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Wakefield District Health & Care Partnership

Our One Year Plan, 2022-2023

# Introduction from Ann Carroll

As the Chair of the Wakefield District Health and Care Partnership Committee I am delighted to share with you our plan for 2022-23. The plan describes the priorities our system will focus on this year.

Our plan comes as we begin our new arrangements following the new legislation for the NHS which was implemented in July 2022*.* To achieve our aims, we have outlined the programmes that our partnership will take forward during this year.

Jo Webster has been appointed as Wakefield’s Place Leader, a role Jo will undertake alongside her duties as Corporate Director Adults and Health for Wakefield Council and Executive Director of Community Services for Mid Yorkshire Hospitals Trust.

Our partnership’s focus of course will remain firmly on enhancing and improving the care our residents and patients experience through driving forward transformation improvement programmes in the following areas during 2022-23.

Wakefield District Health and Care Partnership’s plan drives forward the four priorities of the Health and Wellbeing Strategy for Wakefield to promote health & wellbeing by **reducing inequalities and preventing ill health** for individuals and groups within our population.

This is happening within the context of wider change on a national scale, our plan responds to 10 ambitions overseen by the West Yorkshire Health and Care Partnership.

The purpose of this plan is to set out our **vision** for this year, and the **priority programmes** of work that we have chosen to address collectively. Looking further forward, we plan to spend time this year co-producing a more detailed longer-term transformation plan which will take us from 2023 to 2028.

Dr Ann Carroll, Chair of Wakefield District Health and Care Partnership

# Jo Webster, Accountable Officer

The changes in our health and care landscape as a result of the Health and Care Act present us with a fantastic opportunity to build on the firm foundations already in place across our district partnership, paving the way to an even more integrated approach to providing the best possible health and care services in our local communities.  
  
Our close relationships, single system ethos and willingness to challenge each other are part of the reasons why, in Wakefield and West Yorkshire, these changes feel like a natural progression. We share responsibilities, working together with people to identify local needs and collectively deciding how best to respond.  
  
Our Partnership Plan is an important next step in our growth as Wakefield District Health and Care Partnership.   
  
Wakefield District is expected to encounter a significant demographic change over the next five years, in particular a sustained growth in our older population as we live longer lives. We want to ensure local people don’t just live longer, but that they live long, happy and healthy lives.  
  
I’ve seen time and again the way working together in collaboration makes a real positive difference to people’s health and wellbeing. Through shared leadership, an integrated approach and laser focus on our priorities, our plan sets out further opportunities to enhance the health and care services we provide for our residents.  
  
I am proud to work in Wakefield and to be part of a partnership that puts our communities and our staff at the heart of everything it does.

Jo Webster, Accountable Officer, Wakefield District Health and Care Partnership

# Our vision, purpose statement and strapline

## Vision (from the Wakefield District Health and Wellbeing Strategy):

Our aim is for the people of Wakefield district to live longer, healthier lives

## Purpose statement:

Together, we will work with the people of Wakefield district to create a connected system that supports people in their homes and communities to live healthier, happier lives

## Strapline:

Start well, live well, age well



How will health and care look and feel for local people when we achieve our aims?  
Wakefield District’s model of care for all populations – our ‘I’ statements  
Children and young people, healthy adults, people with long term physical and/or mental health conditions, people living with frailty, people at the end of life.

* I live in a community that I feel part of. If I am a child, my family and networks are central to providing this and are supported to do so. This supports me to live a happier, healthier life and make the most of my opportunities
* If I need extra support from health and care services, these are provided in my own home or as close to it as possible. These services coordinate around me\*
* If I have an illness or an urgent need I\* know where to go and how to access the support I need – this will be in the right place, at the right time and be by the right person. If a hospital admission is needed, I will be discharged to the care of my regular community team as soon as possible for any ongoing care
* If I have a long-term health condition or disability, or am at risk of having a long-term health condition, I\* receive and am an active participant in proactive care and am supported to keep as well as possible
* If I need specialist diagnosis, treatment or surgery I\* can access this in a timely way, and the different parts of the treatment work together in a seamless way. I\* am kept informed and involved in the process and am not kept waiting unduly
* When I do access health and care services I\* am confident that they are of the highest quality and I\* am treated with the utmost dignity, respect and compassion. The information I receive about healthcare services are easy to access and understand

\* and my carer if I have one, and/or my family if I am a child

# About Wakefield District Health and Care Partnership

In Wakefield we have a long history of successful partnership and system working with people at the heart to enable genuine whole system change. There are many examples of how, by working together as a partnership, we have achieved successes and improvements to lives of people who live and work in Wakefield. Building on this success, we want to proactively create the conditions that enable and support our health and care staff from all professions to continue to work together, and with people and communities, to deliver measurable progress towards our ambition to improve outcomes and reduce inequalities for our population.

