditions by **9%**.



We will consider the broader factors that protect against the risk behaviours for ill health and promote protective factors that keep people well. We will remain focused on the existing key preventable risk factors for ill health (smoking, obesity and alcohol) and build on the progress to date by considering additional factors and approaches.

Our approach to primary and community care prevention will consider integrated wellbeing (tobacco, alcohol, obesity physical activity, nutrition, and mental wellbeing).

We will work towards tackling multiple risk behaviours and increasing protective factors whilst addressing health inequalities.

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We will promote healthy resilient communities; design and run targeted co-produced community campaigns to improve awareness and understanding of harm.

The majority of action will happen in our six places.

We will support our places to:

-  Promote safe alcohol consumption
-  Reduce smoking
-  Reduce the rates of childhood obesity
-  Improve access to physical activity.

Our five year ambitions:

- Reduce smoking rates to 11.5% by 2023-24 and in doing so decrease the proportion of people smoking in routine and manual occupations at a faster rate than other groups
- Ensure all people who smoke and are admitted to hospital are offered support to stop smoking
- 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 number of people affected by alcohol related harm by supporting those admitted to hospitals with appropriate help and support including the use of alcohol care teams.

Case Study

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 nine out of 10 smokers under-estimate the one in two risk of dying early from tobacco smoking'.



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 will reduce the number of people catching infections, including people with learning disabilities, making sure they are diagnosed early and treated appropriately. We will also reduce the number of antibiotics prescribed where they are not needed. Our work will include making the most of national Public Health England opportunities and sharing good practice from the award winning NHS Leeds 'Seriously Campaign'.

Our five year ambition:

- Reduce the number of anti-microbial resistant (AMR) infections by 10% and reduce antibiotic usage by 15% by 2023/24.
- This will include working with colleagues in health and social care who work with older people.

Secondary prevention: Making the most of the techniques and approaches that identify and diagnose conditions earlier

We will ensure that people get a faster diagnosis, and reduce inequalities in access. We will promote the uptake of screening including work with the West Yorkshire and Harrogate Cancer Alliance to reduce 420,000 invitations that are declined for screening (see page 30). We will work with six local place leads, partnership programmes and NHS England Screening and Immunisation Teams to better understand the groups of people who are less likely to attend screening. We will work to better understand the groups of people who are less likely to attend screening. This will involve insight from communities to make screening and diagnostic services more accessible to those who are under-represented.

We will promote earlier diagnosis through the Mental Health, Learning Disability and Autism Programme for diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) for children living in West Yorkshire and Harrogate. We will also promote earlier diagnosis for conditions that impact on inequalities in life expectancy and healthy life expectancy, including those living with long term lung conditions, diabetes and heart conditions.

Our five year ambitions:

- Supporting an increase in uptake of the Diabetes Prevention Programme across our system
- Making the best use of NHS Health Checks with a particular focus on groups who are underrepresented such as men, those living in poorer communities and ethnic minority groups.



Case study

Around 100 people attended the Church View Medical Centre 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. A number of people 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 also 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.

Tertiary (specialist) prevention: Supporting 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 mental health, cancer, respiratory disease, diabetes and heart disease (see page 102). We will look particularly at the inequalities people face with access to support such as pulmonary and cardiac rehabilitation, stopping smoking, alcohol, weight management and vaccination. We will also include the wider factors that impact on the quality of life of people living with long term conditions including benefits advice, quality housing, employment and transport.

We will do more to improve the physical health of people living with mental health conditions, learning disabilities and autism. 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 (see page 102).

Reducing inequalities in unplanned admissions for conditions that could be cared for in the community and access to planned hospital care is key. For example people with learning disabilities die earlier on average than other groups of people and we need to make adjustments to enable people with a learning disability or autism to receive the right support from all health services. We also need to understand better the experiences of women and families with a learning disability or autism using maternity services. Our work with health and care champions will explore this further (see page 29).



We will start with a review of the inequalities in the numbers of people having hip replacement surgery for those living in our most deprived areas.



Our five year ambitions:

- 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.



Population health management

Population health management (PHM) 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 support the infrastructure, intelligence and implementation capabilities required to deliver PHM. We will work with places to develop the information governance required to share information and we will support places with organisational and leadership development.

▼ Calderdale Vision. Photo credit: Calderdale Council



We will work with Public Health England to better understand the current workforce. We will consider how we can use intelligence to influence how services are designed and money is allocated.



We will share learning from exemplar sites, for example the approach Leeds has taken to using a PHM approach to improve outcomes for those living with frailty.

We will support the development of PHM in Primary Care Networks (see page 59), with a particular focus on reducing health inequalities.



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
- Throughout the next five years we will continue to share learning from exemplars within the system and across the country.



Case study

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. One example 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. The plan helped ensure he spent 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 importantly gave a lot of comfort to his family.



Personalised care

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 long-term physical and mental health conditions will be supported to build knowledge, skills and confidence 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.

People with one or more long term health 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. Personalised care means that:

- People and their carers will be supported to manage their physical and mental health and wellbeing, and make informed decisions and choices when their health changes



Daz from Wakefield explains the importance of personalised care and social prescribing. Watch the short film [here](#).

We will embed personalised care in all priority programmes and learn from our council partners who have been working in this way for many years.



Lucy Jackson and Johnathan Lace from Leeds Council talk about having 'better conversations' about personalised care. Watch the short 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



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, we have been working to spread the model of personalised care delivered locally.



The Healthwatch Engagement Report (June 2019)

findings showed that people were interested in support from the NHS and its 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 raise awareness of what personalised care means so that we can change the relationship we have with people and support them 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.



Read the Healthwatch Engagement Report [here](#).

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, activities and peers who can offer support.



This will also lead to healthier sustainable communities. There are excellent examples of councils and community organisations working with communities to develop social prescribing models which make a positive difference to people's lives. We need to ensure we support and share good practice widely.

For people at the end of their life we will understand their specific needs and wishes and share this information digitally to make sure all care providers are aware of what is important to the person and act accordingly.

To do this our workforce will be supported to work differently with people so we can change the relationships and conversation we have with our communities. 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 are our council partners, community organisations and other priority programmes, such as carers and mental health.



Social prescribing is the collective term we use, for when the activities and support that would best be 'prescribed' for a person to improve their health, wellbeing and welfare come from local community sources.

These are often activities that are provided by community sector organisations or local councils and span a huge range of vibrant activities including things like community choirs, 'Move More Often' groups, tea dances, cooking classes, peer-to-peer support groups, 'Grow, Share, Cook' groups, arts and crafts, 'Men's Sheds', community cafés, mindfulness groups. These approaches have been proven to be far more effective than medicalised responses to some of the things that make people feel unwell – and all the evidence shows that the presence, variety and quality of options for social wellbeing locally can be hugely beneficial to people.

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

Our core aim is to change the relationship between people and the health and care workforce; working with people to be more knowledgeable, skilled and confident to stay well, so we prevent ill health and engage with them as equal partners in making decisions about and managing their health and wellbeing. We also want to support our workforce to be knowledgeable, skilled, confident and supported by the system to work with people in this way so it becomes business as usual across the whole health and care system.



We will focus our ambitions around four key areas:

1. Changing the relationship between people and practitioners
2. Embedding personalised care across West Yorkshire and Harrogate
3. Building our network for personalised care
4. Building the case for investment and change.

>>

1

Changing the relationship

Ambition:

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 and Harrogate that will change the relationship we have with people and communities.



2

Embedding personalised care

Ambition:

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 a local level.

To deliver targeted pilots exploring what good personalised care looks like for people with a learning disability and people with lung problems.



3

Building our Personalised Care Network

Ambition:

With representation at each of the six 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'. We will work as a 'federation' of six places, learning and sharing with each other, and agreeing things that make sense to do at a Partnership level and what makes sense to do at a local 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 the NHS, councils and community organisations.

4

Building the case for investment and change

Ambition:

In 2019/20 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).



^ Photo credit: Leeds Irish Health and Homes

5

Our five year ambitions:

- Three times as many people will benefit from having choice and control over their health and care through using personal health budgets and integrated personal commissioning
- Social prescribing (where it doesn't already exist) will be part of usual care across all health and social care services
- Over 32,000 people will benefit from a social prescribing referral
- 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 them, and for them'
- 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 more peer supporters and volunteers engaged in supported self-management activity.



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Chapter 3 Transforming services

What we cover in this chapter:

- 58 Transforming services
- 59 Primary and community care services
- 68 Pharmacy, dental and eye care
- 70 Social care
- 72 Urgent and emergency care
- 79 Transforming planned care
- 86 Hospitals working together



Transforming services

The way people want to access services is changing and the use of technology is increasing. You can see evidence of this in [local engagement work](#) and also from 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.



Primary and community care services

Primary care is often described as the 'front door of the NHS'. It provides people with local access to health services for advice, prescriptions, treatment or referral, usually through a GP or nurse. Other primary care providers include dentists, oral health, community pharmacists and optometrists.

Primary medical care is locally led in each of our six places. Clinical commissioning groups have continued to progress their own local commissioning strategies, supported by national work to transform primary care, through the [General Practice Forward View](#) and the [NHS Long Term Plan](#).

We have developed our West Yorkshire and Harrogate Primary Care Strategy to support us to go much further than this. It focuses on the role of primary care in our neighbourhoods and communities, supporting patients and their families and carers, alongside our councils, voluntary and community partners.



^ Photo credit: Leeds and York Partnership NHS Foundation Trust

The 'left shift' is about moving clinically appropriate care and treatment for people from hospitals into the community; with the intention that this will lead to better health and wellbeing, better quality of care as well as sustainable and efficient services.



Helping people and families to plan ahead, stay well and get support when they need it in the most appropriate way is key. People want to be: 'listened to, trusted and taken seriously as experts of their own bodies' and 'a lot of people see social prescribing as a positive and want more access to this support'. We couldn't agree more and this is central to the work we are doing (see page 54).

This section sets out how we are working to transform and join up services.

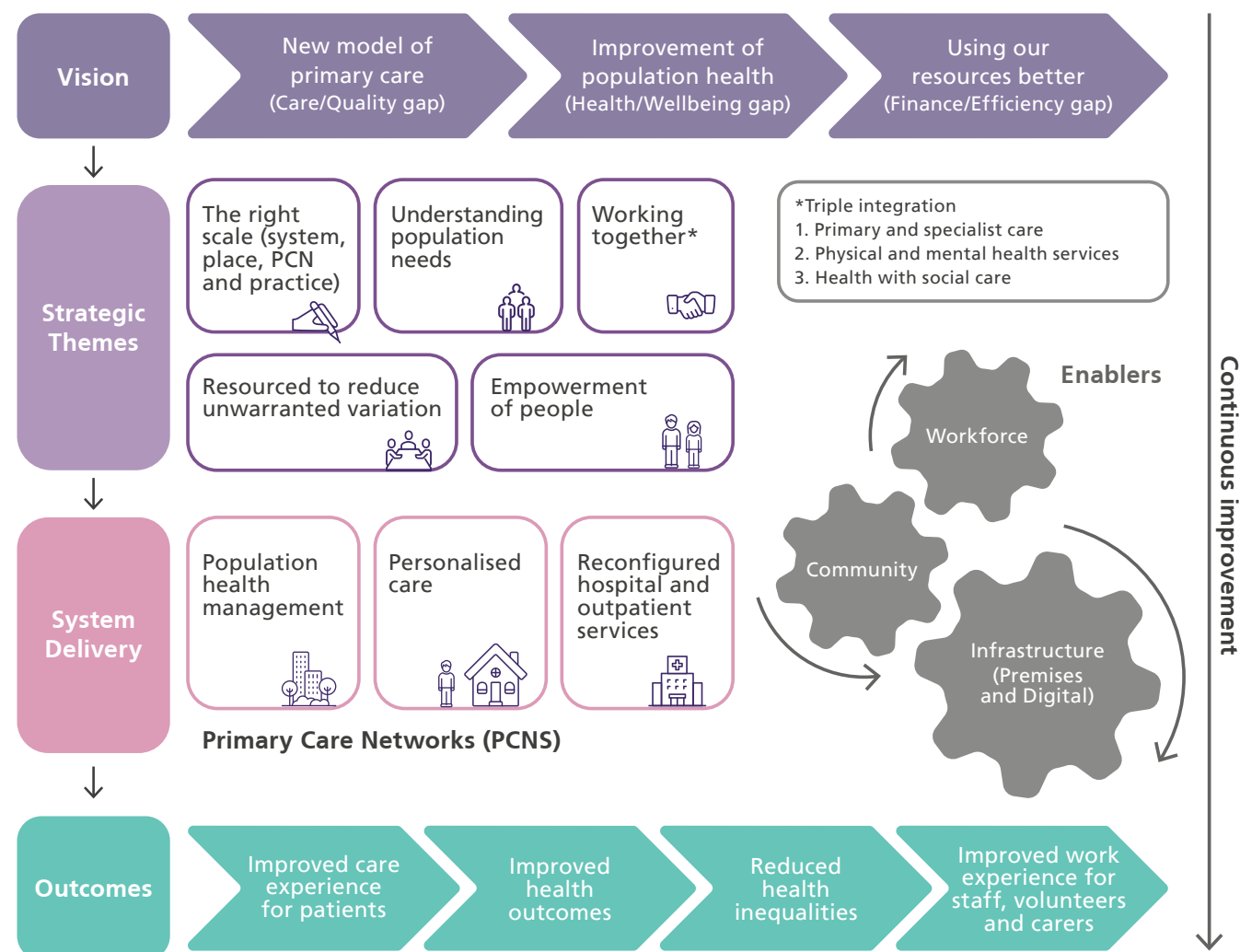




Primary and community care services including councils, dental, oral health, eye care, community pharmacy and general practice are central to bringing care closer to home, managing long term health conditions, preventing unnecessary hospital admissions and helping people stay well, healthy

and independent. [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 primary care strategy can be summarised as follows:



We want to transform primary and community care by integrating services based on the needs of the local population; bridging the gaps between primary and specialist care, between physical and mental health care, and between health and 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.

We will:

- Improve the experience of our staff, volunteers and carers with more staff retained, resulting a more sustainable workforce
- Improve financial sustainability
- Improve population health, patient outcomes and reduce health inequalities.



Developing Primary Care Networks (PCNs)

We have established 56 Primary Care Networks (PCNs), designed around the diverse needs of local people, generally covering populations of 30,000 to 50,000 patients each (see map on page 17). PCNs build on current primary care services to enable greater provision of proactive, personalised, coordinated and more joined up health and social care. They involve primary care professionals working with wider health care providers and other staff to deliver services that reflects local people's needs.

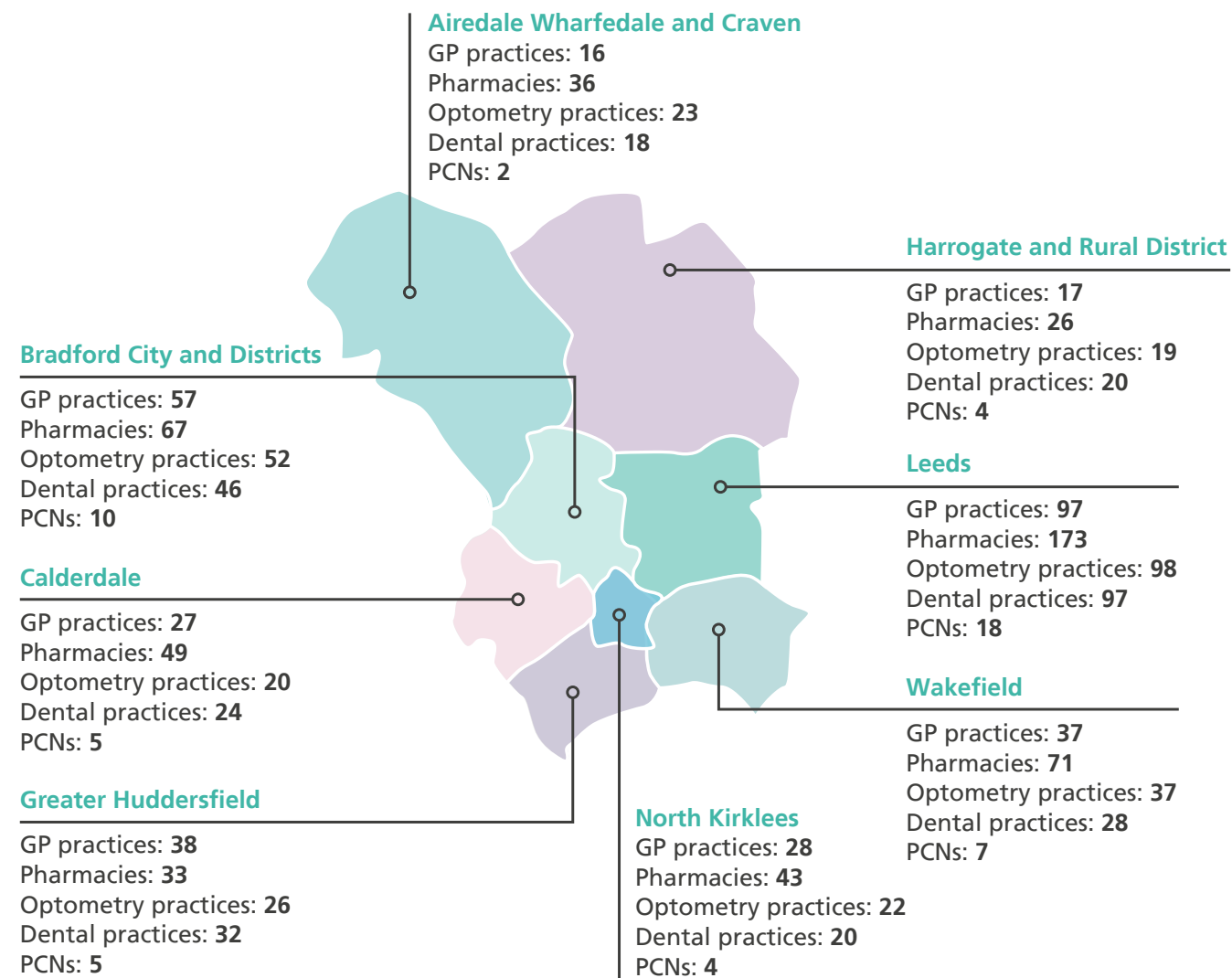
By working at scale, they will support organisations and staff to work together to deliver effective population health management. Clinicians describe this as a 'change from reactively providing appointments to proactively caring for the people and communities they serve'.



^ In all six places the third sector is bringing links to community assets, local intelligence and relationships.

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, building on the relationships with community providers to enhance existing community delivery methods.

We will agree an approach to implementing NHS Improvement's [Community Services Operating Model Guidance](#), delivering improved response times, quality of care and productivity.



Figures accurate at August 2019.

Case study

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 30,000 to 60,000 population sizes, the CPs 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, employment, and social connection, the CPs have adopted a strength-based and 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.

Strengthening the primary and community care workforce

As in many other areas we face challenges in recruiting and retaining a skilled primary care workforce. In addressing these challenges our focus is to attract, develop, support and retain the workforce in our most deprived communities, supporting the wider system in addressing health inequalities alongside community and voluntary organisations.

Support for GP retention is delivered through specific programmes. In 2018/19 we progressed initiatives such as; GP coaching and mentorship, new generation GP, peer networks (early career and legacy GPs), GP leadership and development programmes. Our intention is to implement the 'In at the Deep End Project' to support GP retention in our more disadvantaged communities, and a paramedic accelerator programme working in partnership with Yorkshire Ambulance Service.

Delivering our vision will require a different skill mix and new types of roles for different ways of working. Primary Care Networks are key to delivering this vision. Each network will develop workforce plans to reflect the services and needs of people they support, whilst aligning this to their local place priorities.

For primary care services to be effective there is also a strong need to attract and retain the wider workforce, for example in social care, community care and independent care sector. This is important in areas where it is hard to recruit, for example in home care, residential care, or personal care staff (see page 142).



The integration of primary and community care is important for our workforce, service stability and patient choice.

We will explore opportunities for community services, voluntary and community organisations to support Primary Care Networks.

Our plan is to build on the relationships with community providers to enhance delivery methods.



We are testing system wide working with our community services by exploring scalable solutions with podiatry services, emergency planning and resilience. This work will provide a platform for the acceleration of national programmes, such as the National 'Ageing Well' programme. This will oversee the development of community health services to meet the ambitions of the NHS Long Term Plan ambitions.

The Partnership is committed to supporting the four parts of the programme as part of our priority areas of work.



These are to:

- Improve responsiveness of community health crisis services so that by 2023/24 all services are delivering support within two hours of referral where clinically appropriate and re-ablement care within two days of referral for people who need it
- Support people in their own home for as long as possible. If this is not possible, we must ensure that the best possible care is provided to people living in care homes
- Implement anticipatory care for older people with moderate frailty and people of all ages living with multiple health conditions. This is all about supporting people to think ahead and understand their health needs for the future. Many people with long term health conditions can benefit from having an 'Anticipatory Care Plan' >>

- Join up care across providers of community health, Primary Care Networks, and the voluntary and social care sector. The work also relies on population health management support.

The work in relation to these priorities will be led at place level (Bradford district and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield) supported by West Yorkshire and Harrogate programmes.

Helping to tackle workforce challenges in community services is important to our workforce plans.



We have set ambitious and challenging workforce targets at local and Partnership levels, reflected in our Primary Care Strategy, with the aim of increasing capacity and transforming the existing workforce. Working through the West Yorkshire Local Workforce Action Board, we will deliver integrated working models across organisational boundaries, and develop a stable workforce with the right knowledge, skills and competencies.

Training hubs have a key role in the delivery of our primary care workforce strategy, for example workforce planning, career support and embedding new roles, such as physicians associates, physiotherapists and paramedics. These roles are aligned to our primary care workforce priorities.



In July 2019 £10m was allocated to support this work. There are four training hubs across our area. We are working with our lead training hub to deliver a rotational physician associate model. Learning from this model will support our intention to develop other rotational models, such as physiotherapy and paramedics.

We will continue to build on our good working relationships, encouraging and supporting our training hubs to reach their full potential as quickly as possible.

This work will be taken forward in each of our six places, and at the whole Partnership level on specific initiatives, including the [West Yorkshire and Harrogate International GP Recruitment Programme](#) and [Physicians Associates Acceleration Programme](#).

Case study

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 includes a nurse consultant and practice manager consultant. They also work with key partners including social care to provide tailored and targeted support.



There are 14 allied health professions (AHPs), covering art therapists, drama therapists, music therapists, chiropodists/podiatrists, dietitians, occupational therapists, operating department practitioners, orthoptists, osteopaths, prosthetists, orthotists, paramedics, physiotherapists, diagnostic radiographers, therapeutic radiographers, speech and language therapists.



Improving choice and access to services

Our aim is for people to have more accessible and convenient services, based on their health need and preferences. People report significant variation in daytime access in general practice, and some seek alternative ways of accessing care as a result. We recognise that a proportion of activity carried out in A&E or an out-of-hours primary care setting is often of a routine nature and could be managed more appropriately in a different setting (see page 72).

We will enable self-care and provide more direct access to other services, ensuring we make best use of the wider workforce and greater use of technology, working at scale through Primary Care Networks 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 initiatives have helped people to access timely, convenient care.

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 we invested £11.5m in primary care, and more patients are accessing appointments during extended hours. However, patient experience surveys show considerable variation in access to services and, in some areas, poor patient satisfaction with appointment times. Whilst we compare favourably with national satisfaction rates, we know there is still room for improvement.



▲ Locala Community Partnerships

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 confusion is 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 people who visit a GP 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 create capacity in GP practices for complex care.

We will 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.

- Everyone has the option of an extended access appointment if needed including evenings, weekends and bank holidays
- By March 2020 all patients calling 111 will, if clinically appropriate, 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
- 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 Primary Care Networks to improve choice and options for people including:
 - online and Skype consultations
 - online access to appointment booking and medical records
- We will work with partners to enable a streamlined access point for people. NHS 111 will be able to book directly 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
- Improve people's experience of accessing primary and urgent primary care services.

The role of primary care in reducing pressure on our urgent and emergency care services is vital. Primary Care Networks will work with community provider partners to identify people most at risk of hospital admission and plans will be put in place to support them. As well as health and social care needs, this approach will include other factors such as housing and debt. Two out of the four priorities for community health services in the NHS Long Term Plan require a joint enterprise between community services and GP practices as part of primary care network delivery. This will be supported by the Enhanced Health in Care Homes and Anticipatory Care Framework.

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 to 100%. The hub GP appointments are fully open and directly bookable by the out of hours provider and NHS 111, enabling 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

This will support the transformation of primary care, with funding coming via the GP Forward View, the GP Contract Reform package, Partnership transformation funding and local investment from commissioners and providers.

The Partnership has:

- Invested £2.6m to develop and accelerate Primary Care Networks
- Utilised transformation funding supporting new workforce roles
- Utilised transformation funding to support population health management for Primary Care Networks
- Invested additional funds for workforce initiatives from the Local Workforce Advisory Board and Health Education England
- Invested in primary care infrastructure estate through estates transformation technology funding (ETTF).

Some examples of what estates transformation, technology funding has supported:

- Building new health centres that have a greater range of services for people in one place, including learning disability premises schemes
- New consulting and treatment rooms to provide a wider range of services for people, 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.

NHS funding nationally will grow by 3.4% over the next five years, increasing by £20.5billion by 2023/34.





Pharmacy, dental and eye care

Pharmacy, dental and eye care

Our Primary Care Strategy recognises value of the wider primary care community, including dental, community pharmacy and optometry providers. We will integrate these wider services in our transformation priorities and in the Primary Care Networks, supported by the clinical leadership of our local professional networks.

Pharmacy

Community pharmacy provides a huge opportunity to support the wider health care system in both the delivery of primary care and urgent care, including the management of minor conditions through the [Community Pharmacist Consultation Services](#). There are many good examples of the difference community pharmacy can make to people's experience of care and support, but we need to do more to ensure a consistent approach across all areas.



In July 2019 a new five year [Community Pharmacy Contractual Framework](#) was announced which builds on the aspirations and direction of community pharmacy within the Primary Care Strategy.



▲ Photo credit: Harrogate and District NHS Foundation Trust

Digital transformation will support how services are delivered in community pharmacy. You can see a recent example in the roll-out of NHSmail to community pharmacy. This work has provided a structure for managing referral information and will drive future working.

Eye care

Community eye care services in primary care will be developed in each of our places. The aim is to provide an integrated primary eye care service within each primary care network, bringing care closer to home. An eye health care capacity review led by the Improving Planned Care Programme (see page 79) has been undertaken to support transformation in areas such as; age-related macular degeneration (AMD), cataracts, diabetic eye disease, glaucoma and children's eye care services.

