



D R A F T 1 [27 August]

Five Year Strategic Plan

[Better Health and Wellbeing for Everyone / Planning for the Future Together – title to be decided]

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Front inside cover

Take a look back at some of the improvements West Yorkshire and Harrogate Health and Care Partnership has been making with local people to improve their lives in our short **film**.

We also want to say **'thank you'** to all the people who've shared their stories and given their views about health and care in West Yorkshire and Harrogate and for their contributions to this Plan.

We are committed to honesty and transparency in all our work and also producing information in alternative accessible formats. This Plan is also available in:

- Audio
- EasyRead
- BSL

There is also a public summary which you can read here **[make link once produced]**.

You can get involved in the Partnership's work by:

- Tel: 01924 317659
- Email: westyorkshire.stp@nhs.net
- Visiting www.wyhpartnership.co.uk
- Twitter @wyhpartnership
- **[Text: xxx]**

Our five year ambitions include XXX (different ambitions to run along the top of each page)

Foreword

[To include: signature/s. Produce foreword in film / animation]

Stronger, better, healthier together

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

We are pleased with the start we have made. The right principles and values are in place to guide us and we are keen to make sure we join the dots so when people experience care, advice and support it feels easier and is joined up for the better.

We know that more needs to be done to give everyone the very best start and every chance to live a long and healthy life. When you read our Plan, you will see why this is very important.

To have the greatest chance of achieving the very best for people's health and wellbeing, we need to think and work differently with each other and within our communities.

We are including more community partners in our conversations and are listening better to what staff and local people have to say. Now is the time to take this to a whole new level so that everyone in West Yorkshire and Harrogate is part of our journey.

Our Five Year Plan tells the story of how we are going to do this together. It is also our response to the [NHS Long Term Plan](#).

Our campaign '[Looking out for our neighbours](#)' is a great example of how our staff, partners and communities are already making a positive difference through simple acts of kindness – we are stronger, better, and healthier together. They have touched the lives of over 46,000 people. You can read the evaluation report [here](#).

Proud to be a partnership

We are happy to be working together in our six local areas (Bradford District and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield) and are proud to be part of the West Yorkshire and Harrogate Partnership. Our relationships are very important to us because we will only make a positive change when there is a strong commitment by all to do so and there is.

We have already come a long way and our journey continues to break down the organisational and geographical barriers that sometimes get in the way of giving people the best care possible. As partners we are having better conversations with one another.

We do however, need to get better at talking with people about what they want and need. Our conversations with communities will continue to grow; they often know far better than us what keeps them happy, healthy and well.

Together we want to reduce unnecessary costs, by stopping things that don't meet people's physical and / or mental health needs together or make them feel any better. We need to rethink how we can continually improve and free up money to re-invest in our community partners. There are some great examples in this Plan to show you what we mean.

We also want to make the best use of staff time and make West Yorkshire and Harrogate the best place to live and work. This is very important to us all.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

Our story

This Plan belongs to us all; it covers neighbourhood activities, rural communities, busy towns and vibrant cities. Above all it sets out what we need to do in our local areas and how our Partnership will help through working together.

When reading our Plan what we hope you will see is a shared goal, to make life better regardless of where people live and their life experiences. Everyone is valued and we want to make sure equitable opportunities exist for all.

Reaching further than ever before, we not only want to keep people safe and well; we want them to be happy too. Connecting people to places and local neighbourhood activities; working with communities to make healthier choices and breaking down feelings of loneliness which harm our health.

Making the most of every opportunity, our Plan will embrace fully what our Partnership and communities have to offer. It will also set out our approach to new technology and how this can make a positive difference to our staff's work and people's lives.

We are equal partners

Regardless of where people work, we are partners. Whether you are a community champion, receiving health and care support, attending local wellbeing activities, recovering from an illness, or caring for someone you love, we are equals. There are no boundaries. We are in this together.

Why work together?

People's lives are better when we work together to provide health and social care along with physical and mental health support. We also know that sharing good ways of working makes the money go further. It also creates the best use of staff expertise and importantly gives children the best start in life whilst improving people's chances to live a long, healthy life in their homes and communities.

We are connectors

Our role is to join things up locally and at a West Yorkshire and Harrogate level, to connect organisations and individuals in ways that make better care easier - whether this is delivering services in the home at hospital or putting people in touch with local groups for support. We also want to enable people to take action and improve their own health and wellbeing.

Health and care is more than about services

There are so many factors in keeping people well that are just as important as traditional health and social care services. This includes the house you live in, how warm it is, whether people feel isolated or alone, whether you experience financial or fuel poverty, the food you eat every day, how mobile and independent you are, whether you have a job and have access to parks.

We are challenging traditional ways of working so we see the whole person's needs rather than their stand-alone illness. Listening to people, asking them what they want and acting on what works for them is a good place to start. We have been doing a lot of that. Between us all, we have the power to change things for the better as part of one team. Our Plan sets out our intention to do just that.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

Executive summary

[To be done last thing once all partners have contributed, made comments, approved etc. Info graphic format once document draft signed off. Include a map of the area].

[To include] In 2018 the government announced that the NHS budget would be increased by £20 billion a year in real terms by 2023/24. In January 2019, the NHS in England published a [Long Term Plan](#) for spending this extra money. This covers a broad range of areas, including making care better for people with a learning disability, cancer, heart failure and mental health conditions, investing more money in technology and helping more people stay well.

Partnerships like ours, also known as integrated care systems (ICS) and sustainability transformation partnerships (STP), have been tasked with developing a Five Year Plan. This Plan will set out how we will achieve the ambitions of the NHS Long Term Plan for the 2.6million people living across West Yorkshire and Harrogate with the money we have available.

[To include: summary of the more outcome-focussed five year ambitions in info graphic format].

This Plan sets out what we are going to do together at a West Yorkshire and Harrogate level over the next five years and beyond. It aims to complement the work taking places in our six local areas and does not replace the local plans.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

Our vision

[To do: amend vision circle include the 56 PCNs]

Our five year ambitions include XXX (different ambitions to run along the top of each page)

Content page

[To be done last thing]

Our five year ambitions include XXX (different ambitions to run along the top of each page)

About our Partnership

Introduction

[In a box – list partners, info graphic of the number of people living across our area (2.6million people) with a £5.5b budget. Add in box health inequality stats and figures. Add Healthwatch report front cover. Add map].

What is an Integrated Care System?

[West Yorkshire and Harrogate Health and Care Partnership](#) is also known as an ‘Integrated Care System’ (ICS). An ICS is given flexibility and freedoms from government in return for taking responsibility, for the delivery of high quality local services. **Throughout this Plan we will refer to ourselves as the Partnership because we believe this describes what we do more clearly.**

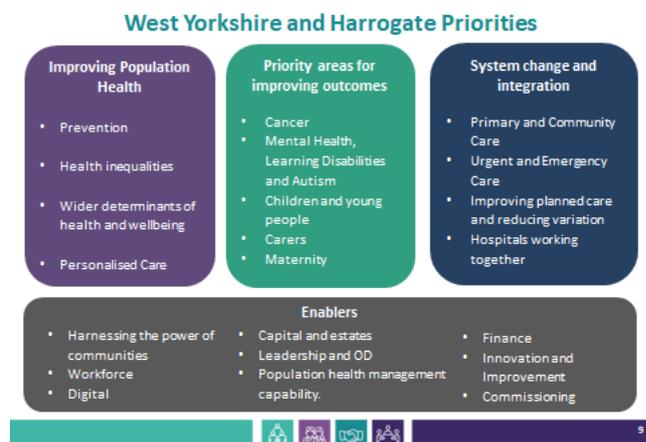
Our staff, partner organisations, six local places, and communities are the integrated care system. Our six local places are:

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

West Yorkshire and Harrogate Health and Care Partnership focuses on the health and wellbeing of local people living in these six places.

The Partnership is not the boss of the partners, it is their servant. And this is crucial. It allows the power and energy to remain aligned to statutory accountabilities and to be given to the Partnership when it matters. The reality is that without our local partners working together, including housing, public health, education, and community organisations, none of us would be able to tackle any issues alone.

As a Partnership, we agreed that we need to address three gaps across West Yorkshire and Harrogate: health inequalities, differences in care people receive, and financial sustainability. In order to do this we agreed to work at a West Yorkshire and Harrogate level on the following priority areas of work (please see diagram below). These important priorities and our five year ambitions are set out in this Plan. **[To do: rework diagram].**



West Yorkshire and Harrogate is made up of six local places: Bradford District and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

[In a box]

We only work at a West Yorkshire and Harrogate level when one or more of the following three tests apply:

- **We need to work at scale to deliver the best care possible to people**
- **Examples of good practice can be shared across the area**
- **There is a complex issue that we all face and working together is likely to deliver better health and wellbeing results for people.**

Partners

The Partnership is made up of many organisations including the NHS, councils, Healthwatch, voluntary, and community organisations who work to provide the best health and care possible to the 2.6million people living across our area. This support is delivered by committed, dedicated staff; unpaid carers and volunteers. It includes a health and social care workforce of over 100,000 people.

We have 56 Primary Care Networks (also known as Primary Care Homes / Communities: see page 40) seven local care partnerships, and eight councils.

We also work with hundreds of other organisations, including the Police, West Yorkshire Fire and Rescue Services, independent care providers and charities. Watch our short animation to find out more here **[To do: once produced]**.

This is our five year plan

This Plan is our response to the [NHS Long Term Plan](#). It sets out the work we will do over the next five years together at a West Yorkshire and Harrogate level and how we plan to achieve the ambitions we have for everyone working and living across the area. It does not replace the plans of our six local places.

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

[To do: Make links to local plans].

We are proud of the [‘Positive difference our Partnership is making’](#) yet we are not complacent. There are some big challenges around rising, unmet health and care needs and significant barriers to better health and health inequalities we need to address. This Plan sets out how we will work with our communities to achieve our ambitions. **[To add: image of case studies].**

Our ultimate goal is to put people, not organisations, at the heart of everything we do so that together, we meet the diverse needs of all communities.

This means at all levels of the Partnership:

- **We are working to improve people’s health with and for them and to make life better**
- **We are working to improve people’s experience of health and care**
- **We want to make every penny in the pound count so we offer best value to the people we serve and to taxpayers.**

Our five year ambitions include XXX (different ambitions to run along the top of each page)
Our healthcare services are treating more people than ever before, providing better services faster, safely and in better environments, as well as supporting more people to live at home independently. This is after all what we all want.

Most importantly we are working locally together with people in our six local places to give them the best start in life and the opportunity to live and age well, whilst working hard to tackle health inequalities we know exist for various reasons (see page 24) for more information about how we work).

We are proud to be the home to many world leading new treatments delivering care to people at the forefront of technology. For example, surgeons at Leeds Teaching Hospitals NHS Trust made history in 2018 by performing the UK's first double hand transplant in a female patient in the UK. In many areas, we are leading the way to develop a culture of innovation across health and care organisations - you can see many examples throughout our Plan.

Despite facing the most significant challenges in health and social care for a generation, we are addressing these issues head on and working to better meet people's needs in care homes, hospitals and communities.

Demand for services is growing faster than resources, and we must keep innovating and improving if we are to meet the needs of people to a consistently high standard.

The current adult social care system is under unprecedented strain. There are increasing demands, especially due to the ageing population living with a number of health conditions and increasing numbers of adults with significant learning disabilities and mental health illness.

The social care sector has experienced many years of under investment. Most care is provided by a huge number of independent sector providers and there are issues across the sector with market stability, quality and workforce shortages. There is also evidence that an even greater burden is falling on unpaid carers.

The delays in publishing the long awaited 'green paper' on the future of adult social care has led to a succession of short term funding announcements and a lack of clarity over long term planning. This Plan has been developed in this context, and we recognise that the publication of the 'green paper' and the subsequent policy changes should have a significant impact on this Plan.

From our conversations with local people (find our more [here](#)) and a recent West Yorkshire and Harrogate [Healthwatch report](#) (June 2019), we know that people want things to be better, more joined up so organisations don't work against each other, and care is more suited to individual need (see page 40).

People with lived experience, staff, carers and volunteers who deliver care are the experts, they know what works well and doesn't in their local areas. It is also essential, that the voice of staff, all communities and people from seldom heard groups are involved in the planning of services, for example people with learning disabilities. Our Plan sets out our commitment to ensure this continues to happen over the next five years. You can see examples of how we plan to do this throughout our Plan.

We want West Yorkshire and Harrogate to be a great place to work and an outstanding place for care and support; whether in the community, in one of our hospitals or online. This commitment binds us together and we have a Partnership [Memorandum of Understanding](#) which sets this out clearly. You can find out more about the way we work on page 12).

Our five year ambitions include XXX (different ambitions to run along the top of each page)

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

We benefit from strong local partnership working in each of our six places and this is where most of our work with communities takes place and the majority of care is provided. Throughout this Plan, you will hear about how health and care services are being joined up to improve the support people receive locally and the added value brought by working together at a West Yorkshire and Harrogate level.

Case study

Leeds is the first city in the UK to report a drop in childhood obesity. The decline is most marked among families living in the most deprived areas, where the problem is worse and hardest to tackle. There is an opportunity to share and spread learning across West Yorkshire and Harrogate through our Children and Young People Programme (see page 69).

The importance of joining up services for people at a local level is at the heart of all our plans. This work is centered on the plans of local Health and Wellbeing Boards, which brings councillors, NHS leaders and community organisations together.

You can see an example of how this works at a West Yorkshire and Harrogate level through the work of the [Partnership Board](#). This brings elected members, non-executives, and independent members into the decision making process. Over 70 representatives make up the Board, including Chairs of the local Health and Wellbeing Boards. The list of members is available [here](#).

How we work

[In box]

We are entering a significant period for the health and care system, with the social care green paper imminent and the ‘[Advancing Our Health: prevention in the 2020s](#)’ green paper consultation document published in July 2019. The development of primary care networks is an opportunity to further improve care in every neighbourhood. Local Government funding, innovation, inclusive growth, and housing also all have a role in our future. There are risks around funding, capacity, staffing, and service pressures. We need to deal with these and be hopeful that national political choices will support our Partnership to meet the needs of local people.

Joining up services to improve the health and wellbeing of communities

In our communities, GPs, community nurses, social care workers, community organisations, charities, mental health services, pharmacists, and other care providers are working together to provide better joined-up services for people.

The new Primary Care Networks (also known as Primary Care Communities / Homes) are an important part of this because they build on local partnerships already in place (see page 40 for more information).

Primary Care Networks (PCNs) are often described as the ‘front door of the NHS’ providing people with community-based access to medical services for advice, prescriptions, treatment, or referral, usually through a GP or nurse.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

It's important to note that our local place approaches go much further than this; to us it is all about communities, supporting carers and the work we do alongside community partners. We want people to be able to get care, information and advice on the full range of support available to them in their community easily and when they need it the most.

[Case study: need picture and sign off]

Cross Gates Leeds Primary Care Network

Nurse Andrea Mann is Clinical Director of the Cross Gates Leeds Primary Care Network (PCNs). The Cross Gates PCN is part of the East Leeds Collaborative (made up of three PCNs) with an approximate 95,000 population altogether or around 30-32,000 patients each. They work together to join up care more effectively to deliver new services. Andrea said: 'Over the next five years we could have a really wide range of workforce roles so patients will be able to access a variety of professionals for different health conditions. Where we have higher prevalence of, for example a specific long term health conditions, we can tailor the models of care and services available to those populations. We will also be engaging more with our patients, community services, third sector volunteers, social care, and patients; we will build relationships with organisations around our populations and start to see better care and outcomes for their personal needs as the models develop. There is so much we can do with it to improve the care for our patients across economies of scale. I'm keen to bring my skills to the table as a nurse leader, practice partner and from a management perspective to help shape the future of general practice.'

Working with our eight council partners (Bradford Metropolitan District Council; Calderdale Council; Craven District Council; Harrogate Borough Council; Kirklees Council; Leeds City Council; North Yorkshire County Council; Wakefield Council) and communities is central to this way of working. Primary Care Networks (PCNs) are key to the work in our communities on the wider determinants of health; for example, housing and health, poverty and employment. Our system leaders are very clear about this.

As the PCNs develop there will be a greater use of an approach called 'Population Health Management' (see page 28). Population health brings together an understanding of the health needs of a given population using big-data analytics, public engagement, and health and care insights.

Watch this [animation](#) from the Kings Fund (August 2019): What is a 'population health' approach? And what role do we all play in keeping our communities healthy?

PHM is important because it gives us the information we need to tackle a range of health and inequality issues and ultimately give us the ability to organise services around people, including those most disadvantaged. It also gives us the opportunity to engage with people on a wide range of health and inequality issues that affect them.

We know people's health is influenced by various factors and the interactions between them. This includes the conditions in which people live and work; social and economic factors like education, income and employment; lifestyles including what people eat and drink, whether they smoke, and how much physical activity they do; as well as the barriers they experience to accessing health care and other public and private services.

Age, sex and genes make a difference to health too, as well as social networks and the wider society in which people live. There is a lot of good work taking place across the area, for example the [Born in Bradford](#) research and we want to share good practice and spread learning across West Yorkshire and Harrogate (see page 12).

Our five year ambitions include XXX (different ambitions to run along the top of each page) Jacqui Gedman, Chief Executive at Kirklees Council, and Sarah Roxby from WDH and NHS Wakefield Clinical Commissioning Group talks about the importance of good housing and health **in our film [here](#)**.

At a local and West Yorkshire and Harrogate level we are working hard to provide more personalised care for people, including greater take up of personal health budgets, peer support and social prescribing.

Social prescribing involves helping people to improve their health, wellbeing and social welfare by connecting them to community services which might be run by the council or a local charity. For example, signposting people who have been diagnosed with dementia to local dementia support groups.

The [NHS Long Term Plan](#) highlights the need to move towards a more personalised approach to health and care so that people have the same choice and control over their mental and physical health as they would have in any other part of their life. We want this way of working to become every day practice. Supporting people to be more knowledgeable, skilled, and confident in engaging with and managing their health care brings benefits for everyone (see page 34).

Daz from Wakefield explains the importance of personalised care and social prescribing **in this [film](#)**.

Local area partnerships

The number of people living in our six places ranges from 160,000 in Harrogate District to 785,000 in Leeds. In each of these places, councils, NHS organisations (including clinical commissioning groups who buy local health services), Healthwatch, and community organisations are working together to understand people's needs better. These local partnerships organise how they use their collective resources, including buildings and staff, to deliver better joined up care for people.

[Case study: picture to be added]

Living a larger life

Using creative activities to help people 'Live Well in Calderdale', is a partnership between Calderdale Council, South West Yorkshire Partnership NHS Foundation Trust, West Yorkshire and Harrogate Health and Care Partnership, Calderdale Clinical Commissioning Group, Creative Minds, and other creative organisations. The vision is to make Calderdale a leader in using arts and culture to support people's health and wellbeing, whilst tackling health inequalities. The mission is to enable people to engage in creative approaches so that they can live well in their community and achieve their potential.

[Case study: picture to be added]

Harrogate and Rural Alliance

Harrogate and Rural Alliance (HARA) is bringing together primary care, community health and adult social care in Harrogate, Ripon, Knaresborough, Nidderdale and the surrounding areas, covering a population of 160000 people. From autumn 2019, integrated community health and adult social care teams are working across four communities, wrapped around primary care practices, to prevent ill health and to provide joined up care. The NHS, social care, mental health, community organisations and independent care providers are working together as one multi-disciplinary team. The Alliance was established as a commissioner and provider partnership in the wake of the national New Models of Care programme demonstrator site in the area and in response to the local clinical commissioning group strategy, '[Your Community, your care: developing Harrogate and Rural District together](#)' and the transformation of adult social care services to promote prevention and reablement of people following an illness or stay in hospital.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

The whole approach links to the development of Primary Care Networks (see page 40) as part of community asset building. The five organisations leading the transformation are Harrogate and District NHS Foundation Trust; NHS Harrogate and Rural District Clinical Commissioning Group; North Yorkshire County Council; Tees, Esk and Wear Valleys NHS Foundation Trust; Yorkshire Health Network – working around the local Primary Care Networks.

HARA is taking forward the West Yorkshire and Harrogate priorities at ‘place’ level:

- **Improving health and well-being for everyone: HARA have developed a new model, anchored in primary care, based on prevention, planned care and unplanned care, optimising all available resource. A Population Health Management approach (see page 28) to frailty within the integration of community teams has been agreed as the first test piece in improving population health by identifying people at risk earlier and working with them to manage their care better, pre-empting and planning responses to future health crises that could result in an admission to hospital. HARA will facilitate a holistic approach by investing in improved care co-ordination; community health assets and workforce developments.**
- **HARA will ensure the person is at the centre of their care, and provide accessible, high quality services and information to make it easier for a person to make healthy choices and stay well. To be able to prevent ill health and move services closer to home, they have committed to working collaboratively across health and social care, and also with community partners, recognising that the workforce and communities are its greatest asset. A workforce and organisational development plan to engage with, empower and develop staff across the alliance is established. This includes development of the leadership, talent and workforce skills needed to provide services in community settings. Flexibility in service delivery will be achieved through the development of generic roles which can work across the system. They will be working jointly with the public as experts with experience, exploring opportunities to improve participation and co-production of services.**
- **The integrated teams will be a primary care network centred model (hybrid model between networks and geography). In addition, options to simplify access to urgent care within primary care are being explored.**
- **The HARA model recognises the need to harness assistive technologies in delivery of the new model. Data sharing agreements are progressing between providers. NYCC are an early adopter site for LHCRE which is seen as a solution for achieving a shared care record.**
- **The current estates model is being evaluated to improve the efficiency of team working across primary and community health and adult social care services.**
- **This new way of working will prioritise people’s needs while managing demand effectively to deliver high quality services that offer value for money for the Harrogate £.**

Health and Wellbeing Boards are driving joined up health and social care and making sure that preventing ill health is at the heart of everything - helping to keep people well in the first place, rather than just managing ill health better. You can read examples of how Health and Wellbeing Boards are working with partnerships like ours, in a publication by the Local Government Association [here](#).

[Case study: picture to be added]

The maternity services at the Calderdale and Huddersfield NHS Foundation Trust have been awarded Unicef’s first joint The Baby Friendly Achieving Sustainability Gold Award – shared with their Locala partners. The services work together to provide parents across Calderdale with the best possible care to build close and loving relationships with their baby and to feed their baby in ways which will best support health and development. The UNICEF assessment of the service said: ‘There is an excellent specialist service in place and there is evidence of integrated working within the community, to ensure that babies, mothers and their families receive seamless care. Of particular note is the peer support programme and Baby Cafes which are well evaluated and effective monitoring suggests they are helping to support a rise in breastfeeding rates’.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

The large majority of hospital services will continue to be provided in each of our six local places. These hospital services will work seamlessly with primary and community services (primary care is the day-to-day healthcare available in every local area and the first place people go when they need health advice or treatment). Increasingly they will operate in networks with other providers across the Partnership to reduce the difference in care people receive, regardless of where they live.

[Case study: picture to be added]

Working together across West Yorkshire on vascular services

In 2018, West Yorkshire Association of Acute Trusts (hospitals working together) agreed it would be best for people needing vascular care if all vascular services in West Yorkshire (except Harrogate, who work with York Teaching Hospitals NHS Foundation Trust to provide vascular services for people in their area) were brought together into a 'single regional service' under one management team. This will create one of the largest vascular services in England covering a population of over 2million and with almost 40 specialist vascular consultants (surgeons and interventional radiologists). For people receiving treatment it will improve ease and equity of access to vascular services as well as continuity of care. Although our outcomes are very good, there are pockets of knowledge, expertise, and technical developments held in different unit across the area. We need to embrace the 'best' practice and share the skills and break down any organisational boundaries. Regional working as a single service should also work to importantly give people increased choice. If there is a long waiting list at one site for a certain type of procedure but a shorter wait on another site, we should be able to offer the person the procedure sooner by moving outside of organisational boundaries. [This will need to be updated following NHS E work].

[In a box]

The majority of our work happens in our six local places. This means we only work together at a West Yorkshire and Harrogate level where it makes sense to do so – where there are economies of scale, where expertise and skills can be shared and where it is better for the workforce.

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

We know that for some complex services we need to plan and work across West Yorkshire and Harrogate to achieve the very best health outcomes for people. There are many examples of this in our Plan, including our work around hyper acute stroke (the care people receive in the first 72hrs after a stroke), vascular services, and cancer. Our work at a West Yorkshire and Harrogate level reflects the fact that very complex services should be provided in centres of excellence; and that hospitals need to work in close partnership with each other in networks to offer the very best care to people (see page 59).

[In a box]

Following extensive public and staff engagement it was agreed in 2018 that West Yorkshire and Harrogate would have four units to provide specialist hyper acute stroke care (the care people receive in the first 72 hrs. after a stroke.). These are in Bradford, Calderdale, Leeds and Wakefield. We agreed to create a stroke clinical network and improve quality and health outcomes across the whole of the stroke pathway for example preventing stroke; support after having a stroke; long-term care and end of life care. We aim to have a standardised 'whole pathway' stroke service specification across West Yorkshire and Harrogate – so that no matter where people live they receive the best quality care possible. We listened to over 2500 people over 18 months, including voluntary, community organisations, people who have had a stroke, unpaid carers, councillors and staff. You can find out more [here](#).

Our five year ambitions include XXX (different ambitions to run along the top of each page)

Sharing good practice across the Partnership

We have a history of innovation across West Yorkshire and Harrogate; but we need to get better at sharing and spreading these new ways of working.

Working together means we can identify share and spread good practice across partners. For example we are making good progress on our ambition to spread 21 innovations, including preventing cerebral palsy in preterm labour (PRECePT). We met or exceeded these ambitions for 18 of those innovations and for six of them we exceeded our ambition for adoption 12 months earlier than expected. This included a medicines optimisation project and treatment for people with an enlarged prostate.

Our Partnership is demonstrating how open we are to innovation and how the whole system can work together with organisations such as the Yorkshire and Harrogate [Academic Health Science Network \(AHSN\)](#), [Leeds Academic Partnership](#) and the health tech industry (see page 99).

[Case study: add picture]

Reducing cardiovascular disease

Atrial Fibrillation (AF) causes devastating strokes every year with one in every 20 sufferers left with a life changing disability. Yorkshire and Humber AHSN has provided hands-on support to GP practices across Yorkshire and the Humber to improve their ability to detect people who have AF and protect them through anti-coagulation drugs. The AHSN has issued hundreds of mobile electrocardiogram (ECG) devices to facilitate testing across the region. Since April 2018 in West Yorkshire and Harrogate 1,500 patients have been identified as having AF with approximately 2,000 people receiving anticoagulation drugs. As a result of this, it is estimated that 81 people with AF in West Yorkshire and Harrogate did not have a life-changing stroke because they received protective medicines.

Yorkshire and Humber AHSN has also worked with Healthwatch Kirklees to make mobile testing devices available to its public engagement team. This included providing training for the team and creating information and sign-posting resources for members of the public who took the test. The AHSN also linked the Healthwatch Kirklees team to the British Heart Foundation, which provided information on AF and the importance of early identification of the condition, its impact on health and wellbeing and the type of treatments required to manage it.

We have some excellent examples of where this is making a positive difference to people's lives. For example we are sharing work from Bradford to reduce the number of people experiencing heart disease by 10% across our area by 2021 via our [West Yorkshire and Harrogate Healthy Hearts Project](#). This would mean 1,100 fewer heart incidents by 2021.

[Case study: add picture]

Leeds researchers have been awarded £10.1m from UK Research and Innovation (UKRI) to expand a digital pathology and artificial intelligence programme across the North of England. The successful partnership bid was led by the University of Leeds and Leeds Teaching Hospitals as part of a network of nine NHS hospitals, seven universities and ten industry-leading medical technology companies, called the Northern Pathology Imaging Co-operative (NPIC). The cooperative is set to become a globally-leading centre for applying artificial intelligence (AI) research to cancer diagnosis.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

Working together to tackle complex (or ‘wicked’) issues

As partners we share many common challenges, including health inequalities linked to wider determinants, and barriers to accessing care; threats to health and wellbeing from poor mental health and substance misuse and the availability of affordable social housing. Like many other areas we have financial pressures and challenges around staff recruitment.

As our Partnership develops we will take collective responsibility for financial and operational performance across West Yorkshire and Harrogate. NHS organisations have agreed to a financial framework which includes a single control total which means that NHS partners will take greater ownership of managing NHS money. In return we hope to be rewarded for delivering financial balance overall (see page 104).

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

Re-thinking the care market

Care services (home care, residential and nursing homes and other services) are a pivotal part of the health and social care system: helping people to stay independent at home, and providing support in a 24 hour setting where they require greater assistance.

In the West Yorkshire and Harrogate area alone, in excess of £800 million [provisional figure] is spent annually by councils, the NHS and individuals who fund their own care.

As with the national picture, the care sector regionally faces a multitude of challenges ranging from: provider viability, variable supply, variations in quality, difficulties with workforce recruitment and retention (especially for nurses), and a fragmented and inadequate funding landscape. These issues when combined have created a system that is going to struggle to meet care needs of communities in the future. We are working already to address the short to medium term issues that are within their gift.

However beyond these issues, is a more fundamental question about what will people need in the future to support them to live a good life and how does the care sector evolve to enable this.

In this context, our Partnership has embarked on a piece of work to fundamentally re-think the care provision of the future. The intention is to look at short, medium and long term interventions that can be put in place to help manage the more immediate problems; whilst shaping a future vision for our care sector.

The early work across the partnership has identified the need to explore the potential of how the combination of taking an asset-based based approach to working in partnership with people and communities, alongside smarter use of housing and technology, and a more joined up approach to the health and social care workforce, can create a care sector that is fit for the future and helps us overcome the systemic, structural, financial and cultural issues that we now face.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

Working in partnership with people and communities

[Case study: add picture]

Craven District Council worked with a local community group to upgrade the facilities in their local park (**Aireville Park**) in Skipton. They agreed a masterplan, which included a new pump track, skate-park and a really ambitious new play area. It was a far-reaching programme and one they could not have funded on their own. The **Friends of Aireville Park** raised money and applied for grants (which the public sector was excluded from), whilst relying on the council's procurement and project management expertise, as well as their negotiations with developers over contributions from s106 agreements to bring it all together. In just over three years everything has been completed and the play provision for tots to teenagers and beyond is vibrant, incredibly popular and well used. The whole project was a real testament to the power of community development and what can be achieved when we work together with our communities.

We know that hospitals and doctors not only keep people well. Where people live, their homes, the community environment, family support and the life choices they make are vital.

Working alongside our communities is therefore a crucial part of our Partnership – recognising people as equal partners who often know what keeps them well and happy much better than us.

The role of voluntary and community organisations, councillors and staff is essential if we are to improve health and wellbeing in our communities. The big long term challenge facing our public services is how they can help people to live well for increasing lifespans, avoiding or delaying the onset of long term health problems wherever possible, and effectively self-managing those conditions they do develop, where safe to do so. This will require a different kind of relationship with people and families, with support that reaches them earlier and in their homes and communities.

A key part of the work we do is around building trust with communities and groups who face barriers to equitable care.

We will continue to do this by listening to the views of people on what is important to them, and acting on what we hear. Our aim is to provide support to communities in a way that enhances community power.

We are committed to meaningful conversations with people on the right issues at the right time. Effective public involvement, particularly with those with lived experience and who are seldom heard, will ensure that we are truly making the right decisions about the planning of our health and care services. This approach is central to our [communications and engagement strategy](#). [To do: make link to new one and easy read when produced].

Community conversations

We have refreshed our existing engagement and consultation mapping documents and are drawing on the wealth of other expertise via our West Yorkshire and Harrogate [priority programmes](#) and local place engagement networks to inform the development of our Plan. These include public assurance groups, patient reference groups, and community champions. We aim to maximise all our networks without duplicating effort and cost.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

[Case study: add picture]

Our community/patient panel is just one of the ways in which West Yorkshire and Harrogate Cancer Alliance is working with those affected by cancer across our area, including patients, their families and carers. This helps to make sure their experiences and views influence the work we do and the decisions we take.

[In a box]

Our engagement and consultation mapping report captures intelligence collected from engagement and consultation activities carried out across West Yorkshire and Harrogate during the period January 2014 to March 2019. It also includes reference to any work stream specific mapping exercises that have taken place, for example mental health, and where available provides details of any issues raised by protected groups. This insightful report helps to ensure we don't duplicate effort and people's time - and most importantly points us to public conversations that have already taken place to inform our planning. We do of course do engagement work where there is a gap in knowledge and where we need to understand people's views more clearly, for example carers.

