Wakefield District Health & Care Partnership

Transformation Delivery Plan

Look back - Celebrating progress during 2023

Start Well, Live Well, Age Well

Proud to be part of West Yorkshire Health and Care Partnership

Foreword

This report reflects the progress made over this past year by individuals and teams across our Health Care partnership.

I want to thank everyone for the significant effort across the system to deliver our commitments across the Wakefield District.

This report showcases the journey, delivery, and progress we have made over the past year since the launch of our strategy. It also provides insight into where we need to continue to invest to support our healthcare system to fully realise our shared vision.

Mel Brown, Director of Integration and Chair of the Transformation and Delivery Collaborative Wakefield Health and Care Partnership.

Introduction

In July 2023 the Wakefield District Health and Care Partnership signed off an ambitious three year Strategic Delivery Plan. The plan outlined our vision for the future of health and care and population health in Wakefield district and demonstrated how we would contribute to our local Health and Wellbeing Strategy as well as meeting our statutory duties. Our vision for health and care:

Our vision and purpose:

Vision (from Wakefield Health and Wellbeing Strategy):

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

Purpose statement:

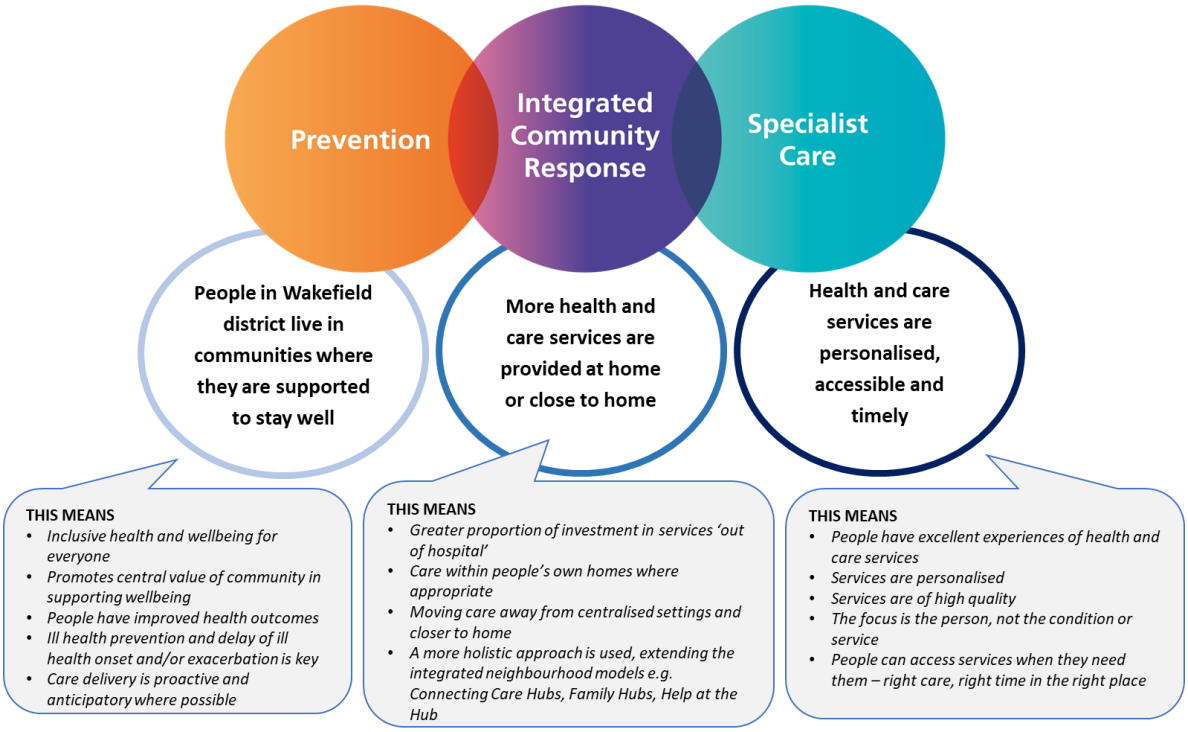
Together, we will work with the people of Wakefield district to create a connected system that supports people in their homes and communities to live healthier, happier lives

Strapline:

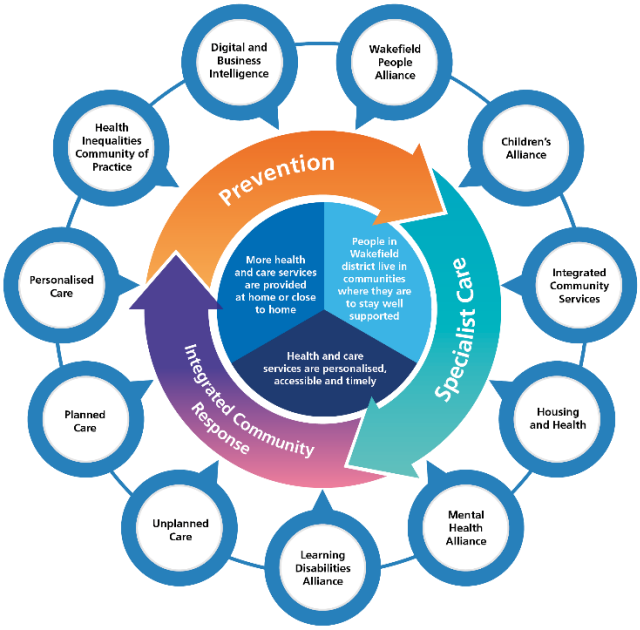
Start well, live well, age well

The Strategic Delivery Plan outlined our strategic goals that are our priority areas for transformation and enable us to organise our resources in such a way that will work towards our vision.

Our strategic goals for transformation and delivery framework:



In order to deliver our vision through our strategic goals for transformation we have implemented a delivery framework through our partnership alliances and programmes:



Looking Back across 2023

In this section, we look back at our journey and achievements during 2023, which represented the first year of our transformation delivery plan. Our delivery plan and programme of work is evolving, and therefore this describes the journey and investment we have made during year one.

We have presented the achievements of our partnership transformation alliances and transformation programmes, based on the goals they set at the beginning of the year.

Where applicable, impact data and case studies are shared, which will be tracked and built upon in subsequent years when we gather further impact data on the delivery plan at local system / organisational levels.

1. Wakefield People Alliance

Aim - create a sustainable health and social care workforce that is fully integrated, working across professional and organisational boundaries.

Senior Representatives from our organisations have formed a People Alliance who come together regularly to steer and oversee the implementation of the Wakefield People Plan. The members of the People Alliance are committed to ensuring that the Wakefield People Plan is implemented consistently across our entire workforce and in line with our shared values.

Development of a System Workforce Team

The Wakefield People Alliance recognises that, in order to deliver the objectives, set out in The People Plan we need a dedicated resource focussing on delivery. It has therefore commissioned the Wakefield System Workforce PMO, hosted by Mid Yorkshire NHS Teaching Trust but jointly funded by health and social care partners. The System Workforce Team is totally focussed on how partners can work together to support recruitment, reduce levels of sickness, retain staff and promote healthy working environments.

