Annex A

NHS

Better health and wellbeing for everyone:

Our five year plan

West Yorkshire and Harrogate
Health and Care Partnership

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.wyhpartnership.co.uk

@wyhpartnership

0781 176 6006 (text us!)

This information was accurate at November 2019.

Contents

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

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 wining 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.

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West Yorkshire and Harrogate Health and Care Partnership is made up of six local places:
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^ Photo credit: Leeds and York Partnership NHS Foundation Trust

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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*

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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.

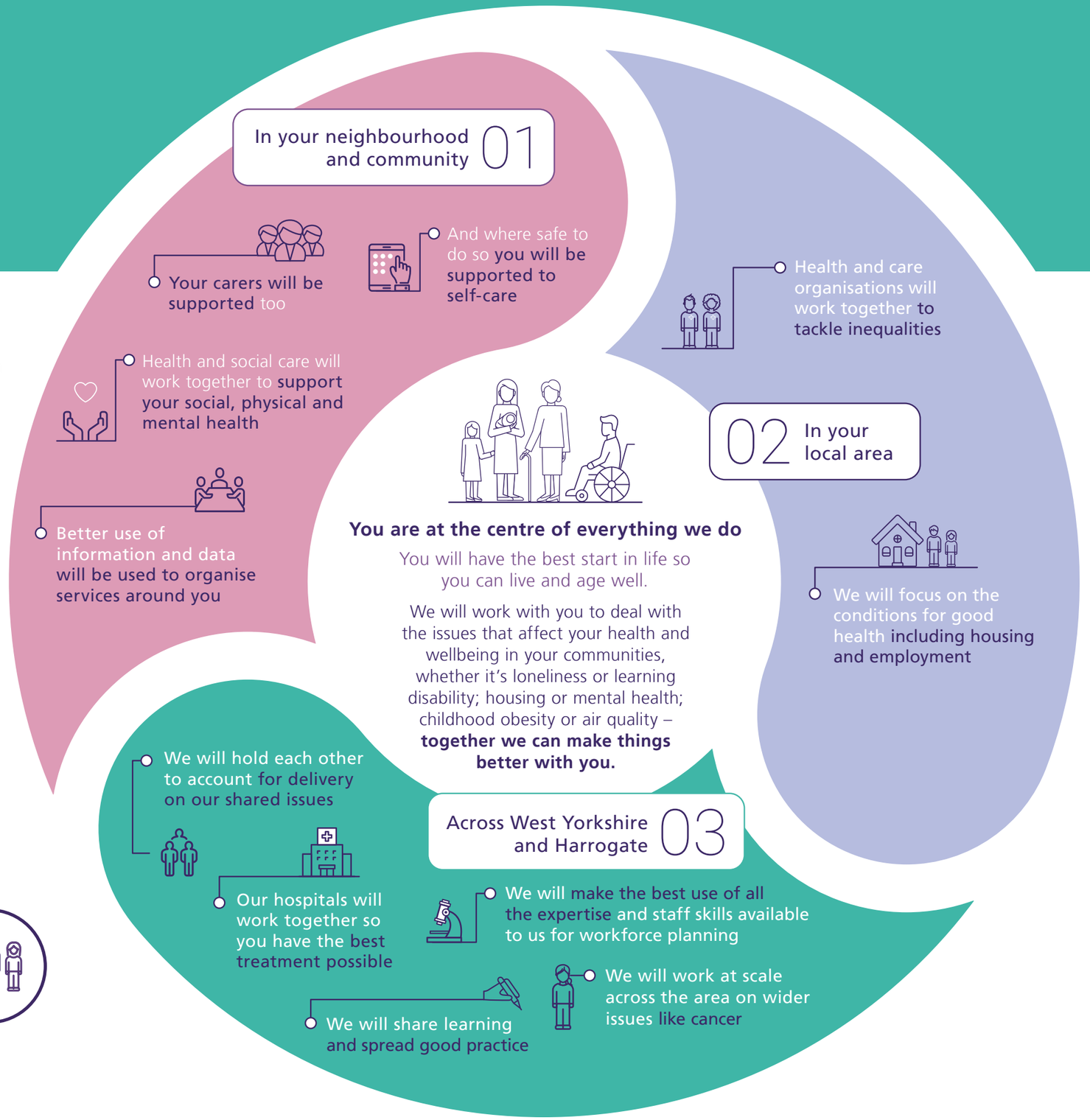
- If you have multiple health conditions, **you will be in a team with your GP, community care staff and social services working together.** This will involve you, your family and carers, the NHS, social care and community organisations - working on what matters to you.

- 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.



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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: Harrogate and District NHS Foundation Trust

^ 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.

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.

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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:

West Yorkshire and Harrogate Health and Care Partnership is made up of six local places:
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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.**

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

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.**

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

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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

