Contents

Will need full access checks
Summary to be produced
Easy read, BSL and audio version
Info graphic and potentially an animation

NHS West Yorkshire Integrated Care Board has five local places. These are Bradford District and Craven, Calderdale, Kirklees, Leeds and Wakefield District

Foreword

Foreword from Cathy Elliott, Chair of the West Yorkshire Integrated Care Board and Rob Webster, Chief Executive of the West Yorkshire Integrated Care Board

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Our West Yorkshire Integrated Care system

Our strategy and vision

Our Partnership has existed since 2016. It was established on the belief that working together towards common goals rather than competition is the best way to join up services to meet people's needs, tackle inequalities and improve outcomes.

Over this time we have built close working relationships with partners such as the voluntary and community social enterprise sector (VCSE), NHS England (NHSE), the Academic Health Science Network (AHSN) universities, the West Yorkshire Police, the West Yorkshire Combined Authority and the housing sector. These partnerships allow us work together on the things that matter for people's health and wellbeing.

During the COVID-19 pandemic we witnessed the best of the health and care service. We rapidly changed working practices so that we could safely treat people with COVID-19 whilst supporting peoples ongoing health and care needs. We significantly increased capacity, such as XXX to deal with the peaks of infection and severe illness; and we delivered the biggest vaccine roll out in our country's history. All our teams across the health, care and voluntary and community sector pulled out all of the stops to keep people safe and well.

The demand for health and care has been rising over time. It's good news that people are living longer. However, for some people they are living a longer life with multiple long-term health conditions. The pandemic further increased demand for health and care services, this now means the pressure on services is higher than ever. People who need an operation are waiting longer, and accessibility to services such as primary care, which includes GPs, dental care and XXX,and urgent care is not as good as we would like it to be. These challenges will increase further because of the significant pressure on funding and workforce pressure on the social care sector.

This is the challenge that our integrated care system (ICS) must now address, by focusing on preventing ill health and proactively supporting people to stay well at home; and secondly by arranging services in a way so that they receive care from the right people in the most appropriate setting. This will mean teams working together to organise care around people and their families, and professional and organisational barriers being broken down.

Whilst these challenges are significant, we believe that working together at all levels in the system is the best way of tackling them.

Our Partnership acts as an influencing voice at regional and national levels for the 2.4million people who live, work or study in West Yorkshire. Our new five-year strategy (which is owned by our Partnership Board – the West Yorkshire Integrated Care Partnership) describes how we will do this, and the ambitions we hope to achieve. A summary of our strategy is outlined in the plan on a page below. This information is available in alternative formats on our website.

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At the heart of our strategy is our agreed vision for the future of health, care and wellbeing in West Yorkshire. To achieve this requires all partners working together so people can thrive in a trauma informed, healthy, equitable, safe and sustainable society. We want to help people live well and stay healthy for as long as possible. If they have mental health or physical problems, we want them to be able to easily access services that meet their needs.

Our vision

Places will be healthy. We will work in partnership to prevent ill health by improving the physical environment where people live and work. This includes having access to healthy green and blue spaces (areas with access to watercourses such as lakes and rivers) that provide safe spaces for outdoor activities and exercise and have good air quality. We want this to be the case for now and future generations.

You will have the best start in life so you can live and age well and die in the place of your choosing. We will work to make sure people are not disadvantaged by where they live, their background, gender or ethnicity. We will focus on supporting people to stay healthy and prioritise approaches of preventing trauma, adversity and ill health, delaying onset of disease and reducing the impact of long term-conditions.

There will be a culture of preventing ill health across the partnership, making this everyone's business. This will include primary, secondary and tertiary prevention alongside a focus on reducing health inequalities and the impacts of climate change.

If you have a long-term health condition **you will be offered trauma informed personalised support to self-care**. This will include peer support, technology and communities of support from people like you.

If you have multiple health conditions, **you will be in a team with your GP, community health services, social services and VCSE including community pharmacy working**

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together. This will involve you, your family and carers, the NHS, social care and community organisations. All working on what matters to you.

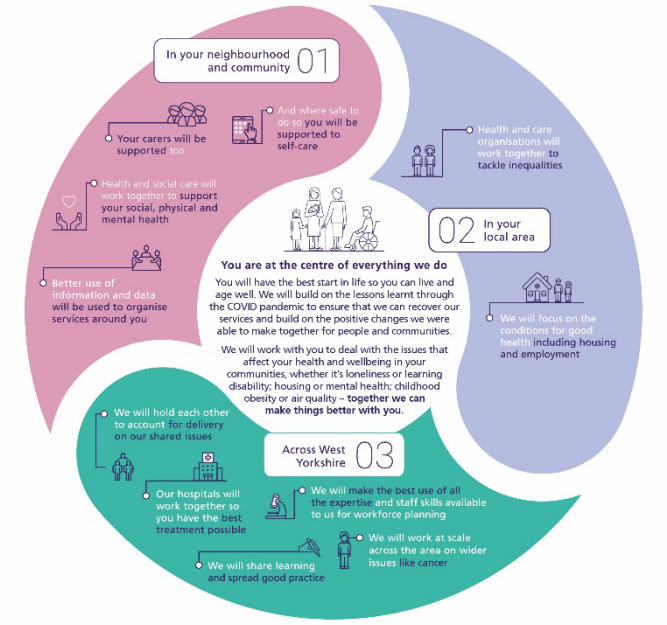
If you need hospital care, it will usually mean that your local hospital, which will work closely with others, will give you the best care possible.

Local hospitals will be supported by centres of excellence for services such as cancer, vascular (arteries and veins), stroke and complex mental health. They will deliver world class care and push the boundaries of research and innovation.

All of this will be planned and paid for once between the NHS, local councils and community organisations **working together and removing artificial barriers to care.**

Our people and communities will be involved in the design, delivery and assurance of services so that everyone truly owns their healthcare.

As a Partnership we intend to deliver our five-year strategy through this Joint Forward Plan.



Our Integrated Care Board (ICB)

The ICB is a statutory body responsible for planning and funding local NHS services and is directly accountable to NHS England for NHS money and performance. Our West Yorkshire ICB reflects the way in which we work collaboratively, with a membership including representatives from NHS providers, such as hospitals and mental health service, primary care, local authorities and the VCSE, led by our Independent Chair, Cathy Elliott, and supported by independent members.

Whilst our strategy is owned and overseen by our Partnership Board, our plans to deliver it and, the NHS elements of it, will be owned and overseen by our ICB. We will continue to do this with our wider partners given that our long history as a partnership shows us that we can only achieve the best health and care outcomes for people by working together. Our Partnership Board and ICB will continue to work together to deliver our vision for the people of West Yorkshire.

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The way in which we work together

Our partnership has a long history of working together with strong foundations and good relationships which have helped us make a positive in our work to date. These foundations are rooted in making sure that we make decisions as close to the person as possible. We make sure we do this by focusing our work in neighbourhoods and local places in everything we do unless there is value in working together across a greater footprint. Our five local places in West Yorkshire are Bradford District and Craven, Calderdale, Kirklees, Leeds and Wakefield.

As an ICB we delegate most functions to our five places to plan and deliver services in response to local people's needs and to ensure that health and care is joined up at the local level. We choose to work at a West Yorkshire footprint where there is a need or a benefit to:

- to achieve a critical mass beyond local population level to achieve the best outcomes;
- to share best practice and reduce variation; and
- to achieve better outcomes for people overall by tackling 'challenging / difficult issues' (i.e., complex, intractable problems).

Whilst most of our work happens in our local places, communities and neighbourhoods, taking decisions and delivering joined up services as close to people and families. Sometimes however, there is real benefit in providers of services coming together (we call these provider collaboratives) across West Yorkshire to collaborate on agreed programmes of work. This work is in addition to working together with other partners within their local places.

Across West Yorkshire we have several provider collaboratives including:

- Our **West Yorkshire Association of Acute Trusts Provider Collaborative (WYAAT**) which has a vision to deliver outstanding, high quality acute and specialist healthcare for the whole population of West Yorkshire. WYAAT has a developing strategy which is aligned to the WY Integrated Care Strategy, formed around five pillars of workforce, service delivery, ways of working, recognising and reducing variation and estates.
- Our **Mental Health Learning Disabilities and Autism (MHLDA) collaborative** which consists of our four mental health/learning disability trusts across West Yorkshire. The MHLDA is designed to help drive forward the system changes that need to be made, remove barriers to integration and ultimately ensure that our resident population receive the best care and support that can be offered within finite resources. We know that the pandemic has had a significant impact on mental health and this is now compounded by the cost of living crisis. As a collaborative much work has been undertaken over recent years to transform services and this will continue through the delivery of our strategy.
- Our **Community Health Services Provider collaborative** which formed in 2021, has come together work collectively on shared issues that of common interest to the sector, such as enabling more healthcare to happen close to home, and where joint approaches or shared learning, such as in workforce development and service redesign, can add collective value. The collaborative has an important contribution in delivery the strategy through both working together and with other partners, ensuring

that community health services has a clear and engaged stake in the direction and decisions.

- Our **Hospice Collaborative** which is built from a powerful basis of trust and has strong relationships through which, it delivers a manifesto for palliative and end of life care. We plan to provide the very best palliative and end of life care for the population of West Yorkshire, which will be personalised, holistic, accessible, a good life to the end of life and a good death. We want to make sure that hospices are working in a seamless way with the NHS and palliative end of life care system, to meet the needs of patients, reduce unnecessary hospital admissions and enable patients to be discharged home or to the setting of their choice.

As a Partnership we work closely with NHS England (NHSE) on a number of areas, to make sure that we can provide the best seamless care for people and communities. NHSE currently plan and deliver those services which are only needed by a small number of people across West Yorkshire, which we call specialised services. We work closely with NHSE to ensure that those services are integrated across a whole pathway of care and to ensure that the needs of our population are met. Over the coming years some of these services will be delegated to our ICB to plan and deliver. Until this happens we will continue to work collaboratively through formalised arrangements to make decisions on these services.

Our values and behaviours

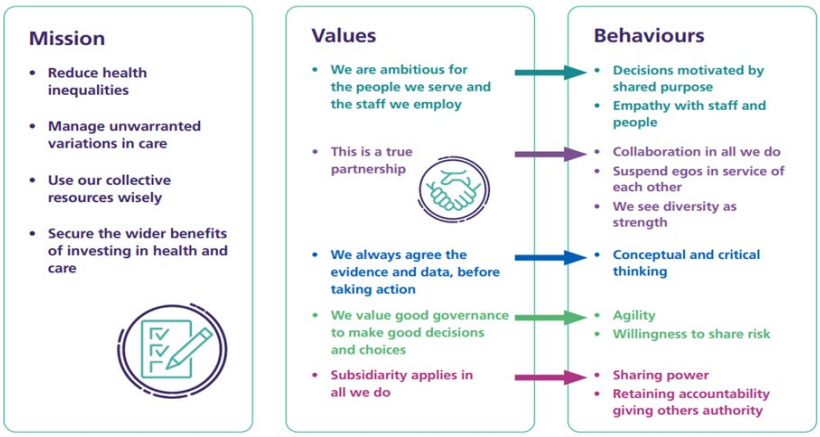
As a large Partnership, agreeing the way we work together is an important part of building on the strong foundations established since 2016. This involves building on our common purpose and vision, agreeing values through which we work and the behaviours that when demonstrated ensure that we deliver. It is important that we get this right to deliver our strategy.

We have a long history of working together in West Yorkshire to improve outcomes for our population which means that the new statutory arrangements are already building on a successful way of working. This is demonstrated through some of the West Yorkshire work we have undertaken together across the Partnership, for example national award winning campaigns such as 'Root out Racism', 'Looking out for our Neighbours' and the 'Check-in Staff Suicide Prevention' Campaign.

We have agreed as a Partnership that:

- We will be ambitious for the populations we serve and the staff we employ.
- The Partnership belongs to us all, local government, NHS, VCSE and communities.
- We will do the work once – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict.
- We will undertake shared analysis of problems and issues as the basis of taking action
- We will make decisions as close to individuals as possible – with work taking place at the appropriate level and as near to local people and communities as possible

The way in which our Partnership will put these principles into action is set out in the diagram below:



The way we work has been demonstrated in being the Health Service Journal Integrated Care System of the year in 2021 and 2022, where leadership values across all health and care sectors was highlighted as a success of how we improve care for people and communities.

What people and communities are telling us

Our approach to involving people and communities

Since West Yorkshire Health and Care Partnership began in 2016, we have been passionate about ensuring that our approach to involvement, in all forms meets the needs of people living, working, caring, and volunteering in West Yorkshire. This includes making sure that people remain at the centre of all planning and decisions, and that we listen to and talk with them, their families and carers, and local communities. We are also accountable to people living in West Yorkshire for their NHS services.

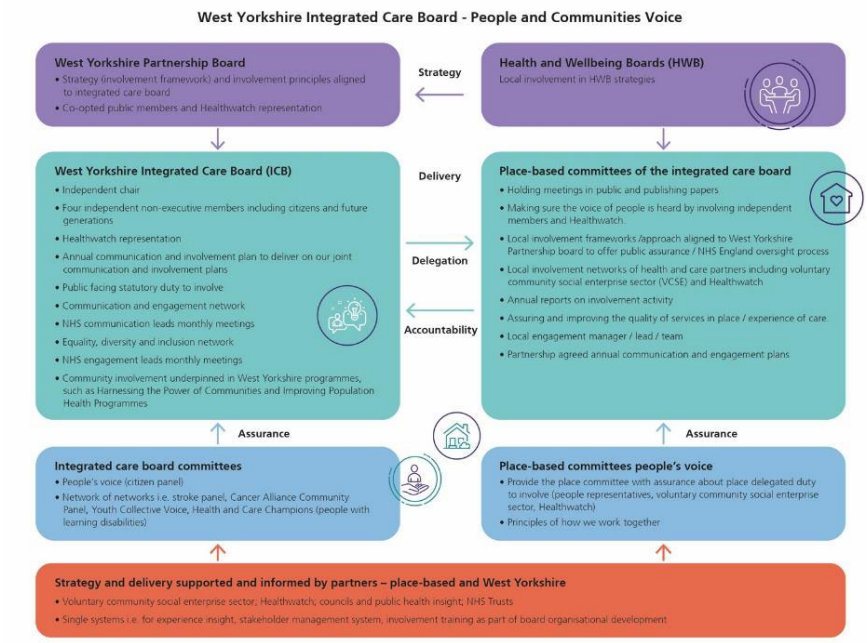
Governance and assurance about involvement supports how we work. This includes how we make sure people and communities in West Yorkshire are involved in our decision-making and can have confidence in our approach.

We work hard in West Yorkshire to build the relationships needed to deliver better health and care locally. These relationships have enabled us to use our collective resources to tackle health inequalities, to innovate and to build partnerships that make sense locally to us. In our new statutory arrangements, we continue to need the freedom and flexibilities for us to innovate and to deliver in the right way for the people of West Yorkshire. At the centre of this is listening to people and communities 'we care, we listen, we act'. Engaging with partners, stakeholders and the public in the planning, design and delivery of services is essential if we are to get this right. You can find out more on our website. There is also our engagement and consultation annual mapping report which sets out what people have told us and what is important to them.

We know that many people are often not heard in our health and care system. To ensure our services meet the needs of all people we work creatively and accessibly to reach those whose voices and views / feedback are too often ignored or not sought. We have agreed principles of how we work together and with people and communities.

Our involvement framework describes our approach . Through this approach we can ensure that we are putting the people of West Yorkshire at the heart of everything we do. We have used the involvement framework to guide us in the development of this strategy and this will be especially important in the development of our plans set out here.

The way in which the people voice is heard in our system is outlined in the diagram below:



What people have told us

As part of the development of this strategy, several reports summarising what people are telling us is their experience of health and care have been produced. This includes a Healthwatch Insight Report published in August 2022, a mapping report published in May 2022 setting out involvement and consultation activity across West Yorkshire and lastly a further mapping report from across the Partnership which provides oversight of engagement in all other areas of work. We also publish a short involvement report setting out recent examples of involvement activity across West Yorkshire.

There are a number of themes which have been raised over the last year (2022) as a result of these discussions in relation to healthcare across West Yorkshire. The changing context has in many cases placed a new emphasis on some of the themes and more recently the cost-of-living crisis has been an escalating issue.

Access to primary care remains a key area of concern. Primary care is considered the front door to the wider health and care service and many feel let down when they can't access their GP in a way that works for them. There is a deep concern that this has a detrimental impact on their health and wellbeing. Recent work has included campaigns to support people get the right care at the right place, for example 'Together we can' and It's a GP practice thing'.

Access to dentistry services continues to be an issue raised for both children and adults. This is both in terms of being able to register with an NHS dentist and access to appointments and treatment when registered. It was also raised that access to urgent dental care was not as responsive as needed.

Of increasing concern is the **cost-of-living crisis** which continues to escalate and impact on peoples' lives. This impacts significantly on the ability to make choices that positively impact their wellbeing, such as accessing healthcare, undertaking activities that support mental wellbeing, eating healthy nutritious food and being able to live in warm, safe housing. These challenges are having a particular impact on those who are living with social disadvantage,

serious illness, addictions and those people who are carers. This has led us to join forces with West Yorkshire Combined Authority and West Yorkshire Mayor to tackle this important issue together.

We also know that suicide rates rise during times of economic recessions and financial exclusion is a significant risk factor in suicide deaths. We have award winning campaigns, and a website with resources for wider support – all coproduced with people impacted by suicide.

There continues to be concern around **accessing support for mental health** in a timely manner, an issue which has increased with the impact of the pandemic. Of significant concern is access to support for our children and young people and the level of support for children who are waiting for assessment for, or have been diagnosed with, autism. Self-harm rates for both adults and children are rising, and the people we are supporting with mental health issues are becoming more unwell, more quickly than they have previously.

We know that the pandemic has led to significant **delays in treatment,** particularly for planned care services. People are telling us that this is causing a deterioration in their physical, mental and emotional health. The impact of this is also extending to family members and carers who are concerned about their loved ones.

The choice people have in **accessing care that is right for them** highlighted concerns about digital exclusion with many appointments and support moving to online services. Many of our population do not have access to digital technology or have additional challenges in using it. This was particularly a challenge for people with learning disabilities

Poorer experiences of **quality of care** are starting to emerge in some care settings. Whilst it is acknowledged that this is in part due to challenges arising from the pandemic in terms of staff shortages, we know it is important to be treated with care and compassion. For example, we know that children and young people from ethnic minority communities and those in poorer areas with diabetes have consistently poorer blood sugar control. We also recognise that there is a variation in access to digital technology such as continuous glucose monitoring.

What people have told us through our Joint Forward Plan consultation

The guidance on developing this plan reminds us of our duty to consult with the public in the development of our plans as set out in the Health and Care Act 2022. The consultation on delivering our five-year integrated care strategy consultation began in January for a period of six weeks. Details of this consultation process and importantly the findings are available on our website. This plan aims to address these findings.

Throughout the consultation period 203 people responded to the survey. Of these 67.9 % were members of the public and 32.1 % were colleagues from health and care settings. Responses were also received from organisations and are attached to the final consultation report which is available at Appendix B. It's important to note, that we also have delivered many other involvement activities around many areas of care, such as autism, climate change and young people services – and this insight is evidenced in our annual mapping report alongside local place involvement work.

Themes arising out of the report align well to the engagement feedback we received as part of the development of the strategy. These are:

- Access to services, in particular access to GP and Dentistry services
- Inequalities
- Co-ordination of services, truly integrated joined up care
- Having the workforce needed to deliver the services for our people
- Poverty and the cost of living and the impact of this on health and wellbeing and access to health services
- Getting the basics right in our delivery of health and care services.

The consultation report provides us with valuable information to support the development of our plans to deliver both the five-year integrated care strategy, via this plan. We will continue to identify any gaps and new areas for involvement as part of ongoing involvement work. Building experience of care into the monitoring and evaluation of our plans will be important to ensure when reviewing our plans annually, we can measure the impact it is having on people and communities.

You can also read our ICB involvement report on our website as well as the engagement and consultation mapping report, which provides insight on involvement work undertaken in 2022/23.

What our Health and Wellbeing Boards (HWBBs) and Overview and Scrutiny Committee members have told us

As already described, our strategy and plans start from improving people's health and wellbeing and having access to high quality joined up health and care services, wherever possible in the communities where people live, informed by the need described in local Joint Strategic Needs Assessments. Our Joint Forward Plan sets out what will be delivered in local places and what will be delivered across West Yorkshire. Each of the place plans are owned by the Place Committees of the ICB and respond to the national planning priorities, delegated functions from the ICB, the ten ambitions set out in our Integrated Care Strategy and priorities set out in the joint local health and wellbeing strategies. More information about how this works is on our website.

Our HWBBs have an important role to play in the delivery of our strategy We have worked closely with them to develop both the strategy and this plan. Starting discussions with the Boards in January 2023 and continuing through the development of the plan, their views on the plan can be described as:

Our local and West Yorkshire Overview and Scrutiny Committees are also key partners to support us in the development of this work and discussions have again been held over the development of this plan.

Improving health and tackling inequalities

How we are meeting the national asks on preventing ill health

Our Integrated Care Strategy has improving health and tackling health inequalities at its heart. We work to bring together partners from across the system to influence a shift in resources to focus on preventing ill health. Focusing on national requirements from the NHS Long Term Plan alongside local priorities. As part of this work we look to identify and share good practice at place that could be accelerated and replicated and to influence regional and national prevention agendas. In addition to the national prevention requirements, the programme has a significant workstream focused on preventing and reducing serious violence.

We have already been successful in securing over £600,000 additional resource because of our ongoing partnership with West Yorkshire Violence Reduction Unit (VRU) to support key areas of work including working with the VRU on our award winning Root Out Racism Movement, research and evaluation.

We will continue to build on the success in a bid for targeted prevention funding from NHS England to which resulted in scaling up of the accident and emergency (A&E) navigator programme in Calderdale and Huddersfield NHS Foundation Trust, broadening the scope beyond reducing serious violence to adversity and trauma across the life course. We will continue to support the remaining acute trusts to scale up Accident and Emergency Navigator Programmes.

Addressing risk factors to support secondary prevention, reducing disparities and improve life expectancy

As an ICB, we are working to address the risk factors and improve health outcomes for our population, particularly for our communities in the most deprived deciles (poorest areas) and communities most at risk. Intelligence for West Yorkshire has shown us that the causes of death that contribute most towards the gap in premature mortality by deprivation are cardiovascular disease, respiratory disease and cancer (specifically lung cancer). At the start of life there are also significant inequalities by deprivation in maternal and infant outcomes.

In addition to this, intelligence from the pandemic has shown us there are also significant gaps in COVID-19 mortality by deprivation decile. It is important therefore, that in addition to the areas listed above we keep a continued focus on reducing inequalities in vaccine uptake in our poorest areas.

In terms of healthy life expectancy, musculo-skeletal (bones and joints) and long-term mental health conditions are the two biggest contributors towards the gap in healthy life expectancy in relation to deprivation. It is important that we retain a focus on inclusive elective recovery to support people on long waits for elective procedures and to reduce the gap in people added to waiting lists. To do this we will need a focus on whole pathway inclusive elective recovery in addition to the inequalities in waiting times. This will need to include first outpatient attendances, waiting well initiatives and reducing inequalities in referrals, for people including those with learning disabilities.

We will work with on initiatives tailored to local need that meet these priority areas. Targeting prevention resource around these clinical areas for care in neighbourhoods, hospitals and specialist centres towards areas of higher deprivation. We will also work with them to consider alternative service models to seek out communities to make help and support more accessible, working closely with the community and VCSE sector.

Delivering NHSE Long Term Plan priorities Modifiable Risk Factors (tobacco, alcohol care teams, digital weight management)

We continue to implement all the prevention asks of the NHS Long-Term Plan, working with all Trusts and integrated partnerships at place to provide support and oversight.

Tobacco: This includes implementing pathways for treating tobacco dependence (as a complement not a substitute for local authority's own responsibility to fund smoking cessation) for:

a. all hospital patients who smoke (including mental health)
b. all pregnant women who smoke and their partners
c. those with long-term mental health conditions who smoke and those who are in learning disability services

You can see one example in our West Yorkshire Mums Can campaign which targets young pregnant women who smoke.

Alcohol care teams: As an ICB we will continue to support Bradford Teaching Hospitals NHS Foundation Trust and Mid Yorkshire NHS Trust to implement their plans for alcohol care teams, support patients and their families who are experiencing harm because of alcohol use disorders by providing specialist expertise and interventions.

Digital weight management programme: Providing access to NHS DWMP through Primary Care referrals particularly for or adults living with obesity, who also have a diagnosis of diabetes, high blood pressure or both, to manage their weight and improve their health. This includes a targeted and tailored approach through primary care to support our populations from black, Asian and minority ethnic communities and people form our most deprived socioeconomic quintile.

Reducing serious violence in partnership with West Yorkshire Violence Reduction Unit

In 2019, the Home Office announced that 18 police force areas (PFAs) would receive funding to establish (or build upon existing) Violence Reduction Units (VRUs) as part of the Serious Violence Fund. The aim of VRUs is to lead and coordinate a preventative, whole-system approach to violence reduction. Since funding began, an estimated 136,000 (or 243 per 100,000 persons) violence without injury offences had been prevented in funded areas. Based on these offences avoided, a return on investment of £4.10 for every £1 of SV funding (VRU and Grip combined) was estimated[footnote 2].

Between October 2021 and September 2022, 26 people lost their lives to violence in West Yorkshire. In the same period, 1863 people were victims of the most serious violent crime. In purely monetary terms, violence cost West Yorkshire over £1.2 billion during the analysed period. The VRU has a created a partnership across West Yorkshire that is breaking new ground on local and national platforms when it comes to tackling serious violence. This collaborative approach ensures that we continue to have our finger on the pulse, understanding what needs to be done and determine exactly how it can be achieved

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Serious Violence Duty

The recently published Serious Violence Duty requires specified authorities (Duty Holders) to work together to prevent and reduce serious violence, including identifying the kinds of serious violence that occur in the area, the causes of that violence, and to prepare and implement a strategy for preventing and reducing serious violence in the area. Integrated Care Boards are one of the five duty holders and as such have a number of requirements to undertake as well as the overall ask of all duty holders.

As serious violence is already an identified key priority within West Yorkshire and the Improving Population Health Programme, we will continue to use our established partnership with West Yorkshire Violence Reduction Unit (VRU) to response to the requirements of the Serious Violence Duty building on existing work with the aim of further reducing incidents of serious violence.

Weight management and living with obesity

We are continuing to work with the colleagues in planned care and partners across system, place and sectors to understand the needs of our population in relation to weight, weight management and living with obesity. This includes those who are struggling now and future generations so that over time we can improve health outcomes and reduce the burden and demand on health and social care services.

As part of our plan we will coproduce a strategy for West Yorkshire that includes our vision and principles/ways of working to support a compassionate, trauma informed life course approach to weight management and living well with obesity. The main ambition of the strategy will be to ensure that people who are struggling with their weight and or living with obesity can be enabled to make lifestyle changes to better manage their weight and wellbeing. In addition to access the right care, in the right place at the right time for them, taking into consideration what has happened to them and free from judgment. We will also build on the work in communities with the VCSE to encourage people to eat well and live well.

The views and experiences of our population and workforce will be the foundations of this work to look at current and new approaches to reducing stigma, responding to and providing equity of access to current and future treatment and services, including good social and emotional support, embedding the science and looking at obesity through the lens of a chronic long term, relapsing condition.

As part of the West Yorkshire programme, we will continue to embed and work towards reaching our targets for the national digital weight management programme (DWMP)

We know that we also have other challenges in terms of healthy weight and healthy relationships with food in our population. We are seeing significant rises in the need for children and young people's eating disorder support and wider 'disordered eating' across West Yorkshire and need to ensure that our focus is across the whole breadth of healthy weight.

Tackling health inequalities in West Yorkshire

Tackling health inequalities is a priority for our ICB and ICS, including seeing inequalities through a lens of anti-racism, adversity trauma and resilience and applying our own mission and values. Across West Yorkshire we are focused on reducing inequalities related to specific protected characteristics including ethnicity through our Race Equality Review and

inequalities related to people living with learning disabilities, Severe Mental Illness (SMI) and Autism through our partnership 10 big ambitions.

CORE20Plus5

Our Partnership has been allocated £10,724,000 recurrent and additional resource to support targeted reductions in health inequalities for 2022/23.

We know that we have over 20% of our population in the most deprived 10% nationally and that delays caused by the pandemic and increasing fuel and food poverty in our places will worsen this. Taking this into account, delivering Core20Plus5 will be challenging, to reduce health inequalities and have the biggest impact we need to will need to deliver this through a range of improving population health interventions and work in place.

Children and Young People Core20Plus5

Together we take a life cycle approach to addressing inequalities, recognising the need to take a family approach to address inequalities experienced by children and young people.

We have an established West Yorkshire Core20Plus5 Leadership Group in place in WY and it has been agreed that this group will also include a focus on the Core20Plus 5 Children and Young People (CYP) Framework. In addition, the Core20Plus5 CYP framework has been embedded into our existing children, young people and families work.

The approach taken in West Yorkshire to the original Core20Plus5 framework was not solely focused on adults and resource will be assessed to address specific pieces of work around reducing inequalities for CYP. This work will consider the insights from the recent Child of the North All Party Parliamentary Group report to ensure we continue to address the health inequality gap for children living in households with the lowest income. This is one of the ten ambitions of our strategy.

Core 20 Plus 5 Connectors Programme: The Core20PLUS Connectors programme is part of the NHS goal to tackle healthcare inequalities 'Exceptional quality healthcare for all through equitable access, excellent experience, and optimal outcomes'. The Connectors programme is part of the support framework for progressing the goals of Core20PLUS5.

Across West Yorkshire the CORE20Plus5 connectors programme is working towards accelerating improvements at scale for two distinct population groups that see some of the greatest health inequalities in West Yorkshire – Refugees and Asylum Seekers and Gypsy and Traveler populations. These groups have been identified priority populations through the West Yorkshire Health Inequalities network and through an independently chaired West Yorkshire Race Equality Review. We plan to use this resource to further strengthen our link to these communities with a focus on targeted improvements in outcomes related to CORE20Plus5 clinical priority areas. Our approach has been codesigned with each of our commissioned partners and target populations.

Health Inequalities Network
The Health Inequalities Network brings together different parts of the system to take collective action at scale to improve equity.

We have a focus on reducing inequalities for the following population groups: people living in the most deprived decile; people living with mental health conditions, learning disabilities and autism; rough sleepers; young carers and women and children at risk of violent crime.

During the pandemic the network expanded to include populations disproportionately affected by COVID-19 including minority ethnic communities and staff. Network membership includes local authorities, primary care networks, WYAAT, Public Health England, mental health trusts, voluntary and community sector organisations and universities amongst others. The Health Inequalities Network aims to add value to the system through working together to increase system capability, capacity, intelligence and insight.