The Spectrum Physical Health Check Service

By looking after our workforce more effectively we will be able to retain staff and ensure that they can be properly supported to do their job.

The People Alliance has commissioned a Physical Health Check Service, run by Spectrum Community Interest Company (CIC) and recently expanded into Care Homes. It is available to everyone who works in the health and social care sector. The service is targeted at front-line staff and provides quick access to therapy for staff with Musculoskeletal (MSK) issues. The service reduces sickness absence levels and prevents future injury.

Addressing the Cost-of-Living Crisis

We recognise the impact of the cost-of-living crisis on our workforce, especially those in lower paid roles. The People Alliance has worked with Leeds on the development of a Money Buddies scheme to address the cost of living crisis for vulnerable staff. We successfully socialised the West Yorkshire Mental Wellbeing hub, ensuring that it is properly utilised by staff who work and live in Wakefield. We have also been working with partner organisations on the development of a joint approach to recruiting, training and supporting mental health first aiders.

By supporting the financial and mental wellbeing of our workforce, we intend to reduce levels of stress-related sickness across the system.

Growing the Workforce

In November the People Alliance coordinated a hyperlocal recruitment event at St. Georges Community Centre in Lupset. We brought together health and social care organisations including the Mid Yorkshire NHS Teaching Trust, South West Yorkshire Partnership NHS Foundation Trust, the Yorkshire Ambulance Service and Wakefield District Council, to promote careers in Wakefield.

The System Workforce Team has worked with the Council and health providers on an engagement strategy with schools and colleges. We want young people in Wakefield to choose a career in health or social care and stay local. Providers are already exploring the incentives we can introduce to encourage young people to join the sector.

Learning and Personal Development

The People Alliance has developed proposals on a learning portal that can be accessed by staff across health and social care. We are supporting the development of a Citizens Coin project, encouraging staff to get involved in voluntary work. We have also actively engaged with the adult social care independent sector and Higher Education Institutes to develop a common approach to workforce planning.

2. Housing and Health

Aim: Mental Health discharge solutions project providing temporary transitional tenancies and wrap around support services.

The housing discharge solutions project went live 1 September 2023. The project is for 2 years. Wakefield District Housing property partners with Inspire North and there are now three properties with Inspire North. The project is fluid in terms of properties required to be leased, however it is anticipated that up to 4 properties will be required in the first year. Inspire North will provide management of the transitional tenancy and deliver the housing and wrap around support to meet the person's needs, therefore reducing the need of multiple organisations being required.

Aim: Mental health and wellbeing support for residents linked with GP social prescribing services and Implement Housing Coordination services across West Yorkshire for patients with diagnosed Learning Disability and/or Autism.

The new housing coordinator for Learning Disability and Autism commenced in role on 4 December 2023. This is a 2-year fixed term position to deliver housing coordination services at regional level to support those living with a learning disability and/or diagnosis of autism. This has been funded by, and is delivered in partnership with, the Mental Health Alliance.

Aim: Enhanced Health and Care Services within supported independent living schemes.

Wakefield District Housing (WDH) is working in partnership with TSS Sport to deliver social activities including armchair aerobics and exercises to ensure engagement and tenancy sustainment. In 2023/24 27,867 people accessed 2803 social events. WDH are also exploring the recruitment of a dedicated engagement coordinator to design, deliver and drive participation in social activity across its Independent Living portfolio. It is envisaged that by engaging more people, tenancies will be sustained with less tenants having to move into residential or nursing home setting.

3. Children's Alliance

Aim: Improve school attendance and inclusion (including emotionally based school avoidance)

Emotional wellbeing providers delivered a webinar to schools to support good school attendance. Education Psychology have created an Emotionally Based School Avoidance toolkit. Compass deliver a group for young people affected by emotionally based school attendance. This is also a proxy measure used to indicate the overall wellbeing of children & young people so there is other activity, not directly related to attendance that should positively impact on this measure.

Aim: Develop a Children's Observation Unit by September 2023

The Children's Observation Hub launched at the beginning of October 2023. The maximum capacity planned for was 20 children per night. Demand increased across the period that the hub has been open. (Closed March 2024 as planned as a winter scheme)
Highlights include:

- 2,559 patients seen in total.
- Presenting symptoms – 813 with fever, 271 with gastrointestinal, 1,145 with respiratory issues, and 330 with other issues
- 2,477 were discharged, 82 admitted, 96.8% of patients supported to remain at home.
- Source of referral – GPs, 111, GP Care, Walking Centre (WIC)/ Out of Hours (OOH), A&E, YAS
- Total number of day passes – 10,484 issued, 450 used – 4.3% of day passes issued were used.

92% of parents said they felt more confident looking after their unwell child as a result of attending the hub. 95% rated their experience of using the hub as good or very good and the Observation Hub now support consistently more than 20 patients per night.

Day passes have been issued with the option to contact the Observation Hub following a visit to primary care. The rate of day passes issued grew to in excess of 500 per week.

Aim: Implement Family/Youth Hubs

A full suite of parenting programmes has been launched. Information is available here: https://www.wakefieldfamiliestogether.co.uk/family-hubs/parenting-support-and-relationships/

A Parent Infant Relationship Team has been established; this is a multi-disciplinary team. The Clinical Lead is within Harrogate District Foundation Trust (HDFT) 0-19 Growing Healthy Service, also linked to Homestart and South West Yorkshire Partnership Foundation Trust (SWYPFT). The team will take an evidence-based approach using Video Interactive Guidance with parents and can offer clinical supervision / consultation across the system.

To support the development of the Home Learning Environment work, an evidence-based training programme has been developed and a multi-disciplinary workforce has started training. Support will be allocated to families based on a data led approach where vulnerabilities have been identified.

Families and Babies have been commissioned to enhance their offer in neighbourhoods with the lowest rates of breastfeeding.

Aim: Widen mental health support for children and the whole family.

Our early advice and support offer for emotional and mental well-being launched in April 2023 with our new provider Compass, this widens the offer to children and young people but also works with the family as a whole to understand the child's emotional and mental well-being needs. Mental Health Support Teams which is called Future In Mind in Wakefield have increasingly embedded within schools, with great engagement from our education providers, additional capacity was added in 23-24 and we have confirmed additional funding to increase capacity in January 2025. These developments alongside the additional capacity and review which was undertaken by SWYPFT has seen our CAMHS waiting lists reduce.

A snapshot of 2023-24 data is below.

Month	Number waiting	CORE Assessment	Number waiting	CORE Individual (first line)	Number waiting	CORE Group (first line)
April 23	39	0-12 weeks = 38 12-26 weeks = 1	176	0-12 weeks = 89 12-26 weeks = 70 26-52 weeks = 17	11	0-12 weeks = 5 12-26 weeks = 6
July	3	0-12 weeks = 3 12-26 weeks = 0	122	0-12 weeks = 39 12-26 weeks = 73 26-52 weeks = 10	1	0-12 weeks = 0 12-26 weeks = 1
Oct*	3	0-12 weeks = 3 12-24 weeks =0	43	0-12 weeks = 23 12-24weeks = 16 24- 36 weeks =4 Over 36 weeks =0	7	0-12 weeks = 5 12-24 weeks = 2 24-36 weeks = 0
Jan	3	0-12 weeks =3 12-24 weeks = 0	13	0-12 weeks = 9 12-24 weeks = 4 26-52 weeks = 0	7	0-12 weeks = 3 12-24 weeks = 4 24-36 weeks = 0
Year end data not available as at 22.05.2024.						
*Note the slightly changed reporting timeframe from October.						
Waiting times for group work often appears longer as you need sufficient numbers of children and young people to make a therapeutic group effective and the cohort also need to be matched based on needs.						