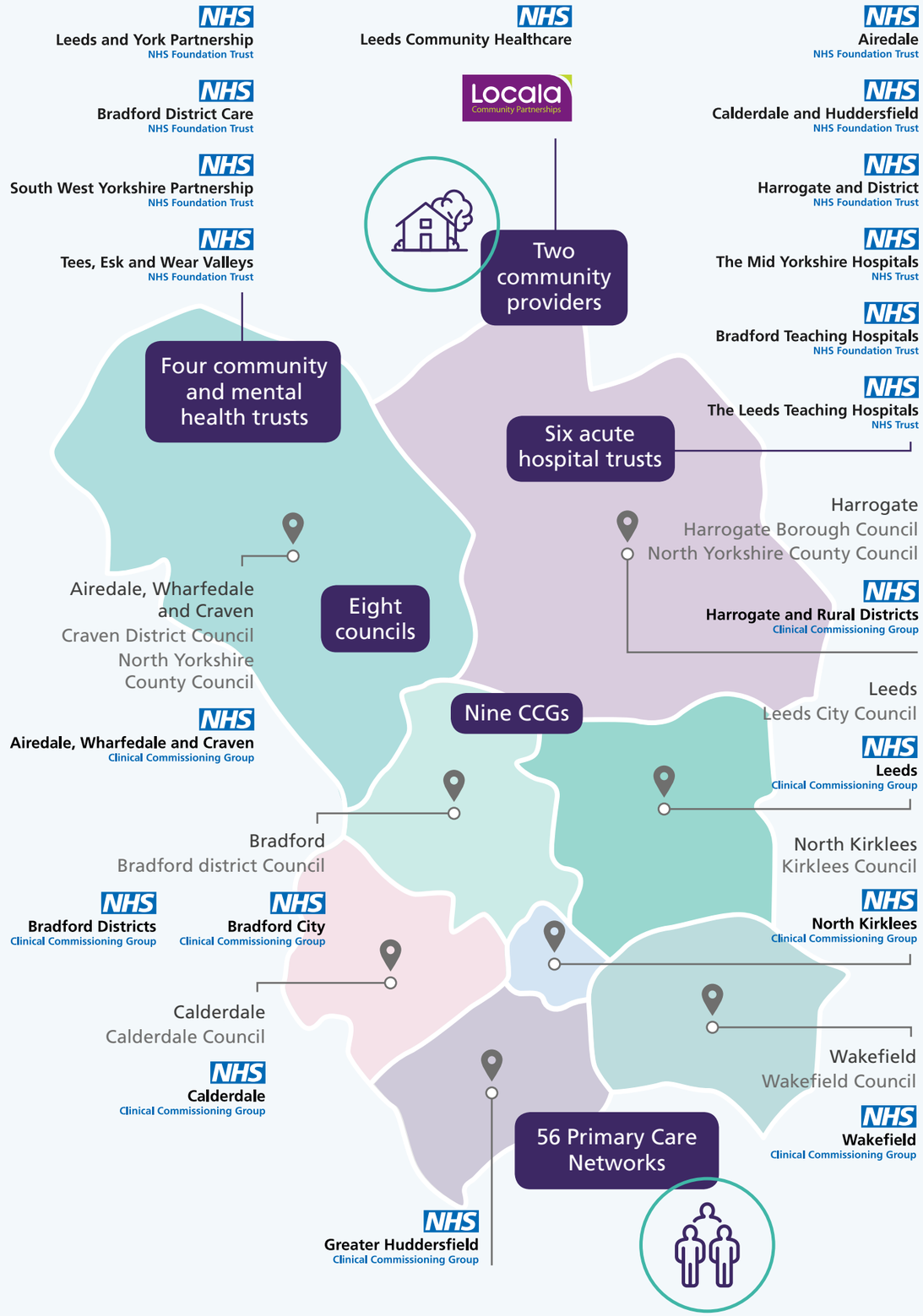
Our councils

Bradford Council
Calderdale Council
Craven District Council
Harrogate Borough Council
Kirklees Council
Leeds City Council
North Yorkshire County Council
Wakefield Council working for you

West Yorkshire Police
West Yorkshire Fire & Rescue Service
Yorkshire & Humber Academic Health Science Network
NHS Yorkshire Ambulance Service NHS Trust
NHS England
NHS Health Education England
NHS Improvement
healthwatch
Public Health England
Local Care Direct we care about people
Leeds City Region Enterprise Partnership
West Yorkshire Combined Authority

- 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.



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Our Partnership's progress

2016/17

Developed our first plan to improve people's health and wellbeing

Partnership formed
West Yorkshire and Harrogate Health and Care Partnership

Agreed to work together on our finances

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

Our clinical commissioning groups (CCGs) agreed a shared work plan

1500 people identified for treatment to prevent stroke

2018

Set up an award-winning programme to **support 260,000 carers**

£1m for our health and social care workforce plans

Developed a programme and training to reduce suicides

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

£1m invested in our communities to tackle loneliness

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

Hospitals work together for the first 72 hours of critical stroke care

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

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

Set up a new community eating disorder service

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

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

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

Launched career workshops for young carers

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

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

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

Managed our money better together

Launched 'Looking out for our neighbours' community campaign

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

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.wyhpartnership.co.uk.

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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).

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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.

v 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.

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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.

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).

> Photo credit: Calderdale and Huddersfield NHS Foundation Trust

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).

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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.

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Bradford district and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield

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.

v 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.

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

^ 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.wyhpartnership.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.

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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 different 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.**

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.

^ Photo credit: WDH

02

Chapter 2
Improving health and wellbeing for everyone

What we cover in this chapter:

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

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.

^ 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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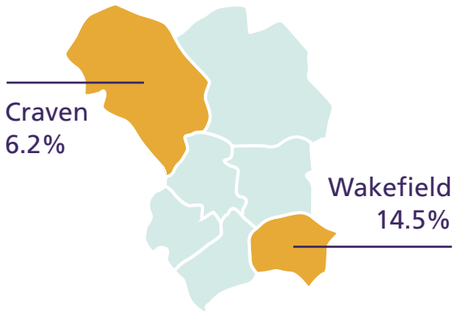
In West Yorkshire and Harrogate 13% of those claiming Employment Support Allowance (ESA) have muscular skeletal conditions as a primary cause. (Please see transforming planned care on page 79).

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.

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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.

v 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'.

v 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.

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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.

v Calderdale Vision. Photo credit: Calderdale Council

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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 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
- 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.

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.

>>

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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:

West Yorkshire and Harrogate Health and Care Partnership is made up of six local places:
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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.

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

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.