Health Inequalities Academy
We have taken leading action nationally on increasing system capability through the launch of a West Yorkshire Health Inequalities Academy in 2021. The Academy brings partners together to establish a coordinated approach to understanding and addressing inequalities across the 2.4 million population we serve. It has influenced a shift in system capacity to resource £1 million investment in affordable warmth, added intelligence and insight to the system through commissioned research which included a report to understand relationship between socio-economic risk factors for young people and their involvement in serious violent crime or exploitation.

The aim of the academy is to spark curiosity and to equip people with the skills required to understand and address inequalities from their specific role within the system. We have established multiple different channels for learning and development including:

- Establishing sector and population specific communities of practice who meet bi-monthly. These include a healthy hospitals community of practice focusing on approaches to reduce inequalities in acute trust settings and a migrant health community of practice focusing on reducing inequalities in health outcomes for refugees and asylum seekers.
- Establishing a healthy hospitals community of practice to share learning and collaborate between hospitals. It has focussed on themes including approaches to inclusive elective recovery, use of intelligence and insight to understand inequalities in inequalities in service access through focusing on did not attend (DNA) appointments and most recently the community of practice has shared approaches to reducing inequalities in determinants of health through working as anchor institutions.
- Establishing a Migrant Health Community of Practice to work on a system plan which has now led us to become a Health and Care Partnership of Sanctuary. This plan supports a system approach to improving health outcomes for refugees and asylum seekers through reducing barriers to access to health services and a wider focus on improving prevention and determinants of health. Work to date has included an engagement report summarising existing insight across West Yorkshire, coordinating safer surgeries training delivered by Doctors of the World for primary care networks (PCNs) and working with Bevan Healthcare on the production of resources to support new arrivals to the country to navigate our health and care system.

- We have worked with Fairhealth to develop deliver bespoke, sector specific learning modules. Through this offer each PCN has nominated a lead to participate in Health Inequalities training which started in January 2022 with an introductory module followed by a leadership module. The first module for Acute Trusts regarding an Introduction to Health Inequalities in Secondary Care will be available online in March 2022

Improving Population Health Fellowship
The Health Equity Fellowship began in 2022 as part of the West Yorkshire Health and Care Partnerships ambition to equip all staff with an understanding of the individual and collective action we can take to create a more equitable health and care system. 32 Health Equity Fellows were recruited and successfully completed a nine-month development programme with protected time to work on a health equity projects alongside a public health foundation training programme run by Health Education England and University of Leeds. Fellows came from a variety of professional and demographic backgrounds which reflect the diverse nature of our workforce and local people.

The fellowship has since developed and year 2 has seen an expansion of the programme to cover 30 Health Equity Fellows, 30 Adversity Trauma and Resilience Fellows, 5 Suicide Prevention fellows and 5 Climate change fellows all under the new umbrella title of Improving Population Health Fellows. Year 2 of the fellowship welcomes 70 fellows recruited from all sectors across the four fellowships.

Inclusion health
Inclusion health is a term used to describe people who are socially excluded and may experience multiple, overlapping risk factors including, but not limited to, poverty, violence, and trauma. Examples of inclusion groups are the homeless, the Gypsy, Roma and travelling population, those seeking sanctuary including refugees, asylum seekers and undocumented migrants, sex workers, and those who have been in the criminal justice system.

People belonging to inclusion groups frequently experience barriers in accessing healthcare and consequently poorer health outcomes with a lower life expectancy than the general population. Individuals often suffer from multiple health issues including mental and physical ill health and substance abuse.

The reasons for people being excluded are numerous and often complex. It can be because of one or more of various factors including unemployment, financial hardship, youth or old age, ill health (mental or physical), substance use or dependency including alcohol or drugs, discrimination on the grounds of sex, race, disability, ethnic origin, religion, belief, creed, sexual orientation, or gender reassignment, poor educational or skills attainment, relationship or family breakdown, poor housing, or crime (as a victim or offender).

Poor access can occur because of several barriers, including but not limited to:

- Difficulty understanding the system
- Poor experiences in the past
- Unable to provide a permanent address/insecure accommodation
- Language/culture challenges including illiteracy
- Fear of professionals/officialdom
- Poverty/financial hardship
- Current or historic experience of trauma

In principle, the NHS provides services which are available to all, and it is therefore imperative that we ensure that socially excluded people can access and benefit from health and care

services. Equality and inclusion within healthcare is vital to ensuring peoples differences are valued and that people are treated equally and supported to take part in whatever they wish to do.

Our Partnership has now become the first Integrated Care Partnership of Sanctuary in the country for going above and beyond to welcome people seeking sanctuary into West Yorkshire, embedding approaches to improve the health of refugees and asylum seekers through learning, embedding and sharing good practice across the partnership.

Addressing inequalities for inclusion health groups may require a different approach and would benefit from work at scale for collective action for those populations that are small in absolute number but great in need. We therefore agreed 12% of the total core 20 PLUS 5 resources would be allocated at a West Yorkshire population footprint for a West Yorkshire Health Inclusion Unit. This would provide capacity for a collective coordinated approach to reducing inequalities in health outcomes for population groups who face some of the starkest health inequalities in our population.

This approach will be developed and led in partnership with local VCSE organisations who are instrumental in providing support for these communities. Bringing together the best of our knowledge and expertise from people working directly with local communities to design and deliver tailored and targeted interventions that improve health outcomes. The Health Inclusion Unit will target improvements in clinical outcomes for these groups through different ways of working. We would also reflect on additional Inclusion Health groups that make sense to focus on for collective approaches across the system. We will focus effort on where we see the most unequal measures of access, experience, and outcomes for each of these groups.

Our system approach to preventing suicide

There was an average of 5.4 suicide deaths registered each week in 2021 in West Yorkshire, up from 4.5 in 2020. Some of this change may be due to reporting lags during COVID, however, these rates remain high. Every death is devastating for those left behind and has a lifelong impact and we know that being bereaved by suicide increases suicide risk. Suicide is our biggest killer of men under 50, and our biggest killer of young people.

The latest data from the ONS shows that the suicide rates for men and women across England and Wales have reduced since 1981, but there is more to be done. In WY we have had a public health focus on suicide prevention for a number of years, yet the rates have not substantially reduced. Except for Bradford, each local authority in West Yorkshire has significantly higher rates than the England average. Apart from Kirklees, our place-based rates rose last year. We know that we need to do something differently if we want to turn the curve over the next five years.

Turning the curve
West Yorkshire Health and Care Partnership has already agreed a five-year suicide prevention strategy 2022 – 2027 which complements our five existing place based strategies and plans. This sets out much of what we intend to deliver over the coming five years. We believe that suicide is preventable, and we have adopted a zero suicide approach at the centre of this strategy.

One of our greatest challenges is knowing where our work has already made a difference. It is difficult to quantify when we have saved a life by preventing suicide, but we know this happens across West Yorkshire day in and day out. Suicide prevention happens over the

course of an individual's life – for example in infancy through safe attachments and loving relationships, in schools through positive and proactive approaches to issues such and bullying, self harm and online harm, in communities in preventing isolation and loneliness, in healthcare settings through the compassionate management of physical health conditions and pain, in mental health settings through early intervention, safety planning and crisis support, in general practice and throughout primary care, in the criminal justice system, through public heath work such as on gambling harms, in the voluntary sector, food banks, safe spaces, in the workplace with employers, in communities and in our streets and families.

It is difficult therefore to identify who is responsible for widening the momentum, creating a movement for change and agreeing how can we turn the curve and bring the suicide rate down. It is clear that the only way we can do this is to make suicide prevention everyone's business and a core part of every organisations' plans and performance framework. We have made some progress, but now need to start with a whole system paradigm shift. The aspiration is for suicide prevention to be a feature of every organisation's safeguarding or business as usual practice, in the same way they would approach fire safety or having a first aider.

The West Yorkshire Suicide Prevention Oversight Group have identified existing gaps based on national and local evidence for place-based consideration, acknowledging that there is currently different levels of investment and provision. All of these are addressed in our 'do once/ do together' plan the detail of which can be read here: [Suicide Prevention Strategy Plan 2022-2027 :: WYH Suicide Prevention (suicidepreventionwestyorkshire.co.uk)]

Over the next five years as part of delivery of our strategy we will:

Influence

Years 1 to 5

Ensure that suicide **prevention** is the business of everyone.

Climb the 'ladder' of **coproduction** to ensure lived experience is at the heart of all that we do.

Enable organisations within the WY HCP to reduce suicide among their **staff and volunteers**.

Aware

Years 1 to 5

Support general practices and **primary care** services to better identify and respond to suicide risks.

Years 3 to 5

Support those providing care for **physical health** and long-term conditions to prevent deaths by suicide.

Do at a West Yorkshire footprint

Years 1 to 5

Target resources where suicide risk is the highest and where it makes sense to do so on a regional basis.

Years 2 to 5

Prevent people who **attempt** suicide from going on to take their own lives.

Work together to prevent suicide among **children and young people**, people who become unemployed or face **poverty** and people involved in the **criminal justice system.**

Years 3 to 4

Work together to prevent suicide among people experiencing loneliness and **isolation**.

Share

Years 1 to 5

Embed system-wide cross-sector **collaboration** in suicide prevention.

Improve system wide **information sharing** around suicide.

Improve the situation for people who reach **crisis** point.

How will we know we have made an impact?

Our ambition for the people is to reduce suicide by 10% across West Yorkshire by focusing on health inequalities, achieving a greater understanding of impact of inequality on suicide, so that suicide prevention becomes everyone's business.

To do this we need a clear focus, and to consider investment, starting with all organisations that make up the partnership, and bringing in other employers, sectors and the public.

Within our plan there are a set of recommendations:

- We use as our key metric, the three-year rolling average suicide rate per 100,000 people, as released in Sept annually by ONS
- We remove the focus on suicide counts as it is well documented that this is less useful
- We have further metrics to be added – stepped approach to 100% of organisations have achieved minimum standards in suicide prevention approaches, including a focused suicide prevention strategy and plan in line with the WY Suicide prevention strategy, local place based suicide prevention plan and the **focus of their specific organisation** as they intersect with suicide risk
- We build this into assurance and accountability frameworks across the partnership so that we are all playing a part in working towards the trajectory.
- We have an suicide prevention oversight group and place- based suicide prevention partnerships to adopt a 'business partner' function – providing evidence, insight, oversight, input and peer review of organisational plans and strategies
- We review the investment we are making into this area
- There is no one plan of action that every organisation can adopt but there is significant expertise, evidence and knowledge across West Yorkshire to support organisations to get their plans and strategies right.

The minimum standards to include as part of this work are:

- Suicide prevention plan for organisation, regular reporting to Board, consideration of suicide as an organisational risk
- A consideration of mandatory suicide prevention training for every employee

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- Employee/ staff and volunteer suicide prevention focus
- Suicide Prevention Champions linked to local Suicide Prevention Action Group or Network and/or Suicide Prevention Network
- Use of local, regional and national resources
- Consideration/ understanding of the population risk factors specific to each organisation, with a focus on life course and early intervention
- Evidence of anti-stigma work.

We are also focusing on supporting our own staff through our staff mental health hub, investing £100k over 18 months to develop and deliver Men in Health, a preventative service supporting men across the health and care partnership who may be at risk of developing the poorest mental health. The first six months of data from the pilot show that Men in Health is reaching male staff from across the Partnership with risk factors for poor mental health, including those who do not access workplace wellbeing services and global majority staff. The programme is delivered by Touchstone in partnership with Yorkshire MESMAC. Details of the programme are available here: Home - Men in Health

Equality diversity and inclusion and race equality

We know that people's ability to live a healthy, fulfilled and safe life is significantly affected by their social, cultural, religious and demographic make-up. Delivering services and change that acknowledge and address this and tackling inequalities and injustice within our workforce is of paramount importance in all that we do.

Through our Tackling Health Inequalities for Black, Asian and Minority Ethnic Communities and Colleagues work, for example, we know that coming from an ethnic minority background in West Yorkshire means that healthy life prospects and opportunities at work are vastly different to the majority culture. We also know, through our WRES and staff survey data, that colleagues from an ethnic minority background working across our partner organisations do not as a whole experience work as positively as their white colleagues. Experiences of discrimination are higher, feelings of equal opportunity for progression lower, and the demographic composition of the workforce increasingly less diverse going up the pay scale.

People's identity is multifaceted, and characteristics intersect. We know that this can have a compounding impact on inequalities, and recognise that in making our Partnership the best place to work we must encourage diversity and inclusion. Critically, we also recognise that much of that which determines health and wellbeing is beyond the immediate scope of health and care services. This makes cross-sector collaborative working imperative to achieving our goals on equality, diversity and inclusion for our population and staff.

Our Partnership has a longstanding commitment to equality, diversity and inclusion, and tackling inequalities and injustice wherever we find them. Recognising the facts of what we know and applying our Partnership's three tests highlights inequalities present a wicked issue that cuts across the entirety of West Yorkshire and thus can benefit from at scale working and the sharing of best practice amongst system partners.

Our work to date on tackling ethnicity based inequalities and racism typifies our approach and commitment. The 8th of our 10 Big Ambitions pledges to diversify our leadership to make it reflective of our communities and ensure that poor experiences of work for ethnic minority staff are a thing of the past. Our Tackling Health Inequalities for Black, Asian and Minority Ethnic Communities and Colleagues report called us to action, resulting in significant progress in the four domains of the report across all system partners in pursuit of our ambitions. The 'Connected on Inclusion' report and week sought to reflect, connect and

improve on our progress and resulted in a renewed focus on and impetus for action. Progressive outcomes include making recruitment more inclusive, establishing the Fellowship, offering coaching/mentoring, a range of initiatives to tackle health inequalities amongst our population, our anti-racism movement, and more.

In recognition of the fact that much of the determinants of health and wellbeing are not related to health or healthcare, we have been working to establish several joint posts with the West Yorkshire Combined Authority that will enable progress on our collective inclusion priorities. This includes the West Yorkshire Inclusivity Champion and joint public-health roles.

Recognising the progress we have made to date, and the foundation that has established for our equality, diversity and inclusion journey, we know that we have more to do and further to go. We know that creating honest and open spaces to share and hear voices of those with lived experience is vital, but that action must follow.

Aligning our statutory equality and inclusion duties as an ICB with existing actions that we have committed to, such as the Connected on Inclusion report actions, coupled with our joint-working prospects with the Combined Authority present a significant opportunity. By aligning our strategic priorities and addressing these through collective endeavour we can consolidate our efforts and extend their impact. We will commit to doing so through an Equality, Diversity and Inclusion Strategy.

Through the development of our strategy we will build on and seek to transfer the wealth of progress made and experience held by our Race Equality Network, to ensure that our work is inclusive of all. In ensuring that this strategy aligns with the ambitions we share with the Combined Authority we will contribute to the wider inclusivity of our socio-economic environment, and ensure that those factors that determine health and wellbeing are more positive for all.

There are measurable ways of tracking our progress and we must develop a framework that delivers tangible outcomes. For example, we know that on average 20% of the West Yorkshire population are from an ethnic minority background, thus we will continue to work toward ensuring our leadership reflects that and that we get things right for a significant proportion of our people.

Our approach to ensuring that our services are trauma informed

Adversity and trauma are experienced within all communities in West Yorkshire however, it is our most vulnerable people who experience the highest levels of adversity and trauma and face the biggest inequalities in health. For this reason, tackling health inequalities, preventing, and reducing trauma is as a core commitment of our Partnership.

The West Yorkshire Adversity Trauma and Resilience (ATR) Programme was established in June 2020, jointly led by the WY Health and Care Partnership and the WY Violence Reduction Unit (VRU). Given the context of COVID at the time, this was the right time to begin the West Yorkshire journey moving towards a culture of being trauma informed, responsive and resilient. In November 2022 the West Yorkshire Senior Leadership Executive reaffirmed their commitment and support for the West Yorkshire Adversity Trauma and Resilience Programme and the shared system ambition to become trauma informed and responsive by 2030.

As a health and care partnership we know that trauma and adversity cannot be tackled in isolation, they must be dealt with as a collaborative partnership identifying and directing

resources appropriately. We know that becoming trauma-informed is always a journey but realises many benefits, for the workforce, people, their families and communities.

We want all our all organisations across to be trauma informed and responsive and to have a workforce that is therapeutic, skilled, confident, trauma informed and responsive, where every interaction matters. As part of our journey, we want to ensure that we support all children and young people who have experienced adversity/trauma and seek to prevent it for those who haven't to reduce their level of vulnerability and risk.

Our ethos continues to be about connections. Connecting organisations, communities, and individuals to understand adversity, trauma, and the impact across the life course to both physical and mental health, to understand our services better, prevent re-traumatisation and offer better care for all that is equitable and accessible. Strengthening these connections across the system creates the opportunities to use our unique partnership assets to improve health and wellbeing. In order to do this, there are a number of actions we will take over the next five years,

All organisations in West Yorkshire becoming trauma-informed - To meet the growing demand, we need to transform how health and care is delivered and accessed and in doing so improve the health and wellbeing of our current and future generations. This can only be achieved if all sectors and organisations, rise to the challenge of becoming a trauma informed and responsive system. Embedding a process of organisational, cultural and system change, aiming to create environments and relationships that promote discovery and prevent re-traumatisation

ATR Foundation Training for all staff appropriate to job role (including managers and leaders) – Becoming trauma informed and responsive with a consistently trained workforce, would mean that we would be able to recognise problems earlier. An initial system-wide training offer will be developed and rolled out across all agencies and organisations, at all levels and grades, in the ATR and Multiple Disadvantage Partnerships at the place level. This offer will include participation of third sector organisations and the inclusion of non-commissioned, peer-led and community organisations.

Embedding trauma informed reflective practice and restorative supervision across all organisations to support the health and wellbeing of the West Yorkshire workforce - We must also prioritise the resilience and wellbeing of the workforce across all sectors in order for our ambition to be realised. Recruitment, supervision, and appraisal systems will need to focus on the behaviours and competencies required in a trauma informed system. Organisations and agencies will need to examine and review their policies and procedures in the light of developing practice.

Prevention, moving upstream to early intervention, improved access and crucially investment to achieve the ambition - Parity of esteem between prevention and intervention to prevent trauma and reduce harm. We need a public health approach preventing and addressing the impact of childhood adversity. Multiple Public Health Organisations have reviewed the evidence for 'what works' and agree that to transform the health and wellbeing of future generations, We can and we must prevent, detect, and mitigate the impact of trauma and adversity. Adversity and trauma (A&T) and their consequences are preventable through the implementation of strategies and practical measures. Successful early help services depend on collaborative working across VCSE partner agencies to provide support to children and families. They also work with child protection services where there is a need for more support or escalation, prevention strategies should have emphasis on:

- Reducing the root causes and inequalities that cause the conditions for adversity and trauma
- Strengthening economic support for families, addressing the cost-of-living crisis and rising poverty
- Promoting social norms that increase protective factors against adversity and trauma, including poor health and wellbeing and violence.
- Reduce traumatisation
- Promote resilience across the life course.

Ongoing support to grow local ATR partnerships, either newly created or built on existing multi agency partnerships that focus on helping vulnerable people - A Trauma informed system can only be achieved if the whole system works together to embed the principles of trauma informed in our ways working and our culture. It is not a fad; it is a way of being and seeing the world through the experiences and eyes of others. It is asking people 'what has happened to them' rather than 'what is wrong with them'

Supporting people during the cost-of-living crisis

The cost-of-living crisis facing our country and region is more than an economic issue. It will have far reaching implications for health and care services across West Yorkshire and will impact across both the people we serve and the staff we employ. We know that financial hardship directly impacts on the mental and physical wellbeing of people, and as more people are pushed into poverty this will increase the number of people who need our support. We also know that a significant proportion of employees in our organisations, as well as carers and volunteers will also be directly affected. This is a priority for us all, and all partner organisations across West Yorkshire are taking action to support people during this time.

The actions are available in more detail here however, the collective actions we have agreed collectively with the West Yorkshire Combined Authority (WYCA) are focused on:

- Reducing costs to households and providing support to employees in financial hardship
- Investing in voluntary and community sector organisations
- Ensuring mental health and suicide prevention services are providing the appropriate support
- Ensuring that services are proactively responding to the impact of the cost-of-living crisis.

The oversight of joint work is managed through the Improving Population Health Function at ICB level, supported by a steering group comprising of the ICB, WYCA, Local Authorities and VCSE partners. The Combined Authority is also taking action by supporting businesses with funding for energy efficiency measures, and reducing the cost of travel by bus, in addition to implementing the Mayor's Cost of Living Fund.

Meeting the climate change challenge in everything we do

Climate change has rightly become an increasingly important feature in our everyday lives. We are all affected by it and, health and social care contribute significantly towards causing it. Climate affects all the determinants of health and wellbeing in our communities. Dealing with climate change requires everyone working and volunteering in health and social care in West Yorkshire to act to reduce our environmental impact, but also to prepare for the changes that are already taking place and that will intensify in future.

Focusing on climate change is challenging in a system which is already overstretched and under significant pressure. However, failure to address our societal and environmental responsibilities will lead to increasingly frequent and severe emergencies.

Delivering the West Yorkshire Climate Change Strategy
Our Climate Change Strategy aligns to our Integrated Care Strategy and sets out system ambitions on climate and sustainability, establishing our economic model of managing trade-offs, and highlighting that we need a risk management approach.

Climate change is fundamentally a human health issue because the drivers of climate change are also the drivers of ill health and health inequalities. We cannot be healthy if our biosphere is poisoned. In providing health and social care, we are contributing to the degradation of the environment on which we all depend by:

- Burning fossil fuels for heat and transport
- Using single-use plastic
- Eating unsustainable food
- Taking too long to adopt digital technologies
- Underestimating our influence on the supply chain
- Undervaluing water supplies
- Being profligate with our medicines
- Accepting unwarranted variations in care
- Underrating the health benefits of our green and blue spaces

Here in West Yorkshire, we have an ambitious Integrated Care Strategy which is helping us to reduce inequalities in our communities as well as weaving climate action into all we do. Our Partnership has an agreed vision for the future of health, care, and wellbeing in West Yorkshire, where all partners are working together so that people can thrive in a healthy, equitable, safe, trauma informed, and sustainable society.

Our Integrated Care Strategy sets out an ambition for this area that ” We aspire to be a leader in the delivery of environmentally sustainable health and social care through increased investment, mitigation and culture change throughout our system”

In a future where we fail to act, we will fail to achieve our ambitions and vision. Instead, we will see more morbidity, mortality, and inequality, and the system will struggle to cope, eventually failing under impossible demand. We can expect:

- More people suffering with cardiac disease
- More people developing and dying of respiratory conditions
- More people in food poverty and facing foodborne illness
- Travel and transport difficulties for patients, residents, and staff
- Increased malaria and other vector-borne diseases
- Disrupted supply chains with essential supplies increasingly unavailable
- New and emerging communicable diseases
- Significantly increased inward migration to the region from other parts of the UK facing extreme weather and flooding
- Community collapse leading to poorer population mental health, trauma, violent crime and possibly increased suicide rates.

But that future is not pre-determined. In a future where we get this right, we can see better outcomes through better models of care, including:

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- More people helped to stay in better health and remain independent
- Care closer to home
- Digital appointments as standard
- Comfortable, efficient, and well-insulated homes safe from extreme temperatures
- Health and care staff who travel actively on flood-resilient green and blue routes, with local public sector anchor organisations leading the way in their adoption of active travel
- Cleaner air leading to fewer respiratory, cardiac, and neurodegenerative conditions
- Good-quality housing, and employment in a sustainable, fair local economy
- A regenerative, local food system that ensures all people can afford a good diet
- Places and system designed to minimise, and prepare for, new infectious diseases
- Green social prescribing and access to green spaces.

This will not be achieved by the work of individuals in isolation. We must act together so that the sum of our improvements is much more than each one of us, or each organisation could do on our own.

NHS Green plan
Big organisations such as NHS Trusts have big footprints because of their estates and fleets and because of the nature of their work. Rightly, they are the first focus of the national Greener NHS team and there are some statutory climate obligations for them to deliver. These are laid out in our Partnership and Trust Green Plans. Local authorities are also doing a lot of good work, some to meet their statutory responsibilities and some are going beyond, of their own initiative. This work is not sufficiently joined up across the different parts of our system so we will create and enhance these relationships, because interconnected challenges need interconnected solutions.

By being agile, smaller organisations have an important role to play. They can make changes quickly and then advise their bigger partners on successes. By distributing, expertise and funding, smaller organisations can contribute, benefit, and thrive, even if some initiatives fail.

Core determinants of health

The detail above has been produced around the main domains within which collaboration between the WY ICB and the WYCA can add value to the health and wellbeing of the population of West Yorkshire. It should be noted however, that plans and timescales may change, depending on funding opportunities which become available, or where funding bids are unsuccessful. The WYCA recently changed its governance structure in order to become more outcome focussed and enact change. However, the Corporate Objectives are unaltered, and the work programmes currently fall under four broad categories:

Housing and healthy places
We know that having a warm safe place to call home is one of the greatest determinants of health and wellbeing and in WY we have worked together to build on housing and health initiatives. Where we live is a major determinant of our health and wellbeing – determined both by the physical nature of our homes and also the emotional and psychological impact of how secure and happy we feel with our living situation. A house may be a shelter to protect against the elements, but our sense of home is the foundation for social and psychological shelter and resilience throughout life.

The pandemic has resulted in a significant impact on the housing sector both in terms of availability and quality of housing. In August 2020, the Health Foundation reported that the

impact of housing on health is likely to have been greater than ever during the lockdown period.

Our Housing and Health partnership has worked to facilitate sharing of good practice across the five West Yorkshire places. Core objectives for our housing and health partnership are:

- Embedding health as a consideration in all WY housing plans and interventions.
- Promoting and supporting the housing and built environment needs of specific groups: ageing well and dementia.
- Promoting and supporting the housing and built environment needs of specific groups: people with multiple vulnerabilities.
- Improving the quality of existing housing stock within the region and reduce health inequalities due to poor living conditions and the built environment.

Economic growth and innovation
As part of our work to deliver the strategy we will be working closely with the WYCA to embed health and health inequalities as a consideration for any growing business or start-up. We will also seek to promote local procurement practices within the anchor institutions of each local area, including healthcare organisations.

As described earlier in this plan we will work to address poverty and the cost-of-living across the region with a co-ordinated approach involved in public sector, third sector and the Leeds City Region Economic Partnership and local businesses. We will also seek to promote and enable healthtech development and testing within all areas of WY, including academia.

Employment and skills
Employment and skills are an important element of people having a sense of purpose and something meaningful to do whether that be paid of unpaid employment. We will work with the WYCA to:

- Take a public health approach to reducing unemployment: people with long-term health conditions
- Take a public health approach to reducing unemployment: school leavers and long-term unemployed
- Use the power of regional healthcare organisations to promote caring and healthcare support careers for local people
- Promote fair work across the region
- Strengthen and grow volunteering pathways into employment across the Partnership.

Transport
Transport is an important contributor to good health and wellbeing, through ensuring the ability to access health appointments and treatment, access good employment and to make the social connections needed. Our work with WYCA will look to develop sustainable routes of transport to healthcare organisations across the region and to consider the impact on health of all future transport infrastructure and planning. We will also work to promote sustainable transport and travel programmes for culture and social value and to promote sustainable travel where appropriate.

Working with partners
Building and maintaining relationships which are crucial going forwards. We will work much more closely with the voluntary, community and social enterprise (VCSE) sector, primary care (including primary care networks), private healthcare providers, educational institutions, local

authorities including social care and wider services, the West Yorkshire Combined Authority (WYCA) and local places.

As in the rest of the West Yorkshire system, Places have an important role to play in creating our sustainable future. They are ideal mechanisms to build networks and relationships across professional boundaries, to plan and deliver projects within a geographical boundary, and to establish new social norms which prioritise impact reduction and adaptation.

We will also continue to establish sustainable networks, including in pharmacy, procurement, respiratory care, primary care, anaesthetics, board level Net Zero Leads and operational Leads. These will support is in sharing good practice and tackling issues together to make the changes we need to see.

Creativity and health

Finding new and innovative ways to support our population to have happier healthier lives is important to us in West Yorkshire and we want to have an active, vibrant, creative health sector. Our work to use creativity to support this is an important element of our work. It is proven to:

- Keep us well, aid our recovery and support longer lives better lived
- Meet major challenges facing health and social care: ageing, long-term conditions, loneliness and mental health
- Save money in the health service and in social care through building health producing and better-connected communities.

As a national leader in creativity and health, we already have good examples of where we have made a real difference through using a creativity and health approach, for example our Calderdale Creativity and Health Programme working with South West Yorkshire Partnership Foundation Trust and Creative Minds. We know that expanding this learning could help us create stronger, healthier, more resilient communities through working at a population health level. We know that it will support us in delivering targeted interventions addressing the greatest health disparities and importantly, be part of a transformation in the way health and care services look and work for everyone.

We will continue to work with the National Centre for Creative Health (NCCH) who are working in partnership with NHS England on a programme of developing a programme of Creative Health Hubs, of which West Yorkshire is one of four nationally. We have been working with NCCH to:

- Capture the stories and learning from Creativity and Health in West Yorkshire, pulling together networks in each of our places and across West Yorkshire; articulating these so that they and their wider partnership groups can effectively advocate at a national level
- Map and evaluate the level of health and care sector investment in arts/ creativity/ cultural projects across the ICS to inform future funding/ commissioning opportunities and to frame future investment discussions with Arts Council England
- Develop a plan of how the learning and successes of how Creativity and Health work could be scaled or replicated. With many successful cultural events already having been held there are still many others to come, including Kirklees Year of Music 2023, Leeds 2023, Calderdale Year of Culture 2024, Wakefield Year of Culture 2024 and Bradford 2025. This alongside strong strategic interest from the Arts Council, there is a significant opportunity to advance this work to the benefit of all of our communities and with tangible benefits for our health and care system.

An example of where this work is having significant success is the Lullaby Project in Calderdale, creating unique lullabies for those suffering or at risk of suffering post-natal depression. This has involved work with care homes, providing opportunities and Music in Care accreditations for staff. It has also involved development of a creativity app to provide everyday creativity opportunities for everybody in our population. Lastly, working with the acute hospital to explore how storytelling, theatre and advocacy for staff and patients might lead to system change and working with people with lived experience and artists to re-design the health check process for people living with serious mental illness

Delivering responsive joined up services

Primary care transformation

Primary care services including general medical practice, dental, eye care and community pharmacy are central to bringing care closer to home, managing long term conditions, preventing unnecessary hospital admissions and helping people stay well and healthy. In addition, a core theme of our Joint Forward Plan is further enabling the integration of all health and care services that work in neighbourhoods (i.e. local communities) including primary care, community health services, social care and the VCSE.