Aim: Provide help for children and young people following a loss or bereavement.

A new Tier three complex bereavement service has been commissioned and will commence delivery in April 2024.

4. Primary Care

Aim: Implement health and care for migrants living or temporarily housed within the district.

Over the last few years there has been an increased number of migrants entering our district through different routes. Following the Home Office decision to increase Wakefield's number of hotels and implement the optimisation policy we have seen a rapid increase of residents in contingency accommodation over a short period of time. We have raised significant risks around this including service capacity, pressure on the wider system particularly coming into the winter period, increased need on mental health services and increased risk of infectious disease outbreaks. We have had to make urgent commissioning decisions to support current arrangements in order to continue safe levels of care.

We have developed an outreach health inclusion service using Core20Plus5 funding and Integrated Care Board (ICB) resources to support the needs of our health inclusion populations. We have worked in partnership between the NHS/LA/Communities and Voluntary Community and Social Enterprise (VCSE) to support additional resource and capacity. We have also successfully secured additional funding from NHS England to support target vaccination programmes focusing on increasing Mumps Measles and Rubella (MMR) uptake in health inclusion cohorts. In the development of the service, we worked with service users at the settings to scope out the needs of the population and produce an engagement piece to support ongoing transformation. This will aid future commissioning decisions and highlight any gaps in service provision.
Our key successes include:

- introducing NHS App/ Online consultations for improving access to care including translation services.
- Working alongside General Practices to support individuals from health inclusion groups to attend appointments and provide healthcare which meets their specific needs, with a focus on taking interventions to the patients.
- Supporting General Practices in managing the healthcare needs of these individuals.
- Delivering the recommendations alongside General Practice from the recent health needs assessments
- Partnership working with key partners such as:
    - Primary Care Networks (PCN) to use Additional Roles Reimbursement Scheme (ARRS) roles to support the work,
    - Working with Community services to provide outreach Advance Clinical Practitioner (ACP) and blood clinics,
    - Mental Health partnership working on outreach low level mental health group sessions,
    - Public Health to co-produce a migrant health needs assessment,
    - VCSE and health colleagues in the setup of One Stop Healthcare Shops,
    - Stakeholder partnership meetings to streamline healthcare pathways,

- Working and sharing best practice via West Yorkshire Migrant Health commissioner's forum.

Furthermore, we aspire to:

- Provide hesitancy work and increasing vaccine uptake.
- Meet initial health needs with populations who have poor health outcomes.
- Supporting health literacy and encouraging digital inclusion.
- Wider training programme for Primary Care on engaging and providing care to health inclusion populations.

Aim: Increase appointments and workforce in General Practice

Wakefield General Practices provided 2,623,970 appointments in 2023/24, this was a 3.36% increase from the previous year. 72.5% of these appointments were face to face which continues to grow. In line with increasing the different roles within general practice 34% of appointments were with a GP. The number of new Additional Roles working in general practice rose by 17.26% with 337.6 full time equivalent staff in this group. We also saw a 4.87% increase in the number of GPs working in Wakefield General Practices as well as a small growth (1.72%) in Nursing staff.

Aim: Widen the Community Pharmacy Consultation Service.

Community Pharmacy Consultations Service (CPCS) was added into our local enhanced service (WPPC7) to incentivise remaining Practices to sign up to the service and for all Practices to increase their referrals to CPCS. As a result, the referral rate has significantly increased from 183 referrals Q4 22/23 to 847 referrals in Q1 23/24 and up again to 1014 in Q2 23/24. Furthermore, in November 22 just 14 Practices were engaged / actively referring whereas now, all 34 Practices are engaged. The next step is to ensure care navigators within practices have received additional training in having CPCS conversations with patients where needed. Community Pharmacy West Yorkshire (CPWY) are supporting with this work and initial results have shown an increase in referrals after receiving additional training. We will also be navigating the introduction of Pharmacy first and how this will affect the CPCS pathway going forwards.

Aim: Increase referrals to the National Diabetes Prevention Programme.

Yearly referral numbers are increasing:
Year To Date – 2023 equals 938. This is an increase compared to previous years.
(2020 – referrals were 614, 2021 referrals were 610 and 2022 referrals were 799).

Index of Multiple Deprivation (IMD)s 1-5 represent 64.2% of IA attendance and 60.9% of Programme attendance. With IMD 1 representing 14.2% IA and 13.5% programme attendance.

Waiting lists are continued to be monitored and are not a concern at present. 48 people waiting 0-1 month for IA, 16 people waiting 2-3 months for IA which is in line with other Places. Monthly meetings between Place Integrated Care Board (ICB) and Provider are taking place for oversight and assurance purposes. There are variation in referrals across the district. On average, 1 Primary Care Network (PCN) accounts for 1/3 of monthly referrals, 3 PCNs account for 80% of monthly referrals. There is a plan to engage and support least referring

PCNs/Practices. The provider is also offering Health and Delivery Coaches to support low referring Practices. There is a plan to work with the Business Intelligence Team to merge monthly MDS Data from Provider into Primary Care dashboards to improve visibility for PCN Managers.

Aim: Learning Disabilities Health Check

As part of the local and national contract practices are required to increase the uptake of Annual Health Checks for Learning Disabilities (LD). 83.9% of people living with Learning Disabilities received their annual NHS healthcheck in 2023-24

Some PCNs are building on the learning from previous one stop shops and are facilitating sessions in the community, they are also working with the Strategic Health Facilitator from SWYPFT to improve practice processes and staff development. We have provided multiple sessions to the practices on top tips to improve the quality of the annual health check and increase uptake. The Strategic Health Facilitator has connected with the LD leads within practice, and we are working with the practices which have lower uptake than expected for the year.

AIM: Healthy Heart Community Hubs CVD prevention

Over the last year working in partnership with Public health, Primary care and VCSE colleagues, more than 15 Healthy Heart Community Hub (HHCH) sessions have taken place in community venues across the district. The project aims are to reduce Cardiovascular mortality and morbidity by helping people to understand more about the risks of Cardiovascular Disease (CVD), then supporting them to reduce their risks, embedding personalised care approaches through a supported self-management and lived experience lens. Improving the detection and treatment of people with undiagnosed hypertension as per the operational planning guidance for 23/24 and to continue to address health inequalities.