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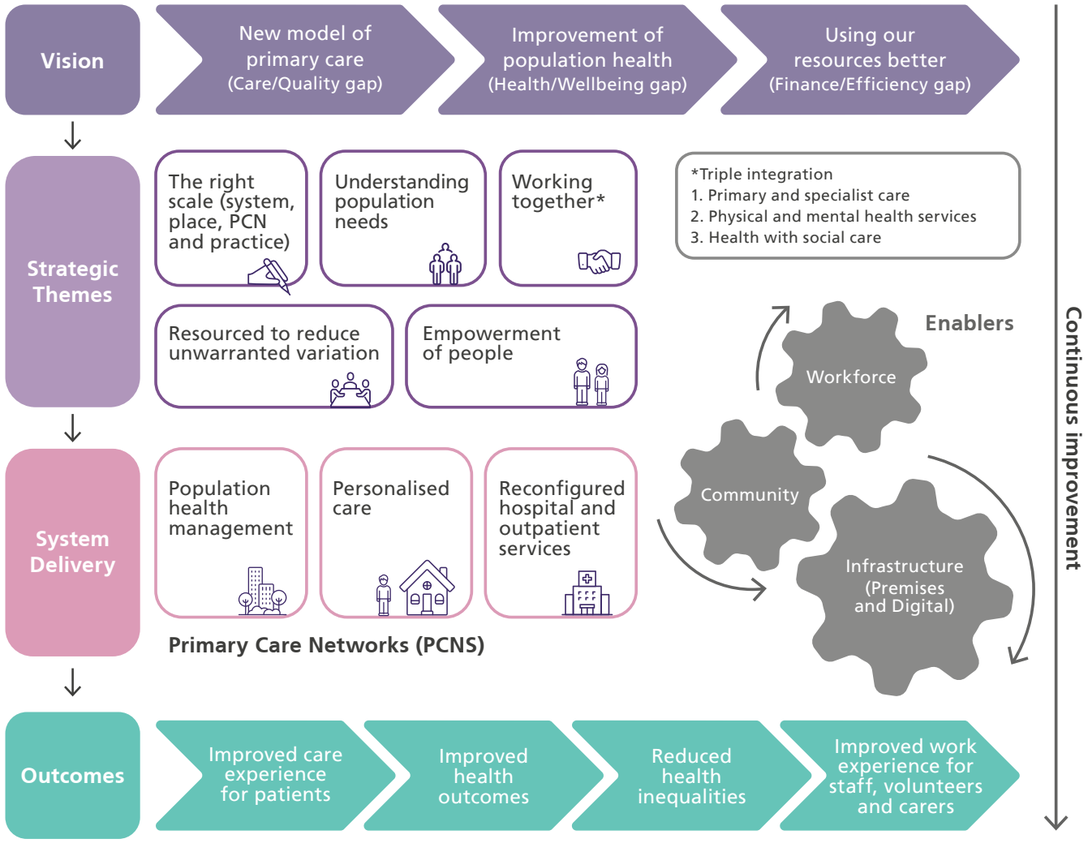
Primary and community care services including councils, dental, oral health, eye care, community pharmacy and general practice are central to bringing care closer to home, managing long term health conditions, preventing unnecessary hospital admissions and helping people stay well, healthy and independent. 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.

^ In all six places the third sector is bringing links to community assets, local intelligence and relationships.

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'.

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.

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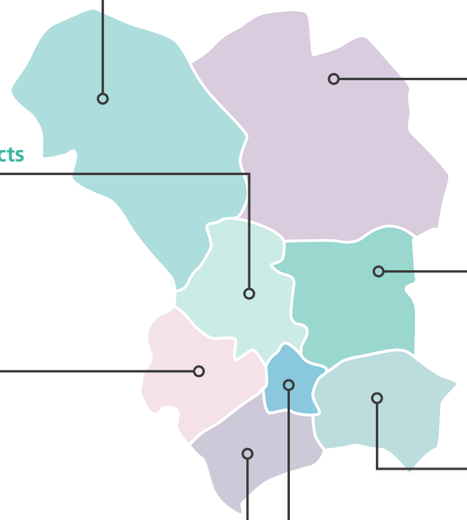

Airedale Wharfedale and Craven
GP practices: **16**
Pharmacies: **36**
Optometry practices: **23**
Dental practices: **18**
PCNs: **2**

Bradford City and Districts
GP practices: **57**
Pharmacies: **67**
Optometry practices: **52**
Dental practices: **46**
PCNs: **10**

Calderdale
GP practices: **27**
Pharmacies: **49**
Optometry practices: **20**
Dental practices: **24**
PCNs: **5**

Greater Huddersfield
GP practices: **38**
Pharmacies: **33**
Optometry practices: **26**
Dental practices: **32**
PCNs: **5**

Harrogate and Rural District
GP practices: **17**
Pharmacies: **26**
Optometry practices: **19**
Dental practices: **20**
PCNs: **4**

Leeds
GP practices: **97**
Pharmacies: **173**
Optometry practices: **98**
Dental practices: **97**
PCNs: **18**

Wakefield
GP practices: **37**
Pharmacies: **71**
Optometry practices: **37**
Dental practices: **28**
PCNs: **7**

North Kirklees
GP practices: **28**
Pharmacies: **43**
Optometry practices: **22**
Dental practices: **20**
PCNs: **4**

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' >>

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- 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.

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Pharmacy, dental and eye care

^ Photo credit: Harrogate and District NHS Foundation Trust

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.

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 or 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, fundng 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.

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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.

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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.

^ Photo credit: Yorkshire Ambulance Service NHS Trust

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.

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.

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.

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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.

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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.

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).

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.

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.

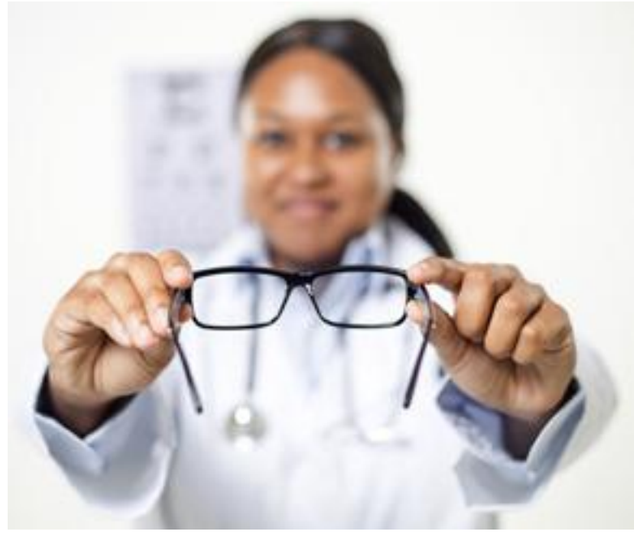
Each team is developing plans for their assigned area of eye care with the aim of improving services. These plans could be in the form of a shared pathway, a new use of technology or a workforce initiative. All plans will reflect clinical evidence, best practice and patient insight.

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.

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.



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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

^ Photo credit: Mid Yorkshire Hospitals NHS Trust

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.

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.

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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 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.

v Photo credit: Carderdale and Huddersfield NHS Foundation Trust

West Yorkshire and Harrogate Health and Care Partnership is made up of six local places:
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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 Scan4Saftety across all the other WYAAT hospitals, with large scale transformation planned for 2020/21.