Over the past three years we have produced and published on our website all engagement activity we have been involved in. This includes:

- [Digitisation and personalisation](#) (June 2019)
- [Mental health and learning disabilities](#) (March 2019)
- [Mapping of organisations for young people across West Yorkshire and Harrogate](#) (July 2018)
- [Audit of urgent and emergency care communication messages](#) (July 2018)
- [Review of engagement and consultation activity on elective care and standardisation of commissioning policies](#) (March 2018)
- [Communication needs for people with a sensory impairment](#) (November 2017)
- [Standardisation of policies](#) (September 2017)
- [Maternity services](#) (August 2017)

Reports are produced following community engagement activity. These have informed the development of this Plan. Other engagement work includes:

- [Healthy Hearts Cholesterol Public Engagement](#) (June/July 2019)
- [Young carers engagement event](#) (25 June 2019)
- [NHS Long Term Plan and Harnessing the Power of Communities showcase event](#) (May 2019)
- [Assessment and treatment units engagement for people with learning disabilities](#) (February/March 2019)
- [How the NHS Long Term Plan can support better outcomes for unpaid carers](#) (April 2019)
- [Our Journey to Personalised Care](#) (February 2019)
- [Developing the NHS Long Term Plan for the NHS](#) (October 2018)
- [Public involvement panel development](#) (July 2018)
- [Unpaid carers and primary care event](#) (May 2018)
- [Stroke stakeholder event](#) (May 2018)
- [Public involvement panel](#) (April 2018)
- [Public workshops on stroke](#) (March 2018)
- [Stroke care event](#) (February 2018)
- [A vision for unpaid carers](#) (December 2017)
- [Working with voluntary and community organisations](#) (November and December 2017)
- [Stroke services](#) (April 2017)
- [Follow-up appointments](#) (April 2017)
- [Urgent and emergency care](#) (Autumn 2016).

You can view more [here](#).

Our five year ambitions include XXX (different ambitions to run along the top of each page) The [Healthwatch engagement findings](#) (June 2019) are also an important part of developing our Five Year Plan. The engagement report was discussed at our leadership meetings, including the Clinical Forum; [West Yorkshire Association of Acute Trusts](#) (hospitals working together); [The Mental Health, Learning Disability and Autism Collaborative](#); and [Joint Committee of the Nine Clinical Commissioning Groups](#); as well as the [Partnership Board](#). Our [priority programme](#) colleagues are taking the findings seriously.

All of the above will help us to tackle the significant health needs and inequalities for people. You will see other examples of engagement work taking place and planned, when reading our Plan. Further community conversations will take place as our [programmes](#) develop their work further.

We are also working with learning disabilities partners and [programme areas](#), including cancer, improving planned care, hospitals working together; and mental health, to develop a 'health champions' network of people with learning disabilities (read more [here](#)). Their role is to advise and help us talk to other people with learning disabilities so we can hear their views and experiences to improve care and support for them. This will give us the insight needed to deliver on some of our big ambitions.

[In a box]

In April and May 2019, the six West Yorkshire and Harrogate Healthwatch organisations engaged with over 1,800 people to ask their views on the NHS Long Term Plan and the Partnership priorities. As well as surveys, local Healthwatch colleagues coordinated over 15 focus group sessions across the area with seldom heard people such as those with mental health conditions; dementia, carers, LGBTQ, disability, faith groups and young people. Feedback on preventing ill health highlighted: *'more awareness for both children and parents of long-lasting problems from living an unhealthy lifestyle and the benefits of being healthier'*. People said they wanted to be: *'listened to, trusted and taken seriously as experts of their own bodies'*. This is central to our work to personalise health care and join up services. Working alongside partners, stakeholders and the public in the planning, design, and delivery of services is essential if we are to get this right'. You can read the report [here](#).

[Case study: add picture]

More than 80 voluntary and community organisation representatives including Age UK, Bradford VCS Alliance, Touchstone, and Community First Yorkshire attended a Partnership event in Bradford in May 2019. The event aimed to raise awareness of the NHS Long Term Plan and how voluntary community organisations could get involved as equal partners. Workshops covered the development of the Partnership's community and voluntary sector plan and its focus on priority areas, including preventing ill health, cancer, mental health, urgent emergency care, supporting unpaid carers, and tackling health inequalities.

To find out how you can get involved in the work of the Partnership visit www.wyhppartnership.co.uk

Voluntary and community sector funding

In 2018 we allocated £1m to support our 'Harnessing the Power of Communities Programme'. Community and voluntary partners in our six places were allocated funding through their partnership work with local councils and the Health and Wellbeing Boards to help tackle loneliness and social isolation, which has a major impact on people's health and wellbeing.

Community organisations make a tremendous difference in their areas. Work in Bradford focused on befriending support to prevent ill health. In Calderdale, the money was used to support 'Staying Well' which takes referrals and supports/signposts people into local support organisations and groups. The funding was used to reach local communities and groups which either do not engage or have barriers to access.

Our five year ambitions include XXX (different ambitions to run along the top of each page)
In Harrogate the focus was on making the best use of existing community health assets, for example community health asset mapping and a district strategy and action plan to tackle loneliness and isolation.

Kirklees have brought together partners Better in Kirklees, Barnardo's Young Carers Service, LAB Project and Support to Recovery to deliver an 'arts on prescription' approach to men over 40 with mental health issues experiencing depression and worklessness.

In Leeds, Health Impact Grants have been given to third sector organisations working on tackling loneliness, carer support in helping people to remain independent, and reducing health inequalities. Wakefield has invested in Age UK Wakefield District to further support short-term, overnight/day support in times of crisis for people over the age of 65 in their own home, when hospital admission is inevitable due to lack of available carer support, or when they are unable to be discharged from hospital due to a lack of support at home. You can read more [here](#).

[Case study: add picture]

When Mr and Mrs G moved home it resulted in them feeling lonely and isolated. Even though they live amongst a community, they miss their former neighbours. They now have regular one-to-one visits from New Horizons at Royd's which they enjoy. Their daughter says this support has proved invaluable. From the one-to-one sessions they have developed the confidence to join a befriending group and are taking part in exercise sessions in their own surroundings. They are developing new friendships and reminiscing around old Bradford, especially their old social meeting places and schools. They have become part of their new community'.

Watch these short films to find out how Julia, Salman, Steve and many others made a positive difference to people in their local neighbourhoods through the 'Looking out for our neighbours' campaign.

[In a box]

To further enhance community asset approaches in our six places advocates are being trained to develop neighbourhood level engagement. Funded by the Partnership, each area received £5k to support local community building initiatives. This built on the work of the Harnessing Power of Communities Programme and Asset Based Community Development (Nurture Development). We worked closely with our communication and engagement colleagues to make sure that we were supporting existing community based work in our local places without duplication.

[Case study: add picture]

Building health partnerships

The aim of our collaboration with the Institute for Voluntary Action Research, through its Building Health Partnerships programme, has been to work with community and voluntary groups to improve the health of people in Calderdale and Wakefield. Each locality has focussed on a different initiative but both emphasise the importance of preventing ill health and self-care.

The project in Calderdale is focussing on conditions that lead to muscle and joint pain and how, through promoting good health and activity at an earlier age, people can reduce the early onset of such conditions. For the Wakefield project, the Partnership in collaboration with Wakefield Council's Public Health team, worked with its partner organisations, local people and voluntary groups to raise awareness of eye health. Half of all cases of sight loss are preventable and one of the key factors in preventing sight loss is having regular sight tests. Community groups were introduced to the Eyes Right Toolkit which is a simple tool designed to screen near and distant vision in adults that can be used by anybody. The toolkit is currently being used by Carers Wakefield which provides this free eye screening for some of the 36,000 carers in the area routinely as part of its support work.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

This initiative is offering real benefits for local carers who often forget about their own health because they are too busy thinking about someone else's. We want to share this good practice wider.

Working in partnership with staff

Our Plan will only be delivered through staff. They are central to better health for people, whilst reducing inequalities, tackling unwarranted variation in care and managing resources.

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

All West Yorkshire and Harrogate priority programmes, such as stroke care, cancer and mental health, are informed by the clinical voice. The West Yorkshire and Harrogate Clinical Forum provides clinical leadership and expertise into all the programmes of work. It is supported by networks of nurses, allied health professionals and medical directors. For example our stroke programme was underpinned by clinical evidence from the Yorkshire and Humber clinical senate, and informed by a clinical summit in 2017.

Improving health and wellbeing for everyone

Preventing ill health

Improving health and wellbeing is at the heart of the Partnership and runs through all our [priorities](#) at a local and West Yorkshire and Harrogate level. We work together to help create the conditions for people to be healthy and to better understand the causes of ill health and wellbeing. This approach aims to improve the physical and mental health of people, whilst reducing health inequalities.

Working at a West Yorkshire and Harrogate level gives us the opportunity to build on the work led locally by Health and Wellbeing Boards and to consider what action we must take to improve health and wellbeing for people living here on a larger scale. Working as a Partnership also allows us to consider and influence the role that wider factors such as housing, employment, education, social networks and the environment have on people's health.

We will continue to work with, communities and organisations on the things which are key to being able to lead healthy lives - in doing so we will help people to have the best start in life, to be healthy into adulthood, to have more control over their health care and to age well.

We will work together to reduce the risk factors that cause ill health, promote earlier diagnosis and support people living with long-term health conditions to help them to be as healthy as they can be, reduce their risk of crisis, promote independence and reduce need for reactive care.

[Case study: add picture]

People with learning disabilities as health champions

People with a learning disability have worse physical and mental health than people without. On average, the life expectancy of women with a learning disability is 18 years shorter than for women in the general population; and the life expectancy of men with a learning disability is 14 years shorter than for men in the general population (NHS Digital 2017) We are working with

Our five year ambitions include XXX (different ambitions to run along the top of each page)

people with learning disabilities so they can become health and care champions for our priority programmes, including cancer, mental health, maternity care and hospitals working together. We are doing this by working with an organisation called Bradford Talking Media (BTM). Over the next 12 months they will help us identify health and care champions with learning disabilities from all equality groups. Their involvement will help us become more informed in their experiences of using health and care services and will inform and improve the way we plan services together. This Partnership approach is supported by councils and NHS organisations.

[In a box]

Poor housing and the impact on health is one area we have pledged to tackle together; it costs the NHS £1.4bn a year but by reducing excess cold to an acceptable level alone we could save £848m nationally and, more importantly, improve people's lives.

[In a box]

Reducing Violent Crime in West Yorkshire

West Yorkshire Police received £4million and West Yorkshire Police and Crime Commissioners have £3.5m to support their crime reduction unit programme to focus on reducing violent crime, including knife crime within West Yorkshire. Currently this is for 2019/20. This could potentially be for a three year programme based on the success of the Glasgow programme which has seen a reduction of 70% over the 10 years of its development. Funding is based on data available, including the number of hospital attendances/admission reported. There is concern that in West Yorkshire this is under reported. Areas for West Yorkshire have the 2nd highest rates outside of London. Discussions are taking place with public health colleagues around the best approach for West Yorkshire. Working together gives us the opportunity to address this.

Tackling health inequalities

Health inequalities are avoidable and unjust differences between people or groups due to social, geographical, biological or other barriers. These differences have a huge impact, because they can result in people who are worst off experiencing poorer health, shorter lives and who find it harder to get better.

In West Yorkshire and Harrogate the numbers of people smoking in routine and manual occupation groups is higher than people in other occupation groups; people living with mental health conditions are more likely to die prematurely and people living in our most deprived communities are less likely to receive hip replacement surgery.

A focus on reducing health inequalities will aim to address some of the preventable differences that contribute towards inequalities. Working as a Partnership we will consider differences in; risk factors for ill health, early diagnosis and screening and access to effective support – all of which contribute towards inequalities in health outcomes.

[In a box]

People in West Yorkshire and Harrogate have a shorter average life expectancy than the rest of England. Males lives are on average 1 year shorter than the England average and females almost 10 months shorter.

Life expectancy varies between our six places and also within our neighbourhoods. Figures for 2009-2013 show a 17 year difference in life expectancy in males and females within different areas across the 382 smaller community areas that make up West Yorkshire and Harrogate and a 22 year difference in the years of life that they live disability free.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

There is a strong association between health outcomes and deprivation. Around 480,000 people in West Yorkshire and Harrogate live in the 10% most disadvantaged areas in the country, and one of our local clinical commissioning groups, Bradford City, is ranked as the most deprived nationally.

[In a box]

In West Yorkshire and Harrogate those living in deprived areas are more likely to die prematurely (before the age of 75 years), figure 3. They are also more likely to be living with a long term illness or disability and to have been diagnosed with stroke or lung cancer than those living in areas where people are on higher incomes. They are also more likely to be living with risk factors for disease such as higher smoking rates and higher levels of childhood obesity.

For people living in West Yorkshire and Harrogate the leading cause of death is cancer which accounts for just over a quarter of deaths as a whole. This is followed by heart disease and stroke, which account for a quarter of deaths. Other leading causes of death are dementia and lung conditions which account for around 1 in 10 deaths each.

[Produce an infographic]

For people who are dying prematurely, before the age of 75 years, cancer remains the leading cause of death, contributing to around four in 10 premature deaths. This is followed by heart disease and stroke accounting for around two in 10 premature deaths and conditions related to lung health which account for around one in 10 of those who die before the age of 75.

Many early deaths from cancer, heart disease and lung conditions are preventable. This can be through changes in lifestyle factors, such as stopping smoking and reducing obesity, earlier diagnosis and treatment; for example cancer screening and equal access to high quality care, for example prescribing the right medications for people living with heart conditions. All of these opportunities to influence are underpinned by the wider factors that impact on the causes of health.

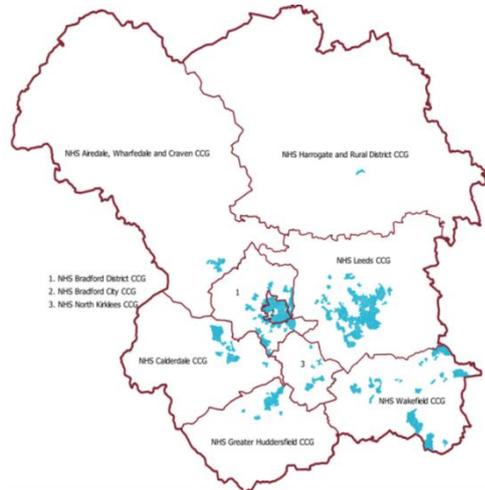
It is not only how long people live that is an indicator of the health of a population but how many years of their life they spend in good health and how many years they live with ill health or disability.

The leading causes of poor health are musculoskeletal conditions (those that affect our joints and muscles) and mental health conditions. In West Yorkshire and Harrogate in 2018 nearly 2 in 10 people reported living with a musculoskeletal condition and around 1 in 10 people reported living with a mental health condition. These conditions impact on a person's quality of life including their ability to work and take part in activities that they enjoy.

John Walsh, Organisational Development Lead and Freedom to Speak up Guardian at Leeds Community Healthcare NHS Trust, tells us about the importance of tackling health inequalities in West Yorkshire and Harrogate **in this film [here](#)**.

[Rework as infographics]

Our five year ambitions include XXX (different ambitions to run along the top of each page)



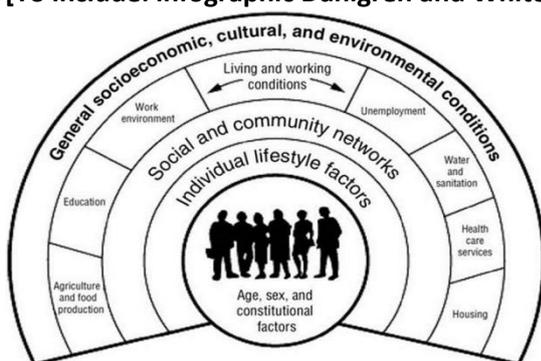
[Case study: include a picture:

The Phoenix Shed in Halifax is open to all men over 55 looking to make a new start in life. Funded by Staying Well, Calderdale Council and charitable donations, it has a kitchen, social area, computers and a workshop. ‘It’s a place for guys to hang out, have a chat and support each other’ says 55 year old Michael Leech, a regular at The Phoenix Shed. Michael was a successful businessman but his life fell apart when he became ill with bipolar disorder. Since spending time at Phoenix Shed, he’s needed less face to face support from his mental health support worker, often just talking to them via text. Michael says that being at the Shed helps him stop feel lonely and gives him a ‘sense of belonging’.

Conditions for healthy lives

We understand the majority of factors that influence our health are much wider than health services alone. When encouraging people to make healthy choices we need to understand the wider factors which influence this and how this impacts on the ability to lead a healthy life. Factors such as income, housing, transport, crime, education and income all impact on the health of an individual and may impact on the control they have of their health. For example poorer neighbourhoods are more likely to have higher numbers of fast food outlets and fewer safe spaces to be physically active, which in turn impacts on unhealthy weight.

[To include: infographic Dahlgren and Whitehead 1991]



Factors such as income, housing, employment, crime and transport contribute towards health, and we need work as a Partnership to understand and influence these factors together and their combined impact on health. It therefore makes sense to pool resources to tackle these factors and promote good health for everyone - access to green space, strong communities, decent housing and the kind of inclusive, equitable growth that expands employment and opportunity for all.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

Creating fair employment and work for all

There is a strong link between economy prosperity and the wellbeing of people. One of West Yorkshire and Harrogate's strong economic assets is the health and care sector. Working with our large organisations can help us understand the role they play as a big employer in promoting good health and contributing towards the local economy.

In West Yorkshire and Harrogate one in three employees are living with a long term health condition which can affect their ability to work. As a Partnership, we have a strong relationship with our Local Enterprise Partnership. We will continue to work in collaboration with them to promote healthy work places that support and encourage healthy behaviours to enable people to participate fully in working life, whatever their health status.

Housing

Housing has a really important impact on health. A safe, settled home is the cornerstone on which individuals and families build a better quality of life, access the services they need and gain greater independence. Good housing is affordable, warm, safe and stable, meets the diverse needs of the people living there, and helps them connect to community, work and services.

In West Yorkshire and Harrogate we have a health and housing working group to help spread good practice. It has identified where partnerships between health, housing and care organisations have enabled people to continue living independently or with support in a place they have chosen, delayed and reduced the need for primary care and social care, prevented hospital admissions, enabled timely discharge from hospital (and prevented re-admissions) or have promoted rapid recovery from periods of ill health or planned admissions. You can find out more [here](#).

Creating and developing healthy, sustainable places and communities

Health is not only influenced by the home we live in but the wider environment. In West Yorkshire and Harrogate we have a wealth of natural environments, areas of outstanding beauty, national parks, waterways, dales as well as many parks with the prestigious Green Flag status. **[To include photos of the area].**

Access to them is unequal for those living in neighbourhoods already suffering the most economic disadvantage because they have the fewest opportunities for outdoor play or recreation.

Access to safe outdoor space is important for providing opportunities for our communities to be more active because it has positive impacts on both our physical and mental health. For people living in urban or built up areas, we know that well maintained and animated spaces, such as pocket parks, community gardens or urban trails encourage physical activity in areas that have limited green space.

We also know that connection to people and communities has a huge impact on people's wellbeing – and there is strong evidence about the impact of loneliness and isolation on a range of conditions including dementia.

In 2014 it was estimated that close to 5,000 people aged over 65 living alone in Calderdale felt lonely or trapped in their own home. Loneliness can be as harmful as smoking 15 cigarettes a day - those affected are more prone to depression and have a 64% increased chance of developing dementia. Socially isolated people are more likely to visit their GP, take more medication, have falls and enter adult social care services earlier. Partners want to reduce social isolation and loneliness. Preventing ill health and putting people in touch with others for support can help improve their lives and reduce pressure on health and social care services.

[Case study: add picture]

'Looking out for our neighbours is making a difference because it is a very simple message. What I think is really good about the campaign is the way it shows people that you don't need to do big things to make big changes. It's the small things, it's talking to people and enquiring if they're alright, offering to do a little bit of shopping. It's that kind of thing, and that's the kind of ethos we offer at Memory Lane Café. Memory Lane Cafe has used the campaign to engage the community in conversations around being neighbourly'. Watch this [film](#) to find out more.

Community organisations provide help, support and services to reduce loneliness and isolation. They have deep local knowledge; have earned positions of trust in their communities and often include people experiencing the same issues as those living in the communities they serve. This community infrastructure – made up of community-led activity, of small, medium and large charities and not-for-profit organisations is vital to help people get well or stay well.

[Case study: include picture]

Bradford District Care NHS Foundation Trust's Champions Show the Way (CSW) programme offers a range of free activities, with the help of local volunteers, to encourage local people to stay physically and socially active and stay well, often whilst living with long term conditions. Barbara joined a CSW walking group and opted to take the CSW walker leader training so she could start her own CSW walking group; she also runs a CSW singing group. Pauline said: 'I started in the singing group four or five years ago and I've not regretted it since. We have fun and for me, being a senior citizen, it gets me out of the house, I make friends and I meet different people'.

Climate change

Working as Partnership gives us an opportunity to reduce future climate change. Together we can:

- Maximise opportunities to improve population health at the same time as making climate friendly choices. For example improving walk ways and encouraging active travel to offset reliance on cars; or promoting community allotments to reduce food miles and promote healthy eating.
- Use the responsibility of our Partnership organisations to reduce their carbon footprint; such as reducing unnecessary single-use plastics in hospitals and care homes; reducing transport costs and carbon; reducing overall waste in medicines and medical equipment and investing the use of lower carbon options.
- Redefine the links between good public transport and affordable and easy access to health care facilities for people and reductions in air pollution.
- Document the impact air quality has on poor health outcomes across our Partnership and the contribution this makes towards widening inequalities.
- Use our collective voice as a Partnership to influence regional and national organisations to deliver on their obligation to transition us to sustainability.

Population health management

Population health management is a way of bringing together health-related data to identify ways to improve services for specific groups of people. For example, data may be used to identify groups of people who are frequent users of accident and emergency departments.

All our work is informed by knowledge from local places and people. It helps our understanding of inequalities within our communities. We will develop the Partnership through:

- Working with Public Health England to better understand the current analytical workforce across the system to inform future workforce planning.
- Developing information governance arrangements which will allow Population Health Management (PHM) to happen.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

- Looking at how we can use intelligence to influence how services are designed and money is allocated within a system so we can focus on improving health.
- Supporting places with organisational and leadership development to support PHM. Including working with partners to promote Chief Information Officer representation on each NHS organisation's board
- Sharing learning from exemplar sites within the Partnership to allow others to learn from their experiences. For example the approach Leeds has taken to using a PHM approach to improve outcomes for those living with frailty (see page 59)
- Working with the expert partners including [Academic Health Science Network](#), [Imperial College Health Partners](#) and the [National Association of Primary Care](#) to support the development of PHM in Primary Care Networks, with a particular focus on reducing health inequalities.
- Using population priority areas, such as those living with frailty, means we are learning about the application of population health management how it can be used to improve outcomes.

Our five year ambitions

- **By 2020 we will have an understanding of the analytical capacity in the system to undertake Population Health Management (PHM).**
- **In 2019/20 and 2020/21 we will support Primary Care Networks with the development of their population health management (see page 28)**
- **Throughout the next five years we will continue to share learning from exemplars within the system and across the country to support the implementation of Population Health Management in West Yorkshire and Harrogate.**

[Case study: add picture]

Starting with the people living with frailty in four areas of Leeds, data was used to understand which groups of people would be most likely to benefit from improved care. This approach was used to bring together people delivering care from across the system to improve outcomes. One example of improved care was a man who was living in a care home and had been admitted to hospital three times in the past year. All health and care professionals working with him met with his family and drew up a new advanced care plan. A copy of this plan was left in his care home. This plan was to help him spend the final months of his life at home rather than in a hospital bed. Using intelligence to bring everyone together made it easier when a move to end of life care was needed – and most importantly gave a lot of comfort to his family.

Health inequalities

To contribute towards a reduction in inequalities we will:

- Take a system wide approach for improving outcomes for specific groups known to be affected by health inequalities, starting with those living in our most deprived communities.
- Use intelligence to identify the inequalities that exist in our population related to risk factors for ill health, early diagnosis, disease prevalence and health outcomes. We will use this intelligence to understand the people in our population we need to be engaging with to understand how we can change our approaches to improve health outcomes.
- Gain insight by seeking the views of specific population groups about planning and priorities (where we haven't done this already). We will start with population groups we know to be greatly affected by inequalities in health; those living in poverty and those living with learning disabilities, those living with serious mental illness, veterans, those in contact with the justice system, ethnic minority groups and homeless people.
- Engage and work with all [West Yorkshire and Harrogate Priority Programmes](#) to support an approach that reduces inequalities.
- Work as a partnership to understand the impact of living in a rural or remote area on access to services and on health outcomes.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

- Be informed by local information and expertise of working in partnership with people with lived experience.

Our five year ambitions

- **We will work towards a reduction in the gap in average life expectancy and healthy life expectancy between those living in the most and least deprived areas of West Yorkshire and Harrogate by 5% by 2023/24 and by 10% by 2028/29.**
- **We will reduce the gap in life expectancy and healthy life expectancy between West Yorkshire and Harrogate and England as a whole by 5% by 2023/24 and by 10% by 2028/29.**
- **By 2020 we will design and implement a health inequality profile for use across all Partnership programmes. This will make sure health inequalities are considered at the beginning and transformation takes place to meets people's needs.**
- **By April 2021 we will have supported Primary Care Networks in the implementation of the service specification for Tackling Neighbourhood Inequalities.**
- **By 2021/22 we will have spoken to different population groups and have a better understanding of the action we can take to reduce inequalities.**

Wider determinants

Working as a Partnership we can have greater impact on preventing ill health if we focus on the wider factors that impact on health and wellbeing. We will:

- Build on learning from the [Health and Housing Partnership in Wakefield](#). We will identify opportunities to improve health through improving the environment and in which people live and considering the role housing services can play in supporting good health and wellbeing.
- Working with other key partnerships for example Leeds City Region, West Yorkshire Combined Authority and West and North Yorkshire Local Industrial Strategy to contribute towards the inclusive growth agenda.
- Work with organisations across the system to maximise their contribution to reducing climate change.
- Understand the impact of transport, green space, active travel and air quality on our population outcomes both in terms of air quality and inequalities in access to services.
- Look for opportunities to influence an increase in safe green space to promote physical activity particularly in our poorer communities.
- Through continued strong relations between the [West Yorkshire Combined Authority](#) and the Partnership, we will take steps to:
 - Improve transportation access to health and care facilities, including looking at making this more affordable for people with ongoing treatment.
 - Improve the quality and availability of active travel options across the region.
 - Reduce the carbon emissions and harm caused by public transport.
- We will support Primary Care Networks to make the links with wider services that impact on health including debt advice, housing, support with benefits and employment.

Our five year ambitions [to quantify at next draft]

By 2024 we will:

- **Continue to share good practice by making the most of the links between health and housing.**
- **Work with our partners to improve access to green space specifically for those living in poorer communities.**
- **Work with primary care to improve links with the wider community assets.**
- **Reduce inequalities in access to employment for those living with long term physical and mental health conditions.**

Our five year ambitions include XXX (different ambitions to run along the top of each page)

Prevention 1: Reducing risky behaviour that contributes towards ill health and promoting what keeps people well.

What we have achieved so far: Prevention at Scale Programme

In October 2016, our Partnership set out three ambitions for preventing ill health:

- To reduce smoking
- To reduce alcohol related hospital admissions
- To reduce the number of people at higher risk of diabetes developing the condition.

The reasons for these ambitions were to prioritise areas that would have the greatest potential impact on people's health in the shortest timescale.

Progress to date

Tobacco harm

The ambition for the tobacco programme was to reduce the number of people smoking from 18.6% in 2015/16 to 13% by 2020-21; a reduction of 125,000 smokers.

To date the programme has seen tobacco smoking reduce to 17.3%, in line with our planned trajectory, a reduction of 23,000 people who no longer smoke. This already equates to a five year financial impact on the NHS of £17million. In addition, this also means that those 23,000 people in West Yorkshire and Harrogate have £84m per year to spend in ways other than on smoking.

[Case study: add picture]

In May 2019, the Partnership launched a quit smoking 'Don't be the 1' campaign as part of our prevention of scale programme work. It delivered a hard-hitting emotional message that at least one in two long-term smokers will die from long-term tobacco smoking, balanced with a positive, empowering call to action that if you quit you can reduce those risks and signposting local quit smoking support. Surveys show around 9/10 smokers under-estimate the 1 in 2 risk of dying early from tobacco smoking, but most find the true figure worrying.

Alcohol harm

Every year, hundreds of people across West Yorkshire and Harrogate are admitted to hospital because of drink. Alcohol accounts for 10% of the UK burden of disease and death but is entirely preventable. Our ambition is to reduce the number of people affected by alcohol related harm by supporting those admitted to hospitals with appropriate help and support. The ambition related to alcohol was to reduce alcohol related hospital admissions by 500 a year and achieve a 3% reduction in alcohol related non-elective admissions by 2021. We have already seen a reduction of 9%, which greatly exceeds the trajectory of 3%.

[Case study: add picture]

The Alcohol Liaison Service (ALS) based at The Mid Yorkshire Hospitals NHS Trust (Pinderfields) emergency department is run by Spectrum Community Health CIC. The ALS team has reduced alcohol specific hospital admission episodes by 34% fewer in 2016/17 compared to 2013/14. Over the same period they have reduced the number of hospital readmissions by 36% and the number of associated bed days per year by 26%. An estimated £1.5 million has been saved in the past 4 years.

Diabetes (also see page 84)

The ambition was to offer 50% of those at high risk of diabetes preventative support through the National Diabetes Prevention Programme. To date the programme has exceeded the target for number of referrals, with 5022 referrals received against a target of 4829, from June 2017 – November 2018. [To do: produce info graphic].

Our five year ambitions include XXX (different ambitions to run along the top of each page)

We will build on this to:

- Support local places with the development of joined up well-being services. Sharing learning on approaches, such as the [Living Well in Bradford](#), which tackle the experiences/causes of risk behaviours, for example smoking and promotes positive health behaviours, such as physical activity. This will include approaches to building resilience and exploring affordable ways to improve and maintain good health and reduce the experience of barriers
- Design and run targeted campaigns, which will be co-produced with communities to promote early help
- Support the delivery of targeted smoking cessation services. Specifically for people who are in hospital who smoke, pregnant women and users of hospital outpatient services
- Reduce the inequalities in the number of people who smoke between those in routine and manual occupations and other groups of people we know are more likely to smoke
- Build on and embed a partnership approach which will tackle illicit tobacco use
- Build on existing good practice in Wakefield and continue to share learning to support the development and improvement of alcohol care teams in hospitals
- Work together to audit immunization programmes so we understand differences in uptake across different groups of people. This will include making the most of the information we have between us all
- Run targeted suicide prevention campaigns for those identified as being at higher levels of risk.
- Develop the skills and capacity of the workforce to deliver preventative interventions, including the use of Making Every Contact Count
- Work towards a reduction in Anti-Microbial Resistance (AMR). AMR happens when infections change and as a result, standard medication treatments no longer work, infections are then more difficult to treat and they may spread to others. We can work together to reduce AMR by; reducing the number of people catching infections, making sure they are diagnosed early and treated appropriately and reducing the number of anti-biotics prescribed where they are not needed.

Our five year ambitions

By 2023/2024 we will:

- **Reduce smoking prevalence in West Yorkshire and Harrogate to 11.5%.**
- **Reduce the proportion of people smoking in Routine and Manual Occupations at a faster rate than other groups.**
- **Ensure all people who smoke who are admitted to hospital are offered support to stop smoking.**
- **Support places within our partnership to establish alcohol care teams.**
- **Reduce the number of Anti-Microbial Resistant (AMR)-infections by 10% and reduce antibiotic usage by 15%.**

Prevention 2: Make the most of the techniques and approaches that identify and diagnose conditions earlier.

We will:

- Work as a partnership to improve uptake of our cancer screening programmes to contribute towards three in four cancers being diagnosed at an early stage when curative treatment is an option by 2028. We will work with the [West Yorkshire and Harrogate Cancer Alliance](#) to review our screening programmes to better understand the inequalities that affect uptake. We will reduce the 160,000 people annually who decline an invitation for bowel screening, the 170,000 women who decline the offer of cervical screening, and the around 90,000 women who decline the offer of breast screening.
- Gain insight from communities to make screening and diagnostic services more accessible to those groups who are under-represented.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

- Monitor and work with places to support an increase in uptake of the Diabetes Prevention Programme across our system (see page 84), which identifies people at risk of developing diabetes and supports them to make healthy lifestyle changes
- Take an intelligence led approach to support earlier identification of respiratory disease particularly in areas where we suspect there to be people living with undiagnosed Chronic Obstructive Pulmonary Disease (COPD) – a long term lung condition. This will include supporting training for the use of spirometry in primary care (see page 81)
- Make the best use of NHS Health Checks to identify those at risk of heart conditions earlier. We will support places to share good practice and target checks towards groups of our population who are underrepresented such as men and those living in poorer communities and ethnic minority groups
- Work with the Mental Health, Learning Disability and Autism Programme (see page 71) to support earlier diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) in the children living in West Yorkshire and Harrogate.