Dental services / oral health

It is important that we strengthen the relationship between dental and other services involved in Primary Care Networks and community care, ensuring better and more efficient support – especially for people living in areas of most socio-economic disadvantage. With a priority to ensure that people have access to a regular dentist, we will take the opportunity to use innovative commissioning that supports providers to allocate an element of their contract to focus on prevention rather than treatment. This will drive the need for a flexible approach to commissioning which removes the emphasis on unit of dental activity counting and towards 'outcomes', supporting practices to deliver a service using all staff skills and which meets the needs in their locality. The collaborative approach will raise the profile of oral health and the prevention agenda, as well as the importance of a consistent, joined up approach to oral health promotion.

We have identified children as a key group for targeting delivery alongside vulnerable groups. The level of need in each of our six local places varies dependant on the demography and geography of the area, dental practice coverage and capacity, pilot projects and the local authority commissioned activity.

We will join up dental and oral health services with the wider primary care systems and encourage partnership working arrangements with dental and medical professions through a number of forums, including local professional networks.

Building on the work undertaken in 2018, funding will be allocated to approximately 20 wards in West Yorkshire with an aim to reduce oral health inequalities and improve child oral health using key deliverables such as 'prevention champions', good oral health promotion and training for staff in the principles of delivering better oral health ['Making Every Contact Count'](#).



Read the Delivering Better Oral Health toolkit [here](#).

The additional funding will focus on children (0 to 5 years), particularly fluoride varnish application, those in community dental services who remain dentally fit for primary care, older people living in care homes and living independently, and homeless people receiving services within health centres or community settings.



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 patients' oral health, also linking to wider health and social care provision where appropriate.



Social care

Care services including home care, residential and nursing homes and other adult and children services are an essential part of the health and social care system. They help people to stay independent and safe at home, provide temporary solutions when people need time and support to recover and support in a 24 hour setting when people require greater assistance.

In the West Yorkshire and Harrogate area alone, councils and the NHS spend in excess of £800 million each year on care services, with significant contributions from people who self-pay.



The care sector nationally and in our region faces a number of significant challenges, including the fragmented nature of provision and funding. The availability of independent social care across West Yorkshire and Harrogate varies widely, as does quality and choice. Many independent providers have withdrawn from the market because of the financial instability, particularly for some types of care that cost more to provide or are more specialised.

This particularly affects more rural areas and areas where there is more competition for staff. All providers - statutory, voluntary and community sector, independent and private - are experiencing significant workforce issues, both in attracting people into the work and retaining them. This is especially true for nursing staff, but impacts on roles across all pay brackets. These issues combine to create a system that is going to struggle to meet the care needs of communities in the future. Increasingly we are working together to address some of the short term issues where we have the flexibility to work around locally. But the medium to longer term picture still requires significant change at national level if we are to meet our ambitions for people to have sustainable, high quality care when they need it.



Beyond these issues for the sector is a more fundamental question about what people will need in the future to help them to live a good life, and how will the care sector will evolve. **Short term council funding inhibits how we can do this over the long term.**

We have 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 help manage the more immediate problems whilst shaping a future vision for our care sector.

Early work has identified the need to explore the potential of how the combination of taking an asset-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.

Nationally, in 2017/18, total expenditure on adult social care by councils was estimated to be in excess of £21bn. However, there is increasing pressure on budgets in the context of increasing demand from an increasing number of older people in the population.



▲ Photo credit: Wakefield Council

At the same time, councils are being charged more for nursing and residential care and for home care that they buy at a much higher rate than inflation. This is particularly apparent in the services provided to over 65s, which have increased on average by 6.6% in the last two years alone.





Urgent and emergency care

Our urgent and emergency care system includes primary care, mental health, social care, urgent care, dentistry/oral health, 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 our other [priority programmes](#) such as West Yorkshire Association of Acute Trusts (hospitals working together), mental health providers and working closely with social care providers.

An important part of our work is ensuring that people's needs are met in the right place, at the right time, with the right support.



Watch our film of Dr Adam Sheppard, Clinical Chair for the Urgent and Emergency Care Programme Board to find out more [here](#).



Our vision for urgent and emergency care is to 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 people with more serious or life-threatening emergency care needs, we aim to support them in specialist centres with the right expertise, processes and facilities to maximise a good recovery.



How we work

Yorkshire Ambulance Service is 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.

We have five Local A&E Delivery Boards (Airedale and Bradford district and Craven, Calderdale and Greater Huddersfield, Harrogate and Rural Districts, Leeds and Mid Yorkshire) covering the six places we work across. The Boards bring together partners that are responsible for delivering and coordinating local services.



The difference we have made

- **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% of the population having 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 and need to maintain this
- **clinical advice:** We have increased the number of people receiving clinical advice via NHS 111.



▲ Photo credit: Yorkshire Ambulance Service NHS Trust



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](#)' 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 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 and when.

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.

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.

Shifting care from unplanned care to planned care as well as early help in our communities

Patient transport services are key to making sure the needs of people can be met within various healthcare settings. We want to create a hybrid service between emergency and planned patient transport to safely manage the non-emergency cases in a timely way. The 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:

We will:

- Bring the points of access together in each of our six places and where appropriate develop a consistent multi-disciplinary clinical offer
- Strengthen joint working between the urgent (NHS 111) and emergency (999) services through our NHS 111 integrated urgent care service.

Our five year ambitions:

We will:

- Deliver the integrated urgent care specification and support people to navigate care and access advice more easily
- Support 100% of the public to access NHS 111 for clinical advice for unplanned health and care problems and where appropriate, onward referral
- Ensure that over 50% of NHS 111 triaged calls will receive a clinical assessment. Clinical commissioning groups will develop local Care Clinical Assessment Service to support the Clinical Advice Service at NHS 111 (March 2020)
- Ensure all 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
- Streamline access to urgent mental health services including preparation towards NHS 111 being the single point of access to crisis services (2019/20)
- Where appropriate, make sure people travel to planned and unplanned care appointments via timely patient transport services
- Ensure people receive a prompt and appropriate response when accessing emergency transport services.



Community urgent care

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.

Urgent treatment centres (UTCs) are GP-led and 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 reasons why people attend A&E.



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Urgent treatment centres ease the pressure on hospitals, so that they are free to treat the most serious cases. Our UTC offer will reduce attendance at A&E and offer people the opportunity to get to the right place for care.

As Primary Care Networks (PCNs) develop and local care partnerships continue to work together we will be clear on how they link with the UTCs to develop more appropriate and additional services for people.



There are currently two urgent treatment centres (UTCs) in West Yorkshire and Harrogate, St Georges in Leeds and Pontefract Hospital in the Wakefield district. Clear commissioning principles that ensure access through NHS 111 is key to the development of more UTCs across our area.

Looking at the development of UTCs gives us the opportunity to better support social care and the development of 24/7 urgent primary care. This will include a review of GP out of hours services and making the most of digital technology.

As part of the Ageing Well programme we will support the primary and community programme to develop urgent community responses to meet the standards of two hours response for urgent care and a two day response for access to intermediate care/reablement.

The [Yorkshire Ambulance Service](#) responds to significant amounts of urgent care in the community. The needs of people vary and include falls, mental health, and respiratory conditions.



▲ Photo credit: Yorkshire Ambulance Service NHS Trust

As UTC models develop, transportation will be reviewed to ensure that people are taken to the most appropriate place for care and treatment.

We will work together to develop alternative care pathways and increase ambulance service capacity whilst reducing attendance at A&E, where safe to do so.

Case study

The Multi-Agency Integrated Discharge Team on the wards at Bradford Royal Infirmary link social care staff and nurses. They visit wards seven days a week to help people to prepare to leave as soon as they are able. This helps reduce delays and solve the non-medical issues which can delay discharge such as housing, social care packages and correct equipment.

Our five year ambitions:

We will:

- 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 UTCs
- Contribute to the achievement of early help / preventing ill health in the community through implementation of UTCs. 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
- Ensure 100% of people living in West Yorkshire and Harrogate has access to bookable in hours GP appointments via NHS 111 by rolling out the full direct booking programme (March 2020)
- Support the development of 24/7 urgent primary care across West Yorkshire and Harrogate, and providing an alternative capability to support the left shift. This involves:
 - supporting the uptake of the community pharmacy consultation service (NHS 111 to community pharmacy)
 - extending the use of the community pharmacy consultation services (which currently links NHS 111 to community pharmacy services) to other areas, such as the interfaces between A&E, UTCs and community pharmacy.



Case study

Calderdale and Huddersfield NHS Foundation Trust has successfully implemented advance care planning. The team is highly motivated and passionate around the care they deliver for frail patients and 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.





Case study

The Connecting Care Hubs in Wakefield is where health, social care, housing, voluntary and community organisations work side-by-side to help those people most at risk stay well and out of hospital. 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 12 months they've seen over 3000 people including over 1200 urgent referrals (accurate at September 2019).



Watch this film where children and young people talk about their experience of using Bradford's ambulatory care [here](#).

Acute emergency care

Reforming acute emergency care helps improve good patient flow, which is central to patient experience, clinical safety and reducing the pressure on staff.



Our five year ambitions:

We will:

- In 2020, 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.
- Embed the Same Day Emergency Care (SDEC) model in every acute hospital with a type 1 A&E department during 2019/20. This will increase the proportion of acute admissions discharged on the day of attendance from a fifth to a third
- 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 (2019/20)
- Ensure 100% of hospital handovers across Yorkshire and Humber will occur within 30 mins (March 2020)
- Reduce and maintain the number of delayed transfers of care at below 2.4% of the total acute hospital bed base
- Record 100% of patient activity in A&E, UTCs and SDEC via the Emergency Care Data Set (March 2020).



Transforming planned care

The demand for planned care continues to increase year on year. 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:

- Offering alternatives to hospital services by developing services in community settings
- Promoting prevention, self-care and healthier choices so that people become their own healthcare experts and less reliant on medical interventions
- Standardising our clinical pathways, clinical thresholds and commissioning policies to reduce any unnecessary differences that currently exist. Having a single approach means that access to planned care services is the same for everyone
- Sharing our learning between places and providers as we develop and implement our plans for transforming and improving planned care
- Using our learning about how to develop the workforce in our current programme to inform sustainable workforce development plans for the future across clinical specialties including diagnostics.



Clinical pathways set out the various steps in the care of people referred for treatment by their GP or other health professionals. 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 one 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.

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. Feedback 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.

The Healthwatch engagement (June 2019) 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.

We recognise the importance of providing self-care information and use the Partnership's various communications and engagement channels, as well as 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 commissioning policies whenever possible.

Feedback from the Healthwatch engagement also highlighted the need for people 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 conditions that affect muscles, joints and bones

In May 2019, the newly developed West Yorkshire and Harrogate [MSK pathway](#) was agreed for implementation. 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.



In parallel with this, acute hospital trusts are leading work on people 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 will have a prototype standardised app by December 2019 for testing with people. It should be ready for use by April 2020.

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.



Case study

People have told us they want to be able to access health care closer to home, including more routine 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 MSK specialists and 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.



Our five year ambitions for 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
- 2020 – work will start on the MSK policies included in [NHS England's Evidence-Based Interventions \(EBI\) programme](#), expected to be released early in 2020. The EBI programme aims to reduce unnecessary medical procedures and prevent avoidable harm to people by making sure that treatments routinely available on the NHS are appropriate and clinically effective.



We are embracing advances in technology for the MSK pathway and hope 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 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.

- We plan to agree the adoption of a clinical pathway for monitoring of patients taking hydroxychloroquine by the end of 2019
- We will continue to review 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
- A single commissioning policy for dry eyes (keratoconjunctivitis sicca) will be developed in 2019/20.



Working with teams from the [West Yorkshire Association of Acute Trusts \(WYAAT\)](#), [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.

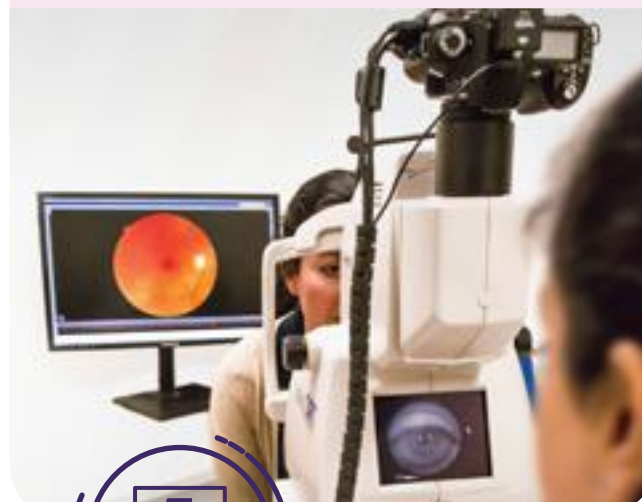
We have established teams of commissioners, clinicians, Local Optical Committee (LOC) representatives, eye clinic liaison officers, charity workers, service managers and vision rehabilitation workers to work on various transformation projects for eye care services. The project areas are: age related macular degeneration; diabetic retinopathy; glaucoma; cataracts; and children's eye services.

Each team is developing plans for their assigned area of eye care with the aim of improving services. 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 in 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. Local service development and implementation will take place between May 2020 and May 2023.

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.

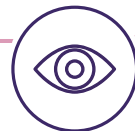
The West Yorkshire and Harrogate Local Eye Health Network, working with the University of Bradford, has been successful in its bid for workforce development funding from Health Education England. The funding will enable optometrists to gain the accreditation required for earlier detection, decreasing 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.



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.

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](#) for conditions that are not urgent (i.e. not related to an accident or an emergency).



Clinical thresholds

Clinical thresholds are points on a pathway used to decide which treatments will be offered 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.

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

[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 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.

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.



Our five year ambitions for medicines and prescribing

- Merging the three local area prescribing committees (APCs) into a single APC for West Yorkshire and Harrogate so that prescribing and medicines use is consistent across the area
- Implementing guidelines on ‘over the counter’ medicines, self-care and low value medicines, and other national initiatives as they are introduced.

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 NHS Improvement to transform outpatient appointments and deliver 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 more virtual and telephone appointments so we are working to make the best use of technology that will allow this to be done effectively and securely.

Case study

Calderdale and Huddersfield NHS Foundation Trust system recovery work is aiming to reduce outpatient attendances by 20% by 2020. The programme is delivering some fantastic results through combinations of virtual clinics, one-stop shops, patient initiated follow-up appointments, apps, smart technology and primary care interfaces.

Waiting times

The work of the planned care programme alongside with work being undertaken in all places support the delivery of reducing waiting times to ensure delivery of national constitutions standards (RTT) and reduction of long waits (52 weeks).

We have a system-wide piece of work to address the main clinical specialties where long waits are challenging and to consider options for patients to make choices about their care if they have been waiting for 26 weeks.

Case study

Our hospital trusts are taking part in the NHS Improvement video consultation pilot, taking their local approach to implementation whilst sharing learning across the area to achieve the best possible outcomes for people. This ‘virtual appointments’ pilot uses an established web platform.



Hospitals working together

The West Yorkshire Association of Acute Trusts (WYAAT) is a collaboration of the six NHS trusts which deliver acute hospital services to the 2.7 million people across West Yorkshire and Harrogate. These are: Airedale NHS Foundation Trust; Bradford Teaching Hospitals NHS Foundation Trust; Calderdale and Huddersfield NHS Foundation Trust; Harrogate and District NHS Foundation Trust; Leeds Teaching Hospitals NHS Trust; Mid Yorkshire Hospitals NHS Trust.

The Association works 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, since 2016, WYAAT has created several joint programmes of work. They cover clinical services, clinical support services and corporate support services.



^ Photo credit: Mid Yorkshire Hospitals NHS Trust



Since 2016, our acute hospitals have been working together on how we can use our collective resources, such as buildings and staff, to deliver the best possible experience and outcomes for people. 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

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 more than 10 clinical areas. A number of these networks form the basis of larger programmes such as vascular, pathology, radiology. More recently we have established five clinical networks in cardiology, dermatology, urology and gastro. 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.



^ Photo credit: Mid Yorkshire Hospitals NHS Trust

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.



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 speciality it focuses with our own staff on sharing best practice and delivering efficiencies and cost savings. West Yorkshire Association of Acute Trusts work with GIRFT not just at individual trust level but as a system. We have delivered system GIRFT events in orthopaedics, vascular, ophthalmology, urology and pathology.

Vascular services

We have established a single vascular service for West Yorkshire. 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.



‘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 units 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 have agreed to establish the West Yorkshire and Harrogate Pathology Network to bring together all pathology services in West Yorkshire and Harrogate.

This will mean collaborating 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 hospital trust by the end of 2022 with implementation of the whole programme being concluded by the end of 2023.

Radiology

The West Yorkshire Association of Acute Trusts are working together with hospitals in Hull, North Lincolnshire and York as the Yorkshire Imaging Collaborative. They aim to ensure that every patient in our part of the region can 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 this is 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 a shared radiology reporting solution that will enable 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

▼ Photo credit: Carderdale and Huddersfield NHS Foundation Trust



harmonise how they undertake patient scans and reporting across our hospitals, in order to allow them to work together to deliver better patient care.



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

Acute trusts employ over 50,000 people. Supporting them to work together is a priority. 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 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 introducing 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 temporary staff. 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 key. 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 on 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. It is estimated it will deliver annual savings of between £7m and £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 Scan4Safety across all the other WYAAT hospitals, with large scale transformation planned for 2020/21.

Procurement (sourcing products and services)

We are working together to 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 has saved over £200k/ So far this work has resulted in a saving of over £1.5m.

In response to the new national procurement model and proposal to make changes at a regional level, the trusts have agreed to establish a networked procurement service. This will include the management of product catalogues, stock and contracts (using common IT systems) at West Yorkshire Association of Acute Trust level and a collaborative sourcing plan with individual trusts managing the purchasing of product categories on behalf of the others.



You can read the West Yorkshire Association annual report summary [here](#).



Our five year ambitions

- Fully establish the West Yorkshire Vascular Service
- Fully establish the West Yorkshire Pathology Network, with the single LIMS in every hospital trust by the end of 2022
- Complete the roll out of the Enterprise Imaging Picture Archiving and Communication System and implement the shared radiology reporting solution by the end of 2021
- Shared medical staff bank established by the end of 2020
- Complete the roll out of Scan4Safety by April 2023.



Chapter 4

Priority areas for improving outcomes

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We have a number of priority programmes which are designed to improve services and health outcomes for specific groups of people.

Maternity



Better Births 2016, the [national maternity review](#), describes the improvements needed to be made in maternity services and identifies how we can work together to ensure women are healthy, make informed choices and are able to have a safe and healthy pregnancy. It was also the starting point for the development of Local Maternity Systems (LMS) and became a priority programme for WY&H Health and Care Partnership. The LMS is now building on progress to date which will include implementation of the recommendations from the [NHS Long Term Plan](#).

We aim to be the place where women and their families choose to receive their maternity care with as much choice as possible. Rather than services working in isolation we now work together as a system. This gives women and their families the opportunity to choose where they receive their care. This way we can make sure that women get the right care, in the right place, at the right time. Wherever women and their families choose, they will be looked after by highly trained staff offering a quality, safe and personalised service.



^ Photo credit: Harro

The [LMS Plan](#) is our response to Better Births and the NHS Long Term Plan and has been co-produced with women, their families, partner organisations and staff. This includes the detail of the work programme, what we want to achieve by when and how.



The development of the LMS is outlined in a short film by Carol McKenna, Senior Responsible Officer for the Maternity Programme. View this [here](#).

Making our maternity services safer for women, babies and staff

Stillbirths and neonatal deaths have been reduced by 10% across West Yorkshire and Harrogate. We will continue to work towards the ambitions of [Saving Babies](#)

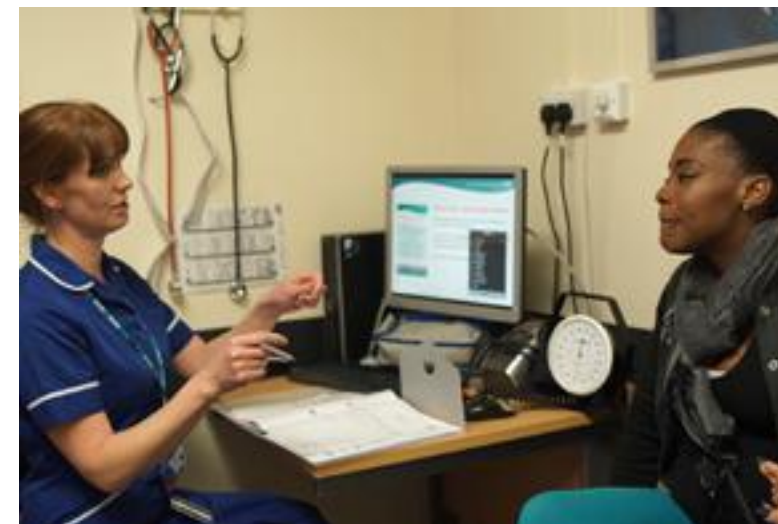
[Lives Version 2](#) with particular focus on reducing pre-term births and improving outcomes of babies born early by increasing uptake of magnesium sulphate to prevent cerebral palsy. Mechanisms have been established across the LMS to review, share learning and change practice when things go wrong.

Working together with women and their families

We hear and act on the voices of women and their families through working together and supporting our local Maternity Voices Partnerships (MVP). We intend to increase engagement and co-production with men as parents and work with the emerging national volunteering programme to develop volunteering at a local level.

Highly skilled and knowledgeable maternity workforce

The LMS intends to attract and retain a highly effective multi-disciplinary workforce that is well led, in a culture which promotes innovation and continuous learning. Priority areas include: staff health and wellbeing, workforce models, preceptorship, leadership and recruitment.



Our ambition is to improve women and babies' safety, preventing harm and the costs associated with it by;

- Reducing stillbirths, neonatal brain injuries, neonatal and maternal mortality by 20% by 2020 and 50% by 2025
- Reducing preterm births to 6% by 2025.

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. We have worked with women and their families to co-produce and publish the choices available. Staff training has been developed to ensure all women have meaningful conversations to make decisions about where they receive their care and the choices they can make, with access to specialist care whenever needed.



You can watch Becky's story where she explains the importance of personal choice and her experience of using local maternity services [here](#).



Our 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.

Digital

We have completed an LMS digital maturity assessment and are developing a plan to meet the national ambition for digital maternity records. Our next steps include a review of how IT systems talk to one another to facilitate the safe transfer of information between providers.



Our ambition is for all women to have their own digital maternity record by 2023/24.

✓ Photo credit: Harrogate and District NHS Foundation Trust



Continuity of carer

We know that women who receive continuity of carer, from a small team of midwives whom they know, build trusting relationships and receive safer care. In 2018, across the LMS, less than 1% of women received continuity of carer throughout their pregnancy journey. By March 2019 over 10% of women in West Yorkshire and Harrogate were placed onto continuity pathways. By 2021 the majority of women across the LMS will experience and benefit from continuity of carer. This will include women for whom we can make the biggest difference, improving their outcomes the most.

Neonatal care

We will work in partnership with the Neonatal Operational Delivery Network (ODN) to improve neonatal care and support families to become more involved in the care of their baby, in line with the LTP Implementation Framework. The LMS will support the expansion and improvement of neonatal critical care services and support the establishment of care coordinators in partnership with the ODN.



Our 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 have begun to explore how postnatal care can be improved and personalised to the needs of each woman and her family to achieve the best start in life for their babies. Our priorities are identified in the postnatal section of the LMS Plan. This includes, transfer of care and information between maternity, health visiting and primary care and access to obstetric physiotherapy services.

Perinatal mental health

One in four mothers suffers from mental health problems during pregnancy or in the first year after childbirth. The LMS is addressing this by working in partnership with West Yorkshire and Harrogate Mental Health, Learning Disabilities and Autism Programme to support women and their families. For more information please see [page 106](#).

Prevention and health inequalities

Wherever possible every woman and their family should experience a safe healthy pregnancy, before (planning for pregnancy), during and after. We want to ensure preventing ill health and tackling health inequalities is at the heart of all we do, providing support for parents as early as possible to ensure children have the best start in life.

We have undertaken and published a comprehensive [health needs assessment and equality impact assessment](#), working with public health colleagues for all our six local places and other key partners; we aim to address the challenges faced by women and their families described in these documents. For further detail on how we will support women and their families please see the [LMS Plan](#).



Our ambition is to:

- Reduce smoking in pregnancy to 6% by 2025
- Ensure all maternity providers have achieved the UNICEF Baby Friendly accreditation by 2020
- Increase breastfeeding initiation rate
- Address multiple risk and protective factors for a safe and healthy pregnancy.

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. We want to improve; the performance of childhood screening and immunisation programmes; maternal nutrition and infant feeding to prevent childhood obesity; parenting and bonding to provide loving and safe environments to support social and emotional development.



Children and young people

The health of children and young people is crucial, but England's levels of 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.



^ Photo credit: Born in Bradford



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 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.

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 95th and Harrogate the 188th (The English Indices of Deprivation 2019).
- 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 care (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% of the median income or in receipt of Employment and Support Allowance/Jobseekers Allowance. 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.

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 inequalities 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.





^ Photo credit: ACE
(Ambulatory Care Experience)



Case study

Bradford Teaching Hospitals NHS Foundation Trust has developed a service with families called the 'Ambulatory Care Experience' (ACE). In collaboration with Bradford City, Bradford Districts 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. Ongoing clinical monitoring is undertaken in the community by specially trained children's nurses.

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.

To achieve the aspirations of the NHS Long Term Plan we will focus on the added value of working together as a system to improve the health and life chances of children, young people and their families. This will include addressing health inequalities, addressing complex issues, acting at scale or standardising 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 with higher than average childhood obesity levels. Our aim is to improve services, 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.



Read more about the Kirklees Healthy Child Programme [here](#).

Our five year ambitions:

- Acute pediatrics (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)
- Palliative and end of life care and 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.