The Primary Care Joint Forward plan builds on the current primary care strategy Primary and Community Care Services Strategy 2019/2024 which describes our vision for primary care to

- deliver a new model of primary care
- Improve population health
- Use our resources better

This Joint Forward Plan builds on the key themes that informed our earlier strategic approaches to primary care within West Yorkshire; the right scale, working together, targeting population health, reduce unwarranted variation and empowering our people and communities. Our strategic focus remains on enabling and transforming primary and community-based care which is reflective of the wider West Yorkshire ambitions outlined earlier in this document, and that can also continue to progress the key transformation enablers for integrating services in neighbourhoods, namely workforce, digital and data, and estates. The importance of key enablers were further emphasised through the national Fuller Stocktake Report.

The Fuller stocktake report, “Next Steps for Integrating Primary Care”, published in 2022, outlined a new vision for primary care that reorientates the health and care system to a local population health approach through building integrated neighbourhood health and care teams teams. At the core of the Fuller Report is a neighbourhood-based model for integrated care centred around streamlining access to urgent care, continuity of care for those with long-term conditions, and a proactive approach to prevention and tackling health inequalities, helping people to stay healthy. Further information on the Fuller Report and way this is being implemented across West Yorkshire is set out in the following sections.

Primary care within the West Yorkshire ICB

Consistent with the overall operating model for West Yorkshire, and the ‘three tests’ described earlier in this Joint Forward Plan, our approach to primary care within the core ICB focuses on what we will do at a WY level which will add value to developments in our five places and achieve the aims of the Fuller Report across our whole integrated system. Progressing the vision in the Fuller Report also has multiple independencies with wider work across our Partnership including the transformation of urgent and emergency care, long term conditions and personalised care, digital and workforce. We have arrangements through our West Yorkshire ICB programme structures to help forge these connections.

NHS West Yorkshire Integrated Care Board has five local places. These are Bradford District and Craven, Calderdale, Kirklees, Leeds and Wakefield District

The delegation of Community Pharmacy, Optometry and Dental Services (POD) to ICBs brings about transformation and joined up care opportunities. Aligning POD services with ICB level strategies, ensuring integrated care within local communicates and neighbourhoods includes our broader ambition for POD.

It should be recognised that the five places have a lead role in determining their local commissioning strategy for their populations and how they will support the development of primary care services to be responsive to the aims of the Fuller Report.

Our work and deliverables
A range of specific underpinning aims, and objectives have been developed and are being progressed to contribute both to the strategic ambition for primary care in WY and the Fuller recommendations. These span The WY Primary care transformation programmes of Workforce Estates and Improving Transformation and capacity for Improving access to services.

Aims	Objectives	Outputs
Estates development **We will enable and support the development of system wide primary care estates strategic plans which align to the strategic service priorities of place and WY.**		
• Integrated approach to clinical and service ICS estates so that estates is considered earlier in the planning process. • Build on the outputs of place estates position and strengthen Primary Care Estates development. • Develop estate infrastructure/ capacity in Primary Care, responding to new models of care to meet population health and integrated workforce	• We contribute to the delivery of the ICS 'one public estate' approach - facilitating the development of primary care PCN estate plans from the perspective of access, digital, population and clinical health, and inequalities. • Strengthened PC estate governance & project oversight across place and WY connecting into other forums such as Capital Working Group and Primary Care Leads	• Developed tools and guidance to ensure a consistent approach to Prioritisation, balancing estate need against available funding. • Develop local premises guidance to support place • Develop criteria to Understand the impact of investment
Improving Access to Services **We will work collaboratively to align priorities to support access improvement across Primary Care, addressing inequalities in access and embedding integration with all Primary Care Contractor groups and Services.**		

• Integrated models and ways of working across our primary care providers, including the integration of community pharmacy into local neighbourhoods • Working with our places and key stakeholders to support improving access to General Practice through integrated models of care, breaking down barriers with other provider services, making it easier for patients to access services based on their health need and preferences. • To give patients increased choice about how and where to access services both in and out of hours.	• Support our places to integrate community pharmacy providers into neighbourhood models. • Provide an effective mechanism for horizon scanning and the sharing of best practice from the five places and where appropriate, provide recommendations to enable the forward planning on the delivery of national priorities relating to primary care access. • Use a broader level of data about primary care services, to understand access system wide, sharing variation and enabling any re focus or revision of WY system wide priorities. • Work with Healthwatch at widening the scope of their work to look across Community Pharmacy and Optometry services. • Continue to work across WY and place to develop local messages which support patients in accessing primary care.	• Increased use of Community Pharmacy Advanced Services. • Timely data readily available to places in an easy-to-use format to enable focused approaches to quality improvement • Integrated approach across Programmes contributing to improvements in access for patients. • Good understanding of patient experience of accessing Primary Care Services.
<u>Workforce</u> **We will continue to work across WY to enable an effective response to the WY People Plan reflecting the 5 pillars.**		
• We align our work to the local and national strategic direction for the delivery of primary care services and transformation. • Focus on our WY wide work across the 3 aims of – recruit, train and retain.	• We will use our collaborative approach within the WFSG to agree our actions and objectives across our three broad aims, underpinned by an action plan which is delivered through the WFSG.	• WY Collaborative Plan co-designed with place through WFSG members. • Continued development and design for

• Enable a workforce in Primary Care that can support the ambitions of the Partnership. • Reach beyond General Practice in our actions to include all Primary Care Providers.	• We will ensure our actions and approaches to strategic development our mapped across to the People Directorate, Place and Regional PC teams, aligning against the pillars of the People Plan. • Our actions will represent what can add value to place workforce strategies, using the representation of the WFSG to support how this develops. • We will continue to maximise the opportunities to enable workforce transformation across all Primary Care services working across our delivery partners in place and in WY. • We will ensure our aims, objectives and actions are dynamic in response to WY Operating Plans, Joint Forward Plan and national changes to Primary Care Commissioning.	WY programmes Examples include – Fellowship Programmes for GPs and GPNs, General Practice Mentorship Offer, WY Group Consultation Training, Workforce Planning working group and Nurse VTS Programme. • Ensure our outputs reach out to all Primary Care Providers for example recent Optometry working group looking at funded training opportunities.
<u>Community Pharmacy and Optometry</u> **We will work within our direct commissioning responsibilities for Community Pharmacy and Optometry to maximise those services and ensure continued access to high quality services and achieve ICS ambitions for care delivered. Our current Transformation programmes and functions across WY will be reviewed to consider the wider scope of PODs.**		
• Work towards the sustainability and greener NHS ambitions • Support the system and place to maximise the current services available and offered	• Support the ICB green plan and seek to identify and promote opportunities to support community pharmacy and optometry practices	• Developed green place for community pharmacy and optometry practices

through Community Pharmacy and Optometry practices, encouraging integration and innovation in pathways of care across neighbourhoods, place and system. • Deliver our ambition around patient engagement and insights work to enable a better understanding of views of those services and how they can be delivered in line with Population Health	• Continue to raise profile and opportunity for services offered in the community and contribute to key enabling forums such as WY Eyecare Working Group; WY Eye health Network; and engagement via ICB Clinical Pharmacy Lead and CPWY • Work with Healthwatch to identify any gaps in service provision and develop options/solutions for • consideration	• eERS enabled for all WY optometry practices • Higher education program in place to develop PC eyecare workforce • Confidence in knowing how patients perceive and use our community pharmacy and optometry services

We will continue to adapt our forward plan to ensure that we can respond to any changes to the national strategic direction of primary care, being aware of the context of national contractual changes across all Primary Care providers.

Joined up working in neighbourhoods and communities

Our Integrated Care Strategy sets out a holistic approach to improving the overall health and wellbeing of our populations and our ten big ambitions as central to this. Neighbourhoods are the building block or foundation of this strategy, is it where our approach to collaboration begins. The health and care context for neighbourhoods – in this broadest sense – encompasses the full spectrum of the wider determinants of health, such as employment, housing and the build environment, transport etc. and which will continue to be major areas of focus through the ICP and local health and wellbeing boards.

In terms of health and care, we know that keeping people well at home, enabling them to access treatment and care where they live, tailored around the needs of individuals and local communities is a fundamental cross-cutting ambition for everything we do. Core to this is the continued development of models of integrated care through integrated health and care neighbourhood teams. The capacity and ability of these teams, and the services they provide, to meet the needs of our communities underpins our ambitions to improve outcomes and tackle inequalities.

The Fuller Stocktake Report

At the heart of the national Fuller Report is a vision for integrating care, improving access, experience and outcomes for communities, based on:

- streamlining access to care and advice for people who get ill but only use health services infrequently: providing them with more choice about how they access care and ensuring care is available in their community when they need it

- providing proactive, personalised care with support from a multidisciplinary team of professionals to people with complex needs, including those with multiple long-term conditions
- helping people stay well for longer through an ambitious and joined-up approach to prevention.

Central to all the above is the accelerated development of **integrated health and care neighbourhood teams**, (INTs) which encompasses general practices and primary care networks, wider primary care (including community pharmacy, dentistry and eye care services), community health services, social care, and the voluntary community and social enterprise sector. INTs are not entirely new concepts, and there is a long history of effective models of integrated team working across different organisations, and based around local communities, within West Yorkshire that provide a good foundation to build further upon.

The approach we are therefore taking across our five places in West Yorkshire, supported at the system level, is that INTs need to develop in a way that best meets the local contexts of the neighbourhoods in which teams work. This means that there is not necessarily a single INT covering a specific local area, rather that (as described in the Fuller Report) it is a more flexible 'teams of teams' based approach. What matters is the shared purpose that brings INTs together, with an emphasis on enabling the most optimal group of health and care professionals to work together with and for patients to provide a seamless experience of care. Supporting INTs to form and work together through enabling transformations in workforce, digital and data, and estates will be key ingredients to their successful development during the lifespan of our Joint Forward Plan.

To support our five places in meeting these ambitions for INTs, the ICB established in December 2022 a new system programme board - the Fuller Delivery Board, which includes senior membership from our five ICB places plus a number of provider sector representatives from the overall ICB Board to ensure we are able to take a multi-sector approach to integrated neighbourhood development The Board's remit will be guided by our refreshed West Yorkshire Five Year Strategy, the Joint Delivery Plan and implementation of recommendations in the national Fuller Stocktake Report.

As per delegated arrangements for both primary care and community health services, the planning, funding and delivery of these services remain matters for ICB place committees. There will also be a need to work closely with other groups, such as the NHS England's Regional Primary Care Group, the West Yorkshire PCN Clinical Director's Reference Group and the West Yorkshire Community Health Services Provider Collaborative.

The Fuller Delivery Board

Our model of delegation within the West Yorkshire ICB means that the transformation and integration of local health services is led in our five places, and owned by the individual place committees of the ICB. The role of WY system programme boards is to support this work, contribute insights to our West Yorkshire strategic system executive groups and statutory committees, and provide a forum for place and system leaders to come together and collaborate on priorities and issues in line with the 'three tests' for partnership working.

A core principle of the work we take forward within the ICB, and working with our wider partners, relating to development of integrated health and care neighbourhoods (with INTs as a key component) is that we develop and implement plans together as a partnership, with subsidiarity being central to this – and the design and delivery happening as close to local communities as possible. Within that overarching approach, the ICB Fuller Board identified a

number of specific areas of focus that both build on the vision in the national Fuller Report, and which inform a shared and collective approach to how we implement the vision through the Joint Forward Plan. Specific information on the individual priorities and transformation plans for each of our five places is contained in the place plans.

Over the next five years, as an ICB and wider Integrated Care System, we aim to:

- Continue to develop integrated neighbourhood teams– supporting their development and expansion, including recruitment, retention, new roles and career pathways
- Support the on-going build of close relationships and engagement across general practices, primary care networks, community health services, social care and wider partners – facilitating approaches to care that can span in a joined-up way across an individual's clinical and wider social and wellbeing needs.
- Improve access to care – aiming to offer more same day for those with urgent needs and for those who face most barriers
- Developing our primary care and wider community-based estate, in a way that facilitates with greater scope for co-location and joint-working of teams in neighbourhoods
- Giving more power to communities, including use of resources, and strengthening partnerships with the VCSE through neighbourhood-based models of integrated care, improving working with communities on the design of local services in their neighbourhoods
- Support neighbourhood teams in tackling inequalities and addressing the priorities of Core20Plus5
- Embedding models of proactive or anticipatory care for patients and service users who may be at high risk of their health and care needs deteriorating before they reach a crisis (such as could result in an emergency hospital admission)
- Enable development of the underpinning 'infrastructure' for organisations to work together well within neighbourhoods, including estates, but also ensuring there is sufficient management and administrative capacity to support front line care teams.
- Increasing community investment, services that are sustainable, and new estates solutions

Delivering on this vision for expanded and more integrated neighbourhood-based care within communities will require concerted effort and investment by the ICB and wider partners during the life of this Joint Forward Plan. This is essential if we are both to increase capacity (whether that is in staffing, technology or estates), ensure services are sustainable, and we can help shift more care towards community and home-based settings.

Our ambition for dental services[to update following Board discussion]

The current strategy and workplan for the commissioning of dental services has been developed with the support of ICBs. Work will continue to focus on three key areas;

- A Flexible Commissioning Programme operates across Yorkshire and the Humber, aiming to improve access to dental care and to increase the delivery of evidence-based prevention in primary care, whilst supporting practices to deliver their contract commitments using the wider skills of the dental workforce.
- This approach to dental commissioning using Oral Health Needs Assessment, enables more focussed support toward delivering more preventative care, improving oral health and targeting Health Inequalities by utilizing an agreed amount of contracted activity in a more flexible way.

- The delegation of dental services presents options and effects far greater opportunities in managing any forecast reduction in activity levels and un-committed budgets.

A number of NHS England commissioned projects are already delivering improvements in access, and Health Inequalities, in addition to a number of other initiatives as follows:

- **Waiting list validation** is being accelerated in a number of practices with the intention to validate the number of and type of patient on waiting lists enabling a better understanding of provision and commissioning gaps when considered alongside the Oral Health Needs Assessment.
- **Additional sessions for providers** to accept patients either from the NHS 111 pathway or from their own waiting lists. A sessional approach is testing the opportunity for providers to see and treat high needs patient who otherwise struggle.
- **Workforce recruitment and retention** including a 'golden hello' scheme, establishment of a Tier 2 Paediatric Accredited Scheme which will support more skills mix and community-based care and continued professional development training for dental teams to support General Dental Council registration.

It is important to both patients and the profession for the ICB to maximise opportunities through flexible commissioning arrangements. This will require a judgement given budgetary constraints and financial limitations. Conversations have already commenced to explore how these and other initiatives can continue in future.

Our ambition for integrated urgent and emergency care

As West Yorkshire is a large and diverse system, a considerable amount of work happens within our local places through place based Urgent and Emergency Care boards (or equivalent). There is a well-established = UEC Programme Board with representation from our five ICB places, providers organisations, West Yorkshire Association of Acute Trusts, clinical quality and the voluntary and community sector. The Boards role is to lead and oversee transformation priorities where they meet one of the three tests of WY working.

Due to the substantial interdependencies, the West Yorkshire UEC Programme Board also promotes the objectives of urgent and emergency care across the wider Partnership.

The WY UEC Programme Board compliments the various place based UEC boards and their priorities.

The **'Delivery plan for the recovery of urgent and emergency services'** (UEC Recovery Plan, January 2023) sets out ambitions for integrated care systems to develop a system that provides more, and better, care in people's homes, gets ambulances to people more quickly, sees people faster when they go to hospital and helps people safely leave hospital having received the care they need.

Our five-year vision and ambitions for urgent and emergency care

Our vision for urgent and emergency care is:

- for those people with **urgent but non-life-threatening needs** - providing highly responsive and effective integrated urgent care services in the community, where more care is delivered either at home or close to where people live, reducing the need to travel to hospital, and disruption and inconvenience for people

- for those people with **more serious or life-threatening emergency care needs**, we aim to support people in the most optimal settings (such as a hospital's A&E Department) with the appropriate expertise, processes, and facilities to maximise a good recovery.

The overall priority of urgent and emergency care is to ensure people can access the right care, in the right place at the right time. This ambition cannot be met by any one organisation in isolation and we recognise that the solutions require system partners to collaborate in order to integrate care for the benefit of our patients.

Access to urgent health and care services

There are too many entry points into the unplanned care system which causes confusion for staff and the public. We know that people understandably often present at the service they are most familiar with, which may not necessarily be the service that could most appropriately meets their needs. Health and care colleagues also report that the unplanned care landscape is difficult and complex to navigate. Whilst we have made significant improvements supporting people to access services and in ensuring consistency in messaging, we need to continually improve communicating what is available to who and when.

Calls to NHS 111 and accessing NHS 111 online will be instrumental in achieving this ambition. We will continue to invest in call handling and clinical advisors within NHS 111 to ensure people get a prompt response and work with partners to make sure that services are available and access to them is easy for patients and healthcare professionals alike. We will also ensure that there is continuous improvement to the Directory of Services and ensure NHS 111 and other points of contact for patients, has the best quality of information available about all our services to help get people to the right service to meet their need.

We will work with Yorkshire Ambulance Service, our regional provider of NHS 111 to maximise integration with urgent care services and directing patients to the right service or care advice both across West Yorkshire and through place-based initiatives.

We work as a single team across the partnership and other providers to deliver consistent and easy to access messages to our public to help them make the right choices. We do this using data and feedback from our public to make this meaningful. Recent examples of this have been the approach we have taken to share information around bank holiday periods and periods of industrial action. This consistency of approach helps provide clarity to our population whether they live in Bradford of Wakefield, etc.

Our messages remain consistent across West Yorkshire as we highlight the alternative methods of accessing health and care and to only use A&E Departments for serious injury or a life-threatening situation. We also align our work to national campaigns (e.g., "Help Us Help You") and amplify and support these messages regionally and across our places.
We have reframed communications so people consider alternative options rather than the first option of 'call your GP' this includes prompts and reminders of how community pharmacy can help, avoiding people calling already busy telephone lines. Promoting digital alternatives allows people to see what self-help support is available and the alternative ways there are of using and contacting health services.

The winter period is always challenging as demand for services tends to increase significantly with the onset of cold weather, flu and other seasonal illnesses. The "Together We Can" campaign promotes simple, consistent messaging in a variety of languages and formats. It encourages people to choose well and to opt for convenient self-care, where safe to do so

during the winter months and ensures people understand which service to use, for example when they should use NHS 111 or go to their local pharmacy or their GP practice.

Urgent and emergency care communications
'Together We Can' (TWC) is West Yorkshire's long term campaign to minimise pressures on urgent and emergency services. This is the second year the campaign has been rolled out as an area wide winter campaign. The signposting campaign has been built on data, insight and user testing. Campaign creatives were updated to reflect the current climate and learning from the previous year. The aim of the campaign was to encourage people to use health services responsibly during what was expected to be another challenging winter for NHS services.

The Together We Can winter 2022/23 campaign evaluation is available to view here.

Integrated same-day urgent care response
Delivering the ambitions of the national UEC recovery plan will mean supporting more patient-centred personalised care, accessed closer to, or at, home – as part of more integrated urgent care services – working together across organisational and team boundaries. This is about ensuring that an individual's urgent care needs can be met in a timely way from the most appropriate service – ranging from lower acuity episodes that could safely be handled same day within primary care (including through enhanced access), through various models of urgent community response and urgent treatment centres, virtual wards, to (where most appropriate) hospital-based and ambulance services.

To achieve this, there will be further developments to knit together the spectrum of services that provide a form of urgent or same day response, streamline and simplify access points, and that the workforce and digital architecture is in place to ensure capacity and supply as far as possible meets anticipated demand.

Acute emergency care
Reforming acute emergency care helps improve good patient flows, which is central to patient experience, clinical safety and reducing the pressure on staff. Whilst most of this work happens in our five places and through A&E Departments in our main hospitals, supported by the ambulance service, our collaborative work on Same Day Emergency care aims to align with Place initiatives through Place Based UEC Boards and local provider relationships and partnerships. Although our ambulance service is regionally provided, they are embedded in our places and work with providers to integrate patient pathways, care and treat people in the community and signpost patients to other appropriate services to meet their needs.

Our planned actions for the next two years (2023/24 and 2024/25)

In addition to the overall approach, we intend to implement over the next five years described in the previous sections, the **national UEC recovery plan** will require sustained focus on several key areas over the next two years. This is specifically on:

Increasing capacity – investing in more hospital beds and ambulances, but also making better use of existing capacity by improving flow:

- Increase capacity in hospitals
- Increase in ambulance service capacity
- Improving processes & standardising care

Growing the workforce – increasing the size of the workforce, and supporting staff to work flexibly for patients

- Increase workforce size and flexibility

Improving discharge – working jointly with all system partners to reduce lengths of stay when people are in hospital and strengthen discharge processes, backed up by more investment in step-down and social care, and with a new metric based on when patients are ready for discharge, with the data published ahead of winter

- Improving discharge
- Scaling up Intermediate Care
- Scaling up social care services

Expanding and better joined up health and care outside hospital – stepping up capacity in community-based care, for example including primary care access, integrated neighbourhood teams, urgent community response services and virtual wards, so that people can be better supported at home and in the community for their physical & mental health needs, avoid unnecessary admissions to hospital

- Expanding and better joining up care outside hospital
- Continuing to develop virtual wards

Making it easier to access the right care – ensuring healthcare works more effectively for the public, so people can more easily access the care they need, when they need it.

Each of our five places has their own programme of recovery and transformation work and are responsible for identifying clear trajectories for delivery against the national UEC recovery plan. As such during 2023/24 across West Yorkshire we will:

- Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
- Improve category 2 ambulance response times to an average of 30 mins across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
- Monitor our collective adult general and acute bed occupancy to move us towards the operational planning target of 92%
- Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard.

Our healthcare providers are implementing or continuing with initiatives to improve flow and patient experience in A&E including:

- Senior decision makers at “front door” triage
- Further development of lower acuity streaming services within A&E to advanced care practitioners and GPs (to support people receiving the most appropriate care to meet their needs)
- urgent care centres for low acuity walk-in presentations
- robust communication campaigns for example the West Yorkshire ICB “Choose Well” campaign promoting where people can access the right care
- Through the Yorkshire and Humber Care Record (YHCR), the Yorkshire Ambulance Service is connecting to share data collected by paramedics at scene with A&E staff when care is transferred to the hospitals. This will ensure a seamless process of sharing key data and streamline the time to handover.

We will support the collaborations and partnership working across Yorkshire Ambulance service, acute, community, primary care and VCS providers to improve the Category 2

response and achieve the 23/24 standard average 30 mins in 23/24 and further improve this in 24/25. This will include ensuring:

- Increased capacity and accessibility into urgent care services in the community
- Increased signposting and referrals direct from ambulance service into urgent community, mental health and primary care services at the point of call and/or following clinical triage of the patient (virtual or face to face)
- Reduced number of delays at hospital by reducing overall turnaround times with specific targeted improvement work at hospitals with the greatest opportunity as well as review turnaround processes to achieve overall improvements and consistent standards across the region
- Upscaling provision of SDEC, simplifying and enabling and improving direct access into these services from the ambulance service
- Maximise availability of the workforce by reducing unwarranted variation in absence levels through targeted interventions in YAS, developing workforce opportunities and improving workforce health and wellbeing
- Optimising the skills of the workforce to ensure patients health and care needs are met, including developing new roles, blended and rotational workforce models.
- Address and tackle the impact of health inequalities to improve the health outcomes of patients and optimise the use of services
- Improve the response for mental health patients who contact 999.

To support the achievement of the 76% A&E standard acute trusts are required to operate with an overall bed occupancy of 92% to ensure system flow is maintained. Currently we are forecasting a year end position of 96.6%. The national target for the 4-hour A&E standard has been set at a yearend achievement of 76%, currently 2023/24 operational plan projects a 77.1% achievement (March 2024). All trusts are confirming they will achieve the 76% by year end. This will be supported by the joint and collaborative work with Yorkshire Ambulance service to maximise the use of urgent care pathways and improving the appropriateness of conveyances direct to A&E.

Our current position across both the A&E standard and bed occupancy will be further impacted once all our mitigations have been considered and the additional capacity schemes funding has been confirmed. There is a range of proposals that have been submitted by the places within West Yorkshire that will see a bed increases in both acute and community settings bed and further investment in-services to support admission avoidance and ensure people access the most appropriate services to meet their needs.

West Yorkshire Urgent and Emergency Care (WY UEC) Programme Board priorities

The WY UEC Programme Board has also agreed three key areas it will focus on over the next two years. This has been informed through a refresh of the work previously been led through the WY UEC Programme and also the UEC Recovery Plan with a focus on those things that will have the biggest impact to enable patient to access care first time and in the right place.

West Yorkshire urgent care services review

We will be reviewing service provision and commissioning of out of hospital UEC care to ensure that:

- The Primary Care Out of Hours service is fit and future proof, integrated with WY and local health systems and that a sustainable WY Clinical Assessment model is incorporated in the service.
- There is system wide ’strong –seamed’ flow of patients

- Delivers local provision provided at place to address local need

A significant part of this review will be the West Yorkshire Primary Care Out of Hours work. This is delivered through a contact centre, and 12 primary care centres (PCCs). These services incorporate GP out of hours clinical assessment and treatment, home visiting services, urgent treatment services, and contacting patients out of hours to inform them of pathology results.

During the time of the Covid pandemic we also developed the WY clinical assessment service (WY CAS) for callers to NHS 111 who have been assessed by NHS 111 as having a one or two hour need to be seen by a GP service. Patients are usually referred to the contracted service via NHS 111. They are then triaged by via a telephone assessment. Patients receive a telephone assessment/consultation and where required are then directed to the most appropriate course of action, such as a face-to-face consultation or a home visit with a clinician or referral to another, more appropriate service.

The NHS 111 Online Emergency Department (ED) Validation was set up as an additional service with the WY CAS, which validates the ED disposition (when the patient has been advised to attend an A&E) reached by patients using the NHS111 Online tool and for specific groups, offers an urgent care alternative via telephone consultation. Where these patients require face to face treatment other than ED, this is provided via booked appointments at an urgent treatment centre or walk-in centre, the out of hours service, or self-care advice.

Some place-based activity is also part of the review, such as the Safe Haven services for patients in the Calderdale and Kirklees areas; Urgent Treatment Centres in Leeds and Wakefield; and the Urgent Care Rapid Response in Kirklees and Calderdale areas.

To deliver this wide number of services Local Care Direct Limited, who provide all of these services employ a range of staff. These include call handlers, reception staff, duty managers, area managers, operational leads, drivers, and advanced nurse practitioners.

Same day emergency care

As all same day emergency care services (SDEC) are being implement in each of our places we are taking a co-ordinated approach to SDEC pathways across WY with similar inclusion criteria where possible. This is to ensure we develop and expand SDEC services with direct referral pathways to ensure patients get the right care in the right place first time and to reduce avoidable ambulance conveyance to Emergency Departments and reduce hospital handover delays. This will also include access by primary care.

Supporting Yorkshire Ambulance Service NHS Trust transformation

We are taking a co-ordinated approach to working with our colleagues in both the 999 and NHS 111 services to produce:

- Integrated work plans to ensure joined up delivery of initiatives and projects both across WY and at place in line with strategic direction, local priorities and planning
- Scoping work with wider partners and places with a focus on key initiatives which aim to improve Category 2 ambulance call out times as set out above
- Focus on urgent care pathways and services such as Urgent Community Response to avoid conveyance to A&E Departments
- Implement urgent and emergency mental health response programme for NHS 111 and 999 service in partnership with the Mental Health, Learning Disabilities and Autism programme.

Whilst the three workstreams above will be the main focus of the WY UEC Programme, we will also work with our system partners to develop and deliver other critical system UEC priorities which will improve patient access to services – these include:

Mental health
The UEC Recovery Plan sets out a commitment to provide better and more timely access to mental health support, in particular to ensure **urgent mental health support** will be universally accessible by using NHS 111 and to increase the number of Mental Health Response Vehicles (MHRV) as part of the ambulance fleet. Work is already underway on these initiatives through a collaboration between YAS and the Mental Health Programme but will require continued commitment and wider system support to ensure sustainable solutions supported through investment and workforce.

Non-emergency patient transport services (NEPTS)
Non-emergency PTS is a crucial part of our UEC service provision and contributes to delivering a wide range of system priorities such as elective care recovery, discharge and supports the most vulnerable patients (cancer and renal patients) to get the care they need. The WY UEC Programme has been supporting a review of PTS services across West Yorkshire to determine the future commissioning model which reflects changes in the nature of the services required (such as demand, acuity of patients and increased cost) and also reflects national guidance in relation to eligibility with the ambition of commissioning services across the WY ICB footprint (and potentially across Y&H) to deliver a sustainable service for the future. This will take into account service changes and the need to provide a flexible service model, for example, transfer of care hubs, service configurations involving step up and down provision ensuring patient flow in and out of hospitals and between services as required.

Tackling health inequalities and unwarranted variation
We know that some groups of people face particular barriers to getting the services that they need. We also see ‘high intensity use’ of emergency services amongst certain groups due to the lack of access to more appropriate care pathways. Whilst there are good examples of where we are undertaking initiatives to address this, there is still more to be done. In partnership with the West Yorkshire Academic Health with the Yorkshire Academic Health Sciences Network (YAHSN) have commissioned a project to understand the correlation between ambulance conveyances & deprivation (Wakefield), in each place partnership with system level co-ordination and support.

Whilst much of the delivery of UEC priorities will happen within our places the WY UEC Programme has a key role in ensuring that we capture learning so that we can share good practice to ensure each of our places to avoid unwarranted variation in the local services and UEC pathways that are being implemented.

How we will deliver
Given the broad scope of the national UEC Recovery plan it is imperative that we build on our collective approach across the ICB and wider region aligning governance structures and transformational workstreams to support improvements, productivity whilst improving the outcomes and experience of our people.

The WY UEC Programme will support local partnership arrangements to deliver place-based plans with a clear understanding of what is being delivered at Place Based UEC Boards and ensure alignment with the priority areas of work for the WY UEC programme.

To ensure we are focussing our collective resource and capacity in the right place we will scope the breath of the current operational and strategic work that contributes to the delivery of the plans recognising the maturity in some areas that work already underway prior to the publication of the UEC Recovery Plan. This is a complex landscape and key to delivery in how we identify the various interfaces and assess the impact of each area on each other to delivery streamline pathways that deliver the right care in the right place in a timely way.

Yorkshire Ambulance Service NHS Trust (YAS) has a footprint across West Yorkshire, Humber & North Yorkshire, and South Yorkshire Integrated Care Boards. An Integrated Commissioning Framework has been established to support the commissioning functions for the YAS services. This arrangement enables a co-ordinated approach across the 3 ICBs and YAS for the commissioning of services provided by Yorkshire Ambulance Service. West Yorkshire ICB hosts this arrangement which is supported by a memorandum of understanding across all partners, which defines the scope and responsibilities. The ambition is to establish a joint committee and agree delegated responsibilities from the three ICBs in 23/24 with a view to establishing the formal committee by April 24/25.