We worked with the 6 engaged Wakefield PCNs to organise and deliver bespoke hub sessions that met the needs of their individual local populations. Each PCN used a targeted data driven approach to recruitment alongside utilising local intelligence to choose venues where good footfall were seen, focussing on populations that may not traditionally attend for preventative screening. Over 269 blood pressure checks and 181 pulse checks have been undertaken to date, we are now in the process of collating the numbers of diagnoses of hypertension and Atrial Fibrillation that will have been made as a direct result of the CVD prevention intervention. HHCH sessions are planned for the rest of the summer months, it is then hoped that the sessions will be taken forward as part of PCN's business as usual.

5. Integrated Community Transformation Programme

Aim: Implement an Anticipatory Care model

The Anticipatory Care agenda was held under the banner of Ageing Well until 2023 when updated guidance was published moving the focus to Proactive Care. Following this we have established a working group to deliver Integrated Neighbourhood Teams to deliver an integrated model of care, of which one of the focuses is the provision of proactive care.

Key cohorts of individuals who are evaluated through the linked data set as being at the highest risk of needing to access specialist/acute services will receive contact to facilitate proactive care plans. This means that teams within defined Neighbourhoods will strengthen their approach to working with individuals to support their longer-term well-being. This is part of the Districts approach to supporting people to live happier, healthier lives and reduce health inequalities.

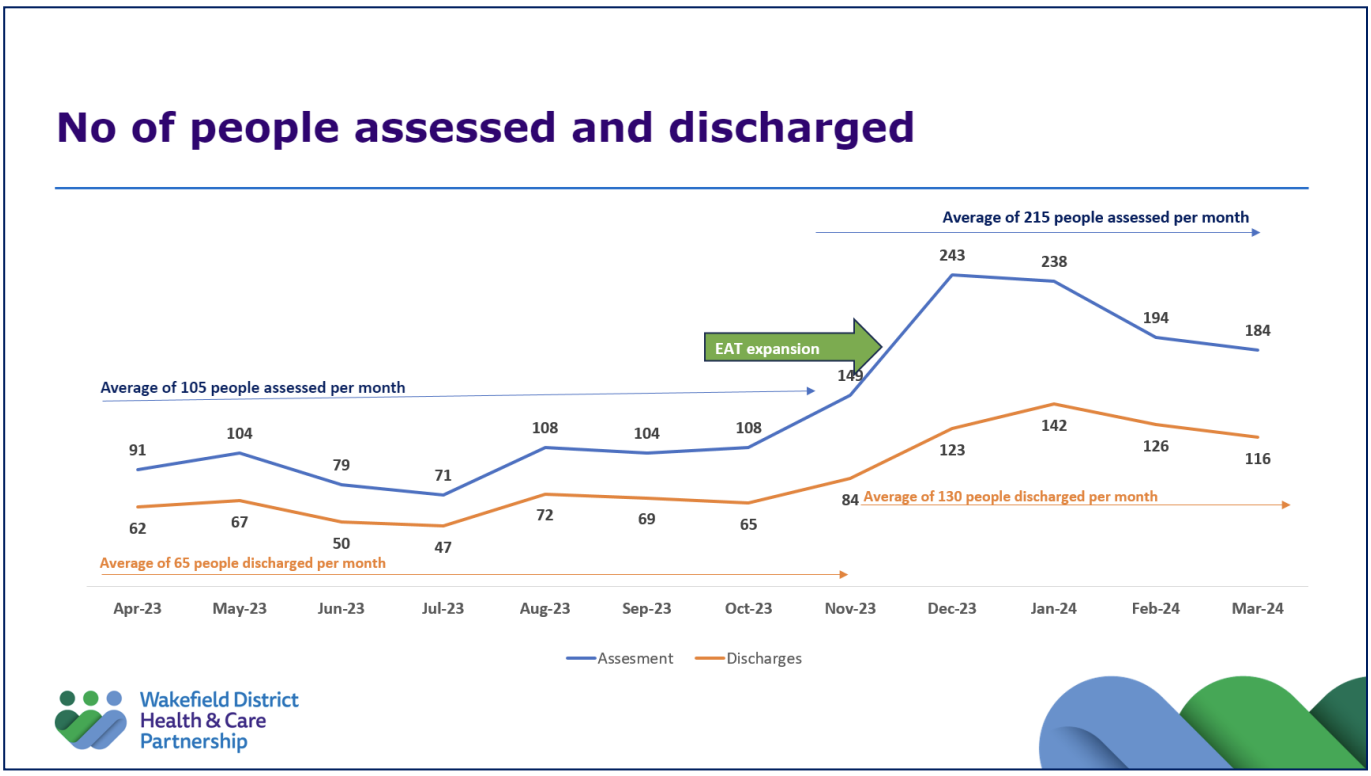
A key part of this has been to establish a state of readiness for health and social care teams to be aligned to Wakefield's primary care networks to enable close working relationships. To this end six Health &Social Care (H&SC) integrated neighbourhood teams have been created to align with the district's seven PCNS, with six senior lead posts from H&SC teams (including therapy, social workers and nurses) to develop relationships with local areas and enable the integrated H&SC functions to work with the existing teams within those neighbourhoods in a more proactive and efficient way.

The next steps are to work with partners across the district to create a solid, unified vision for neighbourhood working across primary, community health and social care and voluntary partners that will truly transform the delivery of care in Wakefield – harnessing the power of collaboration for the benefit of individuals.

Aim: Enhanced Care at Home - Develop a Multi-Disciplinary 'turn around' team based within the acute trust that will assist in the triage of patients at ED and will support those for whom it is identified that their needs could be met in the community rather than through admission to hospital.

Huge successes have been delivered through closer working between community health and social care and the acute trust in 2022/23. The expansion of the current Emergency Assessment Team (EAT) within the emergency department (ED) has seen the addition on community nurses. This means that there are pathways from ED to the community to support people home when they do present to ED. This has been supported by the infrastructure created as a result of the hospital at home (virtual ward) initiative and means that elderly care doctors who support the hospital at home can support the EAT with senior decision making. The team can refer to and support people through a variety of services in the community, including acute care at home, district nursing and therapy as well as implementing short-term social packages of care.

The enhancements of the team have meant that the number of people assessed and supported home has doubled from an average of 93 assessments per month in the first six months of 23/24 with 61 being supported home to 186 assessments and 109 people being discharged home.



Aim: Falls Prevention

Care home falls prevention training:
The care home workstream aims to deliver training to care home staff to support them to identify the reasons why their residents might fall. The training prompts and guides staff to complete actions to reduce falls. This is based on the GtACH (Guide to Action for falls prevention in Care Homes) a multi-factorial tool designed to assess risk of falling on an individual basis to enable the implementation of patient centred fall preventative changes. Identified risk factors and preventative changes are based on a person's Fall history, medical history, Movement/Environment, and Personal need.

Training was delivered in February 2024 via face-to-face training sessions in one care home, and covered majority of staff. Falls data collected pre and post training showed a reduction in the number of falls and the severity score for recorded falls.