West Yorkshire and Harrogate Health and Care Partnership is made up of six local places:
Bradford district and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield



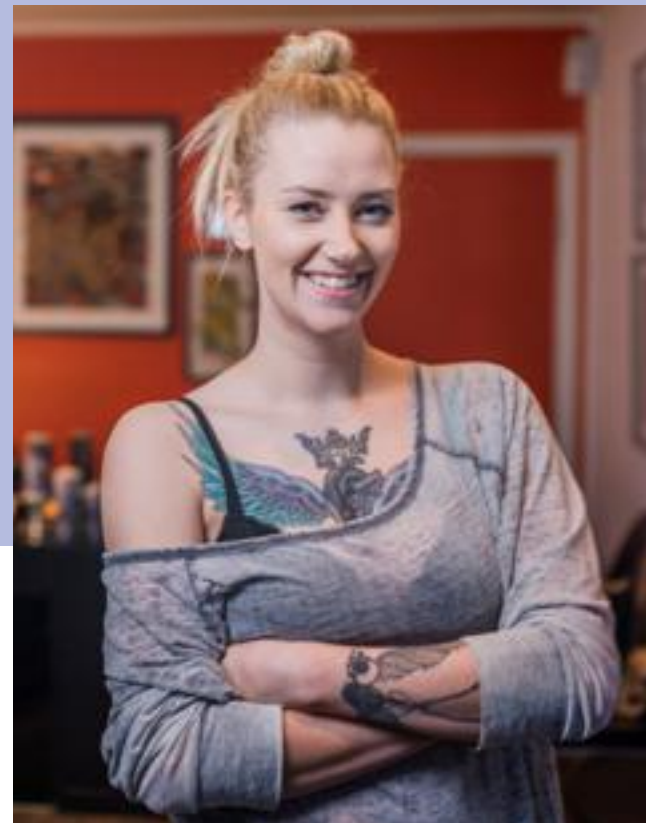
Mental health, learning disabilities and autism

We aim to deliver excellent health and wellbeing for people with a mental health condition, learning disabilities and autism. Our aim is to reduce the variation in healthy life expectancy for these groups of people compared with the wider population.

This section is all about the priorities for people with mental health illness, learning disability and autism; however it is helpful to note that their needs are relevant to many other priorities set out in this plan.

Key to our ambitions will be to ensure groups of people with lived experience (including self-advocates involvement in each local area) are further involved in the development and delivery of our ambitions. We will undertake co-production with local people on:

- The design, development, procurement (including people with lived experience being part of any tendering process) and evaluation of services
- The development of further plans, capturing the voice of local people to describe why and how we are seeking to improve outcomes
- Participation and involvement in focus groups, to ensure diverse opinions are sought, enabling better decision making.



- Service design and development, working alongside professional and clinical staff to make services appropriate for all people with mental health conditions, a learning disability and/or autism.
- Co-facilitation of training - for example making reasonable adjustments in health care and raising awareness of the standards expected of all services.

Up to one in four of us will suffer from poor mental health at some point in our lives and for those with a severe illness it can mean dying 20 years early. Having a learning disability also increases the likelihood of experiencing health inequalities and poverty, whilst having autism limits opportunities for employment and good wellbeing.

We will support more people with a learning disability or autism into employment.

We can improve people's lives by using our collective expertise and resources to provide higher quality services and reinvest financial savings to support care closer to home.



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; tackling the wider determinants of poor mental health; seeing fewer people in crisis, less reliance on hospital beds and fewer people left behind without the support they need to lead a fulfilling life.

Mental health is receiving an increased share of the overall NHS budget. Our priority programme will be overseeing achievement of the [Mental Health Investment Standard](#), working with local places so they spend at least the minimum expected levels of funding to improve mental health. This includes services from NHS providers, community organisations and Primary Care Networks. This will be achieved through an increased focus on early help, preventing ill health (including health-checks), support across the full age spectrum and psychological therapies for common mental health conditions. In addition, by speaking as 'one voice' across the system we can effectively lobby national partners for additional investment in health and care facilities, increasing parity between mental health, learning disability and autism facilities and those of physical health services.

The NHS has committed to making an additional £2.3bn available for Mental Health services by 2023/24.

For West Yorkshire and Harrogate this means we are increasing our recurrent investment in Mental Health services by over £14m in 2019/20, and expect to reach a level of additional investment of around £70m per year by 2023/24.

The Partnership's Mental Health, Learning Disability and Autism Programme works closely with our six local places to make sure our work is connected. This helps to ensure we avoid duplication and adopt a 'do once' approach to commissioning (buying services) where appropriate.



The programme has developed a more detailed strategy which provides some of the why, how and when for our work. It can be accessed [here](#).



Poorer mental health is associated with higher rates of smoking, substance abuse, lower educational attainment, poor employment prospects/rates, decreased social relationships and lower resilience.

We know that people with autism and/or learning disabilities have much higher rates of mental health related illness than many other groups of people alongside the other challenges posed by their diagnoses. [The Healthwatch engagement report](#) (June 2019) highlighted the importance of early access to services for people with a mental health condition. This is clearly an area for improvement.

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The table below sets out why this work is so important to the health, wellbeing, and life chances of people living across our area.

Mental health/illness Approx. 25% prevalence per year	Learning disability Approx. 2-2.5% medical diagnosis	Autism/attention deficit hyperactivity disorder (ADHD) Between 1-4% prevalence
75% of people with long term mental health illnesses are unemployed  50% of people with anxiety/depression for over 12 months are unemployed 50% of mental health problems are established by age 14 62% of Looked After Children are in care because of abuse/neglect  1 in 6 adults has experienced mental health problems in the last week People with severe mental illness die on average 15-20 years earlier than the general population.	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, 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.

We also need to increase access to physical health services such as dentistry, oral health, opticians screening and health checks. And we must ensure support is provided where transition/change occurs within a person's life, where their resilience and that of their carers can be destabilised.

Education and employment opportunities also remain low. This contributes to those with a learning disability or severe mental illness finding it hard to find and stay in work.



Partners need to address this together, by testing employment schemes such as placement support and internships, looking at good practice elsewhere in the country and lobbying locally for change.

Case study
South West Yorkshire Partnership NHS Foundation Trust runs a network of recovery colleges in Calderdale, Kirklees, and Wakefield. 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. They are developed and delivered by people with lived experience of health problems. 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 since attending the college.



^ Photo credit: Leeds and York Partnership NHS Foundation Trust

West Yorkshire and Harrogate Health and Care Partnership is made up of six local places: Bradford district and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield

Carers and families

Unpaid carers save the UK over £132 billion a year and are particularly relevant for people diagnosed with mental ill health, learning disabilities and/or autism/attention deficit hyperactivity disorder. As a Partnership we can better support carers by keeping them psychologically and physically well. One of the ways we will be doing this is via the Worker Carers Passport Initiative (see page 132).



Access to high quality care

Mental illnesses

Each of our six local places is committed to improving access to psychological therapies for adults. Primary Care Networks will provide a multidisciplinary approach, on top of increases in therapists within community care settings. We will share good practice across West Yorkshire and Harrogate to support this increase in access and to improve referral to treatment times and recovery standards.

Care in a crisis

We are working alongside the Urgent and Emergency Care Programme (see page 72) to develop our urgent and emergency mental health care response with Yorkshire Ambulance Service and the police. Our aim is to deliver 100% coverage of 24/7 crisis teams by 2020/21. This includes ensuring that NHS 111 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 and ambulance staff in 999 control rooms. In our local places, alternatives to A&E (safe spaces) are being developed for adults and children. We will ensure these make reasonable adjustments for those with learning disabilities and/or autism and those with conditions such as dementia.



Watch this film about Bradford District Care NHS Foundation Trust's First Response service and partnership working with three community-based safer spaces run by voluntary organisations, to find out how they are supporting people in crisis in their communities [here](#).



^ Photo credit: Leeds and York Partnership NHS Foundation Trust



Children and young people's mental health and wellbeing

Getting services right for childhood mental health and wellbeing means we can prevent the development of more significant problems later in life. We are establishing 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 well so we can roll it out across West Yorkshire and Harrogate by the end of 2023.

We are working in partnership with the children and young people partners and the improving population health programmes to better understand their needs and those of their families. Our aim is to create a 0-25 mental health service, which includes community and hospital services in line with national funding from 2021/22.



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](#).



Case study

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. The unit, operated 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.



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, seven days a week through a single point of access. Each area will have age appropriate, urgent and emergency assessment, intensive home support and liaison functions in place.





Hospital care for people with a mental health condition, or learning disability

We will continue to work in partnership with our six local places to review hospital and community provision. We will ensure that people with a learning disability are cared for in the community where appropriate, whilst providing caring and effective inpatient support when needed through assessment and treatment beds (you can read the engagement report [here](#)) and other residential services, in line with national expectations of the Transforming Care Programme. For mental health services we will establish the appropriate models of care for psychiatric intensive care, forensic services and rehabilitation and recovery.

We will continue to work in partnership with our six local places to review hospital and community care. We will ensure that people with a learning disability are cared for in the community where appropriate, whilst providing safe, caring support when needed through assessment and treatment units (you can read the engagement report [here](#)) and other residential care services, in line with national expectations of the [Transforming Care Programme](#). For mental health services we will establish the appropriate care for psychiatric intensive care, forensic services, 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 sustaining new roles such as care navigators from 2020/21. We will also continue to expand the range of specialised services we provide, including the only problem gambling clinic outside London.

We will assess providers against the [Learning Disability Improvement Standards](#) during 2019/20 and 2020/21 to identify what is needed to improve our service offer. This will include the use of a 'digital flag' in patient records to ensure clinical staff can make reasonable adjustments in how they provide care.

We will act on 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 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 as peer support workers.**



Eating disorders

By piloting a new way of working across West Yorkshire and Harrogate there are now no inappropriate out of area admissions for adult eating disorders. We have achieved savings of £240k and invested this in the CONNECT team to improve 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; including ensuring it meets the needs of people with a learning disability and/or autism.



Case study

CONNECT: a new community eating disorders service for West Yorkshire and Harrogate aims to provide fair access to NHS care – something that had not been in place until 2018. 148 people have been allocated for treatment over the past year (accurate at August 2019).



Suicide

The biggest killer of males under 50; mental health issues and financial problems are some of the biggest contributing factors of suicide in our area.

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. We are working with public health colleagues to create a high-risk decision support tool for primary care and non-mental health services. This will identify people at risk of suicide and will help us target support.



^ Photo credit: Leeds and York Partnership NHS Foundation Trust

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Suicide prevention (cont.)

Case study

A Leeds based postvention suicide bereavement support service has been rolled out across West Yorkshire and Harrogate. The Partnership secured £173,000 from NHS England/NHS Improvement to enhance suicide bereavement support services in the area. The new service will be an extension of the Leeds Suicide Bereavement Service set up in 2015, led by Leeds Mind with support from Leeds Survivor Led Crisis Service and funded by Leeds City Council.



'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 are 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.



^ Photo credit: West Yorkshire Fire and Rescue Service



You can also read our Suicide Prevention Annual Report [here](#).



Autism (and other neurodiversity like attention deficit hyperactivity disorder)

Children and adults wait too long for assessment and diagnosis of autism and ADHD. We will work across West Yorkshire and Harrogate to share good practice and find the right solutions to improve this, both within each place and across the wider system.

Case study

Wakefield services have been assessed as making sufficient progress to improve autism services for children and young people. In June 2017, 614 children and young people aged 0 to 14 were waiting on average two years for their autism spectrum disorder assessments. By June 2019, this had been drastically reduced to 112 children, with a waiting time of no more than 26 weeks for children under 14 years. 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.

Our Partnership enables us to share learning and develop good standards in practice across the whole of the area.



Joining up physical and mental health support

Poor mental health is a major risk factor 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 will work with other programmes to address this, including supporting the expansion in community provision for perinatal care for new mothers and providing more outreach services during maternity, alongside the regional hospital mother and baby unit in Leeds.



Leeds mum Lindsay talks about the mental health support she received following the birth of her third child. 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 [here](#).



We are developing our plans across all of these important areas with other West Yorkshire and Harrogate programmes and national guidance.



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Our mental health, learning disabilities and autism five year ambitions:

- Achieve IAPT (improving access to psychological therapies) referral to treatment times and recovery standards from 2019/20 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 2023/24
- Mental Health Support Teams tested in 2019/20 and 2020/21 for further roll out across West Yorkshire and Harrogate by 2023/24
- Increase in the number of women accessing specialist perinatal mental health services by 2022/23
- A comprehensive 0-25 mental health service across all places rolled out from 2020/21
- Reduce 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 hospital length of stay from 2020/21
- Test West Yorkshire and Harrogate models for suicide prevention and postvention in 2019/20 and 2020/21
- A 75% ambition of health checks for people with learning disabilities
- Review current delivery across all service providers against the Learning Disability Improvement Standards during 2019/20 and 2020/21, meeting requirements by 2023/24.

Taking a zero suicide approach, to reduce suicide rates in all people in contact with services. Our aim is to reduce suicide by 10% across West Yorkshire and Harrogate and by 75% in targeted areas.



We will continue to explore opportunities for further involvement of people with a mental health condition, learning disability and autism in:

- The development of further plans in relation to our work – capturing the voice of local people
- Participation and involvement in focus groups
- Service design and development
- Co-facilitation of training for example making reasonable adjustments in health care and raising awareness of Partnership improvement standards.



Stroke care



In 2018/19 there were 3,441 strokes in West Yorkshire and Harrogate.

Our ambition is to reduce the number of people who have strokes; save more lives and improve recovery outcomes. Our priority is to provide the best stroke services possible to further improve quality and stroke outcomes.

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 across 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 important 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](#)

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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.

Since spring 2018 we have been working with our partners at the [Yorkshire & 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 & Humber Academic Health Science Network is working with each of our 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' [here](#).



You can also find out more about all of the engagement that has taken place [here](#).

Following 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 hours after a stroke). These are in Bradford, Calderdale, Leeds and Wakefield. Led by West Yorkshire Association of Acute Trusts on behalf of the Stroke Programme, the Harrogate hyper acute stroke care services (first 72 hours of care) were transferred from Harrogate to Leeds and York in April 2019. These are important changes to improve patient care smoothly, with no challenges for patients, public or trusts. It demonstrates the strength of the Partnership. We will 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.

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](#).



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 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 local places will use this specification to determine what further actions, if any, will be required to achieve these standards.

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 harness clinical leadership, expertise and encouraging a culture of continuous improvement. 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 which aims to remove the obstructing blood clot from arteries; 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 aim is to have a highly skilled and knowledgeable workforce to ensure people are seen at the right time, and receive the right care in line with national guidelines.



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
- We will increase the % of patients that are admitted to a specialist stroke unit within 4 hours.



Respiratory conditions

Respiratory disease affects one in five people and is the third biggest cause of death in England (after cancer and cardiovascular disease). Lung cancer, pneumonia and chronic obstructive pulmonary disease (COPD) are the biggest causes of death¹. Respiratory disease kills 115,000 people each year, the equivalent of one person every five minutes².

Lung disease is strongly linked to social deprivation and health inequalities. People from the most socially deprived 20% of the population, are two and-a-half times more likely to have COPD and nearly twice as likely to develop lung cancer compared with someone from the least deprived group in society.

The [BLF's Battle for Breath](#) is one of various publications that have explored the link between lung disease, levels of social deprivation and health inequalities in a range of lung conditions. Lung cancer and COPD are considerably more common in the most deprived communities, due to their association with smoking.



Outdoor air pollution, which is generally higher in deprived urban areas, is known to worsen symptoms of lung disease and can cause lung disease to develop. Diesel is a known carcinogen.

In responding to respiratory issues we will therefore focus on targeting and supporting those who suffer social disadvantage and experience health inequalities.

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.

As socio-economically disadvantaged groups of people are disproportionately represented amongst smokers the smoking cessation activity is supported in our programme to tackle health inequalities.

Our Partnership has led on identifying and promoting good practice in the provision of pulmonary rehabilitation across the whole of the north of England. 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 improve respiratory outcomes and tackle health inequalities - and across the north as a whole.



Working closely with [RightCare](#) and the Partnership's Clinical Forum (our clinical leadership) has previously reviewed clinical practice across our six places and the impact this had on people with respiratory disease. It identified good practice that was shared across West Yorkshire and Harrogate to improve outcomes.

We will learn from existing good practice within West Yorkshire and Harrogate, as well as other successful models of improving respiratory outcomes such as the Welsh Respiratory Health Improvement Group.



The Clinical Forum has initiated a collaborative project across the Partnership to achieve our respiratory ambitions across our six local places. This will accelerate improvement in respiratory outcomes and reduce unwarranted variations in citizens' care. This project will build upon existing good practice within the Partnership, whilst bringing learning from outside the Partnership to further inform improvement. The development process will be underpinned by a bottom up clinically led improvement model, designed to improve both the competence and confidence of primary care staff in tackling respiratory issues.



Together with the Joint Committee of Clinical Commissioning Groups (CCGs) the Forum will provide on-going oversight of the project, ensuring that meaningful processes and targets are in place, and monitoring these to ensure achievement.

The Partnership's clinical lead for respiratory will work closely with clinical commissioning group respiratory leads. The Partnership and CCG leads will work with the developing Primary Care Networks (PCN) to establish respiratory interested clinicians in each of the PCNs. Over time, as recommended by the [National Review into Asthma Deaths](#), practices will also be encouraged to have both a GP and a nurse who will take the lead on respiratory. This structure will allow for information, guidance and support to be quickly disseminated.

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¹ NHS Long Term Plan

² The British Lung Foundation's ['Battle for breath'](#)

Practices will be encouraged to join the [Primary Care Respiratory Society](#) (PCRS) giving them access to up to date information and learning opportunities. The CCG and PCN respiratory leads will be encouraged to enrol on the PCRS [Respiratory Leadership Programme](#) where they can hone their respiratory leadership skills, and we can develop a network of respiratory champions across West Yorkshire and Harrogate.

Underpinning this work will be a programme of quality improvement and behavioural change. A trained coach will work closely with one practice initially and develop a model to help clinicians embed gold standard respiratory care into their day to day practice. They will use the [Primary Care National Asthma and COPD Audit](#) data as a blueprint for gold standard care in combination with a behavioural change model. Once established, this model will be rolled out across West Yorkshire and Harrogate with ongoing training and support for practices.

The team will work with other colleagues from Partnerships programmes (such as cancer, and population health improvement) to ensure effective co-ordination of activity, ensuring people do not fall down gaps in services, or there is wasteful duplication.

Our five year ambitions:



Treating tobacco dependency



The successful work to reduce tobacco dependency will continue.

Pneumonia

We shall develop a pneumonia pathway for use across primary care and A&E providing:

- Clearly defining the antibiotics to use and when
- Clearly defining the reasons for patients to move to hospital based care – whether as a day- or in-patient and in doing so improve and optimise our care for patients experiencing pneumonia.



Case finding and diagnosis

We shall identify 'missing cases' by interrogating primary care records to find those at risk of COPD or asthma and not on the register for either of these conditions:

- People presenting with respiratory symptoms who are aged over 35 and are a smoker or ex-smoker
- People with undiagnosed asthma or COPD, for example
 - 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



- People with potentially misdiagnosed COPD and asthma

One option to access this data is to use the Optimum Patient Care Research Database (OPCRD), this has already been used in Bradford's CCGs, and we shall look at extending its usage across the whole of West Yorkshire and Harrogate

Taking a detailed history and examination of these patients will then ensure a correct diagnosis and further diagnostic tests will be offered including, for example spirometry (a simple test used to help diagnose and monitor certain lung conditions by measuring how much air you can breathe out in one forced breath)

To ensure success we shall:

- Undertake a mapping project to identify health care professionals who are currently and are interested in developing their skills. Ideally, we would like to identify at least one interested clinician in each PCN
- Monitor key performance indicators and explore the gap in performing spirometry – ie 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 i.e. are The Association of Respiratory Technology and Physiology (ARTP) trained
- Make primary care spirometry results available when a patient is admitted to hospital
- Make hospital spirometry results available to GPs and any other point of care in the community
- Comply with the requirement of the [COPD Care Bundle](#) to check spirometry results at admission in all cases of acute exacerbation of COPD. This can be monitored via the National COPD Audit
- Develop a variety of options, which reflect our demography and primary care resources, to provide quality assured spirometry for all patients across West Yorkshire and Harrogate. These will include spirometry services in local diagnostic centres, mobile hubs, individual GP surgeries, and access to hospital based respiratory function laboratories.

Pulmonary rehabilitation and breathlessness management

We shall develop breathlessness services based on the Cambridge Breathlessness Intervention Service, in order to better support patients and carers to manage breathlessness.

We shall train nurses in primary care, providing care for respiratory patients, in Cognitive Behavioural Therapy in order to support patients with their mental health, anxiety and breathlessness management. Training courses will be run as a blend of online and face to face training, such training has been shown to be both cost effective and reduce hospital admissions.

We will look at new and novel ways to carry out annual reviews and breathlessness management. These might include providing them in a group setting to, among other benefits, improve efficiency in primary care.



We shall also ensure that pulmonary rehabilitation will 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 patient, these should include:

- Standard 6-8-week pulmonary rehabilitation course
- Standard 6-8 week generic pulmonary and cardiac rehabilitation programme

³ www.ersjournals.com/press/2311/treating-COPD-CBT-reduces-anxiety-hospital-visits

- Individually tailored rehabilitation in the home
- [MyCOPD](#) app supported pulmonary rehabilitation
- Breathe Easy Groups
- Local signposting to physical activity.

We commit to ensuring that 80% of patients recommended by [NICE](#) to receive pulmonary rehabilitation will be referred for it by March 2024.

To improve uptake of pulmonary rehabilitation we will look to 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

We shall 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

To ensure quality outcomes for people, we shall monitor the performance of the pulmonary rehabilitation services according to NICE standards⁴ and through participation in the The National Asthma and COPD Audit Programme (NACAP) pulmonary rehabilitation work stream.

⁴ www.nice.org.uk/guidance/qs10/chapter/Quality-statement-4-Pulmonary-rehabilitation-for-stable-COPD-and-exercise-limitation

Medicines management

We are presently developing local guidelines for inhaler therapy for COPD and asthma, these reflect the up to date clinical evidence and are being produced after extensive consultations with primary and secondary care. Over the next three years we will build on these current local guidelines and work towards a West Yorkshire and Harrogate wide set of guidelines.

Checks of inhaler therapy will be performed on a regular basis consistent with NICE standards. There are several key points for this intervention:

- Annual clinical review at GP practice
- Collaborative working with pharmacists and implementing inhaler support services across West Yorkshire and Harrogate
- Monitoring over-reliance of inhalers in patients with asthma
- Review after acute exacerbation - GP practice or Integrated COPD Service
- Hospital admission for acute exacerbation of COPD - part of the [COPD Care Bundle](#).

In addition to primary care directly supporting patients in their effective use of inhalers we shall also use self-management tools such as videos, and new technology, such as [MyCOPD](#).

Continuous monitoring of the pattern of prescribing inhaler therapy in both primary and secondary care will identify trends for deviation from the local guidelines, and process will be in place to remedy this.

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 a special interest in respiratory disease.



^ Photo credit. Mid Yorkshire Hospitals NHS Trust



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.

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.



We 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 ambitions:

- We will increase the number of people referred to the NHS Diabetes Prevention Programme by 50% by 2023/24
- We will roll out of the digital NHS Diabetes Prevention Programme 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.

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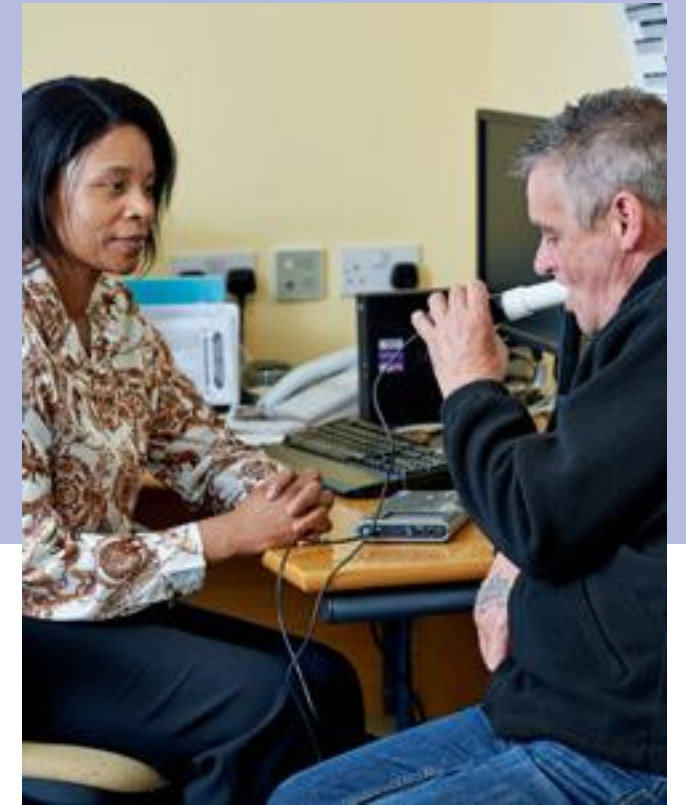
Cancer



One in two of us will be diagnosed with cancer in our lifetime; however, 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.



^ Nurse Fancisca supporting patient John through his targeted lung health check in Bradford

Our [Cancer Alliance](#) is in a strong place to deliver improvements, 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. This 5 year strategy and the capability to work together as a system gives us the opportunity to ramp up our ambition and sharpen our focus to tackle variation and inequalities, 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. It will be crucial to pull together as a whole system to **deliver the national ambition that by 2028 three in four cancers will be diagnosed at an early stage when curative treatment is an option.**

We are working together to reduce preventable cancers before they appear

Lung cancer is our biggest cause of cancer deaths and impacts disproportionately on our most deprived communities.

- West Yorkshire and Harrogate is an early engagement site for the national Healthy Living for Type 2 Diabetes which will provide education for people with Type 2 diabetes. The roll out will begin 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) can 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.



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. The Alliance will collaborate with the broader Partnership prevention activity, continuing to support the [NHS Smokefree Pledge](#) and through our Tackling Lung Cancer Programme investing in specialist smoking cessation support and community support, focusing on capturing patients at teachable moments.

We will find more cancers before symptoms appear by increasing screening uptake

During 2019/20 and beyond we will use transformation funding to increase uptake in the national screening programmes, working with partner screening leads in NHS England and Public Health England. 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.

Shahida Noor, Macmillan Support Co-ordinator > with the Bradford personalised support co-ordination pilot (left) and Rebecca Jowett, Cancer Alliance Living With and Beyond Cancer Programme Manager, at a national personalised care event.

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 and other seldom heard groups such as people with learning difficulties to improve equality of uptake. We will make access to screening easier for people for whom current settings present a barrier to uptake, for example, exploring use of colposcopy clinics to enable women with a physical disability to have cervical screening. We will also explore approaches to support uptake of HPV vaccination in boys developing resources for use in communities and schools.

Working together to diagnose more cancers faster and earlier

Over the past two years Cancer Transformation Funding has been used to test 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.



There is now robust evidence that earlier diagnosis of lung cancer 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.



We have already begun pilot work to apply this evidence in parts of Bradford and Wakefield which have a combination of high smoking rates and poor clinical outcomes in some of our most deprived communities. The estimated outcomes from the Wakefield and Bradford pilots is 100-120 cancers being detected, 75% of which are expected to be at an earlier stage and just 25% at late stage. This is the reverse of the normal stage split currently encountered. 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 five year research programme, the Leeds Lung Health Check service, funded by Yorkshire Cancer Research has started in Leeds. We will be carefully evaluating this work and guided by findings will expand across the Alliance, in line with the NHS Cancer Programme.