New legislation has been introduced in July 2022 which has changed part of the architecture of the NHS. Clinical Commissioning Groups (CCGs) have been replaced by statutory Integrated Care Boards (ICBs) covering larger geographic footprints. The white paper published by the Department of Health and Social Care in February 2021 which introduced this new legislation builds on the NHS Long Term Plan vision of integrated care and sets out the key components ICBs. One of these components is strong and effective place-based partnerships in local places between the NHS, local government and key local partners.

In response to this new system architecture we have established the Wakefield District Health and Care Partnership (WDHCP). WDHCP will carry out delegated statutory functions on behalf of the West Yorkshire ICB, as well as delivering key partnership aims such as those outline in the Wakefield Health and Wellbeing Strategy. Our partnership consists of key local health and care providers and the local authority and includes mechanisms for ensuring that citizen voice and clinical and professional leadership have a strong role in our decision making.

We welcome this new chapter for Wakefield District and believe that it will enable us to transform health and care, and deliver our vision with greater effectiveness and pace than ever.

# Wakefield Place Governance Model

The **Wakefield District Health and Care Partnership** is a subcommittee of the **NHS West Yorkshire Integrated Care Board (ICB).** This is the statutory body that supports integration within the NHS to take a joint approach to agreeing and delivering ambitions for the health of the 2.4million people living across our area. The board oversees NHS money and helps to make sure the services are in place to make the Partnership Board Strategy become a reality on the ground.

The ICB is one of the statutory elements of the **West Yorkshire Health and Care Partnership**. This is a geographically based partnership that brings together organisations that meet health and care needs, improve people’s health, and reduce inequalities across West Yorkshire.

There are similar partnerships in each of the five ‘places’ that make up West Yorkshire, in Bradford, Calderdale, Kirklees, Leeds and here in Wakefield District (Wakefield District Health and Care Partnership). Each ‘place’ is different and brings unique strengths and perspectives to our Partnership. However, we share challenges and have one common goal – to improve people’s health and wellbeing through delivering quality care and support when needed.

Each place-based partnership has an integrated care board committee to make decisions, similar to the NHS West Yorkshire Integrated Care Board. The **Wakefield District Health and Care Partnership Committee** is made up of local health and care leaders, including Wakefield Council, and includes independent people who do not work for health and care organisations.

The Wakefield District Health and Care Partnership is responsible for delivering the Wakefield District Health and Wellbeing Strategy, which is set by the **Wakefield Health and Wellbeing Board**.

The **Integrated Assurance Committee** supports the integrated care board and provides assurance that our local health and care system is working well.

The **Provider Collaborative** brings together representatives of the different organisations and sectors that run services for the district. Its role is to ensure that providers are working together to develop and transform services to meet the health needs of local people. It is accountable to the Wakefield District Health and Care Partnership Committee. The Collaborative is supported by **People Panel** and the **System Professional Leadership Group**. The Collaborative has a key role in system recovery, restoration and transformation in Wakefield. It has been described as the engine room for transformation and new models of care in the district.

The Partnership receives public feedback, as well as advice and assurance on issues relating to public involvement and equality and diversity, from the **People Panel**.

# West Yorkshire Health and Care Partnership and West Yorkshire Integrated Care Board

Wakefield District Health and Care Partnership is proud to be part of the West Yorkshire Health and Care Partnership. Many of our functions will be formally delegated to us by the West Yorkshire Integrated Care Board, which is the formal part of the partnership. In July 2022 West Yorkshire ICB became the statutory body (replacing CCGs). It will delegate the majority of its statutory functions to the five place health and care partnerships.