This arrangement is underpinned by a governance arrangement which enables robust oversight and co-ordination of commissioning functions; operational and strategic planning, contracting, quality and financial allocations. This provides a mechanism to support the delivery of service delivery and transformation initiatives, through commissioning and promotes the 'Duty to Collaborate' introduced in the Health and Care Act 2022.

Supporting people leaving hospitals and developing integrated step-up and step-down intermediate care services

To meet the health and care needs of the population of West Yorkshire, it is essential we proactively support people to stay healthy and well at home and in the communities where they live wherever possible, and that we organise services in a way so that people receive care at the right time and in the right setting for their needs. Our approaches to integrated neighbourhood teams and integrated urgent care are major components of this. It is also essential that there are seamless transfers (or transitions) of care when someone moves between care settings (such following a hospital stay back to their own home). Although we have made considerable here progress over recent years, we know that there are many instances where across West Yorkshire we could, both improve these transitions – so the care experience feels more seamless to patients and service users – but also ensure if someone does require additional health and care support, it happens in the optimum setting.

Both unnecessary emergency admissions into hospital and unnecessary delays in being discharged from hospital does not result in the best outcomes for people.
Evidence shows that it is better for people, and more cost effective, where clinically appropriate, to spend as short a time as possible in hospital, and to avoid going into hospital when healthcare can be delivered safely in the home environment. To support developments in this area across our Partnership, complementing the wider developments on urgent and emergency care described in the previous section, we have established multi-sector arrangements to explore the next steps in developing the strategic aims and vision for discharge and intermediate care, with a focus on provision of care in communities including social care.

The workstreams and working groups we have for this at system level complement similar arrangements that exist in our five places. A significant amount of development and

investment in these areas also happens through the Better Care Fund, for which each ICB place develops a local plan jointly with their local authority partners.
Our ambition is that we ensure the right care at the right time in the right place with a focus on improving the outcomes and experience of discharge and looking more holistically at integrated models of intermediate care. Our challenge in this work is to develop models of care that support people to be discharged to the right place, at the right time, and with the right support that maximises their independence and leads to the best possible sustainable outcomes and experience. It does not just involve our hospitals, but all elements of primary, community and social care.

Our approach includes:

- A clear recognition by all stakeholders of the safety benefits to both people, staff and organisations of a timely and sustainable discharge
- Despite significant operational pressures, there is strong commitment and wide engagement across ICS, systems, providers and a focus on the prioritisation of resources to support areas of most need embedding the 'Home First' approach
- Our proposed approach is to support improved outcomes, experience and performance across health and care services.
- This will be based on verified outcomes using data, evidence, input from across the system striking a balance between place, ICS and region.

The conditions for success for us to achieve our ambition will centre on a focus on an end-to-end pathway, looking at the patient holistically at the centre. Part of this involves considering our future models of integrated intermediate care. This often refers to a short-term, multidisciplinary service that provides support to people who have been in hospital or who are at risk of hospital admission - helping people to recover or rehabilitate at home, or in the community. They are usually provided by a range of NHS, local authority and independent care sector services and should be underpinned by the “home first” principle.

We need to continue the ‘home first’ approach, ensuring that we have both the capacity and capability in communities to facilitate this, this will need to be resourced in financial and workforce terms. To support this work we will need to rebalance our investment across the system (including in social care) so that we have sustainable community capacity that supports people to live well in their own homes (such as virtual wards as described further below). A number of places in West Yorkshire are already considering their long term economic and workforce models for reshaping intermediate care services, which are described in more detail in the local place plans within the overall JFP.

A relatively recent development within intermediate care has been the growth of virtual ward models of care. These support patients who would otherwise be in hospital to receive care, monitoring and treatment at home or place of residence. This is intended to help prevent avoidable admissions, support earlier discharge, and potentially help contribute to freeing hospital bed capacity for other purposes such as elective recovery. National guidance from NHS England states that “a virtual ward is a safe and efficient alternative to NHS bedded care that is enabled by technology”.

There are two main types of virtual ward

- Remote: based on technology-enabled remote monitoring and self-management.
- Face-to-face (‘Hospital at Home’): based on a blended model of technology solutions and in-person care from health professionals, delivering sub-acute level interventions at home. Although these are community models, these are hospital consultant-led ‘virtual wards’.

In 22/23, NHS England set out that all integrated care systems in England should develop and increase virtual ward capacity, with an initial focus on care for those with frailty and with respiratory conditions. National support funding was provided to all ICSs to help with workforce costs and also for additional enabling technology. As per our ICB's delegated operating model, the development and implementation of virtual wards is led in our five places.
We know that we will need to have continued focus and momentum on the delivery of operational and longer-term transformational change, with a willingness to challenge, be challenged and share good practice. This will require our plans to be co-owned with the support of senior leadership and engaged staff on the ground to drive forward and embed change

Whilst this work will evolve over the coming months, we have an initial ten-point plan for 2023 which includes:

- Exploring the use of our resources across the system differently
- Exploring new approaches to our workforce
- Seven-day discharge
- Looking at the work and resources in the context of capacity and demand of the whole pathway
- Building a strong approach to data quality and understanding variation
- Considering work based on a population approach, looking at specific groups
- Maximising virtual care/wards
- Maximising anticipatory care
- Building work into our place-based plans
- Sharing good practice, developing a resource catalogue

Our ambitions to recover and transform planned care services

The planned care programme encompasses elective recovery, the programme of work to tackle the backlog of planned care appointments and procedures following the coronavirus pandemic; transformation of planned care pathways and services; and clinical threshold policy harmonisation to remove variation in access to services that exists as a result of different policies which existed in the five places of the ICB prior to its establishment on 1 July 2022.

The services that are covered by the planned care programme for transformation are those which are identified by the five places of the ICB, the West Yorkshire Association of Acute Trusts (WYAAT) and wider partners from the integrated care system (ICS). Governance of the programme is through the WYAAT programme board, with elements being governed through the Transformation Committee of the ICB where they relate entirely to commissioning decisions.

Elective recovery
Elective recovery meets all three of the criteria for working at West Yorkshire-wide level. Recovery of constitutional targets for waiting is a wicked issue and requires collaboration between our acute providers and places in order that the ambitions can be achieved, and sharing of good practice in ways of working within the trusts enables change and improvement to happen more quickly. The flexibility in use of resources across trusts and the independent sector has supported patients to be offered treatment at alternative providers. It is this collaboration which has enabled West Yorkshire to perform so well in reducing the waiting times for people who had been waiting more than 104 weeks by December 2022, and then 78 weeks by March 2023.

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We have established seven clinical networks in surgical specialties through which we will drive our work to implement the Getting It Right First Time (GIRFT) recommendations for theatre productivity and clinical specialty transformation through rapid adoption of best practice across all our acute hospital providers. We will establish further clinical networks in our most pressured medical specialties to support our clinical staff to work collaboratively across the whole of West Yorkshire to ensure people in all of our places receive treatment in the timeliest way possible. These actions will help us to ensure patients see the right clinician the first time so no appointments are 'wasted' and we can see and treat more people with the existing teams and resources that we have.

A large proportion of our waiting list is for outpatient appointments. Our outpatient transformation work is based on sharing best practice between places and providers to deliver improvements at pace. Each acute provider has its own, well defined projects which address the core priorities in the way that is best for that place, but all are working towards the same core ambitions of: ensuring no one is waiting for outpatient care for more than 65 weeks by the end of March 2024; that where clinically appropriate patients initiate their own follow up if they have concerns, rather than being routinely expected to attend for follow up; and that routine follow up appointments are significantly reduced (by approximately 25%), freeing up these appointments to be used to see people who are still waiting to be seen for the first time.

Delivery of elective recovery plans will be approached with a focus on Health Inequalities by looking at our waiting list with a focus on people living in more deprived areas, ethnicity and people who have a learning disability lenses. These will be reviewed on a regular basis to ensure that delivery of elective recovery objectives does not exacerbate existing health inequalities and that future developments aim to reduce these.

All places as part of their place based planned care programmes are working on approaches to supporting people who are waiting for elective care. These are planned and delivered at place, tailored to the needs of the local population. As they develop these approaches will be targeted to address the needs of those who need them most, and to help reduce health inequalities or prevent the inequality growing through the long waiting period. These include schemes for waiting well and preparing for surgery including initiatives with the voluntary sector in Leeds and a pilot for a cohort of cancer patients to have remote health coaching and support as they prepare for surgery. Shared decision making and personalisation of care are embedded across the ongoing service development work in all places and in the programmes of work and place planned care teams are proactively working on initiatives to improve this in elective recovery.

There will still be a small number of people in West Yorkshire who have been waiting more than 78 weeks for surgery after March 2023 where patients are unable to be treated at another hospital site. These patients will be treated as soon as possible after March.

In 2023-24 our ambition is to continue to increase productivity and treat more people, so that by the end of March 2024 no-one in West Yorkshire will have been waiting for treatment for more than 65 weeks following referral. We will also continue to work to develop and grow the planned care workforce, so we have sufficient, skilled clinical staff to deliver the care required by our population.

Eye care services transformation

For a number of years we have been leading a programme of work across West Yorkshire to improve eye care services. With an aging population the demand for eye care is rising faster

than many other specialities, and a national shortfall in the number of ophthalmologists meant that a different approach to managing care was required. This programme will draw to a close during 2023-24 as the final objectives and deliverables are achieved including: complete implementation of electronic referrals in eye care services; final proposals to provide a greater range of assessment and monitoring of eye conditions in the community; and public facing tools and resources to help people look after their own eyes.

Reducing differences in access to services policies
A proposal for harmonisation of some clinical policies across West Yorkshire has been developed over the past year and will go forward for public involvement and consultation early in the 2023-24 financial year. Harmonising policy removes unwarranted variation, improved health outcomes by ensuring care is evidence based, and improves patient experience. We anticipate making a decision on these clinical policies in October 2023 after feedback from the public has been heard and responded to. Work will continue throughout the year and into 2024-25 to harmonise any remaining policies where geographical variation exists within West Yorkshire.

Pathway and service transformation
As the work on eye care services draws to a close, the planned care programme board will identify future priorities for transformation, and another clinical speciality improvement programme will commence. This will based on those challenges which meet one or more of the three tests for working together across West Yorkshire. Over the period of the Joint Forward Plan we would anticipate two further programme of clinical speciality transformation.

Deliverables
Elective recovery

- No patients waiting more than 65 weeks from referral to treatment by March 2024.
- Increased elective activity to 108% of 2019 baseline
- 85% of elective procedures done as day case procedures
- 85% touch time in operating theatres
- No patients waiting more than 52 weeks from referral to treatment by March 2025.
- 5% of patients on patient initiated follow up pathways by March 2024.
- Outpatient follow up activity reduced by 25% by March 2024.

Eye care transformation

- Implement EeRS in all West Yorkshire Acute Providers
- Eye Health animations for children and adults
- MyEyeHealth web portal for access to information and resources

Policy Harmonisation

- First tranche of policies agreed and harmonised across West Yorkshire
- Second tranche of policies prepared for agreement in late 2023/4 or early in the 2024/5 financial year

How we will embed personalised care

As a Partnership we continue to embed personalised care into all our services and plans. We already have a long history in delivering personalised care in West Yorkshire, having already achieved the following over the last four years:

- 416,000 personalised care interventions;
- 114,000 patients have had shared decision making conversations;
- 191,000 personalised care and support plans developed; and
- 4800 people trained in personalised care.

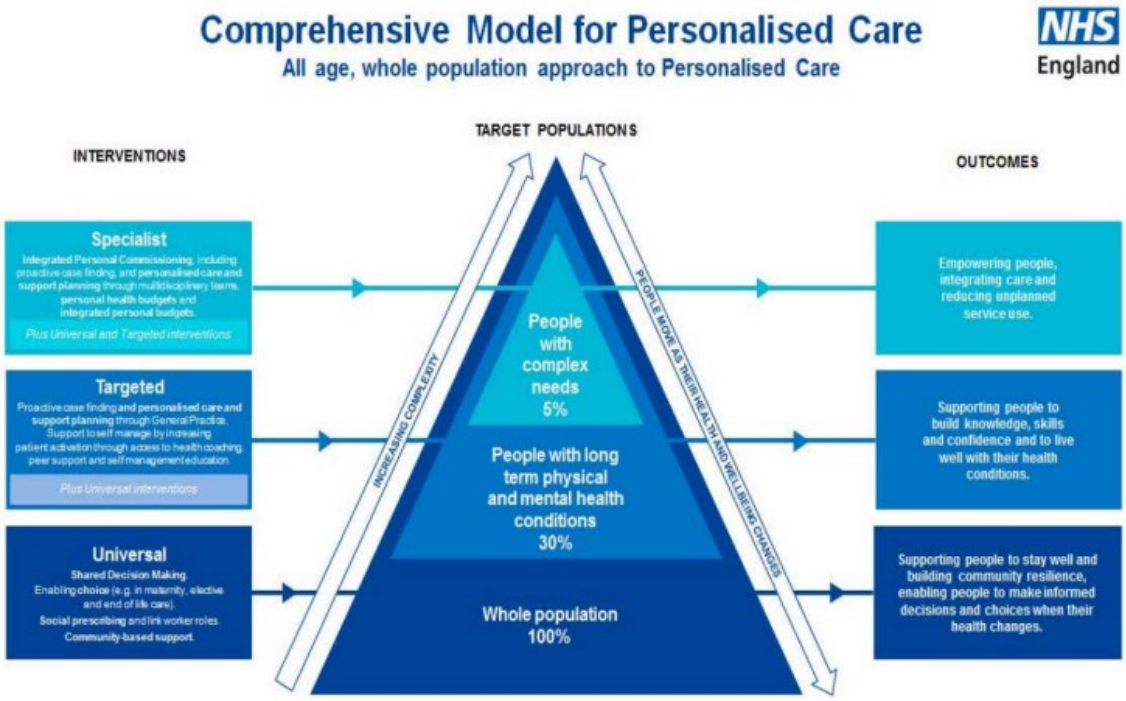
We know however there is much more we can do to give people choice and control over their mental and physical health. Our vision is that everyone in West Yorkshire to be able to access high-quality health and care services that have been codesigned to take account of lived experiences and personalised through shared decision-making. The care will be responsive to health inequalities, trauma informed, and respectfully delivered, resonating with what matters most to the individual, their family and unpaid carers, and in support of the community connecting them.

A one size fits all health and care system cannot meet the increasing complexities of people's needs and expectations and personalised care provides the opportunity to better meet those needs. We also know that training in personalised care approaches, builds confidence in the workforce.

That training supports the development of Personalised Care and Support Plans (PCSP), which must meet the 5 criteria below:

- People are central in developing and agreeing their plan and who is involved in their care
- People have proactive, personalised conversations which focus on what matters to them
- People agree the health and wellbeing outcomes they want to achieve, in partnership with the relevant professionals.
- Each person has a sharable, personalised care and support plan which records what matters to them, their outcomes and how they will be achieved
- People are able to formally and informally review their plan

Personalised care in practice with an all age, whole population approach, can be seen illustrated in the diagram below.



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Social prescribing is a key component of universal personalised care. It is an approach that connects people to activities, groups, and services in their community to meet the practical, social and emotional needs that affect their health and wellbeing.
Social prescribing is an all-age, whole population approach that works particularly well for people who:

- have one or more long term conditions
- who need support with low level mental health issues
- who are lonely or isolated
- who have complex social needs which affect their wellbeing.

In the NHS Long Term Plan, NHS England committed to building the infrastructure for social prescribing in primary care and embed social prescribing and community-based approaches across the NHS.

Unpaid carers

We are committed to continue to support unpaid carers across West Yorkshire with an aspiration 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.

Increasing awareness and support for young carers
We will continue to support young carers being identified especially those who come into contact with NHS 111 and Yorkshire Ambulance Service. We will continue to build awareness of young carers through training resources for staff in education sectors alongside develop young carer champions in schools. We will continue to promote digital app resource created for young carers to enable them to access resources to support them in their caring role and focus on supporting young carers transitioning into adulthood.

Improving the lives of working carers
We will support health and care organisations in West Yorkshire ICS to sign up to Carers Accreditation alongside embedding developed managers guidance to support local policy around supporting working carers. We will continue to promote the health and wellbeing of working carers including those from diverse backgrounds. We will continue to develop targeted communications and resources to increase our reach and identify more working carers.

Better recognition and support in primary and community care
We will improve how we identify unpaid carers and strengthen support for them to address their individual health needs. We will do this by embedding our developed primary care resource packs to increase identification including consistent clinical coding. This work will be further promoted locally by a network of carer champions. We will continue to work with our vaccinations group to champion and ensure carers maintain priority status for vaccinations across the region.

Working with our hospitals
We will develop an offline and digital contingency plan which links to Yorkshire & Humber Care Record to ensure contingency plans can be recorded and accessed in the event of unplanned situations requiring urgent care replacement. We will develop a West Yorkshire toolkit to support unpaid carers being involved in discharge pathways across NHS Trusts to support timely discharges for the people they care, being involved and prepared for meeting their needs.

Recognising carers as experts in care
We want our workforce to continue to recognise the expertise of carers. Through training and resources to encourage better conversations with carers and their loved ones, acknowledging their role in the triangle of care.

Supporting the mental health/wellbeing of carers
We want to enable patients and their carers to better manage their health and wellbeing. Working with Mental health Trusts and VCSE organisations, we will develop a suite of resources focusing on mental wellbeing support for carers. We will engage with communities to better understand the impact of caring on mental health with a focus on learning disabilities and ethnic minorities to improve outcomes for carers.

This work will be measured in a variety of ways, the number of staff trained, registered working passports, organisations signed up to Carers Accreditation, carer champions within schools, coded carers within primary care, registered contingency plans, engagement statistics of digital app, alongside case studies of carers sharing their lived experiences.

Working in Partnership with the VCSE (Voluntary, Community and Social Enterprise Sector)

The West Yorkshire Integrated Care Strategy 2023 sets out our vision for health and care which places prevention, tackling inequalities and improving health and wellbeing at its centre. The role of the VCSE is fundamental to the delivery of this vision. One of West Yorkshire Health and Care Partnership's key strengths is having a vibrant, diverse, and dynamic VCSE sector. The Third Sector Trends Survey 20231estimates that there are:

- 13,987 VCSE sector organisations
- 31,875 employees delivering 52.4 million working hours a year
- 132,214 volunteers giving at least 9 million hours
- A direct economic value of £1.4 billon and a total estimated value of £5.4 billion when considering added and social value2 .

Across West Yorkshire, there are many examples of collaboration between the VCSE sector and statutory health and care partners leading to positive health and well-being outcomes for our population. Nationally, the West Yorkshire Health and Care Partnership is recognised as leading the way in our work with the VCSE and how we have embedded the sector within our governance and decision-making structures, our plans and strategies, and in how we work together to tackle health inequalities and improve the health and well-being of our population. Rooted in our communities, our VCSE organisations are trusted, connected and understand, and respond to local needs.

Our approach
- We reflect the VCSE sector through being flexible and adaptable.
- We promote the authentic, community-based nature of the VCSE and share best practice, innovation, and ideas from the sector with health and care colleagues.
- We communicate openly with all stakeholders at ICB and place levels and do our best to engage the wider VCSE, including smaller, community organisations, across WY in our work.
- We respond to changing population health needs and priorities and work to ensure continued and increasing collaboration between the VCSE and health and care partners at neighbourhood, place, and partnership levels to reduce health inequalities.

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- We build on community assets and place-based development and delivery and ensure the diversity of communities in WY is represented in all we do.

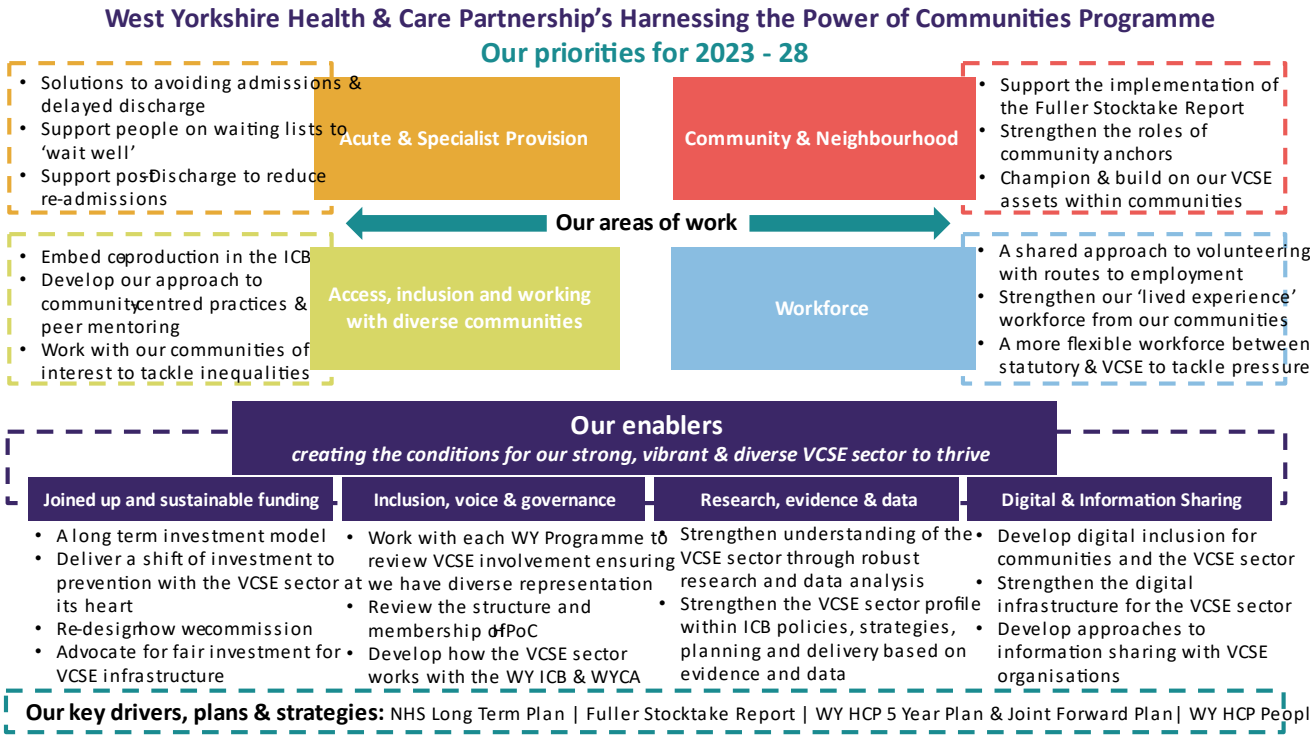
Vision: *For vibrant, sustainable, and resilient communities across West Yorkshire where citizens, the VCSE sector and partners come together to plan, develop, and deliver innovative solutions to improve population health and wellbeing and reduce inequalities*

Ambition: *To establish the VCSE sector as an equal health & care partner in co-creating and shaping strategies, plans and services and delivering improved health and wellbeing for our populations enabled by long term joined up investment to deliver consistent, sustainable solutions to reducing health inequalities*

Throughout everything we do… we work alongside our health and care partners to ensure the VCSE sector are fully part of our approach to tackling rising poverty, the cost of living crisis and climate change

As part of the West Yorkshire Integrated Care Strategy and development of the Joint Forward Plan, HPoC has worked with stakeholders to identify 4 key priority areas for specific focus over the next 5 years, to add value and maximise impact. These are:

1. Acute & Specialist Provision
2. Community & Neighbourhoods
3. Access, inclusion, and working with diverse communities
4. Workforce



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Priority 1: acute and specialist provisions

Across the Partnership, there is a range of strong VCSE activity with a clear evidence base for delivering specialist work including preadmission and those on waiting lists, supporting discharge, and rehabilitation, specialist services and support including for specific long-term conditions. These complement statutory provision often easing pressure on acute and specialist services whilst providing support and care for patients. This includes communities with protected characteristics and those least likely to access statutory services. HPoC will work with the appropriate System level programmes and with Places to build on existing good practice, harness innovation and strengthen collaboration to positively impact on patient health and well-being, specific system pressures and support alternative (often non-clinical, community-based approaches) or provide solutions in the face of growing workforce pressures and system demands.

Priority 2: Community and neighbourhoods

Our local VCSE are often rooted in communities and trusted by them, and much of their work is at a community and neighbourhood level, often focused on minoritised communities. They deliver a diverse range of early help and prevention activity, close to where people live which crucially helps people to stay well for longer and builds resilience. This work builds on the assets in our community and shifts power in a way which emboldens people and communities to take ownership for their own health and wellbeing. It is the work that creates health and wellbeing and addresses the wider determinants of health rather than solely providing services to those who are unwell. The VCSE work at this level contributes to a range of WY ICB programmes and has a clear and close alignment to the Fuller Stocktake, Hewitt Report, Primary Care and Improving Population Health programmes. It is also key in terms of the WY response to the cost-of-living crisis and health inequalities.

Priority 3: Access, inclusion, and working with diverse communities

Our grass roots organisations reflect the diversity of the communities they serve, helping our ICB reach those least likely to access statutory services. Their voice and influence are critical in ensuring we shape and deliver accessible, inclusive services and support to those who often experience the greatest health inequalities.

In HPoC we use co-production as a key aspect of our approach to ensure community and VCSE voices are heard and help shape services. We are committed to embedding this across the WY system as part of building a community powered health and care system.

Priority 4: Workforce

Current workforce challenges across our Partnership and nationally, including recruitment and retention, and staff health and well-being are shared by the VCSE, but the sector also faces challenges due to short term funding leading to fixed term contracts, low pay and high demand for services.

Inclusion of the VCSE workforce – including volunteers – is critical in identifying ways forward to tackle current workforce challenges. There are opportunities to create different pathways to employment, to enable movement across sectors, to align our work with volunteers across the Partnership and to ensure when we commission the VCSE, we pay a fair wage and support our VCSE colleagues with access to training and development and well-being support.

How we support delivery of our plans – creating the conditions for success

HPoC have also identified key enablers which create the conditions for a strong and sustainable VCSE sector in West Yorkshire enabling it to maximise its contribution and impact towards our Integrated Care Boad ambitions for our population.

These enablers include:

- Joined up, accessible funding for the VCSE
- A shift of investment to prevention
- Strengthening VCSE involvement across the ICB governance structures
- Developing, testing and sharing a set of measurement tools
- Contributing to VCSE research and data analysis to inform decision making

Priority areas for improving outcomes

Maternity services

The West Yorkshire and Harrogate Local Maternity and Neonatal System (LMNS) has an ambition to continually ensure maternity and neonatal care is personalised, safe and delivered by kind, competent staff across the whole maternity and neonatal pathway including prevention. The LMNS plan has been developed by women and staff across West Yorkshire and Harrogate and outlines how we will deliver transformation set nationally and by our Partnership. The plan is available here it describes how we intend to transform, commission services in order to:

- Reduce stillbirth, maternal death, neonatal deaths, and neonatal hypoxic ischemic encephalopathy by 50 % by 2025
- Reduce the rates of pre-term birth to below 6 per cent
- Ensure that every women should have an individual care plan that is co-created.

Prior to the pandemic progress was being made against the targets but now less favorable and a key focus, The LMNS has seen a 17% reduction in stillbirths since 2016 which did not meet the target for March 2023 and is not on track to meet the 50% reduction by 2025. LMNS data aligns with national research, that Black women are more than twice as likely to experience a stillbirth and Asian women are 50% more likely to experience a stillbirth in West Yorkshire.

Preterm births in West Yorkshire have continued to rise, throughout the pandemic, up to 8% of all births are born before 37 weeks gestation.

One of the first actions to be taken in year one of this Joint Forward Plan will be a refresh of the LMNS plan now that the Three Year Plan for Maternity and Neonatal Services has been published. Many of the recommendations in the guidance are already addressed in our current LMNS plan however, it will be important for us to review our plan in this context, working in collaboration with our Maternity and Neonatal Voices Partnerships, Clinical staff and stakeholders across the system.

Working more closely with neonatal colleagues is a key to improving the outcomes of mothers and infants from a Trust and Commissioning perspective the LMNS will work with Specialised Commissioning and The Yorkshire and Humber Neonatal Operational Delivery Network

The four themes addressed in the guidance are:

- Listening to women and families with compassion which promotes safer care
- Supporting our workforce to develop their skills and capacity to provide high-quality care
- Developing and sustaining a culture of safety to benefit everyone
- Meeting and improving standards and structures that underpin our national ambition.

Addressing inequalities and focusing on prevention is core to our work. The LMNS needs assessment and Equity and Equality Plan published in 2022 sets out our plans and priorities for the next three years to reduce inequalities Our priorities include ensuring data has a

deprivation and ethnicity lens to understand performance and inform transformation priorities and a new inequalities dashboard has been developed to support this action.
This inequalities dashboard will provide a unique insight into health, care, and outcomes of the different population groups in the LMNS. The dashboard provides data breakdowns for 20+ measures by women's ethnic background, deprivation of residence, postcode and registered GP practice/PCN. This demonstrates potential inequalities across both the entire LMNS and at a local level too. Identified inequalities in late bookings are being used to support an LMNS late booking campaign by crafting the message and medium to those groups with the greatest opportunity for improvement. This campaign will compliment local initiatives by maternity units who are also engaging with the LMNS inequalities dashboard.

While most people using maternity and perinatal services are women, the CQC Maternity Survey (2022) found that 0.65% of respondents stated that their gender was not the same as their sex registered at birth. The information in this plan also applies to these individuals.

Central to the delivery of the transformation is personalised care, ensuring that care is centred on the woman, baby and her family, based around their needs and their decisions, where they have genuine choice, informed by unbiased information. This is central to ensuring that women receive the best care possible. Every woman in West Yorkshire and Harrogate has access to personalised care and we intend to undertake further work to evaluate current effectiveness and to learn from and adapt where required. A key to delivering personalisation is the implementation of midwifery continuity of carer particularly for those at greatest need.

To further support the personalisation agenda the LMNS will become a trauma informed system, this strengths-based approach will support physical, psychological, and emotional safety for women and to empower them to re-establish control of their lives during their pregnancy and beyond. We also intend to work to deliver the LMNS Public Health Recommendations both at place and system level to ensure that we can continue our move to a preventative focus.

The impact of poverty is already evident in the LMNS, having been seen in reviews undertaken of serious incidents. To address this, we are working closely with the VCSE, linking with food banks, ensuring access to freephone numbers, working with local transport services and delivering care close to home to try and mitigate these challenges, ensuring that we continue to evaluate these approaches as we develop.

Central to all our LMNS transformation and quality oversight is the Maternity and Neonatal Voice. Women as experts by experience will have an equal role in the process of understanding local need and developing innovative solutions to address them and importantly quality oversight of services. We intend to undertake further work to ensure appropriate funding and training is in place for women to undertake this important role. Collaboration with the VCSE will ensure the voice of the seldom heard is embedded in this co production process. The LMNS are also partaking in the new Maternity and Neonatal Independent Advocate role, this helps women and families to be listened to and heard by their maternity and neonatal care providers following a death or where a brain injury is suspected or diagnosed. This service will commence in May 2023.