- The total number of falls in the care home before training was 27 (average 5 per month). The total no of falls after training was 6 (average 2 per month). 60% reduction in the average no of falls per month – Diagram 1.
- There has been a reduction in severity score for a fall, less falls recorded with a score of 3 or above post training (Score 1 – no injury/ no further action to Score 6 – Death). The care home recorded 8 falls with a severity score of "3(111/ 999 contacted)" pre training, and 1 falls post training. The care home recorded 1 fall with a severity score of "5" pre training, there were no falls recorded with this score post training – Diagram 2.
- The general feedback from care home staff has been positive, a formal survey question has been sent to the care home.

Diagram 1:

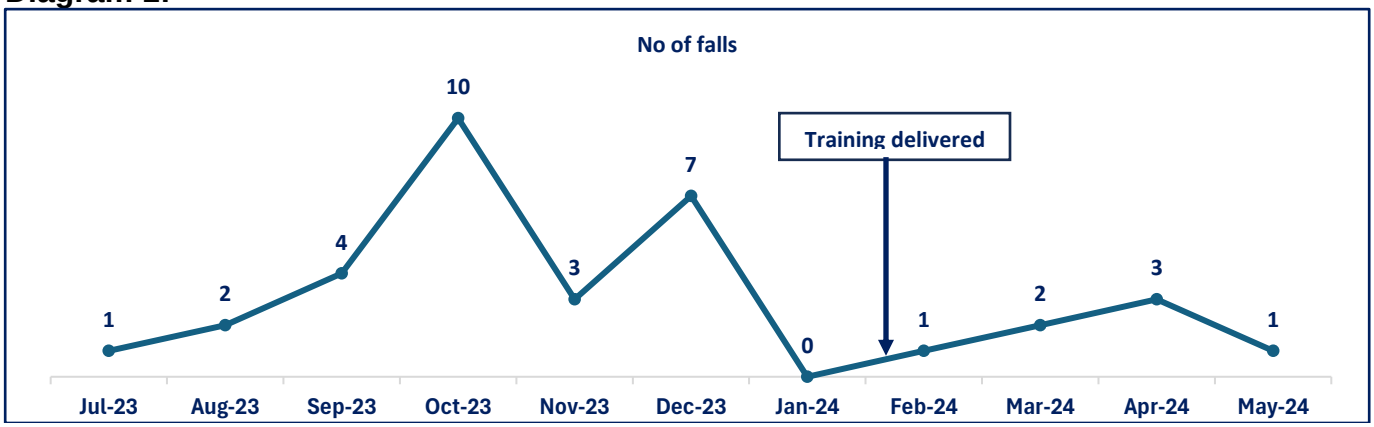
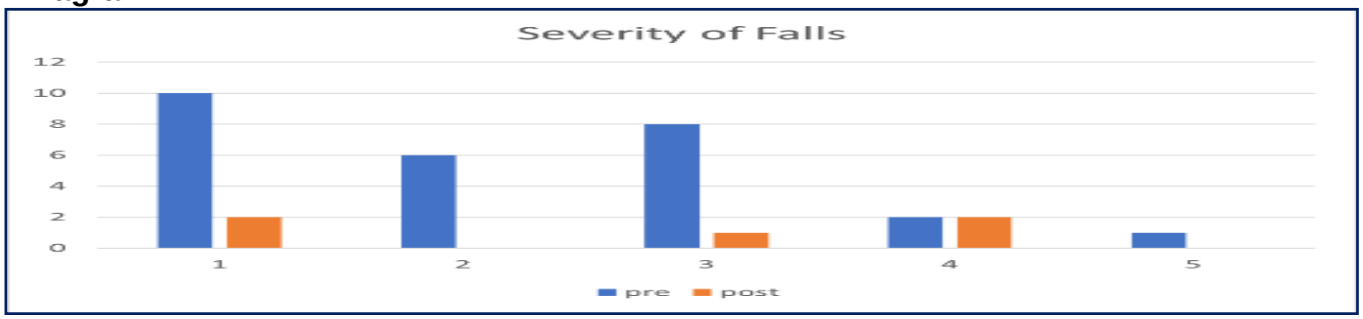


Diagram 1:



Urgent Community Response (UCR) falls pathway

The Wakefield Urgent Care Response (UCR) have a falls response pathway in place to attend and support falls that Yorkshire Ambulance Service (YAS) refer to UCR team via the Local Care Direct (LCD). The response team consists of Advanced Clinical Practitioners (ACPs) and therapy.

Referrals to this pathway are made by using set agreed criteria and as clinically appropriate. Falls lifting equipment and training was provided to the ACPs and the wider team. This has been a small trial in Wakefield and next steps are for Wakefield to trial the push+ model with YAS and LCD hub. This means LCD hub can identify cases that meet the criteria in a more timely way, supporting swift access to care for those for which an ambulance would have otherwise be deployed with long waits. YAS will send text notifications to LCD hub about cases that are suitable for UCR and will call YAS Emergency Operations Centre (EOC) to accept the referral. The impact will be that this will remove unnecessary steps and the UCR will be able to identify and respond to a falls call more swiftly. YAS are also trialling a dashboard that will help to identify which patients can be referred to UCR, further supporting their ability across Wakefield, Calderdale and Kirklees to access urgent community service support and facilitate an improvement in ambulance response times by identifying alternative services to support those in need.

Aim: Implement Community Nursing hospital in-reach

Adding community nursing has also established an in-reach service into elderly care wards and Acute Assessment areas of Pinderfields hospital. This collaborative working has increased the awareness and use of community pathways supporting people home and to recovery hubs,

reducing length of stay of elderly inpatients. There is significant support for this way of working across health, social and acute services. This has been implemented following a pilot initiative which delivered the following outcomes:

Community in-reach into elderly care wards: 59 individuals admitted to an elderly care ward were assessed by community nursing, in 35 cases (60%), alternatives to hospital bedded care were identified. Alternatives included transfer to the hospital at home services, district nurse care, end of life support, recovery hub, community therapy care and voluntary sector support.

By ensuring an increased and consistent community presence we are successfully supporting people home earlier, to receive appropriate care in their own homes or within a specialist recovery hub. The next steps are to increase this resource and model, continue to spread awareness of community options and further build relationships between acute and community care offers.

Aim: Extend Hospital at Home

Hospital at Home (virtual wards) services have grown during 2023/24 growing from 36 beds on average per day and 158 people per month in the first six months, to an average of 67 beds open on average per day in the second half for the year and 254 people per month. Total number of admissions has been 2470 during 2023/24, compared to 985 during 2022/23. These individuals would otherwise have occupied beds in the acute setting.

The service has seen a number of repeat customers return to the care of the virtual ward with 835 individuals being admitted to the services more than once.

Quarter 4 during 2023/24 saw the delivery of the long-awaited remote monitoring system and 2024/25 will see the staged roll out of this, with the anticipated benefits of further increases in capacity to manage the acute needs of more people in the place they call home. This service works in conjunction with hospital in-reach initiatives both in ED and on wards, strengthening the relationships, trust and supporting objective of place and acute strategy, as well as intrinsically linked with integrated neighbourhood teams.

This move towards integrated neighbourhood teams in 2024/25 will see additional training for our integrated H&SC teams to ensure all have skills to contribute and manage acute needs at home.

