Response to the West Yorkshire Joint Forward Plan survey

Sue Ryder is pleased to have the opportunity to contribute to this consultation, which we've also done via the West Yorkshire Hospice Collaborative.

Sue Ryder is part of the Hospice Collaborative in West Yorkshire which is committed to ensuring people die well and have a good death. The Hospice Collaborative has a powerful trust base and strong relationships through which it delivers a manifesto for palliative and end of life care (PEoLC). We are grateful that the Hospice Collaborative is referenced in the Integrated Care System's (ICSs) draft strategy as a key strategic stakeholder to the ICB in West Yorkshire.

The Collaborative plans to provide the very best PEoLC for the population of West Yorkshire, which will be personalised, holistic, accessible, a good life to the end of life and a good death. Providing effective and personalised support for carers, families & friends and ensuring access and inclusion of diverse communities across West Yorkshire.

As part of the Collaborative, we want to make sure that hospice services are working in a seamless way with the NHS and the PEoLC system, to meet the needs of patients, reduce unnecessary hospital admissions and enable patients to be discharged home or to the setting of their choice.

Sue Ryder has two hospices in West Yorkshire; Manorlands and Wheatfields and provide the following services:

- **Inpatient care** - the team develops a personalised care plan for patients based on their needs and preferences. The medical team is made up of palliative medicine consultants, specialty doctors and doctors in training. They consult with our nurses and nursing assistants, an occupational therapist and physiotherapist, spiritual care, the Family Support team, discharge support, complementary therapists.
- **Community services** - Sue Ryder Nurses and therapists care for people out in the community bringing a variety of services straight to patients in their homes. They manage physical symptoms such as pain, nausea and fatigue, all the time working closely with GPs and other health and social care professionals; making sure care and support are coordinated and comprehensive.
- **Complementary therapies** - complementary therapies can help to reduce stress, anxiety and agitation, as well as aiding sleep and relieving aches and pains. The Complementary Therapy service offers relaxing treatments including reflexology, massage, aromatherapy, acupuncture and Reiki. Everyone can access these treatments, whether in day hospice patient, inpatient, outpatient or carer.
- **Day services** - provide a relaxed, protective environment where our expert teams work to identify and achieve personal goals, and help patients stay at home as long as possible. Helping to manage symptoms and improve wellbeing.
- **Palliative rehabilitation** - Physiotherapy and occupational therapy, provided by our expert therapists are a vital part of the personalised care we offer. Their goal is that you maintain function and independence, which means they'll work with you on palliative rehabilitation enabling you to live your life to the fullest.

- **Family and bereavement support** - The Family Support Team is a multi-disciplinary team made up of highly qualified professionals providing much needed support for patients, families, friends and carers. Offering a number of services including:
    - Pre and post bereavement support via telephone or face to face
    - Counselling
    - Social work
    - Chaplaincy (spiritual care)

Sue Ryder's **Online Bereavement Support** makes it easy to connect with the right support for you - whether that's information and resources, qualified counsellors or a community of others with similar experiences. These services are free and easy to access on your computer, smartphone or tablet.

Our responses

Q1 - When reading our strategy, what do you think are the most important things to consider in delivering it?

We have set out our response to this first question across a number of headings and have provided some comments and recommendations for consideration in the development of the Integrated Care Strategy:

Funding and Commissioning

As per the Hospice Collaborative's Manifesto, commissioners should continue working with hospices in West Yorkshire to secure their long term sustainability – staffing, finances, and infrastructure – so that we can play our part in meeting increased demand, ensuring all communities can access the care they need, improving outcomes, and saving the NHS money.

- Commissioning across West Yorkshire should ensure all Places are funded fairly to meet the needs of their population e.g. we are aware that Bradford currently receives less funding than Leeds for people needing PEoLC. With a focus on population need across the ICS we hope this will be addressed and create a more equitable picture for people who need end of life care in West Yorkshire in the future.
- Each ICS should provide their position on how they intend to meet their statutory duties for PEoLC within their Integrated Care Strategy and implementation plan. These plans should be measurable and specific (underpinned by a population health needs assessment) and should provide transparency on how these duties will be delivered for patients. Providers should try to align outcomes data to the measures set out by ICSs in order to help the ICS track its strategic progress and to improve accountability.
- The PEoLC sector and ICSs must reach a joint agreement on the level and shape of the PEoLC population need. The PEoLC sector will use these agreed assessments to present proposals on how best to meet population requirements in order to help the ICS and commissioners meet their aims.
    - This will need to be reviewed over time as PEoLC data collection improves.
- ICS leadership and commissioners should remain committed to appropriate levels of engagement with the Hospice Collaborative to ensure it is not the loudest, largest or those with the best links or relationships who are favoured. The set up (with the

Hospice Collaborative represented on the ICP Board) shows the commitment to engagement with the sector in West Yorkshire.