Our five year ambitions

By 2024 we will:

- **Understand inequalities in uptake of cancer screening by different population groups and target approaches which will improve access to screening for those who are under-represented.**
- **Increase diagnosis of COPD in areas where we expect there are people who are living with the condition who are not receiving support.**
- **Reduce inequalities in uptake to NHS Health Checks.**
- **Increase uptake of the National Diabetes Prevention Programme.**

[Case study: add picture]

Residents most at risk of lung disease in the South Kirkby and Hemsworth areas of Wakefield are reaping the benefits of a pioneering lung health check programme being run from their local GP surgeries. Around 100 patients attended the Church View Medical Centre on Langthwaite Road in South Kirkby to receive their 'lung MOT' during the first week of a targeted lung health check pilot programme led by the West Yorkshire and Harrogate Cancer Alliance, in partnership with Yorkshire Cancer Research. Invitations have been sent to patients of the practice aged 55 – 74 who smoke or used to smoke – individuals who are considered to be most at risk of lung diseases, such as chronic obstructive pulmonary disease and asthma, as well as cancer. Around 95 per cent of all invitations have resulted in patients attending appointments. A number of patients have also taken up free advice and help to quit smoking which is being provided on site by specialist advisors from Yorkshire Smokefree, with funding from Yorkshire Cancer Research. Access to such support gives smokers the best possible chance of giving up. The Wakefield project is part of the Cancer Alliance Tackling Lung Cancer programme, which also includes similar projects in Bradford and North Kirklees, the selected West Yorkshire and Harrogate site for the national roll-out of targeted lung health checks.

Prevention 3: We will support people living with long term physical and mental health conditions to live as well as they can, for as long as they can in their own homes.

We will:

- Support the best outcomes for conditions where we know we could work together to make more of a difference, this includes mental health, respiratory disease, diabetes and heart disease (see from page 88). We will look particularly at the inequalities people living in our local areas face with access to support such as rehabilitation, stopping smoking, weight management and vaccination
- Build into our plans the wider factors that impact on the physical and mental health of people living with long term conditions such as benefits advice, housing, employment and transport

Our five year ambitions include XXX (different ambitions to run along the top of each page)

- Offer care and support to people living with mental health conditions, learning disabilities and autism so we can improve physical health and reduce inequalities in life expectancy. This will include increasing the number and quality of annual physical checks for people living with learning disabilities and autism and a stop smoking offer for specialist mental health and learning disability services.
- Work with the Mental Health, Learning Disability and Autism Programme (see page 71) to learn from [Learning Disability Mortality Reviews](#) (LeDeR) to inform future service planning which will contribute towards a reduction in health inequalities.
- Review inequalities in unplanned admissions to hospital for long term conditions which could be managed in the community. To help better understand variation across the system, the causes of this and how alternative approaches could be taken to reduce avoidable admissions to hospital.
- Gain a better understanding of the inequalities in access to planned hospital care. Starting with a review of the inequalities in the numbers of people having hip replacement surgery for people living in the most deprived areas of West Yorkshire and Harrogate.
- A new universal smoking cessation offer will also be available as part of specialist mental health services for long-term users of specialist mental health, and in learning disability services.

Our five year ambitions

By 2024:

- **75% of people with learning disability and autism aged over 14 years will be offered (annual?) physical health checks.**
- **Inequalities in access to planned hospital care will be reduced for those living in the most deprived communities in West Yorkshire and Harrogate.**
- **We will offer targeted stop smoking support for people in contact with specialist mental health and learning disability services.**

[In a box]

We will continue to work together in Partnership to make a positive difference to people's lives with and for them. This will involve having conversations with people about what they need to stay, happy, healthy and well and making the most of the community insight we have and having further conversations where needed.

Personalised care

Personalised care means that:

- People and their carers will be supported to manage their physical and mental health and wellbeing, build community resilience, and make informed decisions and choices when their health changes
- People with long-term physical and mental health conditions will be supported to build knowledge, skills and confidence and to live well with their health condition
- People with more complex needs will be empowered to have greater choice and control over the care they receive.

We will ensure personalised care is embedded in the work of all priority programmes and learn from our council partners who have been working in this way for many years. By embedding personalised care approaches across all programmes and in all services we deliver and commission (buy) we will be able to scale up our capacity to deliver the personalised care model to everyone in West Yorkshire and Harrogate.

Our five year ambitions include XXX (different ambitions to run along the top of each page)
Lucy Jackson and Johnathan Lace from Leeds Council talk about ‘better conversations’ which is all about personalised care **in this film [here](#)**.

The model of personalised care

This model is defined by a standard set of practices:

1. [Shared decision making](#)
2. [Personalised care and support planning](#)
3. [Enabling choice, including legal rights to choice](#)
4. [Social prescribing and community-based support](#)
5. [Supported self-management](#)
6. [Personal health budgets](#) and integrated personal budgets

The [NHS Long Term Plan](#) says that within five years over 2.5 million more people will benefit from ‘social prescribing’, a personal health budget and new support for managing their own health in partnership with patients’ groups and voluntary organisations.

Across West Yorkshire and Harrogate many of the elements of the personalised care model are already in place or being developed. As part of the NHS England Personalised Care Demonstrator Programme, West Yorkshire and Harrogate have been working to build, develop and spread the model of personalised care delivered locally across our six local places.

Why is personalised care important?

Only 55% of adults living with long-term health conditions feel they have the knowledge, skills and confidence to manage their health and wellbeing on a daily basis and yet 70% of the health service budget is spent on people who are living with long-term health conditions. People with one of more conditions account for 50% of all GP appointments and occupy 70% of hospital beds.

An evaluation of 9,000 people by the [Health Foundation](#) (August, 2018) found that people who had the highest knowledge, skills and confidence had 19% fewer GP appointments and 38% fewer A&E attendances than those with the lowest levels of activation.

[Case study: include picture]

In the [West Yorkshire and Harrogate Healthwatch Engagement Report \(June 2019\)](#) findings showed that people were interested in support from NHS and partners to make it easier to keep fit and healthy. It identified that people were unsure of what ‘personalised care’ is all about. Over the coming months we will be raising awareness of what personalised care means so that we can importantly change the relationship we have with people so that they are supported to be active partners in their health, wellbeing and care. 9% of people also said the NHS could help them to self-care by providing more information and advice about healthy lifestyles so they can monitor their own health. We will take these views forward into our plans over the next five years.

How we will spread the benefits of personalised care?

We will build our model of personalised care at scale across West Yorkshire and Harrogate. The sustainability of our health and care system relies on the need for more choice and control for people on the decisions and support which makes the positive impact on their health. Communities are our biggest asset. We need to give people choice in how their needs are met whilst considering what they need so they have the knowledge, skills and confidence to look after themselves, where safe to do so. Social prescribing involves helping people to improve their health, wellbeing and social welfare by connecting them to community, groups, activity and peers who can offer support.

Our five year ambitions include XXX (different ambitions to run along the top of each page)
This will also lead to healthier sustainable communities.

This way of working brings many benefits. It:

- Improves people’s health and wellbeing
- Improves people’s resilience to stay well and their knowledge skills and confidence to be engaged as active partners in their health, wellbeing and care
- Can reduce pressure on health and care services and provide efficiencies by joining support together.

For people at the end of their life we will embed personalised care and support planning so that we understand their specific needs and wishes at the end of their life and share this information digitally to make sure all care providers are aware of what is important to the person and acts accordingly.

To do this our workforce will develop new skills to work differently with people so we can change the relationships and conversation we have with our communities. Working in partnership to join up services and prevent ill health is the priority. We will establish an approach to support our six local places to meet the needs for people of all ages and the 260,000 carers. This will include young carers across our area so they are able to manage their physical health, and mental wellbeing whilst making well informed decisions and choices should their health change. Key to this way of working is our council partners, community organisations and links to our other priority programmes, such as carers and mental health.

We will focus on building personalised care approaches into clinical and care pathways, for example we have started to build personalised care and support planning, supported self-management, social prescribing and shared decision making into the cancer pathway.

Programme aims and ambitions over the next five years

We will focus our ambitions around four key areas:

1. **Changing the relationship between people and practitioners**
2. **Embedding personalised care across West Yorkshire & Harrogate**
3. **Building our network for Personalised Care**
4. **Building the case for investment and change**

[To do: rework table into a graphic]

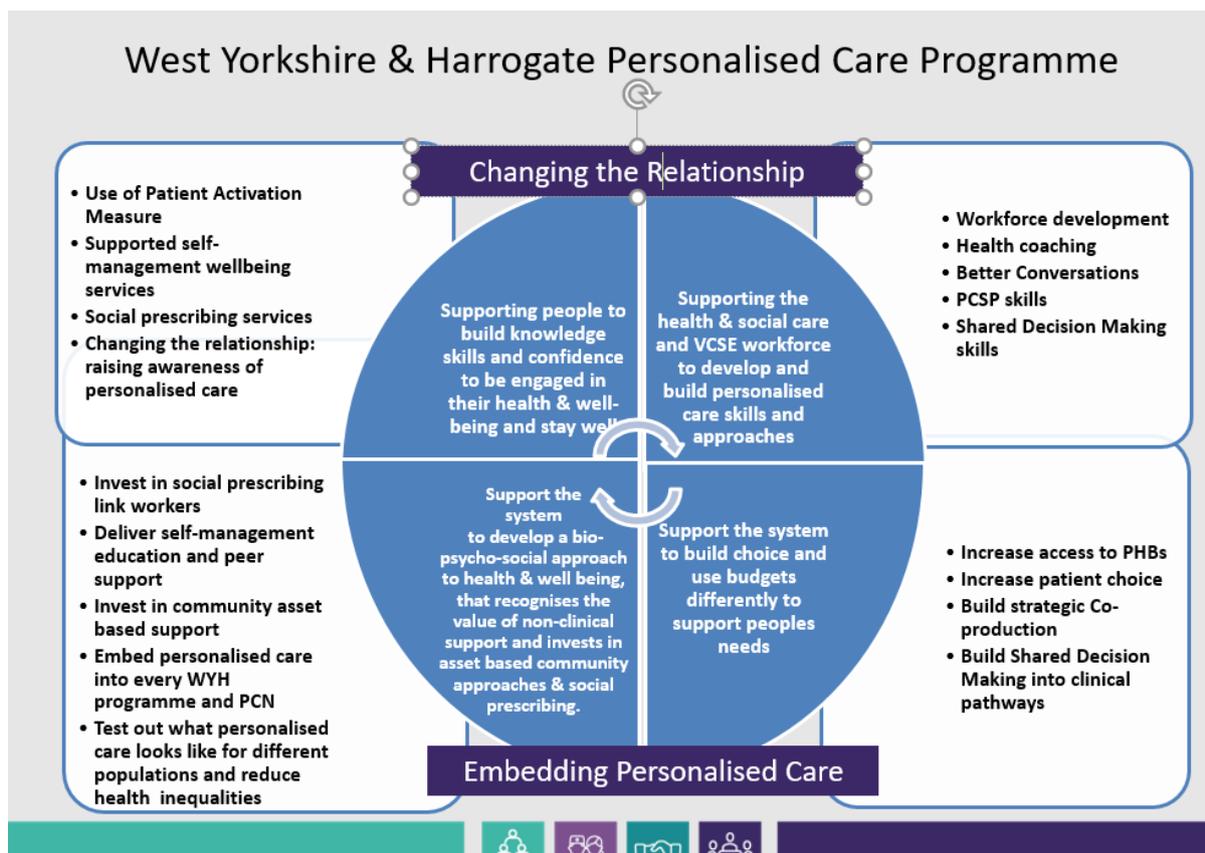
Work stream	Ambition
1. Changing the relationship	To change the relationship that people have with practitioners so that they are an equal partner in their health and care. People will be supported to be more knowledgeable, skilled and confident to manage their own health and care, involved in decisions about their care and work with practitioners to maximise their health and wellbeing. We will develop the skills knowledge and culture change in our workforce across West Yorkshire & Harrogate that will change the relationship we have with people and communities so that the relationship will deliver our ambitions for personalised care.
2. Embedding Personalised Care across West Yorkshire	To integrate personalised care work with the work to progress Primary Care Networks and to make specific links to how we use the intelligence we have about our communities to target our work at Place level. To deliver targeted pilots exploring what good personalised care looks like for people with a Learning Disability and people with lung problems (COPD).

Our five year ambitions include XXX (different ambitions to run along the top of each page)

& Harrogate	
3. Building our Network for Personalised Care	With representation at each of the 6 places, a network for change has been built to map, plan and deliver actions that will realise our ambition to make 'personalised care' the way we do things around here, and the words in the stick of rock that run through everything that WYH HCP does. We will work as a 'federation' of 6 places, learning and sharing with each other, and agreeing which things that make sense to do at Partnership and what makes sense to do at a place level. The impact of our work will be through the whole health and social care system. We will build a model of champions to provide leadership for our targeted areas of work and continue to build our network of place based leads across NHS, Local Authority and VCSE organisations.
4. Building the case for investment and change	In 19/20 will work with the Academic Health Science Network to develop and deliver a programme that will measure and evaluate the impact of personalised care on a group of people with lung problems (COPD). We will identify what good looks like from national and local evidence and build business cases for investment, demonstrating the impact on people and the health and care system.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

[To do: Rework model at graphic stage]



Our five year ambitions

- There will be an increase in the number of people in West Yorkshire and Harrogate who have choice and control over their health and care using personal health budgets and integrated personal commissioning
- Social prescribing will be part of usual care across all health and social care services
- The number of social prescribing link workers employed in Primary Care Networks increases by 55 whole time equivalents
- Personalised conversations through health coaching/ better conversations shared decision making and support planning training will become part of usual care.
- Everyone with a long term health condition or complex needs will be offered a personalised care and support planning conversation which sets out ‘what’s important to and for them’.
- Decision support tools are used in all clinical and care pathways
- Everyone who has a long term condition or complex needs is offered opportunities to self-manage their own health tailored to their needs and activation level
- There are an increased number of peer supporters and volunteers engaged in supported self-management activity.

Five year measures of success [To do: rework table].

	19/20	20/21	21/22	22/23	23/24
Personalised Care reaches x people by 23/24	xxx personalised care interventions benefitting over xxxx people				xxx people by 23/24

Our five year ambitions include XXX (different ambitions to run along the top of each page)

Social Prescribing Link Workers in PCNs Referrals to social prescribing link workers	50 SPLW recruited and trained 15,000 people referred to social prescribing link workers (from whole system)	45 SPLW 15,000	55 SPLW 15,000	55 SPLW 15,000	55 SPLW 15,000 people referred to social prescribing link workers
Support for self-management	3,300 PAMs	3,300 PAMs	3,300 PAMs	3,300 PAMs	3,300 PAMs
Personal Health Budgets	3,570 PHBs total - All CCGs delivering PHBs as default for CHC homecare packages - All CCGs offering Personal Wheelchair Budgets - 40% of all PHBs delivered as a direct payment or third party budget 1-2/1000 people benefitting from a PHB				7,000 people benefitting from PHBs/ IPBs: - CCGs delivering to a range of cohorts and responsive to local needs - 40% of all PHBs delivered as a direct payment or third party budget - All CCGs delivering to areas where there is a legal right 3/1000 people benefitting from a PHB

Transforming services

The way people want to access services is changing and the use of technology is increasing. This has influenced how people access and receive care. You can see evidence of this in local engagement work and also from West Yorkshire and Harrogate's Healthwatch [NHS Long Term Plan](#) engagement report findings (June 2019), where comments were raised about the '*better use of IT and electronic records*' and how all hospital trusts should have computer systems that talk to each other.

The importance of: '*partners working together to make it easier and affordable for people to stay fit and eat healthily, as well as 'more pro-active support around weight loss'*'; and concerns around '*better emergency support for people in mental health crisis*' were all raised. These are all areas we are working hard to address together (see page 71). The voice of carers in the report also endorses our [programme](#) approach that: '*carers needed more support to keep them safe and healthy including regular health checks, respite care and flexible appointments to fit round caring responsibilities*' (see page 91).

Helping people and families to plan ahead, stay well and get support when they need it in the most appropriate way with the resources we have available is key to the way we work. Overall people want to be: '*listened to, trusted and taken seriously as experts of their own bodies*' and that '*a lot of people saw social prescribing as a positive and wanted more access to this support*'. We couldn't agree more and this is central to the work we are doing (see page 34).

This section sets out how we are working to transform and join up services.

Primary and community services

It's good news that people are living longer and we want everyone to have the best chance in life to age well. Between 2017 and 2027 there will be 2million more people nationally aged over 75. As a result of this changing population we need to change our focus from treating individual episodes of illness to working with people to manage one or more long term conditions.

Much of the [new money for the NHS announced in June 2018](#) is directed at primary and community services, and a large amount of this will be channelled through networks.

Primary care is often described as the 'front door of the NHS' and provides people with community-based access to medical services for advice, prescriptions, treatment or referral, usually through a GP or nurse. Other primary care providers include dentists, community pharmacists and optometrists. It has been estimated that around 90 per cent of interactions in the NHS take place in primary care.

Primary medical care is locally led in our six places. Clinical Commissioning Groups have continued to progress the primary care agenda in accordance with their own local commissioning strategies alongside the national work to transform primary care, supported by the [General Practice Forward View](#) document and [NHS Long Term Plan](#).

Our Primary Care Strategy (to do: make link when published) goes much further than this – it is all about communities, carers and the work we do alongside our voluntary and community partners.

[In a box]

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

Our five year ambitions include XXX (different ambitions to run along the top of each page)

The Healthwatch engagement work (June 2019) told us that people want better access to GP and wider primary care services; to be better informed about self-care and health services generally and wrap around joined up care when and where needed.

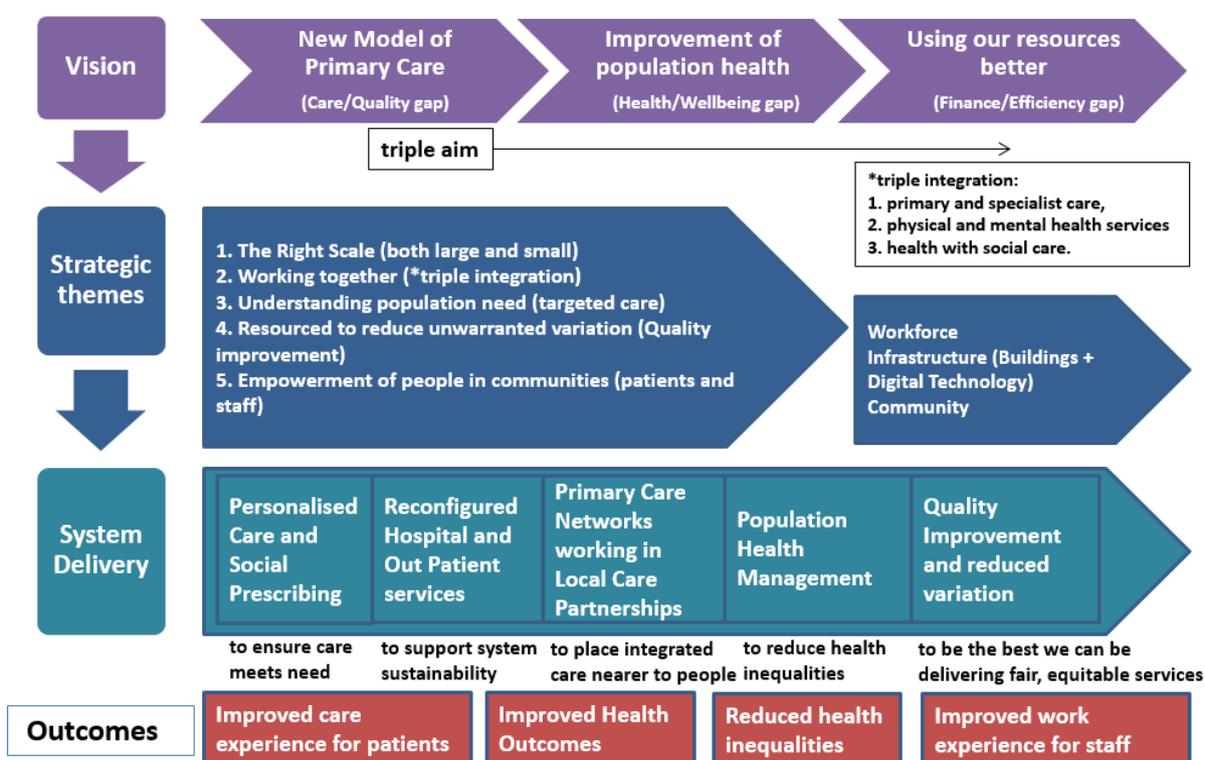
Our vision for primary care is to:

1. Deliver a model of primary care that is new
2. Lead to an Improvement of population health
3. Use our resources better.

We will do this through building primary care at the right scale, working together in integrated teams that target services based on the understanding of population need and resourced to reduced unwarranted variation with empowerment of people in primary and community care.

Our primary care plan can be summarised as follows [To do: rework graph below]

The WY&H Primary Care Plan



We want to transform primary and community care by enabling the integration of services based on the needs of the local population. Triple integration cuts through our strategy, bridging the gap between primary and specialist care, physical and mental health and health with social care.

This will result in our patients having a better experience in accessing consistent high quality joined up care, with empowered Communities involved in service developments, with localised more accessible solutions

We will be the best we can be in primary care delivering;

- Improved experience of our staff, volunteers and carers with more staff retained, resulting a more sustainable workforce
- Improved financial sustainability
- Improved population health, patient outcomes and reduced health inequalities.

Our five year ambitions include XXX (different ambitions to run along the top of each page)
Primary Care Networks are a key part of the NHS Long Term Plan, with all general practices being asked to be part of a network by June 2019. Primary Care Networks (PCNs) generally cover populations of 30,000 to 50,000 patients. They involve wider health care providers and staff to deliver services that reflect local people's needs.

Improving how community services are delivered is essential to achieve the aims of the NHS Long Term Plan. The joining up of primary and community care is important for our workforce, service stability and patient choice. We will explore further opportunities for community services and voluntary and community organisations to support PCNs by facilitating local conversations and provider presence. We plan to build on the relationships with community providers with a view to enhancing existing community delivery methods.

We aim to respond and agree a Partnership approach to NHS Improvement's recently published [Community Services Operating Model Guidance](#). This sets out recommendations to achieve the ambitions of the NHS Long Term Plan in particular for improving response time, quality of care and productivity of the workforce.

[Case study: add picture]

Alan took early retirement after suffering a heart attack and although he's feeling well and keeping healthy, he takes daily heart medication and needs regular checks with his GP. He uses GP online services to book appointments with his GP to review his condition, and to order the medication he needs. Alan told us: 'I can use the online system to order my medication at any time and I don't even need to remember the names and dosages of the individual items as they are all detailed on my 'prescribed medication' page. I can also check when my medication is due to be assessed by logging on and viewing my personal patient record.'

Our Primary Care Strategy (**To do: add link once published**) sets out the detailed ambitions, achievements to date and the actions we will take to achieve our vision. Our deliverables for primary care in 2019/20 and 2020/21 are:

Workforce

- Development of a training needs analysis in place to contribute to commissioning of the future workforce required for skills and competencies primary and community care
- Increase our numbers through GP International recruitment
- Improve workforce planning through the operationalisation of the [apex/insight workload/workforce tool](#)
- Support the further development of our training hubs
- Development of partnership rotational and preceptorship models for PAs and paramedics in primary care
- Implement at scale 'In at the deep end' retention initiative, supporting health inequalities in areas where recruitment is problematic
- Increase our primary care workforce numbers
- Increase the number of mental health therapists co-located in primary care.

Access, resilience and workload

- Increasing usage of online consultations and self-care digital options
- Building on the outcomes of the Healthwatch Report (June 2019), progress a West Yorkshire and Harrogate access review to primary care services
- Develop an implementation plan to address the outcome of the national access review.
- Support increased utilisation rates for extended access appointments
- Enable PCNs to support access and resilience in primary and urgent care through the national network impact assessment fund.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

Primary care transformation

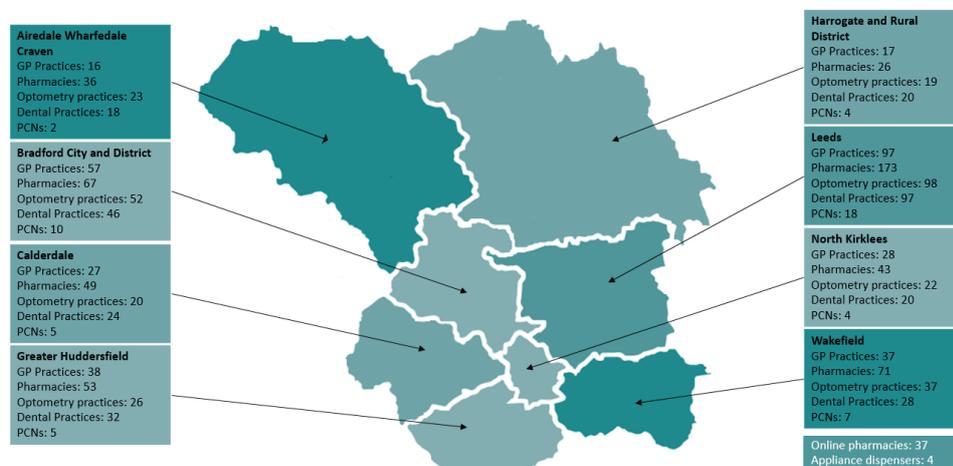
- Continued support to the development of networks and highlighting opportunities for at scale working.
- Each PCN will have a development plan and identified support to enable progression
- PCNs to demonstrate progression to the next step of maturity
- A collaborative approach with other priority programmes in supporting PCNs in the implementation of the national service specifications
- PCNs will be expected to implement the medication review and enhanced health in care homes in April 2020. This presents a huge opportunity to build on the local system work already in place to support this work.

Quality improvement

- Implementation of [carers quality markers](#) in practices and PCNs
- Reduce variation in screening and immunisation for people with learning disabilities at PCN level
- Support place-based population health management to enhance knowledge and understanding of population health management (see page 28).

We want to support people so that they can manage their own health where safe to do so, closer to home and in their communities. Some people who have a health condition could potentially take an increasing role in managing their condition alongside health professionals, and are often more motivated when they share their experiences with others in the same situation (see page 34).

The Primary Care Strategy reflects the work taking place in each of our local six places. It also reflects the needs of the areas whilst highlighting where it makes sense to work together for better health and wellbeing outcomes for people.



[To do: rework the map].

Our priorities

- We will develop Primary Care Networks (also known as Communities/Homes) and bring together joined up teams to deliver better ways of working. Services will be tailored to need and will deliver better health and wellbeing outcomes for people at a local level
- Develop a flexible workforce with the right values, skills and competencies to deliver improved health care and satisfying roles for staff
- Improve access so that people have greater choice and more flexibility.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

Joining up health care

In West Yorkshire and Harrogate we have 56 primary care networks (PCNs) of varying sizes and demographics. They have been designed around local population needs (please see map above). The development of the networks is led locally in our places.

PCNs build on current primary care services and will enable greater provision of proactive, personalised, coordinated and more joined up health and social care, based on the needs of local people. Working at scale across West Yorkshire and Harrogate will bring organisations and staff together to deliver population health management through the development of Primary Care Networks (see page 40). Clinicians describe this as a 'change from reactively providing appointments to proactively caring for the people and communities they serve'.

[In a box]

The Partnership has invested £2.6m in 2018-19 (around £1 per head of population), to help develop Primary Care Networks and accelerate local approaches.

[Case study: add picture]

Community Partnerships (CPs) are Bradford District and Craven's way of working differently with people and communities to deliver improved health and wellbeing outcomes for people. Covering 14 communities of approximately 30-60,000 population sizes, the CP's bring together NHS, social care community organisations and other local services to focus on health and wellbeing. Recognising the impact that wider determinants have on the health and wellbeing of people, for example housing, poverty and employment, the CP's have adopted a strength-based community developed approach to service redesign. Community staff and local people have the opportunity to say what is important to them based on local information, to ensure that future health, care and wellbeing services meet their needs.

Primary and community care workforce

The Partnership aims to support the primary and community care workforce to have the right values, skills and behaviours to work with people as equal partners in their health and care delivering positive outcomes for patients, staff and the population.

[In a box]

West Yorkshire and Harrogate will be a vibrant place to work with a responsive, passionate, engaged, compassionate, and diverse and fit for purpose workforce with great opportunities. Our workforce helps people to live their best lives.

The challenges of recruiting and retaining a skilled primary care workforce are similar to many other areas. Our aim is to ensure that our workforce strategies support the wider system in addressing health inequalities. Our focus will be to attract, develop, support and retain the workforce in the most deprived communities.

Delivering our vision will not simply need more of the same but a different skill mix, new types of roles for different ways of working. PCNs are key to delivering this vision. Each will develop workforce plans to reflect the services and needs of people they support whilst aligning this to their local place priorities.

Nationally workforce targets have been set and our local and Partnership wide plans reflect these in their planning. The targets are as ambitious and challenging. This is reflected in our Primary Care Strategy (To do: make link when published) with our aim being to focus on target delivery whilst fully supporting the workforce transformation and showing an overall capacity increase.

Our five year ambitions include XXX (different ambitions to run along the top of each page) Working together with West Yorkshire Local Workforce Action Board (including Health Education England colleagues) the Partnership aims to develop 'one' approach to workforce through a system which aims to:

- Deliver integrated working models across organisational boundaries
- Develop a stable workforce with the right knowledge, skills and competencies.

This work will be taken forward at local place level whilst creating the opportunity for other work, for example the [West Yorkshire and Harrogate International GP Recruitment Programme](#) and [Physicians Associates Acceleration Programme](#).

[Case study: add picture]

Wakefield GP Resilience Academy

Wakefield is supporting a locally sustainable, resilient general practice workforce by growing its own staff. They are delivering the training they need and providing good career development opportunities with the expansion of skills and new roles.

Wakefield Clinical Commissioning Group (CCG) responded to the pressures within their primary care workforce by launching the [Wakefield General Practice Resilience Academy](#). The team is funded by the CCG. It has developed a 'virtual practice' model which focuses on training, advice and intensive support. The virtual team is made up of a nurse consultant and practice manager consultant. Where needed, the team work with other colleagues to provide tailored and targeted support in the following areas:

- **Diagnostic reviews where there are identified areas for development**
- **Development of remedial action plans**
- **Change management support**
- **Signposting to specific support including education and training**
- **Direct advice and mentoring to clinical and administrative staff for example practice managers**
- **Team building and development**
- **Targeted reviews within the Practice on issues that have been reviewed and highlighted.**
- **Training support on business skills, HR and finance.**

This means the clinical commissioning group is able to identify practices in need of additional support but also provide them with follow-up advice where appropriate.

Improving access to services and choice

Our aim and one of our key outcomes is for people to have easier to access and more convenient services based on their health need and preferences. There is significant variation in day time access, reflected in patient experience rates in general practice and it is recognised that a proportion of activity carried out in A&E or out of hours primary care setting is often of a routine nature and could be managed more appropriately in a different setting (see page 49).

Access to more convenient services is important to the transformation of general practice; enabling self-care with direct access to other services, best use of the wider workforce, greater use of technology and working at scale across practices to shape capacity.

Our Partnership has built on the learning and successes of the [National Access Fund](#) as well as the acceleration sites in Leeds, Wakefield and Harrogate. These sites have helped people to access timely, convenient care and accelerate the achievement of the national expectations for extended access in primary care.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

[In a box]

Since October 2018, 100% of our population have been able to access GP services on evenings and weekends. Put simply this means 137,000 additional appointments being made available to patients in general practice.

In 2018/2019 £11.5m of national funding was invested in Primary Care Extended Access. Patient experience rates show there remains considerable variation in terms of access to services and in some areas in West Yorkshire and Harrogate poor patient satisfaction rates with appointment times. As a system we compare favourably with national satisfaction rates, however within our six local places there are high levels of dissatisfaction. Whilst we are seeing an increase in extended hour's appointments, there is still room for improvement.

There are various ways in which people can access care, including 'in hours' and 'out of hours' GP, extended access hubs, NHS 111 urgent treatment centres and A&E resulting in many patients struggling to understand what services to access, how and where. This is also reflected in the [Healthwatch Report](#) (June 2019). Access to appointments was the single most mentioned theme in the Healthwatch survey with 18% of responses citing access as the biggest thing the NHS could do differently to help them stay healthy and well. People want the NHS to provide easier access to appointments, not only with their GP but also with hospitals. We also know that:

- There are inequalities in access and some groups of people struggle to access services in a timely way.
- Urgent and emergency care is relied upon because other services are not available or sufficiently responsive.
- Approximately 40% of patients do not require GP input. Social prescribing and community empowerment through personalised care will be a key feature of primary care delivery which will enable more self-care and more resilient communities, enabling more capacity in GP practices for complex care.