Procurement (sourcing products and services)

We are working together to 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.

04

Chapter 4
Priority areas for improving outcomes

What we cover in this chapter:

West Yorkshire and Harrogate Health and Care Partnership is made up of six local places:
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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.

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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

^ Photo credit: Born in Bradford

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.

Case study

'I was terrified when I became pregnant with my first child aged 18. All I could think about was that I had 'messed up'. I lived with my grandmother who was so disappointed in me she threw me out. I had to move in with my partner. Living off his sole wage life was tough. When my baby arrived I struggled with the responsibility and found I couldn't bond with him. I felt isolated and would lie awake at night crying. I attended the Home-Start young parents group. The peer educator (PE) made me feel so welcome. I had lots of support and learned a lot. I decided to train as a PE myself but a couple of days before the course started I found out I was pregnant again. I was so determined I completed it anyway. Returning to college was a way to sort myself out. My confidence has grown massively, I have been through some hard times but I can officially say I have signed off support and have stepped up to being a PE and am now supporting other young mums currently attending group.'

Jane is a peer educator in Kirklees.

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.

West Yorkshire and Harrogate Health and Care Partnership is made up of six local places:
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^ 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.

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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.

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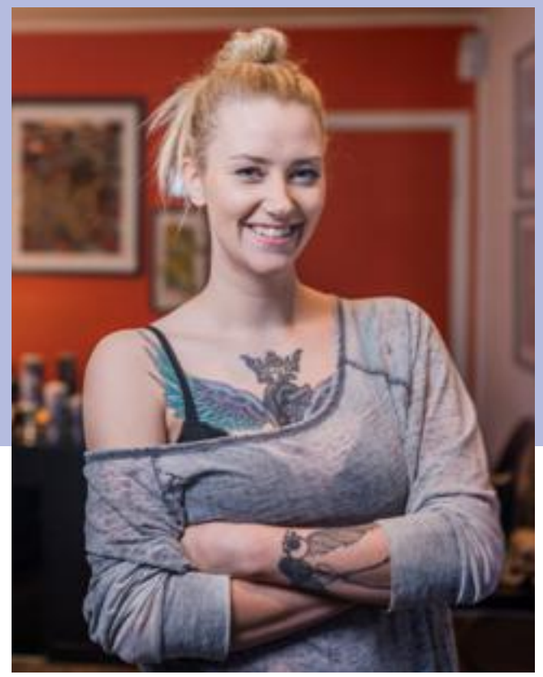
Mental health, learning disabilities and autism



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 heath 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

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.

Learning disability
Approx. 2-2.5% medical diagnosis

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.**

Autism/attention deficit hyperactivity disorder (ADHD)
Between 1-4% prevalence

Wait too long for diagnosis across the age spectrum & receive little pre or post diagnostic support

Have **worse physical and mental health** than the general population

Suffer from **lack of awareness** about their condition (& late diagnosis)

Need **better understanding** of what reasonable adjustment to services looks like to ensure access to care, employment, education is improved

Leading cause of premature death for adults is **suicide**

Only **16%** of adults in full- time paid employment; **32%** in any paid work.

Carers 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).

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

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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.

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.

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.

^ 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.

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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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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 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.

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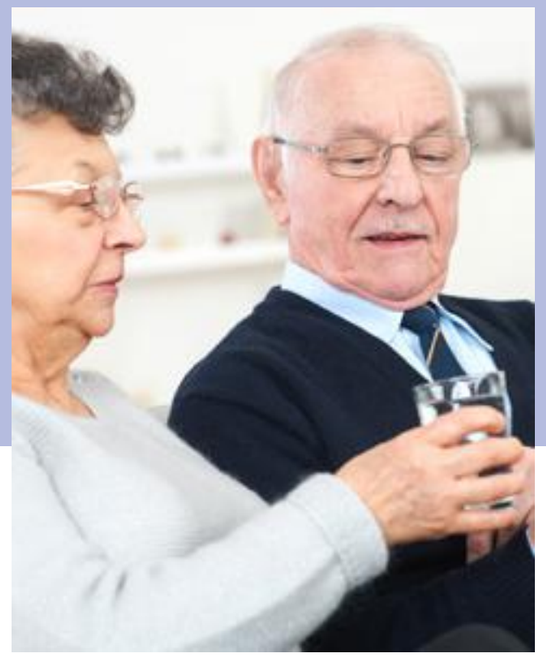
Respiratory conditions

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 death[1]. Respiratory disease kills 115,000 people each year, the equivalent of one person every five minutes[2].

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
- 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 standards[4] and through participation in the The National Asthma and COPD Audit Programme (NACAP) pulmonary rehabilitation work stream.

[3] www.ersjournals.com/press/2311/treating-COPD-CBT-reduces-anxiety-hospital-visits

[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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- 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.

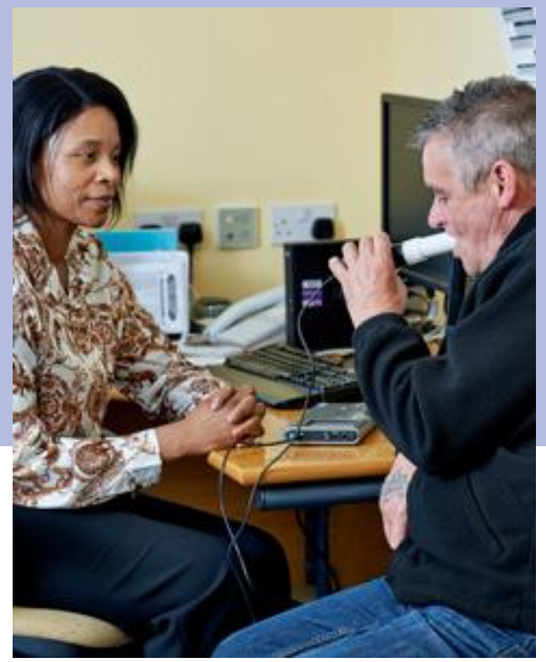
The Partnership will work towards improving joined mental health services to ensure people with Type 1 and Type 2 diabetes are supported with issues such as stress and anxiety due to needle phobia and phobia to insulin pens and also anxiety around hypoglycaemia (also known as low blood sugar, is when 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.