The Alliance team works closely with provider colleagues and West Yorkshire Association for Acute Trusts to improve our pathways.

In July 2019 we launched an 'improvement collaborative' approach led by our acute hospitals chief executives and attended by more than **100 patients and cancer team members** from across our Alliance.



^ Three of the Chief Executives from the West Yorkshire Association of Acute Trusts (WYAAT) at the launch of the WYH cancer improvement collaborative – (left to right) Julian Hartley, Owen Williams and Martin Barkley.

We committed to putting people with cancer at the centre of the way we work together, breaking down organisational barriers and learning and sharing what works to give the best outcomes and experience.



We will continue to support providers to understand capacity and demand for diagnostics across our system, making the most of our diagnostic resources through networking, use of digital technologies, flexible and integrated use of workforce (in collaboration with Health Education England). This work will support development of a strategy for expanding diagnostic capacity, requiring additional workforce, capital equipment (including CT and MRI) and recurrent funding of associated activity, increasing the emphasis on proactive investigation of symptoms to deliver faster, safer diagnosis of cancer and other conditions where earlier diagnosis can improve outcomes.

Over the next few months we will develop a clear vision for where additional capital funding could support earlier diagnosis across our communities so that we have a strong business case should capital funding become available. This will also support implementation of the 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.

Key to earlier diagnosis and a good outcome is the availability of rapid diagnostic pathways to get people onto the correct treatment pathway as early as possible.



We are working across the Alliance to implement nationally agreed 'optimal pathways' for patients whose symptoms indicate an obvious referral route.



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, such as unexplained weight loss, pain or fatigue could indicate a range of conditions.

Over the past two years the Alliance has invested transformation funds across our providers allowing them to test approaches to managing these non-specific symptoms.

Over the next five years we will be developing a more consistent approach to integrated rapid diagnostic services for this group of potential cancer patients in line with the national service specification. We will design services which deliver a holistic diagnostic service to establish the cause of the troubling symptoms and appropriate onward referral, rather than just to exclude or confirm cancer.

Our Alliance vision is a service model integrating diagnostic expertise in primary and secondary care featuring 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 other possible cancer symptoms.

Developing more holistic investigation and providing a greater range of managed pathways should reduce the chance of people experiencing delays in diagnosis because symptoms are less clear cut. As it is often those in our population least able to speak up for themselves who can get stuck in a 'diagnosis loop' this should also contribute to reducing inequalities in access and outcomes.

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.

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We will work together to deliver more consistent access to optimal treatment and faster, safer and more precise treatments



Over the next year we will establish optimal pathway groups 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 also build on and develop our pilot work to review multi-disciplinary team working to maximise use of our specialist workforce.



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 for implementation in subsequent years.
- We will work with the regional Genomic Laboratory Hub to promote 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 WYAAT 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 linking active research and development and improved outcomes.





^ Cancer charity Hope for Tomorrow and Airedale NHS Foundation Trust launched a new mobile cancer care unit for West Yorkshire.

We will offer personalised care for all patients and transform follow up care.

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 stop once cancer treatment is complete 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 which meets both 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. 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.

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. We have also been working with patients, carers and professionals on the particular needs of people whose cancer is treatable but not curable.

Supported by [Macmillan Cancer Support](#) the Alliance is providing practical help to front line staff in our acute hospitals to spread the availability of the Recovery Package and risk stratified follow up pathways. We will also be testing approaches to improved community based support for people affected by cancer. We will build on the findings from a pilot multi-agency scheme in Bradford to support people to live better with and beyond cancer (case study video). 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 progressing the following:

- By 2028, 55,000 more people in England will survive cancer for five years or more each year; and
- By 2028, 75% of people nationally 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.



Supporting unpaid carers

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). **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.**

Case study

In April 2019 we brought together over 100 carers and health and social care partners 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.



^ Photo credit: Carers Leeds

Watch this film with Karen, who is a carer for her wife, talking about her experiences and the support she receives from Carers Leeds [here](#).

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 showed 61% of carers are more likely to have a long term condition, disability or illness compared to 50% of non-carers.

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Our six 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 organisations also support carers to have essential time out from caring. Our approach relies on the expertise of councils and community organisations to develop share and implement good practice and funding opportunities.



Case study

In Bradford, Christopher Fisher, is able to receive respite from his caring role for his father looking after birds of prey due to receiving a time out grant from his local carers organisation' Carers Resource. Christopher cares for his wheelchair-bound father, 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, 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.



In this film young carer Kirsty talks about her experiences and the support she receives from Carers Leeds. Watch it [here](#).

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.





Bradford districts Care NHS Foundation Trust runs three Carers Hubs across their district that provide free activities, support and advice for carers, from mindfulness to infection prevention. This also offers them the chance to meet other carers and take time out for themselves.

Case study

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. We are rolling these events out across other areas of the Partnership.



You can read the report [here](#).

Our achievements

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
- All acute and mental health trusts have signed up 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 six 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 is 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:

- 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.

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Our priorities for supporting carers over the coming years are as follows:

Primary & community care	Working with our hospitals	Young carers
• West Yorkshire and Harrogate clinical leaders to adopt quality markers within their Primary Care Networks and GP practices by 2024. 	• Development of carers contingency plan. • Every organisation to have a carers champion at board level.	• To have delivered three young carers careers events with a proposed reach of 2000 people and 240 young carers in attendance. • Supporting our GP practices to proactively identify and support young carers. 
Indicator: • All Primary Care Networks/GP practices to have signed up to deliver quality markers by 2023.	Indicator: • Contingency plan available across West Yorkshire and Harrogate. • 3000 carers signed up to carry a carers contingency plan by 2021.	Indicator: • Number of young carers who attended careers events. • All GP practices to have signed up to the top tips checklist for young carers.

Carer awareness, communications and engagement with Black Asian Minority and Ethnic and LGBTQ+ community and young carers

We aim to improve the lives of all carers over the next five years (cont.)



- 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.



Personalised care

- All size places prioritise carers as a cohort group within their social prescribing plans by 2019
- Embedded social prescribing approaches for carers to maintain health and wellbeing.



Indicator:

- All six of our local places have plans to support carers in their social prescribing models by 2020.

Working carers

- All NHS trusts to have adopted a digital working carers passport including a suite of digital resources for line managers to support their working carers.



Indicator:

- All NHS trusts to have adopted the Working Carers Passport by 2022.

Mental health

- For mental health trusts to:
- Adopt the Dementia Charter
 - Be carer friendly and adopt the six principles of good practice (Triangle of Care, 2010)
 - Easier access to social prescribing and self management support for carers.

Indicator:

- All mental health trusts to have signed up to carer friendly environments and the Dementia Charter by 2021.

Carer awareness, communications and engagement with Black Asian Minority and Ethnic and LGBTQ+ community and young carers

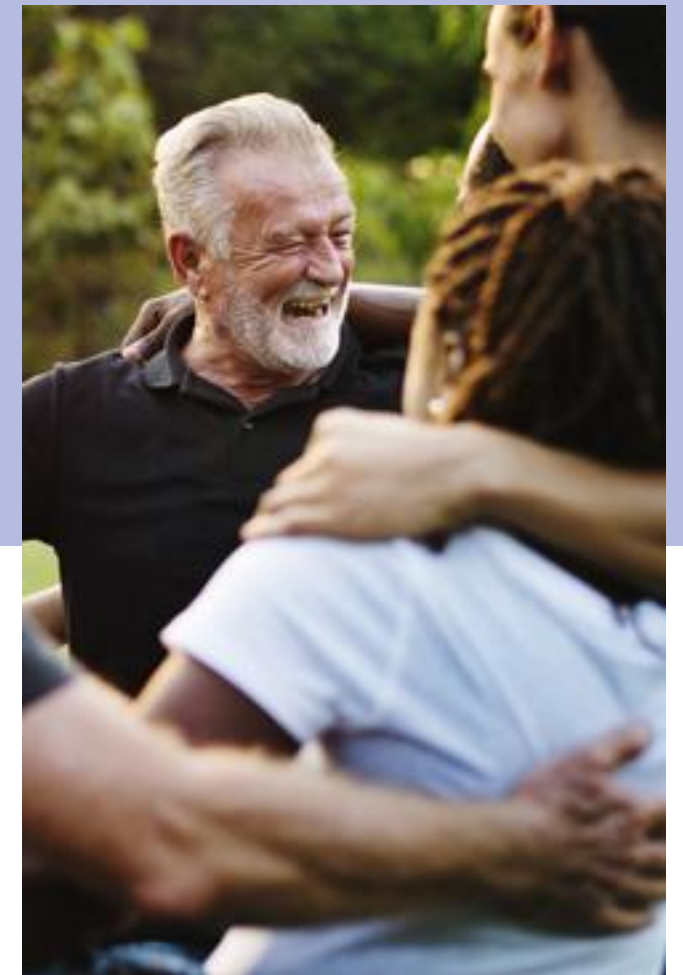


Improving care for people at the end of their life

Death is an inevitable part of life and an incredibly important life stage. However, there is significant unmet needs and many people do not get access to the right care and support before they die. More than half of the complaints referred to the Health Service Ombudsman in the UK concern end of life care, and over half of these are upheld.

This challenge will grow over the coming years, as there is a sustained increase in the number of deaths, and more deaths that are at an older age, and associated with greater complexity, multi morbidity and dementia.

The case for better palliative and end of life care contributes to each of the 'triple aims' of the 'Five Year Forward View', and is a priority in the NHS Long Term Plan. The NHS Long Term Plan requires systems to personalise care, to improve palliative and end of life care.



Our commitment to boosting 'out of hospital' care supports patient choice in receiving end of life care in all settings and the most effective use of resources:

- At least 20% of the entire NHS budget is spent on care provided to someone in the last year of life, and the majority of this is the cost of acute hospital care
- Around 30% of people in our acute hospital beds are in the last year of their life.

End of life care is a priority for the Partnership. The aim is to achieve the highest quality palliative and end of life care across all settings and reduce health inequalities for our population, taking account of the different needs of local communities. Working with hospices across our six local places is key to our approach.



A roadmap to achieve this is provided in 'Ambitions for Palliative and End of Life Care, 2015/20' and embodied in the statement: 'I can make the last stage of my life as good as possible because everyone works together confidently, honestly and consistently to help me and the people who are important to me, including my carers'.

We are committed to ensuring that all people with end of life care needs are identified and those that require specialist services can access these seven days a week in all settings.

Below you can see an example of how partners are working together in Kirklees, to support people and families around quality end of life care.



Case study

In Kirklees, The Valleys Health and Social Care Network is a primary care network (PCN) including six GP practices. They work in collaboration with a range of local organisations and healthcare providers. The Valleys PCN decided to focus on improving end of life care for the registered population. The PCN undertook a clinical audit to assess the current baseline performance to understand how people on a palliative care pathway are managed locally. The audit helped to inform needs and understand better areas of focus. People are recorded on the Electronic Palliative Care Co-ordination System (EPaCCS) to ensure their wishes and priorities are kept up to date. A long term objective is to reduce the number of avoidable hospital admissions and deliver end of life care in an increasingly integrated way.

We want to see improvements in palliative and end of life care that will benefit all our communities. We will focus on improvements that can be made at scale across the partnership, and identifying best practice that can be shared in each place.

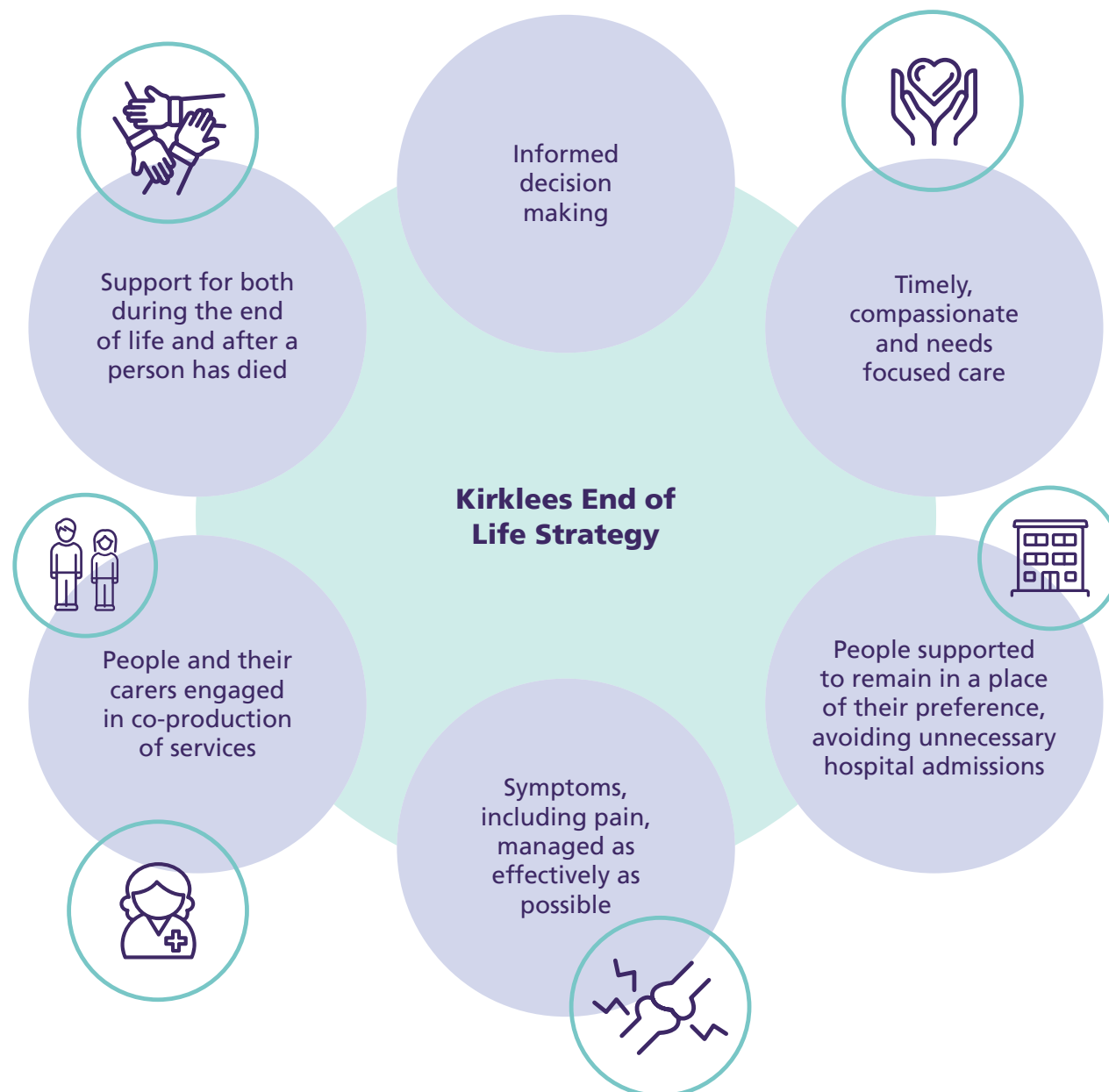
Progress will be reviewed using three key metrics:

- Number of people on a GP palliative care register per 100 people that died
- % of people who have three or more emergency admissions during last 90 days of life
- Bereaved carers survey at least annually which will include core questions agreed across the Partnership.

Focussing on improving care for people at end of life will not only improve outcomes and experience for people, it will also improve health and care flow. It will reduce the pressure on ambulances, urgent and emergency care and hospital beds through timely and appropriate responses to urgent unscheduled needs in their usual place of care.



^ Photo credit: Kirklees Council





Chapter 5

Supporting work programmes

What we cover in this chapter:

142 Supporting people who work in health and care

152 Innovation, improvement and digital

160 Finance



Supporting people who work in health and care



Staff are our most important asset. Well over 100,000 people work in health and care across West Yorkshire and Harrogate.

This number continues to increase 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 evolving to meet the needs of our communities, changing the way that healthcare is delivered requires a reshaping of the health and care workforce.

New individual and team functions are emerging with an increased role for lead professionals working alongside family, carers and unpaid volunteers. There is a greater role for staff 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.**



Our intention is to ensure that our staff base is representative of the people we serve, this will include individuals from minority groups in prominent 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 modern employer. This is especially important if we are to attract and retain our workforce.

We are developing a system wide workforce plan that is inclusive of all staff from health and social care not simply the traditional NHS workforce. This will outline how future demand can be achieved via various means such as increasing supply, retention strategies, upskilling the current workforce, supporting new models of care, international recruitment and new role development. This will be available early in 2020.



Volunteer, carer, and community sector engagement is critical.

There is a need for a shared understanding of their hugely important role across the Partnership so we can support, develop and promote the work that they do. This will be done in partnership with our priority programmes, including supporting unpaid carers and community organisations.

In order to succeed we need to plan the future health and social care workforce together rather than simply considering individual organisation demands, this will offer potential efficiencies in situations where staff can be 'shared'.

It will also 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 Action Board (LWAB) and Health Education England (HEE), to develop solutions that will allow our system to develop and thrive.

Primary care, maternity and mental health all have 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.

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 59) where people are cared for in the community as opposed to hospital settings wherever possible.

We are aligning our priorities to the recently published NHS Interim People Plan, whilst keeping in view all the Partnership workforce challenges. On page 142 is a summary of current initiatives and future priorities. Our six local places are already making great progress against the NHS Interim People Plan and the LWAB will be taking forward system wide priorities addressing those "wicked issues."



^ Photo credit: Leeds Council

West Yorkshire and Harrogate Health and Care Partnership is made up of six local places: Bradford district and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield

Making West Yorkshire and Harrogate the best place to work

The NHS is the largest employer in England. 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 Asian and Minority Ethnic (BAME) staff. We need to work hard to improve the experience of these individuals 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. In addition we need to change the perception of the NHS and promote it as a positive and rewarding place to work.

Health and social care staff often work in a stressful environment that is operating at full capacity, where unmet needs are prevalent and resources scarce; this combination of factors contributes to possible practice mistakes.



Culture change is needed to **make sure staff feel supported** when things do go wrong.

Following the establishment of the [West Yorkshire and Harrogate Excellence Centre](#) we have made good progress in supporting our workforce through the identification of 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 providers, 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 for several role groups.

Specific career campaigns have been produced including one around Operating Development Practitioners (see below).

Case study

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 was called 'the most rewarding job you probably never heard of'.



You can watch the campaign film [here](#).



You can find out more about other workforce developments on our website [here](#).

Improving leadership



An 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 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 x](#)) and across West Yorkshire Association of Acute Trusts ([see page x](#)). Many fellows take up senior leadership roles earlier if they feel better supported.



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 a new role of nursing associate that is designed to work in collaboration with existing healthcare support workers and registered nurses to deliver clinical care for people.



In 2018 we had **379 nurse associates** starting in West Yorkshire and Harrogate and have aspirations for a similar number in 2019.

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^ Photo credit: Leeds Council

- 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. **Our six 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 take increased numbers of students, including within primary care and care homes
- We are currently piloting a programme within our Local Maternity System that is designed to improve employee engagement and wellbeing whilst delivering service change, as this programme progresses it will be evaluated and lessons learnt then shared across other areas and programmes.

Case study

In Bradford, a health and care industrial centre of excellence works with schools to help young people find out about careers, gain work shadowing experience, and know which courses and qualifications they need to get started. Bradford ran a summer school at the University of Bradford where young people worked with health and care staff on projects, learnt new skills and furthered their understanding of the sector. In Bradford employment rates amongst south Asian women are lower than for other groups. As a Partnership we have a need for more people in care roles, and a need for the workforce to better mirror the diversity of our communities.



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 34).



We will look at transforming the workforce and explore new ways of delivering care using multidisciplinary teams and new and different skill mixes.

New roles will emerge, as well as the utilisation of existing roles in different ways. In addition our current workforce will need new skills to achieve our aspiration of attaining integrated primary care and community 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 the ageing population.



We will support the growth of new roles, such as advanced clinical practitioners (ACPs), physician associates and nursing associates.

In 2018, **110 advanced clinical practitioners 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.**

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 across the region.** All colleges are addressing their curriculum with a view to offering more generalist training; however this is moving at varying 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 of the levy to pay for apprenticeship training** in other health and social care organisations. **This money could fund at least 108 jobs across the region.** We are looking to grow apprenticeships for both clinical and non-clinical roles, 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 152) to ensure we have a digital ready workforce with a **clear plan for developing the workforce to facilitate, 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.

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 **£1 million 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 continue to support transformation across the area.



In 2018/19 Health Education England invested £3.8 million in workforce development

and in 2019/20 this will be £4m. This is largely being utilised to fund continuing professional development programmes from universities and other education, training providers.

Our Partnership agreed to pool the entire budget for West Yorkshire and Harrogate, with decisions being made collectively 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 and the ambulance service, alongside universities.

If we are to truly transform our workforce over the next five years and make West Yorkshire and Harrogate the best place to live and work, we need to be more ambitious and show system wide working with all our partners. We have an opportunity to take on a greater leadership role in workforce planning, though this will require investment and partnership working in a way which has never been done before.

The table on page 149 outlines some of the ambitions for the next five years, all of which will be expanded in our workforce plan, with agreed action plans, performance indicators and impact assessments.

Making West Yorkshire and Harrogate the best place to work

- Offer all incoming employees across the system 'a job for life'
- Enable a Partnership wide passport, with standardised job descriptions and recruitment
- Provide more flexible models of employment (step up/down, retire and return, return to practice)
- Promote Partnership wide career campaigns, pathways and educational opportunities, particularly around apprenticeships
- Analyse the Workforce Race and Disability Equality Standards data and staff survey to identify key West Yorkshire and Harrogate equality issues and priorities and share good practice
- Agree key principles and share good practice around health and wellbeing of our employers, including tackling bullying and harassment
- Provide appropriate support for staff following serious incidents.



Improving leadership culture (across West Yorkshire and Harrogate)

- Identify opportunities to offer Leadership Fellowships within the Partnership
- Agree a talent and succession plan and strategy for the ICS
- Ensure that all population groups are visibly represented in leadership roles across the Partnership, particularly amongst the BAME (Black, Asian and Minority Ethnic) workforce
- Embed a 'one team' ethos throughout our Partnership, to help break down historical boundaries between professional groups.



^ Photo credit: Carers Leeds

Urgent actions on nursing

- Work collectively with our universities and providers to increase placement capacity (exploring new models of supervision)
- Introduce rotational working and roles (acute hospitals, mental health, primary care, voluntary and community sector)
- Work with larger organisation such as the armed forces and retail industry to attract new people
- Roll out of RePAIR 2 recommendations to minimise attrition
Find out more [here](#)
- Explore the potential to support overseas educated nurses who are residents in the UK and working in non-registered roles to enter the register
- Explore 'back to the floor' programmes to support those Registered Nurses whose registration has not lapsed but are out of practice to return to clinical practice settings
- Ensure that candidates can access support to achieve academic requirements in order to start programmes.



Releasing time for care

- Work with the digital programme to enable a digital ready workforce
- Assess the digital literacy/ preparedness of our workforce
- Explore digital innovation to support workforce learning and development
- Develop a pipeline of digital health practitioners in preventing ill health, primary care, secondary care and mental health.



Workforce redesign

- Initiate a higher education training collaborative that starts people on appropriate health and care programmes
- Encourage shared training and education of all disciplines and grades at every available opportunity
- Look for opportunities for alternative staff groups to deliver care
- Offer rotational posts within the Partnership to assist in the delivery of care in the difficult to recruit areas
- Work with employers/universities to offer dual programmes and awards to enable blended skills
- Ensure public health knowledge and skills and health inequalities are included in the development of further, higher education courses
- Develop a voluntary service overseas offer
- Develop a model of employment (including preceptorship) for physicians associates (PAs) in primary care.



Securing current and future staff

- Work with higher education institutions to develop a pathway in order to "grow our own" – via apprenticeship and similar 'on the job' routes
- Make training flexible, with 'step on/off' points
- Explore a way to facilitate a 'system surplus' of individuals to work across employers as required to provide 'backfill' in order to allow staff to access training (apprenticeship)
- Explore avenues to offer work to people that have successfully rehabilitated
- Explore the option of guaranteeing under-represented communities jobs within West Yorkshire and Harrogate.

Analysis insight and affordability

- Agree a standard workforce modelling tool across West Yorkshire and Harrogate to assess supply and demand and look at this across all sectors including public health, social care and primary care
- Look at a Partnership approach to procuring, managing and supporting international recruitment.



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 \(AHSN\)](#).



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.



Case study

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 people are most likely to take their lives. The prototype of the automated suicide predictor is locally adapted to the Trust. The AI could be adapted for other mental health services.



^ Scan4Safety

The Partnership is mobilising to deliver [The NHS Patient Safety Strategy](#). Working with Yorkshire & Humber Academic Health Science Network (AHSN), we will strive to understand our safety culture and embed principles of safety culture in all that we do. We will learn from our partners with excellent safety practices and spread their lessons so that we can effectively measure patient safety locally, respond to safety incidents and rapidly respond to concerns. Our programmes that support our workforce and local people are critical to our patient safety ambitions.



We will support our staff who are involved in patient safety incidents with insights gained from our local Patient Safety Translational Research Centre on 'second victims' and we will support carers to advocate for safety through evidence-based techniques.

Building on the work of Yorkshire and Humber Patient Safety Collaborative, delivered with the AHSN, **the Partnership will continue to reduce avoidable harms.**

The initial focus will be on medicine safety, people where illnesses are worsening and maternity services. We will extend across this work across mental health, frailty, learning disability and antimicrobial resistance over the course of the next five years. Safeguarding the most vulnerable people in our community is a shared responsibility for our Partnership. We will build on the infrastructure we have already in place to better prevent abuse and neglect. Integral to our plans to make people safer is our commitment to both innovation and improvement which is underpinned by 'Human Factors; the science of patient safety'.



Our strategy has three themes:

1

Spread and adoption of innovation:

Led by the Yorkshire & Humber Academic Health Science Network (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.

2

Discovery:

We will work to identify NHS and care-sector system needs and generate innovative responses including Medtech and new processes, pathways and techniques.

3

Improvement:

Foster the systemic adoption of continuous improvement for quality, safety and innovation.

>>

Spreading good practice

The commitment to national funding for the AHSN until April 2023 supports 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 [Leeds 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** (accurate at August 2019). This is as many as 400 strokes avoided over five years (see page X)
- '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 babies 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. 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. 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

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.**

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 signed 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](#).



Case study

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.



Improvement

With the support of the 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 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.

We 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 the AHSN to ensure people can fully benefit from breakthroughs enabling prevention of ill-health, earlier diagnosis, more effective treatments, better outcomes and faster recovery
- Implement the regional Test Bed Clusters from 2020/21
- 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 whose illnesses are worsening and maternity services
- 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



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 as six local health and care systems.