We have made a commitment to align areas of the health system to enable simpler access into the most appropriate pathway. Progressing digital approaches will greatly enhance the way patients and clinicians interact with services, bringing about improved access and experience, a positive impact in practice workload, care closer to home, and better use of the primary care buildings. We will improve access for people making sure that general practice and PCNs continue to adapt and deliver the national initiatives that will improve people's choice and facilitate greater more convenient access.

[In a box]

- **Everyone in West Yorkshire and Harrogate has the option of an extended access appointment if needed including evenings, weekends and bank holidays.**
- **By March 2020 all West Yorkshire and Harrogate patients calling 111 will if clinically appropriate to do so be directly booked into an appointment in an Extended Access Hub. Currently 23% of our Extended Access hubs can accept bookings in this way.**
- **We are piloting e-Referral Service (eRS) roll out in ophthalmology where community optometrists will be able to refer directly into hospital eye services where required, impacting positively on workload for GP practices (see page 40)**
- **One plan for enabling Online Consultation capability for every practice across 2019/2020 and 2020/2021 is being delivered.**

Our ambition is to offer more convenience, choice and control for people when accessing GP services, helping them to be more informed and involved in decisions about their own healthcare.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

Our five year ambitions

- **We will support health care providers including PCNs to deliver improved choice and options for people including:**
 - **Online and skype consultations**
 - **Online access to appointment booking and medical records**
- **We will work with partners, including our Partnership priority leads to enable a streamlined access point for people. 111 will be able to book direct into GP practices and extended access hubs**
- **Have one point of call for accessing primary and urgent care services, supported through a Direct Booking Service**
- **Have a fully integrated model for primary and urgent care**
- **Improved people's experience of accessing primary and urgent primary care services.**

[In a box]

Booking GP appointments online helps to reduce the number of missed appointments because it's easy for people to cancel or re-book their appointment online – there and then - without having to wait until their practice opens or wait in a call queue.

[Case study]

Greater Huddersfield Integrated Partnership

The out of hours provider and the local GP Federation are working in partnership to provide a more joined up delivery model to provide extended access and urgent and emergency care. The model is hub provision at Huddersfield Royal Infirmary, clinics at two physiotherapy locations with a number of GP practices acting at satellites. Since March 2018, the hub service has been expanded to include physiotherapy and phlebotomy (blood test) appointments. User rates are consistently high, with monthly rates ranging from 80-100%. The hub GP appointments are fully open and directly bookable by the out of hours provider and NHS111, enabling the wider healthcare system to support people to access the support at the most appropriate point. The service was evaluated by Healthwatch in October 2018 and a further survey was undertaken by the providers in April 2019. Findings from surveys showed the service is highly valued by people.

Primary care transformation and infrastructure investment

To deliver transformation, funding for primary medical and community services will increase by over £4.5billion by 2023/24. This will be available through the GP Forward View, the GP Contract Reform package, the Partnership transformation funding and local investment from commissioners and Providers across West Yorkshire and Harrogate. The partnership has to date;

- Invested £2.6m, to develop and accelerate PCNs
- Utilised transformation funding supporting new workforce roles
- Utilised transformation funding to support Population Health Management for PCNs
- Invested additional funds for workforce initiatives from the Local Workforce Advisory Board and Health Education England.
- Invested in primary care infrastructure estate through the estates transformation, technology funding (ETTF).

Some examples of what ETTF has supported in West Yorkshire and Harrogate include:

- Building new health centres which have a greater range of health services for patients in one place, including learning disability premises schemes. New consulting and treatment rooms to provide a wider range of services for patients, including improved reception and waiting areas
- Building new facilities to deal with minor injuries
- Creating better IT systems to improve the way information is shared between health services in the area

Our five year ambitions include XXX (different ambitions to run along the top of each page)

- Extending existing facilities to house a wider range of health staff.

Pharmacy, dental and eye care

Our Primary Care Strategy recognises the opportunities and value of the wider primary care community. This includes dental providers, community pharmacy and optometry providers. We will work hard to integrate these wider services in our transformation priorities and will ensure engagement of wider primary care in the PCNs across the Partnership.

The Partnership is supported by clinical leadership through our existing local professional networks for dentistry, pharmacy and eye health.

Pharmacy

Community pharmacy provides a huge opportunity to support the wider health care system in both the delivery of primary care and urgent care. The Partnership's Primary Care Strategy (make link once strategy is published) supports the integration of community pharmacy services across the area.

In July 2019 a new five year [Community Pharmacy Contractual Framework](#) deal was announced which builds on the aspirations and direction of community pharmacy within the Primary Care Strategy.

The future of community pharmacy recognises the valuable contribution that our contractors can make to the management of minor conditions through the [Community Pharmacist Consultation Services](#). The Partnership recognises the opportunities of making the most of pharmacy and how it can support the demand in primary and urgent care.

We will work together to effectively implement the Community Pharmacist Consultation Service to support the urgent and emergency care system.

We are also working to make sure that community pharmacists are engaged in the work of Primary Care Networks alongside practice-based pharmacists.

There are some good examples across the area which demonstrates the difference community pharmacy make to people's experience of care and support but more needs to be done to ensure a consistent approach across all areas.

The Primary Care Strategy describes how the digital transformation agenda will support how services are delivered in community pharmacy. You can see a recent example in the roll out of NHS mail to community pharmacy. This work has provided a structure for the management of referral information and will drive forward future ways of working.

The Partnership recognises the work needed to progress how community pharmacy will develop and transform in line with PCNs. We are working hard to ensure that community pharmacy becomes an effective partner in the delivery of primary care services.

Eye care

Community based eye care services in primary care will be developed within each of our six local places to bring activity closer to home. The aim is to provide an integrated Primary Eye Care Service within each PCN across the Partnership. An eye health care capacity review led by the Improving Planned Care Programme (see page 55) has been undertaken to support service transformation in programmes such as; age-related macular degeneration (AMD), cataracts, diabetic eye disease, glaucoma and children's eye care services.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

Dental services

We are seeing a growing number of people with dental problems accessing medical care with poor health outcomes. It's important that we strengthen the working relationship between dental and other sectors involved in PCNs ensuring better and more efficient care for people. Our aim is to join up dental and oral health services with the wider primary care systems working in PCNs and emergency care to improve people's oral health. We will encourage partnership working arrangements with dental and medical professions through local professional networks.

Starting Well is a nationally led pilot, which aims to reduce oral health inequalities and improving child oral health in the under-fives. Of the 13 local authority areas identified as having the greatest need, one is in Wakefield.

Seven practices in Wakefield successfully bid to be part of the pilot project. Some of the key deliverables are 'Prevention Champions', good oral health promotion and training for all staff in the principles of '[Delivering Better Oral Health](#)', '[Making Every Contact Count](#)' and basic oral health messages. An advanced practice must also adopt a setting to work with (for example a local nurse) to promote oral health and work with health professionals (for example Health visitors) to create referral/signposting opportunities.

Our five year ambitions

- **Dental and oral health services will be integrated with wider primary care systems working in Primary Care Networks and emergency care systems ensuring benefits to patient's oral health, also linking to wider health and social care provision where appropriate.**

Urgent and emergency care

[In a box]

Our vision for urgent and emergency care is that we should provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for people including unwell children and young people, carers and families. For those people with more serious or life-threatening emergency care needs, we aim to support people in specialist centres with the right expertise, processes and facilities to maximise a good recovery.

Our approach

Our urgent and emergency care system includes primary care, mental health, social care, urgent care, dentistry, community pharmacy and voluntary organisations. Our aim is to further develop our system so it delivers a highly responsive service for people. This involves working with other [priority programmes](#) who share common themes, such as mental health (see page 71) and supporting carers to avoid carer breakdown (see page 91). It means making sure that people's needs are met in the right place, at the right time, with the right support.

Watch this film of Dr Adam Sheppard, Clinical Chair for the Urgent and Emergency Care Programme Board to find out more.

How we work

Working together to improve our urgent and emergency care services is not new. In July 2015, West Yorkshire was selected by NHS England as one of eight Urgent and Emergency Care (UEC) Vanguards as part of its New Care Models Programme. Building on this solid platform, the West Yorkshire Acceleration Zone (WYAZ) was the first of its kind. It was set up to deliver improvements at pace in urgent and emergency care across West Yorkshire.

Our five year ambitions include XXX (different ambitions to run along the top of each page)
Our Yorkshire Ambulance Service partners are key to our urgent and emergency care work. As well as providing the 999 response service across Yorkshire and the Humber, they also provide the [Integrated Urgent Care NHS 111 service](#). The role of this service is to help people in our six local places receive the best care possible in the most appropriate place.

[In a box]

West Yorkshire and Harrogate has five Local A&E Delivery Boards (Airedale and Bradford, Calderdale and Greater Huddersfield, Harrogate and Rural Districts, Leeds and Mid Yorkshire) covering the six places we work across. The Boards bring together the people and organisations that are responsible for delivering and coordinating local services. By working together they identify solutions to make sure that people receive the same quality of care wherever they live.

The difference we have made

Our programme leads on three improvement targets:

- **Clinical Assessment Service:** This joined up service allows for a greater level of clinical expertise in assessing a person's health needs than would normally be expected of a referring clinician (such as a GP). People are directed to the most appropriate care. We have achieved the target for 100% (To do: when to be added) of the population to have access to an Integrated Urgent Care (IUC) Clinical Assessment Service
- **Direct Booking:** This means that when a person calls NHS 111 and needs an appointment at their registered GP practice, call handlers at NHS 111 can make a booking for them. This saves people having to be 'passed around' the system. We have achieved the target for bookable face to face appointments in primary care services through NHS 111
- **Clinical advice:** We have increased the number of people receiving clinical advice via NHS 111.

[In a box]

A Health Foundation report (December 2018) highlighted how living alone can make older people 50% more likely to find themselves in A&E than those living with family. Pensioners living alone are also 25% more likely to develop a mental health condition. Social isolation can raise the risk of having a stroke by a third and is considered as unhealthy as smoking 15 cigarettes a day. In March 2019 we launched our first Partnership campaign 'Looking out for our neighbours' (see forward) which encourages communities to look out for each other through simple acts of kindness.

Our future priorities

Access to unplanned health and care services

There are too many entry points into the unplanned care system which causes confusion for staff and the public (see [Healthwatch Engagement Report](#), June 2019). The majority of unplanned care services offer walk in options – yet this offer differs across our six local places.

People present at the service they are most familiar with, as opposed to the place that best meets their needs. Health and care colleagues report that the unplanned care landscape is difficult and complex to navigate. There is inconsistency in messaging and we need to get better at communicating what is available to who and when.

Across West Yorkshire and Harrogate there are multiple points of access, some available to the public, some to health and care colleagues only, some to both. One of our priorities is to bring the points of access together in each of our six places and where appropriate develop a consistent multi-disciplinary clinical offer.

The national concept of 'Talk before you walk' encourages people to ring NHS 111 before choosing to attend an unplanned care service, such as A&E. Our NHS 111 Integrated urgent care service will

Our five year ambitions include XXX (different ambitions to run along the top of each page) create greater working together between the urgent (NHS 111) and emergency (999) services. This will allow for a more seamless transition between services and ultimately people accessing the right care based on their need.

[Case study]

The jointly commissioned Integrated Urgent Care service for Yorkshire and the Humber began on 1 April 2019 for an initial five-year term. It replaces the old NHS 111 service. The main changes are:

- Increase in clinical advice and direct booking
- Clinical validation for emergency department referrals
- Managing dental calls for children under five only and working with the new dental clinical assessment and booking service (CABS) provider who will manage callers aged five and over
- Additional patient pathways utilising local clinical advice services
- Greater collaboration and integration with locally commissioned services.

Shifting care from unplanned care to planned care as well as early help in our communities

Planned and unplanned (emergency 999) Patient Transport Services (PTS) is key to making sure the needs of people can be met within various healthcare settings. We want to create a hybrid service model between emergency and planned patient transport to safely manage the non-emergency cases in a timely way. The development of transport services programme will improve the National Ambulance Response Programme (ARP) targets, and accelerate access and joined up care between health and care transportation.

Our five year ambitions (To do: numbers for be added)

- **To improve access into the unplanned care system for public and staff**
- **To make the right thing to do, the easiest thing to do**
- **To support people's needs being met as close to their home as possible.**

Objectives

- To deliver the integrated urgent care specification and support people to navigate the system and access advice more easily.
- 100% of public will have the ability to access NHS 111 for clinical advice for unplanned health and care problems and where appropriate, onward referral.
- 100% of appropriate staff are able to access a single entry point into unplanned health and care services for advice and/or placement of people as needed. Including discharge from care services.
- Where appropriate, people will travel to planned and unplanned care appointments via timely Patient Transport Services (PTS)
- People receive a prompt and appropriate response when accessing emergency transport services.

Community urgent care

People tell us that there is a confusing mix of services for urgent care. These include walk-in centres, minor injuries units, urgent care centres and A&E's. In addition, general practices (GPs) offer different appointment systems and varied offers of core and extended services exist.

The publication of the [NHS Long Term Plan](#) (January 2019) and the [NHS Operational Planning and Contracting Guidance 2019/20](#) highlights that commissioners who buy health services, should continue to redesign urgent care services outside of A&E and establish the majority of urgent treatment centres (UTCs) by December 2019.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

[In a box]

Urgent treatment centres (UTCs) are GP-led; open at least 12 hours a day, every day. They offer appointments that can be booked through NHS 111 or through a GP referral, and are equipped to deal with many of the most common ailments people have who attend A&E.

UTCs ease the pressure on hospitals, so they are free to treat the most serious cases. Our UTC offer will reduce attendance at A&E or and offer people the opportunity to get to the right place for care.

UTCs should meet national standards so they operate effectively as part of a network of services including primary care, integrated urgent care, ambulance services and A&E.

At present we have two UTCs in West Yorkshire and Harrogate; St Georges (Leeds) and Pontefract Hospital (Wakefield). Key to the development of more UTCs will be the establishment of clear commissioning principles across our area to ensure access through 111.

As primary care networks (PCNs) and local care partnerships come together (see page 40), we will be clear on how they link with the UTC's to develop clearer more appropriate, additional services for people.

Looking at the development of UTC gives us the opportunity to support the development of 24/7 urgent primary care. This will include a review of GP Out of Hours and making the most of digital technology and the role of Primary Care Networks (PCN's). This will help us to make the most of resources and improve the health and wellbeing of people.

[Yorkshire Ambulance Service](#) responds to significant amounts of urgent care in the community, the needs of people is wide and varied. It includes falls, mental health, and respiratory conditions.

As UTCs models develop, transportation to UTCs will be reviewed and developed, to ensure that people are taken to the most appropriate place for care and treatment. We will work together through the UEC Programme to develop alternative care pathways and increase ambulance service capacity whilst reduce attendance at A&E (where safe to do so). This work will be commissioned and developed in partnership with our ambulance service.

Community urgent care priorities

- Implement UTCs where required to meet the 27 national core standards and provide a consistent 24/7 urgent primary care offer
- Agree key commissioning principles for the flow of people across the UTC's
- Contribute to the achievement of early help / preventing ill health in the community through implementation of UTCs
- To support the development of 24/7 urgent primary care across West Yorkshire and Harrogate, and providing an alternative capability to support the left shift.
 - Maximise opportunity to left shift by supporting the uptake of the Community Pharmacy Consultation Service (NHS 111 to community pharmacy).
 - Explore using the Community Pharmacy Consultation Service model (which is currently from NHS 111 to community pharmacy) to other interfaces such as A&E to community pharmacy and UTCs to community pharmacy.

[In a box]

The left shift is about moving clinically appropriate care and treatment for people from hospitals into the community; with the intent that this will lead to better health and wellbeing, better quality of care as well as sustainable and efficient services.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

Acute hospital flow

Acute hospital flow relates to the movement of people through a hospital from the moment the person arrives at the hospital, until their discharge for an unplanned episode of care.

Efficient acute hospital flow is all about quickly, skilfully, and effectively meeting the demand of hospital care. It involves effective coordination of patient care, moving people through pathways safely, to achieve the best possible health outcomes for them. Poorly managed patient flow in hospitals can lead to adverse health outcomes, including increased re-admissions and mortality rates.

[In a box]

Care pathways are a way of setting out a process of best practice to be followed in the treatment of a person with a particular condition or with particular needs.

Priorities

- Ambulance handovers
- Non elective pathway development (see page 55)
 - Supporting the development of new pathways of care so that people do not get admitted to hospital
- Same day emergency care (SDEC) and ambulatory care
 - There will be an agreed timelines and targets for SDEC and the Integrated Urgent Care Services (IUCS)
- Co-located UTCs (see page 49)
- Provide an acute frailty service for at least 70 hours a week, and work towards achieving clinical frailty assessment within 30 minutes of arrival at hospital. Frailty can be defined as a state of high vulnerability for poor health outcomes, including disability, dependency, increased risk of falls, need for long-term care and mortality. Frailty is more common amongst older people. It can also affect younger people with long term health conditions as well.
- Hospital discharge processes working in partnership with social care services
- Reviewing emergency department areas including:
 - Developing new ways to look after patients admitted to A&E with the most serious illnesses and injuries particularly in relation to people who arrive in A&E following a stroke, heart attack, major trauma, severe asthma attack or with sepsis
 - Developing a standard model of delivery in smaller acute hospitals who serve people living in rural communities.

Our five year ambitions

- **Reduction in the number of admissions**
- **Contribute to the left shift through working in partnership**
- **Provide same day emergency care services for 12 hours a day/7 days a week**
- **Ensure same day emergency care areas are all recorded consistently.**
- **Implement the SAFER bundle ensuring 33% of people are discharged before midday**
- **Increase the number of people discharged over the weekend**
- **Reduce and maintain the number of delayed transfers of care at below 2.4% of the total acute hospital bed base**
- **Reduction of long length of stay patients to agreed targets**
- **Reduce the amount of people who are discharged when they are not as well as they could be – ensuring community support is in place**
- **Reduce the number of people who are medically fit to leave hospital but who have no community support in place**

Our five year ambitions include XXX (different ambitions to run along the top of each page)

- Ensure people with the most serious illnesses and injuries receive the best possible care in the shortest possible time in line with the [NHS Clinical Standards Review](#) (publication due Spring 2020)
- Achieve 95% [Emergency Care Standard Target](#).

[In a box]

Winter is always tough but if we can help people quickly and get them home once they're medically fit then everyone benefits.

[Case study: add picture]

A special team on the wards at Bradford Royal Hospital link social care staff and nurses. They visit wards seven days a week to help patients to prepare to leave as soon as they are able reducing delays helping solve the non-medical issues which can delay discharge such as housing, social care packages and correct equipment.

[Case study: add picture]

Calderdale and Huddersfield NHS Foundation Trust routinely involve families and carers in decision making, and recognise the valuable input they provide in maintaining safe delivery of ongoing care. They have developed and changed to the needs of the patients and are successfully implementing Advance Care planning. The team is highly motivated and passionate around the care they deliver for frail patients, they have been particularly successful in building a strong team which not only incorporates the immediate members but reaches out to community, palliative care, care of the elderly wards, GP surgeries and voluntary sectors. The frailty service is successful in avoiding an average of 180 admissions every month and has reduced the length of stay for the frail patients that have been admitted. The team work very closely with patients, carers, community, social, mental health services and voluntary sector to deliver all care in the community and ensure we can avoid admission and discharge timely from when a patient has been admitted.

[Case study: add picture]

The Connecting Care Hubs in Wakefield is where health, social care, housing, voluntary and community organisations work side-by-side - helping those people most at risk stay well and out of hospital. This presents the opportunity to share learning and good practice. The Hubs are funded by both Wakefield Council and NHS Wakefield Clinical Commissioning Group. The Hubs have multiple agencies working together, all under one roof, to seamlessly support people with health and/ or social care needs who could otherwise receive fragmented care, with multiple referrals and handovers. This is joined up care at its best and in the last six months they've seen almost xxx people including xxx urgent referrals [To do: numbers to be updated].

Children and young people talk about their experience of using ambulatory care [in this film here](#).

Our five year ambitions

- From October 2019 we will maximise opportunity to support the uptake of the Community Pharmacy Consultation Service (NHS 111 to community pharmacy). During 2019/2020 we will embed the Same Day Emergency Care (SDEC) model in every acute hospital with a type 1 A&E department. This will increase the proportion of acute admissions discharged on the day of attendance from a fifth to a third
- During 2019 – 2020 we will ensure every acute hospital with a type 1 A&E department has an acute frailty service for at least 70 hours a week, and work towards achieving clinical frailty assessment within 30 minutes of arrival at hospital
- Work will be undertaken in 2019 – 2020 to ensure streamlined access to urgent mental health services including preparation towards NHS 111 being the single point of access to crisis services

Our five year ambitions include XXX (different ambitions to run along the top of each page)

- **Between 2019 – 2021 we will aim to maintain an average DTOC figure of 4000 or fewer delays and over the next five years (2019 – 2024) reduce them further. We will reduce and maintain the number of delayed transfers of care at below 2.4% of the total acute hospital bed base**
- **The new emergency and urgent care standards are being tested as part of the Clinical Standards Review. We will not know the outcome of this until spring 2020**
- **As part of the NHS Clinical Standards Review, during 2020 we will further develop ways to look after people arriving at A&E with the most serious illness and injury, ensuring that they receive the best possible care in the shortest possible timeframe**
- **Commissioners will work together to commission an appropriate, effective and efficient GP Out of Hours service for 2020 and beyond, taking in to consideration the impact of Primary Care Networks, Extended Access and UTCs. The West Yorkshire and Harrogate ambition is to ensure there is access to 24/7 urgent primary care, to ensure appropriate care is delivered in a timely way and reduce the likelihood of unnecessary admissions via A&E**
- **By March 2020 we will ensure 100% of the population of West Yorkshire and Harrogate has access to bookable in hours GP appointments via NHS 111 by rolling out the full direct booking programme**
- **By March 2020, NHS 111 will be able to book more than 40% of people that have been triaged into a face to face appointment where this is needed**
- **By March 2020 50% + triaged calls receive a clinical assessment. Clinical Commissioning Groups will develop local Care Clinical Assessment Service to support the core Clinical Advice Service (CAS) at 111**
- **By March 2020 we aim to record 100% of patient activity in A&E, UTCs and SDEC via the Emergency Care Data Set (ECDS)**
- **By March 2020 100% of hospital handovers across Yorkshire and Humber occur within 30 mins.**
- **By autumn 2020 we will fully implement the Urgent Treatment Centre model so that all localities have a consistent offer for out-of-hospital urgent care, with the option of appointments booked through a call to NHS 111**
- **A three year plan (2019 – 2021) has been agreed at regional level for workforce and fleet changes to deliver the Ambulance Response Programme and the programme is committed to supporting this**
- **By 2023, CAS will typically act as the single point of access for patients, carers and health professionals for integrated urgent care and discharge from hospital care.**

Transforming planned care

The demand for planned care continues to increase year on year so our work to transform these services, to make sure they are the best they can be now and for the years to come, is crucial. To do this, we are:

- Shifting the focus away from hospitals by developing sustainable service models and clinical pathways that provide patient focussed health services in community settings where appropriate;
- Promoting prevention, self-care and supporting healthier choices so that people become their own healthcare experts and less reliant on medical interventions; and
- Standardising our clinical pathways, clinical thresholds and commissioning policies to reduce any unnecessary differences that currently exist. Having a single approach means the requirements that must be met to access and receive planned care services are the same for everyone.

Clinical pathways set out the various steps in the care of people referred for treatment by their GP or other health professional. For patients on a clinical pathway, there are various points at which decisions are made about their care. Decisions are based on medical evidence to make sure that patients receive the best and most appropriate course of treatment for them. These points on a pathway are known as clinical thresholds and are used to decide which treatments will be provided and funded by the NHS to provide the best care for patients. In [episode 1 of our #WeWorkForYou podcast](#), Dr James Thomas,

Our five year ambitions include XXX (different ambitions to run along the top of each page)

Clinical Lead for the Partnership's Improving Planned Care Programme, explains more about clinical pathways and clinical thresholds. He also talks about commissioning policies, and why standardisation of clinical pathways, clinical thresholds and commissioning policies is a priority for the Partnership.

Our ambition is to transform local planned care services to make sure that we provide the right care to the right people at the right time. Further feedback from service users, and from those who work in planned care, will be invaluable in supporting us over the next five years in continuing to bring about this transformation.

In June 2019, Healthwatch carried out engagement around the NHS Long Term Plan and this revealed that people are committed to self-care but want the NHS to help them with this by providing more information and advice about healthy lifestyles and how they can better monitor their own health. The programme recognises the importance of providing self-care information and uses the Partnership's various communications and engagement channels, and those of our partner organisations, to do this at every opportunity. In addition, we incorporate self-care initiatives and guidance into our revised clinical pathways and policies whenever possible.

Our programme has an emphasis on personalised care (see page 34) and supports shared decision making which means a shift in emphasis from clinicians telling people what will happen, to clinicians discussing the best options with patients so they can make an informed decision about their own care. Feedback from the Healthwatch engagement highlighted the need for patients to be fully involved in all discussions regarding their care plan to make sure it meets their needs as far as possible. It's not a case of 'one size fits all'. Shared decision making is essential to successful implementation of our standardised clinical pathways, clinical thresholds and commissioning policies so we're working with clinicians and other health care colleagues to make sure that these important conversations routinely take place.

We will invest our funding as efficiently as possible to get the best personalised care for the greatest number of people. Whether it's community-based support or a surgical procedure, personalised care means that people receive the care that is right for them.

Musculoskeletal (MSK) services for muscles, joints and bones

In May 2019, the newly developed West Yorkshire and Harrogate [MSK pathway](#) was agreed for implementation across West Yorkshire and Harrogate. This single pathway supports the recurring theme of self-management with its inclusion of services that promote physical activity, pain management and psychological therapy. People have told us they want it to be easier and more affordable to use leisure facilities which can be expensive and not equitable for all. The pathway reflects this [patient insight](#) and includes a full range of treatment and support services, many of which can be accessed from GP surgeries or in the community.

[Case study: add picture]

People have told us they want to be able to access health care closer to home, including more specialist 'hospital' services available in community settings, so initiatives like our First Contact Practitioners (FCP) scheme are reflecting this feedback. The scheme moves appointments related to MSK conditions away from busy GPs and onto physiotherapists who are able to spend more time with patients. This is something patients have told us they would benefit from and in addition, longer appointments allow FCPs ample time to discuss self-care with their patients. This community-based scheme also links in with one of the priorities detailed in the [NHS Long Term Plan](#) and the GP contract (2019), which is the need for an expanded primary and community care workforce, developed around primary care networks. By 2023/24, this scheme should be extended throughout West Yorkshire and Harrogate offering all patients access to a FCP physiotherapist as part of the national elective care programme.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

[In box]

The programme is also embracing advancements in technology for the MSK pathway and hopes to explore the potential for extending ‘any to any’ electronic referrals to MSK services to help speed up and streamline the referral process. Implementation of the MSK pathway and local service development is underway and is expected to continue up to May 2022.

Our five year ambitions MSK services

- Implementation of the MSK pathway and local service development is expected to continue up to May 2022.
- Ongoing work to develop single clinical pathways, clinical thresholds and commissioning policies for: knees; shoulders; hips; feet and ankles; and children’s shoulder surgery is currently taking place. The implementation of shoulder policies is expected to start in late 2019 and will be followed by knees and hips in early 2020.
- September 2019 – work will start on the MSK policies included in the second EBI list due to be released in August 2019.

Eye care services (ophthalmology)

As with MSK services, our work on ophthalmology services will help manage rising demand by providing patient focussed services in ‘out of hospital’ settings where appropriate. The introduction of advanced clinical practitioners for eye health in community settings will also help to support this shift.

[In a box]

Our ambition is to make the best use of the eye care expertise we already have in our communities. Having some eye care services in local settings rather than hospitals makes them easier and more convenient to access. This will encourage more people to attend for the important checks that could potentially save their sight.

We are also making the best use of technology with initiatives such as the NHS e-Referral Service (eRS) that will enable [community optometrists to refer directly into hospital eye services \(case study\)](#) for conditions that are not urgent (i.e. not related to an accident or an emergency). The pilot (20 sites) will reduce unnecessary delays in referrals and take some of the pressure off GPs by using technology that makes it possible for optometrists to connect to eRS and refer patients directly to the hospital eye service they need.

[Case study: picture to be included]

The West Yorkshire and Harrogate Local Eye Health Network, working with Bradford University, has been successful in its bid for workforce development funding from Health Education England. The funding will enable optometrists to gain the accreditation required for earlier detection, decreasing false positive referrals and managing more people in a community setting. Health Education England has already funded over 200 local optometrists to train for the Professional Certificate in Glaucoma. This means that 15% of the area’s optometrists are qualified to identify this common eye condition that can lead to loss of vision if it isn’t diagnosed and treated early.

[Case study: pic to be included]

Half of all cases of sight loss are preventable. Through the Institute for Voluntary Action Research’s ‘Building Health Partnerships’ programme, we are working with Wakefield Council and local community groups to raise awareness of sight loss prevention and promote eye health and regular checks from birth right through to old age.

Working with teams from [West Yorkshire Association of Acute Trust](#), Getting It Right First Time ([GIRFT](#)), [NHS RightCare](#) and [Public Health England](#), we are building on data collected from a regional eye health capacity review to progress the transformation of local eye care services.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

We have established teams of commissioners, clinicians, Local Optical Committee (LOC) representatives, eye clinic liaison officers, charity workers, service managers and vision rehabilitation workers to work on various transformation projects for eye care services. The project areas are: age related macular degeneration; diabetic retinopathy; glaucoma; cataracts; and children's eye services.

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

We have been talking to service users, who are all members of the Kirklees Visual Impairment Network (KVIN), about their experiences of local eye care services. Public involvement around eye care service transformation is in the very early stages but this patient insight, and hopefully a great deal more to follow, will be invaluable in supporting the project teams as their work progresses over the next year or so. We expect to have these plans agreed by November 2019, with local service development and implementation taking place from May 2020 to May 2023.

Our five year ambitions for eye care services

We expect to have the eye care project plans agreed over the next year with local service development and implementation taking place over the next five years.

- September 2019 - a clinical pathway for monitoring of patients taking hydroxychloroquine agreed for adoption.
- Ongoing – clinical pathways, clinical thresholds or commissioning policies related to the eye care services project areas (age related macular degeneration (AMD); diabetic retinopathy; glaucoma; cataracts; and children's eye services) will be progressed over the next five years.
- 2019/20 - a single commissioning policy for dry eyes (keratoconjunctivitis sicca) will be developed.
- Other policies that fit in with the eye care project plans may also be considered for standardisation?

Clinical thresholds

Clinical thresholds are points on a pathway used to decide which treatments will be provided and funded by the NHS to provide the best care for people. In West Yorkshire and Harrogate we have unnecessary differences in some of our pathways and thresholds, meaning that some people may be receiving different treatments depending on where they live – often referred to as the 'postcode lottery'. We are working to remove this difference by making sure all treatments reflect the most up-to-date medical evidence and best practice. We have already standardised clinical pathways, including [the new MSK pathway](#), and commissioning policies, including a single policy for [flash glucose monitoring](#) (for some people with type 1 diabetes) and a single policy for [liothyronine](#) to treat underactive thyroid gland. We estimate that by March 2024 we will have introduced a total of xxx standardised pathways and xxx single commissioning policies for West Yorkshire and Harrogate – do we include something like this?

Medicines and prescribing

We are working with pharmacy leaders and clinicians to identify and address unwarranted variation and waste in prescribing and this work is expected to continue until the end of March 2024. One example of this is our medicines optimisation scheme in care homes which is reducing the risk of harm from medicines and cutting down on waste.

[Case study: add picture]

The Medicines Optimisation in Care Homes (MOCH) scheme aims to reduce the risk of care home residents being harmed by medicines taken inappropriately or incorrectly. The scheme is a two-year project that is due to finish in our region in September 2020. The new GP contract announced on 31 January 2019 has a focus on care home patients with an Enhanced Health in Care Homes (EHCH) scheme. It is hoped that pharmacists and pharmacy technicians will have a role to play in the future as part of this scheme to further reduce the risk of medicine-related complications and unplanned

Our five year ambitions include XXX (different ambitions to run along the top of each page)

hospital admissions. In addition, the scheme is addressing the issue of medicines waste in care homes which is estimated to cost the NHS around £300 million each year, and it is helping to support care home staff with training and advice.