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.

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.

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.

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. >

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.

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^ 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

^ Photo credit: Carers Leeds

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.**

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.

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.

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.

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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

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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.

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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

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Chapter 5
Supporting work programmes

What we cover in this chapter:

West Yorkshire and Harrogate Health and Care Partnership is made up of six local places:
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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.

^ Photo credit: Leeds Council

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."

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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 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.

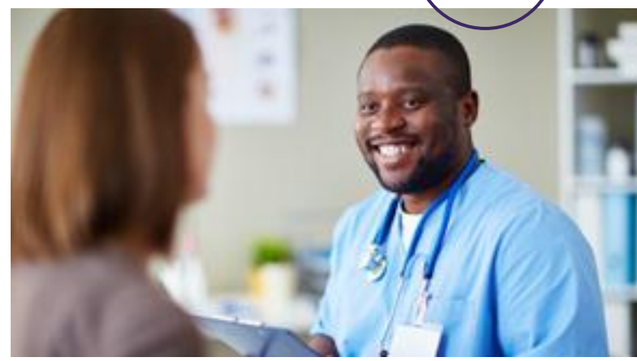
More emphasis is needed around population health needs and a greater knowledge of wider issues that will impact on people living across our area, for example climate change and the ageing population.

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.

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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.

^ Photo credit: Carers Leeds

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.

West Yorkshire and Harrogate Health and Care Partnership is made up of six local places:
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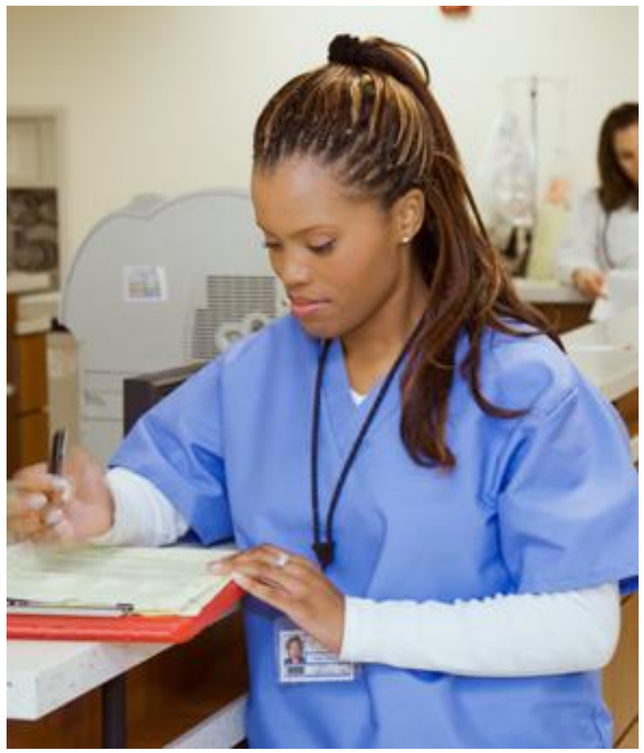
Urgent actions on nursing

- 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.

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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.

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- 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.

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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.

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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**

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'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.

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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 organsiations, 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.

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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).

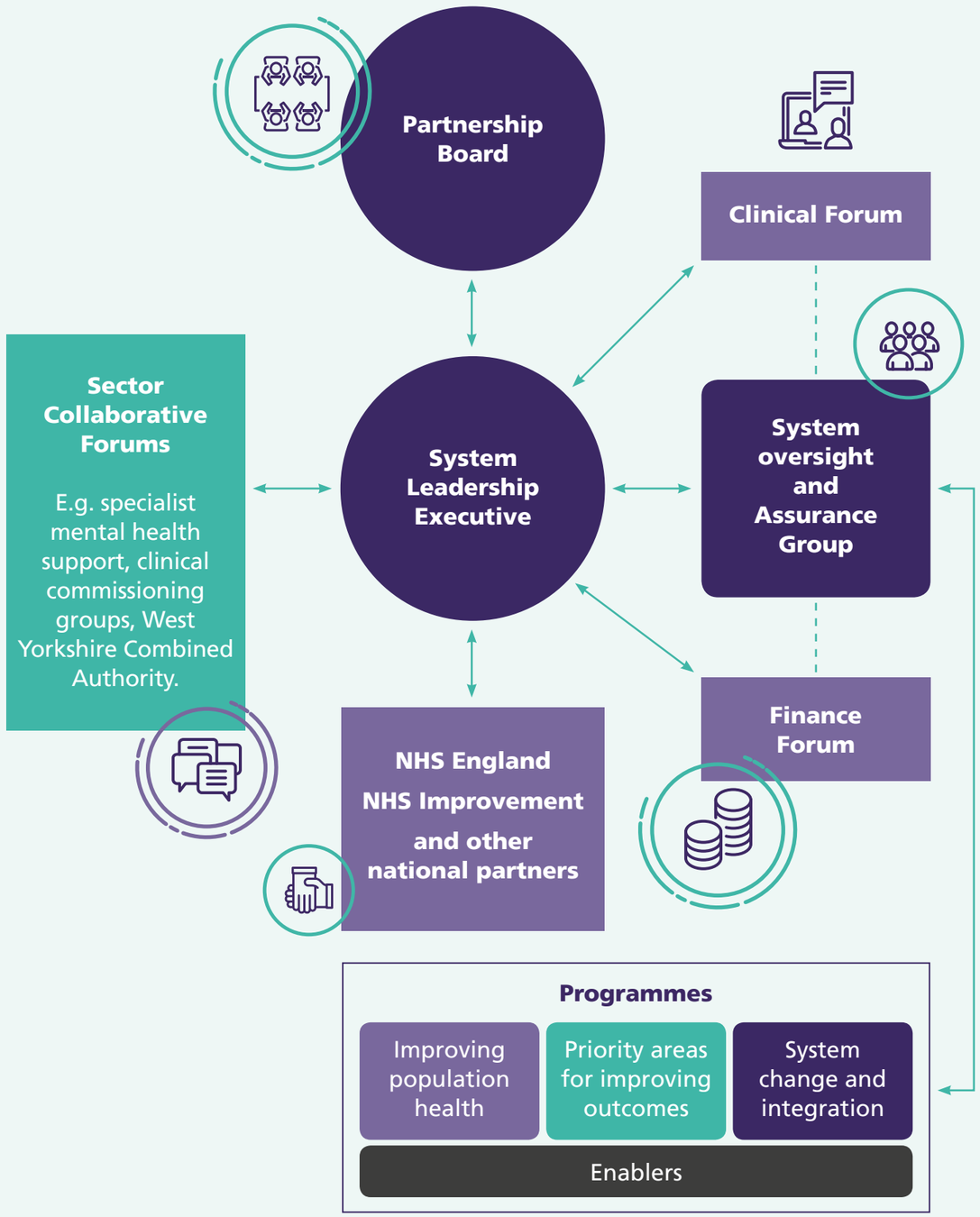
You can read our Partnership Memorandum of Understanding here.