The Digital Health and Wellbeing Charter for Yorkshire and the Humber underpins the commitments of all Partnerships like ours across the area. It includes a set of principles and standards that seek to **develop our collaborative working to ensure partners maximise the opportunity from our collective digital delivery across Yorkshire and Humber** for the benefit of communities and the wider health and care workforce.

This approach will provide the foundations to become an exemplar region for health and care digital delivery, data and research. The Charter includes:

- Developing our health and care, business and professional leaders to understand how digital enables transformation
- Work together to address digital inclusion across the region so all can benefit from digital innovations in their health and wellbeing
- Enable our workforce to effectively use digital services to do their jobs
- Integrate with, use and leverage maximum benefit from the Yorkshire and Humber Care Record
- Adhere to a common set of digital principles and standards.



**Yorkshire & Humber
Care Record**



^ Photo credit: AHSN and Healthwatch

The Digital Programme has seen many successes this past year. This past year the 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. This work will continue this year where 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. The Digital First objective will continue with all primary care work.
- In 70% of our GP practices there is now free Wi-Fi for people to use. 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 NHS Foundation Trust. The Shared Care Record Programme will also provide a person held record and access to the summary care record for all of our patients using the NHS App. Further work is being planned utilising the three Integrated Care Systems that form the Yorkshire and Humber Care Record. This is likely to include joint work on advancing a digital workforce and digital citizens, remembering the importance of supporting all patients and citizens.
By 2023/24 16.8% of people will have registered for the NHS App
- We are supporting easier working for our staff by putting in GovRoam wifi 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 the end of this year.** Easier working will include enabling community and mobile workers with the right tools
- A new, secure health and social care communications network is being put in to replace the old, separate networks for 64+ organisations. Implementation is taking place now and will complete by the end of the year.

This has already been successfully tested between The Mid Yorkshire Hospitals NHS Trust and Bradford Teaching Hospitals NHS Foundation Trust.



Case study

SmartLeeds is fundamentally changing not just the way people can engage with digital services but more importantly providing them with the technology to do so. Leeds has already loaned over 300 iPads to people and is deploying high-speed internet. These changes, among others, will enable people to take advantage of digital services, like health care video consultations. Their aim is to engage with 10,000 people each year.



Case study

In Kirklees over 100,000 people now use their Alexa, MyCitizenAccount, to access Kirklees Council services. People can ask Alexa about their waste collection and their council tax, among many others. This approach is accessible for many people that cannot personally attend council offices or phone or use mail services. A truly inclusive initiative. Kirklees is showing us the way for all of our health and care services, opening up better access to community pharmacies and the NHS App as a start.



Case study

Our ambulance service has been developing their own electronic patient record, by staff, for staff and ultimately to expedite emergency care. Their electronic patient record (ePR) allows them to capture key clinical information electronically so that it can be shared with A&E departments on route.

Next steps

We welcome the Healthwatch engagement findings (June 2019) and the [West Yorkshire and Harrogate engagement and consultation mapping](#) on digitisation and personalisation. We are taking people's views seriously and are including them in our strategy. The information will be used to inform further work with people who access care and wider public involvement.

Principles have been developed to direct the strategy. These principles support the sharing of resources to leverage expertise, consolidation of common technologies for future financial savings and the utilisation of negotiating power.

This sharing will ensure A&E departments have time-sensitive information pushed to them before patients arrive by ambulance. We will also prioritise sharing information with care homes, community pharmacies and hospices along with sharing appropriate information with social care to support carers and in support of safeguarding. In the longer term this will support shared care plans between all organisations.



We have 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 technology. We will also ensure we design solutions with staff
- Supporting the programmes of work to digitally streamline urgent and emergency care, i.e. clinical information between ambulance and hospitals
- Continuing the work to digitally mature our organisations, including for example the completion of electronic prescribing solutions
- We have also prioritised establishing mechanisms to share resources, conduct joint procurements, support development and application of innovation, apply standards, 'how to' guides, 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, removing faxes by 2020, a digital Redbook for babies by 2021, and expanding our use of analytics and modelling for planning purposes.



Finance



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. 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 which 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.

Council 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.

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 (accurate at November 2019).

For 2019-20 the scale of the financial challenge remains significant. But the NHS system in West Yorkshire and Harrogate is now forecasting the delivery of a £24m surplus for the year.



This surplus position is after the provision of incentive funding (£72m) and non-recurrent support funding to organisations that would otherwise be in deficit (£32m); without this funding, we would have a planned deficit of £80m. This position is subject to a lot of potential risk. We need to deliver efficiencies higher than the 1.1% minimum; an average of 2.81% for the system as a whole (a total of £224m) – failure to manage either has the potential to impact heavily on how much of that money our Partnership may get.

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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.

Although there are still a few organisations that continue to forecast deficits up to the end of the current medium term planning period ending in 2023-24, as a partnership we will work closely together to deliver all of the funding commitments highlighted in the long term plan, whilst also ensuring we deliver services in more efficient ways.



By making sure we do everything right the first time, working together to deliver economies of scale in purchasing, streamlining services for the benefit of people and generally making sure all elements of waste are reduced across the Partnership, people experience will be improved and we will begin to work towards a more sustainable financial situation for the Partnership.



^ Photo credit: Leeds Irish Health and Homes



For 2020/21 onwards all incentive payments will be rolled up into one combined Financial Recovery Fund, aimed at supporting the cash position for organisations in deficit, and there will also be an additional scheme (worth 0.5% of income) to reward providers that maintain surpluses in 2020/21, or move from a deficit to a surplus position during the five year planning period. When taking these payments into account, the Partnership plans to improve its financial position every year for the next five years. It will increase surpluses from 2020/21 onwards.

The reliance on the use of the financial recovery fund (FRF) remains relatively high in 2020/21 compared to the years after that. Principally because of the fact that some of the financial risks in 2019/20 can only be solved in that year non-recurrently. That means that the underlying position (i.e. the one excluding non-recurrent savings used in the year) would be worse if those things didn't happen. Savings made non-recurrently in 2019/20 will need to be replaced by recurrent ones from 2020 onwards. This will increase the size of the challenge in 2020 and savings plans after that are mainly based on the delivery of recurrent efficiencies.

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. It is 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.



Read the NHS Long Term Plan [here](#).

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, 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 people.



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. This 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 the Partnership has a clear understanding of the financial allocations in each of our six local places.

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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.



Money is a finite resource and so difficult choices will still need to be made around where it is best spent. 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 and ask for people's views.

Innovation and best practice is at the heart of how we work together. 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. This means no one loses out on incentive funding. Control totals are being replaced by Financial Improvement Targets for the next four years, and our Partnership approach of agreeing to work together towards a shared total will continue.

The Partnership will receive additional funding over the next five 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. Some of the allocations are to fund specific things, and the table below provides a breakdown of where additional funding is expected to go.

Long Term Plan (LTP) allocations	2019/20 £m	2020/21 £m	2021/22 £m	2022/23 £m	2023/24 £m
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	18.6
LTP funding allocation, total	26.7	27.6	39.2	58.0	83.5

‘Other’ in the Long Term Plan includes cardio-vascular disease, stroke and respiratory (mainly funding new drugs and rehabilitation services), children and young person services, maternity, learning disabilities, autism and prevention (funding things like smoking cessation).

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 page 165) 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 direct 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. (accurate at November 2019).

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 £67m of transformation funding from national organisations to support these projects.

The table on page 165 highlights the key areas that have benefitted from this funding in the past, and those it continues to support today.

Funding	2016/17 £m	2017/18 £m	2018/19 £m	2019/20 £m	Total £m
Cancer	0.2	7.0	5.4	6.6	19.2
Urgent and emergency care	6.2	4.4	6.3	3.8	20.7
Primary care	-	1.7	2.6	5.6	9.9
Mental health, learning disabilities and autism	-	-	0.3	5.5	5.8
Digital	-	-	0.1	-	0.1
Improving the health of the population	-	2.7	0.9	1.4	2.3
Voluntary and community sector	-	-	1.0	0.9	1.9
Other	-	0.7	2.5	3.7	6.9
Total	6.4	13.8	19.1	27.5	66.8

Capital and buildings

We have significant capital requirements to ensure that our buildings and equipment are fit for purpose and meet people’s needs. Our capital and estates strategy summarises the approach and requirement.

Working together gives us a better chance of bringing additional money into the area to invest in our staff, buildings, community partners or digital technology. It also gives us greater buying power and the potential to make savings by buying things together, for example medical equipment.

Through working together since 2018 the Partnership has secured the largest share of national capital investment totaling £883m for ten schemes. These include £197m to support the reconfiguration of the hospitals at Calderdale and Huddersfield NHS Foundation Trust, £600m for Leeds Teaching Hospitals NHS Trust to build two new hospitals (one for children and one for adults) at Leeds General Infirmary (LGI) which will benefit the wider region. £27m has also been allocated to create a brand new specialist hub laboratory for the West Yorkshire and Harrogate Pathology Network. We are also seeing investment in mental health services with £11m for rehabilitation and recovery; and £13m for a much needed specialist regional mental health unit for children and young people.

We will transform hospital services by investing in a world class children's hospital and adult facilities at our regional specialist centre at Leeds General Infirmary. This will include continuing our conversations with local people and staff for their views.



As well as receiving £29m to support the delivery of specific programmes over the last two years, for example cancer and mental health we have also received over £17m to invest in the areas we decide as a Partnership are a priority for us. This has included us boosting investment in voluntary and community organisations, targeting loneliness, in accelerating the pace of our primary and community care networks, in prevention services and developing localised approaches to improved mental health.



^ Photo credit: Airedale NHS Foundation Trust



These Partnership priorities are agreed by our Partnership Board. The Board is an important group for our Partnership, as it puts elected members, non-executives and public lay members at the heart of our strategic decision making process.



Read about our Partnership board [here](#).

Over the next five years capital expenditure is forecast to significantly rise across the Partnership. Funding for this higher level of expenditure is expected to come from a number of different sources, some of which are likely to be subject to external agreement, but the aspiration to invest for the benefit of the West Yorkshire and Harrogate population is clear.



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.



'Scan4Safety' [GS1 - £15million]

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.



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. Hospitals are working together with hospitals in Hull, North Lincolnshire and York as the Yorkshire Imaging Collaborative. They aim to ensure that every patient in our part of the region can 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.



NHS Capital Funding [£12million]

£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](#).



Read our blog to find out more about funding arrangements [here](#).



Strengthening our health and care partnership



^ Partnership Board co-opted members



^ Marie Burnham, Independent Lay Chair for Joint Committee for the Clinical Commissioning Groups

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 in the crux tends to always be about relationships and how they are changing.

If our Partnership is transforming what it does, **we need to 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**. This aims to create an environment and culture conducive to change, collaboration and partnership that enables 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 our Partnership Memorandum of Understanding [here](#).

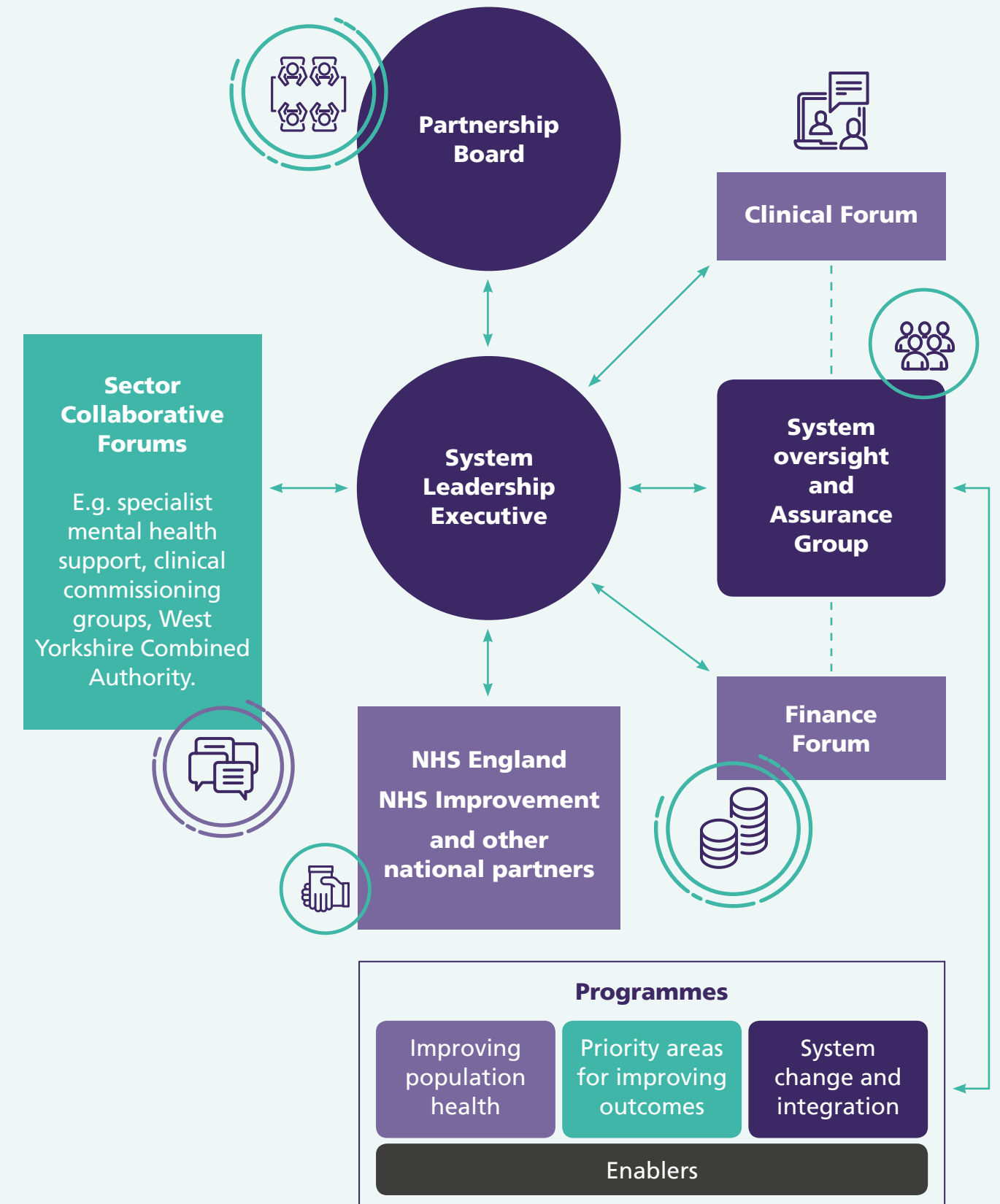
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✓ Cllr Tim Swift, Leader of Calderdale Council and Chair of West Yorkshire and Harrogate Health and Care Partnership Board



The diagram below shows how the way we work fits together.

Bringing together the way we work at a West Yorkshire and Harrogate level



West Yorkshire and Harrogate Health and Care Partnership is made up of six local places: Bradford district and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield

We are a Partnership of places, sectors and programmes

There are well established partnership working arrangements in our six local places, 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 the Partnership's 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 [here](#).

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.

Developing our partnership commissioning arrangements

The functions of commissioning are moving in three directions:

- Commissioning functions built into Integrated Care Partnerships (ICPs)
- Closer integrated commissioning of services in place and at a West Yorkshire and Harrogate level between clinical commissioning groups (CCG), local councils and providers
- Services commissioned once at a West Yorkshire and Harrogate level – delivering the aim in the NHS Long Term Plan to enable single commissioning decisions at system level.

Our view is that a single clinical commissioning group for a system as complex as West Yorkshire and Harrogate would not lead to better outcomes for the 2.7 million people who live across the area. We believe this would dilute accountability and would be too far removed from communities. Instead we want to focus activity at a local place level, where most of the work happens.

At a West Yorkshire and Harrogate level, we have already added significant value by working together at system level:

- Delivery at scale, for example acute stroke reconfiguration and integrated urgent care procurement
- Tackling wicked issues, for example standardising commissioning policies, evidence based interventions and our work to end the 'postcode lottery'
- Learning from each other, for example atrial fibrillation (to prevent stroke and save lives), the Healthy Hearts project; quality and equality impact assessment.



We will build on these successes and consolidate these arrangements over the coming years. We will work with NHS England/NHS Improvement to explore ways to better integrate specialised services into care pathways, focussing on population health for West Yorkshire and Harrogate. We will do this through lead provider and collaborative commissioning approaches.



By developing commissioning in this way, we will combine the strong local relationships of our six places with the capacity and organisation to do things once, at scale, across our system where it makes sense to do so.

▼ Stuart a helpful, kind neighbour from Leeds





Useful information



Get involved

You can get involved in health and care in many ways, by becoming a member of Healthwatch or joining our health and care champions group for people with learning disabilities.

You can also volunteer with a health and care organisation or charity. Many of our programmes also include opportunities to join their steering groups and these are advertised on our website. The list is endless.

The Partnership Board meets in public every three months, four times a year. You can also access the agenda, papers and watch the meeting live [here](#).

Our Joint Committee of the Clinical Commissioning Groups meets in public every other month. The Joint Committee meets in public every other month. You can also watch the meeting live [here](#).

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To register your interest in attending these meetings or to ask a question before the meeting takes place please email westyorkshire.stp@nhs.net or call 01924 317659. You can also contact us with any other questions you may have. Our contact details are on the back cover.

Films

A wide range of films have been produced to support our work.



You can access our YouTube account [here](#).

Acronym busters

NHS Confederation have brought together definitions of more than 1,000 commonly used acronyms and abbreviations in the NHS.



You can view it [here](#).

Helpful publications

We publish a range of plans, publications and engagement reports.



You can find these [here](#).

'Looking after our neighbours' campaign.



Find more information about the campaign [here](#).

West Yorkshire and Harrogate Health and Care Partnership communication and engagement plan.



You can find the plan [here](#).



There is also an easy read version [here](#).



Our engagement framework is also on our website [here](#).

Useful web links

- ✎ [Healthwatch UK](#)
- ✎ [Local Government Association](#)
- ✎ [NCVO \(national council for supporting the voluntary sector\)](#)
- ✎ [NHS England](#)
- ✎ [NHS Improvement](#)
- ✎ [NHS Providers](#)
- ✎ [NHS Confederation](#)
- ✎ [NHS Clinical Commissioners](#)
- ✎ [Nuffield Trust](#)
- ✎ [The Kings Fund](#)
- ✎ [Yorkshire & Humber Academic Health Science Network](#)

This information is available in alternative formats, for example EasyRead, audio and British Sign Language.

For more information contact:

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 @WYHpartnership

A Partnership made up of the NHS, local councils, care providers, Healthwatch, voluntary and community organisations and charities.

West Yorkshire and Harrogate
Health and Care Partnership





Delivering better health and care for everyone

Summary of our Five Year Plan

West Yorkshire and Harrogate
Health and Care Partnership





You can 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 [here](#)

You can also find out more about the positive difference our Partnership is making online [here](#)

We also want to say thank you to all the people who've shared their stories so far and given their views about health and care in West Yorkshire and Harrogate.



Watch our thank you film [here](#)

We are committed to honesty and transparency in all our work and also producing this information in accessible formats. Our Five Year Plan summary is available in:

- Audio
 - EasyRead
 - BSL
 - Animated film
- Watch [here](#)

For more information:

 visit www.wyhppartnership.co.uk

 or call 01924 317659

This information was accurate at November 2019.



Our Partnership



^ Photo credit: Leeds Irish Health and Homes

Clinical Commissioning Groups (CCGs)

[NHS Airedale, Wharfedale and Craven CCG*](#)

[NHS Bradford City CCG*](#)

[NHS Bradford Districts CCG*](#)

[NHS Calderdale CCG](#)

[NHS Greater Huddersfield CCG](#)

[NHS Harrogate and Rural District CCG](#)

[NHS Leeds CCG](#)

[NHS North Kirklees CCG](#)

[NHS Wakefield CCG](#)



Local councils

[City of Bradford Metropolitan District Council](#)

[Calderdale Council](#)

[Craven District Council](#)

[Harrogate Borough Council](#)

[Kirklees Council](#)

[Leeds City Council](#)

[North Yorkshire County Council](#)

[Wakefield Council](#)



Care providers

[Airedale NHS Foundation Trust](#)

[Bradford district Care NHS Foundation Trust](#)

[Bradford Teaching Hospitals NHS Foundation Trust](#)

[Calderdale and Huddersfield NHS Foundation Trust](#)

[Harrogate and District NHS Foundation Trust](#)

[Leeds Community Healthcare NHS Trust](#)

[Leeds and York Partnership NHS Foundation Trust](#)

[Leeds Teaching Hospitals NHS Trust](#)

[Loca Community Partnerships](#)

[The Mid-Yorkshire Hospitals NHS Trust](#)

[South West Yorkshire Partnership NHS Foundation Trust](#)

[Tees Esk and Wear Valleys NHS Foundation Trust](#)

[Yorkshire Ambulance Service NHS Trust](#)

Others involved

[Healthwatch](#)

[Health Education England](#)

[Leeds City Region Enterprise Partnership](#)

[NHS England](#)

[NHS Improvement](#)

[Public Health England](#)

[Universities](#)

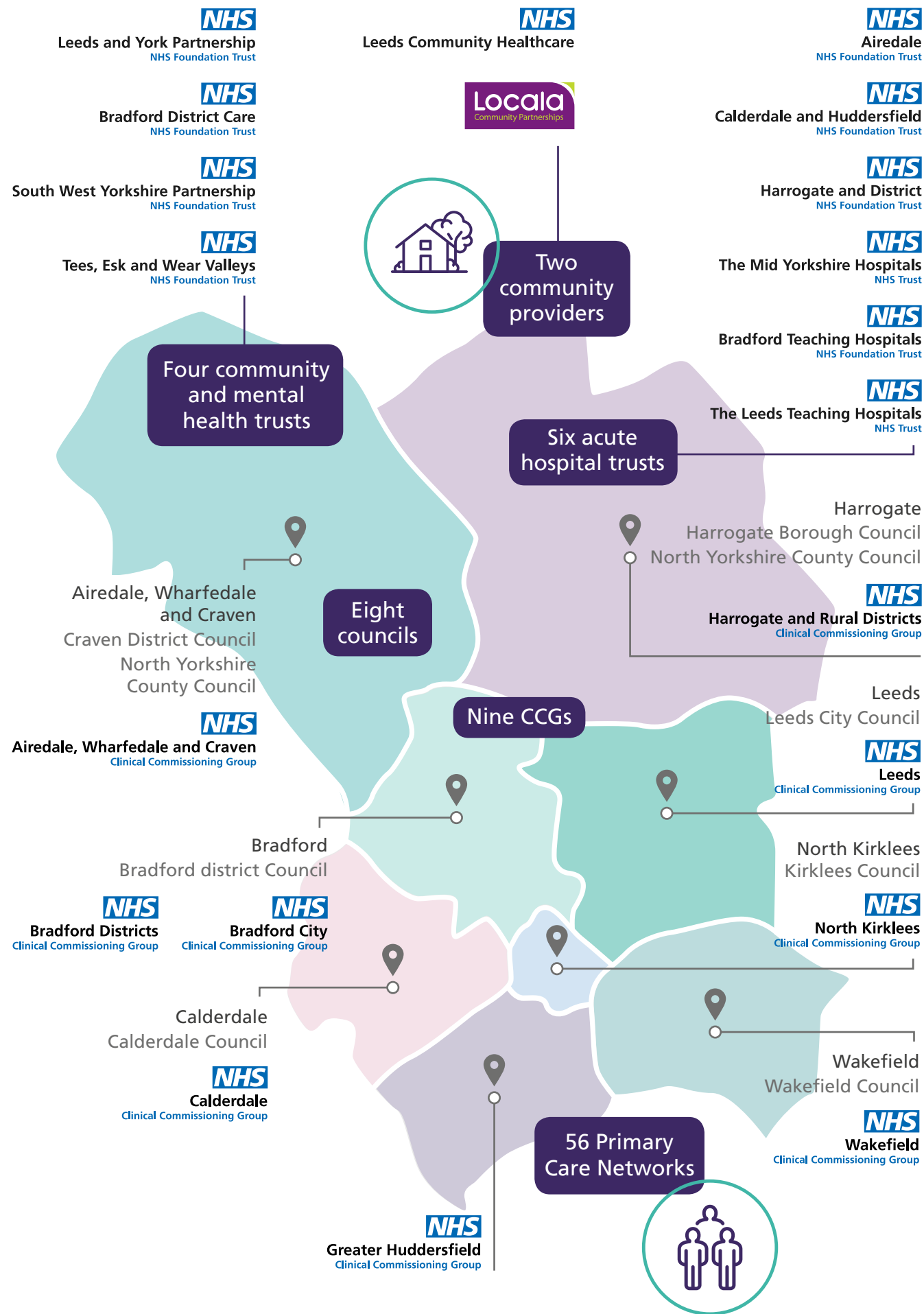
[West Yorkshire Combined Authority](#)

See page 4 for more partners

The third sector: is made up of voluntary and community organisations, charities, social enterprises, co-operatives, faith based initiatives and other bodies with a not for profit constitution.

**The future plan is to have one NHS Bradford District and Craven, Clinical Commissioning Group from April 2019*

West Yorkshire and Harrogate Health and Care Partnership is made up of six local places:
Bradford district and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield



The West Yorkshire and Harrogate Health and Care Partnership is made up of organisations working closely together to plan health and care services across the area.



Our health and care landscape

Our councils



- 316 GP practices
- More than 600 care homes
- 555 community pharmacies, plus 38 online
- 11 hospices
- 431 providers of services in people's homes
- Thousands of voluntary and community organisations including those who support carers
- Hundreds of independent care providers

Figures accurate at November 2019.

West Yorkshire and Harrogate Health and Care Partnership is made up of six local places: Bradford district and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield



Introduction

Stronger, better, healthier together

Since our Partnership began in 2016, we have worked hard to build the relationships needed to deliver better health and care locally and across West Yorkshire and Harrogate with people to improve lives.

We are pleased with the progress we have made. We are confident we have developed the right principles and values to guide us. We are keen to 'join the dots' so when people experience care, advice, support or treatment it feels joined up, is easier to find your way around and results in better outcomes.

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. This includes working with partners to create good jobs and increase everyone's lives with investment in skills, housing, culture and infrastructure. To have the best chance of achieving this, we need to think and work differently with each other and with our communities.

As a Partnership we embrace community partners in our conversations and are listening 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 shared purpose.



Our Five Year Plan tells the story of how we are going to do this together.



You can read the Five Year Plan at: [add link once complete](#)

This sets out all our five year ambitions, some of which are included on page 12.

Proud to be a partnership



Our strength comes from starting with people where they live, their communities and their places. The six local areas (Bradford district and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield) are the bedrock of better health and care across West Yorkshire and Harrogate. Working together these areas can both enhance their unique strengths but draw upon trusted strong relationships across a wider area.

Why work together?

We know people's lives are better when organisations who provide health and care work together, particularly at the times

when people most need it. People's lives are better when we plan, and invest in services that support mental and physical health at the same time.