Everyone should have the same access to the same treatments, including when new medicines become available on the NHS, so one of our main priorities for medicines and prescribing is to introduce standard prescribing policies.

We are already very efficient in relation to prescribing and achieving best value from our medicines budgets, but there are still opportunities to improve. We will continue to reduce the prescribing of medicines that have little evidence to show that they work well, and raise awareness of medicines that can be bought 'over-the-counter' such as paracetamol and antihistamines for short term use. This national scheme involves carrying out in-depth reviews of the medication being taken by individual care home residents to make sure that it is still appropriate and working well for them. In West Yorkshire and Harrogate, we are already carrying out these reviews in care homes for people with learning disabilities and have started reviews in care homes for older people too.

Our five year ambitions for medicines and prescribing [To include: next draft]

Transforming outpatients

By offering people more options and supporting them to have greater involvement in choosing what care to have and where, we can reduce unnecessary referrals to outpatients. We are working with the West Yorkshire Association of Acute Trusts (also known as WYAAT and [hospitals working together](#)) and [NHS Improvement](#) to transform outpatient appointments and support the delivery of the NHS Long-Term Plan ambition to reduce face-to-face outpatient appointments by 30% in five years, by the end of March 2024. We know that people want to see more availability of virtual appointments, and telephone appointments so we are working to make the best use of technology that will allow this to be done effectively and securely (see page 102).

Hospitals working together

The [West Yorkshire Association of Acute Trusts](#) (WYAAT) is a collaboration of the six NHS trusts who deliver acute hospital services to the 2.6 million people across West Yorkshire and Harrogate. These are:

- Airedale NHS Foundation Trust
- Bradford Teaching Hospitals NHS Foundation Trust
- Calderdale & Huddersfield NHS Foundation Trust
- Harrogate and District NHS Foundation Trust
- Leeds Teaching
- Hospitals NHS Trust
- Mid-Yorkshire Hospitals NHS Trust.

The purpose of the association is to work together on behalf of patients and the population to deliver the best possible experience and outcomes within the available resources. In order to deliver more integrated, high quality and cost effective care for patients, services will increasingly be organised around the needs of the whole West Yorkshire and Harrogate population rather than planning at the level of each individual trust.

In support of this purpose, since 2016, WYAAT has created several joint programmes of work. They cover clinical services, clinical support services and corporate support services.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

[In a box]

Since 2016, our acute hospitals have been working together to look at how we can use our collective resources, such as buildings and staff, to deliver the best possible experience and outcomes for people living across West Yorkshire and Harrogate. This reflects the need to consider the requirements of everyone together so we can deliver more integrated, high quality, and cost effective care for people.

Clinical services

Our clinical teams are working collaboratively in a number of ways.

We believe that patients should be seen and treated locally wherever possible; however for reasons of expertise and economies of scale some services may need to be delivered in a smaller number of centres of excellence and therefore require a networked approach to provide fair access to specialised care for all.

We have already created networks in five specialties – cardiology, dermatology, oral and maxillo-facial surgery, urology and gastroenterology. These teams have started to come together to share best practice, policies and procedures with the aim of increasing the consistency of care given to patients wherever they live in West Yorkshire and Harrogate. We will build on this work in other specialties.

In addition to better collaborative working across our hospitals, our clinical teams will work in a more co-ordinated way with their colleagues in primary and community care, social services and mental health services. Two examples are in elective orthopaedics and ophthalmology where the solutions to best care will require streamlined pathways between the hospitals and community care services.

By teams working together and seeing their place in the wider system, we will be in a good position to deliver services that are integrated and offer best treatment and care for all our citizens wherever they live in West Yorkshire and Harrogate.

[In a box]

‘We all know that health and social care in the UK is under increasing pressure. If you have read the NHS Five Year Forward View you will know that it identified the triple challenge of better health, transformed quality of care delivery and sustainable finances. It is clear that we need to do things differently as a Partnership, and where appropriate, take a systems view. Dr Robin Jeffrey, Clinical Lead for West Yorkshire Association of Trusts.

[Case study]

GIRFT (‘getting it right first time’) is a national clinically led programme, that is designed to improve the quality of care within the NHS by encouraging standardisation of our practice and reducing unwarranted variations in care. By looking in detail at each specialty it focuses with our own staff on sharing best practice and delivering efficiencies and cost savings. In WYAAT we have started to work with GIRFT not just at individual trust level but as a system. This allows us to look at collaborative solutions, innovation and new models of working. It also puts clinicians at the heart of change and development. We shall continue this approach as the GIRFT programme rolls out to all of the major hospital specialties.

Elective surgery

This programme has had an initial focus on patients needing a hip or knee replacement. This work led by clinicians from all six acute hospitals, is based on using data and evidence to agree a consistent approach to patient pathways. Progress to date has been on developing standard referral

Our five year ambitions include XXX (different ambitions to run along the top of each page) policies for GPs, designing a new approach for operating procedures to improve productivity in theatres and developing a common approach to patient information and education. In terms of the latter, we are exploring the potential for an interactive app to support patients in their journey.

We will complete and implement these initiatives across all acute hospitals, with our next focus being on how we help patients recover after surgery, for instance through physiotherapy. We are also piloting a national project for the procurement of orthopaedic prostheses, which we hope will increase consistency of practice and save money.

Vascular services

We have agreed to establish a single vascular service for West Yorkshire. Harrogate is not part of the service as their vascular services are provided by York Teaching Hospital NHS Foundation Trust. This will bring together the skills and expertise of staff from five acute hospitals, helping to attract and retain staff to support the delivery of sustainable services for all patients with conditions affecting their veins and arteries.

We are working with NHS England on proposals to consolidate the provision of complex and high risk vascular care into two major arterial centres, bringing together clinical expertise and high-tech facilities to provide specialist care. One centre will remain at Leeds General Infirmary, alongside the major trauma centre for the area. Following a comprehensive options appraisal process, involving senior vascular clinicians and independent clinical experts, WYAAT has recommended that the second centre should be at Bradford Royal Infirmary. A public consultation on this proposal will take place **[To do: add more information when we know more]**.

[In a box]

‘For people receiving treatment the West Yorkshire Vascular Service will improve ease and equity of access to vascular services as well as continuity of care. Although our outcomes are very good, there are pockets of knowledge, expertise, and technical developments held in different unit across the area. We need to embrace the ‘best’ practice and share the skills and break down any organisational boundaries. A single vascular service would allow development of regional wide sub-specialist teams to ensure everyone receives the same care and treatment no matter where they live’. Neeraj Bhasin, Regional Clinical Director for the West Yorkshire Vascular Services; West Yorkshire Association of Acute Trusts.

Pathology

We are working to develop a network for pathology services in West Yorkshire and Harrogate. This will mean collaboration across the area to address challenges around staffing, increasing demand and equipment upgrades. Standardisation of processes and increased consistency will release resources that can be invested in developing staff and services such as digital pathology to improve services for patients. While each trust will retain onsite testing to support urgent and acute care needs, other testing will be done in fewer places.

To underpin this standardisation of processes, we have been successful in securing £12 million national capital funding to implement a single [Laboratory Information Management System](#) (LIMS) across West Yorkshire and Harrogate. This will enable all data to be captured consistently in one system, provide an ability to track samples moving between laboratories and with results available for all clinicians to view across the area, reducing the need for duplicate testing of patients. It is expected that a single LIMS will be operational in every trust by the end of 2022 with implementation of the whole programme being concluded by the end of 2023.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

Radiology

The WYAAT hospitals are working together with hospitals in Hull, North Lincolnshire and York as the Yorkshire Imaging Collaborative. Their objective is to ensure that every patient in our part of the region is able to attend an appointment at any hospital and the clinicians there will be able to access the patient's medical images and associated reports irrespective of where the image was taken. This will avoid the need for patients to travel to other hospitals, have repeated scans and exposure to additional radiation.

The first step towards achieving this objective is the implementation of a new, common picture archiving and communication system (PACS) across the hospitals. This is the system that allows doctors to view medical images such as x-rays and MRI scans. As well as improving care for patients by providing access to images and reports across the region, this programme has reduced the costs of running the system. The new software is being implemented in a phased approach: five trusts are already using the new software with the remainder of the programme to be completed by July 2020.

The next phase is the implementation of a sharing solution, technology that will deliver the ability for images taken in one hospital to be reported by radiologists and reporting radiographers working in different hospitals to where a scan took place. This will maximise the collaborative capacity of these radiology reporting staff and shorten the elapsed time between images being taken and the necessary reports reduced. For the WYAAT hospitals this work is due for completion in late 2020/21.

In order to maximise the benefits of the common PACS and sharing solution; clinicians have begun working in Special Interest Groups (e.g. Breast, Neurology) to harmonise how they undertake patient scans and reporting across our hospitals, in order to allow them to work together to deliver better patient care.

[In a box]

Working in a collaborative image sharing network is good for radiologists. It allows them to share expertise, balance workload during times of staffing shortage and work better at scale. This is one of many reasons why our Partnership exists.

Pharmacy

This is another programme where the WYAAT hospitals are working with hospitals in other parts of Yorkshire to improve our medicines supply chain. This aims to reduce costs, improve service levels, manage any risks and drive innovation, ensuring that the medicines supply chain is able to meet future challenges and demands. This collaborative approach has allowed the nine trusts to reduce the value of stock held. A future programme may involve a joint approach to the preparation of parenteral products including chemotherapy; reducing the risk of medication error and freeing up nursing time from preparing medicines.

Corporate Support Services

Workforce

Our dedicated staff is our biggest asset and we employ over 50,000 people between us. Supporting them to work together is a priority. We have pursued a number of initiatives.

We have put in place a 'portability' arrangement to make it easier for staff employed in one trust to work in any of the others. This will give staff the chance to develop a wider range of skills and experience without the need to leave their current job and be recruited to another elsewhere. We have moved to a single occupational health system across our organisations supporting our staff in a consistent manner. We have also developed a new standard job description for band 2 and 3 clinical support workers, again increasing the ability for staff to work across the WYAAT hospitals.

Our five year ambitions include XXX (different ambitions to run along the top of each page)
Plans for the future include working to introduce a common approach to electronic rostering of staff, which will help free up time ward and other department managers. We are also exploring opportunities to reduce fees paid to agencies who supply staff to meet a temporary need. This is initially focussed on junior doctors. Building on the 'portability' arrangement we are looking to establish a shared staffing bank so that doctors employed by one trust on NHS terms and conditions can not only look to fill vacant shifts in their employing organisation but can also fill vacant shifts at other WYAAT hospitals.

Planning for our future workforce is a key issue. As part of this we are developing a policy and pay framework for apprenticeships, maximising the use of this route for training staff. We are also working with [NHS Improvement](#) and Huddersfield University regarding new nursing roles in medical assessment units, which will be piloted at Airedale NHS Foundation Trust

Scan4Safety

Scan4Safety is a digital innovation that will deliver huge benefits to the NHS. The programme uses barcodes and scanning technology to track patients and the products used in their healthcare, improving patient safety and experience and also reducing costs significantly, releasing funds to provide better care.

The idea is to make sure we have the 'right patient, right product, right place and right process' every time. Mobile applications are used to capture a person's details at their bedside, increasing the amount of time staff can spend providing care. Scan4Safety will improve data quality in patient records and administrative systems, such as stock control, and it is estimated it will deliver annual savings of £7-10m across West Yorkshire and Harrogate.

Leeds Teaching Hospitals NHS Trust took part in a national pilot programme, following the success of this pilot, in 2018 West Yorkshire and Harrogate made a successful bid for national funding. Work has begun to start the roll out of Scan4Safety across all the other WYAAT hospitals, with large scale transformation planned for 2020/21.

Procurement (sourcing products and services)

We are working together to identify areas where we can standardise products and purchase them collectively to reduce prices and achieve better value for the public purse. For example, standardising the selection of surgical gloves will save £200,000 and also help staff as they can access the same gloves when working at different sites. So far, this work has resulted in savings of just over £1 million. We are continuing to look for opportunities and to provide procurement expertise into the work of other WYAAT programmes.

In response to the implementation of the new national procurement model and proposals to make changes at a regional level, Heads of Procurement in the WYAAT trusts are now starting to look at ways in which they can collaborate in the delivery of the procurement function itself. Initial priorities are the development of a collaborative sourcing plan, with individual trusts managing the process for particular categories on behalf of the others; and the central management of the implementation and maintenance of procurement systems including product catalogues, e-sourcing tools, inventory solutions and a central contract database.

You can read the West Yorkshire Association Annual Reporter here **(To do: add link once completed)**.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

Priority areas for improving outcomes

Our Partnership has a number of priority programmes which are designed to improve services and health outcomes for specific groups of people.

Maternity

Better Births, the [national maternity review](#) published in 2016, celebrates the improvements that have been made in maternity services and identifies how we can work together to ensure women are healthy, make informed choices and are able to have the safest possible birth for themselves and their babies. It is also the starting point for the development of Local Maternity Systems which are responsible for implementing the recommendations of the review.

[In a box]

We aim to be the place where women and their families choose to receive their maternity care and birth their babies with as much choice as possible but also make sure that we have specialist help available within our area. Rather than working in isolation we now work together as a local maternity system (LMS). This gives us the opportunity to give women choice across a wide geographical area and also allows us to concentrate specialist services where they are most effective. This way we can make sure that women get the right care, in the right place, at the right time. Wherever women choose, they will be looked after by highly trained staff offering a quality, safe and personalised service. You can read more [here](#).

West Yorkshire and Harrogate Maternity Programme has been working to establish the Local Maternity System (LMS) since 2017. It is now firmly embedded as a priority programme in our Partnership.

A comprehensive LMS Plan has been co-produced with women and staff and is available [here](#). This includes our measures over time and performance to date, including our risks and how we will address them.

The LMS has a robust [Governance structure](#), with all key decisions being approved by the LMS Board, including how our transformation monies are allocated and spent.

The LMS brings together partners with one ambition to deliver the vision to transform maternity and neonatal services across West Yorkshire and Harrogate. The partnership includes maternity, neonatal and paediatric services, primary care, health visitors, commissioners, our councils, women and their families. Carol McKenna, Senior Responsible Officer for the Maternity Programme outlines **our ambitions in this [film](#)**.

The LMS vision is based on a partnership approach with women, their partners and families. It considers all their needs and wishes. To deliver the vision, strong leadership is embedded from the delivery of [Better Births](#) and we will continue to build on this to fulfil the requirements of [The NHS Long Term Plan](#). We have identified interdependencies with our other Partnership priorities, such as mental health, urgent care and preventing ill health and most importantly working with communities in partnership with our six local places (Bradford District and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield).

Working together with women, their partners and families

We hear and act on the voices of women and their families through working together and supporting local Maternity Voices Partnerships (MVP).

Our five year ambitions include XXX (different ambitions to run along the top of each page) Where areas did not have an MVP the LMS has successfully supported their development. MVPs have co-produced our local maternity offer ([My Journey](#)) in a variety of accessible formats. You can read the easy read version [here](#).

LMS next steps include:

- Continuing to support and develop our MVP network
- Increasing engagement and co-production with men as parents
- Work with the emerging national volunteering programme to develop volunteering across our maternity services at a local and West Yorkshire and Harrogate level.

Highly skilled and knowledgeable maternity workforce

The LMS has nationally recognised maternity services that attracts and intends to retain a highly effective workforce that is well led, innovative and will continuously learn. The LMS workforce priority areas include: a staff health and wellbeing project to support sustainable organisational change to working patterns and models of care for the maternity workforce; staff preceptorship; leadership and recruitment. The LMS will continue to support staff to deliver care which is women centred, work in high performing teams, in organisations that are well led, in a culture which promotes innovation and continuous learning. We are working together to coordinate recruitment activity to minimise inefficiencies, support the most vulnerable services and avoid duplicate job offers.

LMS next steps include:

- Improving the cost effectiveness and consistency of training for the maternity workforce with early focus on standardising the preceptorship programme for newly qualified midwives and mandatory and primary training for existing and new staff
- Investing in the capability and skills of the maternity workforce, concentrating on the maternity support worker role
- Improving leadership culture by establishing the cultural values and behaviours we expect from our senior leaders through the new LMS Professional Midwifery Advocate Network.

Making our maternity services safer for women, babies and staff

Stillbirths and neonatal deaths have been reduced by 10% across WY&H (Yorkshire and Humber Maternity Dashboard). There has been a focus on improving care for preterm infants - more mothers in preterm labour have received magnesium sulphate to prevent cerebral palsy in their preterm infant. Mechanisms have been established for reviewing incidents across the LMS to share the learning. Collaborative work has been undertaken to improve pre-hospital maternity care with Yorkshire Ambulance Service. The LMS has supported hospitals to achieve safety standards in the NHS Resolution Maternity Incentive Scheme. We will continue to work towards the ambitions of [Saving Babies Lives v2](#) with particular focus on the new element on reducing pre-term births.

LMS next steps include:

- Increasing uptake of magnesium sulphate by women in preterm labour to prevent cerebral palsy in preterm infants
- Participating in exception reporting and review of babies less than 27 weeks born outside of a Neonatal Intensive Care Unit, ensuring themes and lessons are learned and shared
- Establishing a multi-disciplinary preterm prevention working group
- Full implementation of Saving Babies Lives v2 by 2020
- Review and implement where appropriate the recommendations from the [National Patient Safety Strategy \(2019\)](#), to improve women and baby's safety, preventing harm and the costs associated costs with it.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

The LMS ambition is to

- **Reduce stillbirths, neonatal brain injuries, neonatal and maternal mortality by 20% by 2020 and 50% by 2025**
- **Reduce preterm births to 6% by 2025.**

We will also:

- **Continue working with the [Maternity and Neonatal Health Safety Collaborative](#)**
- **Publish and circulate crib-cards for community midwives to improve pre-hospital transfers**
- **Participate in the development of a Maternal Medicine Network**
- **Deliver new specialist services and clinics including Maternal Medicine and Preterm clinics**
- **Consider recommendations and actions for women with specific physical and mental conditions before, during and after pregnancy e.g. diabetes, respiratory, perinatal mental health**
- **Ensure that pregnant women with Type 1 diabetes are offered glucose monitoring from April 2020, where clinically appropriate**
- **Co-produce system wide guidelines along the maternity care pathway with staff and women**
- **Work in partnership with the Neonatal Operational Delivery Network (ODN) to improve neonatal care in line with the [NHS Long Term Plan Implementation Framework](#) to support the expansion and improvement of neonatal critical care services and develop allied health professional (AHP) support; and ensure that there are care coordinators within each of the clinical neonatal networks across England to support families to become more involved in the care of their baby (please note the regional specialist commissioning team and ODN are responsible for this work).**

Working together to provide choice and personalised care for women and their families

Women are able to choose where they have their antenatal, birth and postnatal care, and we are working across the LMS to ensure women are fully informed about the choices available. Our Partnership has increased the number of babies born in midwifery settings, such as home or a birth centres; we have worked with women and their families to co-produce and publish the LMS choice offer. Training has been developed for staff to ensure all women have a meaningful conversation about where their baby can be born and what choices they can make.

You can watch [Becky's story](#) explaining the importance of personal choice and her experience of using local maternity services.

One in four mothers suffers from mental health problems during pregnancy or in the first year after childbirth and the LMS works collaboratively with the Partnership's Mental Health, Learning Disabilities and Autism Programme to support women and their families (see page 71).

LMS next steps include:

- **Offering personalised care to all women and their families and co-producing a personalised care plan framework for women and their families to record their choices and wishes**

The LMS ambition is to increase the number of women...

- **With a personalised care plan to 50% by 2020 & 100% by 2021**
- **Reporting they have received personalised care to 50% by 2020 & to 95% by 2021**
- **Able to choose from three places of birth to 75% by 2020 & 90% by 2021**
- **Giving birth in midwifery settings to 30% by 2020 & 60% by 2021.**

Our five year ambitions include XXX (different ambitions to run along the top of each page)

Continuity of carer

Women who receive continuity of carer from a small team of midwives, whom they know and trust, build trusting relationships and receive safer care (Sandall et al: 2016). In 2018 less than 1% of women received continuity of carer throughout their pregnancy journey in our LMS. Over 10% of women in WY&H were placed onto continuity pathways in March 2019. New models are being developed and learning from these will be shared, through our Continuity of Carer Forum, so that by 2021 the majority of women across our area will experience and benefit from continuity of carer.

LMS next steps include:

- Evaluating the current continuity of carer models
- Continuing to involve our MVP network and sharing lessons learned as we proceed
- Increase the number of models and teams delivering a continuity of carer pathway
- Focussing on continuity of carer models for those women and families for whom we believe we can have the biggest impact and improve outcomes for women and families, including for women in the most deprived areas, to address health inequalities.

The LMS ambition is to increase the number of women receiving continuity of carer:

- **To 35% by March 2020**
- **To most women by 2021**
- **To 75% women from black and minority ethnic groups and areas of greatest deprivation by 2024**

Better postnatal care

The LMS has brought partners and families together and begun to explore how postnatal care can be personalised to the needs of each family to support their best start. LMS next steps include:

- Co-producing a strengthened postnatal action plan for the LMS
- Improving the transfer of care and information between midwifery and primary care & health visiting services
- Scoping our current obstetric physiotherapy services; then improving access and care pathways to specialist pelvis health clinics.

The LMS ambition is

- **To ensure all providers are accredited or have commenced the process to achieve the UNICEF Baby Friendly initiative by 2020.**

Prevention and health inequalities

We want to ensure preventing ill health and tackling health inequalities is at the heart of all we do in all areas of improvement and change. The LMS has undertaken and published a comprehensive [Health Needs assessment and Equality Impact Assessment](#). Providing support for parents as early as possible is essential to ensure infants and children live healthier lives.

Every woman and their family should experience a healthy pregnancy wherever possible – starting from supporting women and their families to plan for pregnancy through to being in the best possible health before, during and after.

Our LMS Maternity Prevention and health inequalities work stream is led by public health colleagues from our six local places, who work at a local level to identify good practice which can be shared across the whole of our area.

Our five year ambitions include XXX (different ambitions to run along the top of each page)
They also identify issues that impact on the health and wellbeing of women and their families, such as some of the challenges parents face around whole family health and activities.

LMS next steps include:

- Ensuring all maternity units have an accredited, evidence-based infant feeding programme, such as the UNICEF Baby Friendly Initiative
- Working with women and families experiencing multiple unhealthy risk factors and understand how the social and clinical needs of women are interlinked
- Exploring the many health inequalities faced by women and their partners in pregnancy which add to the clinical risk to both women and their babies
 - Identifying and working with specific target groups of women and families including Black and Ethnic Minority Groups, poor socio-economic back groups, Gypsy and Traveller communities and vulnerable women to fully understand their needs and the barriers to care

The LMS ambition is to

- **reduce smoking in pregnancy to 6% by 2025**
- **increase breastfeeding initiation rates**
- **offer continuity of carer to 75% women from black and minority ethnic groups and areas of greatest deprivation by 2024**

Birth to 1001 Days

We will identify strategies to contribute to the [1001 Critical Day's](#) manifesto and the findings of the All Party Parliamentary Group to ensure that babies born in West Yorkshire and Harrogate have the best possible start in life from conception to age two.

Our next steps include:

The LMS will work closely with the Children and Young People's (CYP) Programme and the National CYP Transformation Programme, to achieve the following ambitions:

- Improve performance of childhood screening and immunisation programmes and meet the standard in the NHS public health functions agreements
- Improve maternal nutrition and infant feeding to prevent childhood obesity
- Improve parenting and bonding to provide loving and safe environments to support social and emotional development.

Digital

We have completed an LMS digital maturity assessment and are developing a plan to respond to the recommendations and meet the national ambition for digital maternity records. Within the LMS, we will learn from the local digital maternity pilot site. There is a number of different electronic patient record systems utilised across the LMS.

Our next steps include a review of the interoperability (IT systems which talk to one another) opportunities to facilitate the safe transfer of information between providers when care is transferred.

The LMS ambition is for all women to have their own digital maternity record by 2023/24

Our five year ambitions include XXX (different ambitions to run along the top of each page)

Communications and engagement

We have co-produced and are delivering our communications and engagement plan. We have identified areas of excellent engagement and areas for improvement.

Our next steps include:

- **A series of LMS Roadshows in provider trusts**
- **Targeted engagement sessions with identified professional groups.**

Alison Pedlingham, Head of Midwifery at Harrogate and District NHS Foundation Trust, talks about how the West Yorkshire and Harrogate local maternity system is improving maternity services. You can **watch it [here](#)**.

Children and young people

The health of children and young people is crucial to our future of this country, but England's levels of care and wellbeing currently lag behind the rest of Western Europe. The health of children and young people is determined by far more than healthcare. Household income, education, housing, stable and loving family life and a healthy environment all significantly influence young people's health and life chances. By itself, better healthcare can never fully compensate for the health impact of wider social and economic influences.

[Case study]

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

Children and young people (0-18) account for 23% (570,000) of the total West Yorkshire and Harrogate population. Improving the health and wellbeing of children and young people is an investment in future generations and the prosperity of this country.

Many of our children and young people are already achieving positive outcomes across aspects of well-being and enjoy life to the full. Over recent years we have seen improvements across West Yorkshire and Harrogate most notably:

- School readiness has increased from 51.2% in 2012/13 to 67.5% in 2017/18.
- 6% of 16-17 Year olds in West Yorkshire and Harrogate are not in education, employment or training. This is the same as the England rate (To do: add what it has improved from).

However, we know that too many of our children and young people still live with poor mental health, in poverty, experience homelessness or insecure/unsafe environments. Recent figures show

- Deprivation rates vary, with Bradford being the 11th most deprived area in the country, Kirklees the 95th and Harrogate the 188th.
- Rates of children looked after are higher in West Yorkshire at 72.1 per 10,000 compared to 63.6 for England.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

- Infant death rates for England are declining, however in West Yorkshire and Harrogate the rates have been increasing year on year since 2012.
- The rate of hospital admissions for dental caries (0-5 years) per 100,000 is 64% higher in West Yorkshire and Harrogate (534 per 100,000) compared to England (325 per 100,000).
- 19.2% of West Yorkshire and Harrogate children aged 0-16 are living in families in receipt of Child Tax Credit whose reported income is less than 60 per cent of the median income or in receipt of ISA/JSA. The England average in 2016 was 17%.
- The rate of children who started to be looked after due to abuse or neglect across West Yorkshire and Harrogate is 17 per 10,000 children aged under 18.
- The rate of children and young people killed and seriously injured on England's roads per 100,000 is 10% higher in West Yorkshire and Harrogate (45 per 100,000) compared to England (41 per 100,000).

All our six local places have a Children and Young People Plan; some of these are in draft or under review.

Ofsted inspection findings vary across West Yorkshire and Harrogate for Education, Childcare and Children's Social Care, Local Area Special Educational Needs or Disability (SEND).

The local child health profiles show that there are common challenges across the system for example children and young people road accidents and there are outcomes where inequalities can be seen across the system.

Many of the West Yorkshire and Harrogate [Priority Programmes](#) include a focus on children, young people and families, for example carers, maternity and mental health and we will work across these areas to ensure links are made.

The [West Yorkshire Association of Acute Trusts](#) (hospitals working together) have been developing a Clinical Strategy on behalf of the Partnership and have produced a report on the early engagement work on children, young people and families.

[Case study: add picture]

Bradford Teaching Hospitals NHS Foundation Trust has developed a service with families called the 'Ambulatory Care Experience' (ACE). In collaboration with Bradford Clinical Commissioning Groups and GPs, ACE aims to provide an alternative to a hospital referral or admission for children and young people who have become acutely unwell with common childhood illnesses and need a period of observation after initial assessment for up to three days. Referrals are accepted from GPs, nurses, A&E and the paediatric ward at the Bradford Royal Infirmary. Ongoing clinical monitoring is undertaken in the community by specially trained children's nurses.

We also know there are recruitment and retention challenges in health and social care. Over the next decade, technologies and treatments will advance; changing demographics will result in further changes to the population. There will be a reduction in acute illnesses and children with single gene disorders and cancer will have better, more effective treatments. This will be offset by an increasing population of children with complex needs, technology dependence and 'normal' children presenting with 'normal' symptoms or psychiatric / psychosomatic problems. This will require a different workforce and delivery methods to meet those changing needs.

The NHS Long Term Plan sets out the priorities for improving care quality and outcomes, addressing unmet need, unexplained local differences and developing new models of care fit for the changing needs and demands of the population. The plan calls for the NHS to increasingly be:

- More joined up and coordinated in its care
- More proactive in the services it provided

Our five year ambitions include XXX (different ambitions to run along the top of each page)

- More differentiates in its support offer to individuals.

The NHS Long Term plan also calls for closer working relationships between health and local councils for a greater focus on preventing ill health, health inequalities and the wider social and economic determinants of health (see page 23).

To achieve the aspirations of the NHS Long Term Plan for the Children and Young People Programme we will focus on the added value of working together as a system to improve children, young people and their families health and life chances. This will include opportunities to address health inequalities, complex issues and influence or implement actions at scale or standardise practice to improve outcomes for children, young people and their families.

[Case study]

In West Yorkshire and Harrogate there are many children and young people growing up in poverty and higher than average childhood obesity levels. Our aim is to improve the way that services are provided with a greater focus on helping people earlier rather than later and keeping people well. One example of how we are working more closely in our local areas is the ‘Kirklees Integrated Healthy Child Programme, working under the banner of ‘Thriving Kirklees’. It is made up of Local Community Partnerships, South West Yorkshire Partnership NHS Foundation Trust, Northorpe Hall, Home-Start and Yorkshire Children’s Centre. You can find out more [here](#).

Our five year ambitions

Initial scoping work for the programme has identified the following priorities:

- **Acute Paediatrics (children’s hospital care) linked into the West Yorkshire Association of Acute Trusts work with an initial focus on ambulatory care experience**
- **Early intervention and prevention by ‘intervening early in the life of a problem’**
- **Complex needs, Special Educational Needs and Disabilities (SEND)**
- **Long term health conditions**
- **Palliative and end of life care- link into the Yorkshire and Humber Pediatric Palliative Care network**
- **Working with the Mental Health, Learning Disability and Autism Programme to agree collective priorities alongside a focus on the behaviour of adults impacting on the lives of children.**

Mental health, learning disabilities and autism

We aim to deliver excellent health and wellbeing outcomes for people with a mental health condition, learning disabilities and autism.

[In a box]

Up to one in 4 of us will suffer from poor mental health at some point in our lives and for those with a severe illness it can lead to dying 20 years earlier than the rest of the population. Having a learning disability also increases the likelihood of experiencing health inequalities and poverty, whilst having autism limits people’s opportunities of employment and good wellbeing (see page 71).

Working together in partnership gives us a greater opportunity to improve people’s lives. If we use our collective expertise and resources (money, buildings and staff) we can provide higher quality services and reinvest financial savings to support care closer to home, such as for people with an eating disorder, anxiety and depression, or a child with complex behaviours who needs specialist understanding.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

Good hospital and community services are only part of the picture. We want people to be at the centre of their care with all their physical, mental and social needs met through joined up care and support.

By sharing what works well across West Yorkshire and Harrogate we can tackle the wider social determinants of poor mental health, ultimately seeing fewer people in crisis, less people reliant on hospital beds and smaller numbers of people left behind without the support they need to lead a fulfilling life.

We intend to:

- Eliminate people who have to go outside of West Yorkshire and Harrogate for their treatment, including for those with complex needs
- Work together to make best use of our hospital beds
- Ensure people in crisis get treatment at any time of day either at home, or close to home
- Reduce the number of people who end up being treated in A&E
- Reduce the number of people being held in police cells when they are in crisis
- Reduce the number of people who take their own lives
- Develop new ways of working for specialist services such as children & young people's mental health, eating disorders and mental health services for those who may be a risk to others
- Reduce waiting times for autism and attention deficit hyperactivity disorder (ADHD) assessments
- Support people with a learning disability and challenging behaviours in the community rather than hospital settings
- When people with a learning disability do require hospital care we want to make sure this is of the highest quality and tailored to their needs
- Help people with a learning disability and or autism have a longer, better life by improving their physical and mental health.

Just like our other programme areas, the majority of work takes place in our six local places (Bradford District and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield) through partnerships of NHS organisations, councils and community groups.

Mental health is receiving an increased share of the overall NHS budget and the programme will be overseeing achievement of the [Mental Health Investment Standard](#), holding local places to account so that they spend at least the minimum expected levels of funding to improve mental health.

Each area has a [Local Transformation Plan](#) overseen by the Health and Wellbeing Board. Mental health and wellbeing features heavily in Primary Care 'Home' developments through increased focus on early help, preventing ill health (including health-checks), support across the full age spectrum and as providers of psychological therapies for common mental health conditions (see page 71).