Aim: Intermediate Care Recovery Hubs

The Recovery Hub in Dovecote Lodge continues to support people with non-acute recovery needs before they return home, reducing time in hospital and ensuring people are able to return home with confidence.

Throughout 2023/24, the model has included 24 beds within Dovecote Lodge supported by social care teams together with therapy professionals that support people to recover following an episode that has seen them deviate from their normal state of well-being.

Over 2023/24, the Recovery hub has supported increased admissions directly from ED, enabling individuals to be transferred from Pinderfields who might otherwise have been admitted to a hospital bed as a 'social admission' where no medical treatment was required. They have also supported a number of hospital in-reach approaches that have allowed people to be transferred to a recovery bed earlier in their hospital stay, thereby reducing the length of time that people are unnecessarily in hospital.

Work is ongoing in the district to expand and develop the model, ensuring the correct number and type of recovery beds are available to support the wider Home First approach.

6. Mental Health Alliance

AIM: Individual Placement and Support

Supporting people with severe mental illness to regain employment. Our offer, linked to the community mental health teams, has received exemplar status following a national fidelity review This exemplar status relates to the quality of clinical integration, employer engagement and supporting over 30% of those accessing IPS into paid employment.

AIM: Access to mental health crisis support

The following services have been funded to provide additional capacity for access to mental health support and reduce impact on the secondary mental health and general acute systems:

- Here for You (Safe Space)
- YAS Mental Health Support Vehicle's reduction in conveyance to ED
- 24/7 Mental Health Helpline
- New enablement service including mental health support.
- Mental health support in the ITOC and Complex Needs teams at MYTT
- Leeds Survivor-Led telephone support service in place to support patients discharged from the Intensive Supported Home-Based Treatment Team to avoid readmission.
-

AIM: SWYPFT Care Closer to Home programme

Aimed at optimising care in the community, point of admission, appropriate inpatient pathway and flow management. Measures include:

- Reduction of Out of Area Placements with the aim of achieving zero (since the programme has been in place there have been less than 6 at any one time across Calderdale Kirklees and Wakefield (CKW) and currently zero in Wakefield).
- Reduction in discharge delays.
- Increased discharges.

AIM: An integrated offer of 'low level' mental health support

This has been provided by various VCSE organisations to offer early intervention and support.

Aim: Community Mental Health Programme - Increasing access to support for people with enduring and severe mental illness directly within primary and community care settings.

Annual Health Checks for people with severe mental illness. Improve uptake of checks so we can proactively manage the general health of the cohort population. We are adopting a two-pronged approach – linking in with the system Severe Mental Illness (SMI) Steering group and developing local strategies with our PCNs. The ambition is to improve the number by 10% until we reach the national target of 2403.

The data for SMI health checks for practices in Wakefield as of the 31 March 2024 is at least 90.61% have received a check, 71% have received all 6 elements of the check.

We are currently working to improve practice processes, interface with secondary care, data gathering and sharing to support increase in uptake. We are also working with the PCN's on different access routes for the SMI health checks such as drop-in clinics in the community.

AIM: Dementia Diagnosis

The diagnosis performance is impacted by the demand on services for people aged under 65 which is about 25% higher than the national average. It is right that people with potential symptoms are referred for diagnosis, but these patients are not counted by the current target. We are currently reviewing the service to engage the target cohort better and exploring funding opportunities to support these actions. The national target is 66.7% and the local target 62% with the most recent diagnosis rate of 64.5%, this target is currently being exceeded.

7. Learning Disability Alliance

AIM: Health Checks for People with SMI and LeDeR reviews.

Health checks for people with Learning Disabilities and the Learning from lives and deaths - People with a learning disability and autistic people (LeDeR) reviews (and subsequent actions) which are undertaken following the death of someone with a learning disability are fundamental to supporting a reduction in inequalities in life expectancy. For the health checks, according to WY local data, Wakefield has achieved 83.9% against a national target of 75%. We are proposing that we set a local stretch target for 24/25 of 85%. This is an aspirational target that we will encourage practices to aim for and support them in that.

AIM: Additional capacity for adult ADHD diagnosis

There has been investment in the South West Yorkshire Partnership Foundation Trust service to streamline triage and deliver more capacity for diagnosis to reduce the waiting list.

8. Urgent and Emergency Care

Aim: Rapid Access to Drug & Alcohol Recovery specialist support for patients presenting with these needs with Mid-Yorkshire Teaching Hospital at Pinderfields Hospital site.

This service based at Pinderfields was expanded throughout winter 2023/24 using resilience monies. Expansion of the trust's Substance Care Team (SCT) to improve rapid access to alcohol and drug recovery in the local population. The plan to increase access to alcohol and drug recovery or patients is clearly outlined in the governments harm to hope agenda. Within Mid Yorkshire Teaching NHS Trust (MYTT) the expansion of the team and referrals into community partners has been the area of focus.

Patients seen by the SCT team in the month ending 31st March increased by 19.7% (45 patients) and stood at 274 patients. This was an 255.8% (197 patients) increase in comparison to March 2023 and the highest number of patients to date.

Referrals into community services increased by 17% (48 patients) in comparison to the previous month and stood at 64.6% (177 patients) for the month ending 31st March.

In March, the SCT team working with medical staff prevented 34 hospital admissions from ED

Aim: Introduction of Acute Respiratory Infection (ARI) Hubs in the community

3316 Wakefield patients with respiratory symptoms were treated in the two ARI hubs in the Wakefield District this winter. Ability to flex and extend arrangements until end of March (previously due to end in mid-Feb). Only 10 (0.3%) of those patients required admission to hospital. 99% of all of the 3352 appointments made available were utilised.

The hubs were open to referrals from GP practices, 111 and patients could also be redirected from ED.

This service has received positive patient and staff experience feedback.

Aim: Expand access to Social Work staff at the front door of Emergency Department

The purpose of implementing the Emergency Assessment Team is to prevent unnecessary attendances to Emergency Department or admissions and ensure more prevention support is offered within the wider community.

The expansion is of this service is ongoing. Two care coordinators are currently now in place and recruitment is ongoing to add three more to provide a Multi-Disciplinary Team approach to respond and assess patients.

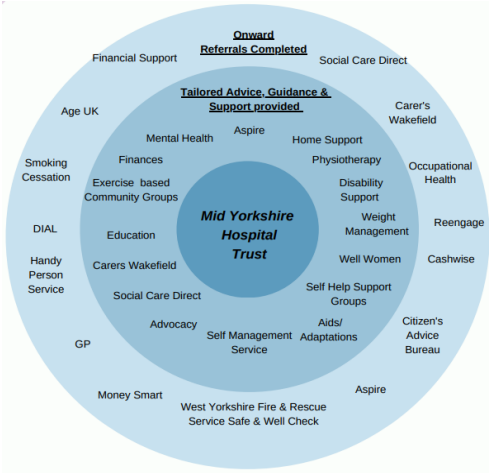
Supporting this additional support at the front door, Trusted Assessors have been introduced into the Calderdale, Kirklees and Wakefield systems to support the smooth transition of patients into care homes either as a new placement or a returning resident. This is managed independently of acute hospitals overseen by KirkCA (the Care Home association of Kirklees).