We also know that sharing good ways of working makes the money go further, creates the best use of staff expertise and increases the quality of what we all provide.

By working together, it gives us the chance to create the conditions so that children get the best start in life and everyone's chance of living a long, healthy life improves.

Community conversations

Effective public involvement, particularly with those with lived experience and who are seldom heard, ensures that we make the right decisions together about health and care services.

Over the last three years we have published all the engagement activity in which we have been involved, for example stroke care and cancer.



A full list of this activity and reports is available on our website [here](#)

These include public assurance groups, patient reference groups, events and community champions. We aim to learn from feedback from all our networks without duplicating effort and cost. Our Five Year Plan sets out further engagement activities needed to realise our ambitions, including findings from the Healthwatch Report (2019).



You can read the Healthwatch Report [here](#). More information on how you get involved is on page 39.



Our ambition is for as many people as possible to contribute, influence and co-produce the direction of the Partnership.

Health and care is far more than services

We know that most of what keeps people healthy and well is a wider set of factors than traditional health and care services. This includes the house you live in, how warm it is, whether you feel isolated or alone, whether you experience poverty, the food you eat every day, how mobile and independent you are, whether you have a job and have access to parks and open spaces.

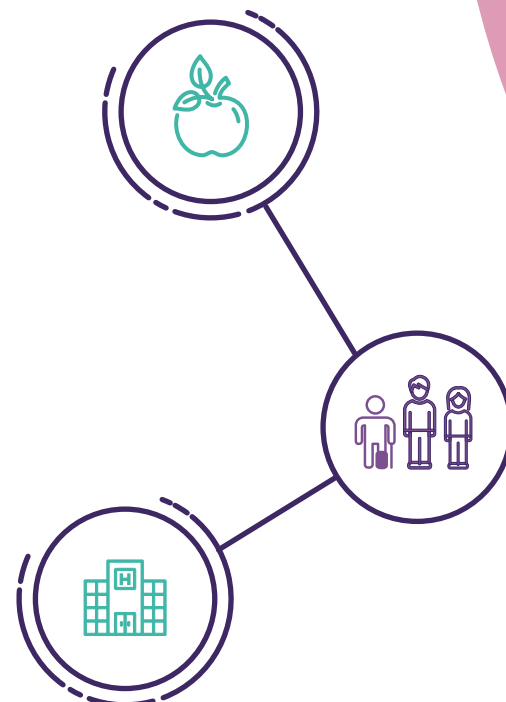
If we want to improve everyone's health, we will have to target those factors that cause some people to experience significantly worse health.



Our vision

- **Places will be healthy; you will have the best start in life so you can live and age well, and die in the place of your choosing.** We will work to make sure you are not disadvantaged by where you live, your background or what you do.
- If you have a long-term health condition **you will be offered personalised support to self-care.** This will include peer support, technology and communities of support from people like you.
- If you have multiple health conditions, **you will be in a team with your GP, community care staff, social services and voluntary and community organisations working together.** This will involve you, your family and carers, the NHS, social care and community organisations. All working on what matters to you.
- If you need hospital care, it will usually mean that your local hospital, which will work closely with others, will give you the best care possible.
- **Local hospitals will be supported by centres of excellence** for services such as cancer, vascular (arteries, veins), stroke and complex mental health. They will deliver world class care and push the boundaries of research and innovation.

- All of this will be planned and paid for once between the NHS, local councils and community organisations **working together and removing artificial barriers to care.**
- People and staff will be involved in the design, delivery and assurance of services so that everyone truly owns their healthcare.



In your neighbourhood and community 01

Your carers will be supported too



And where safe to do so you will be supported to self-care

Health and social care will work together to support your social, physical and mental health



Better use of information and data will be used to organise services around you



You are at the centre of everything we do

You will have the best start in life so you can live and age well.

We will work with you to deal with the issues that affect your health and wellbeing in your communities, whether it's loneliness or learning disability; housing or mental health; childhood obesity or air quality – **together we can make things better with you.**

Across West Yorkshire and Harrogate 03

We will hold each other to account for delivery on our shared issues



Our hospitals will work together so you have the best treatment possible



We will make the best use of all the expertise and staff skills available to us for workforce planning

We will share learning and spread good practice



We will work at scale across the area on wider issues like cancer

02 In your local area



Health and care organisations will work together to tackle inequalities

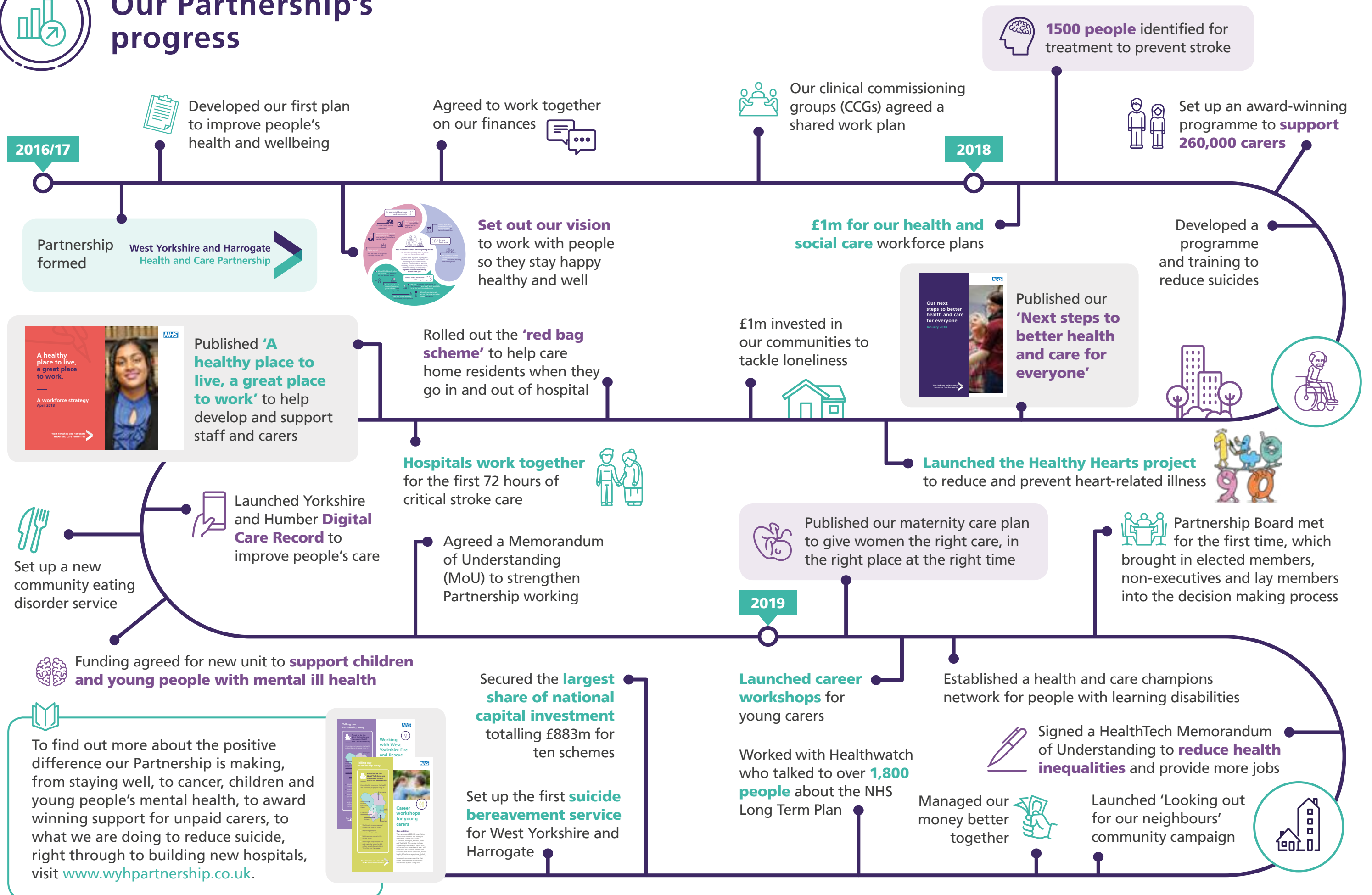


We will focus on the conditions for good health including housing and employment



Our Partnership's progress

Page 292





Ten of our big ambitions

We have been bold in setting out our Five Year Plan. It contains a large number of specific ambitions that we are committed to achieving through our programmes of work. Beyond that we have set ourselves the target of putting our combined efforts into tackling some of the long-term trends that are causing ill-health and unhappiness for people across West Yorkshire and Harrogate. Through working together, we believe will be able to make a measurable difference to people's lives by 2024.



^ Photo credit: WDH

As a successful partnership we expect to deliver on national targets, on people's experience of care, such as accident and emergency, cancer, mental health and operation wait times.



You can read our full Five Year Plan at: [add link](#)

Our ambitions, include the following:

1

We will increase the years of life that people live in good health across West Yorkshire and Harrogate compared to the rest of England. We will reduce the gap in life expectancy between the people living in our most deprived and least deprived communities by 5% by 2024, reducing the gap by six months of life for men and five months of life for women.



2



We will achieve a 10% **reduction in the gap in life expectancy between people with mental health, learning disabilities and autism** and the rest of the population by 2024 (approx 220,000 people). Within this we will focus on early support for children and young people.



3

We will address the health inequality gap for children living in households with the lowest incomes. This will be central for our approach to improving outcomes by 2024. This will include **halting the trend in childhood obesity**, including those children living in poverty.



4



By 2024 we will have increased our **early diagnosis rates for cancer**, ensuring an additional 1,000 people will have the chance of curative treatment.

5

We will reduce suicide by 10% across West Yorkshire and Harrogate by 2020/21 and a 75% reduction in targeted areas by 2022.



6



We will achieve at least a **10% reduction in anti-microbial resistance infections** including a 15% reduction in antibiotic usage by 2024.

7



We will achieve a **50% reduction in stillbirths, neonatal deaths, brain injuries** and a reduction in maternal morbidity and mortality by 2025.

8

We will have a **more diverse leadership** that better reflects the broad range of talent in West Yorkshire and Harrogate. Poor experiences in the workplace that are particularly high for Black, Asian and Minority Ethnic (BAME) staff will become a thing of the past.



9

We aspire to become a global leader in responding to **climate emergency** through increased mitigation, investment and culture change throughout our system.



10



We will **strengthen local economic growth** by reducing health inequalities and improving skills, increasing productivity and the earning power of people and the region as a whole.

Living and working in West Yorkshire and Harrogate

West Yorkshire and Harrogate is home to 2.7million people. We are recognised nationally for having a strong, successful economy where everyone can build great businesses, careers and lives - we are immensely proud of the area and our diverse communities.



Well over 100,000 people work directly in health and care across West Yorkshire and Harrogate. Many more work in the businesses that make and supply goods and services to our health and care sector, and at least as many again volunteer their time and skills in hospitals, care homes, community organisations and support groups. The numbers of people employed have been increasing year on year. However, the increasing pressures of work have made it difficult to recruit and retain enough staff to meet people's health and care needs.

Reports of poor experiences in the NHS workplace are particularly high for Black Asian Minority Ethnic (BAME) staff.



We will work hard to improve staff experience and ensure that our **whole workforce reflects the diversity of our communities and is supported to deliver the highest quality of care.**

In addition we need to change the perception of health and care services and promote it as a positive and rewarding place to work.

Over 260,000 people in our area are unpaid carers for their family, friends or neighbours. Their investment in time alone is worth the equivalent of £4.5bn each year to our regional economy. But nationally, we know more than 600 people a day have to leave their jobs to care for a loved one, because it is incompatible with work.



Our aim is to provide adequate support for unpaid carers and to give them every opportunity to stay well and in work, should they wish.

Our workforce plan '[A healthy place to live, a great place to work](#)' sets out our ambitions to develop, train, recruit and retain staff across all health and care sectors, including the NHS, councils, the independent care sector, community and voluntary organisations. It also rightly recognises the huge contribution of unpaid carers and volunteers and the support they need to keep doing these important roles.



You can read our workforce plan '[A healthy place to live, a great place to work](#)' [here](#).

The role of the whole third sector (also known as the voluntary and community sector) is vital. From the very smallest volunteer-led community group, to the largest not-for-profit organisation, they enable people to take collective action on issues that matter to them.



Our thriving third sector is a vital part of our health and care system, as they often have established high levels of trust with people who may have faced multiple barriers when accessing statutory services.



^ Photo credit: Leeds Carers

Working together across West Yorkshire and Harrogate

We know that in some areas it makes sense to work together across West Yorkshire and Harrogate. We apply three tests for joint working:

- Working at scale to ensure the best possible health outcomes for people
- Sharing good practice across the Partnership
- Working together to tackle complex (or 'wicked') issues.



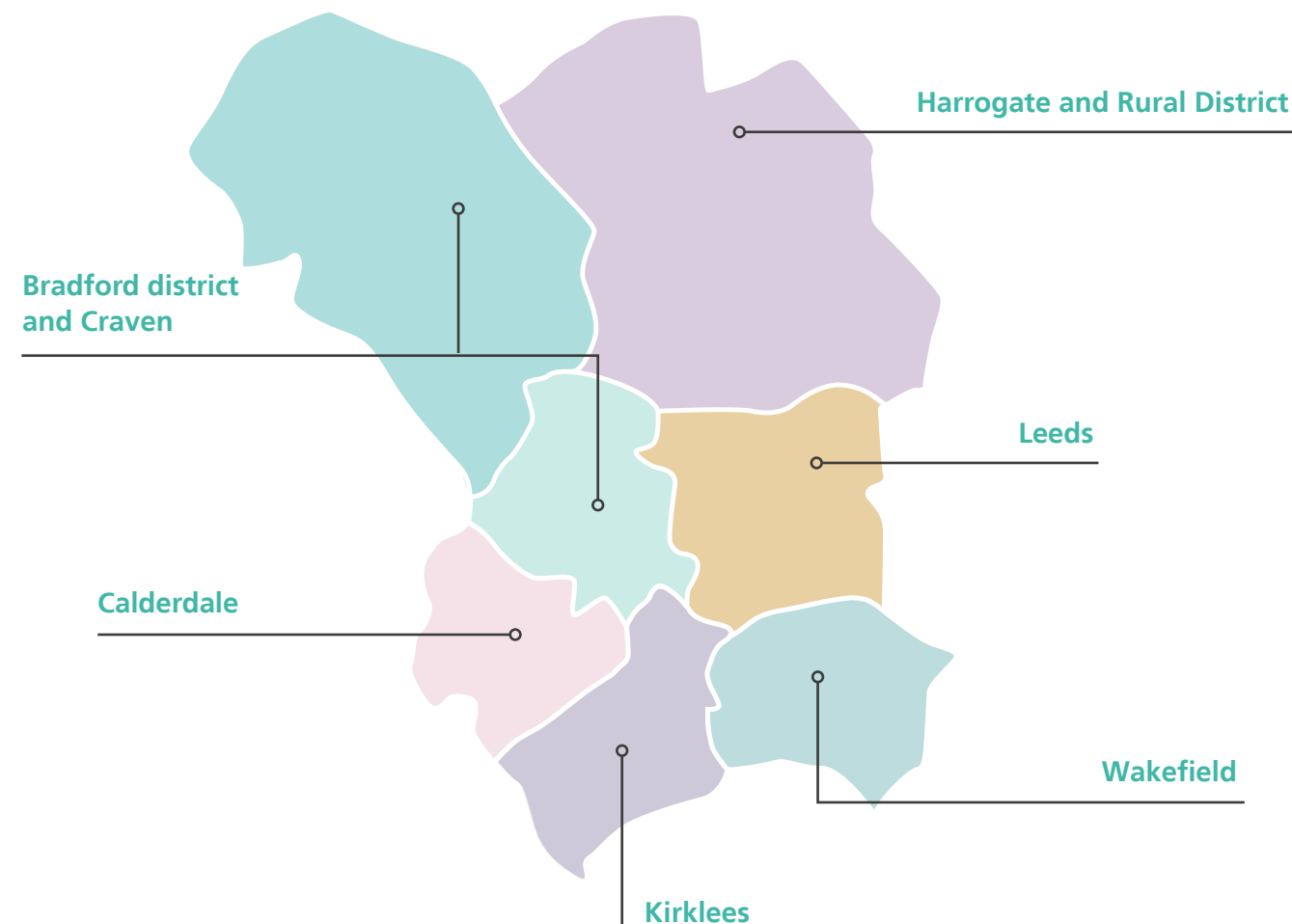


Our six local places

The six places that make up West Yorkshire and Harrogate are different and unique. However, they share challenges and have one common goal - to improve people's health and wellbeing through delivering quality care and support when needed. Each of these places brings unique strengths and perspectives to the Partnership.



^ Stuart, a helpful, kind neighbour from Leeds



Bradford district and Craven

Bradford district and Craven is a place of great contrasts. It is served by a health and care system working closely together to support people to be 'Happy, Healthy at Home'. This includes providing nationally recognised innovative paediatric services in the community and ensuring stays in hospital are amongst the shortest in the country.



Bradford is the fifth biggest metropolitan authority in the country (534,000) and the UK's youngest city with one in four residents aged under 16.

36% of people are from BAME backgrounds (Black, Asian and Minority Ethnic).

Craven brings together 55,000 people living in rural communities spread across 450 square miles of North Yorkshire. Together, Bradford district and Craven is served by a health and care system committed to supporting people to be 'Happy, Healthy at Home'.

▼ Photo credit: City of Bradford Metropolitan District Council



There is much to support wellbeing in Bradford district and Craven, ranging from magnificent landscapes, a UNESCO world heritage site marking our rich industrial heritage, and a cultural vibrancy borne of this internationally connected city.

27% of the Bradford district's population are classed as in the 10% most deprived areas in England whilst, in Craven, one ward (where 2,200 people live) is amongst the 20% most deprived in England. 22% of children are growing up in poverty. As a result the healthy life expectancy of people living here is below average, and the inequalities between communities are significant. For example, a woman in Bradford typically spends 22 years of her life in poor health.

Changing this is what motivates our local health and care partners to work as one partnership together, putting the needs of people first. With much to do we are confident that we can achieve better wellbeing for everyone by working with people through our community partnerships.

Health and wellbeing priorities include:



- Ensuring children have the best start in life
- People have good mental wellbeing
- People in all parts of the area are living and ageing well
- The area is a healthy place to live, learn and work.





^ The Piece Hall, Halifax

Calderdale

Calderdale is home to market towns and diverse communities, set in landscapes ranging from rural settings to green suburbs. When you're in the Upper Calder Valley you're at the heart of the southern Pennines and at the crossroads between Lancashire and Yorkshire. Halifax is home to the world famous Piece Hall.

Most people are fit and healthy, and generally the quality of life here is good. The health and wellbeing of people in some communities is not improving at the same rate as others. Every year, far too many people suffer avoidable ill-health or die earlier than they should.



The ambition is that people of Calderdale can **'lead a larger life' and enjoy more years of healthy life.**

And that the gaps in healthy life expectancy between different communities are reduced; and that everyone, whatever their health or disability, is supported and enabled to lead the fullest life possible.

Local partners tackle these challenges by working together in a more integrated way. Calderdale Cares is the answer. It is a community-led approach for delivering health and social care services and is forging strong partnerships across Calderdale where organisations, including the NHS, Calderdale Council and the voluntary and community sector, are all working together, sharing resources to deliver a range of support to meet each person's individual needs, within their community.

For the people of Calderdale this means:

- Easier and faster access to a wider range of joined-up care where people tell their story once
- Better outcomes based on what is important to people
- Fewer trips to hospital as more services will be available in the community
- More advice and guidance to help people make the right choices and manage their own health
- Better access to local voluntary and community groups
- More involvement in the design of care services near where people live.

Harrogate and Rural District

Harrogate is a relatively rural district of around 160,000 people, centred on the towns of Harrogate and Knaresborough and the cathedral city of Ripon. It is relatively prosperous, and has a comparatively older population. It is located on the borders of the Yorkshire Dales and North Yorkshire Moors national parks.

The people of Harrogate and Rural District benefit from some of the highest rated healthcare in England.

The clinical commissioning group (CCG) also has a larger older population than the national average with **one in five**



residents aged over 60. This percentage is projected to grow.

The increasingly ageing population is shaping the health and care needs of Harrogate and Rural District and local partners are working closely together to evolve the support needed appropriately, including taking a system-wide approach to health and care and looking for innovative ways to do things differently.



Photo credit: >
Harrogate and
District NHS
Foundation Trust

Harrogate and Rural District priorities include:

- A focus on preventing ill-health, early intervention and sustained recovery
- Keeping people out of hospital where appropriate to do so, with a focus on care in the community whenever possible and admission to hospital only when it is the best clinical option
- Integrated community health and social care to deliver a joined up service to local people
- Best practice services for vulnerable people including mental health, safeguarding, children's services and transition to adulthood, and continuing healthcare for those with longer term needs
- Reducing health inequalities and clinical variation across the clinical commissioning group.





^ Marsden, Kirklees

Kirklees

Kirklees is home to more than 430,000 people living in the major towns of Huddersfield and Dewsbury as well as many other towns and villages with strong communities, and even stronger identities. Kirklees forms part of the south Pennines and Peak District National Park and has a thriving cultural industries sector. In Kirklees partners are turning a proud industrial heritage into innovation and entrepreneurship. From advanced textiles to turbo technologies, supplying the Ministry of Defence, the aerospace sector and the motorsport industry including others.

The Kirklees Health and Wellbeing Plan 2018-2023 sets out the ambition that no matter where they live, people in Kirklees can live their lives confidently and responsibly, in better health, for longer, and experience less inequality.

Kirklees priorities include:

- Redouble efforts to shift investment and activity into preventing ill health and early intervention
- Ensure access to healthy housing, decent work and strong communities
- Create environments that enable healthy behaviours
- Ensure interventions are designed and targeted to reduce inequalities
- Promote independence and resilience to start well and age well
- Ensure changes are driven by community assets and strengths to achieve positive and sustainable outcomes
- Further joining up social care and community services with voluntary and community organisations.



The seven shared outcomes are the pillars that support this overall ambition for Kirklees to be a place that combines **a strong, sustainable economy with a great quality of life.**



Leeds

Leeds is home to 887,900 residents and is a vibrant centre for innovation and emerging industries. It is a world leader in health innovation, with 22% of all digital health jobs across England and Wales. The city has an 'outstanding' children's service, is the first UK city to lower childhood obesity, has an 'outstanding' rated clinical commissioning group, 'good' community and secondary hospitals and three leading universities. The newly established Leeds Health and Care Academy promotes training, education and social mobility for existing staff, whilst attracting talented people to work in the health and care sector, including Leeds Teaching Hospitals NHS Trust, Leeds and York Partnership NHS Foundation Trust and Leeds Community Healthcare NHS Trust.



The financial contribution of the 75,000 unpaid carers in Leeds is estimated to be around £1.4billion per year and Leeds has a vibrant third sector with **over 1,642 charitable organisations and over 200,000 volunteers.**

Not everyone is benefitting from this economic success. More than 174,000 people in Leeds live in poverty and population growth is most rapid in the areas experiencing most disadvantage.

Inclusive growth analysis confirms growth of in-work poverty, estimating that over 71,000 working age adults across the city are from working households and in poverty. The Leeds ambition is for everyone to live healthy and fulfilling lives, both now and for future generations. Local partners want Leeds to be the best city for all ages; a healthy, compassionate, climate resilient city with a strong economy, where people who are the poorest improve their health the fastest.

Leeds priorities include:

Leeds partners will be giving specific focus and attention to four areas, these are:

- Get more people more physically active, more often
- Build prevention into everything we do
- Deliver person-centred care every time
- Develop a community model of health, care and wellbeing called 'Local Care Partnerships'.



▼ Photo credit: Leeds NHS





The role of the Partnership

We work together through West Yorkshire and Harrogate Health and Care Partnership **on agreed priorities to improve the health and wellbeing** of people living in our six local places.

Improving population health

- Preventing ill-health
- Health inequalities
- Wider determinants of health and wellbeing, e.g. housing, poverty
- Personalised care

Transforming services

- Primary and community care
- Urgent and emergency care
- Improving planned care and reducing variation
- Hospitals working together

Priority areas for improving outcomes

- Cancer
- Mental health, learning disabilities and autism
- Children and families
- Carers
- Maternity

Supporting work programmes

- Harnessing the power of communities
- Workforce
- Digital
- Capital and estates (buildings)
- Leadership and organisational development
- Partnership commissioning
- Finance
- Innovation and improvement



^ Photo credit: Wakefield Council

Wakefield

Around 325,000 people live in the city of Wakefield and the 'Five Towns' of Normanton, Pontefract, Featherstone, Castleford and Knottingley. The district has a rich industrial heritage, rooted in the former mining industry. Wakefield has a strong cultural history and produced some of the country's most acclaimed artists including Barbara Hepworth and Henry Moore.

The district has a progressive and forward-thinking approach to integrated working across health and care, led by the Wakefield Health and Wellbeing Board and delivered through the Wakefield Integrated Care Partnership.



The Health and Wellbeing Plan includes a strong focus on **tackling the wider determinants of health and building healthier sustainable communities.**

Wakefield's priorities include:

- Ensuring a healthy standard of living for all – developing our approach to early intervention, community regeneration, skills, tackling poverty and the links between health and housing
- Giving every child the best start in life – developing arrangements with the children and young people's partnership to strengthen health and wellbeing services and early intervention for children. This involves working with partners on programmes of work around the first 1,000 days of a child's life, particularly focussing on school readiness, childhood obesity and family poverty
- Strengthening the role and impact of preventing ill-health including supporting people to self-care, where safe to do so
- Creating and developing sustainable places and communities – in areas of high population growth, revitalising neighbourhoods and working with businesses.



Our ambitions

As partners we share many common ambitions – including a commitment to preventing ill-health, removing barriers to accessing care whilst making sure that everyone has the chance to be healthy.

Put simply we want everyone to have **‘somewhere to live, someone to love and something to do’**.



The work we do at a West Yorkshire and Harrogate level reflects and supports these important ambitions.

These ambitions stretch far beyond health services. We have a strong relationship with the [West Yorkshire Combined Authority](#) that is working through the [Leeds City Region Local Enterprise Partnership](#) to develop the Local Industrial Strategy. This is a long-term, evidence-based plan to strengthen local economic growth, improve skills, productivity and the earning power of people living across the region. This firmly aligns to the Partnership’s ambitions and these cannot be seen in isolation of each other.



However, we have a higher rate of people not in work who would like to be,

including people with learning or physical disabilities, with mental illness and carers. For those in work, 25% of the jobs in our area pay below the national living wage. One in three people in our workforce has a chronic health condition that can sometimes affect their ability to work or reduce their ability to work full time or for as many years as they would like before retirement.