Our Mental Health, Learning Disability and Autism Programme works work closely with 'place' to ensure local and the West Yorkshire and Harrogate work is connected. This helps to ensure we avoid duplication and adopt a 'do once' approach to commissioning (buying services). The programme has developed a more detailed strategy which underpins this chapter and it can be accessed here [to add once completed].

The story

Many people's mental health problems begin in childhood, are shaped by where and how they live, and can have a lifelong impact within their family and across generations. Poorer mental health is associated with higher rates of smoking, substance abuse, lower educational attainment, poor employment prospects/rates, along with decreased social relationships and lower resilience.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

We know that people with autism and/or learning disabilities have much higher rates of mental health illness than many other groups of people alongside the other challenges posed by their diagnoses. The contribution of wider determinants of health and the impact they have on keeping children and people with learning disabilities and/or autism and those with mental illness well is a priority for the improving population health programme (see page 28).

Creating one programme of work across all these areas will enable greater understanding of the challenges people who access care and their carers' face. Care services will adjust what they do to support those more challenging needs, from improving access to providing information in accessible formats and ensuring staff demonstrate the right attitudes to people.

Addressing these issues requires close working with other programmes of work such as maternity, cancer and primary care. The table below sets out why this work is so important to the health and wellbeing, and life chances of all those we support.

[Info graphic to be produced for the table]

Mental health/illness Approx. 25% prevalence per year	Learning disability (LD) approx. 10% prevalence	Autism/ADHD Between 1-4% prevalence
<ul style="list-style-type: none"> -75% of people with long term MH illnesses are unemployed -50% of people with anxiety/depression for over 12 months are unemployed -50% of MH problems are established by age 14 -62% of Looked After Children (LAC) are in care because of abuse/neglect - 1 in 6 adults has experienced MH problems in the last week - People with severe Mental illness die on average 15-20 years earlier than the general population (often from poor physical health) 	<ul style="list-style-type: none"> - twice as likely as the general population to suffer mental health issues - more likely to experience deprivation, poverty & other adverse life events early in life - higher risk for poor physical health - 4x more likely to die of something that could have been prevented - dying on average 20 years earlier than the general population - unlikely to be in paid employment (less than 6% in 2017) - can spend too long, inappropriately in hospital and be over medicated 	<ul style="list-style-type: none"> - 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
<p>Carers/families – unpaid carers save the UK over £132 billion a year and are particularly relevant for individuals diagnosed with mental ill health, learning disabilities and/or Autism/ADHD. As part of this strategy particular attention will be paid to how, as an integrated system, we can better support carers and recognize the daily challenges that carers face when either trying to navigate support/care for their loved one or trying to support them to keep them psychologically and physically well. The programme will also actively support the Worker Carers Passport Initiative.</p>		

We need to not only work on these wider determinants but also increase access to specific services, including to other important physical health services such as dentistry, opticians screening and health checks. And we also need to ensure support is provided where transition/change occurs within a person's life, as their resilience and often their carer's resilience, can be destabilised.

Our five year ambitions include XXX (different ambitions to run along the top of each page)
Further education and employment opportunities also remain low, contributing to those with a learning disability or severe mental illness finding it hard to keep in work. Yet we are optimistic we can address this together at a West Yorkshire and Harrogate level, by testing employment schemes such as individual placement and support, looking at good practice elsewhere in the country and lobbying locally for change.

[Case study: add picture]

South West Yorkshire Partnership NHS Foundation Trust runs a network of recovery colleges in Calderdale, Kirklees, Wakefield and within forensic services at Fieldhead Hospital. Colleges focus on developing people's strengths, helping them understand their own challenges and how they can best manage these in order to live fulfilling lives. Courses are developed and delivered by people with lived experience of health problems alongside professionals. Some of the colleges are already offering training packages to workplaces and there are plans to extend the offer across the region to help raise awareness of mental health issues and reach even more people. Recent evaluation of learners' progress at Wakefield & 5 Towns Recovery College found that 29% of students have self-reported a decrease in their contact with health services and 18% have gone into employment, volunteering or education following attending the college.

[In a box]

As a Partnership we commit to all new health and care buildings being learning disability and autism friendly, that the company building the development supports learning disability apprenticeships and we also employ them to work as peer supporters.

Programme priorities

We adopt three approaches across West Yorkshire and Harrogate depending on the challenges we face and what these mean for each of our six local places. We:

- Share learning across our places, collaborating to reduce differences in practice but ultimately leaving decisions on what to do to be taken locally
- Standardise practice, ensuring that for those services that cross local boundaries there is common practice, agreed by each place but undertaken locally in the same way
- Reconfigure services, doing things across West Yorkshire and Harrogate on behalf of all places to meet unmet need and build resilience, particularly when care needs to be highly specialised.
- As we receive more accountability from NHS England to make and take decisions relating to services such as adult eating disorders, Tier 4 CAMHS and forensics, future decisions on reconfiguration of specialised services will be taken by our provider collaborative.

Access to high quality care

Common mental illnesses

Each of our six local places across West Yorkshire and Harrogate is committed to improving access to psychological therapies for adults. Primary Care Networks will ensure that a multidisciplinary approach is provided for people, on top of the necessary increases in therapists within primary care settings (see page 40). We will share good practice across West Yorkshire and Harrogate to support this increase in access and to achieve referral to treatment times and recovery standards from 19/20 onwards.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

Care in a crisis

We know, from those who have had experience of a mental health crisis, the importance of being able to depend on a fast, 24/7, appropriate response. We are working alongside the Urgent and Emergency Care Programme to develop our urgent and emergency mental health care response in collaboration with regional providers such as Yorkshire Ambulance Service and police with the aim of meeting national expectations of 100% coverage of 24/7 crisis teams by 20/21. This includes ensuring that NHS111 can be used as a consistent access point for help, standardising how care plans are used by all agencies, training the ambulance workforce and developing how mental health staff can support police in 999 control rooms. We are also testing in places how to make reasonable adjustments for autistic people when in crisis.

Watch this film about Bradford District Care NHS Foundation Trust's First Response service and partnership working with Haven at the Cellar Trust to find out how they are supporting people in crisis in their communities.

In our local places, alternatives to A&E (safe spaces) are being developed for adults and children and we will ensure that these include access for those with learning disabilities and/or autism and those with conditions such as dementia.

Children and young people's mental health and wellbeing

We want young people to receive care closer to home when they have serious mental health problems, such as severe personality and eating disorders, so they don't need to travel outside the area for specialist care. Our Partnership information shows that by adopting a shared approach across West Yorkshire and Harrogate the number and length of hospital bed days for children and young people across the area has reduced in the last six months from 708 occupied days in April 2018 to 536 in September 2018. The money saved means our places have been able to invest £500k in community services - ensuring more children and young people are cared for closer to home. This is progress, yet we know much more needs to be done to support children, young people and their families. We will continue to build on this progress for as long as needed.

Getting services right for childhood mental health and wellbeing means we can prevent the development of more significant problems later in life.

This is why we are using trailblazer funding from NHS England to establish Mental Health Support Teams (MHSTs) in Bradford, Leeds and Kirklees. These teams will test new ways of working between health and education, identifying what works to roll out across West Yorkshire and Harrogate by the end of 2023.

[Case study]

Around one in 10 children are believed to have a diagnosable mental health disorder, with half of all mental health conditions beginning before the age of 14, making it vital that children with early symptoms receive the support they need

Mental Health Support Teams (MHSTs) will support several schools and colleges, covering a population of around 8,000 children and young people. Their new workforce of Education Mental Health Practitioners will work with education settings to provide early intervention on mild to moderate mental health issues and provide help to staff in schools and colleges. A programme jointly delivered with the Department of Education, teams will also act as a link with local children and young people's mental health services and be supervised by NHS staff. Bringing mental health and education professionals together is a positive step forward and this much needed support is going into three areas of our Partnership. We can then share learning and spread good practice everywhere – which is one of the very reasons why our Partnership exists'.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

We recognise the need to treat each child and young person as an individual, encompassing their mental and physical health. We are working in partnership with the children and young people (see page 69) and Improving Population Health Programmes (see page 28) to better understand their needs and those of their families. This work will put our places in a good position to redesign community services, alongside primary care and councils, creating a comprehensive 0-25 mental health service (in line with national funding from 2021/22).

We will also continue to explore the opportunities that new care models offer us to refocus on intervening early and supporting children as close to home as possible, including providing the very best hospital bed services in West Yorkshire and Harrogate, so that people do not need to go out of area for treatment.

[Case study: add picture]

West Yorkshire to get new child mental health unit

A new £13million child and adolescent mental health unit is set to be built in Leeds after it was announced in 2017 as one of 12 successful bids to receive NHS England capital funds. The successful bid, led by Leeds Community Health Care NHS Trust on behalf of the West Yorkshire and Harrogate Partnership, will see a new purpose built specialist community child and adolescent mental health (CAMHS) unit to support young people suffering complex mental illness, for example severe personality and eating disorders. The Trust finalised plans for the new unit based on the experience for young people accessing care.

Anne Worrall-Davies, Clinical Lead for West Yorkshire Child and Adolescent Mental Health Services, talks about how health and care partners are working together to improve the way we deliver mental health services for young people in our areas, including through the role of care navigators. **Watch the film [here](#).**

We will also continue to work together to ensure that by 2023/4 all children and young people experiencing a mental health crisis, including those with a learning disability and/or autism will be able to access crisis care 24 hours a day, 7 days a week through a single point of access and that every area will have age appropriate, urgent and emergency assessment, intensive home treatment and liaison functions in place.

Hospital care

Our ambition is to ensure that people are cared for within their community by primary care services where possible and only those who need a hospital admission are admitted, and when they are, that as many people as possible are kept within West Yorkshire and Harrogate for support.

The Programme will continue to work in partnership with our six local places to review hospital and community provision, including the availability of psychiatric intensive care, the configuration of assessment and treatment beds (you can read the engagement report [here](#)), inpatient learning disability beds via the Transforming Care Programme, forensic services and rehabilitation and recovery. In line with national ambitions for mental health our programme will learn from good practice in other areas to develop new ways of working that help reduce length of stay, including better use of personalised care planning and new roles such as care navigators; sustaining these from 2020/21 once new NHS England funding is made available for each place.

We will also review current delivery across all service providers against the [Learning Disability Improvement Standards](#) during 2019/20 and 20/21 to identify what is needed to improve our service offer and share these findings so that everyone with a learning disability and/or autism feels more comfortable, confident and cared for in all our health and care services by 2023/24.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

We will also continue to expand the range of specialised services we provide across West Yorkshire and Harrogate, including the creation of the only problem gambling clinic outside London.

Eating disorders

There are now no inappropriate out of area admissions for adult eating disorders. By piloting a new way of working across WY&H we have achieved a saving of £240k and invested in the CONNECT team to achieve improvements in length of stay, the amount of time people spend in hospital and how close to home their care is given (you can read more [here](#)). We will continue to develop and refine this model; ensuring it meets the needs of people with a learning disability and/or autism. [To do: info graphic].

Metric	Current/Baseline	2018/19 target	2018/19 achieved
# admissions	54	49	42
LoS	90 days (average)	81 days (average)	92 (median)
Number out of area placements	22	7	0
Distance from home	40 miles	16 miles	6 miles
OBDs	6,545	5,449	5229

[Case study: add picture]

CONNECT: a new community eating disorders service for West Yorkshire and Harrogate aims to provide fair access to NHS care for adults with eating disorders across the area – something that had not been in place until 2018. The team includes doctors, psychologists, therapists, nurses, dietitians, occupational therapists, social workers, health support workers and peer support workers - who have experienced mental health problems either themselves or as a carer. 148 people have been allocated for treatment over the past year. The service won an award at the Positive Practice Awards for Mental Health in November 2018 and was nominated and shortlisted for two HSJ awards in the specialist services and mental health provider categories. The service received a ‘highly commended’ award in the mental health category for its outstanding work in this area.

Suicide prevention

West Yorkshire and Harrogate and the wider Yorkshire and Humber region have some of the highest suicide rates in England. The biggest killer of males under 50, mental health issues and financial problems are some of the biggest contributing factors of suicide in our region.

Suicide prevention takes place at both a local and West Yorkshire and Harrogate level. There is a multiagency Suicide Prevention Advisory Network (SPAN) across all Partner agencies. The Partnership has a vision that all suicides are preventable and is adopting a collaborative, evidence-based approach to ensuring fewer people die by suicide. Funding from NHS England/NHS Improvement will allow support workers with lived experience to provide advice, training and support for up to 600 men in the area, drawing on voluntary organisations like State of Mind and Luke’s Lads to help.

We are also working to improve suicide bereavement services across the area, and with public health colleagues we are creating a high risk decision support tool for primary care and non-mental health services to identify people at risk of suicide and target support where necessary.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

[Case study: add picture]

A Leeds based postvention suicide bereavement support service will be rolled out across West Yorkshire and Harrogate in the latest funding boost for mental health services in the area. The Partnership secured £173,000 from NHS England/NHS Improvement to enhance suicide bereavement support services in the region. The new service will be an extension of the Leeds Suicide Bereavement Service, now in its fourth year; set up in 2015, led by Leeds Mind with support from Leeds Survivor Led Crisis Service and funded by Leeds City Council.

[In a box]

'Losing someone to suicide is an experience that no-one should have to go through. Having spoken to people who have thought of taking their own lives I think it is important that we work with our partners to make our staff aware of the warning signs, to enable them to support both colleagues and community members. By working with the Partnership we can hopefully raise awareness of this subject and most importantly help to save more lives.' Deputy Chief Fire Officer Dave Walton. You can also read our Suicide Prevention Annual Report [here](#).

Autism (and other neurodiversity like ADHD)

Autism (and other neurodiversity like ADHD) can be a barrier to some services. We will increase awareness about the challenges faced, improve access to mainstream services for this group of people and make reasonable adjustment to ensure barriers are removed. Children and adults wait too long for assessment and diagnosis of both autism and ADHD and we will work across West Yorkshire and Harrogate to improve this, both within each place and across the wider system.

[Case study: add picture]

Following an OFSTED and CQC inspection in June 2017 and a revisit in June 2019, Wakefield services have been assessed as making significant progress to improve autism services for children and young people. In June 2017, 614 children and young people aged 0 to 14 were waiting for ASD assessments – the average waiting time was almost two years. By June 2019, this had been drastically reduced to 57, with a waiting time of no more than 26 weeks. Local health, council, schools and community partners will now focus on their learnings from the under 14's programme of work, which made up around 88% of all referrals across the district; replicating ideas and changes, where appropriate, to ensure waiting times for over 14's are reduced in the future.

Integrating physical and mental health support

People using health and care services commonly find that their physical and mental health needs are addressed in a disconnected way despite the evidence that neglecting one can damage the other. . Poor mental health is a major risk factor implicated in the development of diabetes, chronic obstructive pulmonary disease and cardiovascular disease. Conversely, we know that those who are dealing with or surviving a cancer diagnosis, or have a long term condition are more likely to suffer from depression and anxiety. We know the opportunities presented by joining up physical and mental health have not yet received sufficient attention – we will work with other programmes to address this. We are also supporting the expansion in community provision for perinatal care for new mothers within each place, alongside the regional inpatient mother and baby unit in Leeds see (page 64).

Mum Lindsay talks about the mental health support she received following the birth of her third child, and specialist midwife and perinatal team leader Alex Whincup from Leeds Teaching Hospitals NHS Trust tells us about the variety of perinatal services available to women and their families **in this film**.

Our five year ambitions include XXX (different ambitions to run along the top of each page) Underpinning all of the above are several enablers that have not yet been fully exploited. We are developing our plans across all of these in tandem with other West Yorkshire and Harrogate programmes and national guidance.

[To do: develop an info graphic]

- Co-production: we need to do more to ensure our service users shape how services are designed
- Personalisation: we need to ensure service users always have choice and control over their care
- Digital: we need to ensure staff can communicate across West Yorkshire and Harrogate services effectively and where people who access care can be empowered to manage their own care where appropriate
- Workforce: we need to understand the common challenges across the system, develop new attractive roles and ensure our staff are supported and valued.

The way we work

NHS mental health providers in West Yorkshire have set up new shared governance arrangements. Known as the West Yorkshire Mental Health Services Collaborative, the organisations have been working together to improve mental health services for local communities.

The Mental Health Collaborative includes:

- Bradford District Care NHS Foundation Trust
- Leeds and York Partnership NHS Foundation Trust
- Leeds Community Healthcare NHS Trust
- South West Yorkshire Partnership NHS Foundation Trust.

Our mental health, learning disabilities and autism five year ambitions:

- **Achieve IAPT referral to treatment times and recovery standards from 19/20 onwards.**
- **100% coverage of 24/7 crisis teams in all places by 2020/21 with all children and young people able to access crisis care 24/7 by 23/24**
- **Mental Health Support Teams tested in 2019/20 and 2020/21 for further roll out across West Yorkshire and Harrogate by 2023/24**
- **A comprehensive 0-25 mental health service across all places rolled out from 2020/21**
- **Reduce inpatient (hospital beds) provision for people with a learning disability in line with national expectations by 2023/24**
- **Sustain new ways of working that help reduce inpatient length of stay from 2020/21**
- **Test West Yorkshire and Harrogate models for suicide prevention and postvention in 2019/20 and 2020/21**
- **Review current delivery across all service providers against the Learning Disability Improvement Standards during 2019/20 and 2020/21, meeting requirements by 2023/24.**

Stroke care

[In a box]

In 2018/19 there were 3,441 strokes in West Yorkshire and Harrogate (Apr 2018-Mar 2019). Our ambition is to reduce the number of people who have strokes; save more lives and improve recovery outcomes. Providing the best stroke services possible to further improve quality and stroke outcomes is a priority for us all.

Our aim is to improve quality outcomes for people requiring stroke care, ensuring that services are resilient and 'fit for the future'. Work has taken place cross West Yorkshire and Harrogate to improve the quality of care and recovery for people who have had a stroke. This includes preventing

Our five year ambitions include XXX (different ambitions to run along the top of each page) 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](#)

Identifying and supporting people at risk of stroke

Atrial fibrillation (also called AFib or AF) is a quivering or irregular heartbeat (arrhythmia) that can lead to blood clots, stroke, heart failure and other heart-related complications. In West Yorkshire and Harrogate there are around 12,000 undiagnosed (and therefore unmanaged) atrial fibrillation (AF) patients. We know that this increases the likelihood of stroke (see page 79).

Since spring 2018 we have been working with our partners at the [Yorkshire and Humber Academic Health Science Network](#) to more proactively detect, diagnose and treat people who are at risk of stroke so that around 9 in 10 people with AF are managed by GPs with the best local treatments available. This will save lives and contribute to reducing both the health and well-being gap and the care and quality gap.

The Yorkshire and Humber Academic Health Science Network is working with each of our six local places to roll out best practice care for people with AF in every GP practice and aims to prevent over 190 strokes in the next three years. We are also reducing other risks linked to stroke. For example the treatment of hypertension (high blood pressure) which has the potential to reduce a further 620 strokes within three years.

Our stroke engagement work

A key part of the way we work is being open and honest, so that people can get involved and have their say from the beginning. People who access health and social care often know better than us what keeps them well and healthy and what care they need to support their return to independence. It is also important that people know how their views have shaped our work.

We talked to over 2500 people over 18 months, including voluntary and community organisations, people who have had a stroke, unpaid carers, councillors and staff.

You can find out how these views have shaped our work by reading the ['You Said, We did'](#). You can also find out more about all of the engagement that has taken place by clicking [here](#).

Whole stroke care pathway approaches

Our conversations with people have highlighted the importance of further improving care from preventing stroke, hospital care, community rehabilitation services, through to after care. In view of this we have produced a draft whole pathway service specification which recognises the minimum standards and service outcomes for each of part of the stroke pathway.

The draft service specification includes specific outcomes we aspire to achieve, for example rehabilitation and community services. Each of our six places will use this specification to determine what further actions, if any, will be required to achieve these standards.

To support the six places we asked the Stroke Association to fund a project manager for six months to undertake a gap analysis of the community rehabilitation services for stroke. The project will aim

Our five year ambitions include XXX (different ambitions to run along the top of each page) to help identify the actions either locally or at West Yorkshire and Harrogate level required, if any, to improve community rehabilitation stroke services.

Providing high quality hospital stroke services

We are re-establishing a clinical network across West Yorkshire and Harrogate, so that we can further support, develop and retain our skilled workforce.

The stroke clinical network will provide learning and development opportunities through master class type events and an annual conference for colleagues who provide specialist stroke care. The network is also a place where clinicians can review, progress and provide peer support to implement the new standards and new developments in the treatment of stroke such as Mechanical Thrombectomy.

In addition our clinical lead has worked with the Local Workforce Action Board to ensure our work is aligned with our wider [workforce strategy](#).

The stroke clinical network will harness clinical leadership, expertise and encouraging a culture of continuous improvement across West Yorkshire and Harrogate. It aims to further reduce differences in key clinical standards and ensure new guidelines and national developments are aligned. For example, the establishment of Integrated Stroke Delivery Networks (ISDNs), the further roll out of mechanical thrombectomy services (this aims to remove the obstructing blood clot from arteries within the brain directly by introducing a clot retrieval device delivered via an intravascular catheter, thereby restoring blood flow and minimising tissue damage), improvement in the use of thrombolysis (emergency treatment to dissolve blood clots that form in arteries feeding the heart and brain), development of higher intensity care models for stroke rehabilitation and changes to workforce models.

Our five year ambitions

- **By 2022 will deliver a ten-fold increase in the number of people who receive a thrombectomy after a stroke so that each year 1,600 more people will be independent after their stroke.**
- **By 2025 will have amongst the best performance in Europe for delivering thrombolysis to all who could benefit.**
- **By April 2020 we will have established an Integrated Stroke Delivery Networks (ISDNs) to support discharge, meet seven-day standards and National Guidelines for stroke - there needs to be an accountable ISDN governance structure in place.**

Respiratory

Respiratory conditions include common cold, flu, whooping cough, bronchitis and chronic obstructive pulmonary disease (COPD).

[In a box]

Respiratory diseases may be caused by infection, by smoking tobacco, or by breathing in second-hand tobacco smoke, radon, asbestos, or other forms of air pollution. Respiratory diseases include asthma, COPD, pulmonary fibrosis, pneumonia, and lung cancer.

Levels of smoking tend to be higher across West Yorkshire and Harrogate when compared to national averages. The numbers of people stopping smoking also tends to be below the national average. For these reasons an early objective was to tackle the difference in the levels of smoking and quit rates so that people have healthy longer lives.

To date there has been a reduction in the number of smokers within West Yorkshire and Harrogate of 23,000 (check time period).

Our five year ambitions include XXX (different ambitions to run along the top of each page)
Most socio-economically disadvantaged groups of people are disproportionately represented amongst smokers (as they are within respiratory disease incidence); this work is supported in our programme to tackle health inequalities. The successful work to reduce tobacco dependency will continue (see preventing ill health on page 29 for further details).

Our Partnership has worked with the other six northern partnerships (sustainability and transformation partnerships and integrated care systems) to build on work with [RightCare](#) to identify and spread good practice to improve respiratory outcomes.

Our Partnership has led on identifying and promoting good practice in the provision of pulmonary rehabilitation. We have focused on understanding the barriers to people being referred to pulmonary rehabilitation; and once referred the barriers to them completing programmes. This work will support our Partnership's ambition to tackle health inequalities, and across the north as a whole.

Working closely with RightCare the Partnership's Clinical Forum reviewed clinical practice across our six local places and the impact this had on people with respiratory disease. It identified good practice that we shared across West Yorkshire and Harrogate.

[In a box]

We will learn from existing good practice within West Yorkshire and Harrogate, as well as other successful models of improving respiratory outcomes such as a current Welsh national programme.

The Clinical Forum has now started a collaborative programme across the Partnership to share and support learning across our six places. This will accelerate improvement in respiratory outcomes and reduce unwarranted variations in people's care.

The programme will:

- Emphasise patient choice and empowerment
- Be clinically driven and led
- Increase the focus on upstream prevention
- Integrate with other relevant programmes, including cancer and population health management
- Support moving delivery as locally as possible
- Reduce health inequalities
- Reduce the differences in support that people receive
- Make the most of digital solutions.

Our five year ambitions

Treating tobacco dependency

The successful work to reduce tobacco dependency will continue (see page 34).

Diagnosis

Identify 'missing cases' - analyse records to find people at risk of COPD or asthma and not on the register for either of these conditions:

- Are recorded as current or ex-smokers
- Are aged over 35 years
- Are prescribed inhaler therapy
- Are prescribed at least one course of Prednisolone for respiratory symptoms in the last two years
- Are prescribed two or more courses of antibiotics for respiratory symptoms in the last two years.

Our five year ambitions include XXX (different ambitions to run along the top of each page)
Offer spirometry to those people mentioned above (spirometry is a standard test doctors use to measure how well your lungs are functioning).

- Monitor key performance indicators and explore the gap in performing spirometry - how many people are on the COPD register with no record of spirometry.
- Explore the gap in quality of spirometry - how many surgeries providing spirometry meet the standards for equipment and staff.
- Make primary care spirometry results available when a person is admitted to hospital.
- Make hospital spirometry results available to GP and any other point of care in the community.
- Comply with the requirement of the COPD Care Bundle to check spirometry result at admission in all cases of acute exacerbation of COPD. This can be monitored via the National COPD Audit.
- Develop a variety of options to provide quality assured spirometry for all patients across Yorkshire including spirometry services in individual GP services, local diagnostic centres offering spirometry and access to hospital based respiratory function laboratories.

Pulmonary rehabilitation

Pulmonary rehabilitation should be available for a range of respiratory conditions including COPD, asthma, interstitial lung disease and bronchiectasis.

Pulmonary rehabilitation should be considered as a group of interventions with a choice to select the ones most appropriate for each person.

These should include:

- Standard 6-8 week pulmonary rehabilitation course.
- Individually tailored rehabilitation in the home.
- [MyCOPD App](#) supported pulmonary rehabilitation.
- Breathe Easy Groups
- Local signposting to physical activity

Monitor the performance of the pulmonary rehabilitation services according to [NICE QS10, Quality Statement 4](#) and through participation in the [National Asthma and COPD Audit Programme \(NACAP\)](#): pulmonary rehabilitation work stream.

Assess indications and willingness to participate in pulmonary rehabilitation at key points of care:

- Annual clinical review at GP practice.
- Review after acute exacerbation - GP practice or Integrated COPD Service.
- Hospital admission for acute exacerbation of COPD - part of the COPD Care Bundle.

Provide swift access to pulmonary rehabilitation for all who need it including:

- Opportunity to start pulmonary rehabilitation within four weeks of discharge from hospital following acute exacerbation of COPD.
- Suitably timed pulmonary rehabilitation before and after lung volume reduction intervention.

Medicines management

The local guidelines for inhaler therapy for COPD and asthma are documents that reflect the up to date clinical evidence and are produced after extensive consultations with all involved. These need to be updated every three years following a well-structured approach.

Check of inhaler therapy should be performed on a regular basis in consistence of NICE quality standard QS10, Quality Statement 2. There are several key points for this intervention:

- Annual clinical review at GP practice.
- Review after acute exacerbation - GP practice or Integrated COPD Service.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

- Hospital admission for acute exacerbation of COPD - part of the [COPD Care Bundle](#).
- Continuous monitoring of the pattern of prescribing inhaler therapy in both primary and secondary care to identify trends for deviation from the local guidelines.

We will develop teams of suitably qualified specialists to support units showing deviation from the agreed guidelines with the objective to improve prescribing. These teams could include hospital based specialists, intermediate care (respiratory/primary) specialists, senior pharmacists or GPs with special interest in respiratory disease. It will involve developing adequate services for prescribing and monitoring 'specialist only' treatments such as biological agents, Roflumilast, which is recommended as an option for treating severe chronic obstructive pulmonary disease in adults with chronic bronchitis as and when appropriate.

Diabetes

There are currently 3.4 million people with Type 2 diabetes in England with around 200,000 new diagnoses every year. While Type 1 diabetes cannot be prevented and is not linked to lifestyle, Type 2 diabetes is largely preventable through lifestyle changes.

The prevalence of Type 1 and Type 2 diabetes in West Yorkshire and Harrogate ranges between 5.7% in Harrogate and Rural District to 10.4% in Bradford Districts. One in six of all people in hospital have diabetes – while diabetes is often not the reason for admission, they often need a longer stay in hospital, are more likely to be re admitted and their risk of dying is higher.

As well as the human cost, Type 2 diabetes treatment accounts for around 9% of the annual NHS budget. This is around £8.8 billion a year.

[In a box]

The large geography and diverse population of West Yorkshire and Harrogate poses some key diabetes challenges. We aim to ensure that the diabetes prevention programme and structured education programmes are both targeted to address health inequalities and tailored to the needs of local communities.

Our Partnership will work to prevent the development of Type 2 Diabetes in those people who are at high risk.

This will involve a diabetes treatment programme which focusses on:

- Improving the achievement of the [NICE](#) recommended treatment targets (HbA1c, cholesterol and blood pressure) and driving down variation between clinical commissioning groups.
- Improving uptake of structured education
- Reducing amputations by improving the timeliness of referrals from primary care to a multi-disciplinary foot team for people with diabetic foot disease; and
- Reducing lengths of stay in hospitals for diabetics.

Working together to prevent the development of Type 2 Diabetes

There are 110,000 people at high risk of developing Type 2 Diabetes in West Yorkshire and Harrogate. There are currently five million people in England at high risk of developing Type 2 diabetes. If these trends continue, one in three people will be obese by 2034 and one in 10 will develop Type 2 diabetes.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

[The Healthier You: NHS Diabetes Prevention Programme \(NHS DPP\)](#) identifies people at high risk and refers them onto a behaviour change programme. The NHS DPP is a joint commitment from NHS England, Public Health England and Diabetes UK. We will continue to deliver the programme across West Yorkshire and Harrogate.

Our ambition is to increase the number of people referred to the NHS Diabetes Prevention Programme. This will include the roll out of the digital NHS DPP from August 2019 to increase access to the course, particularly for those of working age and people from ethnic minority groups. We will also explore options to pilot NHS DPP courses that expand access to the programme for people with learning disabilities and mental health illness.

Improving the achievement of NICE recommended treatment targets

Over the past two years some of our Partnership's clinical commissioning groups have worked to improve the achievement of the three NICE recommended treatment targets and eight care processes. The treatment targets and eight care processes are monitored via the [National Diabetes Audit](#) which is mandatory for all GP Practices. The achievement differs across our areas and addressing this difference is a priority for the Partnership.

Our five year ambition for diabetes includes:

- **Using the funding available until 2023/2024 to increase the achievement and reduce variation particularly around education and the sharing of best practice**
- **We will offer personalised care for people. Along with increasing the achievement of the three NICE treatment targets we will ensure that diabetes care is individualised ensuring that frailty is recognised and targets are adjusted according to the person with diabetes. Frailty is related to the ageing process that is, simply getting older. It describes how our bodies gradually lose their in-built reserves, leaving us vulnerable to dramatic, sudden changes in health triggered by seemingly small events such as a minor infection or a change in medication or environment.**
- **West Yorkshire and Harrogate is an early engagement site for the national [HeLP diabetes online self-management platform](#) which will provide education for people with Type 2 diabetes. The roll out will commence in February 2020 and will be accessible to all areas across the Partnership for three years.**

Diabetes education is the cornerstone of diabetes management, because diabetes requires day-to-day knowledge of nutrition, exercise, monitoring, and medication. The [Diabetes Transformation Funding](#) has been used to expand provision and increase the uptake of digital and face to face education for people with Type 1 and Type 2 Diabetes.

Work is ongoing to look at different models of structured education which are accredited. The Partnership is also working to ensure that health inequalities across the diverse geography are targeted by ensuring delivery of culturally sensitive support that makes adjustment for people with learning disabilities including help in the evening and at weekends.

Reducing diabetes related amputations and reduction in length of stay for diabetes hospital stay

Multi-disciplinary team working is at the heart of providing best treatment and care. Over the past eighteen months a number of diabetes specialist clinical teams have been testing approaches to streamline the way diabetes multi-disciplinary foot teams work with the aim of sharing the findings.

Diabetes Inpatient (hospital stays) Specialist Nurse Teams have been expanded to provide support to people in hospital with diabetes. The Partnership will continue to support the specialist teams using funding available to ensure universal coverage across West Yorkshire and Harrogate.

Diabetes technology

Our five year ambitions include XXX (different ambitions to run along the top of each page)
We will ensure that pregnant women with Type 1 diabetes are offered continuous glucose monitoring from April 2020. West Yorkshire and Harrogate will ensure that up to 20% of people living with Type 1 diabetes will receive [flash glucose monitoring devices](#) if they are eligible using the agreed clinical criteria.