The West Yorkshire Health and Care System Partnership which is the collective of all commissioner, provider and partner organisations working together to improve outcomes for the population.  The partnership covers a population of 2.4 million people living in Bradford District and Craven, Calderdale, Kirklees, Leeds and Wakefield District.

The West Yorkshire Health and Care Partnership founding principles:

* We are ambitious for the populations we serve and the staff we employ
* The West Yorkshire Health and Care Partnership belongs to commissioners, providers, local government and NHS
* We do the work once – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict
* We undertake shared analysis of problems and issues as the basis of taking action
* We apply subsidiarity principles in all that we do –with work taking place at the appropriate level and as near to local as possible.

The West Yorkshire Health and Care Partnership has a Five Year Plan that includes 10 big ambitions:

* We will increase the years of life that people live in good health in West Yorkshire compared to the rest of England. We will reduce the gap in life expectancy by 5% (six months of life for men and five months of life for women) between the people living in our most deprived communities compared with the least deprived communities by 2024.
* We will achieve a 10% reduction in the gap in life expectancy between people with mental health conditions, learning disabilities and/or autism and the rest of the population by 2024 (approx 220,000 people). In doing this we will focus on early support for children and young people.
* We will address the health inequality gap for children living in households with the lowest incomes. This will be central for our approach to improving outcomes by 2024. This will include halting the trend in childhood obesity, including those children living in poverty.
* By 2024 we will have increased our early diagnosis rates for cancer, ensuring at least 1,000 more people will have the chance of curative treatment.
* We will reduce suicide by 10% across West Yorkshire by 2020/21 and achieve a 75% reduction in targeted areas by 2022.
* We will achieve at least a 10% reduction in anti-microbial resistance infections by 2024 by, for example, reducing antibiotic use by 15%.
* We will achieve a 50% reduction in stillbirths, neonatal deaths, brain injuries and a reduction in maternal morbidity and mortality by 2025.
* We will have a more diverse leadership that better reflects the broad range of talent in West Yorkshire, helping to ensure that the poor experiences in the workplace that are particularly high for Black, Asian and Minority Ethnic (BAME) staff will become a thing of the past.
* We aspire to become a global leader in responding to the climate emergency through increased mitigation, investment and culture change throughout our system.
* We will strengthen local economic growth by reducing health inequalities and improving skills, increasing productivity and the earning power of people and our region as a whole.

# Wakefield Health and Wellbeing Strategy

Our aim is for the people of Wakefield district to live longer, healthier lives.

The work and priorities of the WDHCP is closely aligned to our local health and wellbeing strategy, which is led by the Wakefield Health and Wellbeing Board.

The Wakefield Health and Wellbeing Board brings together key organisations to oversee the strategy for improving the health and wellbeing of the people in Wakefield, with a focus on four core priorities:

* Giving every child the best start in life
* Strengthening the role and impact of ill health prevention
* Creating and developing sustainable places and communities
* Ensuring a healthy standard of living for all

The role of WDHCP is to act as a key partner to oversee and be accountable for the health and care response to delivery of the Health and Wellbeing Strategy.

# Aligning our priorities

The WDHCP priorities are aligned to:

* West Yorkshire Health and Care Partnership 10 Big Ambitions
* What is important to our partnership
* Wakefield Health and Wellbeing Board four priorities
* Triple Aim: quality, sustainability, population health improvement

# What is most important to our Partnership?

Care should be…

* Personalised and focused on ‘what matters most to me’
* Seamless and connected with no wrong door
* Efficient and effective
* Focused on delivering prevention and targeted anticipatory care
* Less of a ‘medical model’ (bio/psycho/social)
* Co-produced
* Easy to understand and navigate for services users and colleagues
* Focused on community and where people live
* Delivered in a kind and compassionate way
* Strengths-based – ‘what’s strong, not what’s wrong’
* Enabled by joined up data

# Our priority work programmes for 2022/23

Over the coming year we will work together to deliver our vision, purpose and transformation and themes through:

Key Alliances and Programmes:

* Children and Young People’s Partnership Board
* Primary and Community (Connecting Care) Alliance
* Mental Health Alliance
* Housing and Health
* Urgent and Emergency Care Programme
* Planned Care Programme

Supported by enabling programmes including:

* Wakefield People Plan
* Digital Transformation
* Quality improvement
* Citizen voice

# Children and Young People’s Partnership Board

Overarching aims   
For children and young people to tell us they are happy, healthy and safe and thriving in communities where families and services work together to help them achieve their potential and dreams.