The LMNS will support trusts to implement their digital strategies and develop the system interoperability plan. Giving access to all information available means healthcare professionals will be able to provide more focused, individualised care and therefore improve the experience for the woman and her family. It will also enable women to have a more active

role in their own pregnancy care. Many women won't have access to digital systems and alternatives will be developed.

The LMNS continues to address clinical variation, share best practice and learn from incidents. The Perinatal Quality Surveillance Model is embedded at Place and System and a governance structure is in situ that supports the quality oversight including regional and ICB reporting. Our biggest challenge is workforce, the newly developed Maternity Workforce Strategy outlines the LMNS plans in order to become the place of choice for maternity staff to work, ensuring maternity and neonatal staff are listened to and supported to deliver the best possible care. Central to the implementation of the plan is compassionate leadership to ensure psychologically safe cultures, the LMNS will support trusts to embed this essential element. The plan also supports us in our drive to address inequalities and poverty as a key focus is to bring people from deprived areas into our workforce.

Throughout our work we will to align to the West Yorkshire Climate Change Strategy, supporting sustainable practice.

Supporting our children, young people and families

The impact of the covid-19 pandemic and cost of living crisis has meant we are seeing widening health inequalities for children and young people across West Yorkshire. We know inequalities manifest in many ways and the Child of the North Report 2021 provided some sombre reading as it highlighted the stark reality of inequality experienced by children in the North.

The report outlined children and young people in the North have increased levels of obesity, increased chance of living in poverty, increased chance of living in a low income household, more likely to die under the age of one, have more missed schooling, increased rise in mental health challenges, and are significantly more likely to be in care.

Across West Yorkshire we know that as a child or young person, you are more than twice as likely to live in a most deprived decile of England than the average England resident. We also know that if you are 18 years or younger in West Yorkshire, the odds increase to almost three times as likely than the average child and young person in England. 28.7% of our 0-18 year old population live in a most deprived decile.

We see a range of intersectionality factors impacting our communities including a high percentage of children and young people from black, asian and minority ethnic backgrounds who live in deprived areas. This means certain population groups are further impacted by the widening inequality in education, poorer health outcomes and access to services. We also see more children and young people, parents and carers reporting they are feeling lonelier.

Data from NHSE highlights the significant increases in backlogs for elective care. We know the elective waits for children and young people are taking longer to reduce compared to the adult population across West Yorkshire. And we are also seeing a rise in children and young people requiring urgent treatment for eating disorders, almost doubling in 2020/21 compared to the year before Children and Adolescents Mental Health Services (CAMHS) Data.

We know there is variation in access to health and care services including those for complex needs/SEND and long term conditions. We have also seen increases in domestic violence, rising numbers of food instability and seasonal pressures beginning in the summer for secondary care admissions in the NHS. Insights from across West Yorkshire paint a similar, if not worse reality.

A review of children and young people mental health activity across West Yorkshire has shown, the overall demand for mental health support is increasing and more children and young people are being seen. We have seen an increase in the number of children and young people requiring specialist inpatient care in the last 4 years and particularly in relation to eating disorders, self-harm, neurodiversity (over 50%).

Children and young people mental health community team caseloads have increased by up to 70% in some areas and the complexity of people's needs has changed. This includes high referrals for children and young people needing naso-gastric feeding which has impacted access to local and national provision.

We are also seeing challenges around children and young people waiting times for autism spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD) diagnosis. The gap in waiting times between the initial assessment and follow up contacts/plans is also a challenge. A review of pathways aims to address this. Ongoing workforce challenges only exacerbate these pressures and we recognise the opportunities the Health and Care Bill 2022 brings to work in collaboration across all health and care sectors across West Yorkshire to improve access, experiences and outcomes.

What are we already doing?

Working as a true health and care partnership to address the outlined inequalities means we have a unique opportunity to make a difference. Our ambition is to close the gaps in health and wellbeing outcomes for all children and young people across West Yorkshire no matter where they were born, where they live or where they go to school.

The vision to realise this ambition across West Yorkshire is '***All children and young people will have the best start in life and the support to be safe from harm, enjoy healthy lifestyles, do well in learning and have skills for life'.*** This is in keeping with the West Yorkshire HCP 10_big_ambitions to address the inequality gap for children living in the households with the lowest incomes.

We therefore remain focussed on our objectives to support all children and young people to have:

- The best start in life and promote healthy weight
- Support with family resilience and early help interventions
- Access to new models of care as we develop a workforce fit for the future
- Equitable and consistent access to complex needs/SEND services
- Equitable and consistent care for long term conditions and transition.

To address the outlined challenges, there are a number of initiatives already in place across West Yorkshire that are focused on closing the gaps in inequality for children and young people. This is made effective by working in collaboration with all sectors and young people themselves.

Work includes projects tackling obesity, oral health, poverty proofing, parenting support, adversity trauma and resilience, digital innovation, mental health, clinical pathways, palliative and end of life care, variations in SEND, asthma care bundle, improving access to continuous glucose monitoring, reducing variation in epilepsy care and transition.

Review of priorities for children and young people

Following transition to a statutory Integrated Care System the West Yorkshire ICB children, young people and families programme have used a co-production approach to hold numerous design discussions with system representatives and young people. These discussions have been informed by the statutory requirements of ICB's including operational planning guidance and the Long Term Plan Policy, CORE20PLUSFIVE CYP framework, the three tests of subsidiarity across the West Yorkshire HCP, and a data informed approach.

This has been an opportunity to ensure we are making the best use of resource, ensuring the right work is taking place in the right part of the system by the right people, we are supporting distributed models of leadership and subsidiarity at Place, we are amplifying the voice of children and young people, and that we are '*connecting our system to more of itself'.*

A diagnostic survey to identify key priorities for children and young people was particularly helpful in understanding work taking place locally across the five Places in West Yorkshire as was the development of a prioritisation criteria using a system priorities framework. This has informed mapping of children and young people priorities across West Yorkshire and has been tested at various governance groups across the West Yorkshire health and care system.

What do we need to do to meet our requirements?

There are a number of strategic objectives we are undertaking to meet our requirements so that we can deliver our ambitions for children and young people. These include:

Focus on best start and healthy weight. This includes promotion of integrated working across West Yorkshire to share learning on pre-conception and early years whilst aiming to reduce variation in outcomes; particularly focusing on working with the local maternity and neonatal system and first 1001 days, health and nutrition, oral health, language and communication and social and emotional development, and tackling complications of excess weight and obesity.

The national 23/24 planning requirements specifically sets outs aims for improvement in oral health for CYP in line with the recently launched CORE20PLUSFIVE CYP framework. In considering the trajectories for medium to longer term transformation within the joint forward plan, this objective will be an area of focus predominately during Year One, Two and Three with likely demonstrable outcomes in Years Three to Five.

Build family resilience and early help. This involves working together to connect across all West Yorkshire sectors to align approaches, sharing of good practice around prevention, assessments and early help interventions, support for looked after children, reduced variation in early interventions, collaborative training and development opportunities, building resilience of families and communities to support each other and build skills for life. In considering the trajectories for medium to longer term transformation within the joint forward plan, this objective will be an area of focus predominately during Year One and Two with likely demonstrable outcomes in Years Three to Five.

Improve children's healthcare in the community. This includes collaborative design and influence of new models of care across West Yorkshire to reduce children and young people unplanned admissions to secondary care, increased use of digital devices and technology that provides care closer to home, supporting a workforce that is fit for the future, design of specialist palliative care service and shared learning on ambulatory pathways. In considering the trajectories for medium to longer term transformation within the joint forward plan, this objective will be an area of focus predominately during Year One, Two and Three with likely demonstrable outcomes in years three to five.

Create equitable complex needs and special education needs and disabilities (SEND) services. This involves creating a co-ordinated West Yorkshire approach to improvement, reduce variation in outcomes, collective view on work taking place across system in order to meet statutory requirements, support collective approach to early and correct complex needs/SEND diagnosis with MHLDA. In considering the trajectories for medium to longer term transformation within the joint forward plan, this objective will be an area of focus predominately during Year One and Two with likely demonstrable outcomes in Years Three to Five.

Deliver improvements for children and young people with long term conditions. This includes working collaboratively to share best practice for long term conditions across West Yorkshire to reduce variations in outcomes, parity of access to technology and services, system level datasets, focus on transition and learning from audits. In considering the trajectories for medium to longer term transformation within the joint forward plan, this objective will be an area of focus predominately during Year One, Two and Three with likely demonstrable outcomes in Years Three to Five.

The objectives and related initiatives led by the West Yorkshire ICB Children, Young People and Families function are in keeping with the 3 tests of subsidiarity. These include sharing of best practice across a large system to reduce variation, working at scale to achieve best outcomes or that we recognise there is an opportunity to solve complex intractable problems once across the system.

There are also a number of strategic objectives relating to CYP mental health which are delivered by the West Yorkshire Mental Health, Learning Disabilities and Autism (MHLDA) Provider Collaborative and West Yorkshire ICB MHLDA Programme. We work in collaboration with partners across the system to create parity of esteem between physical and mental health; joint initiatives include a focus on supporting the needs of CYP with mental health needs in acute settings and youth worker function to enhance experiences for CYP and their families.

Alignment with the West Yorkshire 10 Big Ambitions

In alignment with delivery against the West Yorkshire HCP 10_big_ambitions the best start and healthy weight project groups use a health inequalities lens to focus on communities from the most deprived areas. For example, this involves shared learning from the development of family hubs across West Yorkshire. This approach is a system wide model of providing high quality, joined up whole family support services so that local needs can be met from conception, through a child's early years up until early adulthood.

The impact of poverty and cost of living on children, young people and families using this approach can be met in a tailored way. The West Yorkshire role in supporting this work is to benefit from the sharing of good practice across the HCP. Further work on poverty proofing will be undertaken in collaboration with the West Yorkshire ICB Improving Population Health Programme.

The West Yorkshire HCP has a strong adversity, trauma and resilience network with an ambition for all organisations to become trauma informed by 2030. There is strong alignment between the children, young people and families function and this work. An example of this through the work on family resilience and early help, includes work on using a trauma informed approach for 'Project Hope'. This is a project across West Yorkshire designed to

offer care experienced young people with career development opportunities and helps us to work at scale for critical mass to achieve best outcomes.

The work on long term conditions including improving asthma care and reducing the number of unplanned admissions relating to asthma, highlights the opportunities to respond to climate change and sustainability. We recognise the correlation between high asthma admissions and children and young people living in neighbourhoods with poor air quality. This is why we are working with air quality leads and influencing for Integrated Care Partnership strategies to improve air quality. This means we are able to work to address variations in outcomes across a large system.

Work with children, young people and families in a co-production approach enables us to maintain a focus on the experience of care and ensuring people and communities are involved with service developments. This includes the work we carry out on complex needs and SEND parent and carer forums. The role across the broader West Yorkshire ICB is to benefit from sharing best practice by enabling the collective voice from parents and carer to be heard and influence decision making. There is also a strong Youth Collective presence in the design of our priorities as a system.

There are strong links to all programmes of work and enabling functions to support the ambitions for children and young people across West Yorkshire. This includes close working with colleagues in digital, organisational development and equality diversity and inclusion functions.

Delivery plan

The delivery of our Children and Young People priorities as a collective system will take time. It is an investment of time and other resource well worth making both the intrinsic value of helping our children and young people have the best start to lead happy and healthy lives, and the inherently preventative nature of dealing with challenges and inequalities early in life is clear.

In developing this delivery plan it is recognised that our aspirations involve reversing established trends, addressing inequalities and complex issues, and being part of a strategic “left-shift” in thinking and practice. It is also critical that delivery will not happen in isolation, only through working in partnership with a range of place-based actors and adopting matrix working with other system partners can we achieve our ambitions. The CYPF function will be key to delivery in this way.

Whilst time can constrain progress, it’s clear that we will build on our progress to date through immediate delivery into year one and beyond. Throughout the life course of our five year strategy and each instalment of the annual Joint Forward Plan, recognising that we must remain agile, we will strive to deliver as follows:

a. **In year one:** we will continue to deliver through our established workstreams, in alignment with our system strategic priorities and NHSE operational planning requirements. Deliverables for Year One include:
    - We will deliver a multi-disciplinary West Yorkshire Tier 3 complications from excess weight service for a 100 patients a year
    - We will deliver workshops to share best practices on various initiatives including approaches to best start for CYP in life working in collaboration with the local maternity and neonatal system, establishment of family hubs, SEND Inspection

journey's and Written Statements of Action, clinical approaches such as learning from the Epilepsy 12 audit and diabetes
- We will deliver a career development project 'Project Hope' across West Yorkshire for 25 care experienced young people to gain employment into the health and care sector
- We will launch online parenting support research across West Yorkshire and support implementation across sectors
- We will deliver a Healthier Together website that provide an alternative route for access to health and care services using digital technology and this includes promoting physical activity
- We will deliver an outcomes framework that supports us to reduce variation in SEND assessments and EHCP's across West Yorkshire
- We will continue to deliver the asthma care bundle for CYP across West Yorkshire focusing on health and housing link including roll out of asthma friendly schools
- We will deliver a digital platform vCreate Neuro across acute NHS Trusts in West Yorkshire for CYP with epilepsy.

b. **In years two to three**: we will build on existing work in alignment with our system strategic priorities and NHSE operational planning requirements. Deliverables for Years Two and Three include:
    - We will aim to deliver initiatives to reduce variation in school readiness across West Yorkshire
    - We will aim to deliver a review of oral health provision across West Yorkshire including dental backlogs and extractions in <10yrs old
    - We will aim to realise joint commissioning opportunities to support family resilience and early years, complex needs and SEND services
    - We will aim to deliver workshops to share learning from Ofsted Inspections for Children's Services across West Yorkshire including self-assessments and peer reviews
    - We will aim to deliver a West Yorkshire 24/7 CYP palliative care service
    - We will aim to support the design of virtual ward pathways across West Yorkshire by sharing best practice
    - We will aim to deliver an enhanced and accredited CYP nursing skills and development course (EPNS4)
    - We will aim to deliver improved pathways including 'Think Vision' approach for learning disabilities and special needs eye care and improvement approaches for hearing services for CYP with complex needs and SEND
    - We will aim to deliver equity of access to CGM devices for CYP across West Yorkshire including data on usage from black, asian and ethnic minority population groups
    - We will increase access to an epilepsy specialist nurse across West Yorkshire and clinical psychology.

c. **In years four to five**: we will further build on existing work in alignment with our system strategic priorities and NHSE operational planning requirements. Deliverables for Years Four and Five include:
    - We will aim to deliver a West Yorkshire obesity strategy for all ages
    - We will aim to deliver data connectivity between sectors for CYP
    - We will aim to reduced unplanned admissions using data informed approaches in collaboration with the Urgent and Emergency Care Programme
    - We will aim to deliver a West Yorkshire community services dataset supporting data connectivity across sectors for CYP with complex needs and SEND

- We will aim to have delivered the asthma care bundle linked to core20plus5 CYP framework, focusing on health and housing link including roll out of asthma friendly schools
- We will aim to deliver a West Yorkshire approach for CYP Sudden Unexcepted Death in epilepsy.

Tackling antimicrobial resistance

Antimicrobial is a term used to describe the type of drugs that kill microorganisms (bacteria, viruses, fungi, and parasites), or stop them growing and causing infection.

Anti-microbial resistance (AMR) happens when bacteria and other microbes find ways to stop antimicrobial medicines working making some infections harder or sometimes impossible to treat. Many human lives are lost to resistant infections with potential to spread to other people; and this is happening more often.

The United Kingdom's Governments current five-year national action plan (NAP) "Tackling antimicrobial resistance 2019-24" contains a set of ambitions aimed at reducing both the number of antibiotics prescribed, and the need for their use. The plan had been designed to ensure progress towards the 20-year vision in which resistance is effectively contained and controlled by 2040. It focuses on three keyways of tackling AMR:

- Reducing the need for, and unintentional exposure to, antimicrobials
- Optimising the use of antimicrobials
- Investing in innovation, supply, and access.

Our West Yorkshire five-year AMR ambitions
The West Yorkshire ICB AMR strategy sets out how we will contribute to the national 20-year vision and current 5-year action plan and deliver the partnership AMR ambition to **achieve a 10% reduction in anti-microbial resistance infections by 2024.**

We will do this by aiming to achieve the National Action Plan targets of:

- reducing antimicrobial use by 15% by 2024
    - a 25% reduction in antibiotic use in the community from a 2013 baseline
    - a 10% reduction in use of ‘reserve’ and ‘watch’ antibiotics in hospitals from a 2017 baseline.
- halve the number of healthcare-associated Gram-negative blood stream infections by 2024

The Department of Health and Social Care (DHSC) is developing the next five-year AMR plan, which will run from 2024 – 2029. As the WY ICB AMR plan aligns to the national ambition targets, this next iteration will inform a refresh of our strategy and our plans for the next five-year period, as well as reflecting deliverables outlined in the NHS Long Term Plan.

The West Yorkshire AMR steering group (AMR Board) membership includes representation from each of our five local place partnerships together with partners from academia / research. Newly established AMR, infection prevention control and data sub-groups allow us to act together to consider opportunities for shared learning where antimicrobial stewardship and infection prevention and control can be strengthened. Our environmental and sustainability group promotes and supports sustainable AMR messaging and aims to contribute to planning. Workstreams developed within these groups add value to local place strategy and single individual organisational AMR plans and are the initiatives that experts on

the steering group consider as emerging issues that would benefit from a co-ordinated system-wide approach.

The West Yorkshire AMR steering group will provide oversight of performance against national indicators whilst assurance of the contractual and guidance requirements of individual providers is provided within quality boards, IPC / medicines optimisation / pharmacy committees and health protection boards at place. The board will provide challenge to the strategy delivery, and where appropriate, implement the aims and priorities of the programme.

Our objectives
Whilst the West Yorkshire strategy supports the National AMR vision and NHS priorities, our strategy is built around five local key objectives:

1) Reduce inequalities related to E. coli Gram negative Blood Stream Infection (BSIs)
One of the biggest drivers of AMR infection in humans in the United Kingdom is a rise in the incidence of infections, particularly Gram-negative bacterial BSIs (including those caused by the E. coli). The burden of disease is also known to disproportionately impact vulnerable groups leading to inequalities. We are working to understand this in order to develop actions to change this trend. Localities have therefore prioritised E. coli reduction within their plans, which incorporate generic and specific actions for the SICBLs and the health and social care economy. Focus has been made to community engagement and IPC support for carers, in particular those that are unpaid or caring for people living in social care **[Case study 1–** I-Spy E. coli - Leeds**]**

As a system, we have taken action to raise the profile of AMR across the partnership by developing educational resources to support prevention for the public and health care professionals. [**Case study 2** Link to AMR Videos]

A priority for our strategy will be expanding successful work in this area across West Yorkshire. The Leeds 'Seriously Resistant' campaign to raise awareness of antibiotic resistance is a good example of where positive campaigns can have success. In2023/24, we will continue rollout of key messaging together with a bespoke targeted campaign in our highest prescribing area. We will work with colleagues and people and communities across the system to co-produce the delivery of targeted interventions to prevent and reduce infections in specific groups of people. Throughout this work we will take a trauma informed approach to co-production, acknowledging the life experiences of the communities in which we work.

2) Reduce the number of urinary tract infections (UTIs) across the system
Urinary tract infections are common often preventable infections which often lead to a high incidence of emergency admissions. In the elderly, UTIs are often over diagnosed and over treated. To reduce the number of UTIs across the system, our local IPC community teams have focused on supporting healthcare colleagues in social care by providing education to

improve hygiene and hydration in at risk groups, whilst taking proactive action to reduce the risk of re-infection via effective treatment pathways. As a system, we are actively supporting and sharing hydration improvement learning via the regional Hydration Network.
[**Case study 3** – Hydration project]

3) Appropriate antibiotic prescribing in primary care
Across our places, the priority is to ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance. Throughout the next five years, medicine leads at place will work with primary care partners to optimize prescribing. This will includeproviding education to prescribers and supporting general practices to put in place ieffective workflows for 'back-up' prescribing of antibiotics. This will involve reviewing antibiotics on repeat prescription for infection prophylaxis and stopping where no longer required or advising a 'drug holiday'. They will regularly review prescribing tools such as Point of (Prescribing) Care software (available to all West Yorkshire GP practices) and Ardens templates to support diagnosis and effective prescribing. In addition, under the 2021/22 Pharmacy Quality Scheme 87% of all pharmacies in West Yorkshire participated in the prevention domain and so created antimicrobial stewardship action plans with a workforce committed to be Antibiotic Guardians.

Our approach to reducing primary care prescribing will be to be provide insight to GPs and other prescribers to optimise antibiotic prescribing and guide a reduction in broad-spectrum antibiotic use. [**Case study 4** - The Lowering Anti-Microbial Prescribing (LAMP) programme was introduced in 2019 as a clinical audit and feedback approach. As part of planned WY ICS response to AMR, the research team now work with all General Practices in West Yorkshire and started their fourth year of data collection and feedback in 2022].

The Antimicrobial Stewardship (AMS) subgroup will lead on system wide West Yorkshire guidance to support antibiotic prescribing, including remote prescribing and access to antibiotic alternatives

We will also aim to report on the percentage of prescriptions supported by a diagnostic test or decision support tool by 2024; and by 2025, will set targets to provide a vision for improvement. Whilst local teams follow national diagnostic pathways and trial innovative practice such as point of care testing at place, we will additionally work together with the AHSN to identify any demand for emerging innovation that would benefit from system wide investment and coordinated West Yorkshire delivery.

4) Increase infection prevention control workforce capacity
A clear understanding and plan of the current workforce is needed for NHS IPC teams and social care staff to maximise workforce capacity. In social care settings, there needs to be sufficient time for care staff to provide patient's needs, including those around infection prevention and antimicrobial stewardship. Without this, there is a risk that infection management is deprioritised. Over the next five years, we will work together with providers and to understand the development and training needs of the system, support implementation of the National IPC manual and increase IPC workforce capacity across the system.

5) Understand and share learning from COVID-19 and implications on immediate and future risk of antimicrobial resistance (AMR)
The COVID-19 pandemic has changed the landscape of healthcare, presenting consistent challenge and demand on healthcare services. Throughout the next five years, we will continue to review and mitigate the impact of external factors on antibiotic prescribing. This is likely to include understanding the epidemiological implications of current and potential infections in West Yorkshire and additional factors such as cost-of-living, as much as COVID.

We will continue to support IPC leads during the COVID-19 response and as a system gain more understanding of changes seen in the management of suspected infections and healthcare delivery a result of the pandemic.

Our System
We will build relationships and networks to work together on infection prevention and antimicrobial stewardship. This will enable joined-up working on AMR between primary care and other parts of the system with their own AMS involvement, including providers in public health, acute care, community services, mental health, out-of-hour GP collaboratives, and education and training. Where beneficial, the AMR board will also interface with existing medical, pharmacy, nursing, health informatics and other professional networks seeking to reduce AMR.

Mental health, learning disabilities and autism

Across West Yorkshire everything that our providers do contributes to our ambition to reduce the gap in life expectancy between people with mental health conditions, learning disabilities and/or autism and the rest of the population. Strong family and friendship connections, good quality employment and safe, healthy accommodation are vital. Our work across West Yorkshire covers– service delivery and improvement, alongside the culture change needed so that all partners focus on the holistic mental and physical needs of people and communities.

We remain committed as a system to ensuring parity of investment in mental health, delivering the Mental Health Investment Standard as a minimum but continually seeking ways to ensure that support for mental health, learning disability, autism and **Attention** deficit hyperactivity disorder (ADHD) is prioritised; particularly to reduce inequalities and unwarranted variation in access to care and outcomes.

Each of our five places has their own programme of local transformation work and are responsible for identifying clear trajectories for delivery against the national priorities. As such during 2023/2024 across West Yorkshire we will:

- Reduce our use of inappropriate out of area placements towards the national ambition of ‘0’
- Increase our use of NHS Talking Therapies so that at least 69,000 people access services
- Increase the number of women accessing specialist Perinatal Mental Health services to over 2,300
- Deliver a Dementia Diagnosis Rate of over 67%
- Delivery at least 75% of Learning Disability Annual Health Checks
- Deliver at over 27,000 occasions where people received two or more contacts from Community Mental Health Teams
- Deliver at least 34,000 occasions where Children & Young People receive at least one contact from CYP Mental Health services
- Ensuring for those people who are autistic, have a learning disability or both that:
    - no more than 30 adults are in inpatient beds commissioned by the ICB
    - no more than 19 adults and in inpatient beds by NHSE or the provider collaborative
    - no more than 8 children and young people are in inpatient beds commissioned by NHSE or the provider collaborative.

In addition to the above, our West Yorkshire Mental Health Learning Disabilities and Autism (MHLDA) Provider Collaborative is accountable for delivering services across West Yorkshire and beyond, ensuring the quality of all services provided. This includes for:

- **Adult eating disorders** – improving management of complex needs in inpatient and community settings, treating more people at home and ensuring safe and effective monitoring of physical health within the community

- **Adult secure services** – developing a consistent community offer, reducing placements outside of natural clinical flow and better awareness of West Yorkshire wide capacity and demand

- **Tier 4 children and young people's mental health** – further reducing the number of young people receiving hospital treatment outside of West Yorkshire and reducing length of stay

- **Forensic child and adolescent mental health services (CAHMS)** – ensuring the smooth transition of the Yorkshire and Humber Community Forensic CAMHS Service into provider collaborative arrangements and developing the service to include enhanced training offers, improving feedback mechanisms and reviewing the current workforce composition

- **Assessment and treatment units for learning disability** – strengthening clarity on clinical decision making and escalation processes and reviewing assumptions about the existing inpatient model.

Through our West Yorkshire MHLDA Partnership Board, we also have several agreed transformation priorities for the whole system, agreed by all of our five places. These are:

- **Learning disabilities** – delivering our health inequalities challenge to raise awareness of the inequalities faced, supporting the roll-out of Autism friendly wards, the development of keyworker roles for Children and Young People and reviewing our current approaches to LeDeR (Learning from Deaths of People with a Learning Disability)

- **Children and young people's mental health** – developing services, training and pathways for eating disorders/disordered eating, improving the regularity of effective transition to adult services, access to 24/7 crisis support, implementing risk registers in line with Dynamic Support Registers and benchmarking our self-harm pathways against National Confidential Inquiry into Suicide and Safety in Mental Health recommendations

- **Adult mental health pathways** – establishing a system mindset for our Psychiatric Intensive Care Units to help reduce out of area placements, delivering the requirement for people to be able to dial NHS111 in mental health crisis and support quality and enhancing quality & safety within adult acute inpatient units

- **Community mental health transformation** – developing new and integrated models of primary and community mental health care, developing our approach to eating disorders/disordered eating in the community and meeting the needs of older people and young people transitioning into adult services

- **Neurodiversity** – improving consistency in neurodevelopmental service provision including how we collect and use data, improving the availability of needs led, holistic support, implementing the right to choose consistently and ensuring that co-production is at the heart of all the work we do

- **Older people's mental health** – improving support following a dementia diagnosis, improving access to talking therapies for older adults and networking the system together to promote equity for the older adult population

- **Complex rehabilitation** – to develop a complex emotional needs pathway, continue the roll-out of the Complex Rehabilitation Enhanced Support Team (CREST) and develop a collaborative approach to the commissioning of inpatient beds in WY for people with complex rehabilitation needs

- **Perinatal mental health (PMH)** – to improve the understanding and awareness of Perinatal Mental Health in specific communities, reducing barriers to access and support, taking learning from the Maternal Mental Health Services pilots into a finalised model and mobilising the PMH provider collaborative for Yorkshire & Humber

- **Workforce** – Increasing diversity in the workforce across the Mental Health Trusts, establishing an ethnical migratory pathway for Mental Health Nursing and Consultant Psychiatrists and establishing a non-medical collaborative bank across the Trusts

- **Data and intelligence** - improving collaboration between Trust BI teams, places and the system, mapping current capabilities and capacity and linking this to the national strategic direction

- **Wider determinants and inequalities** – increasing collaboration across specialist MH services, local authorities and physical healthcare, supporting Mental Health Trusts to implement the objectives of the Patient and Carer Race Equality Framework and enhancing support to health promoting activities

Supporting long term health conditions

As part of our work to support long term health conditions, we ensure that everything we do meets the West Yorkshire Health and Care Partnership three tests:

- Things that make sense to do at scale are central to our programmes to achieve the best outcomes, such as policy harmonisation and implementation of continuous glucose monitoring (CGM) role out aligned to NICE[1] guidelines; National Diabetes Prevention Programme and Type 2 Diabetes Pathway to Remission (TD2R), previously Low Calorie Diet, services; and the National Stoke Service Model and the National Service Model for an Integrated Community Stroke Service
- We share best practice and reduce unwarranted variation, such as through our personalised care workforce training and unpaid carers discharge principles
- we aim to achieve better outcomes for people overall by tackling 'difficult issues' (i.e., complex, intractable problems) such as coming together to identify gaps in community stroke services and ensure mechanical thrombectomy is available across the region to improve outcomes

Three of the disease specific long-term conditions we focus on in this work are diabetes, stroke and cardiovascular disease. Details of our plans for these areas are outlined below:

Diabetes

Prevention – We will continue to work to deliver the National Diabetes Prevention Programme (NDPP), using quality person-centred conversations to identify the right pathway for patient needs, promoting referrals and working with providers to optimise uptake of the programme through tailored delivery methods to meet the needs of local communities across clinical networks and primary care networks. We will also seek to increase uptake of T2DR to support weight loss and remission, in particular working with IMD practice areas via places to increase referral rates.

Given the importance of accurate data and insight we will continue to ensure access to the national diabetes data dashboard through Power BI. We will also build on the success of Let's DiaBEAT through structured communications to increase referrals into NDPP and T2DR. Personalised care and support plans will continue to enable people to better manage their needs; work with those in ARRS roles (additional roles reimbursed via a funding scheme for primary care networks) will enable healthy lifestyles through support to self-management and social prescribing, making the most of the assets available to people in their own community. Lastly, we will integrate the role of prevention between diabetes, cardiovascular disease (CVD), stroke and other long-term conditions, including obesity, to address the wider inequalities across the population.

Treatment and care - To achieve NHSE targets for the following Diabetes Treatment & Care areas:

- Diabetes in-patient specialist Nurse (DiSN) - sustainable provision across all Places
- Multi-disciplinary footcare teams (MDFT) - sustainable provision across all Places
- NICE recommended 8 care processes
- NICE recommended 3 treatment targets relating to blood pressure (hypertension) management, CVD prevention (cholesterol) and blood glucose levels (Hba1C)
- Access to quality Structured Education (SE) for everyone living with diabetes
- Evaluation/coproduction of SE with patients and carers to support service improvement as per NICE guidance
- Develop regular data flows from providers to inform progress against trajectory targets
- Specialist workforce to be trained in personalised care approaches e.g. health coaching and shared decision making.