>>

v 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.

v Stuart a helpful, kind neighbour from Leeds

West Yorkshire and Harrogate Health and Care Partnership is made up of six local places:
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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.

>>

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

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

This information is available in alternative formats, for example EasyRead, audio and British Sign Language.

For more information contact:

01924 317659

NHS Wakefield CCG
White Rose House
West Parade
Wakefield
WF1 1LT

@ westyorkshire.stp@nhs.net

www.wyhpartnership.co.uk

@WYHpartnership

Information accurate at November 2019.

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

Annex B

NHS

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.wyhpartnership.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
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

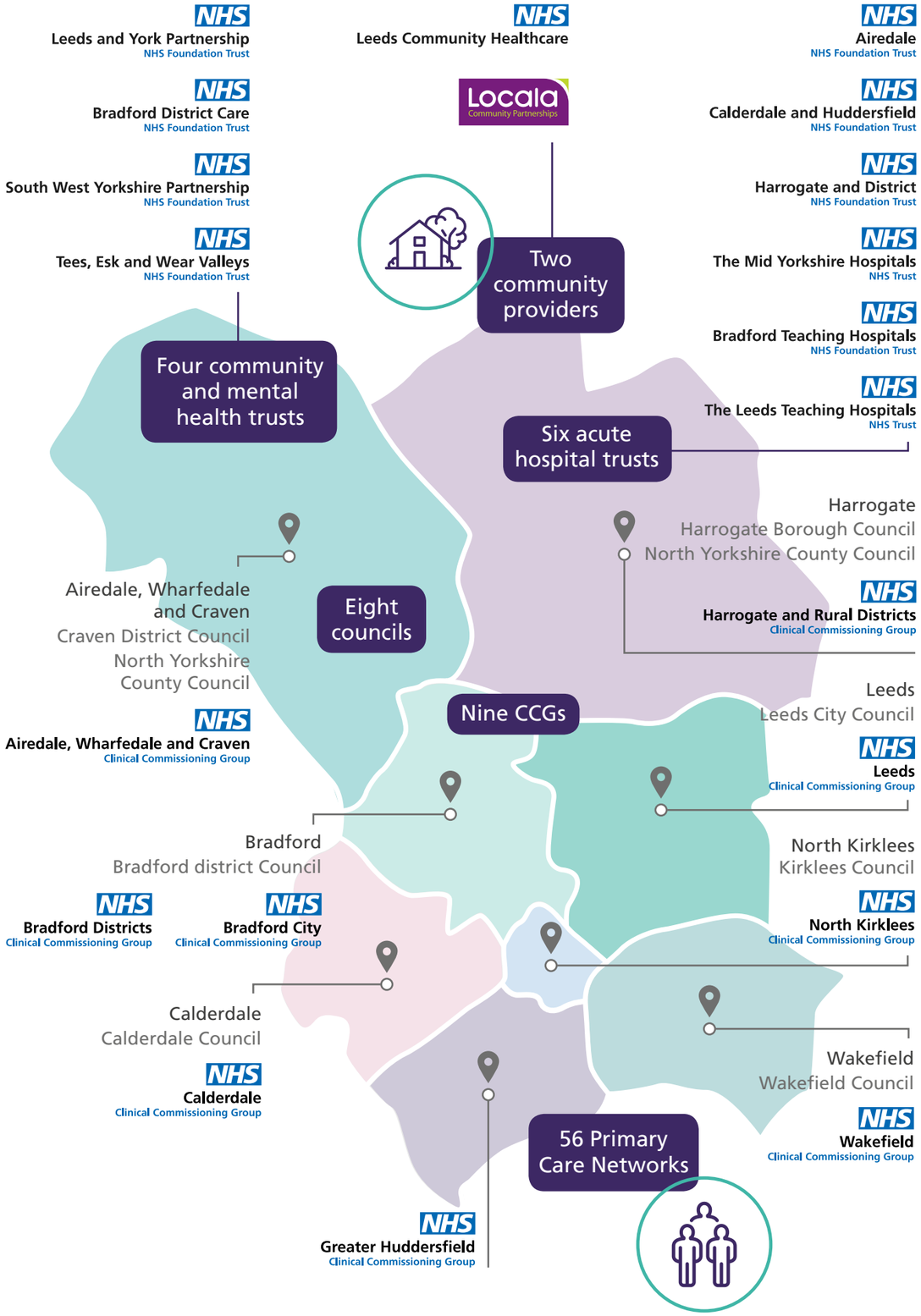
Others involved

Healthwatch
Health Education England
Leeds City Region Enterprise Partnership
NHS England
NHS Improvement
Public Health England
Universities
West Yorkshire Combined Authority
See page 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

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 working for you

West Yorkshire Police
West Yorkshire Fire & Rescue Service
Yorkshire & Humber Academic Health Science Network
Public Health England
NHS Yorkshire Ambulance Service NHS Trust
NHS Health Education England
NHS England
NHS Improvement
healthwatch
Local Care Direct we care about people
Leeds City Region Enterprise Partnership
Working in partnership with the West Yorkshire Combined Authority

- 316 GP practices
- 555 community pharmacies, plus 38 online
- 431 providers of services in people's homes
- Hundreds of independent care providers
- More than 600 care homes
- 11 hospices
- Thousands of voluntary and community organisations including those who support carers

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.