### Key priorities

* Development of Family/Youth Hubs
* Understand and respond to paediatric demand for unplanned care
* Provision of accessible, good mental health provision/support for children and the whole family
* Strengthen response to prevention of and recovery from domestic abuse
* Ensure right partnerships, commissioning and pathways in place to support Children and Young People (CYP) with Special Educational Needs and Disabilities (SEND)

### Partnership inputs:

* Partnership commitment to co-location
* Information sharing and commitment to developing a shared view of data of CYP and families
* Supporting Children’s Alliance with joint commissioning arrangements
* Exploring opportunities to develop pooled budgets

### Outputs:

* Nine Family Hub, three Youth Hubs and a connected network of VCSE and stat partners are delivering a co-ordinated and connected early intervention and prevention offer.
* Unplanned Care Model in place
* Clear pathway for emotional and mental wellbeing (inc. Mental Health Support Teams in Schools)
* System-wide Domestic Abuse pathways in place
* SEND Action Plan is implemented in readiness for inspection

### Outcomes

All children, young people and families get the right help at the right place at the right time evidenced by:

* decrease in number of re-referrals to the Integrated Front Door
* demand for paediatric unplanned care benchmarks appropriately with statistical neighbours
* reduced demand for higher tier mental health services
* waiting lists for acute health services are reduced & well-managed
* repeat domestic abuse cases are reduced

Work is delivered under the ethos of Wakefield Families Together (WFT) which aligns seamlessly with all the WDHCP transformation design principles. There is also very close alignment with the I statements as WFT is about:

* Children and families easily accessing help and support at the earliest point
* A co-ordinated early support, intervention and prevention offer
* Working together as one integrated team, no matter who pays the wages.
* Engagement and co-production with children and young people and families is integral to WFT.

# Wakefield Primary Care & Community (Connecting Care) Alliance

## Purpose

The Alliance will oversee primary care and community integration and transformation to create a connected system that supports people in their homes and communities to live healthier, happier lives.

### Responsibilities

* The Alliance will be a key force in bring local stakeholders together to shape and take forwards the next steps in our integration agenda across primary care and services in the community to maximise opportunities for joint working and shared objectives and service outcomes.
* The Alliance will define a programme of work, underpinned by a robust needs-based population health assessment, that drives forward our local agenda and embeds national deliverables in a way that meets the needs of our local population.
* The Alliance will build upon and strengthen our Primary Care Network (PCN) approach and neighbourhoods models of care with alignment to the Connecting Care framework.
* The Alliance will maintain strategic links between other relevant Alliances within the Provider Collaborative structure and across the West Yorkshire Health and Care Partnership, in order to benefit from ‘crosscutting’ activities, avoid silo working and avoid duplication.

### Development

* This is a new Alliance which is being developed and co-produced by Place partners.
* Terms of reference and priorities have been developed which will be formally approved when the Alliance is launched.
* The Primary Care & Community Alliance was formally launched in July 2022.

### Initial priorities

* Ageing Well Programmes
* Our enablers of workforce, estates and data and digital
* End of Life programme
* Virtual wards

### Key deliverables 2022/23

* 50 active virtual ward beds by April 23
* Up to 239 patients per month in virtual wards by April 2023
* UCR contacts increase from 434 to 580 per month by November 2022
* UCR - estimated 575 emergency admissions avoided Nov 22 to Mar 23

# Mental Health Alliance (MHA)

## **Overarching aim**

To meet the mental health, learning disability, autism, attention deficit hyperactivity disorder (ADHD) and Dementia needs of the Wakefield District population.

Whilst the team and leadership are responsible for all the above services, the Mental Health Alliance is currently only responsible for mental health.