Monitoring and management – We will work to address NICE guidance for CGM and Flash Glucose and will deliver an audit of existing technologies to address inequalities in access and take up across WY. We will continue to embed supported self-management and personalised care approaches for patients and their carers, using PHB where appropriate to support management of condition. We will work to use ARRS roles to support a holistic approach to self-management and wellbeing.

Digital and innovation – We will adopt the Healthy Living App for people with type 2 diabetes, a web-based structured education programme via self-referral for type 2 diabetes. We will complete an evaluation of the Healthy.io app to inform our approach to supporting people at **increased risk of chronic kidney disease** to complete their annual urine test at home. Lastly we will seek to increase usage of the Cambridge Education Programme (CEP) through increased license usage across WY.

Stroke

Health inequalities - We will use existing data to aid the completion of a stroke specific health needs assessment. A programme of work will follow, designed in collaboration with

places to address the priorities identified, and using co-creation workshops to progress developments.

Prevention - We will work with local primary care networks (PCNs) to ensure strategies are in place to identify those at risk of stroke, and work to prioritise assessments in patients with cardiovascular disease (CVD) risk factors. We will develop a regional stroke prevention strategy in collaboration with our neighbouring Integrated Stroke Delivery Networks (ISDNs), ensuring a coordinated approach across Yorkshire and the Humber. We will use this strategy to create a delivery plan in association with our partners in the cardiac network, and the CVD and diabetes programmes, to provide a comprehensive approach to prevention and avoid any duplication.

Diagnosis - We will collaborate with partner organisations across the network to raise awareness of stroke symptoms and to standardise triage tools and pre-alert processes. We will work with the Yorkshire Ambulance Service and our acute trust colleagues to trial stroke telemedicine, and we will collaborate with partners to understand current Transient Ischaemic Attack (TIA) pathways and services, identifying areas for improvement in pre and post hospital settings.

Treatment - We will work with our local acute trusts to improve access to thrombectomy services across the ICS area, ensuring a regional mutual aid agreement is in place and working towards the delivery of the National Optimal Stroke Imaging Pathway (NOSIP). We will collaborate with our partners to improve the entire acute stroke pathway, ensuring parity of access to assessment and treatment for everyone within our local places.

Rehabilitation and life after stroke - We will collaborate with partner organisations across the NHS, social care, and the voluntary sector to ensure equity of service and access across the entire stroke pathway, providing a seamless experience for people affected by stroke, irrespective of their locale or social background. We will continue to work in coproduction with people affected by stroke, using their lived experience to codesign the optimal recovery journey, personalised to individual need.

Workforce, education, and training - We will employ an integrated approach to workforce development, merging stroke-specific and professional practice education with training opportunities that encompass all staff involved in the delivery of effective, safe, and compassionate stroke care, including those from the voluntary sector.

Cardiovascular Disease (CVD)

Using personalised care to support people to live well supporting prevention of CVD or identifying as early as possible. We will work to increase the number of annual health checks and improve their quality. We intend to focus on our work to support high risk groups such as Learning Disabilities/Severe Mental Health (LD/SMI). We will work to embed personalised care approaches across CVD prevention including ARRS roles in primary care. Utilising NHSE Peer Leadership to grow peer leaders across LTCs in development e.g., diabetes/stroke/CVD. We intent to increase workforce training offers for CVD workforce in personalised care approaches

> **Working to reduce hypertension across West Yorkshire**.We will reduce the number of people with undiagnosed/treated hypertension to pre pandemic levels using Making Every Contact Count (MECC) approaches. We intend to undertake targeted work to reduce variation, focusing on health inequalities working in coproduction with patients and their unpaid carers. We plan to deliver proactive case finding targeted at specific groups including working age men, and Familial Hypercholesterolaemia (FH) and

undertake the West Yorkshire targeted health check project driven by core20plus5. Work with the Integrated Stroke Delivery Network (ISDN) and support any initiatives designed to improve patient outcomes. BP@Home Programme.

We aim to reduce the gap in life expectancy by 5% by 2024 between most and least deprived an increase the percentage of patients with hypertension treated to NICE guidance to 77% by March 2024

Working to improve detection and treatment of CVD. We intend to increase the number of people with undiagnosed Atrial Fibrillation (AF). Treating people diagnosed with AF Direct Oral Anticoagulants (DOACs). Metrics 85% of the expected number of people with AF are diagnosed by 2029.

90% of patients with AF known to be at high risk of stroke to be adequately anticoagulated by 2029.

We will increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%. We will use cardiac and diabetes networks to support the work programme with a focus on CVD Prevention. We will work closely with the ISDN to develop a CVD prevention strategy for system wide working which reflects hypertension, AF and lipids and linking into the evolving regional stroke prevention strategy. We will embed personalised care across diabetes, cardiac, stroke and CVD prevention networks utilising tools such as the shared decision-making tool for Atrial Fibrillation (AF)

Educating communities about CVD prevention and empower them to take action. We will work with the Improving Population Health Programme to focus on primary prevention work – smoking, alcohol reduction, obesity, high salt diet to raise public awareness and improve patient outcomes. We will undertake a communications campaign – know your numbers (Sept) national campaign to encourage people to get blood pressure checked. We will develop a West Yorkshire communication campaign showcasing good practice and encouraging people to check their blood pressure, with a health inequalities focus.

Cancer

As an ICB we are committed to ensuring that by 2024, 1,000 more people should have the opportunity for curative cancer treatment than was the case when the national cancer strategy was originally set back in 2019. We are making good progress towards this goal, which sets the platform for how we approach the proposed outline of a five-year strategy.

Linked to this headline goal, we have two main strategic goals for the Joint Forward Plan for cancer in West Yorkshire, both of which require us to work collaboratively with other ICB programme leads and with other colleague organisations in the Health and Care Partnership.

1. Reduce the incidence of avoidable cancer by acting with our partners to change population behaviours.
2. Increase one-year survival from cancer from 70 to 75%, and early-stage diagnosis to 62%, as a first step towards the goal set out in the NHS Long-Term Plan.

The ICB is required to report on delivery of the following trajectories for cancer linked to the operational planning process for this year.

1. Proportion of patients diagnosed at early stages 1 and 2 (improve).
2. The number of patients waiting more than 62 days for cancer treatment (aim to reduce to less than 6.4% of the entire patient tracking list size, expressed as a fair share formula).
3. Delivery of the Faster Diagnosis Standard (75% by March 2024).
4. The proportion of patients referred on the lower gastrointestinal cancer pathway who have a FIT test recorded; (the national aim is for 80% of such cases to be recorded, local progress will be made towards that aim in 23/24).

Our Joint Forward Plan strategic success metrics for 2027/28

By the end of the **2027/28 financial year (year 5)** and the end point of the Joint Forward Plan, the Cancer Alliance will have supported the West Yorkshire Integrated Care Board, and its constituent members and partners, to have delivered the following:

1. **Lung health checks:** All residents in West Yorkshire and Harrogate who have either ever smoked, or smoke currently, will have been invited to undertake a lung health check if aged between 55 and 74 (Goal 1). This is important because it will reduce avoidable cancer mortality in the short to medium term.
2. **Smoking cessation:** The adult smoking rate in West Yorkshire and Harrogate will be 13% or less (Goal 1). This is important because, supporting the efforts of our population health and local colleagues, we will be able to reduce avoidable cancer mortality in the medium to longer term. We will specifically support this goal through incorporating this focus into lung health checks and secondary influencing opportunities; supporting all tobacco control boards locally; encouraging local teams to invest in this area via Core20Plus5 recurrent funding and other commissioning opportunities; and by undertaking specific promotional campaigns highlighting the benefits of smoking cessation.
3. **Earlier presentation:** We will have met and exceeded the ICB ambition for 1,000 more patients to have access to curative treatment; improved population awareness of cancer signs and symptoms; and be continuing to close the health inequalities gaps in our system (Goals 1 & 2).
4. **Faster diagnosis:** At least 4 in 5 people receiving either a diagnosis of cancer, or an exclusion of cancer, within one month of being referred with cancer symptoms (Goal 2).
5. **Best treatment, sooner:** At least 95% of people receive cancer treatment within one month of a decision to treat being made. No more than 1 in 20 people on our cancer patient tracking list are waiting more than two months in total for a first definitive cancer treatment to take place after being referred for urgent cancer symptoms by their GP (Goal 2).
6. **Personalised care:** We have a fully embedded system for genomics testing in West Yorkshire and Harrogate, reflecting national strategy aims; all suitable patients have a personalised care support plan (PCSP) and benefit fully from the living with and beyond cancer programme (Goal 2).
7. **Innovation:** Alongside an enabling innovation pipeline, we will have transformed cancer diagnostic management by introducing asymptomatic and symptomatic blood test screening for the local population, based on service evaluation and clinical trial evidence (Goal 2).
8. **Highly effective collaboration:** We will bring patient experience to the heart of what we do by developing and extending our partnership working. We will expand our reach and connection across the Partnership, further expanding opportunities to work with primary care, research and the VCSE sectors as priorities (Goals 1 and 2).

Why have we chosen these strategic goals to build on the ICB ambition?

Reduce the incidence of avoidable cancer by acting with our partners to change population behaviours

This is because we know that 1 in 2 people will receive a cancer diagnosis at some stage of their lifetime[1]. Around 4 in 10 of these cancers may be avoidable due to changes to population behaviours such as tobacco use; poor diet; alcohol intake and substance misuse; sedentary behaviour; and excessive ultraviolet (UV) exposure. The Cancer Alliance specifically supports work around other determinants than tobacco use, via its healthy communities' programme, and is also undertaking specific work to look at the risk factors associated with some cancers arising from lifestyle factors, such as the liver cancer surveillance programme, oral cancer checks, and proposed targeted screening for kidney cancers. The Cancer Alliance also supports the plans from other stakeholder in the Partnership involved in primary disease prevention.

Each of these factors are associated with socio-economic deprivation and broader inequalities in society. Environmental factors which can be associated with excess cancer burden include the impact of climate change and global warming; poor air quality; and poor access to green, recreational spaces. Other indirect factors associated with excess cancer burden may include limited access to public transport – causing more private car journeys and worsened air quality locally; inequities in the provisions of physical and mental health services, including fatalism; weakened access to community-based and primary care health services; worklessness; poor housing and unequal income distribution profiles across society.

The burden of cancer impacts significantly on society and will grow in prominence over the next three decades. This means that without defined action to improve outcomes in population health and healthcare; tackle inequalities in outcomes, experience, and access; enhance productivity and value for money; and NHS action to support broader social and economic development, this burden will contribute significantly to a worsened population health profile.

Within this picture, we know that one of the biggest causes of avoidable cancer cases and premature mortality is tobacco smoking. This means that we will support all efforts across our Partnership which support tobacco control and help reduce our smoking rates to 13% by 2027/28, as a trigger to encouraging broader lifestyle choices change, most commonly in parts of society experiencing significant health inequalities. Our main direct contribution to this goal will be the Targeted Lung Health Checks programme which will run throughout the course of this strategy.

Increase one-year survival from cancer from 70 to 75% and early-stage diagnosis to 62% as a first step towards the goal set out in the NHS Long-Term Plan

We know that the key ingredients to achieving improved early-stage diagnosis and one-year survival from cancer begin with improving earlier presentation, so that fewer patients are diagnosed through emergency routes (i.e.via an accident and emergency department) than planned routes (i.e.by attending their GP and being referred into secondary care at the earliest stage, based on the presenting symptom). Such an approach also makes better use of available resources. We need to continue to work with others to change the current trend, so that patients are seen earlier; can be diagnosed quicker; and, through improved system-working, at an earlier cancer stage, therefore achieving better 1 year survival.

[1] Cancer Research UK

The nature of the challenge is clear. Across Yorkshire, including our area, around 33% (or 1 in 3) patients are diagnosed with lung cancer via emergency presentation. This figure which is around 10% higher than international comparators. Australia has significantly less emergency presentation of lung cancer and a higher one-year survival rate (49.2%) versus 43.7% in West Yorkshire. If West Yorkshire had the same survival rate as Australia, then we could expect around 191 fewer lung cancer deaths each year.

In the case of bowel cancer, across Yorkshire, including our area, around 1 in 4 are diagnosed via emergency presentation, higher than international comparators. Australia's one-year survival rate for bowel cancer is 87.7%, higher than the West Yorkshire figure if 77.4%. On the same measure, we could expect around 158 fewer deaths from bowel cancer each year.

Our plan to reduce the incidence of avoidable cancer by acting with our partners to change population behaviours.

Plan for 2023/24 (Year 1)

Lung health check (Leeds, Kirklees, Wakefield, Calderdale, and Bradford)

One of our key contributions to this goal is continuing the Targeted Lung Health Checks programme. Through an existing national programme, residents in West Yorkshire and Harrogate who have either ever smoked, or smoke currently, are being invited to undertake a lung health check if aged between 55 and 74. In our current model and based on a clinical assessment, a lung health check can lead to a low-dose CT scan.

This has, in turn, detected more than 1,350 lung cancers nationally, 75% of which have been at stages one and two. Stage one and two cancer cases are directly associated with better treatment prospect and survival than later stages three and four. It is likely that many of these cases are lives directly saved or improved arising from the running of the programme. A further group of patients are detected with diagnoses with require surveillance, such as lung nodules, which can be kept under regular observation.

Based on the success of the programme to date, the National Screening Committee has endorsed proposals for a lung cancer screening programme, building on those already in place for breast, bowel, and cervical cancers. This means that subject to national decision making, this intervention will be sustainably deliverable for future generations.

Locally, 46% of the eligible population has been contacted so far and we have identified more than 50 serious findings (including lung and other cancers) in North Kirklees and Bradford, with data from the Lung Screening Trial in Leeds (supported by Yorkshire Cancer Research) to follow. These programmes have been developed in partnership between the Cancer Alliance and place-based teams including Curo in North Kirklees and the TPC federation in Bradford. Patients who take advantage of lung health checks can often present a secondary opportunity to have a conversation about smoking cessation and referral to specialist services can be arranged as part of the same appointment.

In quarter 1 of 2023/24, the initial invite and assessment programme in North Kirklees will have been completed and by quarter 3, we will have begun expanding the programme into the remaining primary care networks in Bradford, which will continue across 2024/25, taking our population coverage above 55%. We will also continue all our current work, promoting uptake and awareness of the programme via our communications and engagement colleagues working in place, supported by our Cancer Alliance team.

Our next projects will be working in the Wakefield; South Kirklees, Calderdale, and Huddersfield; and Harrogate localities, with further discussions taking place about exact plans. We will also consider the range of different provision models which can help secure the best success for this programme.

Improving population awareness of cancer and encouraging participation in national cancer screening programmes, where available (all Places)

We know that people who experience health inequalities and populations from lower socio-economic communities tend to engage with cancer screening programmes less and their outcomes from cancer presentation are poorer. Good progress has been made, but there is more work to do to challenge unwarranted variation in coverage and uptake.

For example, in Leeds, in a pattern which is replicated across most places we have variation:

- In cervical cancer coverage rates of 32.5% (low) – 80.3% (high) for 25-to 49-year-old women and 56.5 (low) - 80.3% (high) in 50-to-64-year-olds; against an 80% reference target.

Coverage is defined as the percentage of individuals eligible for screening at a given point in time who were screened adequately within a specified period (within three and a half years for those aged 25 to 49, and within five and a half years for those aged 50 to 64).[2]

The low figure represents the worst coverage and the high figure the best coverage. Variation may be explained due to demographic factors - people from some minority communities are less likely to come forward for screening; deprivation factors – people from lower socioeconomic decile communities may need enhanced physical access to screening services, greater choice and promotion, and tailored information to enable them to participate; and other factors such as the effectiveness of local services/systems to invite eligible participants and encourage their informed choice to participate (or not).

- In bowel cancer, with a 60% reference target, we have variation in uptake between 46.6% and 79.2% and 46.4 and 77.2% coverage.

In this context, uptake means number of invited men and women aged 60 to 74 who adequately participated in screening within 6 months of the invitation[3]. Coverage means the proportion of eligible men and women aged 60 to 74 invited for screening who had an adequate screening result in the previous 30 months[4].

- In breast cancer screening, the similar variations are 34.3% to 73.8% uptake and 40.6% to 76.9% coverage.

The Cancer Alliance and its primary care network facilitator team will continue to work with the bank of care coordinators and place-based leads to support targeted uptake increases in primary care networks with lower rates and amongst minority communities who may experience barriers to uptake due to difficulties including communication methods; service accessibility and design issues; and inability to understand the process without adjustments being made. These efforts will also ensure that our approach carefully considers the impact of poverty on our plans, by making sure that we recognise the full scope of barriers which prevent engagement with healthcare services.

[2] NHS Digital

[3] BCSP-002 gov.uk

[4] *ibid*

Building on our work so far, our collective efforts in year 1 will focus on embedding interventions linked to support for patients affected by a learning disability; access to smear testing for the LGBTQ+ community; breaking down barriers to smear testing amongst women from the South Asian community; and focussing on screening uptake amongst minority groups such as the gypsy traveller community. We will support access to screening appointments by expanding behavioural science and personalised message interventions to every practice by 2024 using an innovation provider, Appt-Health, to support this. Behavioural science considers which types of messages are likely to trigger the desired response – for example, a personalised/tailored message to a patient, or one which is sent from the patient's registered doctor may carry more weight than a "blanket" message.

We will also build on the learning from the health equity fellowship programme, which colleagues in our team have invested in and continue to invest in our Cancer SMART programme and our collaboration with Yorkshire Cancer Community which delivers a community advocate model to deliver improved population awareness around cancer signs and symptoms. We also plan in to expand reach in to targeted prostate cancer awareness campaigns through partnership working; further enhance our successful liver cancer surveillance programme working with partners in Leeds and the hepato-bilary operational delivery network; and run a full suite of cancer awareness raising campaigns via a refreshed website and enhanced social media presence.

Plan for 2024/25 (Year 2)

Lung health check (all local places)

In 2024/25, our aim is to ensure that the lung health checks programme becomes live in at least Wakefield, and preferably also South Kirklees, Calderdale, and Huddersfield. We will also have adopted the Yorkshire Lung Screening Trial in Leeds into a lung health check, by working to invite the "control group" from the existing clinical trial and then any patients who have "aged in" to eligibility i.e., these are people who were too young to be invited when the programme was launched but are not in scope. This will also be an opportunity to re-approach people who may have changed their minds and decided that a lung health check is the right plan for them. By the end of year 2, we will also have agreed a planning trajectory for Harrogate, meaning that we have will have a solid approach to delivering full population coverage by the end of year 5.

So far, the selection group for lung health checks has been based on health inequalities and smoking prevalence data. In Wakefield, and potentially in other future lung health check programmes, we think that there is an opportunity to target this programme more effectively, by working together with the ICB climate change team to identify those geographies with poor air quality, which is also associated with respiratory illness and lung cancer in some cases.

We also know that this group of patients can be at elevated risk for detection of other cancers. For these reasons, and subject to approvals, we are planning to collaborate with the Yorkshire Kidney Cancer Screening Trial so that, by 2024, some patients are additionally offered a scan of their kidneys in the same appointment slot as the check of the lungs. This work will continue across years three, four and five. We further know that this group can be at risk of other cancers such as head and neck, and cancers of the oral cavity. Therefore, a physical inspection of these areas, building on a successful pilot in Leeds, is part of our plans.

Improving population awareness of cancer and encouraging participation in national cancer screening programmes, where available (All Places)

By year 2, we propose to work collaboratively with place-based partners to invest further in the infrastructure of cancer care coordinators, with clearly defined objectives and a tailored support package, which reflects the needs of local communities and avoids duplication of effort. These colleagues will work collaboratively with the primary care network facilitators in the Cancer Alliance core team. In the first instance, this will look at cancer screening rates, but, in areas where appropriately high rates of cancer referral and screening are achieved, we will examine other areas where the approach can make a difference.

Building on what we have learnt from our patient panel and as part of our efforts to ensure that the experience of cancer care is on a par with service delivery, we will use their insights to review priority areas such as access to primary care professionals for cancer patients and tracking of results for investigations ordered locally. This will dovetail with a broader intervention looking at cancer care reviews, pre-habilitation, holistic needs assessments, end of treatment summaries, and the creation of an expanded network of community beacon information points with single point of access provisions; all linked with the wider and important living with and beyond cancer agenda and reflecting our enduring partnership with Macmillan Cancer Support. These initiatives and innovations, developing further our population awareness raising programmes, such as Healthy Communities, and working collegiately with colleagues overseeing the Core20Plus5 health inequalities programme, will help us deliver our input to the strategic goal, contributing to the overall ambition.

Year 3 - 2025/26

Funding for Cancer Alliances has been set on a two-year trajectory, with confirmed financial plans for the 2023/24 and 2024/25 financial years, subject to an annualised review of national priorities set out in the operational planning guidance.

For cancer, there is an expected broader, national strategy for long-term conditions management, over a ten-year horizon, but details have not been published, following a consultation process in 2022/23. We will reflect on our plans once this is published. Our intentions across years three, four and in to five of the plan are to continue with these same programmes, and to pursue our strategic goals on the same thematic basis.

Year 4 – 2026/27

Same as 2025/26

By the end of year 5 (2027/28)

- We wish to ensure that every primary care network delivers, at a minimum, the targeted coverage and uptake rates for each of the three main cancer screening programmes. Where this is not possible, due to populations taking an informed choice not to participate, we wish to eliminate unwarranted variation in uptake, as assessed by NHS Right-Care data for similar demographics.
- We also wish to demonstrate significantly improved population awareness of the signs and symptoms of cancer, working with Cancer Research UK to use the Cancer Awareness Measure (CAM)[5], as a market intelligence tool to detect resonance of population health messaging.

[5] https://www.cancerresearchuk.org/health-professional/awareness-and-prevention/the-cancer-awareness-measures-cam

- We want to demonstrate impact of our work by both meeting and going further than the current ICB ambition. In practice, this means that hundreds of extra lives will be saved per year, every year, in West Yorkshire, and we have met our strategic goal in full.

Our plan to increase one-year survival from cancer from 70 to 75% and early-stage diagnosis to 62% as a first step towards the goal set out in the NHS Long-Term Plan

Plan for years 1 and 2 (2023-2025)

Deliver innovation, faster diagnosis, personalised care, and best treatment sooner as part of improved cancer pathways (All Places)

Faster diagnosis and best treatment sooner

Alongside our ongoing efforts to ensure that provision of cancer assessment and treatment in accordance with NHS Constitution standards, the Cancer Alliance will invest in a wide range of pathway-based innovations, focussing on delivering better, timelier care, wherever possible closer to the patient's home.

- We will invest in securing sustainable services in priority areas of need, including working with the diagnostics programme, overseen by WYAAT, to take advantage of new developments such as community diagnostic centres and the expansion of GP Direct Access for patients with lower risk cancer symptoms (All Places)

- We will invest in non-surgical oncology services so that a new, targeted operating model can be achieved with excellent patient, staff, and other partner engagement. This will include supporting Leeds Cancer Centre to develop proposals to expand access to radiotherapy, via renewals of linear accelerators (Leeds Place)

- We will also support recommendations arising from the breast cancer resilience project, focussing on the development of resilient services arising from the community breast pain pilots. Building on this, we will commence reviews of the skin and lower GI pathways at system level (All Places)

By the end of year 1, building on our work with acute trust partners and others, where we have closed the referral gap, we will have closed the remaining treatment gap, in net terms. This means that we will have treated the same number of patients for cancer had we not had the Covid-19 pandemic. Our plan for 2023/24 builds on earlier successes - this year, we are one of the few Cancer Alliances in England to meet the expected reduction in the backlog of patients awaiting cancer treatment from the Covid-19 pandemic. A peak of near 1,480 patients waiting in June 2020, has now more than halved, with services meeting a 30% increase in the volume of cancer referrals in 3 years, alongside an 8% increase in cancer treatment across the same time-period. We have amongst the lowest rates of patients in the "cancer backlog" across the whole country.

Our plans across years 1 to 5 will continue to focus here because there is a clear relationship between the timely provision of care and clinical outcomes – for example each four-week delay between cancer diagnosis and surgery can be associated with a 6-8% relative increase in all-cause mortality, whilst the same effect is 9-23% for radiotherapy, and 1-28% for adjuvant (after initial treatment) or neoadjuvant (before initial treatment) chemotherapy. Innovation potential and these factors also feature on the "waterfall" diagram, showing the gap and plans to address the early-stage cancer challenge.

Innovation and personalised care

The Cancer Alliance, working together with its partners, has a strong track record of delivering innovation and improved pathways to secure earlier diagnosis of cancer. We have more than 20 live innovation schemes covering a diverse range of areas including improved management of frail patients on the lower gastrointestinal pathway (Leeds and Harrogate Places), an academy style programme for cancer nursing (All Places). This year, we will expand our innovation programme further by developing new competitions for the VCSE sector, focussing on the living with and beyond cancer agenda (All Places); an acute-sector competition focussing on earlier diagnosis (All Places); and a sub-acute competition focussing on cancer screening, early detection, and prevention (All Places).

Our plans for this year include:

- Improve the lower gastrointestinal pathway for patients by expanding the use of colon capsule endoscopy (CCE) and supporting evidence-based use of Faecal Immunochemical Testing (FIT) on both the lower (DG30) and higher-risk symptoms (NG12) pathways (All Places)

- West Yorkshire and Harrogate is a national leader in the service evaluation of PinPoint and clinicians in Calderdale are leaders in the delivery of cytosponge which is used in oesophageal cancers. We will expand use of this technology (Calderdale and Harrogate)

- Expanded use of testing for lynch syndrome in colorectal and endometrial cancers (all Places)

- Complete the service evaluation of PinPoint blood testing in urological cancers, using the evidence to consider the use-case for expansion (all Places)

- Prepare to adopt Grail blood testing, subject to the receipt of satisfactory clinical trials data later this year (all Places)

- Facilitate the expansion of recruitment to the EUROPAC trial for patients at higher risk of pancreatic cancer (newly diagnosed adult diabetics with significant weight loss and families with two or more cases – Leeds Place)

- Encourage the wider adoption of GP direct access to diagnostics for suspected, lower risk, cancer patients and further support the development of three proposed community diagnostic centres in Wakefield, Leeds, and Bradford (Wakefield, Leeds, Bradford Places – interdependencies with others)

- Support colleagues in Bradford to develop a business case for a purpose-built endoscopy unit to transform care for patients with suspected lower gastrointestinal cancer (Bradford Place)

- Complete the progress to routine commissioning arrangements for non-site-specific cancer pathways (NSS) (All Places)

- Expand the treatment variation programme, working with our network of optimal pathway groups to consider priority recommendations from all cancers with a clinical audit report (All Places)

- Develop new clinical networks in rare cancers, focussing on sarcoma, brain and central nervous system (CNS), and HPB (Leeds Place)

- Consider the opportunities for a streamlined, local, approach for quality surveillance of cancer services, recognising the gaps left in provision from the reduction of the regionally led programme, building on the advice of our Lead Cancer Nurses group (All Places)

- Continue and expand all actions to secure the genuine co-production of service users in our work. This will include continuing the patient panel and Cancer SMART programme and the patient experience strategy and improvement group, reporting directly to cancer alliance board (All Places)

- Continued investments in the end-of-life care programme, new investment in the mental health, learning disability and autism programme, and refreshed investment in the improving population health and wider clinical leadership agenda (All Places)

- Improve access to psychosocial support with a dedicated plan, also expanding community-based personalised care and introducing concepts such community beacon information points and single-point of access, for example, to improve patient experience and reduce inequalities of access (Model to be developed by Place)

- Evaluate the effectiveness of service innovations in progress including:

    - A colorectal advanced nurse practitioner (Bradford Place)
    - A screening uptake programme for people affected by learning disabilities (Bradford Place)
    - Investment in the dietetics pathway for cancer patients (Calderdale Place)
    - Pump-priming of work for the Thinking Ahead Programme – hosted by Harrogate and based out of Calderdale (Harrogate and Calderdale)
    - A physician associate model for non-site-specific services; an onco-geriatric clinic for lower gastrointestinal patients in Harrogate (Harrogate Place)
    - A pharmacist independent prescriber in Leeds and similar support in to an onco-geriatric clinic (Leeds Place)
    - Tele-dermatology investment in Mid Yorkshire (Wakefield and Kirklees Places)
    - An oral lesions virtual clinic in Leeds (Leeds Place)
    - Enhanced recovery programme for pancreatic cancers in Leeds (Leeds Place).

Year 3 - 2025/26

Funding for Cancer Alliances has been set on a two-year trajectory, with confirmed financial plans for the 2023/24 and 2024/25 financial years, subject to an annualised review of national priorities set out in the operational planning guidance.

For cancer, there is an expected broader, national strategy for long-term conditions management, over a ten-year horizon, but details have not been published, following a consultation process in 2022/23. We will reflect on our plans once this is published. Our intentions across years three, four and in to five of the plan are to continue with these same programmes, and to pursue our strategic goals on the same thematic basis. However, we will continue the same focusses on faster diagnosis, personalised care, and innovation.

Year 4 – 2026/27

Same as 2025/26.

Year 5

- By 2027/28 we want to ensure that our work has helped to deliver at least 4 in 5 people receiving either a diagnosis of cancer, or an exclusion of cancer, within one month of being referred with cancer symptoms (diagnosis measure)

- We also want to ensure that at least 95% of people receive cancer treatment within one month of a decision to treat being made (treatment measure), and that no more than 1 in 20 people on our cancer patient tracking list are waiting more than two months in total (backlog measure)

- By 2027/28 we want to have a fully embedded system for genomics testing in West Yorkshire and Harrogate, including BRCA gene mutation testing; testing for Lynch syndrome in colorectal and endometrial cancers; and surveillance testing for people with elevated risk of rarer cancers, such as pancreatic cancer

- We also want to deliver a model of care where personalised care support plans, irrespective of the treatment modality or plan, are the norm for all suitable patients

- We also wish to significantly expand our business intelligence capabilities, so we have improved capacity to track, monitor and evidence the impacts of our interventions on population health

- We will have ensured that local people will have benefitted from cancer care assessment transformation such as the PinPoint blood test, which analyses tumour markers in the blood amongst people with cancer symptoms, and the GRAIL blood test, which examines for the risk of cancer amongst the asymptomatic population.[6]Both interventions, along with others may be pivotal to our aims to deliver better, timelier diagnosis of cancer. With GRAIL blood testing, we are conscious that the experience of testing asymptomatic people for cancer needs to be sensitively handled and may detect additional need. This would be the case particularly where the test describes an elevated risk of cancer, which the person was not previously aware about. It follows that we will work together with our Trauma and Adversity programme to make sure that the programme is designed to consider the broader repercussions of this important prospective innovation

- PinPoint and GRAIL will remain part of a broader portfolio of innovation which will span the voluntary, community and social enterprise (VCSE) sector; primary care; secondary care and other partners; and be relevant right across the span of prevention through to early treatment and end of life care

- Our reputation for enabling and adopting innovation, achieved through schemes such as the Small Business Research Initiative (SBRI), our innovation competitions, and our co-working with the Academic Health Science Network (AHSN) will help the Cancer Alliance both enhance its relationships with research institutions and develop greater income diversification from hypothecated NHS funding, as a platform to build success

- We will have an expanded portfolio of investment in clinical leaders to cement our role as a clinically-led team, and support for interdependent ICB programmes with needs which span across the needs of people affected by cancer – such as mental health, learning

[6] Both PinPoint (service evaluation) and Galleri (GRAIL – clinical trial) are subject to clinical validation and assessment.

disabilities and autism; personalised care, long-term conditions, and unpaid carers; improving population health; trauma and adversity; and suicide prevention

- We will have used our influence positively, as advisors to specialist commissioning functions, fully devolved to ICBs from 2024/25 onwards, following joint committee arrangements this year to ensure that the focus of cancer transformation responds to local need and support for the four core purposes of the ICB as set nationally.