9. Planned Care Redesign Programme

Aim: Implement personalised care with training on making every contact count, waiting well and social prescribing made available to all users of provider services as part of pathway. In conjunction with Personalised Care

During 2023 all patients who were waiting for >35 weeks for a procedure were contacted and offered the waiting well programme via social prescribing at Wakefield Live Well. This was a fantastic example of joint system working across three organisations and it was nominated for the finals of the Healthy Service Journal (HSJ) Patient Safety Awards.

100% of people who used the service said it improved their wellbeing and 90% improved their confidence and preparedness. Over 30 different services were contacted to provide support as part of waiting well, as shown below:



This was real personalised care and alongside the offer of Making Every Contact Count training supported planned care.

Aim: Enhance the patient portal to allow people to access their health record, provide better information on health and care services in accessible formats and language, and to allow them to upload their own information to clinicians to personalise their care pathway.

The growth of the Mid Yorkshire Teaching Trust (MYTT) patient portal has been vital to the programme. It has been used in multiple ways to improve access at MYTT. As a result, membership has grown 22% to 146k users.

Some of the key improvements include:

- Mid Yorkshire therapy waiting well videos for patients waiting for treatment are now online via the portal. These support people to get ready for their procedure and consider improving their lifestyle.

- A key element of the portal is providing access to test results and 65 further test results added in 2023.
- Work is underway to improve the level of information the patient receives in the appointment diary- this will include method of appointment e.g., video/ Face to Face/ telephone call as well as the option to cancel/ amend appointments via requests in the portal.

Aim: Support Shared Referral Pathway (SRP) to establish within appropriate specialties, right size referral demand for outpatients and diagnostics by providing an eConsultation service and develop further opportunities.

The Shared Referral Pathway (SRP) has been rolled out to all appropriate Mid Yorkshire Teaching Trust's specialties and is now being optimised via joint review with clinical and operational leads to make it more effective and efficient. Work taking place on ensuring the delivery model is resilient. The SRP continues to offer both patients and clinicians a quicker, alternative care pathway for care and support via eConsultation.

- On average, over 5000 requests come through it each month for 14 specialties. It facilitates patients to be cared for closer to home by their GP, and when a referral is needed reduces waiting times for many of MYTT's services, improving outpatient capacity and saving both patients travel time and costs.
- The Dermatology service expanded last summer, improving access for patients with lesions of concern or skin cancer. The SRP supports a review of 'dermascopic' images using a dermascope as part of the eConsultation and has led to a significant increase in offering advice only instead of an appointment. Now, over 40% of all referrals sent via SRP are given advice and over 90% of requests are coming with images attached. The next step is to support all Dermatology referrals to come with an image so they can be reviewed on SRP.
- This year we launched a new pilot scheme for a Community Palpitations service using SRP, where patients can now access monitoring of their condition at home instead of a referral being sent to MYTT to have an initial appointment followed by diagnostic tests. After four weeks of monitoring the service can advise the GP if they need to refer on to MYTT for further advice. Caring for people with palpitations accounts for a large proportion of GPs time so this improving capacity in primary and secondary care. The feedback has been excellent to date and the overall confidence is growing in primary care on when to refer or not.
- Further projects using SRP are now underway in some of our most fragile services, including Inflammatory Bowel Disease (IBD), Gynaecology, Neurology, Respiratory and Rheumatology. These involve new straight to test pathways reducing the need for an initial appointment.

Aim: Establish Patient Initiated Follow Up as the main approach to offering follow up and apply retrospectively to follow up backlog of outpatient appointment. Use 'Get it Right First Time' (GIRFT) recommended pathways.

The technical implementation of Patient Initiated Follow-up (PIFU) has completed, and the numbers of patient added has remained stable during 2023 at an average 1500 per month. The number of patients on a PIFU pathway has from grown 3k to over 10k. Work continues to support specialty services to increase uptake on appropriate pathways. The national Outpatient

GIRFT pathways continue to be used to audit services at MYTT and work with the clinical and operational team to make improvements.

Aim: Operationalise the new Community Diagnostic Centre (CDC) in Wakefield city centre.

In Spring 2024 Mid Yorkshire Teaching NHS Trust opened its new centre for diagnostic tests, having secured £12.2m government funds. Wakefield Community Diagnostic Centre, based at Westgate Retail Park, will be a convenient way for patients to get the healthcare tests they need.

One of 40 new diagnostic centres across the country, the facility provides planned outpatient tests including: x-rays, ultrasounds, CT, MRI and bone-density scans, as well as bloods, cardio-respiratory tests and some ophthalmology (eye) tests. Tests and scans for emergency and in-patients will continue to be provided at hospital.

Westgate Retail Park was chosen as a central location, just five-minutes' walk from the city centre, easily accessible by public transport and with free car parking, to make journeys easy for the people who will use it.

The additional CDC diagnostic capacity creates opportunities to develop new clinical pathways, seeking to coordinate tests so patients have to make as few visits as possible and referrers have the information, they need to make fast, accurate diagnoses. Diagnostics is one part of wider work to improve planned care pathways. Work is underway, involving primary and secondary care clinicians, to identify where the increased diagnostic capacity can have most impact. This pathways work is part of the Planned Care Transformation Programme, to ensure that decision making, and approvals have a clear governance route.

10. Health Inequalities Programme – CORE20PLUS5 Programmes

The overall Core20PLUS5 framework (Adults) was implemented by locally adopting a partnership approach and building on and bolstering the work that was already taking place within the district. Three major programmes were pre-allocated funding: Building Healthy and Sustainable Communities, West Yorkshire Finding Independence (WY-FI), and the health inclusion service.

Through a competitive bidding process, a further eight programmes were allocated recurrent funding, again working with some of the most vulnerable populations and communities in the district.

Building healthy and sustainable communities

This is our local approach to community development, seen as key to addressing health inequalities for those living in our most deprived communities. A model will be developed that is targeted and tailored to the specific needs of communities. It will be co-produced alongside partners and existing community assets. The key aim of the project is that communities become more self-supporting places and better resourced, preventing crises through early intervention, increased support to volunteer, train and work and families able to contribute as assets.

West Yorkshire Finding Independence (WY-FI)
The WY-FI (West Yorkshire Finding Independence) scheme works with the most with vulnerable groups, those with the most chaotic lifestyles to deliver personalised intensive support to work towards a stable and structured and healthier life.

Roving health inclusion team
Building on the learning from the roving vaccination team, a health and wellbeing team undertook focused and targeted work with specific groups at more risk of experiencing health inequalities. This service worked in tandem with relevant VCSE service including Live Well Wakefield and Citizen's Advice Bureau and be established on a pilot basis initially.

Wakefield Council Pulmonary Rehabilitation
A targeted exercise and education programme for people experiencing debilitating breathlessness due to respiratory disease. Disease is higher in disadvantaged and protected groups and areas of social deprivation.