### Key priorities

* Delivery of NHS Long Term Plan programmes
* Mental Health Investment Standard (MHIS) collaborative prioritisation and assurance process.
* Meeting local need through integrated working
* Managing demand, capacity and Covid recovery
* Supporting ICB programmes and WY MHLDA West Yorkshire Mental Health Learning Disability Alliance (MHLDA) Provider Collaboratives
* To review how this oversight of Learning Disability, Autism, ADHD and Dementia is embedded in the Wakefield Provider Collaborative

### Some highlighted programmes

* Community Mental Health Transformation
* Children and Young People (CYP) Access to Mental Health Services
* Early intervention in Psychosis
* Health checks for people with Severe Mental Illness
* Crisis support
* Achievement of Mental Health Investment Standard
* Joined Up Thinking – a joint VCSE programme aimed at bridging the gap between NHS and the third sector to engage people in hard-to-reach areas or the most deprived areas in the District of Wakefield

### Outcome measures:

* 23,075 people with Severe Mental Illness (SMI) accessing 2 or more contacts from community service by the end of 22/23
* 25,653 Children and Young People aged under 18 supported through NHS funded mental health services receiving at least one contact by the end of 22/23
* 60% of people with suspected first episode psychosis or at ‘risk mental state’ who start a NICE-recommended package care package in the reporting period within 2 weeks of referral
* 13,672 people with SMI receiving physical health check by the end of 22/23
* Core 24 (liaison mental health model) compliant
* 95% of people referred to the Psychiatric Liaison Team seen within 1 hour in A&E and 24 hours on a ward

### Audited assurance of MHIS Target delivered

Improved general health/wellbeing, recovery from health/economic inequality/deprivation. Reduction of pressure on primary care Hospitals, GPs, wellbeing, and support services. Part of our growing community. Non-clinical, co-productive approach. Clients show self-sustainability/normal living. Increased emotional resilience. They will be back into employment, not living off the state. Positive impact in home/local community by mitigating anti-social behaviour. Quicker recovery from setback/loss. Have a support network which works for them.

# Housing and Health

## **Overarching aims**

The Housing for Health Partnership supports delivery of the WDHCP vision as a strategic enabler, having a focus on housing as a wider determinant of health. The partnership works to ensure that people have warm and affordable housing that is safe and secure and promotes independence.

The partnership contributes to the transformation design principles by having a personalised and focussed approach on the importance of a healthy home. The partnership aims to prevent health inequalities through the promotion of good quality, sustainable homes with appropriate support. There is less emphasis on medical models with more focus on enabling self-care in a person’s own home. The partnership also focussed on the importance of a good community and the lasting impact this can have on a person’s health.

### Top priorities for 2022/23

* Tackling poor property conditions and affordable warmth
* Reduction in hospital admissions and timely discharge through the use of technology enabled care in the home and Independent Living schemes
* Delivery of the Wakefield Housing Plan
* Tenancy sustainment and supporting the needs of homeless and rough sleepers

### Deliverables 2022/23

* Housing Plan launch and programme commenced
* Fuel Poverty Fund, Big Boiler and Energy Savers schemes delivery
* Money Smart and MBS support delivered
* Frontline health referral pathways established
* The number of rough sleepers expected to rough sleep on any give night will not increase and over the Rough Sleeping Initiative (RSI) 2022-2025 it is anticipated that this number will decrease•
* Integrated model of delivery for independent Living Schemes
* Greater volume of Extra Housing with integrated support offer
* Embedding the WYFI and Homeless Health Assessment Service

### Outcomes

Measurables:

* Number of new homes built
* Number of rough sleepers
* Number of statutory homeless presentations
* % of ambulance call outs following Care Link response intervention
* Improved housing conditions private rented sector
* Reduced fuel poverty /cold homes
* Delayed admission to residential and/nursing care for older people
* Reduction in number of older people being admitted to hospital
* Better discharge arrangements for older people leaving hospital
* Reduction in levels of homelessness and number of homeless people attending A&E

# Unplanned Care Programme

## Aim

We want to make sure our population can easily access the care they require in the safest way possible when they need it

### Programme of work: Managing your need in your home

Key deliverables in 22/23

* A robust understanding of the alternative care pathways aligned with new models of service delivery

Key metrics:

* Reduction in patients conveyed to A&E who are discharged with no treatment or a less than 1 day length of stay (LOS)\*
* Consistent delivery of all three Ambulance handover targets by 14th September 22

Programme of work: Managing your need when you need to leave home

Key deliverables in 22/23

* A new model for delivery of urgent care
* A primary care access line that supports simple and easy access to same day emergency care services
* A same day emergency care infrastructure that responds quickly

Key metrics:

* By April 23 the Primary Care Access Line (PCAL) service will deliver a 40% reduction in the number of patients attending Emergency Department (ED) after consultation with their GP
* By April 23 there will be a 20% increase in the number of patients streamed from ED to Same Day Emergency Care (SDEC).