Palliative and end of life care

We are committed to ensuring that people of all ages with end-of-life care needs are identified and those that require specialist services can access these seven days a week in all settings. Our vision is for people to die in a place of their choice, with their loved ones, and with their end of life wishes in place. Our programme delivery will be focused on the following areas:

Choice and control supported through personalised care and honest conversations – This includes supporting our local places to offer a shareable advance care plan (ACP) to those in the last year of their life. A toolkit of advance care plan and bereavement resources has been recently published to support personalised conversations We will work with the Cancer Alliance and Ageing Well Programmes to ask for feedback about how shared decision making and advance care relating to NICE guidance on Shared Decision Making (NG197) is being implemented. We will support development of personal health budget approaches in palliative and end of life care (PEoLC) and we will develop resources to support our diverse populations to understand the legal requirements relating to death certificates.

Fair access to PEoLC is driven through early identification and reduction in inequalities – We will develop a consistent approach for identification of patients in the last year of their life, using data from completed GP records to understand those numbers of people identified early. A key priority is to complete an all-age health needs assessment across West Yorkshire focusing on health inequalities. The core purpose of the HNA is to guide the future development of equitable PEoLC services across the WYHCP footprint. The HNA will also ensure WYHCP is compliant with PEoLC statutory guidance. Outcomes from the HNA will be used to implement an equitable all age vision of PEoLC across West Yorkshire, working with people with lived experience and their carers, the public, the voluntary sector, place colleagues andWYHCP programmes. We will also support place led research opportunities relating to PEoLC inequalities

Comfort and wellbeing are maximised - We have asked Healthwatch to speak with adults, children and young people experiencing PEoLC, and their families and carers, ensuring there is a focus on engaging with people experiencing health inequalities. Healthwatch will be asking people about the quality of their care and the responses they receive will inform the Health Needs Assessment. We will build a West Yorkshire wide approach to reviewing availability and access to bereavement support. Working in partnership with West Yorkshire Hospice Collaborative, Living and Ageing Well and MHLDA Programmes we will evaluate how people with complex communication difficulties are being supported when they may be experiencing distress.

Access to coordinated 24/7 care across all services is improved – We are working across the Partnership to collate information about the number of emergency admissions people experience in the last three months of life. We are also working with colleagues from the digital team to widen the information sharing of PEoLC records and recommended summary plan for emergency care and treatment (ReSPECT) records through the Yorkshire and Humber shared record. We will ensure across West Yorkshire people have access to

24/7 coordinated support for PEoLC from health, social care and community services and we will co-ordinate a working group to focus on the transition from children to adults' services.

Staff are skilled to be compassionate and person-centred – We will support the development of the NHS England PEoLC workforce strategy for West Yorkshire and the delivery of ECHO programme specialist palliative care clinical nurse specialist development programme. We will deliver advanced care planning and bereavement training for health, social care, VCSE staff and volunteers. We will develop an approach to involving people with lived experience to evaluate staff training courses, to coproduce resources to support any gaps they identify and to support the delivery of personalised care training. We will work across West Yorkshire to share personalised care training and good practice.

Communities are compassionate and resilient – We will work with the NHSE lived experience team and peer leaders in PEoLC to develop a coproduction group to:

- Identify what it means to be part of a compassionate and resilient community experiencing PEoLC
- Identify how unpaid carers supporting someone at end of life are supported to access local services using NICE QS13 End of life care, quality statement five.

We will support conversations about advance care planning end of life care with our local communities across West Yorkshire. We will implement'Tell three people what matters to you' communication and working with voluntary sector colleagues to hold a West Yorkshire Good Grief festival.

Building and Retaining our Workforce

The West Yorkshire People Plan

Our West Yorkshire People Plan sets out our ambitions for our 'one workforce' which includes those working in health, social care, the voluntary, community and social enterprise (VCSE) sector, unpaid carers (approximately 400,000 people, as many do not access formal support) and recognises the contribution made by our education sector in developing the current and future workforce.

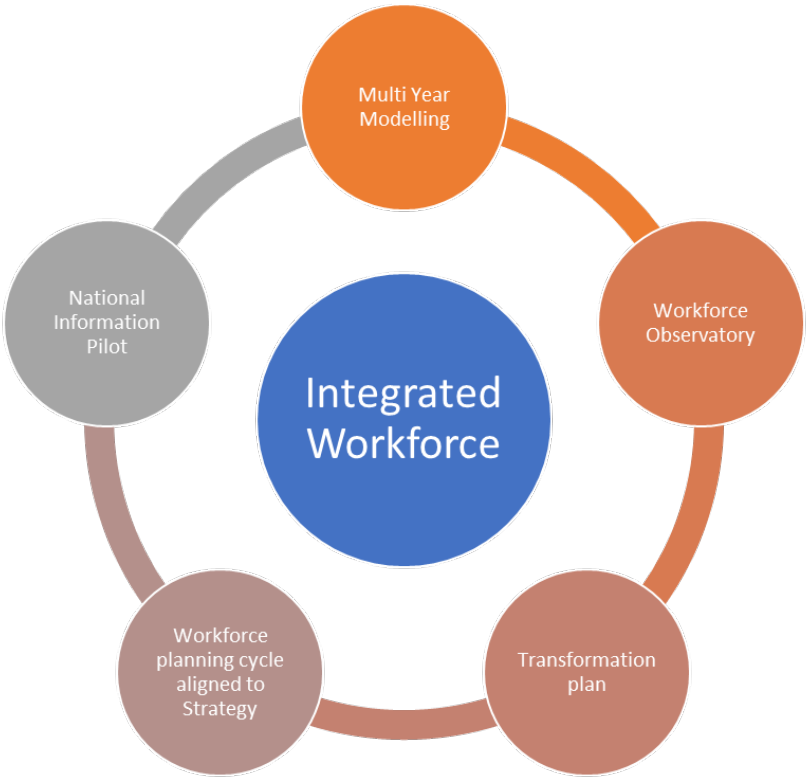
The People Plan is a published document, the detail of which can be found at: Five pillars of our People Plan :: Workforce Transformation (wypartnership.co.uk) As well as the online version, you can read or download the People Plan as a PDF, or in a variety of accessible formats.

Evidence-based, integrated, inclusive workforce plans

Strategic workforce planning
To deliver the workforce of the future, we need to develop our capacity and capabilities to deliver system wide strategic workforce plans which reflect population health management, new models of care and digital innovations.

We are developing strategic workforce planning guidance/framework document in 2023/24 for places and programmes, which will be delivered in 2023/24. This will enable places to be better informed of the wider annual workforce planning cycle and events, as well as information that sets out key details and expectations from a West Yorkshire perspective. At West Yorkshire we respect the primacy of place and support the view that places are best positioned to plan, deliver, and evaluate their workforce needs. At a West Yorkshire level, we will coordinate, enable, and facilitate work, education and training which supports them in doing so, for example, with our multi year workforce modelling events (quarterly) and our collaborative approach to producing our operational planning narrative.

The process for the operational planning includes collaboration with West Yorkshire ICB programmes and places. In working in this way, we have collated information for the narrative, ensuring all are cited on information provided.



We are facilitating **Multi Year Workforce Modelling** workshops with each of our five places. These events are attended by staff from health and social care providers, the VCSE sector, education, and local authority. We recognise the need to continue to better understand the profile of our collective workforce by improving the quality and standard of data to inform decision making across sectors/roles. We have made a good start with this, with all five places having had two workshops so far, with further quarterly events planned throughout 2023/24. The workshops are facilitated by the WY ICB workforce strategy and planning team (which includes our NHSE colleagues) and have identified the areas where improved data and scenario planning would be useful (e.g., children's care services, VCSE and primary care). The requirement to increase training placements in community settings was identified by all places. The output from these engagements has been to inform NHSE **investment in education and training**.

We recognise the complexity of working on multiple footprints and that demand must be informed by an understanding of population needs and future models of care, captured through sector, pathway/programme, and neighbourhood planning lenses. Building a consensus around future size and shape of our workforce is key to supporting workforce and service transformation and to achieving our vision.

ICBs and the places within them, require a range of data and intelligence to inform their interventions and undertake their functional responsibilities with evidence-based approaches.

The ambition of the **National Information System Pilot** is to create a comprehensive range of data products and dashboards which fully support ICBs, and which are driven by genuine user engagement. The work is not limited to NHS workforce data and there is the potential to explore:

- User needs across workforce and education, finance, and activity data,
- Include primary and social care,
- Provide aggregation and benchmarking services,
- Focus on key questions,

NHS West Yorkshire Integrated Care Board has five local places. These are Bradford District and Craven, Calderdale, Kirklees, Leeds and Wakefield District

- Develop new ESR (electronic staff record) data

Our ambition is that these initiatives will influence spending on education and training, allowing us to target key areas to build and develop our West Yorkshire workforce. West Yorkshire ICB is leading the National Information System pilot project nationally in with NHS England.

The **West Yorkshire Workforce Observatory** is an exciting new interdisciplinary initiative, which has been running from January 2020, and involves researchers from higher education (HE) working in collaboration with the West Yorkshire ICS (Integrated Care System). The West Yorkshire Workforce Observatory takes an innovative approach to workforce planning and has forged an interdisciplinary, cross-sector network that has been able to create innovative approaches to evidence-based workforce development.

Examples:

- Recruitment and retention of care workers
- Review of strategic workforce planning in health and social care
- Planning the radiology workforce for cancer diagnostics in West Yorkshire
- A review of the health and social care digital workforce in West Yorkshire

Current funding which supports operations of the Workforce Observatory ends at the end of March 2023. A business case has been developed to present options for investment in the West Yorkshire Workforce Observatory from 1April 2023 for the medium term (next three years) as part of a system wide response, and in partnership with the five places, to ensure the continued prioritisation of an integrated system-wide approach to workforce planning and development that provides transformational results and aids decision making through evidence base research on how health and social care services are delivered across the sector, shaping our future workforce.

Social and economic development
As part of our wider work on workforce integration, we need to consider and address the ongoing economic effects the current cost of living crisis, industrial action, and the impact these may have on our colleagues whose households may be impacted in these tough times, and the additional anxiety this will bring. We need to further scope how the health and care sector can contribute to social and economic recovery, ensuring that as we plan our future workforce requirements, we maximise the potential of our anchor institutions to support growth and job opportunities within our local communities.

Reducing health inequalities
A key priority for the West Yorkshire Workforce Programme in 2023/24 will be the scoping and development of a community workforce framework, encompassing the prevention agenda and delivering care closer to home (neighbourhood teams and virtual wards), supporting wider urgent and emergency care pathways, which will go some way to addressing the workforce issues outlined in the NHSE delivery plan for recovering urgent and emergency care services. The workstream ambition is to explore the creation and utilisation of new roles, innovation in recruitment, retention, placement opportunities, career, and education/learning pathways.

Social care

The social care sector within West Yorkshire both public and independent, have significant workforce challenges which range from the ability to attract sufficient numbers across all roles, in part due to the competitive labour market and associated terms and conditions,

through to the ability to retain colleagues with sustainable career development opportunities. The West Yorkshire Partnership recognise the opportunities of working collectively on this agenda, with colleagues representing the West Yorkshire care sector, playing a key part on Yorkshire and Humber work programmes to support the development of the social care workforce. The West Yorkshire ICB People Directorate supports this work with identified activity to date including the development of an International Recruitment infrastructure, the exploration of enhanced placement capacity into social care and collaborative work to enhance the access to training for social care colleagues available within the health sector.

Education and training

The Health Education England (HEE) workforce transformation team are embedded as a key function in the ICB's People Directorate as part of the workforce strategy and planning team. The HEE team are working with several stakeholder partners to support transformation using a variety of workforce transformation techniques and tools. These initiatives encompass service redesign, new ways of delivering care, new ways of working, service delivery and upskilling.

RISK: With the transition of HEE to NHSE, there is a risk that funding for workforce development is lost The influence the ICB can exert on the funding for Education and Training is critical to delivery of a workforce with the right skills in the right place over the period of the Joint Forward Plan.

Some examples include:

Calderdale framework projects

- Leeds Children's Hospital are working with clinical teams in the children's day surgery unit to help to maximise the effectiveness of the workforce, ensuring that the registered staff perform tasks only they can do, supported by a skilled, safe, and competent support workforce, benefitting staff, patients, and their families.
- Airedale NHS Foundation Trust working with the breast surgery and breast imaging teams, we have identified elements of the service that can be delegated to other professions and skills that can be shared across professions to create resilience in the service and free up clinical nurse specialist time to focus on more complex cases. Through competency framework mapping, upskilling opportunities have been identified for the assistant practitioner roles. There are plans to develop a proposal for how the Genomic testing service can be delivered when the Trust picks up this work.

NHSE Star workshops:

- Pharmacy – Workshops have been held that have identified a clear action plan for increasing supply, upskilling the workforce, developing new roles, introducing new ways of working and strengthening leadership. Specific actions include:
    - Reducing student attrition
    - Developing a taxonomy to clearly articulate and define scope and purpose of roles in all settings enabling cross system working and the introduction of pharmacy roles to services that do not traditionally employ pharmacists
    - Scoping and promoting dual/cross sector roles
    - Introduction of pharmacist roles in virtual wards
- Maternity - Supporting the West Yorkshire and Harrogate Local Maternity and Neonatal System (LMNS) workforce group in pre-workshop awareness raising and information gathering from a wide range of staff involved in the delivery of maternity and obstetric care, ahead of a Star workshop to be held with Heads of Midwifery (HoMs), Directors of

Midwifery (DoMs) and service leads to explore effective solutions to the priority workforce challenges across the service.

Service redesign
WYAAT (West Yorkshire Association of Acute Trusts) has a well-established Theatre Forum group with representation from all six West Yorkshire and Harrogate Trusts. Created in March 2022, this group provides a platform for theatre staff to come together on a regular basis to engage and discuss current workforce issues. We have made progress on several workforce initiatives, which has recently led to us forming three subgroups focused on recruitment, retention (including education, health, and wellbeing) and transformation.

The WYAAT forum offers an opportunity to discuss ideas and generate unique and constructive solutions to address some of the workforce issues collaboratively as well as celebrate some of the amazing work that is happening across our hospitals.
We have representation from regional NHSE at this group who provide support, advice, and guidance and recognised the WYAAT theatre model as an exemplar. WYAAT are also part of the 'National Building Outstanding Theatres Team' (BOTT) who are keen for this group to play a significant part in the key deliverables of the national programme.

More recently, Leeds Teaching Hospital NHS Trust (LTHT) and Calderdale and Huddersfield Foundation NHS Trust (CHFT) theatres have been selected to be part of a National pilot with the CLEAR programme supporting elective recovery through priority themes.

New ways of delivering care and service delivery
We recognise the value that students bring to service delivery and have been working to ensure that our students play a contributory role in service delivery in an environment that is safe for them and our patients. We have several initiatives that support this:

The **Multi-professional student-led clinic project** aims to increase placement capacity across all practices, whilst additionally maintaining, and sometimes improving, quality. It significantly supports capacity issues by targeting waiting lists, and in turn this is contributing to patient safety and satisfaction. This moves towards greater focus on work in the community and a greater attraction for people to want to work in the community following their experience with patients.

For the learner, this project becomes an invaluable placement experience in building confidence with increased patient exposure, developing early leadership skills and gaining a sense of value from feeling part of a team. For general practice it is becoming a valuable resource in reducing service pressures, supporting staff wellbeing and feedback suggests it has had a significant success in tackling health inequalities:

- Primary care - multi-professional student led clinics are in the early pilot stages running across two large west Yorkshire PCN's currently focussed on managing serious mental illness reviews. The West Yorkshire Primary Care Workforce and Training Hub have appointed a student led clinic manager who will support the roll out of the student led clinics across West Yorkshire.

- The Learning Environments and Placements Programme has worked alongside Leeds Community Podiatry and The University of Huddersfield in piloting a number of student-led Podiatry clinics - the first of 10 clinical sessions were piloted in January 2023. In the pilot, the areas focused upon were Heel Pain clinics, new assessments of patients who were placed on waiting lists in 2021, and clinics to reassess 'at risk' patients who had not had a face-to-face appointment for over 15 months. A thorough assessment was undertaken of

each patient, which included additional Patient Education advice on how to safely manage their condition at home. Because of the Patient Education element within the clinics, we were able to extend review times and increase capacity. Generally, one registered Podiatrist would have around 45 appointment slots in a five-day period. Five days of student led clinics created 120 additional appointments, which is an increase in capacity of 166%.

- Urgent care - We are currently exploring the possibility of student led clinics within urgent care to help support waiting times for minor injuries.

- Elective care - we are also exploring the possibility of student led clinics to support rehabilitation to prevent deconditioning and reduce the length of hospital stays following surgery and those awaiting discharge.

- Students working as bank staff – Nursing and AHP (Allied Health Professionals) programmes across West Yorkshire now include the care certificate. This enables our students to undertake bank work as health care assistants, supporting service delivery as well as developing their competence and confidence.

Growing new skills and the **West Yorkshire Workforce Transformation Plan**
The NHSE West Yorkshire workforce transformation team led a West Yorkshire wide learning needs analysis to inform the investments for upskilling via the NHSE Workforce Development Programme. The programme is aimed to upskill and support new ways of working across the whole workforce, including registered and non-registered staff in hospital, community, social care, and VCSE.

The learning needs assessment has been led at place, with place workforce leads developing steering groups to ensure an ongoing iterative process. There is an ongoing programme of modules and training offered by West Yorkshire education institutes and the LNA will be used to identify emerging and new skills required. There are indications of increase demand for modules and training that support community provision and addressing health inequalities such as frailty, monitoring long term conditions (diabetes, cardiovascular and dementia) and remote monitoring. Work is being done to identify new ways of delivering accessible training in these areas. The LNA is identifying where staff need skill development to support workforce transformation. By April, we will be working with West Yorkshire universities and other training providers to confirm the offer for 2023/2024.

Upskilling – The NHSE West Yorkshire workforce transformation team have supported utilisation of LOT3 Health and Care Adult Skills Funding from the West Yorkshire Combined Authority (WYCA) which is managed by West Yorkshire Training Providers. Courses have been developed in partnership with five health and care organisations, where gaps in current provision are preventing staff progression, particularly where this is impacting staff retention. Courses in project management and palliative care are amongst the training developed so far and more is planned. NHSE will track and provide updates to the ICS.

Global partnerships

International recruitment
Our partners across the system are developing workforce strategies related to Global Partnerships for the West Yorkshire ICS. In addition to supporting ongoing IR practices across the partnership, the West Yorkshire ICB Global team promotes collaborative working between partner organisations within the area and embedding retention and progression from the outset.

A key element of this is working in close collaboration with NHSE on several small-scale pilots to develop new ethical, sustainable international recruitment pathways for roles in the collaborative West Yorkshire Mental Health, Learning Disabilities and Autism Programme (five psychiatrists and 25 mental health nurses) and Cancer Alliance (five medical oncologists) and Yorkshire Ambulance Service NHS Trust (five senior clinical advisors for the NHS 111 service). Once these pathways have been piloted and evaluated, they will then be usable by all organisations within the Partnership, which will reduce reliance on agency costs

These recruitment pipelines of internationally educated colleagues will continue to grow through 2023 and are likely to become sustainable workstreams over the next five years. Expansion of international recruitment of other professional groups is ongoing, with the planned supply targets across West Yorkshire from international recruitment in 2023/24 standing as:

- Registered nursing, midwifery and health visiting staff 165 whole time equivalent
- Allied health professionals 8 whole time equivalent
- Medical consultants 42 whole time equivalent
- Trust doctors/non-consultant career grades 14 whole time equivalent
- Paramedics 60 whole time equivalent

In 2022, the ICB established a partnership with the Government of Kerala in India that provides an ethical and sustainable supply of nurses to all West Yorkshire health and social care partners. This pathway for large scale nursing recruitment, along with all other ethical migratory pathways developed for other clinical specialties, will be fully evaluated in 2023, to establish an effective recruitment process and experience for staff and organisations, and that quality improvements to all recruitment pathways are ongoing.

To take advantage of the opportunities of the **Kerala MoU (Memorandum of Understanding)**, and to mitigate the challenges in recruiting fully trained Mental Health Nurses, the Mental Health and Learning Disabilities and Autism (MHLDA) collaborative along with the ICB and NHSE Global teams are exploring options to develop a pathway by recruiting internationally educated general nurses who already have some mental health experience with a view to undertaking further training as mental health nurses on arrival to the UK. Several models are under consideration currently. Similarly, an option to bring healthcare assistants as a development pathway into nursing is being explored.

Profession and thematic collaborations are now working successfully together, with the MHLDA Alliance of 3 trusts (South West Yorkshire Partnership Foundation Trust, Leeds and York Partnership Foundation Trust and Bradford District Care Trust), the West Yorkshire Cancer Alliance, and an allied health professional collective of five trusts (Leeds and Yorkshire Partnership Foundation Trust, Mid-Yorkshire Hospital Trust, Calderdale and Huddersfield Foundation Trust, Bradford Teaching Hospitals Foundation Trust, and South West Yorkshire Partnership Foundation Trust) all demonstrating positive results. There are also ongoing discussions related to collaborative work across the Partnership, both at local levels and the wider setting.

To ensure effective use of ethical, sustainable international recruitment pathways that deliver value at scale and reduce variations in staff experience across the workforce and integrate retention of our international workforce from the outset, collaborative approaches are taking shape at diverse levels. Across Leeds place, the Leeds City Resourcing Group (LCRG) has a workstream focused on international recruitment, collaborating with partners across the city to develop a demand led recruitment model over a 2-year period where partners will share

success measures and look at opportunities to collaborate on key aspects of recruitment activity including accommodation and pastoral support. Other West Yorkshire Places are also exploring the potential for a system-wide approaches to international recruitment and retention, this is inclusive of social care workforce too.

System leadership

The aim of the West Yorkshire system and leadership development work is to ssupport the partnership to achieve our 10 big ambitions through enabling culture change, encouraging collaboration, and supporting our partners in fulfilling their potential by developing leadership capacity and capabilities.

The specific priorities of system and leadership development are to:

- Increase the **diversity of our workforce** so it represents our community through developing and continually improving an inclusive recruitment approach, and routes into employment from underrepresented groups e.g., via project search
- Increase the **diversity of our leadership** through delivering the fellowship leadership programme across WY, reciprocal mentoring programme, ILM coaching programme and the coaching hub, and developing a talent pool of diverse future leaders.
- Enabling our people to access **health and wellbeing offers**, particularly where there are no offers available e.g. social care, primary care, voluntary, community and social enterprise sector through implementing initiatives to address the research findings into the barriers in accessing health and wellbeing offers, supporting our organisations to achieve menopause friendly employer accreditation, providing system wide menopause awareness sessions, delivering a suicide awareness training pilot, measuring staff experience with the development of staff surveys beyond health and scale and spread of a compassionate leadership development programme across West Yorkshire
- **Develop system leadership and OD capacity and capability** across WY through developing the WY OD network and associated initiatives including an OD fellowship, curation, and hosting of resources on the WY website, and development of training and development offers
- Enable the development of our partnership into a system where the whole is greater than the sum of its parts through **leading and facilitating OD and system development** with the component parts of our partnership including places, provider collaboratives, programmes and the ICB, embedding values and behaviours development into our approach
- Enable the delivery of the **five-year strategy** and joint forward plan through facilitating and equipping the component parts of the partnership with OD tools and skills

NHS West Yorkshire Integrated Care Board (ICB) Corporate HR Team

The corporate people team have several priorities and areas of focus following the establishment of the West Yorkshire ICB in July 2022:

- **ICB operating model** implementation
- **ICB transition** activity:
    - Policy consolidation
    - Terms and conditions reviews etc
    - New Ways of Working
- **Staff network** and staff engagement group development
- **ICB People Plan**

Emerging workforce transformation priorities for 2023/24

Dentistry

- AT level 2 – examples of GPs with special interest taking some pressure of community care in foundation practices, which attract upskilling as part of the model
- Local centres for dental development (possibly two in West Yorkshire)
    - Provide a focus for specialised care
    - Provide training in community settings.
    - Delivers a mini specialist care centre which also provides.
    - Community based reason for people to work and develop their trade/career.
    - Support to overseas recruitment

Community / prevention / neighbourhoods workforce framework

- New workforce workstream established for 2023/24 and beyond.
- Scoping to be undertaken to identify gaps in workforce provision that can be tackled at West Yorkshire level in collaboration with community provider collaborative, primary and community care programme, urgent emergency care programme and ageing well programme.
- Multi-year approach to work, workstream ambition is to explore the creation and utilisation of new roles, innovation in recruitment, retention, placement opportunities, career and education/learning pathways.
- Encompassing the prevention agenda and delivering care closer to home (neighbourhood teams and virtual wards), supporting wider urgent and emergency care pathways, which will go some way to addressing the workforce issues outlined in the NHSEdelivery plan for recovering urgent and emergency care services.
- Strands of work are likely to sit across some of our current workstreams, e.g., international recruitment, expanding community placements, student led clinics and retention.

Expanding community placements

- Following the multi year modelling events, a priority around expanding student placements in primary and community care environments was established as a theme across each of our five places.
- The expansion and development of student placements is a priority. A new workstream has been established to engage with a wide range of stakeholders to develop new placements outside of secondary care.
- Exploration of student led clinics in community settings.
- This workstream will also involve working closely with HEE colleagues involved in the various linked work programmes, including (but not limited to):
    - enabling effective learning environments
    - clinical placement expansion programme
    - nursing workforce expansion programme
    - AHP workforce expansion programme
    - Bring back staff programme
- Developing additional community-based student placements will enable us to train more students in environments such as virtual wards and neighbourhood teams, providing an insight into working as part of these teams, and attracting newly qualified students to apply for roles in these areas.

West Yorkshire healthcare science workforce group

The West Yorkshire Healthcare Science Workforce Group is a newly formed group, in which there are 52 professional specialisms. Collectively West Yorkshire ICB and the Healthcare Science Workforce group will work together this year to:

- Undertake an analysis of current activity and demand for diagnostic service that require health care scientists input
- Undertake an urgent workforce review of the identified HCS hotspots and develop a robust action plan to mitigate current shortfall gaps, considering the age demographic and require growth of the workforce to meet service demand.
- Development of a longer-term training and education plan that is reflective of regional requirements for all HCS specialism
- Explore the development of a HCS Clinical Lead role for the ICB.

Expanding the peripatetic workforce to address workforce shortages

There are several reservist models being explored at Places across the system.

To support learning and scale across West Yorkshire, three reservist exemplar pilot projects which cover health and the social care sector, are planned to commence in 23/24. These initiatives factor in mechanisms to enable flex of the workforce to meet service needs with an ambition to integrate these arrangements into integrated workforce planning and contingent workforce strategies including emergency planning to meet operational pressures going forward. The exemplar sites / projects are:

- **Bradford District Care NHS Foundation Trust (BDCFT)** – **Implementation of a bank retention and workforce lead role** – This resource will be based in the Resourcing Team with a focus on Bank and Reservist retention. They will provide capacity to increase pastoral and direct support for all temporary bank workers including the covid bank team. They will align with trust core functions around local workforce modelling to increase resilience and capacity to manage surge/ emergency at pace and enable a proactive approach to the engagement and retention of staff ensuring a robust approach to mutual aid; increasing the capability to ramp up, step down or pause operations safely. There's an ambition to reduce agency spend and a reliance on managed service provider resources.
- **Leeds Community Healthcare NHS Trust**– This project will build on the trust's in-house designed workforce initiative, **the STaR model – Staff Trained and Ready**. The STaR is a 'pool' of volunteers (any clinical or non-clinical staff) who have expressed an interest to be temporarily deployed to support critical services under extreme pressure. Recruitment to the pool will be based on the skills required by the critical service. Staff engagement insight and communication including vlogs and case studies will be an essential part of this project to improve awareness and understanding of its objectives and benefits. Staff are upskilled thereby enhancing their continual personal development. The STaR Reservists scheme will be integrated into trust inductions and staff appraisals. By embedding innovative business continuity and resilience related workstreams, this initiative will ensure the organisation can withstand future periods of pressure.
- **Bradford Council in collaboration with Bradford Care Association** – **The Social Care Reservist Bank** – In Bradford District, the Local Authority holds a 'casual staff bank' that provides casual care staff to both Local Authority care providers and private care providers. Private providers pay the Local Authority for this service. Development of the Staff Bank to include the Reservist Scheme could provide a good quality, cost effective alternative to heavy reliance on agency staff, this would build better resilience into workforce planning and supply. Further conversations planned with providers and service managers to build into workforce planning cycles and forward plans when people are recruited onto the Reservist Scheme. A recruitment campaign is planned to attract people onto the Reservist Scheme as a key pathway into work in the Care sector and provision of a £50 incentive for people who complete the care certificate (up to 150 people).

Digital staff passports / porting of staff across systems, places and providers

- Another priority identified as part of the Multi Year Modelling process was the ability to shift resources to the areas of a system that need it most (e.g., social care, urgent care).

- The NHS Digital Staff Passport is an easy-to-use app that holds staff members' essential information – including personal, employment (excluding pay), skills and occupational health. The passport will ensure the quick and secure transfer of information that's required, without duplicate form filling, checks and training. It will reduce unnecessary duplication and repetition of employment checks, paperwork and training records that will move with them from employer to employer. The Digital Staff Passport is currently for use for NHS to NHS staff movements, it does not include movement outside of the NHS for example primary care, social care or private healthcare.
- Expansion of innovative recruitment practices, e.g., lead employers, and flexing staff where the need is greatest based on capacity and demand and workforce modelling.
- Build relationships across health and social care and strengthen career pathways in social care.