There are links between the economic prosperity of our area and the wellbeing of the people who live here, just as there is between a person’s economic circumstances and their lifetime health.

Working together helps us to better understand the role we play as employers in promoting good health and contributing towards the local economy. This includes looking at the main causes of long-term staff sickness, such as musculoskeletal problems (for example back and neck pain) and mental ill-health, which are also major factors in reducing healthy life expectancy.

In West Yorkshire and Harrogate in 2018 nearly two in 10 people reported living with a musculoskeletal condition and around **one in 10 people reported living with a mental health condition.**



There are also inequalities in employment for people with health conditions and learning disabilities. For example there is a gap of between 6.2% (Craven) and 14.5% (Wakefield) in the employment rates for those living with a long-term health condition and overall employment.



^ Photo credit: Leeds and York Partnership NHS Foundation Trust



Our ambition is to improve the healthy life expectancy for West Yorkshire and Harrogate people versus the rest of England, by reducing the gap between the worst off 10% and the wider population by 5% by 2023/24. **This involves improving people’s quality of life.**



By working together on healthier work places we can encourage healthy behaviours in staff, prevent ill health, support people with health conditions to stay working and be more flexible to support people with caring responsibilities. Someone’s skill level at the age of 18 is the single biggest changeable factor in their lifetime health. Just as we know that our area’s prosperity is linked to having people with the right skills across all sectors of the economy, so too is having a healthy workforce.

Working together

Working together also gives us the opportunity to be more innovative – to learn, share and spread good practice on what works.



For example rolling out best practice on atrial fibrillation (detecting abnormal heart rhythm) has **prevented an estimated 123 strokes over the first 18 months** of the programme (accurate at October 2019).

Photo credit: Mid Yorkshire > Hospitals NHS Trust



The Patient Safety Collaborative has **prevented over 2000 people from having a fall whilst in hospital**, meaning they left hospital earlier and with a better quality of life.

Our aim is to continue to deliver world class care and push the boundaries of research and to save people’s lives. As a region we have a thriving university sector, over 250 HealthTech businesses, and a strong [Academic Health Science Network](#). By working collaboratively with these partners, to build a thriving health economy that is open to innovative new approaches to delivering healthcare, we will attract new businesses and jobs to the region. This will help drive improved health outcomes and create an environment that supports retention of staff in healthcare across the region.

Over the next five years more people living across our area will receive the benefits of innovation as it drives faster, more convenient, higher quality care, supported by services that are digitally connected and striving forward to make improvements. Key to this is ensuring staff and citizens have the skills to use the new systems and information since it is people, not systems, who will transform health and care.



Improving health and wellbeing for everyone

What makes a good life?

The factors that keep people healthy are much wider than the impact health and care services have alone. Decisions that affect people's health are not taken solely by health and care organisations, but by a much wider set of partners. For example decisions about transport, housing, parks and countryside, community facilities, the economy, educational opportunities, public safety, opportunities for culture and socialising or air quality are all important to the health of people.

Homes and communities



People who live in neighbourhoods already suffering the most economic disadvantage have the fewest opportunities to benefit from outdoor play or recreation. Through our councils and their relationships with agencies and local groups, we can improve access and opportunities for people to improve their physical and mental wellbeing by accessing the outdoors.

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. We have been identifying good practice in our local places that have proven outcomes.



^ Photo credit: Craven District Council

This has shown that when we work together and learn from each other, we can improve people's health.



Connecting people and communities also has a huge impact on people's wellbeing.

There is strong evidence about the impact of loneliness on a range of conditions and this is one of the reasons we started the 'Looking out for our neighbours' campaign. Evidence shows that people with strong social connections are less likely to visit their GP, take less medication, have fewer falls and are less likely to need residential care in later life.



You can read more about our 'Looking out for our neighbours' campaign [here](#).



Tackling unjust differences

Health inequalities are the avoidable, unjust differences between people or groups due to social, geographical or other barriers. These differences have a huge impact, because they can result in people who are worst off experiencing poorer lifetime health, shorter lives overall and slower rates of recovery from illness.

We know that some people are benefiting more from the improvements we are making than others. Healthy life expectancy varies between our six places and neighbourhoods (page 14). People in West Yorkshire and Harrogate have a shorter average healthy life expectancy than the rest of England. Men's lives are on average one year shorter than the England average and for women almost 10 months shorter.



10% reduction in the gap in life expectancy between people with mental health, learning disabilities and autism.

People with a learning disability have worse physical and mental health than people without.

On average, the healthy life expectancy of women with a learning disability is 18 years shorter than for women in the general population; and the healthy life expectancy of men with a learning disability is 14 years shorter than for men in the general population (NHS Digital 2017).



If average healthy life expectancy is 81.5 years for both sexes, it is on average **15 years worse for people with mental health, learning disabilities and autism** (66.5 years).



Around 480,000 people in West Yorkshire and Harrogate live in areas ranked as the 10% most disadvantaged areas in the country. They are more likely to have a long-term illness or disability and to have been diagnosed with stroke or lung cancer than others. They are also more likely to be living with risk factors for disease such as higher smoking rates and levels of obesity.

>>

Preventing ill-health



In West Yorkshire and Harrogate the leading cause of death is cancer. This 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 one in 10 deaths. Many of these deaths could be prevented. Through changes in the home, work or environment, through personal choices, such as stopping smoking or reducing obesity. It can also be importantly through access to screening and earlier diagnosis and to constantly improving treatments. Also, as more people are surviving cancer for longer, the right support for people living beyond cancer treatment, focused on what is important to the individual, can help people live well for longer.



Over the last 30 years, there has been a sustained increase in the number of older people living longer. This is coupled with an increase in the number of years people are living in ill-health.



It is therefore not only how long people live that is important, but how many years of their life they spend in good health and how many years they live independently free of ill-health or disability.

We need to reduce the factors that contribute towards ill-health; increase earlier detection and diagnosis of disease and better support people living with long-term conditions. This will involve considering the broader factors that protect against ill-health and promoting factors that keep people well.



^ Photo credit: Born in Bradford

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; tackling the wider determinants of poor mental health; seeing fewer people in crisis (including children and young people); less reliance on hospital beds; and fewer people left behind without the support they need to lead a fulfilling life.

Our ambition is to also reduce the number of people getting infections, making sure they are diagnosed early and treated appropriately. This involves reducing the number of antibiotics prescribed where they are not needed.



We will work together to **reduce the number of antimicrobial resistant (AMR) infections by 10%** and reduce antibiotic usage by 15% by 2023-24.



We will remain focused on the lifestyle risk factors for ill-health, including smoking, obesity and alcohol and build on the progress to date by considering additional approaches, for example physical activity, nutrition, and mental wellbeing. This will include increasing the number and quality of annual physical checks for people with learning disabilities or autism, and a stop smoking offer for people in specialist mental health or learning disability services.



The health of children and young people is crucial. England's levels of wellbeing currently lag behind the rest of Western Europe.

In addition to all the factors that determine the health of adults, children's health is also greatly affected by their parent's or carer's physical and mental wellbeing and the stability of the household and family relations they are growing up within.



Just under one in four people who live in our area are currently under the age of 18. A focus on **improving their health and wellbeing is an investment in our future generations.**

>>

^ Photo credit: Mid Yorkshire Hospitals NHS Trust



Many of our children and young people are already achieving positive outcomes and enjoy life to the full. Over recent years we have seen improvements across West Yorkshire and Harrogate, for example **school readiness has increased from 51.2% in 2012/13 to 67.5% in 2017/18.**

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. Rates of children in local authority care are higher in West Yorkshire at 72.1 per 10,000 compared to 63.6 per 10,000 for England. Our focus over the coming years will be on tackling these challenges so all children have the best start in life.



We will work together towards a significant **reduction in the gap for children living in the households with the lowest incomes.**



Climate emergency

Climate change is a global threat. As a Partnership, we believe that we can make immediate changes that could be simple, significant and sustained. We can improve people's health at the same time as making climate-friendly choices – such as improving walkways, promoting active travel to offset reliance on cars, or investing in local food growing.



We aspire to be a global leader in responding to the climate emergency. This can be done by reducing unnecessary single-use plastics in hospitals or care homes, reducing transport costs and carbon emissions by smarter use of technology.

Exploring overall waste in medicines and medical equipment through investing in the development of alternative, lower carbon options is also important.

Together we will increase our preparedness to deal with the direct impact of climate change on health conditions in the UK, including projected increases in morbidity due to air pollution, higher temperatures and extreme weather events.



Together, we aspire to become a global leader in responding to climate emergency through mitigation: reducing carbon through our buildings, our supply chains, how we travel and how we use digital technologies; as well as through investment: encouraging innovation, rethinking and developing climate-friendly products and practices throughout our health and care system.

Suicide

The single largest cause of death in men under 50 is suicide. Mental health issues, relationship breakdown and financial problems are some of the biggest known contributing factors to this.

The Partnership has a vision to reduce all suicides. It is adopting a collaborative, evidence-based approach to ensuring fewer people die by suicide.

We have recruited support workers with lived experience to provide advice, training and support for up to 600 men in the area, drawing on the expertise and relationships in 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 working with public health colleagues to create a high-risk decision support tool for primary and community services. This will better identify people at risk of suicide and will help us target support.



Our ambition is to reduce suicide by 10% across West Yorkshire and Harrogate by 2020/21 and 75% reduction in targeted areas by 2022.



^ Photo credit: Allied Health Professions



Joining up services

Partnerships in our six places make decisions on how they use their collective resources, including buildings and staff. For example, by using their collective expertise and resources to provide higher quality services and use **financial savings to invest in care closer to where people live.**



Our local places all have, or are developing, a 'connecting care' approach. This involves health, social care, housing, voluntary and community organisations working side-by-side, helping those people most at risk to stay well and out of hospital. Multiple agencies work together, often all under one roof, to seamlessly support people with health or social care needs who could otherwise receive fragmented care, with multiple referrals and handovers.



For all our local places, this involves putting people at the centre of their care.

This includes their physical, mental and social needs met through joined up care and support; tackling the wider factors that determine poor physical and mental health and seeing more people before they reach crisis.



^ Photo credit: Calderdale and Huddersfield NHS Foundation Trust



We want to be less reliant on hospital beds and ensure there are more people with the support they need to lead a fulfilling independent life.

Primary and community care services are the day-to-day healthcare available in every local area and the first place people go when they need health advice or treatment. Traditionally, these have been built around the role of GPs, but increasingly primary care is showing better outcomes when it is planned around all professions and community organisations who have a role to play. This includes GPs, community nurses, social care workers, community workers, mental health workers, community pharmacists, allied health professionals (for example art therapists, chiropodists/podiatrists, dietitians, speech and language therapists), advice workers and many other care providers increasingly 'joining up' to improve local services.



This is why as a Partnership **we are supporting the development of 56 Primary Care Networks (PCNs).**



These are localised partnerships, serving between **30,000 and 50,000 people in neighbourhood areas**, that provide the structure and funding for services to be developed locally, in response to the needs of the people living there. Primary Care Networks are built on strong local partnerships already in place.

Working with councils, community organisations, charities and local elected members in their development is important if people locally are to feel the benefits.

Planned and unplanned (emergency 999) patient transport services are key to making sure the needs of people can be met within various healthcare settings. We want to create a hybrid service between emergency and planned patient transport to safely manage the non-emergency cases in a timely way. The transport services programme will improve the national Ambulance Response Programme targets, and **accelerate access and joined up care between health and care transportation.**

The large majority of hospital services will continue to be provided in each of our six local places and these hospital services will increasingly work seamlessly with primary and community care services.



^ Photo credit: Yorkshire Ambulance Service NHS Trust

They will also operate in networks with other providers across the Partnership to reduce the difference in care people receive, regardless of where they live.

Importantly we need to give people personalised choice and control over how their needs are met so they are an equal partner in their care and have the knowledge, skills and confidence to make their own decisions and manage their own health, where safe to do so.

Our workforce will develop new skills to work differently with people so we can change the relationships and conversation we have with our communities. This will be influenced by public involvement – a joint approach.



We will join up dental and oral health care with other services to encourage partnership working arrangements through a number of medical forums, including local Primary Care Networks.

Building on work in 2018, funding will be allocated to approximately 20 areas in West Yorkshire. This will aim to reduce oral health inequalities and improve child oral health.

We will do this through 'prevention champions', good oral health promotion and training for staff in the principles of ['Delivering Better Oral Health'](#), ['Making Every Contact Count'](#) and basic oral health messages. The additional funding will focus on children (0-5 years), particularly fluoride varnish application, as well as older people living in care homes and independently, and homeless people receiving services within health centres or community settings.



World class services and care

Working with HealthTech

Developing a closer and mutually beneficial working relationship with the HealthTech sector is an important part of our ambitions. 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. We have been working with the [Leeds Academic Health Partnership](#) to develop a new way of working with the HealthTech sector across the [Leeds City Region](#). This defines a new way of working between the HealthTech sector, universities, and health and care organisations. We have a strong relationship with the West Yorkshire Combined Authority who are working through the Leeds City Region Local Enterprise Partnership to develop the Local Industrial Strategy. This is a long-term, evidence-based plan to strengthen local economic growth, reduce health inequalities and improve skills, productivity and the earning power of individuals and the region as a whole.



We want to deliver world class care and push the boundaries of research and innovation.

We are proud to be home to many world-leading new treatments designed by people at the forefront of technology.



^ Targeted lung health checks in Wakefield

For example, surgeons at Leeds Teaching Hospitals NHS Trust made history in 2018 by successfully performing the first double hand transplant in the UK.

Through the [West Yorkshire Association of Acute Trusts](#), our hospitals will also operate in networks with other providers.



Our hospital collaboration (West Yorkshire Association of Acute Trusts) and mental health partnerships are increasingly delivering local hospital services, both physical and mental health, through networks of care, complemented by **centres of excellence in cancer, vascular, stroke, children's care and complex mental health.**

Our [Cancer Alliance](#) is in a strong place to deliver improvements, with a clear national strategy and a long history of partnership working amongst providers of cancer care which is essential to support people across the system.

This gives us the opportunity to ramp up our ambition and sharpen our focus to tackle variation and inequalities, 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.

It will be crucial to pull together as a whole system to deliver the national ambition that more cancers will be diagnosed at an early stage when curative treatment is an option.



We will work together so that by 2023/24 an extra **1000 people can be offered the chance of curative treatment**, rising to an extra 6,000 by 2028.



Our aim is to also improve quality outcomes for people requiring stroke care, ensuring that services are resilient and 'fit for the future'.

This includes preventing stroke happening in the first place, improving specialist care, making the most of technology, the skilled workforce, and connected high quality support for people recovering from a stroke.

Since spring 2018 we have been working with our partners at the [Yorkshire and Humber Academic Health Science Network](#) (AHSN) to more proactively detect, diagnose and treat people who are at risk of stroke so that around **nine in ten people with atrial fibrillation are managed by GPs with the best local treatments available. This will save lives.**

Every woman and her 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. One priority for us is to better understand the experience of women and families with a learning disability or autism using maternity services.

We know that when women experience continuity of care from a small team of midwives who they know by name and

have built trust with, they receive safer care overall. In 2018, in West Yorkshire and Harrogate less than 1% of women experienced continuity of carer throughout their pregnancy journey. By March 2019 over 10% of women experienced continuity of carer.



By 2021 the majority of women across our area will **experience and benefit from continuity of carer.**

All maternity units will have an accredited, evidence-based infant feeding programme, such as the UNICEF Baby Friendly Initiative, working with women and families experiencing multiple risk factors and understanding how the social and clinical needs of women are interlinked.

End of life care

Wherever possible, we want people at the end of their life to die in a place of their choosing with the right services and support to do so with dignity. We know that currently across the country, we fall far short of that ambition. More than half of the complaints referred to the Health Service Ombudsman in the UK concern end of life care, and over half of these are upheld.

All indicators are that the scale of this challenge will grow over the coming years, as there is a sustained increase in the number of deaths at an older age, and associated with greater complexity, multi-morbidity and dementia.

Palliative and end of life care is a priority for the Partnership. We aim to achieve the highest quality palliative and end of life care across all settings and remove barriers that mean people have unequal access to choice at the end of their life.



A great place to work

 **Health and social care is changing to meet the changing needs of people.** Reshaping

healthcare requires a reshaping of the health and care workforce. 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 represent the people we serve, including more ethnic minority employees in leadership roles and staff with disabilities in employment. The NHS 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 a diverse workforce across all sectors that truly reflects and understands the people we serve.

We will work together to improve the experience of staff working in health and care, and we will ensure our workforce is a true reflection of the diversity of our communities; this will involve empowering colleagues, particularly from Black, Asian and Minority Ethnic (BAME) groups, to achieve their full potential.



If we are to 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. 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. This will build on our workforce plan.

^ Photo credit: Mid Yorkshire Hospitals NHS Trust



^ Photo credit: Harrogate and District NHS Foundation Trust



We also want West Yorkshire and Harrogate to be a great place to volunteer.

This means ensuring we provide the right support, incentive and opportunities for people to give their time and skills to improving people's health. Every day already thousands of people across West Yorkshire and Harrogate give their time freely, driven by a passion and determination to help. This includes a range of diverse actions such as reading aloud in a hospice, driving a motor bike with donated blood, being a run guide for people with visual impairments or a survivor offering peer-support to others.

We know the contribution of these volunteers is invaluable and as a partnership we want to make it even easier for people to give their time, skills and dedication wherever they can with whatever they can offer and we want to celebrate their contribution and promote the work they do. Empowering people to contribute to the delivery of improved healthcare in the region is essential, we won't change the system from the top down and the voices of all our healthcare community need to be heard.

Photo credit: Calderdale Council >



We are planning the future health and social care workforce together rather than looking at individual organisational demands. In return this will enable funding to be targeted and future investment planned on a system-wide level.

We know that strengths-based social work and high quality social care can have a huge impact on people's lives: supporting people to live independently; enabling people to make their own choices and ensuring that people get the right help at the right time to stay well and happy. The care sector nationally and in our region however, faces a number of significant challenges, including the fragmented nature of provision and inadequate funding for all providers.

The availability of independent social care across West Yorkshire and Harrogate varies widely, as does quality and choice. Many independent providers have withdrawn from the market. This particularly affects more rural areas and areas where there is more competition for staff.

Beyond these issues for the sector, there are more fundamental questions about what people will need in the future to support them to live a good life, and how the care sector evolves to enable this. We are working to re-think the care provision of the future.





Spending money wisely

Working together gives us a better chance of bringing additional money into the area to invest in our staff, buildings, community partners or digital technology. It also gives us greater buying power and the potential to make savings by buying things together, for example medical equipment. We also want to focus investment towards preventing ill-health and providing support in community settings, to enable the left shift. The 'left shift' is about removing the need for avoidable clinical care to take place in hospitals, because more appropriate and more timely support is being provided in communities. It is about providing better health and wellbeing, better quality of care and more sustainable services because we have planned in advance, invested in prevention and targeted early intervention.

Through working together since 2018 the Partnership has secured the largest share of national capital investment totalling **£883m for ten schemes.**

These include £197m to support the reconfiguration of the hospitals at Calderdale and Huddersfield NHS Foundation Trust and £600m for Leeds Teaching Hospitals NHS Trust to build



^ Photo credit: Airedale NHS Foundation Trust

two new hospitals (one for children and one for adults) at Leeds General Infirmary (LGI) which will benefit the wider region.



£27m has also been allocated to create **a brand new specialist hub laboratory** for the West Yorkshire and Harrogate Pathology Network.

As well as receiving £29m to support the delivery of specific programmes over the last two years, for example cancer and mental health, we have also **received over £17m to invest** in the areas we



decide as a Partnership are a priority. This has included boosting investment in voluntary and community organisations targeting loneliness, in accelerating the pace of our primary and community care networks, in prevention services and developing localised approaches to improved mental health.

These Partnership priorities are agreed by our Partnership Board. The Board is an important group for our Partnership, as it puts elected members, non-executives and public lay members at the heart of our strategic decision making process.



Useful information

Get involved

You can get directly involved in improving health and care across our area in many ways:



by being a member of your local NHS foundation trust applying to be a lay member



joining a clinical commissioning group public patient involvement group



via your local council



becoming a member of Healthwatch



joining our health and care champions group for people with learning disabilities.



by volunteering with a health and care organisation or charity



getting involved in the 'Looking out for our neighbours' campaign.

Many of our Partnership's programmes also include opportunities to join their steering groups and these are advertised on our website [here](#).



^ Photo credit: Leeds Community Foundation

The Partnership Board meets in public every three months, four times a year. You can also access the agenda, papers and watch the meeting live [here](#). Our Joint Committee of the Clinical Commissioning Groups meets in public every other month. You can also watch the meeting live [here](#).

To register your interest in attending these meetings or to ask a question before the meeting takes place please email westyorkshire.stp@nhs.net or call **01924 317659**. You can also contact us with any other questions you may have. Our contact details are on the back cover.

Helpful publications

We publish a range of plans, publications and engagement reports.

 You can find these [here](#).

‘Looking after our neighbours’ campaign.

 Find more information about the campaign [here](#).

West Yorkshire and Harrogate Health and Care Partnership communication and engagement plan.

 You can find the plan [here](#).

 There is also an easy read version [here](#).

 Our engagement framework is also on our website [here](#).

 Films

A wide range of films have been produced to support our work. You can access our YouTube account [here](#).

Acronym busters

The NHS Confederation has brought together definitions of more than 1,000 commonly used acronyms and abbreviations in the NHS. You can view it [here](#).

Useful national and regional web links

 [Healthwatch UK](#)

 [Local Government Association](#)

 [NCVO \(national council for supporting the voluntary sector\)](#)

 [NHS England](#)

 [NHS Improvement](#)

 [NHS Providers](#)

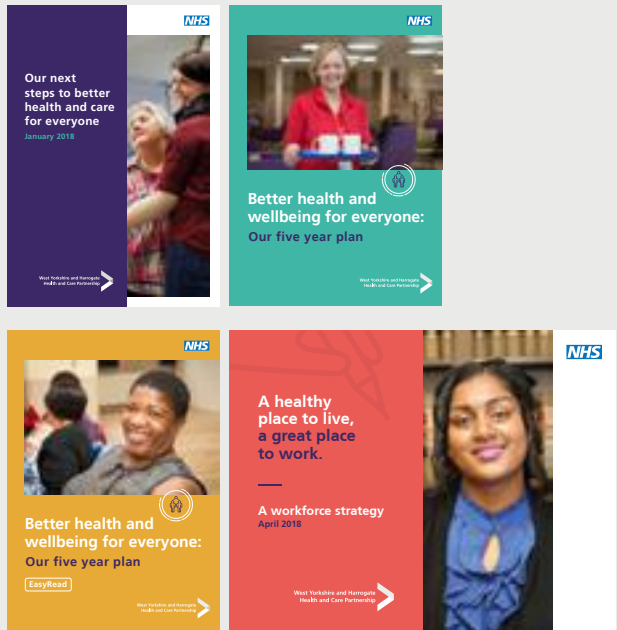
 [NHS Confederation](#)

 [NHS Clinical Commissioners](#)

 [Nuffield Trust](#)

 [The Kings Fund](#)

 [Yorkshire & Humber AHSN](#)



Next Steps 2018, Our Five Year Plan 2019 and the Workforce Strategy 2018.

You can get in touch with the Partnership by:



01924 317659



westyorkshire.stp@nhs.net



www.wyhpартnership.co.uk



@wyhpартnership



07811766006 (text us!)

A Partnership made up of the NHS, local councils, care providers, Healthwatch, voluntary and community organisations and charities.

*This information was accurate at production in November 2019.

**West Yorkshire and Harrogate
Health and Care Partnership**





Better health and wellbeing for everyone:

Our five year plan

EasyRead

West Yorkshire and Harrogate
Health and Care Partnership



Foreword

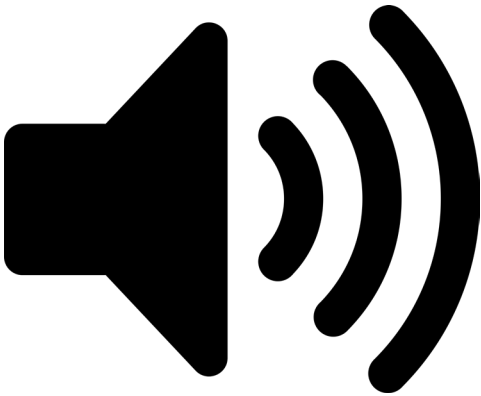


You can take a look at some of the things that West Yorkshire and Harrogate Health and Care Partnership have been doing to improve the lives of local people by watching this film.

<https://www.youtube.com/watch?v=tK-YLB3AJDk&t=3s>



We want to say thank you to all the people who've shared their stories with us and given their views about health and care in West Yorkshire and Harrogate.



This is the easy read summary of our 5 year plan. It is also available in:

- Animated film
- Audio
- BSL
- You can find the full version of the plan here ((ADD LINK))



Our Partnership includes:

Clinical Commissioning Groups (CCGs)

- NHS Airedale, Wharfedale and Craven CCG
- NHS Bradford City CCG
- NHS Bradford Districts CCG
- NHS Calderdale CCG
- NHS Greater Huddersfield CCG
- NHS Harrogate and Rural District CCG
- NHS Leeds CCG
- NHS North Kirklees CCG
- NHS Wakefield CCG

Local councils

- City of Bradford Metropolitan District Council
- Calderdale Council
- Craven District Council
- Harrogate Borough Council
- Kirklees Council
- Leeds City Council
- North Yorkshire County Council
- Wakefield Council

Care providers

- Airedale NHS Foundation Trust
- Bradford District Care NHS Foundation Trust
- Bradford Teaching Hospitals NHS Foundation Trust
- Calderdale and Huddersfield NHS Foundation Trust
- Harrogate and District NHS Foundation Trust
- Leeds Community Healthcare NHS Trust
- Leeds and York Partnership NHS Foundation Trust
- Leeds Teaching Hospitals NHS Trust
- Locala Community Partnerships
- The Mid-Yorkshire Hospitals NHS Trust
- South West Yorkshire Partnership NHS Foundation Trust
- Tees, Esk and Wear Valleys NHS Foundation Trust
- Yorkshire Ambulance Service NHS Trust

Introduction: Stronger, better, healthier together



Our Partnership began in 2016 because we wanted to improve the lives of everyone in the West Yorkshire and Harrogate area.



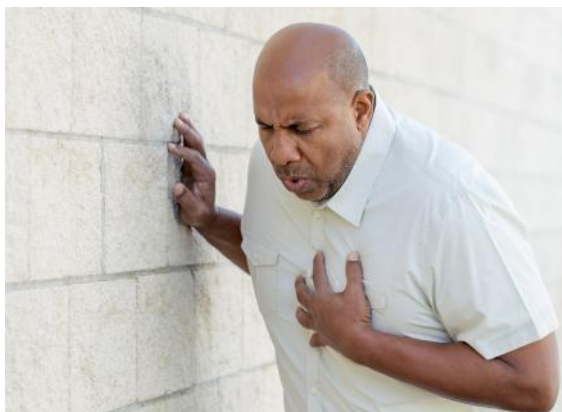
We wanted to make sure health and care services were available to everyone, no matter who they were or where they lived.