West Yorkshire and Harrogate Health and Care Partnership is made up of six local places:
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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

02 In your local area

- Health and care organisations will work together to tackle inequalities

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.**

- 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

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 Partnership's progress

2016/17

Developed our first plan to improve people's health and wellbeing

Partnership formed — West Yorkshire and Harrogate Health and Care Partnership

Agreed to work together on our finances

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

Our clinical commissioning groups (CCGs) agreed a shared work plan

1500 people identified for treatment to prevent stroke

Set up an award-winning programme to **support 260,000 carers**

2018

£1m for our health and social care workforce plans

Developed a programme and training to reduce suicides

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

£1m invested in our communities to tackle loneliness

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

Hospitals work together for the first 72 hours of critical stroke care

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

Set up a new community eating disorder service

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

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

2019

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.wyhpartnership.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

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

Managed our money better together

Launched 'Looking out for our neighbours' community campaign

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

Ten of our big ambitions

^ Photo credit: WDH

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.

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.

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

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:

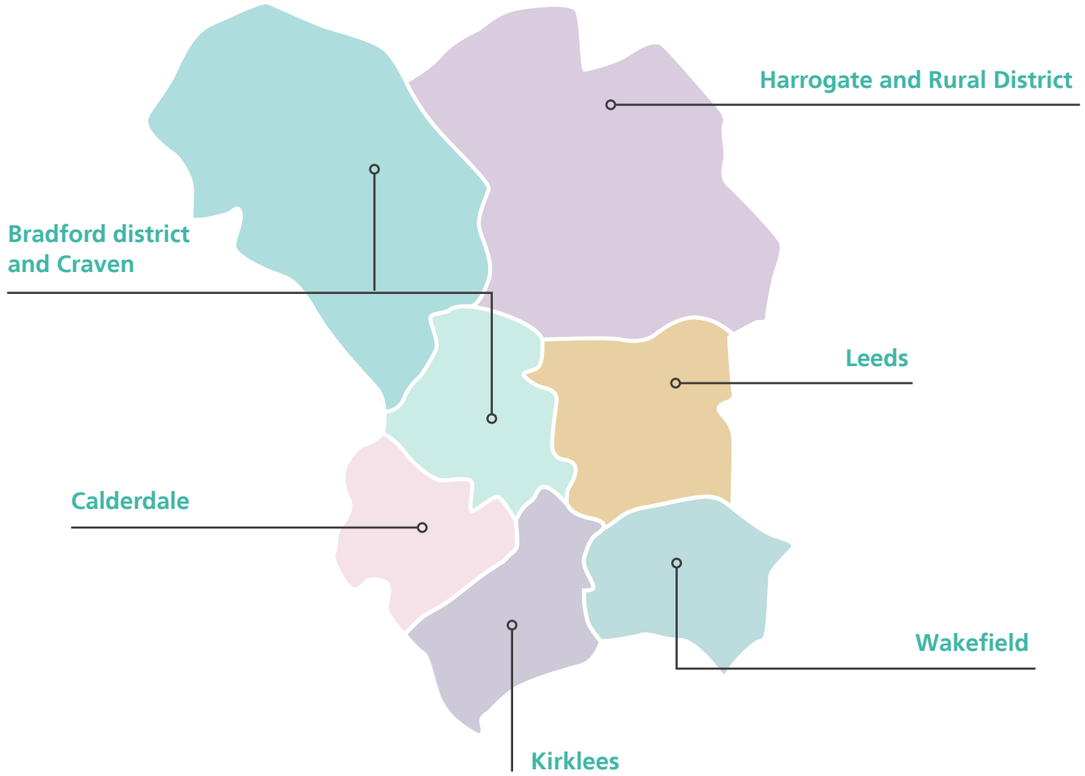
- Working at scale to ensure the best possible health outcomes for people
- Sharing good practice across the Partnership
- Working together to tackle complex (or 'wicked') issues.

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 six local places

^ Stuart, a helpful, kind neighbour from Leeds

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.



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'.

v 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.

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^ 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.

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.

Photo credit: > Harrogate and District 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

^ 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.

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.**

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.

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'.

v Photo credit: Leeds NHS

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

^ 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.

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

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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).

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.

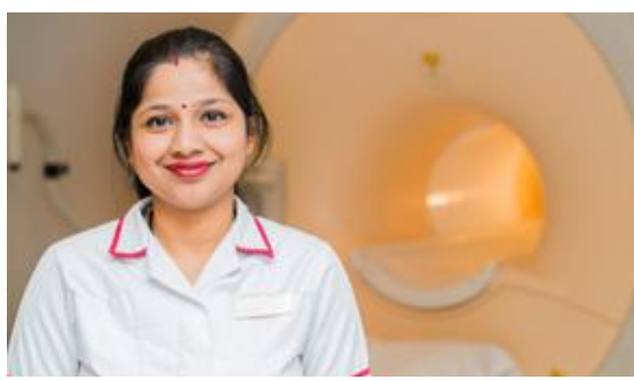

Photo credit: Mid Yorkshire Hospitals NHS Trust >

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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.

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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.

^ Photo credit: Mid Yorkshire Hospitals NHS Trust

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.**

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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

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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.

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World class services and care

^ Targeted lung health checks in Wakefield

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.

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.

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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.

^ Photo credit: Mid Yorkshire Hospitals NHS Trust

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: 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 of 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.

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Spending money wisely

^ Photo credit: Airedale NHS Foundation Trust

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 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

^ Photo credit: Leeds Community Foundation

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.

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.

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

Helpful publications

We publish a range of plans, publications and engagement reports.

You can find these here.

‘Looking after our neighbours’ campaign.

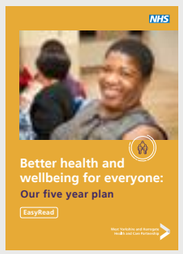
Find more information about the campaign here.

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.



Next Steps 2018, Our Five Year Plan 2019 and the Workforce Strategy 2018.