Programme of work: Managing your ongoing needs in the place best for you

Key deliverables in 22/23

* A robust discharge to assess (D2A) model of screening and assessment
* Embedded true system integrated transfer of care hub
* Aligned capacity and demand within Intermediate care team (ICT) and reablement
* Revised models of care to support dementia patients

Key metrics:

* By April 23 a reduction of 20% in the total number of patients with no reason to reside occupying an acute bed

\*baseline and target being finalised and will be confirmed by end of July 22.

# Planned Care Redesign Programme

## Programme Deliverables:

A single system-wide strategy for Planned Care delivery of strong seamed, integrated and personalised care

### System Project Deliverables 2021 to 2023

1. Planned Care Performance

* Improved system information for decision making in one place
* Access to Demand & Capacity modelling
* Delivering Theatre Efficiencies
* Activity monitoring
* Implementing ‘Getting it Right First Time’ and ‘High Volume Low Complexity’ best practice

2. Transformational Care

* Shared Referral Pathway
* Shared Decision Making including Patient Initiated Follow Up (PIFU) care
* Shared clinical pathways
* Using Telemedicine / digital healthcare

3. Partnership Delivery

* Working in partnership across all providers
* To have flexible & responsive shared contractual arrangements
* Removing the shared capacity gap

4. Designed Diagnostics

* Implementation of the Community Diagnostic Hub
* Rapid, one stop shop, patient centred
* Supportive reporting

5. Prepared and Informed

* Accessible records and information to enable people to take more responsibility for their own health and well-being
* Anticipatory care and waiting well to stay well in their own homes and communities

Key Themes: Reducing Health Inequality and Digital Opportunities

Golden Threads: Co-design, Meeting Patient Expectations, Benefits Driven

### Programme Benefits:

* Deliver significantly more elective care to tackle elective backlogs, reduce long waits and improve performance against waiting times standards
* Develop better information and effective use of digital technologies to transform the delivery of care and patient outcomes
* Support a personalised care approach and place the public need at the centre of transformation reducing any unnecessary variation
* System working to strengthen the seams of our services and improve integration to ensure a right place and right time approach for all patients

### Key Deliverables 2022 to 2023

|  |  |  |
| --- | --- | --- |
| Performance Standard | National | MYHT |
| Eliminate waits of over 104 weeks | * Cleared by July 2022 | * Maintain Zero |
| Eliminate waits of over 78 weeks | * Cleared by April 2023 | * Achieve target & go further (see 52 weeks) |
| Eliminate waits of over 52 weeks | * Cleared by March 2025 | * By March 2023 * Zero Non-Admitted 52 week waits * <300 Admitted 52 week waits |
| Activity | * 104% of 19/20 by end of 2022/23 | * Achieve 104% |
| Completions | * 110% of 19/20 | * Achieve 110% |
| Reduction of Follow Up | * 25% | * Achieve 25% reduction |
| Diagnostic | * 120% of 19/20 * DM01 Recovery to see patients within six weeks from request to image acquisition | * By March 2023 * Request to Report (as opposed to Request to Image Acquisition so represents the whole pathway): * For Cancer maximum two-week pathway * For all routine maximum four-week pathway |
| Expanding the uptake of PIFU to all major outpatient specialties, moving or discharging 5% of outpatient attendances to PIFU pathways | * Achieve by end of 2023 | * Achieve 5% target by March 2023 |
| Referral optimisation, including through use of specialist advice services to enhance patient pathways – delivering 16 specialist advice requests, including advice and guidance (A&G), per 100 outpatient first attendances | * Achieve by end of 2023 | * Achieve 16% target by March 23 |
| For cancer, Return the number of people waiting for longer than 62 days to the level in February 2020 (based on the national average in February 2020) |  | * By March 2023 achieve all cancer targets including 62 days (only exception would be external treatments at other providers, but they must be referred by day 38). |

# Wakefield People Plan

The overarching aim of The Wakefield People Plan is to ensure Wakefield has a confident, motivated workforce and the skills, values and behaviours to undertake their roles. The Plan will support delivery of the WDHCP strategic objectives.