Diabetes remission

We will explore low calorie diets for people who are obese with Type 2 diabetes to reduce HbA1c levels (HbA1c is your average blood glucose (sugar) levels for the last two to three months and turn the clock back on diabetes putting it into remission.

The Partnership will work towards improving joined mental health services to ensure people with Type 1 and Type 2 diabetes are supported with issues such as stress and anxiety due to needle phobia and phobia to insulin pens and also anxiety around hypoglycaemia (also known as low blood sugar, is when blood sugar decreases to below normal levels. This may result in a variety of symptoms including clumsiness, trouble talking, and confusion, loss of consciousness, seizures or death).

We will also express interest in being a pilot to ensure expansion of the diabetes prevention programme to include learning disabilities and severe mental health illness.

Cancer

Cancer survival is the highest it has ever been. In West Yorkshire and Harrogate the percentage of people surviving at least one year following diagnosis increased from 66.2% in 2005 to 71.7% in 2015.

More cancers are also being diagnosed early when curative treatment is more likely and patient reported experience of care is high (as measured through the national Cancer Patient Experience Survey). Despite this too many people have their lives cut short or significantly affected by cancer, with consequent impact on their families and friends. Within West Yorkshire and Harrogate the overall one year survival figure hides a variation from 69.6% (Calderdale) to 74.7% (Harrogate and Rural District).

Some places with lower survival rates also perform less well than comparable populations across England, meaning these local differences in outcome cannot be explained away by population mix. This 5 year strategy gives us the opportunity to ramp up our ambition and sharpen our focus to tackle variation, learn from and support each other to accelerate what we know works to improve outcomes and offer quality to life through personalised health and wellbeing support.

Our [Cancer Alliance](#) is in a strong place to deliver this with a clear national strategy and a long history of collaboration amongst providers of cancer care which is essential to support patient pathways which cross the system – but we need to pull together as a whole system to **deliver our ambition that by 2028 three in four cancers will be diagnosed at an early stage when curative treatment is an option.**

Working together to reduce preventable cancers before they appear

Lung cancer is our biggest cause of cancer deaths. One in two smokers will develop cancer and there are around 351,000 smokers in West Yorkshire and Harrogate. Tobacco use remains the most important preventable cause of lung cancer and the focus of the [Alliance](#) prevention effort. The Alliance will continue to support the [NHS Smokefree Pledge](#) and through our Tackling Lung Cancer Programme we have invested in boosting specialist smoking cessation support and community

Our five year ambitions include XXX (different ambitions to run along the top of each page) support, focusing on capturing patients at teachable moments. [Mid Yorkshire Hospitals](#) is leading the way locally on delivering a smoke free NHS.

We will push as far as possible to replicate their approach across [West Yorkshire Association of Acute Trusts](#) (also known as hospitals working together) in the next five years.

We will find more cancers before symptoms appear by increasing screening uptake

Over the past year the Alliance has worked with local and regional screening leads to boost screening uptake. During 2019/20 and beyond we will use transformation funding to develop a Healthy Communities programme which will increase screening uptake in all the national screening programmes. In the first year we will focus on the bowel and cervical programmes where uptake is lower and more variable across our geography. Across West Yorkshire and Harrogate around 160,000 people annually decline an invitation for bowel screening with uptake in Bradford City at around 30%. Around 170,000 women annually across West Yorkshire and Harrogate decline the offer of cervical screening, and around 90,000 women decline the offer of breast screening. We will be using best available evidence to encourage more people to accept their screening invitations. We will work with local communities and primary care networks to co-design campaign activities that suit the needs of the local population, with particular care to tailor approaches to the needs of ethnic minority groups and other seldom heard groups such as people with learning difficulties. We will also make access to screening easier for people for whom current settings present a barrier to uptake, for example people with physical or sensory impairments.

We will diagnose more cancers faster and earlier

Over the past two years Cancer Transformation Funding has been used to make more efficient use of diagnostic resources and improved pathways to provide rapid diagnosis or reassurance. This has included support for use of technology (digital pathology, tele dermatology), new roles within diagnostic teams to improve skill mix and career progression, support to the [Yorkshire Imaging Collaborative](#) to enable the radiology community to work more closely together and support each place to improve our offer to people with non-specific but worrying symptoms.

In relation to lung cancer there is now robust evidence that earlier diagnosis can be encouraged through a combination of targeted lung health checks to high risk areas, public awareness, clinician education and better access to diagnostic testing. **(To note: possible case study piece here based on Elaine's story)**

We will take a systematic approach to finding and diagnosing lung cancers at an earlier stage, thereby making more cancers curable. Our pilot work has been focussed in parts of Bradford and Wakefield which have a combination of high smoking rates and poor clinical outcomes.

Our work combines support to stop smoking, raising awareness so people seek information and advice earlier, providing easily accessible community based 'lung health checks' for those at most risk of cancer, and improving the experience of people affected by lung cancer by ensuring care and treatment pathways are as speedy and efficient as possible. The estimated outcomes from the Wakefield and Bradford pilots is 100-120 cancers being detected, 80% of which are expected to be at an earlier stage. Early in 2019, North Kirklees was invited to join the national Targeted Lung Health Check Programme with funding for a four year pilot. In addition a 5 year research programme, the Leeds Lung Health Check service, funded by Yorkshire Cancer Research has started in Leeds. This means that many of our areas are now prioritising lung cancer outcomes. We will be carefully evaluating this early work and will spread and expand the scope across the Alliance, guided by those findings in line with the NHS Cancer Programme.

Key to earlier diagnosis is the availability of rapid diagnostic pathways to get people onto the correct managed treatment pathway as early as possible. Over the next five years we will continue to work with the developing primary care networks and our hospital based colleagues to make best use of

Our five year ambitions include XXX (different ambitions to run along the top of each page) knowledge and resources to spot symptoms that could be cancer and investigate promptly through managed approaches.

There are a number of nationally agreed optimal pathways for different types of cancer which we are in the process of implementing across West Yorkshire and Harrogate. Where such nationally developed pathways don't yet exist we will work with clinical colleagues and patients to develop local versions to ensure a consistent offer to people regardless of where they live. Whilst there is often strong clinical consensus about the pathway steps, having the capacity to move patients along that pathway in a timely way is often a challenge.

The Cancer Alliance already works closely with provider colleagues and West Yorkshire Association for Acute Trusts for leadership to improve our pathways. We will continue to support providers to develop systems to monitor capacity and demand for diagnostics, make the most of the diagnostic resources at our disposal through networking, use of digital technologies, flexible and integrated use of workforce (in collaboration with Health Education England). This work will inform discussions about the case for expanding diagnostic capacity and increasing the emphasis on proactive investigation of symptoms.

This will also lay the foundations for a new Faster Diagnosis Standard from 2020 which aims to provide an answer to the 'could it be cancer?' question within a month of initial referral. We already have a number of optimal diagnostic pathway groups involving clinicians, patients and managers established for prostate, lung and colorectal cancers. Over the next year we will be expanding the range of tumours supported by a cross system optimal pathway group, providing stronger and more sustainable clinical leadership.

Unfortunately less than 40% of all cancers nationally are diagnosed following an urgent suspected cancer referral, (or 'two week wait' referral) which takes the person straight into a rapid managed pathway. The majority of cancers are still found following non cancer specific urgent or routine referrals, or they present as emergencies. This is often because the symptoms of many cancers are quite vague or could indicate a range of conditions, such as unexplained weight loss, pain or fatigue. Over the past two years the Alliance has invested transformation funds across our providers allowing them to test a range of approaches to managing these vague but concerning symptoms, supported by a Community of Practice and building on learning from our two national pilot sites in Leeds and Airedale.

Over the next five years we will be further developing a more consistent approach to integrated rapid diagnostic services, honouring the national requirement to have at least one rapid diagnostic service established in each Alliance during 2019/20. The objective will be to design services which deliver a holistic diagnostic service featuring a rapid and coordinated set of investigations designed to establish the cause of the troubling symptoms and appropriate onward referral, rather than just to exclude or confirm cancer. This will be a service model (making the most of resource and expertise in primary and secondary care) rather than necessarily a physical centre, and not necessarily a one stop shop, but a personalised and planned rapid series of tests with a single point of contact. Over time it is envisaged that this 'single front door' concept could expand to cover anyone with cancer symptoms.

We will deliver more consistent access to optimal treatment and faster, safer and more precise treatments

Multi-disciplinary team working is at the heart of providing optimal treatment and care. However it is just as important that team working processes do not slow the patient pathway through investigation and treatment unnecessarily and also that they make efficient use of the specialist workforce. Over the past eighteen months a number of clinical teams across the Alliance have been testing approaches to streamlining the way teams work and sharing the progress and findings.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

Over the next year we will be establishing optimal pathway groups led by a clinical director covering key adult tumours, children and young people and, teenagers and young adults. These will bring together clinicians, patients, provider and commissioner managers to drive out unwarranted variation and improve outcomes and experience (including delivery of national waiting times standards). They will build on and develop our pilot work on multi-disciplinary teams.

Other specific priorities to support delivery of optimal treatment are:

- During 2019/20 we will support the development of a Yorkshire and the Humber Radiotherapy Operational Delivery Network accountable to the three Yorkshire and the Humber Cancer Alliance Boards for the delivery of a national service specification.
- During 2019/20 we will work with WYAAT colleagues and Health Education England (liaising with our neighbouring Alliances where appropriate) to develop a more sustainable workforce model for clinical and medical oncology. Implementation of the plan will form a work programme for subsequent years of this strategy.
- We will work with the regional Genomic Laboratory Hub to promote the use of and support providers implement whole genome sequencing for all eligible cancer indications. This in turn will support use of genomics to target treatments more effectively, using the established Alliance and West Yorkshire Association of Acute Trusts infrastructure to support engagement;
- We will work with Teenage and Young Adult (TYA) services in Leeds Teaching Hospitals NHS Trust to support the service in becoming a Principle Treatment Centre (PTC) for TYA with Cancer, according to the new service specification. The service would work in partnership with TYA designated hospitals to ensure that teenagers and young adults receive the right care in the right place at the right time. NHS England also requires that a PTC should host and support a TYA Cancer Network which would have agreed criteria and functionality.
- We will work with NHS England Specialised Commissioning colleagues to develop plans to build capacity in treatment for key under pressure pathways, for example prostate and lung.
- Through our Optimal Pathway Groups we will encourage increased numbers of cancer patients at all ages, children, young people and adults being entered into clinical trials due to the strength of evidence around the link between active research and development and improved outcomes.

We will offer personalised care for all patients and transform follow up care. With improvements in survival more and more people are living beyond their initial cancer diagnosis. There are currently around 88,500 people across the Alliance living with cancer and this figure is expected to rise to around 117,000 over the next ten years. The effects of cancer do not suddenly stop once cancer treatment is over and many people face long term difficulties such as worry and depression, concerns about money, family and relationship issues, as well as dealing with the physical effects of having cancer which can effect patient outcomes and experience. Our goal is to provide personalised care and support to people affected by cancer which meet both their ongoing cancer related health needs and the more emotional, social and practical support needs that currently often go unmet. These can be addressed at least in part by better coordination and signposting to services already based within communities.

During 2018/19 our focus has been to understand our baseline position against a set of evidence based interventions known collectively as the [‘Recovery Package’](#) and the availability of risk stratified follow up. We have worked with front line staff to develop and promote a common understanding of these interventions and begin to embed them in everyday practice. Over 100 front line staff have attended training sessions. In the past year we have focused on four common tumours and the programme is developing momentum, for example five more teams are now offering end of treatment health and wellbeing events, three more teams are offering treatment summaries and three more teams are offering holistic assessment at the end of treatment.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

We have also undertaken a significant piece of engagement work with patients, carers and professions on the particular needs of people who are treatable but not curable to inform local action planning and improvement. By providing people with access to support beyond their clinical needs, we can empower patients to manage their health, provide tailored support to patients, harness the power of existing community services and create capacity within clinical teams.

In 2019/20, with support from [Macmillan Cancer Support](#) we will be providing additional intensive improvement support to front line staff in our acute hospitals to spread the availability of the Recovery Package and risk stratified follow up pathways. The Alliance team will also be working on our longer term aim to provide improved community based support to meet the needs of people affected by cancer. We will build on the findings from a pilot started in February 2019 with partners in Bradford to support people to live better with and beyond cancer (case study video in development). By 2021, every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support. By 2023, stratified follow up pathways will be in place for all clinically appropriate cancers.

Our five year ambitions for cancer include:

- **By 2028, 55,000 more people will survive cancer for five years or more each year; and**
- **By 2028, 75% of people will be diagnosed at an early stage (stage one or two).**
- **From September 2019, all boys aged 12 and 13 will be offered the HPV vaccination.**
- **By 2020, HPV primary screening for cervical cancer will be implemented across England.**
- **From summer 2019, the Faecal Immunochemical Test will be used in the bowel screening programme.**
- **By 2023/24, significant improvements will be made on uptake of the screening programmes**
- **By 2023 the first phase of the Targeted Lung Health Checks Programme will be complete, with a plan for wider roll out (depending on evaluation).**
- **By 2020, one Rapid Diagnostic Centre will be implemented in each Cancer Alliance, with further roll out by 2023/24.**
- **From April 2020, all local systems should be recording their Faster Diagnosis Standard data.**
- **By 2023/24 Primary Care Networks will be working with the Cancer Alliance to help to improve early diagnosis of patients in their own neighbourhoods**
- **The Yorkshire and Humber Radiotherapy network will be established by 2019/20 to fully implement new service specifications by 2021/22.**
- **New service specifications for children and young people's cancer services will be implemented by 2021**
- **More children and young people will be supported to take part in clinical trials, so that participation among children remains high, and the NHS is on track to ensure participation among teenagers and young adults rises to 50% by 2025.**
- **From 2019, whole genome sequencing will begin to be offered to all children with cancer.**
- **From 2020/21, more extensive genomic testing should be offered to patients who are newly diagnosed with cancers so that by 2023 over 100,000 people a year can access these tests.**
- **By 2021 everyone diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support.**
- **By 2020 all breast cancer patients will move to a personalised (stratified) follow-up pathway once their treatment ends, and all prostate and colorectal cancer patients by 2021.**
- **From 2021, the new Quality of Life (QoL) Metric will be in use locally and nationally.**
- **Recruit an additional 1,500 new clinical and diagnostic staff nationally across seven priority specialisms between 2018 and 2021.**
- **All patients, including those with secondary cancers, will have access to the right expertise and support, including a Clinical Nurse Specialist or other support worker.**
- **We will also support the development of a Yorkshire and Humber Children and Young Persons Cancer Operational Delivery Network.**

[Case study: add picture]

Putting people with cancer at the centre of the way we work together

Our Cancer Alliance has ambitious plans to transform services and improve care, treatment and support for those affected by cancer in West Yorkshire and Harrogate. We are working together to break down organisational barriers so we can improve people's experience in a number of ways. This includes improving cancer waiting time performance across the area. We launched a new way of working together to improve waiting times in July 2019 to get everyone together in one room to discuss how we can do this. Led by the Chief Executives of our six acute hospital Trusts, the launch of the West Yorkshire and Harrogate Cancer Alliance improvement collaborative was attended by more than 100 patients, clinicians, managers and cancer team members from across Bradford District and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield. The initial focus is on lung and prostate cancer. However, we plan to roll out this new way of working across all tumour pathways in the future. By listening to people who have cancer, sharing learning and spreading good practice we can improve the care given to people, so that no matter where they live they receive high quality services which puts them at the very heart of planned improvements'.

Supporting unpaid carers

[Case study]

In April 2019 we brought together over 100 carers and health and social care professionals to discuss how the NHS Long Term Plan can support better outcomes for unpaid carers. This has helped us align the West Yorkshire and Harrogate carers' strategy with the NHS Long Term Plan.

It's estimated that there are 260,000 unpaid carers in West Yorkshire and Harrogate and as our population ages; this number is set to increase. This combined with changes in retirement age means the demographic of unpaid carers is also altering; people are working until much later in life, sometimes juggling work commitments, whilst caring for others longer. Evidence shows people who are carers have poorer health and can be socially isolated (Carers UK).

[In a box]

We recognise the huge contribution of unpaid carers. We aspire to be a region where carers are recognised, given the support they need to both manage their caring role and remain in work and education.

Watch this film with Karen, who is a carer for her wife, talking about her experiences and the support she receives from Carers Leeds.

Carers often suffer social deprivation, isolation and ill health. They may have fewer opportunities to do things that many people take for granted, including having access to paid employment or education, or even having time to themselves or to spend with friends. A recent NHS England GP Survey ([make link](#)) showed 61% of carers are more likely to have a long term condition, disability or illness compared to 50% of non-carers.

Our six local places provide vital support in a variety of settings, including GP practices and hospitals, to support carers to maintain their caring role and avoid carer breakdown. Carers Wakefield and District work closely with local hospital and community services to support carers who are struggling to cope with the demands of caring. Carers organisations also support carers to have essential time out from caring.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

[Case study: add picture]

In Bradford, Christopher Fisher 57, is able to receive respite from his caring role looking after birds of prey due to receiving a time out grant from his local carers organisation' Carers Resource. Christopher who carers for his wheelchair-bound father, 89, five days a week, with support from his brother. He carries out tasks such as washing, cooking and cleaning. His sister cares for their mother, 85, who has dementia. Christopher spends his two days of respite each week volunteering in many different roles, but despite all the busyness in his life the birds of prey really caught his attention. He adds: 'Getting so close to the birds was a special and unique encounter I'll never forget'.

Many carers, including children and young people, are hidden. They are caring for a loved one with a long-term health condition and often provide the majority of care without formal support. For young carers, it can often mean life chances are severely limited. A key priority is to strengthen support for carers by using [quality markers](#), and using personalised care approaches that identify and address the health and wellbeing needs of unpaid carers (see page 91).

In this film young carer Kirsty talks about her experiences and the support she receives from Carers Leeds.

Emerging evidence suggests that investing in support for carers can contribute significantly to the sustainability of health and social care. In particular, that early help and targeted support for carers reduces carer breakdown and limits the use by the cared for person for hospital services, social care and other care. Investment in supporting carers helps prevention and self-care which can in turn support carers to stay in work, to the benefit of the wider local economy.

The Department of Health (October 2014) estimates that each £1.00 spent on supporting carers would save £1.47 on care costs and benefit the wider health and care system.

[Case study: add picture]

We held the first in a series of events, named by the young carers as 'Couldn't Care Less', which aims to show young carers how their skills can be transferred into exciting and varied roles in the health and care sector, supported by role models from across local business and the NHS. The event was attended by young carers from across Kirklees and Calderdale and included representation from five schools with pupils aged between 12-15 years old. Following the event, survey results showed 83% of pupils who attended were interested in pursuing careers in health and social care. The following shows the words mentioned throughout the student feedback surveys. You can read the report here.

Our achievements

It is important that partners and carers see that we are making a positive difference. By working in collaboration with all our six places we share good practice more widely and create better results for carers. We have:

- Engaged 240 young carers with a series of workshops to encourage them pursue careers within health and care sector, develop their confidence and support their resilience.
- Signed up all acute and mental health trusts to *John's campaign* which gives carers of people living with dementia greater access to the hospital beyond normal visiting hours
- Created processes within GP practices to identify and signpost carers to support in their local area.
- All mental health and acute hospitals have agreed to adopt the 'carers working passport' which identifies members of staff who are carers so that appropriate support can be put in place.
- Supported all of our 6 places to access tailored and joint-branded digital platform hosting Carers UK's products and resources combined with local information and support for carers. This is

Our five year ambitions include XXX (different ambitions to run along the top of each page) available for all NHS and Local Authority organisations as well as small and medium sized organisations.

Our five year ambitions

One of our key priorities for the next five years is e to identify and support carers. We work closely with our six local places to share good practice and continuously improve the lives of carers. Carers have also told that they think a priority should be to address the needs of carers from minority communities. We recognise these particular groups can experience inequalities and may not always be identified and supported effectively within their caring role. We will be working with our partners to highlight the fact that carers exist and their contribution to the health and care system and beyond. This is to ensure that all carers, irrespective of their background or where they live, have the same standard of support.

We are working with NHS England's Dementia Networks to engage with carers and the people they care for who are living with dementia from a wide range of communities. The work focused on working with organisations embedded within these communities and with carers from different backgrounds. The aim is to support a better experience of care for both the carer and their people they care for.

We aim to improve the lives of all carers over the next five years. This includes:

- **Making sure that more carers have access to a contingency plan supported by all mental health and acute hospital trusts across West Yorkshire and Harrogate**
- **Supporting a consistent offer for emergency care and out of hours support to ensure carers know how to access out of hours care when they need it.**
- **Supporting in excess of 43,000 working carers across our acute trusts and mental health trusts to ensure our carer NHS acute workforce has access to a working carer passport to enable them the flexibility and support to continue their caring role and remain in employment.**
- **Working with our partners in primary and community care to ensure that all carers when visiting their GP practice are recognised, have access to flexible appointments and are signposted to effective support to maintain their caring role**
- **Raising awareness of the contribution of our young carers, ensuring that they are identified and supporting them to access careers in health and social care.**

Our priorities for supporting carers over the coming years are as follows **(To do: rework infographic)**.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

Primary & community care	Working with our hospitals	Young carers	Personalised care	Working carers	Mental health
<ul style="list-style-type: none"> WY & H Clinical leaders to adopt quality markers within their primary care networks and GP practices by 2024 	<ul style="list-style-type: none"> Development of carers contingency plan. Every organisation to have its carers champion at board level 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> All six 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 	<ul style="list-style-type: none"> 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. 	<p>For mental health trusts to:</p> <ul style="list-style-type: none"> 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
<p>Indicator:</p> <ul style="list-style-type: none"> All PCNs /GP Practices to have signed up to deliver quality markers by 2023 	<p>Indicator:</p> <ul style="list-style-type: none"> Contingency plan available across WY & H and 3000 carers signed up to carry a carers contingency plan by 2021 	<p>Indicator:</p> <ul style="list-style-type: none"> Number of young carers who attended careers events All GP Practices to have signed up to the top tips checklist for young carers 	<p>Indicator:</p> <ul style="list-style-type: none"> All six places have plans to support carers in their social prescribing models by 2020 	<p>Indicator:</p> <ul style="list-style-type: none"> All NHS trusts to have adopted the working carers passport by 2022 	<p>Indicator:</p> <ul style="list-style-type: none"> All mental health trusts to have signed up to carer friendly environments and the Dementia Charter by 2021
<p>Carer awareness & communications and engagement with BAME and LGBTQ communities and young carers</p>					

Supporting people who work in health and care

Staff are our most important asset. Over 100,000 people work in health and care across West Yorkshire and Harrogate. This number has been increasing year on year. However, the increasing pressures of work and ongoing national pay restraint have made it difficult to recruit and retain enough staff to meet people's health care needs.

Health and social care is changing to meet the needs of our communities. Reshaping healthcare requires a reshaping of the health and care workforce. New teams are emerging with an increased role for non-medical staff to work alongside medical staff, non-registered staff to work alongside registered professionals, new roles alongside traditional roles and the unpaid volunteers and carers working in partnership with health and care sector employees. There is a greater role for people working outside of hospitals, where most health and social care takes place.

We want West Yorkshire and Harrogate to be a great place to work. This means ensuring that staff represents the people we serve, including ethnic minority staff in leadership roles. [The Interim People Plan](#) (June 2019) emphasised the need to promote positive cultures, build a pipeline of compassionate and engaging leaders and make the NHS an agile, inclusive and a modern employer. This is especially important if we are to attract and retain our workforce.

If we are to truly transform our workforce and make West Yorkshire and Harrogate the best place to live and work, then we need to be more ambitious and show system wide working with all our partners to tackle the issues we face.

We have an opportunity to take on a greater leadership role in workforce planning. This will require investment and partnership working in a way which has never been done before.

We are developing a system wide workforce plan to include the social care workforce, primary care and community workers as well as the traditional NHS workforce.

Our five year ambitions include XXX (different ambitions to run along the top of each page)
This will outline how future demand can be achieved through various routes such as increasing supply, retention strategies, upskilling the current workforce, supporting new models of care, international recruitment and new role development.

Volunteers, carers, and community sector engagement is critical. There is a need for a shared understanding of their role across the Partnership so we can support, develop and promote the work they do. This will be done in partnership with our priority programmes, including supporting unpaid carers and community organisations.

This means planning the future health and social care workforce together rather than looking at individual organisation demands. In return this will enable funding to be distributed accordingly and future investment planned on a system wide level.

As well as the six local places taking greater ownership for developing their workforce, there is a need for our priority programmes to collectively identify and work with partners, such as the Local Workforce Acton Board and Health Education England, to develop solutions.

Primary care, maternity and mental health has workforce groups taking forward specific challenges. They are working across the Partnership to develop solutions. The intention is for our other priority programmes to follow suit.

Local Workforce Action Board

The Local Workforce Action Board includes a wide range of key stakeholder from across the health and social care system. It is chaired by a CEO from one of our hospital trusts. We are currently reviewing membership with the aim of having an executive decision making board and various groups feeding into this.

In April 2018 we published our workforce strategy '[A healthy place to live, a great place to work](#)'. It identified strategic workforce priorities around increasing supply; maximising the contribution of the current workforce; improving productivity; transforming teamwork; making it easier for people to work in differing places and different organisations. It also includes growing the general practice and community workforce to enable to 'left shift' (see page 51) where people are cared for in the community as opposed to hospital settings wherever possible.

We are aligning our priorities to the recently published NHS Interim People Plan, whilst keeping in view all the Partnership workforce challenges. Below is a summary of current initiatives and future priorities. Local places are already making great progress against the NHS Interim People Plan.

Making West Yorkshire and Harrogate the best place to work

The NHS is the largest employer in England, yet we have a higher than average sickness rate and the number of people leaving the NHS is rising.

Reports of poor experiences in the workplace are particularly high for black and minority ethnic (BME) staff.

We need to work hard to improve their experience and make sure that staff are engaged and supported to deliver the highest quality of care by making the NHS the best place to work.

Staff are often working in an environment of operating at full capacity, where unmet need is prevalent and resources scarce. Culture change is needed to make sure staff feel supported when things go wrong.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

Following the establishment of the [West Yorkshire and Harrogate Excellence Centre](#) we have made progress in supporting our workforce through identifying training and development opportunities. Focusing on school children we have developed best practice guidance on work experience and produced a tool kit for placements.

A central hub has been developed which directs schools, colleges, higher education, employers and employment seekers to quality information, advice and guidance at a place, regional and national level. A careers hub has also been developed which is a central portal for information for all sectors. This includes career ladders.

Specific career campaigns have been produced including one around Operating Development Practitioners (see below).

[Case study: add picture]

Operating Department Practitioners (ODPs) are a vital part of the multidisciplinary operating theatre team, providing a high standard of patient- focused care during anaesthesia, surgery and recovery, responding to patients physical and psychological needs. In 2018 we developed a campaign in partnership with Huddersfield University to recruit more people. The campaign called ‘the most rewarding job you probably never heard of’. You can find out more here and watch the campaign [film](#).

You can find out more about other workforce developments on our website [here](#).

Our five year ambitions [to do: quantify numbers]

- **Share and promote best practice across our six places, and work collectively to ensure all have the same opportunities**
- **Engage the younger generation by changing the narrative around retention and provide more flexible models of working**
- **Change the role of HR directors to move away from operational to transformational areas of work**
- **Put the health and wellbeing of our employers at the forefront of everything we do**
- **Make the NHS an attractive place to work by looking at some basic principles around travel, parking and pension issues**
- **Look at the redistribution of trainees to areas of greatest need**
- **Further develop and promote initiatives that are underway via Health Education England to enhance the lives of junior doctors, including piloting various initiatives including:**
 - **Less than full time training in emergency medicine**
 - **Flexible training portfolios for physicians**
 - **General practice nursing and GP fellowship pilots. We are looking at a day a week for personal development/leadership**
 - **Clinical educators in emergency medicine who will be specifically dedicated to supporting education and training one day a week as opposed to providing clinical care.**

Improving leadership

Inclusive, person-centred leadership culture at all levels across the NHS is needed. This work will be led by the Leadership and Organisational Development Programme (see page 109) and Talent Management Board with support from the Local Workforce Action Board.

Work is taking place nationally to expand the NHS graduate management training scheme whilst also identifying high-potential clinicians and others to receive career support to enable career progression to the most senior levels of the service.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

Locally, we have promoted Health Education England Clinical Leadership Fellows Programmes and have been successful in appointing these to the Local Maternity System (see page 64) and across West Yorkshire Association of Acute Trusts (see page 59). Many fellows take up senior leadership roles earlier if they feel better supported.

Our five year ambitions

- **Work across priority programmes to prioritise actions to prevent duplication**
- **Ensure our Partnership is a visible leader in making sure that talented black and minority ethnic (BAME) leaders emerge. This will include celebrating the talent that exists and continuing to make the business case for diversity**
- **Leadership team sessions on BAME staff will showcase talent**
- **Look at the impact of programmes such as Future Leaders at Health Education England to review the impact**
- **Identify and encourage aspirational leaders and develop them as system leaders.**

Tackling the nursing shortage

- We need to ensure we are supporting and retaining the nurses we already have whilst looking at how we can increase the supply of newly qualified nurses at home and through international recruitment
- We are developing specific mental health nursing, learning disabilities nursing and social care nursing career campaigns to try and improve recruitment into these areas. Health Education England has agreed a training grant for learning disability nursing apprenticeships with £2 million funding to support an increase of 150 trainee nursing associates and up to 230 registered learning disability nurse apprentices in 2019/20 across the country
- Health Education England has introduced nursing associates. This is a new role that sits alongside existing healthcare support workers and fully-qualified registered nurses to deliver hands-on care for people. In 2018 we had 379 nurse associates starting and have a target of 373 in 2019/20
- NHS Improvement and Health Education England are working together with local organisations and universities to increase clinical placements with an aim to facilitate the Department of Health and Social Care's intended 25% increase in nurse graduate places. Local places have been successful in securing additional funds from NHS England for clinical placement expansion with a particular focus on supporting community and mental health providers to prepare staff to take increased numbers of students including in primary care and care homes
- We are piloting a programme with our Local Maternity System to improve employee engagement and wellbeing whilst delivering service change.

Our five year ambitions

- **Increase placement capacity whilst not compromising quality**
- **Look at how our Universities can work together to increase supply**
- **Focus on return to practice and flexible working models**
- **Explore leadership development for nurses.**

Delivering 21st century care

The NHS Long Term Plan sets out a new model of care for the 21st century which includes increasing care in the community; redesigning and reducing pressure on emergency hospital services; more personalised care; digitally enabled primary and outpatient care; and a focus on population health and reducing health inequalities (see page 29).

Our five year ambitions include XXX (different ambitions to run along the top of each page)
We will look at transforming the workforce and explore new ways of working with a different skill mix. New roles will emerge. Our current workforce will need new skills to achieve the aspiration of integrated primary care and community health services.

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

We will support the growth of new roles, such as advanced clinical practitioners (ACPs), physician associates and nurse associates.

[In a box]

In 2018, 110 ACP's began training in West Yorkshire and Harrogate funded by Health Education England and this has increased to 140 in 2019. The Local Workforce Action Board has also supported the pilot of existing roles in new settings such as psychologists and occupational therapists in general practice. We will work with the newly established primary care workforce steering group to look at joint development and collaborative work plans.

Nationally there has been a push to increase medical school places from 6,000 to 7,500 per year. The University of Leeds had an additional 20 places. There has also been a shift from highly specialised roles to more generalist ones and recruitment for core medical training has improved in the region. All college curricula are looking at more generalist training; however this is moving at differing pace across our area.

We are working together to support the expansion of apprenticeships through information and advice from the Excellence Centre. Health Education England has provided funding to facilitate levy transfer between apprenticeship levy paying organisations and organisations that are non-levy paying or have spent their levy.

Several of the larger levy paying organisations have committed to transferring over £880,000 to pay for apprenticeship training in other health and social care organisations. This money could pay for at least 108 apprenticeships across the region. We are looking to grow apprenticeships in both clinical and non-clinical jobs, with the expectation that employers will offer all entry-level jobs as apprenticeships before considering other recruitment options.

We need to work closely with the digital programme (see page 102) to ensure we have a digital ready workforce with a clear plan for developing the workforce to run, manage, improve and transform the healthcare technology environment. Digital leadership capacity and capability needs to be mapped with upskilling of current staff to deliver digitally-enabled care. Mapping of roles where technology will release staff for redeployment or retraining needs to be in place.