Year one priorities

West Yorkshire ICB developments 2023/24:

We will develop and deliver an integrated workforce plan, working across sectors with partners to enable:

- West Yorkshire to be the most attractive place to work, volunteer, learn and develop individuals and teams across all settings enabling both recruitment and retention of our workforce across all sectors
- Support to programmes in cancer, urgent and emergency care, mental health, learning disabilities and autism and others through international partnerships to create additional supply routes for both health and care organisations
- Phase 2 of our Workforce Observatory to create information that informs decision making and strategic priorities
- Working with employers and the University sector to build on our workforce transformation plan, aligning new roles and ways of working to the five-year strategy and making the best use of investment in education and training across all sectors
- Our collaboratives in acute, mental health, learning disability and autism, and community services, undertaking work to improve flow and productivity supported by the wider system
- Reducing health inequalities through the development of community-based workforce to address and deliver intervention and prevention. System wide planning events have identified the need to create greater learning opportunities in quality learning environments to support this ambition
- Continuing our work in Global Partnerships, including expansion of international recruitment pathways
- Reviewing our retention workstream and developing a retention strategy
- Ensuring our 2023/24 Operating Plan is monitored and delivered in line with the activity, finance and workforce expectations outlined within it, with assurance against actual progress provided to the relevant governance forums
- Increase the diversity of our workforce so it represents our communities through developing and continually improving an inclusive recruitment approach, and routes into employment from underrepresented groups e.g., Project SEARCH and Project CHOICE
- Increase the diversity of our leadership by expanding the Fellowship Leadership programme across West Yorkshire, reciprocal mentoring programme, ILM coaching programme and the coaching hub, and developing a talent pool of diverse future leaders
- Enabling our people to access health and wellbeing offers, particularly where there is no or little offers available e.g. social care, primary care, VCSE through implementing initiatives to address the research findings into the barriers in accessing health and wellbeing offers, supporting our organisations to achieve menopause friendly employer accreditation, providing system wide menopause awareness sessions, delivering a suicide awareness

training pilot and scale and spread of a compassionate leadership development programme across West Yorkshire
- Develop system leadership and Organisational Development (OD) capacity and capability across WY through developing the WY OD network and associated initiatives including, an OD fellowship, curation, and hosting of resources on the WY website, and development of training and development offers
- Enable the development of our partnership into a system through leading and facilitating OD and system development with the component parts of our partnership including places, provider collaboratives, programmes and the ICB, embedding values and behaviours development into our approach
- Enable the delivery of the five- year strategy and joint forward plan through facilitating and equipping the component parts of the partnership with OD tools and skills
- Enable the delivery of the new ICB Operating Model through facilitating and equipping the component parts of the partnership with OD tools and skills
- Continue the Partnership wide cost of living work and conduct a real living wage review.

Supporting workforce wellbeing

As an indicator of the value our system places on supporting workforce wellbeing, we have committed to build on the non-recurrent funding provided by NHS England to establish Staff Mental Health and Wellbeing Hubs, by recurrently supporting our 'hub' to continue as a permanent offer to staff across health, social care and the VCSE sector.

During 23/24 our priorities for the hub are to:

- Transition the temporary hub arrangements into a permanent structure – including continued deliver of direct therapy provision to those staff who refer into the service
- Develop the Critical Incident Support Model to align with Emergency Planning & Preparedness work
- Develop the West Yorkshire Health and Care Partnership microsite and social media presence to support staff mental wellbeing

Using our Finances to support Delivery

Our strategy for finance

Decisions about where and how we use the financial resources we are allocated as a Health and Care Partnership, serving the population of West Yorkshire, plays a critical part in the delivery of the strategic objectives of the Partnership.

The strategy sets out a high-level framework that links our strategic objectives to how we manage our financial resources in the partnership. It is intended to provide an overarching sense of direction and principles that will guide the development of a series of finance strategies across places, provider collaboratives and individual organisations. At the same time, it is designed as an enabler to the overall West Yorkshire Health and Care Partnership five-year integrated care strategy, and will similarly be an enabler to Health & Wellbeing strategies at place.

The fiscal outlook is very challenging for the NHS, local authorities and voluntary, community and social enterprise organisations. The NHS is emerging from the COVID-19 pandemic with an imbalance between service demands (whether relating to elective recovery, urgent care, mental health/learning disability and autism services) and availability of financial resources. At a national, regional and local level, the underlying financial position is one of financial deficits.

Local authorities are also experiencing significant financial pressure, having to find ways of balancing the books within a context of shrinking revenues, lower grants from central government, inflationary cost pressures and growing demands for services, not least social care services for adults and children.

- 3.5 The impact on the third sector has also been noticeable and has threatened the viability and sustainability of some organisations, whether through reductions in grant funding or donations from the public.

- 3.6 All of these pressures run alongside the cost of living issues that people are facing across West Yorkshire, and the unequal impact on those individuals and parts of the population who are already disadvantaged.

- 3.7 This context means that decisions about resource allocations and utilisation will be more important than ever.

Our priorities for capital

Operational capital
We have been allocated £158m to invest in 2023/24 on operational capital schemes, across our ten NHS providers with plans worked up to fully spend this in the context of backlog maintenance across ten NHS providers of £750m (includes £350m for Airedale RAAC issues)

We have also received £4m to spend on primary care medical (GP) premises and technology which does mean that we have to access other sources of funding for any significant primary care developments. This may be through third party private funding or local authority borrowing.

National policy priorities
In terms of national policy priorities, we have also received £74m in 2022/23 for a range of other schemes including:

- Mental health/urgent care - £1m
- Community diagnostic centres - £21m
- Digital/technology - £13m
- Surgical hub at St. Luke's, Bradford - £7.3m
- Surgical Hub at Dewsbury District Hospital - £5.3m
- Ambulatory fleet - £1.5m
- Diagnostics (imaging capacity) - £2.6m
- New Hospital Programme - £22m.

Approved large scale schemes

Calderdale and Huddersfield NHS Foundation Trust continues to be the West Yorkshire Health and Care Partnership's top priority for capital investment. New state of the art healthcare facilities to improve the safety, quality, and outcomes of patient care and ensure the sustainable provision of acute and emergency services in the future form part of this priority. Work is currently underway at Huddersfield on the Accident and Emergency department. There is cross Partnership commitment to the project and approval is currently being awaited by Her Majesties Treasury.

Leeds Teaching Hospitals NHS Trust: Hospitals of the Future Project. Includes construction of a new children's hospital, new adult hospital and new maternity centre (which will meet increasing demand for specialist regional services). This project will unlock five hectares of land in a prime city centre location, bringing with it an estimated 3,000 new jobs and more than £11bn boost to the local and wider regional economy. The project is currently awaiting approval of an Outline Business Case.

New hospital programme bids

Replacement of Airedale General Hospital. The hospital was built 52 years ago with an expected 30-year life. Structural engineer advice is that hospital should be fully replaced as soon as possible, and no later than 2030 due to having the most extensive presence of RAAC in the UK). The Trust has a robust inspection and monitoring programme supported by structural engineers, and a programme of structural works and decanting underway. This work is accelerated in view of two significant incidents which have occurred in 2022 which are redefining the scope of works to manage the RAAC risks.

Replacement of Lynfield Mount Hospital for mental health services. Lynfield Mount is considered significantly outdated, with safety issues identified by the CQC. It has severe privacy and dignity issues (eg large numbers of patients sharing a single bathroom) and is a very poor therapeutic environment. The rapidly failing infrastructure results, for example, in sewage often flooding patient areas. It's no coincidence that Lynfield Mount has one of the worst average patient lengths of stay in the country, both in terms of patient experience and budget (eg £6m of out of area placements p.a.). A relatively modest £90m scheme would be transformative and could be underway within one year.

Bradford Teaching Hospitals NHS Foundation Trust: Two land-locked sites at Bradford Royal Infirmary and St Lukes Hospital, some of which constructed over 100 years ago, some of which is listed, with significant backlog maintenance requirements. This restricts our ability to meet the needs of our growing population, achieve the right clinical adjacencies and to achieve our net-zero commitments. The future offers opportunities to integrate with our system partners, collaborate with the university to contribute to future workforce development and contribute to the local economy and built environment.

Our approach to productivity and efficiency

As budgets across the health and care sector and beyond remain continue to be challenged further, it will become even more important to ensure that we are using the collective resources we have better. To support this, we intend to establish arrangements to support and to better link the transformation and efficiency agendas, in the context of the challenging financial position across the Partnership in 2023/24 and beyond, ensuring that we maximise the use of available resources to achieve our strategic objectives as an integrated care system

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development.

This will include the establishment of a system-wide Transformation and Efficiency Oversight Group, as well as setting out the key expected areas of a system-wide efficiency strategy. As part of this work, it is expected that there will be at least four levels of focus to tackle the transformation and efficiency challenge:

- Individual organisational arrangements
- Local place arrangements
- Provider collaboratives
- System (West Yorkshire) arrangements.

The efficiency challenge will be a fundamental part of developing robust activity, quality, workforce, performance and financial plans for 2023/24. Ensuing that the development of the financial and efficiency plans is not done in isolation from the other parts is more important than ever, and it will be critical to continue to develop ways of working that means that this happens.

In terms of the focus on efficiencies, and a full and shared involvement of stakeholders, all NHS provider organisations have a range of arrangements in place. Some have maintained a focus on waste reduction/efficiency delivery during the Covid pandemic, some have reinvigorated their arrangements due to emerging financial challenges and some are now starting to bring this arrangement back into operation.

Our places will also continue to develop place-based arrangements to identify and implement collective efficiencies through integration of services, shared risk management and joint initiatives. These arrangements will build on the history of joint working between NHS organisations and between NHS, local authorities and other partners in all places.

Our provider collaboratives also continue to work through a range of initiatives and joint projects to manage risk, improve access and outcomes, achieve better value for money, address workforce challenges amongst other areas. We will continue to work together to

NHS West Yorkshire Integrated Care Board has five local places. These are Bradford District and Craven, Calderdale, Kirklees, Leeds and Wakefield District

support these through the lifetime of this plan. Likewise, our work to refresh our WY operating model will also ensure that the dedicated programme resources at WY system level are focussed on productivity and efficiency, alongside improving population health, reducing health inequalities and maximising societal impact.

There have been a number of demonstrable successes in how Partnership resources have been managed over the last six years. These have only been possible because of the partnership and collaborative ethos that has driven decision-making over this time. Achievements include successful bidding for NHS England capital to support system-wide capital investments (an additional £300m into West Yorkshire). In addition the operation of a Single Control Total for NHS organisations in 2019/20 which resulted in system balance for the first time in many years (also resulted in securing £22m of additional incentive funding from NHS England/Improvement) has been a significant achievement.

Outside of the NHS our collective action to deploy resources into social care providers in 2021/22 to allow the early introduction of the national living wage for low-paid employees has also been a successful example of using our collective resources differently. All of these issues have led to improvements in how money has been allocated and utilised to better meet the needs of the people we serve.

Our single West Yorkshire Integrated Care System Financial Framework published in 2021/22, sets out how we will work together on:

- Financial revenue planning
- Service development funding
- Financial capital planning
- In-year performance monitoring
- Improvement support/peer review
- Risk management
- Payment and incentive regime
- Joint budgets with councils
- NHS England/Improvement delegated commissioning responsibility.

In each case, further actions will be required at system, place, provider collaborative and organisational level. To make a meaningful and lasting impact will require the full weight of all partners across the public, private and voluntary sectors to work together on common goals. These will require change and adaptation over the next 5 years.

Finance strategy objectives
Our finance strategy supports the delivery of our Integrated Care strategy and includes what in terms of finance we will do to:

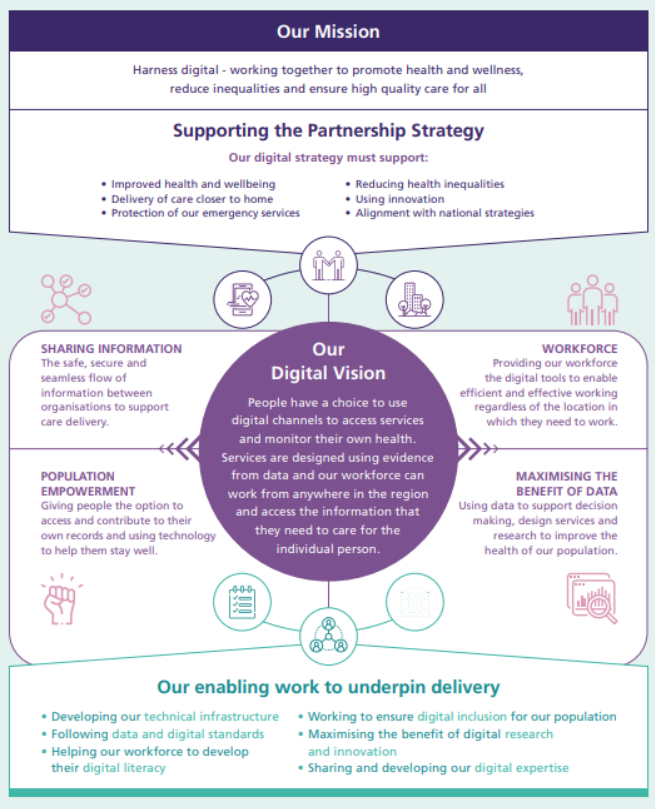
- Reduce health inequalities
- Manage unwarranted variations in care
- Use our collective resources wisely
- Secure the economic and social benefits of investing in health and care.

Full details of our finance strategy and how we intend to achieve the above are available here.

Using Digital and Innovation to Support Delivery

Our strategy for digital

Our digital strategy sets out an approach to how digital innovation can support the delivery of our Integrated Care strategy. Harnessing digital so that we can work together to promote health and wellness, reduce inequalities and ensure high quality care for all. The plans arising out of the digital strategy will flex and evolve as we move through the lifetime of our Joint Forward Plan, reviewing each year with the refresh of our plans. A plan on a page illustrating the digital strategy is set out below:



Our digital priorities

With the West Yorkshire Digital Strategy, the Yorkshire and Humber (YH) Digital Health and Wellbeing Charter, and the recently published NHSx “What Good Looks Like” framework, the direction and ambition of digital in the region is clear and has the commitment from all stakeholders. The changing role of the Integrated Care System (ICS) and greater accountability as the Integrated Care Board (ICB) requires the leaders within the wider digital team to be responsible for turning this desire and ambition into a reality, working together to provide inclusive access to digital and information tools and services to deliver the quadruple aim of health and social care.

NHS West Yorkshire Integrated Care Board has five local places. These are Bradford District and Craven, Calderdale, Kirklees, Leeds and Wakefield District

Recognising the ambition within the West Yorkshire Digital Strategy and its associated Charter will need multi-year work and clarity around investment to ensure the steps on this journey are clear.

The ICS appreciates the value of the transformation range digital can bring and have agreed to recruit a Chief Digital Information Officer (CDIO) and Chief Clinical Information Officer (CCIO), who will work together to steer the region to meet its digital ambitions.

As part of our ongoing plans to deliver the strategy, our seven proposed ICS Digital Priorities for collaboration are as follows:

Shared care records

- That each Place has a shared care record available across most care settings.
- That each Place has an agreed strategy and plan for moving to increased use of the YHCR and the removal of local solutions.
- That each Place has an agreed data strategy and plan that aligns with the WY Data Strategy to support improved use of data across the ICS.
- That each Place shared care record strategy considers the empowerment of patients through patient held records, patient instigated follow up and digitally connected patients and that these approaches are considered within the ICS framework. Ensuring we utilise digital to reduce health inequalities where possible and offering access and preference to different approaches where digital isn't appropriate.

Our regional shared care record is the Yorkshire and Humber Care Record (YHCR), now known as Interweave. We have live services as follows:-

- GP Connect data is available in the portal for organisations to view.
- Airedale Hospitals NHS Trust (AFT) are live with sharing their maternity documents into the portal for other organisations to view.
- Bradford Teaching Hospitals NHS Foundation Trust (BTHT) are live with sharing their core hospital data into the portal for other organisations to view.

- Calderdale and Huddersfield NHS Foundation Trust (CHFT) are live with sharing their maternity documents into the portal for other organisations to view. They have also implemented the maternity viewing portal, so they can view maternity documents from other Trusts once they have gone live.
- Leeds Teaching Hospitals NHS Trust (LTHT) are live with the regional tab in their Leeds Care Record. This allows clinicians in Leeds to view information from YHCR that other organisations have shared.

All the provider Trusts are progressing to make a core set of data available in the portal for other organisations to view. We are also engaging with primary and social care colleagues to provide visibility of the data.

Cyber secure infrastructure

- That each Place/organisation has a clear understanding of its cyber security position
- That each Place/organisation has a plan to remediate any weaknesses
- To assess the role of the ICS in supporting Place and organisations, including but not limited to:
    i. Processes to support mutual aid
    ii. Virtual WY Operations Centre (SOC)
    iii. Shared resources

Planning is underway to run a West Yorkshire wide "war games" cyber event in May 2023 to simulate the process of one of our strategic IT systems being unavailable. Linking in to the existing team who run the Y&H Warning Advice Reporting Point (WARP), who already run annual war games events. There are a small number of organisations who aren't currently members of WARP but they have agreed to join. This will become an annual event as part of business continuity planning.

Staff capacity and capability

- For the ICS to understand the digital staff capacity and capability across the region and work with Place leads to agree approaches to strengthen capacity and capability where needed. Also working with the West Yorkshire Workforce Observatory to understand some of the barriers with the digital workforce.

Legacy remediation

- Across most of our organisations there are areas of IT legacy that create risks for both service provision and for the cyber position. The ICS should be aware of these areas, the plans Place and organisations have for remediation and the associated funding, capacity and capability challenges.

Maintaining the digital networked relationships and collaborative ways of working

- The WY CIO and CCIO meetings have proved valuable in many ways, the relationships and connections forged there allow effective sharing of knowledge, experience and increase opportunities for mutual support. Without the collaborative nature of these networks the ICS would be more siloed and our chance of delivering to the Strategy and Charter would be much more difficult. It is essential that these networks are retained and enhanced.

  We also have established networks for WY digital programme managers and WY clinical safety officer to gain peer support and work collaboratively together.

Embed the engagement between the digital teams, ICS programmes and workstreams (particularly business intelligence, population health management and innovation and

improvement), councils, voluntary sector, other qualified providers, industry partners, AHSN, ABHI, NHS E/X/Digital (now DH Transformation Directorate) and regional innovation partners.

Using the strength and size of the West Yorkshire region to exploit and influence our strategic suppliers. Ensuring we gain economies of scale for our partner organisations and utilising or relationships with our strategic suppliers to drive forward the vision for WY.

Whilst these seven collaborative priorities are core to the work we deliver, we also support the ICS programmes with their individual priorities that are digital in nature and also the provider collaboratives, where they agree single schemes to progress, such as the single laboratory information management system (LIMS) that is currently progressing across WYAAT.

Our approach and priorities for innovation

The Role of The West Yorkshire Innovation Hub
Our Partnership has a vision for everyone in their diverse communities to live a happy, healthier life for longer. This vision is supported by The Hub's commitment to creating a culture of learning and innovation, recognising that achieving the scale of ambition set out in the Integrated Care Strategy and this Joint Forward Plan will require doing things differently and bringing into practice the best evidence-based ideas from across the region and beyond.

The Partnership has a strong and long-standing partnership with the Yorkshire and Humber Academic Health Science Network (AHSN), a core delivery partner within the system who are committed to supporting WY HCP in the delivery of three core innovation themes:

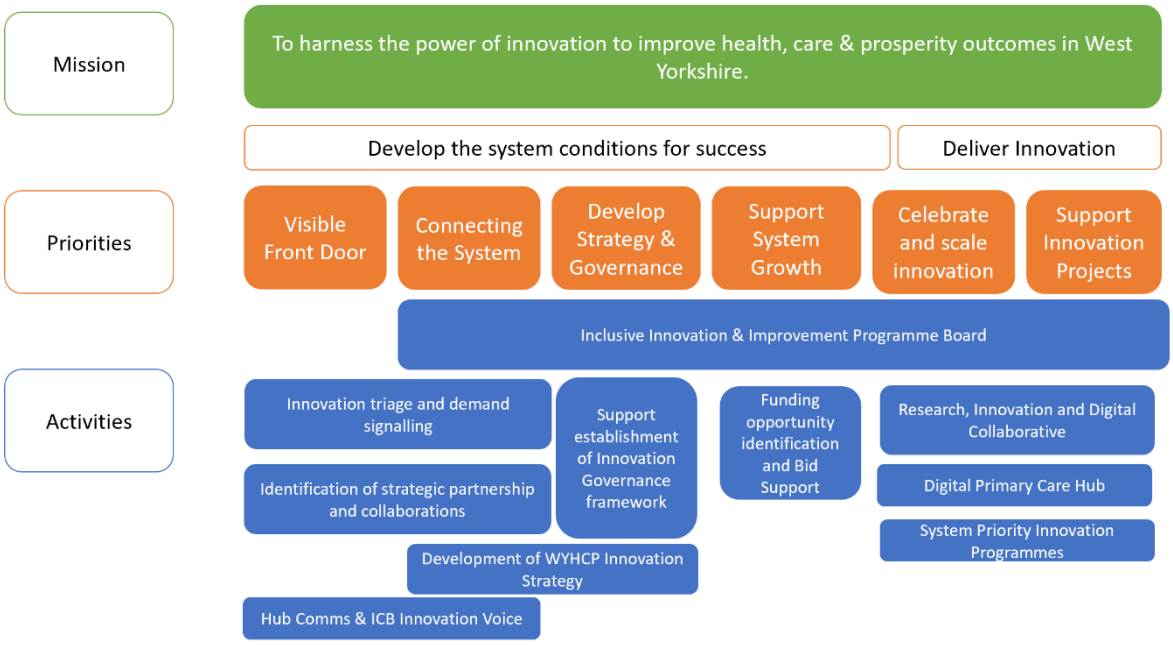
- Spread and adoption of innovation
- Discovery
- Improvement

To deliver system innovation, an understanding of process and priorities is essential, at system, place and provider level. The Hub enables innovative ways of working to tackle the biggest challenges facing the health and care system. The connections and networks made by The Hub position it as the first port of call for anyone seeking support or exploring opportunities for innovation and improvement against WY HCP priorities across the health and care system. It is a centralised resource for other innovation infrastructures (for example the Digital Programme) to access support, such as network establishment and innovation proposals and is seen as a vital partner in the success and growth of the region and its commitment to system economic growth to drive down health inequalities.

The Partnership's Inclusive Innovation and Improvement Programme Board (IIIPB) supports The Hub by acting as the conduit for sharing innovation and best practice, removing barriers and blockages, and ensuring inclusive design of innovation programmes. This will be supported further by the Research, Innovation and Digital Collaborative (RID), which brings the three interlinked disciplines together to offer assurance and governance on opportunities presented to the WY HCP.

By embedding Y&H AHSN staff into the Partnership's Hub has the ability to evolve and adapt to system needs, to help identify the system's innovation requirements, act as a front door for innovators and support the development of networks which promote the spread and adoption of best practice.

Figure 1 below shows the role of The Hub within the system.



Overview of 2022/2023

As The Hub was only established in April 2022, a lot of activity has been focussed on improving connections, building strong relationships with key stakeholders and understanding the WYHCP landscape. These key activities have provided a strong backbone to enable The Hub's delivery in future years. Alongside these activities, The Hub has delivered activities which support WYHCP to deliver on their programmes and priorities. Key items to note are:

- Direct support provided to place-based innovation hubs/directorates linked priorities with innovators, provided peer support and the development of innovation showcases. Supporting these groups enabled The Hub to raise the profile of the Y&H AHSN and demonstrate the expansive landscape of innovation in which the AHSN works in.
- The Hub was a key contributor to multi-million-pound innovation bids. These are still undergoing review but if won, The Hub will act as the innovation expertise for WYHCP and the West Yorkshire Combined Authority.
- The Hub's ability to act as a trusted and neutral partner has facilitated increased relationships between healthcare and industry. These relationships improve outcomes for patients and the prosperity of the region. For example, the Mid-Yorkshire Hospital Knowledge Asset Grant Funding application utilising the Pulse Health innovation platform relied upon The Hub to facilitate conversations and bring the right partners together.
- The triage of innovations for the West Yorkshire Cancer Alliance has been highlighted as an area of best practice in collaboration between an ICS, Cancer Alliance and local AHSN provider and is being showcased to NHS England in view of potential spread and adoption of this approach.
- The Primary Care Innovation Collaborative (PCIC) has worked with the ICB Digital Programme to identify primary care digital solutions and has been instrumental in the roll out of PATCHS (online consultation tool) to GPs across West Yorkshire. The approach used by the PCIC to understand the unmet needs within primary care has been utilised by other Digital Primary Care Innovation Hubs as best practice.
- The Serious Mental Illness (SMI) programme brought together mental health leads in all five places to identify ways to share good practice and improve health equity across

West Yorkshire for their SMI populations. Interviews and a thematic analysis report has been completed to identify areas for collaboration in 23/24.

- The Inclusive Innovation and Improvement Programme Board have refreshed how the group and the overarching programme will work moving forward. Some of the agreed changes involve face to face meetings to showcase innovations in each of the five places and bring the wider innovation community together, and the development of the RID.

Outside of The Hub, Y&H AHSN has been working with WY HCP to deliver numerous innovative programmes. These programmes were developed from working with regional and national stakeholders to understand priority areas and challenges. Impacts include:

- Coordination of a West Yorkshire wide pre-eclampsia testing service and support to the development of regional clinical guidance. This collaborative approach is rare and is being seen very positively by regional and national stakeholders.

- As part of the Asthma Biologics Rapid Uptake Project (RUP), Y&H AHSN funded the Straight Talking Project in Mid-Yorkshire whose aims were to combat some of the myths and stigma surrounding asthma. This collaborative project has been shortlisted for a HSJ Partnership Award.

- Delivery of the Propel@YH programme and intensive international bootcamps has led to multiple innovators (including overseas organisations) locating their UK Main Office in West Yorkshire.

- Leeds Teaching Hospitals were the first Trust in Yorkshire & Humber to adopt XprESS, a minimally invasive treatment to treat chronic sinusitis as part of the MedTech Funding Mandate. Bradford Teaching Hospitals are fast followers and are close to adoption.

- 13 Innovation Exchange Events for over 450 innovators has taken place throughout 22/23. These events link innovations to unmet needs, support them to improve their offer to the NHS and facilitate conversations between innovators and healthcare to improve the health and wealth of the region.

- The NHSx funded Virtual Wards programme led to 1400 patients benefitting in West Yorkshire across its 2-year delivery. A series of resources have been produced to support Trusts to implement virtual wards now the project has finished.

- Y&H AHSN alongside the Improvement Academy are leading nationally on the Medicines Safety Workstream to reduce harm from opioid prescribing in non-cancer patients as part of the Patient Safety Collaboratives. This is utilising the expertise in Yorkshire to enable the national delivery.

- Y&H AHSN support to the WY Cancer Alliance has enabled the collection of blood samples from over 7000 patients for processing through the Pinpoint project, which is an NHS England funded scheme involving a real-world evaluation.

Plans which have been identified to support upcoming programmes of work across the Partnership for 2023/24 include:

The Hub's core activities

As identified in Figure 1, core priorities and activities of The Hub are extensive and will adapt appropriately to system need, providing core innovation leadership to the system. There are a number of continuing programmes as part of The Hub's core delivery which include:

- Continued delivery of the IIIPB and development of the innovation strategy to enhance innovation collaboration across WYHCP, and delivery of the RID.

- 2nd year delivery of the PCIC alongside the WY Digital Programme. The PCIC will continue to support the roll out of PATCHS into GP practices across WY as well as development and delivery of a digital champion approach for the region.

23/24 Innovation Hub projects

Alongside these core activities, priority programmes have been identified through conversations with key stakeholders in WY HCP and a portfolio of work for 23/24 has been designed to reflect system need. These are:

- Understanding the correlation between Ambulance Conveyance and Deprivation to assess what can be utilised in the community to reduce impact on emergency services. This will be a proof of concept with the aim of spreading across the rest of West Yorkshire in the following years. It has gained interest from the Leeds DHSC Health and Wellbeing hub, as well as the Regional Office for Health Improvement and Disparities.

- The development of a central resource for training needs in research, innovation and improvement alongside the creation of a research ambassadors programme. Be Curious aims to upskill all staff in WYHCP and help them understand that research is available for all not the select few. This has gained interest from the NHS England Research Team who have recently release guidance around research in ICBs.

- Delivery of roundtable discussions around the delivery of physical health checks for people with Serious Mental Illness (SMI); sharing best practice and innovative solutions to improve access and equity across West Yorkshire.

- Continuing the support to WY Cancer Alliance with their core strategic aims and ambitions with innovation as well as the identification and implementation of a Clinical Diagnostic Support Tool.

- Continued delivery of the West Yorkshire Healthy Hearts Programme to improve cardiovascular disease (CVD) care and recording, and reduce the life expectancy gap between our least and most deprived areas in WY.

Additional AHSN delivered projects within West Yorkshire

The Y&H AHSN are funded by NHS England to deliver programmes based on national and regional priorities to improve the health and wealth of our region. The delivery of these projects are at no additional cost to WY HCP but can have significant impacts to patients and the system as a whole. Examples of our national and regional projects include:

- Supporting the implementation 11 products as part of the MedTech Funding Mandate. Products include treatments for Chronic Sinusitis, Benign Prostatic Hyperplasia and Sickle Cell Anaemia. These products are mandated by NHS England for organisations to adopt, have all been NICE approved and demonstrate significant ROI to providers.

- Working closely with Leeds Teaching Hospitals to combat regional inequalities in automated red cell exchange access for Sickle Cell sufferers. Y&H AHSN are leading the delivery of this programme nationally across the AHSN Network.

- Supporting an innovation in health improvement project which is looking at the most deprived areas alongside underserved populations to provide health education around CVD, and to identify and treat individuals with NICE approved medication in these underserved communities.

- Support the West Yorkshire Virtual Wards. Tender for 2023-2025 including innovator and implementation support once an innovation has been selected. The Y&H AHSN team are also exploring evaluation opportunities with the Leeds City Council led virtual ward to support people with long term conditions.

- Working across North East and Yorkshire to develop a regional approach and methodology to deliver workforce transformation, including training, promotions of assets and tools such as the Calderdale Framework and development of a network to improve workforce transformation.

- Identification and active engagement of GP practices to refer potential cancer patients through the Pinpoint pathway. This diagnostic tool is able to stratify a patients risk of cancer and identify biomarkers in the blood to assist in reducing the 2-week wait list burden.

- Working with Partners across WY, including Huddersfield University, the development of a Community Engagement Framework to support better connections with underserved communities by providing guidance and structure which can be adapted to all health areas and population groups.

Delivering our strategy across our places

Wakefield

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Leeds

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Calderdale

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NHS West Yorkshire Integrated Care Board has five local places. These are Bradford District and Craven, Calderdale, Kirklees, Leeds and Wakefield District

How will we know we have delivered?

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Useful links

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