Leeds Gypsy And Traveller Exchange (GATE)
Leeds GATE, in partnership with Gypsies and Travellers and agencies in Wakefield, will work to tackle inequalities and increase access to healthcare across the Core20Plus, five clinical focus areas, achieved through a blended approach of front-line health advocacy, community health development and systems change.

Wakefield Council Warmer homes
A warmer housing coordinator will work with those in the most deprived areas to prevent fuel poverty and reduce the risks of exacerbations of respiratory conditions.

Wakefield Council, Energy Savers
An extension of a local scheme to address fuel poverty. This will reduce cold homes, such housing conditions exacerbate health inequalities and impact health conditions such as respiratory conditions and cardiovascular diseases.

Live Well Wakefield, link workers
A link worker based with the Wakefield Social Prescribing service will work in partnership with two Community Anchor organisations to identify individuals at risk of experiencing health inequalities. A Peer Support Volunteer will be assigned to assist those individuals to attend their upcoming appointments, supporting early diagnosis and improved outcomes.

MYHT, maternity befrienders for women new to the country and/or women with limited English language
Women who are new to the country and/or who speak English as a second language are at higher risk of experiencing infant mortality. This scheme will identify befrienders from within these communities as peer support for engaging in maternity services with an aim to reducing poor outcomes.

SWYPFT, Healthchecks for those on SMI register
People living with serious mental illness are one of the most at risk groups of experiencing health inequalities. This intervention is one of a range in the district that aims to increase the numbers of people with SMI accessing NHS health checks - seen as a key action for addressing health inequalities in these groups.

Rosalie Ryrie Trust, CBT for victims and perpetrators of domestic abuse

This VCSE sector organisation will implement CBT for low level mental health conditions for both perpetrators and victims of domestic abuse. These groups are at higher risk of experiencing health inequalities and this intervention aims to break the cycle enabling people to improve their health and wellbeing.

Turning Point, Dual diagnosis training

Access to Dual Diagnosis training for staff of this VCSE sector organisation allowing more effective working for people with serious mental illness and substance misuse.

Turning Point, Spirometry

Turning Point were able purchase spirometry equipment to enable them to support better respiratory health for their client groups - people living with mental health conditions, learning disabilities and those who misuse substances.

11. Personalised Care

AIM: Blood Pressure Wellness Champions launch

Hypertension prevalence rates in Wakefield are around 15.5% (JSNA 2023) substantially lower than the national expected prevalence rate of around 30%. Hypertension is the largest single known risk factor for cardiovascular disease (CVD), 50% of heart attacks and Strokes are associated with the condition. The Blood Pressure Wellness Champions project provides local volunteers, based within voluntary and community organisations with the skills, knowledge, and confidence to provide opportunistic blood pressure checks to people visiting their services and groups. This will give an opportunity to target communities who are not currently attending primary care services for health screening.

The project was launched on 16 May 2024 falling with May measurement month and aligned to World hypertension day. 21 volunteers were trained at the launch session and are now equipped with the equipment, resource, skills, and confidence to start undertaking blood pressure checks. All who attended also received CVD Making Every Contact Count (MECC) awareness training to help them initiate conversations within their local community setting. Further BP Wellness champion training is planned within the summer months to extend the offer to other VCSE organisations and to include people with lived experience who are part of a community group such as Patient Participation Group (PPG).

The Blood Pressure Wellness Champion role builds upon the HHCH an existing CVD prevention project workstream that's aspirational impact will be for attendees of the HHCH to take ownership of their own health and wellbeing becoming better able to self-manage. Building communities that are more resilient and self-reliant, therefore having less reliance on both planned and unplanned clinical services. This should provide a more effective system that can demonstrate a return on investment.

To date 15 HHCH sessions have been held across the district with really positive outcomes thus enabling us to work towards achievement of the following project aims and ambitions.

- Increase number of people identified with Hypertension and therefore on optimal treatment.
- Decreased number of CVD related deaths

- Increased awareness of how to check your own Blood Pressure (B/P) and what the numbers mean via a health promotional approach.
- Improvement on the ability to self-manage own health and wellbeing.
- Building of local CVD prevention group / resource
- Lived experience and coproduction being recognised and embedded into all strategic discussions.
- Promotion of NHSE Peer Leadership Development Programme

AIM: Equipping people with the skills, knowledge, and confidence to use their lived experience to influence decision making at a strategic level.

Wakefield is the first and only place in England to host a placed based Strategic Coproduction Group, emulating the National Strategic Coproduction Group. Since the first meeting was held in November 2022 the group continues to go from strength to strength, recruiting new members along the way. Twenty members have successfully completed NHSE Peer Leadership Development Programme (PLDP).

Throughout 2023/24 our members have been involved in many different workstream at a local, regional, and national level, influencing service transformation. Peer leaders have been instrumental in the success of the HHCH project, working in partnership with PCN based health and wellbeing coaches and care coordinators. They have influenced staff recruitment, are active members of friends of groups, have shared their lived experiences at many forums and webinars. Peer leaders are valued members of many task and finish groups. The Stronger Together group is part of Wakefield District Health and Care Partnership (WDHCP) Citizen Voice Strategy, helping the organisation to fulfil its statutory duty for public assurance and can lead to better more inclusive decision making.

We plan to grow and strengthen the Stronger together group throughout 24/25 striving for peer leaders to be involved in as many strategic discussions as possible.

12. Carers

AIM: Carers Wakefield and District (CW&D) provide support to unpaid carers across the district:

Wrap around service: Community, Care Home Support and Hospital including Discharge Support.
Advice and Information: Navigate the system, liaise with other professional/organisations, benefits/grants, legal (Power Of Attorney (POA), wills/trusts).
Group and Peer Support: 12 groups across the District meeting on a monthly basis.
Events and Activities.
Training and Awareness: Carers and Professionals/Public.
Distribution of funds: for carer breaks and support towards the cost of living.
Work with GP Practices: to encourage Carer friendly practices, training for Care Quality Committee (CQC) Quality Markers and establish a Primary Care Resource pack to support unpaid carers.

During 2023 CW&D have identified 854 new cares. Made 14673 contacts to 5345 individual carers. We have distributed funds to 597 carers to allow them to take a break from their caring role.

We were given access to supermarket vouchers to provide financial support to carers during the cost of living crisis and were able to distribute £60,000 worth of vouchers during 2023 to carers most in need.

We have refocused our work within Mid Yorkshire hospital and are now an integral part of the Integrated Transfers of Care team (ITOC) where CW&D Support Workers work alongside Health and Social Care colleagues to facilitate safe discharges from hospital ensuring that the un-paid carer is kept at the forefront of discharge planning. Our hospital team have provided support to 264 carers during this period. The team have also introduced timely discharge contact with family carers who provide significant care at home after a person has been discharged from hospital to increase family resilience and reduce readmission.
517 post discharge contacts have been made to individual carers as well as contacts made on behalf of the carer to other agencies etc.

We have worked closely with colleagues to development of a West Yorkshire & Humber wide Discharge Support Tool which was launched February 2024 and supported the Trusts development of the Carer Lanyard (allowing Carers some benefits whilst their loved one is in hospital).