### 2022/23 deliverables:

* Set the strategic direction for workforce transformation
* Identify current and anticipated workforce challenges and solutions
* Support a learning needs approach to training, recruitment and role redesign
* Promote collaborative, compassionate, distributive system leadership

### The Six Pillars of The Wakefield People Plan

* Pillar 1: Looking after our people
* Pillar 2: Enhancing and growing system leadership
* Pillar 3: Belonging to the Wakefield District Health and Care Partnership
* Pillar 4: New roles and new ways of working
* Pillar 5: Growing our workforce and developing our people
* Pillar 6: Strategic workforce planning

### Outcomes

The Wakefield Health and Care Partnership People Plan focuses on how we can bring workers together across professional and organisational boundaries to deliver a seamless health and social care service. It supports the integration agenda, through the development of new roles, system leadership training and the introduction of new ways of working.

A programme management office (PMO) approach will ensure each of the Pillars’ priorities are monitored.

Workforce data will be utilised and analysed to understand the impact of the outputs.

# Health inequalities - CORE20PLUS5

## Our framework for tackling health inequalities

Framework expected to be taken into account for all commissioning and delivery where appropriate

Additional investment for people at greatest risk of experiencing health inequalities:

* People who live in geographical areas of highest deprivation (according to IMD)
* People who belong to health inclusion groups or who have protected characteristics

Expectation that approach includes wider determinants of 5 clinical areas

Leadership group at ICB have agreed a loose set of criteria – majority of decision making is at place

A local partnership leadership group will be established to oversee the work for Wakefield District

More information about CORE20PLUS5 is available on the NHS England website: [www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5](http://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5)

# Digital Transformation – key themes

* Data driven decision making
* Real time system demand management
* Population Health Management datasets enabling identification of at-risk cohorts and interventions to prevent ill health
* Sharing of pseudonymised service utilisation information
* Self-management support
* Shared care record

# Quality at Place

## Principles

* Collective approach
* Based on transparency and trust
* Inclusive / participative, communicating with partners through established networks
* Mutual peer support, constructive challenge and solutions
* Respectful of an organisation’s ‘own business’
* Shifting focus from assurance to improvement, support and shared learning
* Low bureaucracy – keep it simple
* Acting with kindness and civility
* Quality at Place:
  + keeps residents at the centre of what we do
  + improves quality of care
  + links to reducing health inequalities
  + is multi-organisational / pathway driven
  + focuses on areas that make a real difference to residents
  + looks at issues where a collective approach adds real value

### Embedding quality at place

Each programme will consider…

* What contribution is the programme making to reduce health inequalities?
* Does the programme promote and improve quality and safety?
* Does the programme have appropriate measures to determine the impact on quality and safety?
* Has the programme undertaken quality and equality impact assessments on the proposed change, and mitigated any risks that are created?
* Does the programme introduce best practice and how far is it evidence based?
* How is the patient and community voice being embedded throughout the programme?
* Does the programme have a focus on improving experience of care?
* Does the programme consider implications for the workforce (including training and development)?
* How will the programme know that it is a making a demonstrable difference to outcomes – clinical and non-clinical?
* Are there any concerns from a regulatory perspective and if so, how are they being addressed?
* How will the programme be evaluated and to what extent will this be independent of programme governance?
* How will the programme impact on and support ‘recovery’ and ‘reset’ requirements?

### Quality enablers

* Use of quality improvement methodologies as the basis for transformation programmes
* Understand the Wakefield population need and inequalities – JSNA and Health and Wellbeing Strategy
* Live quality and equality impact assessment (QEIA) process
* Measures identified can be track improvement over time
* Formal evaluation of the change, including public voice, to ensure benefits realisation and no unintended consequences

# Patient and Citizen Voice

Our approach to involvement is aligned to the West Yorkshire involvement framework, which also includes the involvement principles which have been contributed to and adopted locally.