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

You can get in touch with the Partnership by:

01924 317659

westyorkshire.stp@nhs.net

www.wyhpartnership.co.uk

@wyhpartnership

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

Annex C

NHS

Better health and wellbeing for everyone:

Our five year plan

EasyRead

West Yorkshire and Harrogate
Health and Care Partnership

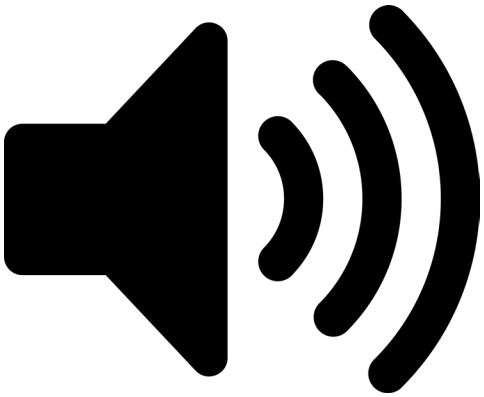
Front page photo credit: The Leeds Jamaica Society and Leeds Irish Health and Homes.

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, Wharfdale 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

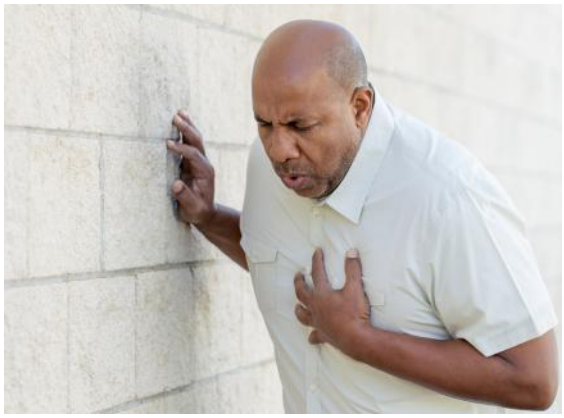
Introduction: Stronger, better, healthier together

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.

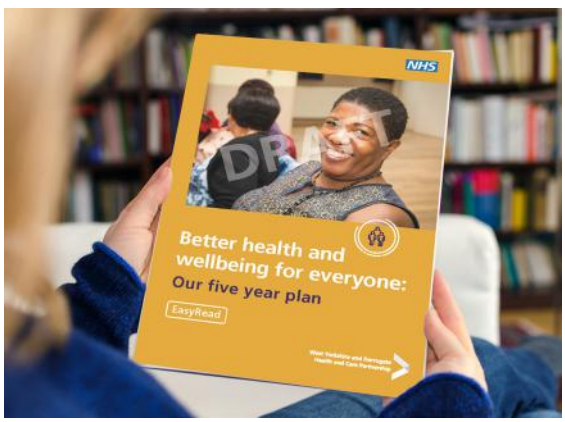
Our Partnership Board first met in June 2019. We were pleased with the work we were doing but knew we needed to do more.



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.

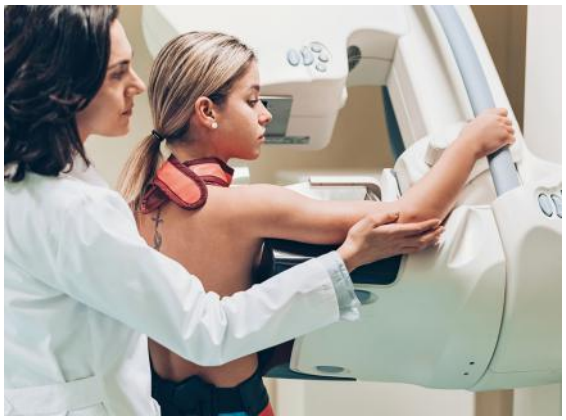
Organisations will work better together.

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.

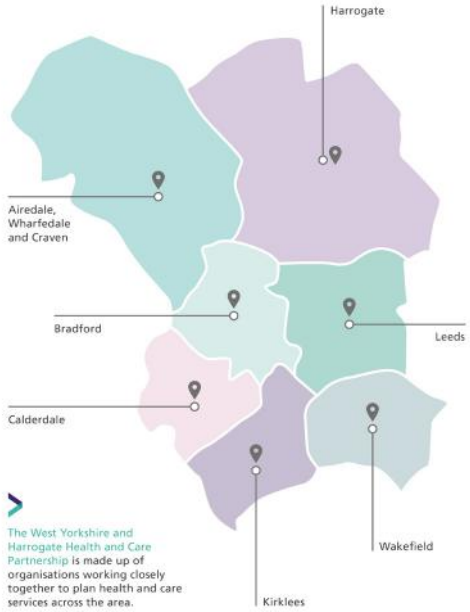
Cut down on the amount of antibiotics that people take.

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.

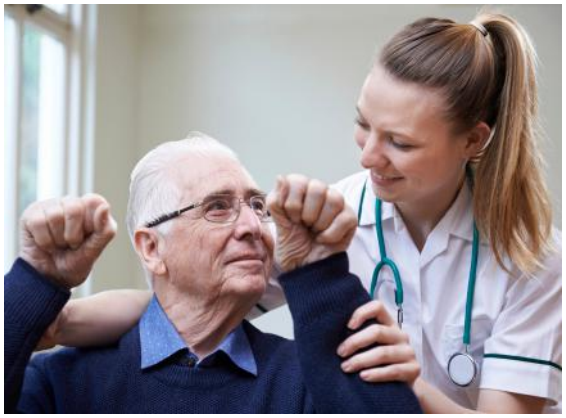
- Make sure more women have the same staff to support them throughout their pregnancy.

- Reduce the amount of woman who smoke when they are pregnant.

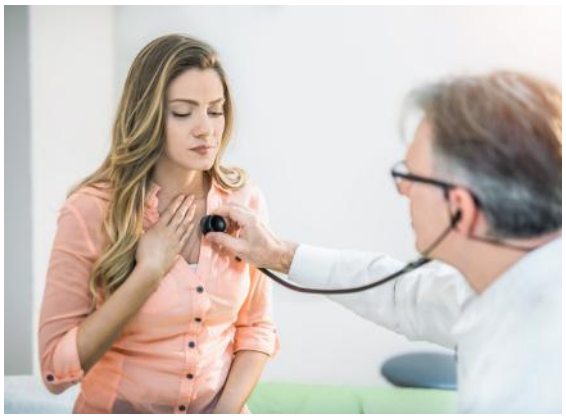
- Increase the number of woman who breastfeed.

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:

01924 317659

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www.wyhpartnership.co.uk
@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

West Yorkshire and Harrogate Health and Care Partnership

November 2019