Workforce

- Every ICSs current workforce strategy should specifically include their PEoLC health and care workforce, with input from providers, stakeholders and professionals. This is fundamental to being able to provide the joined up, responsive and fully operational services across West Yorkshire that we aspire to.
- This strategy should:
    - be developed in line with projected population demand across all vital health services (not just NHS and social care) and be reviewed periodically;
        - identify what the gaps in capacity are across each “Place” within the ICS footprint and work collaboratively and innovatively to find solutions;
    - be adopted by regulators as a key indicator of the actions necessary to ensure the ongoing quality and safety of patient care;
    - set out measures to increase recruitment from local communities (both long and short term); and
    - consider the potential for factors to impact the workforce in the future such as, the use of technology, grading/pay and conditions.
- The PEoLC sector, as part of its work as a collaborative, should proactively identify workforce gaps and potential solutions, which will feed into the ICS workforce strategy (as per the recommendation above).

Collaboration within the system

- Having a dedicated PEoLC lead who, among other things, is responsible for driving sector engagement and collaboration at a local level is incredibly important to achieve collaboration across the system. We are pleased that Charlotte Goulding, Palliative and End of Life Care Programme Manager, is doing just that. From our experience as a PEoLC provider with services in different ICSs, having dedicated ICS staff resourcing has a positive impact on PEoLC within that ICS and we believe the continuation of this role in West Yorkshire is highly valuable.
- The PEoLC sector is successfully working together to show how important voluntary PEoLC organisations are in meeting the ICS’s aims and for generating local impact. We hope this collaboration continues to increase the opportunities to influence and shape the way the system designs, commissions and delivers services for the future. Being represented on the ICP Board shows the value placed on the VCSE sector and particularly the Hospice Collaborative, which is very much welcomed.
- We are pleased that the strategy recognises that ‘The Partnership belongs to all of us’.

Health inequalities

The focus on health inequalities within the strategy is welcomed, particularly the work being undertaken by the Health Inequalities Academy, but there needs to be flexibility within the system to allow it to adapt to any learning or identified changes in the population that may happen in the future.

- The VCSE has a strong track record of being a trusted pillar of the communities they serve and often has strong links into population groups that are at greater risk of health inequality. ICSs should work with the VCSE sector to understand the needs of

their communities and work with PEoLC providers to reduce health inequalities. We acknowledge that such work is currently underway and are supportive of it.
- Every ICS should aim for a workforce that better reflects the communities they serve. Equality, diversity and inclusion should feature within every ICS's workforce strategy, setting out how they plan to improve representation.
- The development of an ICS collaboration framework should include an exchange between the ICS and the PEoLC VCSE sector of their plans for tackling health inequalities. This would avoid duplication, promote areas for collaboration, enable better use of resources, and ultimately improve services for patients.
- As more information becomes available on the PEoLC needs of different communities and Places, ICSs should consider these against their current and projected population demographics.
- Ensuring accessible, well funded, culturally appropriate and joined up PEoLC for all is essential, and we support the steps set out in the strategy for this to happen.

Data

- The West Yorkshire Digital Strategy (January 2022), which we are supportive of, should ensure it delivers the following:
    - Each ICS should centralise the data collected within their systems in order to support an ICS-wide understanding of PEoLC needs and improve the knowledge that innovations and service adaptations are built on.
        - Improved ICS level data can be shared nationally to facilitate a consistent national data set which is underpinned by a drive to use common recording systems across all ICSs.

A number of the above points can be found in our joint summary paper, published in Autumn 2022, entitled 'Enablers for end-of-life care: Key recommendations for commissioning and delivering better end-of-life care within Integrated Care Systems'.

Q2 - Is there anything else you would like to tell us to help with our plans?

The West Yorkshire ICS has identified that it needs to focus on prevention and proactively support people to stay well at home (pg.4 Five year forward plan) and have arranged services in a way that people receive care from the right people in the most appropriate setting. We believe the PEoLC sector across West Yorkshire is well placed to help achieve this for the population. For example, Sue Ryder's hospices and community service provision supports the region to deliver care to PEoLC patients in order for them to stay well at home, or receive care in an inpatient setting if this is most appropriate for the patient.

These services can, for example, help ease the pressure on hospitals/A&E which aligns with the NHS 23-24 priority areas of **Urgent and Emergency Care and Community health services.** This can be seen directly though our community based care and where virtual wards are enabling PEoLC patients to remain at home, if they choose to.

Additionally, we would like to see consideration given to how resources (e.g. staff and data) could be better shared across the whole ICS. This would build on the work that is currently underway through the Hospice Collaborative which is focusing on identification of PEoLC datasets and the standardisation of data collection.

We are pleased to see a strong focus on health inequalities within the Strategy. Sue Ryder has recently completed a project in Peterborough exploring the health inequalities faced by the local communities, including their understanding of and access to PEoLC services. We think there are learnings from this project that could support the ICS's work going forward in this area and would welcome the opportunity to work closely in this area.

Q3 - If you want to be involved with this and other West Yorkshire Health and Care Partnership work please add your contact details below.

We would like to be kept up to date, please contact:

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