Principles and ways of working for 2022/23 of the WDHCP will embed and reflect our citizen voice within our work.  This will include, but not be limited to:

* Evidence of appropriate patient and public involvement taking place in our WDHCP transformation work programmes.
* Avoidance of duplication and mutual support for seeking patient and public feedback across Wakefield Place.
* Consideration of possible impacts of proposals and plans.
* The approach to public involvement will be transparent, accountable, and evoking trust from the public.
* Reflection of findings from the ICB review of public involvement within the approach for WDHCP planning and reporting.

It is proposed that citizen voice is represented at the WDHCP through the following ways:

* Continuation of engagement as one of the key enablers for the WDHCP going forward and regular updates/reporting at WDHCP meetings to provide up to date information on planned and completed activity and feeding in the patient and public voice into the WDHCP.
* Continuation of the Patient and Community Panel to advise on and quality assure engagement and equality activity.  This would be supported by development of the Panel to include increased diversity, strengthened links to currently under-represented groups, mental health, Learning Disabilities, young people and other cohorts either through membership or working links. This arrangement would support the principle of no action or decision being made prior to evidence of appropriate patient and public involvement taking place.
* Task and Finish Group of the Patient and Community Panel to be established specifically to consider the business of the WDHCP and relevant documentation prior to each WDHCP meeting. This Task and Finish Group will be led by Healthwatch Wakefield’s Chief Executive Officer.
* Current WDHCP Citizen Engagement enabler reporting to be utilised alongside these arrangements and Healthwatch Wakefield Chief Operating Officer, as Senior Responsible Officer for the Enabler, remain the point of contact for this including reporting to the Health and Wellbeing Board.
* Overview of feedback received utilising patient experience monitoring mechanisms and linking to Quality at Place workstream. This aspect would link with the proposal on place-based approach to quality, as outlined in the work of the CCG’s Quality Team and the Experience of Care Network.
* Service user stories at WDHCP meetings, represented in various formats.
* The voice of the citizen to be represented at WDHCP meetings as a standing agenda item, building on local engagement and patient experience work.
* Current engagement mechanisms to continue to ensure that Wakefield has varied channels and approaches across the ladder of involvement, from sharing of information to co-production.
* Make recommendations to the WDHCP Board on any anticipated issues via the Citizen Engagement enabler Senior Responsible Officer lead who is also the Healthwatch Wakefield Chief Operating Officer.

# Climate Change

As a partnership we take our responsibility to addressing climate change seriously. Partners have already taken a range of actions to contribute positively to this agenda, such as modifying estates, incentivising reductions in car use and ensuring that procurements facilitate best practice. We recognise that we can go further, faster by working together going forward.

We will…

* Work closely with the West Yorkshire Integrated Care System Climate Change Strategy and play our part in making change in Wakefield district.
* Facilitate an increase in active sharing of ideas, best practice and actions across local organisations
* Establish a Climate Change partnership group meeting regularly to drive innovation in climate change
* Identify Climate Change Champions in and across organisations
* Create a workforce movement supporting individuals to make small incremental changes in personal and community lives

# Financial Challenge and Opportunity

The financial challenge across the Wakefield place is significant across all partner agencies. The lack of a long-term agreement for the funding of social care continues to present challenges to service sustainability.  The financial agreements that have underpinned the NHS and local authority response to Covid-19 are now starting to diminish. As part of this, the national direction is to reduce the NHS funding that has been provided to the West Yorkshire ICB to fund the Covid-19 response; the extent to which matching costs can be reduced is far less certain. To support elective recovery, additional revenue and capital funding is being made available to systems.

As the financial governance arrangements in Wakefield start to move more closely to a partnership model through the WDHCP, there will be a need for an increased focus on an open-book approach, a clear understanding of underlying costs, a clinically-led and data-driven approach to productivity and efficiency, and a framework for partnership decision-making that delivers on outcomes, improving population health and wellbeing, and reducing health inequalities

# **Our Development Journey – what’s next for Wakefield District Health and Care** Partnership?

* We are continuing our journey as WDHCP and are beginning this part of our journey
* We have achieved so much by working together and we now have the opportunity to do more
* We want to look to the future and work towards where our citizens tell us we need to be by 2028
* We need to take time to develop those plans together and will do so over the coming year.
* We will publish our five-year transformation strategy by April 2023.

Proud to be part of West Yorkshire Health and Care Partnership