Our five year ambitions

- **Develop a model of employment for physicians associates (PAs) in primary care to promote the role and increase the number of PAs within the next 12 months**
- **Prepare people for different ways of working and provide a system wide model and approach**
- **Preventing ill health needs to be much higher on the agenda both in curricula for trainees and also in terms of Making Every Contact Count**
- **We will work with the digital programme to enable a digital ready workforce.**

Our five year ambitions include XXX (different ambitions to run along the top of each page)

A new operating model for workforce

We will continue to work collaboratively and be clear what needs to be done locally, regionally and nationally, with more activities undertaken by the Partnership.

Funding the development of a Workforce Hub will involve current Health Education England staff as well as two programme managers and various project managers dedicated to mental health and cancer.

In August 2018, a £1million investment plan (utilising Health Education England funding made available to the Local Workforce Action Board) was approved by the Partnership to support the delivery of the workforce strategy. A further £1m was made available in 2019 and successful bids have been agreed which again support transformation across the area.

In 2018/19 Health Education England invested £3.8million (**is this national?**) in workforce development and in 2019/20 this will be £4m. This is largely being used to buy continuing professional development programmes from universities and other education, training providers.

Our Partnership agreed to pool the budget for West Yorkshire and Harrogate. Decisions are made with local NHS providers via the newly formed delivery group. This group brings together employer education and training leads from acute hospitals, mental health, primary care, social care, councils and hospices alongside universities.

The Local Workforce Action Board also works closely with the West Yorkshire Association of Acute Trusts (WYAAT) and provides capacity to help take forward projects such as the planned collaborative medical bank. WYAAT in turn engages with the work of other Partnership programmes to support initiatives, such as the plans to support working carers.

We are also working with the Harnessing the Power of Communities Programme to develop a standardised approach to the training of volunteers to ensure they feel valued, supported and developed whilst ensuring consistency across the Partnership.

Our five year ambitions

- **Consider our capacity and capability to take on devolvement of workforce planning**
- **Inequality between places needs to be taken into account**
- **Population health needs to be taken into account when developing a workforce plan for the Partnership.**

Innovation, improvement and digital

Innovation is transforming health and care across our Partnership. As a health and care system we have a track record for innovation and as a region we have a wealth of assets, including a thriving university sector, over 250 HealthTech businesses, and a strong [Academic Health Science Network \(AHSN\)](#).

[Case study: add picture]

South West Yorkshire Partnership NHS Foundation Trust is working with the University of Huddersfield to pioneer the use of computer artificial intelligence (AI) to predict which mental health patients are most likely to take their lives.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

Now that the potential to predict suicides using AI has been established, work will continue so that the technology can be used by healthcare professionals in their day to day work. The prototype of the automated suicide predictor is locally adapted to the Trust; but the AI could be adapted for other mental health services.

By driving forward new approaches to keeping healthy, the management of long-term health conditions and by curing illness, we have the potential to further harness expertise and capability in HealthTech. Working as a Partnership gives us a greater opportunity to spread good practice, learn what works well and also implement innovation faster.

Working in this way will speed up improvements in care, and drive inclusive economic growth and productivity across the region and the UK. By working in partnership, we will advance a mutually beneficial approach to the development, evidence-based testing, adoption and spread of clinically effective and cost-effective innovation. We will position the region as an area of expertise, growth and productivity that will deliver high quality outcomes and clear benefits for people.

People will receive the benefits of innovation as it drives faster, more convenient, higher quality care which is supported by services that are digitally connected and striving forward to make improvements.

Our strategy has three themes:

- Spread and adoption of innovation: Led by the AHSN we will spread nationally and locally identified good practice that meets our ambitions. The AHSN will be the bridge between the national Accelerated Access Collaborative Support Programme and the local system to capitalise on regional test bed clusters from 2020/21.
- Discovery: We will work to identify NHS and care-sector system needs and generate innovative responses including Medtech and new processes, pathways and techniques.
- Improvement: Foster the systemic adoption of continuous improvement for quality, safety and innovation. This includes the work of the Yorkshire and Humber Patient Safety Collaborative.

Spreading good practice

The commitment to national funding for the AHSN until April 2023 enables the Partnership to deliver system wide innovation including:

- AHSN's portfolio of nationally funded technologies and innovations
- Innovations with significant opportunity to improve care through the [Propel@YH](#) digital accelerator
- Innovations identified by the [Leeds Academic Health Partnership](#) and the Centre for Personalised Health and Medicine.
- Real-world evaluations as part of the nationally funded Innovation Exchange and the Leeds Academic Health Partnership.

Work in West Yorkshire and Harrogate has already had significant impact:

- The Atrial Fibrillation project has prevented 123 strokes over 18 months **(To note: need dates)**. This is as many as 400 strokes avoided over five years (see page 79)
- 'Healthy Hearts' for Cardio-Vascular Disease has already implemented a new simplified protocol for managing high blood pressure.
- Connect with Pharmacy (Transfer of Care Around Medicines) has helped over 4000 people to use their medicines well and avoid being re-admitted to hospital.
- PreCePT has protected 40 pre-term infants from developing Cerebral Palsy.
- The Emergency Laparotomy Collaborative is supporting doctors from across the region to exchange ideas on how to protect patients needing emergency abdominal surgery.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

- Patient Safety Collaborative has prevented over 2000 people from having a fall whilst in hospital. The majority of people live in West Yorkshire and Harrogate. This means they left hospital earlier and with a better quality of life. This work has prevented over £7m of healthcare costs across Yorkshire.
- 491 staff from the Yorkshire and Humber workforce have taken part in the AHSN programme to use quality improvement methods including human factors and achieving behaviour change in A&E. We have 47 case studies showing how quality improvement methods have improved work.
- Housing for health is identifying work in the housing sector that has a direct benefit on health. The initial work identified 40 case studies. Six of these will be fully evaluated to inform housing policy and decision makers on how to maximise the benefits of housing to improve healthier lives.

Closer partnership working with industry

Since our Partnership was established in March 2016 we have had a clear ambition to foster innovation in health and care services. Developing a closer and mutually beneficial working relationship with the HealthTech sector is an important part of this ambition. As well as improving health services and outcomes, it also has the potential to attract inward investment into our region, drive productivity and promote inclusive growth (jobs).

We have been working with the Leeds Academic Health Partnership to develop a new way of working with the health tech sector across the Leeds City Region. We have produced a Memorandum of Understanding (MoU) which defines a new way of working between the health tech sector, universities, and health and care organisations. More information is available [here](#).

Improvement

We recognise the value of improving care through both the adoption of innovation and the application of continuous improvement. With the support of AHSN we will mobilise the capacity and capability for quality improvement across the Partnership. This includes bringing together improvement expertise from within the region, such as the Bradford Institute of Health Research Improvement Academy, the region's members of the Health Foundation Q community and innovators such as Clinical Entrepreneurs and NHS Innovation Champions – this will help attract national and global partners.

The Partnership will establish a network to support hospital trust and other health and care providers that already have an approach to continuous quality improvement; and to support those organisations that are planning to adopt and embed a systemic method.

Building on the work of the Yorkshire and Humber Patient Safety Collaborative, the Partnership will continue to reduce avoidable harms. The initial focus will be on medicine safety, people whose illnesses are getting worse and maternity services.

Our five year ambitions

- **Continue our programme of system wide innovation led by YHAHSN to ensure that our patients can fully benefit from breakthroughs enabling prevention of ill-health, earlier diagnosis, more effective treatments, better outcomes and faster recovery.**
- **Work collaboratively with YHAHSN to identify opportunities for innovations in real world settings.**
- **Implement the regional Test Bed Clusters from 2020/21 to further strengthen our processes and capacity to undertake real world testing to ensure that future innovations are backed by real world data on benefits and costs.**

Our five year ambitions include XXX (different ambitions to run along the top of each page)

- **Build on the work of the Yorkshire and Humber Patient Safety Collaborative, and continue to reduce avoidable harms. The initial focus for 2020-21 will be on medicines safety, people's whose illnesses are worsening and maternity services.**
- **In partnership with YHAHSN establish a network to support hospital trusts and other health and care providers that already have an approach to continuous quality improvement; and to support those organisations that are planning to adopt and embed a systemic method.**

Digital work and connecting systems together (interoperability)

[Case study: add picture]

Calderdale and Huddersfield NHS Foundation Trust (CHFT) is now one of the most digitally advanced Trusts in the country and currently shares number 1 ranking in the digitalhealth.net league table for digital maturity. CHFT has some of the highest utility of the national electronic staff record (ESR) and has been successfully using an App (application software) for recruitment of bank staff for several months, as well as leading the way nationally on implementing the K2 Athena maternity patient record and recently the same system went live in Leeds Teaching Hospitals Trust again providing consistency of approach in West Yorkshire.

Our lives are being transformed by digital every single day. Digital is also transforming our Partnership – the way we interact with people, the way we deliver our services, and the way in which we work together across West Yorkshire and Harrogate.

The Digital Programme is 'harnessing digital - working together - to promote health and wellness and ensure high quality care.

This past year the Digital Programme has primarily focussed on improving our infrastructure to make access easier for people.

- Over 870,000 people can now book and cancel their GP appointments online and we expect 950,000 people to have access by the end of the year. These people are also now able to seek medical help virtually using the online triage tools
- 100% of first-time referrals for patients from GPs to medical specialists are now electronic, making the process to receive an appointment faster
- In 70% of our GP practices there is now free Wi-Fi. We are targeting 100% by the end of the year.
- In all unplanned care settings we have provided access for health care workers to information about vulnerable children to ensure these children are cared for
- Working with the Cancer Alliance and the Yorkshire and Humber Care Record Exemplar, the Partnership is now sharing key data to expedite cancer care. The first wave included Leeds Teaching Hospitals Trust, Harrogate Foundation Trust and Yorkshire Ambulance Service. The second wave will be completed this year and include Bradford Teaching Hospitals
- We are supporting easier working for our staff by putting in the 'GovRoam' Wi-Fi and 'federated' email allowing staff to access a single email address book for everyone and work digitally from any of our sites. Over 50% of organisations have installed GovRoam with 100% planned by this year
- A new, secure health and social care communications network is being put in to replace the old, separate networks for 64+ organisations. This will be completed by the end of the year
- Working with the Yorkshire Imaging Collaborative, across the Partnership and the Humber Coast and Vale Partnership, it is expected that this year all hospitals will have access to all radiology images. This has already been successfully tested between Mid Yorkshire Hospitals and Bradford Teaching Hospitals.

Our five year ambitions include XXX (different ambitions to run along the top of each page)

[Case study: add picture]

Yorkshire Ambulance Service

Designed and developed by our staff for our staff, the intuitive and easy-to-use YAS ePR electronically captures assessment and interaction information about our patients. This enables us to accurately share relevant and timely information with other healthcare providers involved in their care, leading to improved quality, clinical safety, audit and patient experience. Future developments of the YAS ePR will enable a seamless transfer of care with the wider healthcare economy. This will be done by:

- **Supporting clinical decision-making by incorporating Paramedic Pathfinder, NHS Service Finder and JRCALC**
- **Facilitating the sharing of patient data, e.g. the Yorkshire and Humber Care Record, Local Health and Care Records Exemplar and the National Record Locator Service**
- **Integrating with electronic referral via our Clinical Hub, the NHS Spine, defibrillator data and community first responders.**

[Case study: add picture]

Kirklees Council

With the use of Alexa in Kirklees, more people will be using technology to help them stay well and independent at home where possible. With more and more technology we need to be careful to also ensure that people feel comfortable with this change. We will aim to make digital as easy as possible for everyone.

Our five year ambitions

We are developing a digital strategic plan for the Partnership. This will help define the model for delivering our digital initiatives, including

- **How the digital ambitions in the NHS long term plan are realised.**
- **How different organisations and places within our Partnership work together on digital**
- **How digital could enable the other ICS priority programmes.**

This is of course only part of an important picture – we also need to understand what people accessing health and care think about digital. We welcomed the Healthwatch engagement findings and the recent report on digitisation and personalisation. We are taking these views seriously and are including them in our strategy.

Our top priority is sharing information between all health and care partners in the six places. This sharing will, for example, this year ensure A&E departments have time-sensitive information before patients arrive by ambulance. We will also prioritise sharing information with care homes, community pharmacies, hospices and social care to support carers and in support of safeguarding.

We have also prioritised the following initiatives:

- **Helping people, to stay healthy and manage their help in their own homes when possible, for example with the use of home monitoring devices or apps**
- **Improving digital literacy across all staff. This improvement will help staff analyse and use new data and new technology**
- **Supporting work to digitally streamline urgent and emergency care**
- **Continuing the work to digitally mature our organisations, including electronic prescribing.**
- **Mechanisms to easily share resources, conduct joint procurements, apply standards, blueprint 'how to' guides, and to optimise voice and communication and telecare infrastructures**
- **Ensuring cyber security compliance by 2021 along with ensuring we meet all other aims outlined in the NHS Long Term Plan, for example, ensuring all staff utilise electronic rostering and expanding our use of analytics and modelling for planning purposes.**

Our five year ambitions include XXX (different ambitions to run along the top of each page)

[Case study]

Often people feel like they are pulled from one place to another as they try to find the help they need, with multiple visits to different organisations which might all seem very disjointed. The Partnership is working together to break down these barriers, and provide a more joined up approach to delivering care. One way we are doing this is through the introduction of a system wide Local Health Care Record. One of the main frustrations of both patients and staff is that medical records aren't currently shared between organisations. This means that often people need to repeat things all the time, and potentially have repeat tests for the same thing because there is no record in one place of a visit to another. This new system will stop that from happening by pulling together information into one single, secure place. This will lead to better outcomes for people because more informed decisions will be made with more information available to health and care professionals.

Finance

Current financial outlook

With the announcement by the Prime Minister in June 2018 of additional funding to the NHS, growth is forecast to increase to an average of 3.3% in real terms for the next five years. In recent years demands on our resources have grown faster than the funding that has been available, and as a result services have come under ever increasing pressure, with many organisations finding it difficult to deliver care within what they have available. Across West Yorkshire and Harrogate there are still organisations who have underlying planned deficits going into next year and beyond, so while increases in funding are very welcome, much of it is likely to be needed to help restore financial balance.

Local Authority budgets have fared significantly worse over this decade. Public health grants have fallen significantly since 2012. Social care spending has fallen across the country by 5% in real terms since 2010/11 and despite recent increases, spending was around £1bn less than in 2010/11, at £17.8bn. The government has yet to set out long-term funding plans for social care.

For 2019-20 the scale of the financial challenge remains significant, but the NHS system is now forecasting the delivery of a £21m surplus for the year. This surplus position is after the provision of incentive funding (£69m) and non-recurrent support funding to organisations that would otherwise be in deficit (£32m); without this funding, we would have a planned deficit of £81m. This position is subject to a lot of potential risk, and needs us to deliver efficiencies higher than the 1.1% minimum – failure to manage either has the potential to impact heavily on how much of that money our Partnership may get.

Whilst the 2018 announcement of additional NHS funding is very welcome, it will be critical that additional resources identified for West Yorkshire and Harrogate allows us to apply our local discretion to meet local priorities.

The NHS Long Term Plan set out a number of financial tests that the NHS (and each local system) will need to satisfy to demonstrate that the additional investment is being put to good use

[To include figures and description from the data collection]

Our five year ambitions include XXX (different ambitions to run along the top of each page)

Approach to financial delivery

Although the NHS financial settlement will go some way to improving the financial outlook of the West Yorkshire and Harrogate health system, all organisations will need to maintain focus on delivering services in the most efficient way possible.

The aspiration included in the [NHS Long Term Plan](#) is that the scale of these targeted efficiencies will be significantly lower than in recent years, but set against the context of lower than required growth for the last few years and the fact that many organisations have already had to reduce costs as a result, continuing to deliver efficiencies locally will present a challenge.

This is why it is important that we continue the work collaboratively within each of our six local places and across the Partnership to improve services in a more joined-up, efficient way. We will do this by sharing best practice and working closely together.

[Case study]

We can make savings by buying things together. Buying medical equipment as a single Partnership, for example, will mean we get better prices than if each organisation negotiated their own deals. By 2022 we aim to double the products bought through one centralised organisation called Supply Chain Coordination Limited, driving savings as a result, and will also bring together local and regional teams to keep costs down. This would be much more difficult to achieve if we didn't negotiate as a Partnership, and more savings means more money to spend on improving the care needs of the population.

[In a box]

We will continue to focus on system-wide efficiencies and delivering improvements that benefit people across the Partnership. This will mean considering the total available funding and how it can be best used to deliver the best care possible across West Yorkshire and Harrogate.

We have reviewed the funding system known as 'payment by results'. This was designed to pay individual hospitals for each episode of care that they provided, but encouraged individual organisations to focus on their own requirements rather than working collaboratively with other partners to minimise demand and improve overall population health. We have now moved to a risk-sharing approach to contracting where income is dependent on pre-agreed broader outcomes rather than hospitals being paid on a case by case basis. By sharing information and moving to open-book accounting across the system (where each organisation shares its financial information with each other) the Partnership has a clear understanding of the financial allocations in each place. By removing the barriers that payment by results created, and focussing as a Partnership on the resources available as a whole, broader discussions about collaborative ways of working to improve services across the Partnership have now become the norm.

Working together to meet the diverse needs of our citizens and communities

Financial resources will remain constrained, so it is important that we work together to make difficult choices about how we prioritise the resource we have available.

All partners have signed a [memorandum of understanding](#) that describes the way organisations across our Partnership work together, and how and where decisions are made. It builds on mutual trust built up since the Partnership was created in 2016.

As long as money is a finite resource, difficult choices will still need to be made around where it is best deployed, and while we will ensure that these choices are made locally wherever possible, there will be occasions where we will make decisions that impact on services across West Yorkshire and Harrogate. In all cases, we will be transparent and honest, and constructively challenge where necessary.

Our five year ambitions include XXX (different ambitions to run along the top of each page) Innovation and best practice is at the heart of how we work together, and we will make sure that our learning benefits the whole population. Over the last few years NHS organisations have been expected to work towards a specific financial target each year, set by NHS England and NHS Improvement, known as a control total with some areas accepting that target and others not. Those that did were eligible to receive incentive funding to help their financial positions, but those that didn't received no additional support. To try and avoid this mismatch, our Partnership has established shared control totals. This means that we support each other in delivering a shared financial target, with ups and downs in individual organisations being offset by each other so no one loses out on incentive funding.

This, together with risk-sharing contracts and system-wide efficiencies means that we will continue to make financial decisions for the benefit of the people we serve. All [West Yorkshire and Harrogate priority programmes](#) will have senior finance support to help them maximise access to funding, and make sure that investments are prioritised in a way that delivers the greatest impact for everyone. The Partnership will receive additional funding over the next 5 years to help deliver all of the targets set out in the NHS Long Term Plan – by 2023-24. This will bring in an additional £83 million of funding per year. We will use these funds in the most efficient manner, and will work together as a system to ensure these funds are distributed on a fair share basis to all places across the Partnership, with organisations needing to account for how best they will spend the money to deliver the maximum benefit to people living in West Yorkshire and Harrogate.

Managing NHS resources across the Partnership

As well as collectively managing commissioning risks across the system, the Partnership will also take on greater responsibility for system financial management. Our goal is that by demonstrating maturity as a system we will have more access to additional funding, as well as a greater say in how we spend it. We have already had access to new money called transformation funding (see box) and can decide on how that is spent across the Partnership. We have seen real improvements in services for people as a result.

We want to expand this approach over the next few years, working together as a successful Partnership.

The shared control total is a way of demonstrating this commitment to work together. With the Partnership now adopting a risk-sharing approach, 15% of the incentive funding available to the Partnership is dependent on us delivering our shared financial position; for 2019-20 this is worth £8m. This means that there's a clear incentive for organisations to work together to manage within their allocated financial envelope, and in doing so maximise income for the Partnership and the people it serves.

The absence of a long term settlement combined with demographic and socio-economic pressures on social care budgets, as well as ongoing workforce issues, means that there are significant concerns about the sustainability of social care in our health and care system. There is a causal relationship between decisions made on health budgets and costs in social care budgets. A lack of local authority funding for prevention services, decisions made about healthy environments, housing quality and support services for people with a range of needs and conditions, has a direct link to health spending. We are clear that the future sustainability of social care is dependent on collaboration with the NHS and vice versa.

[In a box]

Our five year ambitions include XXX (different ambitions to run along the top of each page)

Main types of funding

- **Incentive Funding:** as part of the NHS financial framework, organisations can get additional money if they agree to and deliver a financial position that has been set by NHS England and NHS Improvement. This is called sustainability funding and is available to NHS providers and commissioners. For 2019/20 15% of this funding is now dependent on our Partnership delivering a shared financial position i.e. the sum of all the financial balances of NHS organisations in the system. This encourages us to work much more closely together to maximise funding for the Partnership and the people it serves. There are two types of incentive funding; Provider Sustainability Funding for Trusts and Commissioner Sustainability Funding for commissioners
- **Non-recurrent support funding:** since 2019-20 NHS organisations that are forecasting to make a deficit can gain access to a non-recurrent Financial Recovery Fund. This helps support their financial positions in this financial year so they can continue to provide services, but is part of a recovery package where all those in receipt have to demonstrate how and when they will return to surplus. Transformation Funding – by agreeing to work together as a Partnership to deliver our shared financial target, we are able to access additional money called Transformation Funding. This is then allocated by the Partnership to support the work of its programmes
- **Capital:** as well as day-to-day expenditure incurred throughout the year (to pay for staff, drugs or clinical supplies, for example), organisations also have to invest in new equipment, IT infrastructure and buildings, and this is known as capital expenditure. Traditionally most of this is funded by organisations using specific money put aside for that purpose, but in recent years the NHS has had access to additional capital which it gains access to through a bidding process. The Partnership have worked collaboratively to maximise the amount of money we can get for this, by prioritising bids that provide the maximum benefit to the system's populations.

In box: (move into a glossary)

Financial terms explained

- **Control total:** for the last few years NHS organisations have been set a financial target to achieve by NHS England and NHS Improvement. Financial incentives have been made available for those that successfully achieve that target
- **Shared control total:** rather than individual organisations being incentivised to achieve a control total specific to them alone, a shared control total sums the targets from across the Partnership and a proportion of the individual incentives (15% in the case of West Yorkshire and Harrogate) is now only payable based on the delivery of that joint target
- **Financial Recovery Plans:** these are the plans that organisations in deficit need to take to return to financial balance. Where this isn't going to happen in just one year, a stepped approach will be agreed with annual improvements expected year on year – these annual improvement targets are also known as trajectories
- **Provider:** a term used in the NHS to describe organisations that provide services to patients.
- **Commissioner:** a term used in the NHS to describe organisations that pay providers for the services that they provide
- **Efficiencies / efficiency targets:** each year the NHS is expected to reduce the cost of delivering the services it provides, either by making savings on the costs of things it buys, reducing waste, looking for more streamlined ways of working, or seeing more patients without increasing the costs (known as higher productivity). The combined term for all of these things is 'efficiencies' and each year NHS organisations having a target amount of efficiencies to deliver in order to achieve financial balance.
- **Unwarranted variation:** with such a diverse range of communities it is inevitable that many will have specific needs, characteristics or personal circumstances that means there may be differences in the way they are treated for the same condition. These types of variation are referred to as "warranted", and are considered acceptable in any healthcare system,

Our five year ambitions include XXX (different ambitions to run along the top of each page)

anywhere in the world. However, whenever these variations are unacceptable or harmful to patients, their families or their carers, this is known as unwarranted variation

- **Risk: anything which may stop an organisation from achieving what it needs to achieve. In a financial sense this could be where efficiencies are dependent on something needing to happen which is not certain to happen or it could be where providers and commissioners have different assumptions about how demand for services may grow in the future.**

Capital and buildings

We have significant capital requirements to ensure that our buildings are fit for purpose and meet people's needs. We will work together to understand capital priorities across the system and, as a Partnership rather than as individual organisations, prioritise those that support new and improved ways of working. By embracing the Partnership approach to capital prioritisation, since 2018 the Partnership has secured national capital investment for eight schemes totalling £270m. These include £200m to support the reconfiguration of the hospitals at Calderdale and Huddersfield NHS Foundation Trust, £26m for the consolidation of pathology services and £11m for child adolescent mental health services.

We will transform hospital services by investing in a world class children's hospital and adult facilities at our regional specialist centre the Leeds General Infirmary.

Building the Leeds Way will deliver sustainable clinical models by creating much needed critical care and theatre capacity to support demand for specialist services such as spinal surgery. In addition the centralisation of maternity, neonatal and children's services will improve patient experience and enable safe and sustainable staffing models. The new hospitals will be digital by design and enable the transformation of outpatient services, supporting the 'left shift' and a 30% reduction in face to face attendances. The development will deliver around £1bn economic benefit, release 155000m² poor quality estates and reduce back log maintenance by £100m.

[To include: Table of successful schemes to be added]

Transformation funding

The Partnership works hard to secure transformation funds, and this is key to enabling new ways of working across the system. To date we have been successful in securing £Xm **(to add)** of transformation funding from national organisations to support these projects.

[To include: Table of transformation funding – five year outlook to be added]

Our five year ambitions

- **NHS budget to be increased by £20 billion a year in real terms by 2023-24**
- **Partnership to develop 5 year plan to address all deliverables in the NHS Long Term Plan, while working to deliver financial balance for all NHS organisations in the Partnership by 2023-24**
- **Deliver a system surplus of £21m by the end of 2019-20**
- **Double the volume of products bought collectively as a Partnership (to drive down cost) by 2020**
- **Continue to operate shared control totals and improve access to additional funding as well as getting a greater say in how we spend it**
- **Develop shared programmes to deliver at least 1.1% efficiencies per year for the next five years.**

[Case study: to add picture]

Our five year ambitions include XXX (different ambitions to run along the top of each page)

The Pathology Department in St James's University Hospital in Leeds, is one of the largest in the UK processing over 1,000 pathology slides a day, and is now digitally scanning every slide. This makes getting a second opinion much quicker and easier than the traditional method.

[In a box: develop info graphic]

- **National pathology exchange [£2million] - To deliver a lab-to-lab messaging solution that connects Laboratory Information Management Systems (LIMS) together across the area to facilitate the electronic transfer of pathology test requests and results. The solution is based on NHS Digital standards and connects to a large number of LIMS regardless of supplier and vendors. This will be led by the Health Informatics Service which is a shared service hosted by Calderdale and Huddersfield NHS Foundation Trust. [To do: update with system LIMS]**
- **Telemedicine in care homes [£1.5million] - Commissioning of the Airedale NHS Foundation Trust (ANHSFT) care home telemedicine service across a number of our care homes in the WY&H area. The funding will enhance the Digital Care Hub infrastructure, reduced activity pressures generated from nursing homes across West Yorkshire and Harrogate and improve people's care. This will be led by Airedale NHS Foundation Trust.**
- **Scan for Safety [GS1 - £15million] - GS1 is a global not-for-profit organisation dedicated to the design and implementation of standards that improve organisational efficiency. Leeds Teaching Hospitals NHS Trust is currently a demonstrator site. The work will increase data accuracy and reliability enabling improved analytics and decision making; patient safety and experience improvements through "right patient, right product, right treatment". It will increase automated data transfer between systems and organisations reducing potential errors and time delays. This work will support the roll-out in the other five NHS acute providers in West Yorkshire and Harrogate**
- **Yorkshire Imaging Collaborative [£6.1million] - The funding will be used to collaboratively procure imaging solutions to transform radiology services to meet capacity and demand issues. Yorkshire Imaging Collaborative will improve quality and create efficiencies and enable further regional clinical service transformation. This work is being led by the Yorkshire Imaging Collaborative which comprises the six NHS acute hospital providers in West Yorkshire and Harrogate plus a further two NHS acute providers from outside our health and care partnership**
- **The Partnership will receive £12million of NHS Capital Funding to develop a single, shared Laboratory Information Management System (LIMS) for the area. The funding will be used to deliver a one system wide approach for pathology across West Yorkshire and Harrogate acute hospitals.**

A new health and care partnership

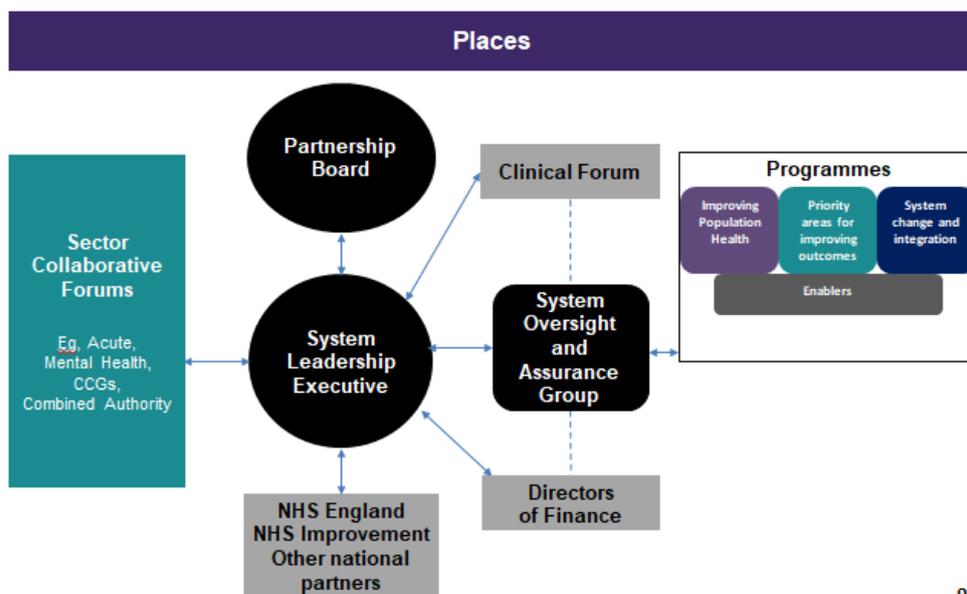
The way that we do things, is as important as what we do. We need to take time to describe 'the way we do things round here'. How we do 'change' is as important as the change we are making. We know change is deeply personal and if we think of any change we have been involved the crux tends to always be about relationships and how they are changing. We have adopted the mantra of 'be the change you want to see' (Gandhi, 1945).

If our Partnership is transforming what it does, we need give people the tools to engage with it on both a personal and professional level, if the partnership is also to transform how it does it. To support delivery of this transformational approach, the System Leadership and Development programme has been established, aiming to create an environment and culture conducive to change, collaboration and partnership that enable people to flourish and our citizens to benefit directly as a result.

Our five year ambitions include XXX (different ambitions to run along the top of each page)
 Our Partnership has been created through the authority of the boards and governing bodies of its constituent organisations. Each of them remains sovereign, and of course, local councils remain accountable to their electorates. The large majority of work, delivery and decision making will still be taken locally.

We have established a set of arrangements to facilitate joint working which are set out in our Partnership Memorandum of Understanding (MoU). You can read it [here].

The diagram below shows how the various components of how this fits together [rework graph].



9

We are a Partnership of places, sectors and programmes.

There are well established partnership working arrangements at place level, and Health and Wellbeing Boards have a critical role as the vehicle for joint system leadership at place level.

The Partnership Board, System Leadership Executive and System Oversight and Assurance Group provide the core infrastructure for our joint working at a West Yorkshire and Harrogate level.

- The Partnership Board is responsible for setting the strategic direction. It brings together Chairs and Chief Executives of NHS organisations in West Yorkshire and Harrogate, council leaders, chief executives and senior representatives from other partner organisations. It meets quarterly in public. You can find out more [here](#).
- The System Leadership Executive includes the chief executive / accountable officer leadership and representation from other partner organisations. The group is responsible for overseeing delivery of our strategic priorities and building leadership. They have collective responsibility for our shared objectives.
- The System Oversight and Assurance Group is the mechanism for partner organisations to take ownership of system performance and delivery.

We have established a set of sector collaborative forums, which bring together similar organisations across West Yorkshire and Harrogate to work on shared priorities within sector.

This includes the Committees in Common for acute trusts ([West Yorkshire Association of Acute Trusts](#)) and mental health trusts; the [Joint Committee of Clinical Commissioning Groups](#); and the

Our five year ambitions include XXX (different ambitions to run along the top of each page) Local Workforce Action Board. Further information on the priorities and ways of working for each of these sector forums can be found on our website at www.wyhpartnership.co.uk

Each of the West Yorkshire and Harrogate priority programmes work by bringing together place and sector representatives to work on shared priorities. Each programme has a senior responsible officer (SRO), typically a chief executive or accountable officer and has a structure that builds in clinical and other stakeholder input. The programmes are underpinned by strong governance and programme management arrangements. Programmes provide regular updates to the System Leadership Executive and System Oversight and Assurance Group.

Useful information

- Where people can get involved in our work
- Web links to documents
- Available publications
- Acronym buster link
- For the printed version – all links to documents to be included in a list
- You tube account
- More information
- Contact details
- Alternative formats