In 2018 we worked hard on our plans to make services better for everyone who lives and works in our area.



Our Partnership Board first met in June 2019. We were pleased with the work we were doing but knew we needed to do more.



We improved things, such as stopping people having a stroke and heart problems, where possible.



We created health care champions to involve people with learning disabilities.



We spoke with over 1,800 people about the NHS Long Term Plan. This helped us know what people felt was important.



We have used this information to build our Five Year Plan. The plan says what we are going to do to make sure that everyone has the chance to live a long and healthy life.

Why work together?



All the organisations in our partnership work together to make things better for everyone who lives and works in our area.



Working together we can share our skills, resources and money and give a better service to everyone.



We know that there are lots of other things that help people to feel healthy and well.

This includes things like, the food you eat, the house you live in, feeling safe, not feeling alone and being part of the community. If people don't have these things they can experience worse health.

Our vision



Places in West Yorkshire and Harrogate will be healthy. Everyone will get the same high quality care no matter where they live, who they are or what they do.

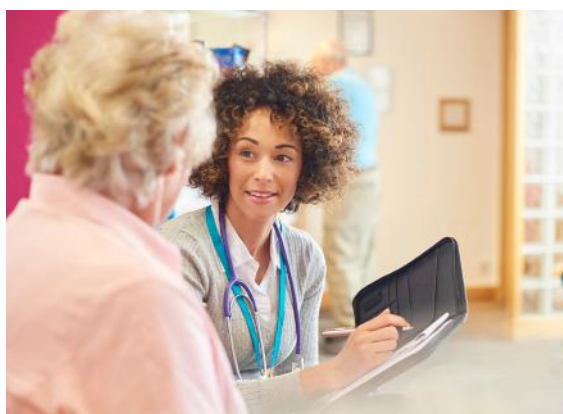


If you have a long-term condition we will support you to stay as well as possible in the right way for you.

If you have lots of different health conditions, we will make sure you and your family are included in your health and social care team.



If you need hospital care it will usually be at a hospital close to where you live. Your local hospital will work closely with others to give you the best care possible.



Local hospitals will be supported by centres of excellence for services such as cancer, strokes and mental health.

Organisations will work better together.

Everyone will be involved in planning their own health care.

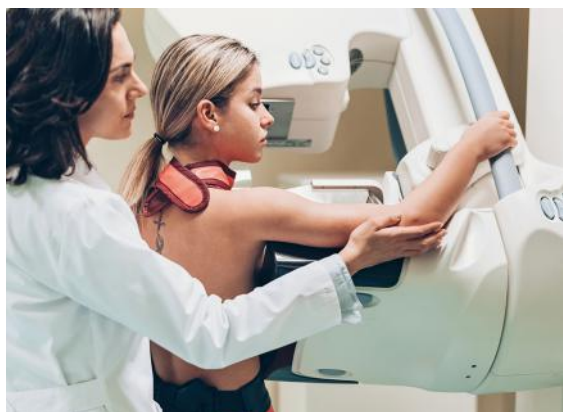
Our big ambitions



Improve the quality of life for everyone in our area so they can live as long as people in other parts of the country.



Improve the health of children who live in poorer families and who are over-weight.



Make sure many more people get tested for cancer much earlier giving them a better chance for treatment.



Greatly reduce the amount of people who take their own lives.



Do more to stop people getting infections, making sure that they are diagnosed early and get the right treatment.

Cut down on the amount of antibiotics that people take.



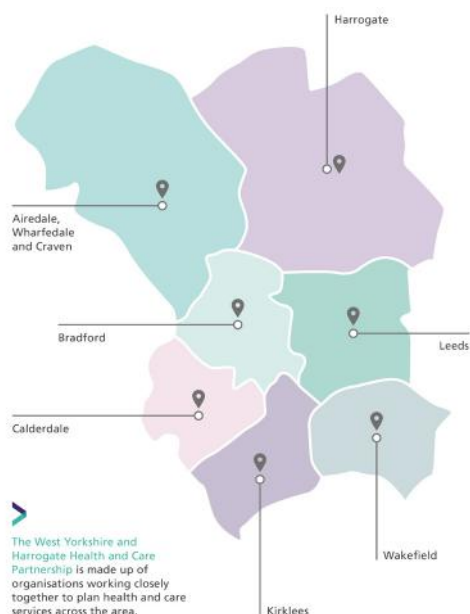
Work to reduce the amount of babies that are stillborn, die very young or have brain injuries.

Cut down on the amount of women who have physical or mental illness because of pregnancy.



Employ more skilled people from BAME (Black, Asian and Minority Ethnic) groups in leadership roles to best support the different communities we have in our area.

Living and working in West Yorkshire and Harrogate



There are 2.7 million people living in West Yorkshire and Harrogate.

We are known in other parts of the country as a great place to live and work.



We are proud of our area and the different types of people who live in our communities.

There are many people across the area who work and volunteer in health and care organisations.



But we know we find it difficult to keep the good staff we have working for us, especially from BAME communities.

We will work hard to make sure that everyone that works for us is supported to give the best care they can.

Our priorities

The most important things that we will be working together on are:

- Cancer.



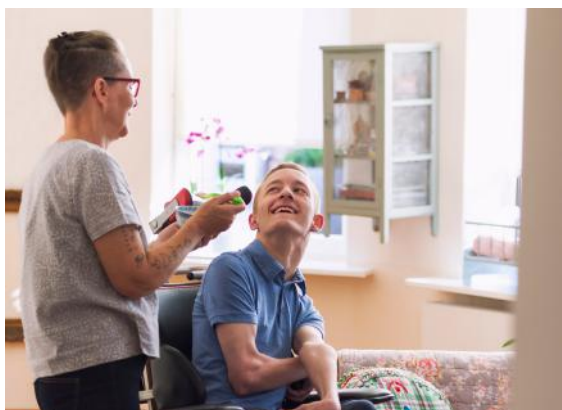
- Mental health, people with learning disabilities and autistic people.



- Children and young people.



- Carers.



To help us with our priorities we need to look at lots of other things like:



- Prevention – stopping people getting ill in the first place.



- Health inequalities – making sure everyone has the same chance of good health.



- Looking at the other things that can affect people's health such as where they live and how much money they have.



- Personalised care – making sure that people have more choice and control about their care.

We want organisations and services to work together which include:



- Primary and community care, this means GP practices and other health services that people use in their communities.



- Urgent and emergency care, this means accident and emergency services, ambulance services and the NHS 111 helpline.



- Planned care, which are appointments booked in advance.



- Hospitals working together to offer the best care possible to everyone.



We want to work with local communities better. We will fund community services that are important to people.

We will help people use these services to improve their health and wellbeing.



We want to improve the way you can use services by making more things available online.



We will look at what buildings we have and the places we use to deliver health and care.

We will see if we can make them work better for people.



We want to join up services to improve health and wellbeing for all the people across the West Yorkshire and Harrogate Partnership.

You can watch our short animation by scanning the QR code.



We also want to listen to ideas from people with learning disabilities and autism. To make sure we can do this we now have a 'Health and Care Champions' network to help us.

There are lots of things that can affect your life and how healthy and happy you feel like:



- Work. Having a paid job or volunteering.
- Where you live.
- Having access to parks and open spaces.
- Being part of a community.
- Easy access to transport.
- Active travel. Getting to the places you need to by walking and cycling and so on.



Children and young people

Some of the things we will do over the next five years are:



- We will ensure babies have the best start in life and young children are ready for school.



- We will support children with special educational needs and disabilities and their families. We will support children with long term health conditions in all aspects of their life.



- We will work with health partners, children's services, voluntary sector and schools to improve health and well-being outcomes for children and young people.

Carers

Some of the things we will do over the next five years are:



- Identify and support carers, especially those from minority communities.



- Make sure that all carers have the same standard of support.



- Make clear to everyone how important carers are.



- Make sure that carers know how to access out of hours care when they need it.

Maternity

Some of the things we will do over the next five years are:



- Make sure more women and their families have personalised care plans.



- Make sure women know of their choices and choose where they want to have their baby.



- Make sure more women have the same staff to support them throughout their pregnancy.



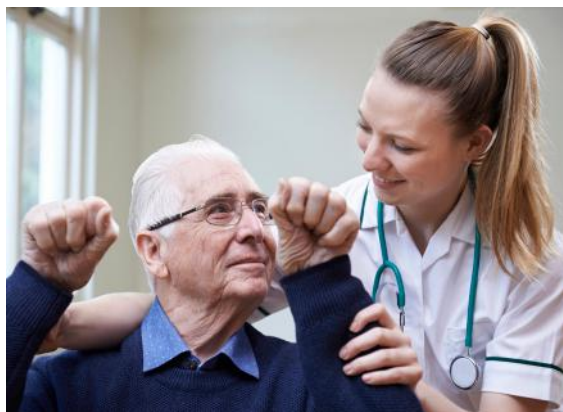
- Reduce the amount of woman who smoke when they are pregnant.



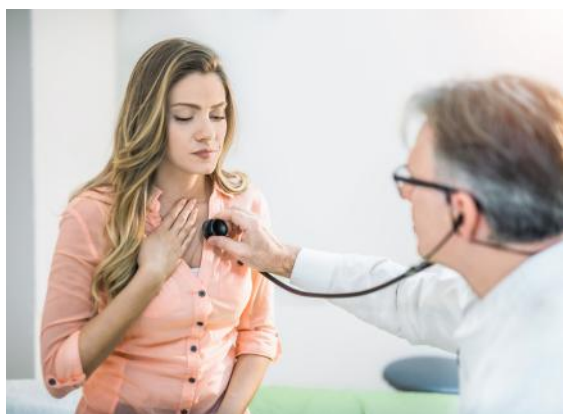
- Increase the number of woman who breastfeed.

Support work programmes

We also want to work on improving health and care in the following areas:



- Stroke care.



- Respiratory conditions like pneumonia and asthma.



- People at risk of having or who have diabetes.



- End of life care.

This information is available in alternative formats, for example large print, Braille and community languages. For more information contact:

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 www.wyhppartnership.co.uk

 [@WYHpartnership](https://twitter.com/WYHpartnership)

A partnership made up of the NHS, local councils, care providers, Healthwatch, community organisations and charities.

EasyRead



EasyRead version by BTM, 11-12 Eldon Place,
Bradford BD1 3AZ

Tel: 01274 848150 or visit www.btm.org.uk

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**West Yorkshire and Harrogate
Health and Care Partnership**



Leeds Health and Wellbeing Board



Report author: Rosemary Reynolds

Report of: Leeds Health and Care Partnership Executive Group (PEG)

Report to: Leeds Health and Wellbeing Board

Date: 11th December 2019

Subject: Leeds Health and Care Quarterly Financial Reporting

Are specific geographical areas affected?	☐ Yes	☒ No
If relevant, name(s) of area(s):		
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?	☐ Yes	☒ No
If relevant, access to information procedure rule number:		
Appendix number:		

Summary of main issues

This report provides the Health and Wellbeing 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 (Appendix 1). Key system headlines:

- At the end of September 2019/20, the system is reporting a slight year end forecast surplus position against plan of £0.4m.
- Leeds City Council's Children's Social Care, Adults Social Care and Public Health is forecasting a deficit against plan of £0.5m offset by a forecast surplus at Leeds and York Partnership Foundation Trust of £0.9m.

Recommendations

The Health and Wellbeing Board is asked to:

- Note the 2019/20 April to September partner organisation financial positions.

1. Purpose of this report

- 1.1 This report provides the Health and Wellbeing Board with a brief overview of the financial positions of the health and care organisations in Leeds, brought together to provide a single citywide quarterly financial report (Appendix 1). This report is for the period ending months ending September 2019.
- 1.2 Together, this financial information and associated narrative aims to provide a greater understanding of the collective and individual financial performance of the health and care organisations in Leeds. This provides the Health and Wellbeing Board with an opportunity to direct action which will support an appropriate and effective response.
- 1.3 This paper supports the Board's role in having strategic oversight of both the financial sustainability of the Leeds health and care system and of the executive function carried out by the Leeds Health and Care Partnership Executive Group (PEG).

2. Background information

- 2.1 The financial information contained within this report has been contributed by Directors of Finance from Leeds City Council (LCC), Leeds Community Healthcare Trust (LCH), Leeds Teaching Hospital Trust (LTHT), Leeds and York Partnership Trust (LYPFT) and NHS Leeds Clinical Commissioning Group (CCG).

3. Main issues

- 3.1 At the end of September 2019/20, the system is reporting a slight year end forecast surplus position against plan of £0.4m (Q1 deficit against plan of £0.2m).
- 3.2 Leeds Teaching Hospitals, Leeds Community Healthcare and Leeds CCG are continuing to forecast to achieve plan. Leeds and York Partnership Foundation Trust is forecasting a slight surplus against plan of £0.9m whilst Leeds City Council's Childrens' Social Care and Adults Social Care and Public Health are reporting a slight deficit against plan of £0.5m (an improvement of £0.6m compared to Q1).

4. Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

- 4.1.1 Development of the Leeds health & care quarterly financial report is overseen by the Directors of Finance and equivalents from Leeds City Council, Leeds Community Healthcare Trust, Leeds Teaching Hospital Trust, Leeds and York Partnership Trust and the Leeds Clinical Commissioning Group.
- 4.1.2 Individual organisations engage with citizens through their own internal process and spending priorities are aligned to the Leeds Health and Wellbeing Strategy 2016-2021, which was developed through significant engagement activity.

4.2 Equality and diversity / cohesion and integration

- 4.2.1 Through the Leeds health & care quarterly financial report we are better able to understand a citywide position and identify challenges and opportunities across the health and care system to contribute to the delivery of 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', which underpins the Leeds Health and Wellbeing Strategy 2016-2021.

4.3 Resources and value for money

- 4.3.1 The Health and Wellbeing Board has oversight of the financial stability of the Leeds system with PEG committed to using the 'Leeds £', our money and other resources, wisely for the good of the people we serve in a way in which also balances the books for the city. Bringing together financial updates from health and care organisations in a single place has multiple benefits; we are better able to understand a citywide position, identify challenges and opportunities across the health and care system and ensure that people of Leeds are getting good value for the collective Leeds £.

4.4 Legal Implications, access to information and call in

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

4.5 Risk management

- 4.5.1 The Leeds health & care quarterly financial report outlines the extent of the financial challenge facing the Leeds health and care system. These risks are actively monitored and mitigated against, through regular partnership meetings including the Citywide Director of Finance group and reporting to the PEG and other partnership groups as needed. Furthermore, each individual organisation has financial risk management processes and reporting mechanisms in place.

5. Conclusions

- 5.1 At the end of September 2019/20, partner organisations are collectively forecasting a slight surplus against plan. However the system continues to deal with significant challenges.

6. Recommendations

- 6.1 The Health and Wellbeing Board is asked to:
- Note the 2019/20 April to September partner organisation financial positions.

7. Background documents

None.



How does this help reduce health inequalities in Leeds?

An efficient health and care system in financial balance enables us to use resources more effectively and target these in areas of greatest need.

How does this help create a high quality health and care system?

Driving up quality depends on having the resources to meet the health and care needs of the people of Leeds. Spending every penny wisely on evidence based interventions and ensuring we have an appropriate workforce and can manage our workforce effectively promotes system-wide sustainability.

How does this help to have a financially sustainable health and care system?

It maintains visibility of the financial position of the statutory partners in the city

Future challenges or opportunities

Future updates will be brought to the Health and Wellbeing Board as requested and should be factored into the work plan of the Board.

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

Quarterly Finance Report to Leeds Health and Wellbeing Board

A. Quarter 2 (April-September financial position for 2019/20)

A1 - City Summary

At the end of September 2019/20, the system is reporting a slight year end forecast surplus position against plan of £0.4m (Q1 deficit against plan of £0.2m).

Leeds Teaching Hospitals, Leeds Community Healthcare and Leeds CCG are continuing to forecast to achieve plan. Leeds and York Partnership Foundation Trust is forecasting a slight surplus against plan of £0.9m whilst Leeds City Council's Childrens' Social Care and Adults Social Care and Public Health are reporting a slight deficit against plan of £0.5m (an improvement of £0.6m compared to Q1).

Section 1 - City Summary

6 months ended 30th September 2019	Total Income/Funding			Pay Costs			Other Costs			Total Costs			Net surplus/(deficit)		
	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Leeds City Council	323.6	324.1	0.6	72.3	71.7	0.6	251.3	252.7	- 1.3	323.6	324.4	- 0.8	-	- 0.2	- 0.2
Leeds Community Healthcare Trust	80.1	80.0	- 0.1	57.2	57.0	0.2	22.3	22.3	-	79.5	79.3	0.2	0.6	0.7	0.1
Leeds Teaching Hospitals NHS Trust	648.7	657.6	8.9	385.0	392.5	- 7.6	272.8	273.9	- 1.1	657.8	666.4	- 8.6	- 9.0	- 8.8	0.2
Leeds & York Partnership Foundation Trust	84.8	86.0	1.2	59.9	59.9	0.0	24.6	24.7	- 0.0	84.6	84.6	0.0	0.2	1.5	1.3
Leeds CCG Partnership	637.2	637.2	-	5.0	4.7	0.3	632.2	632.5	- 0.3	637.2	637.2	-	-	-	-

Forecast year end 2019/20	Total Income/Funding			Pay Costs			Other Costs			Total Costs			Net surplus/(deficit)		
	Plan	Forecast	Var	Plan	Forecast	Var	Plan	Forecast	Var	Plan	Forecast	Var	Plan	Forecast	Var
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Leeds City Council	647.1	648.2	1.1	144.5	143.4	1.1	502.6	505.3	- 2.7	647.1	648.7	- 1.6	-	- 0.5	- 0.5
Leeds Community Healthcare Trust	157.6	157.4	0.2	113.1	113.2	- 0.1	42.8	42.5	0.3	155.9	155.7	0.2	1.7	1.7	-
Leeds Teaching Hospitals NHS Trust	1,309.4	1,335.8	26.3	768.3	782.6	- 14.3	529.1	541.1	- 12.0	1,297.4	1,323.7	- 26.3	12.01	12.01	- 0.0
Leeds & York Partnership Foundation Trust	170.0	170.9	0.9	119.5	119.5	-	49.2	49.2	-	168.7	168.7	-	1.3	2.2	0.9
Leeds CCG Partnership	1,300.1	1,300.1	-	9.8	9.6	0.2	1,290.3	1,290.5	-	1,300.1	1,300.1	-	-	-	-

Sign convention: (negative numbers) = adverse variances

Numbers may not sum due to roundings

A2 – Organisational commentary on quarter 2 position

a. Leeds City Council

The numbers quoted above relate solely to the Adults and Health directorate (which includes Adult Social Care, Children's Social Care and Public Health).

Adults and Health are projecting a balanced budget. The overall savings plan target is expected to be delivered.

Children and Families are reporting an overspend of £0.5m. The pressure is primarily within Children Looked After (CLA), financially supported Non-CLA and client transport.

b. Leeds Community Healthcare Trust

At the end of Quarter 2 the Trust's surplus is running £0.1m more than planned. Pay costs are £0.2m underspent. Identified CIPs are being delivered; there remains £0.2m of unidentified CIPs for 2019/20, these continue to be mitigated by non-recurrent underspending. The Trust's forecast outturn is that the agreed control total will be achieved. Both the year to date and forecast outturn positions assume the Provider Sustainability Fund and the CQUIN income are achieved in full. The main risks to the financial position are increases in costs as a result of service pressures.

c. Leeds Teaching Hospitals Trust

Prior to PSF and MRET income, the Trust ended Q2 £17.9m in deficit, which was £0.2m better than the £18.1m planned deficit. This position meant the Trust was eligible to receive £6.0m of PSF and, because it signed up to its control total, £3.1m MRET as well, totalling £9.1m. An additional £0.9m year-end distribution PSF was also recognised in Q1, but adjusted out so as not to improve the overall Trust I&E position, as per NHSI guidance. Taking all of the above together, at the end of Q2 the Trust's financial position was a deficit of £8.8m, which was £0.2m better than plan.

d. Leeds and York Partnership Trust

The Trust reported a £1.484m surplus variance for quarter 2 2019/20. This position is attributable to additional unplanned Provider Sustainability Funding (£0.936m) relating to 2019/20.

e. NHS Leeds CCG

The CCG is forecasting to achieve its financial control total. The CCG position is based on the best available information but there are a number of inherent uncertainties which are currently outside of the CCG's direct control. These include regional/system and national funding streams in respect of additional Long Term Plan allocations, other ICS allocations, Primary Care Networks and resources targeting the development of Technology infrastructure funding as the main examples. The specific risks associated with these funding streams range from not being clearly quantifiable at this point in time, the lack of detail around their application and associated workforce deployment issues and simple timing of the allocations in the context of procurement and service engagement timelines.

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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: 11 December 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 carers, women in Leeds, and the draft Mental Health Strategy.

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 change¹. 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 workshop: Mental health and wellbeing - making it real, making a difference (23 Oct 2019)

- 3.1 Leeds Health and Wellbeing Board has maintained Mental Health as a priority for a number of years. At this workshop HWB members shaped and influenced work, identified and committed to action to support improvements in mental wellbeing and reduce mental health inequality through a focus on carers, women in Leeds, and the city’s draft Mental Health Strategy.

Supporting carers in our health and care workforce

- 3.2 Building on discussions at Health and Wellbeing Board (16 Sept) on the draft Leeds Carers Partnership Strategy, members wanted to really challenge the health and care system to address longstanding issues and hold each other to account in creating a cultural change that ensures carers are supported to remain a valued part of our workforce, alongside their caring role.

¹ *Making an impact through good governance – a practical guide for Health and Wellbeing Boards*, Local Government Association (October 2014)

3.3 Val Hewison (Chief Executive, Carers Leeds) and Ian Brooke-Mawson (Leeds City Council) led and facilitated a powerful discussion on carers as a fundamental part of 'Team Leeds' and a vital part of our workforce beginning with the experiences of carers currently and where we can go further. Through discussions it was agreed to progress the following actions:

- Anchors Healthy Workplace work-stream to conduct a carers policy review creating consistency between policies, procedures, and managers interpretation of those policies.
- Anchors Healthy Workplace work-stream to learn from partners and create a good practice guide to influence and improve standards of supporting working carers.
- Strengthen connections with the work occurring at West Yorkshire & Harrogate ICS level around carers.
- Promote the carers newsletter throughout health and care organisations.
- Leeds Health and Care Academy works to offer training for carers to care safely.
- Leeds Health and Care Academy works to offer training to help all staff understand issues and support carers.
- Ensuring that the work is connected into the ambitions for a Women Friendly Leeds recognising that women are disproportionately impacted by caring responsibilities.

Creating a Women Friendly Leeds

3.4 Leeds is the first city in the UK to produce a comprehensive picture of life, health and wellbeing for women and girls known as the *State of Women's Health in Leeds Report*. After supporting the report in June 2019, the Health and Wellbeing Board highlighted the importance of shaping improvements that the city and health and care system can make for women in Leeds. Tim Taylor (LCC), Jeanette Morris-Boam (Women's Lives Leeds), Nik Peasgood (Leeds Women's Aid), Flavia Docherty (Getaway Girls) and Prof. Alan White led the discussion at the workshop where the Health and Wellbeing Board welcomed Leeds becoming UK's First Women Friendly City and recognised it as a great opportunity to build on this work.

3.5 Through discussions it was agreed to progress the following actions:

- For the Women Friendly Leeds initiative to be an opportunity to showcase and celebrate nationally and internationally the Leeds approach.
- Further build on our offer of support for young women and girls who self-harm and/or have other mental health problems.

- Strengthen connections with carers, particularly, young adult carers (aged 16-25).
- Greater focus on safety and (sexual) violence.
- Ensure women and girls are at the heart of every decision – mirroring Child Friendly Leeds.
- Ask women what's important and focus on empowering women to have a voice and influence decisions.
- Strengthen links with women in paid caring roles on the front line of health and care services.
- Focus on creating a city where women feel safe linking together the Safer Leeds Community Safety Strategy to Climate Emergency (e.g. using public transport), Leeds Health and Wellbeing Strategy, Get Set Leeds and active travel (e.g. women feeling safe to use public spaces, etc.).
- For Leeds to challenge ourselves on how we commission and deliver our services that reflect gendered health and other characteristics.
- For Leeds to be a Women Friendly City, this means working for greater gender equality and creating a culture shift around men as carers, their role within the family, community and workplace for Future Generations. This needs to be reflected in the language and proposals within the initiative and linked to the State of Men's Health Report with an update at a future HWB.

Draft Leeds Mental Health Strategy

- 3.6 As highlighted earlier, the Health and Wellbeing Board has maintained Mental Health as a priority of its work for a number of years. The Leeds Mental Health Strategy and our vision that “Leeds will be a mentally healthy city for everyone” was first discussed at HWB in April 2019. At the workshop members considered the latest draft version and designing a system with diverse services but a shared culture to make Leeds a mentally healthy city where people can get early help, help to maintain/access employment and support in crisis too.
- 3.7 Through discussions it was agreed for the draft Mental Health Strategy to be updated to reflect the following:
- Greater focus on physical activity as a means of prevention, early intervention and treatment of mental health and wellbeing aligned to our ambition to create a social movement around physical activity (e.g. Get Set Leeds).
 - Ensuring that priorities relating to employment and early intervention includes how we can better support people claiming employment and support allowance in Leeds; the majority of whom have anxiety and/or depression and MSK.

- Greater focus on how we can support people with physical long term conditions to stay mentally healthy, Priority Neighbourhoods and areas experiencing the highest levels of deprivation and Housing.
- Further build on the importance of parental mental health through 'Think Family', early support to young people and working across the whole life-course with an intergenerational approach.
- Strengthen connections with work occurring through the West Yorkshire & Harrogate Partnership and how the health and care system in Leeds will commission differently to support our ambitions and improve system flow.
- For the strategy to represent and celebrate what Leeds is already doing well.
- Greater focus on how Leeds will support the mental health and wellbeing of the health and care workforce, particularly by taking an early intervention approach to anxiety and depression.

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 workshops other sessions 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 piece of work highlighted in this report evidences how the Leeds health and care system is 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 other sessions 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. Key to this going forward is continuing to strengthen our alignment with the Leeds Inclusive Growth Strategy. Work will be undertaken to extend the Health and Wellbeing Strategy from 2021 to 2023 to enable this.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Note the contents of the report.

7 Background documents

- 7.1 None.

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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	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