Experience of Care 2025

Calderdale and Kirklees Annual Report

January 2026

Contents

1. Executive foreword

I am pleased to introduce the Experience of Care Annual Report 2025 for Calderdale and Kirklees. This report brings together a powerful collection of examples that demonstrate our shared commitment, across health and care partners, to listening, learning and acting on what matters most to the people who use our services, their carers and our workforce.

Experience of care is fundamental to quality. Alongside safety and effectiveness, it is one of the core pillars of high-quality healthcare, and a vital driver of improvement. The stories, initiatives and learning contained within this report show how partners across Calderdale and Kirklees are embedding compassion, dignity and inclusion into everyday practice, and using insight to shape services in ways that reflect the diverse needs of our communities.

This year's report represents a deliberate shift away from traditional, siloed reporting towards a more collaborative, system-level approach. Developed through co-design with partners across the NHS, local authorities, the voluntary, community and social enterprise (VCSE) sector, and people with lived experience, it showcases work that has made a real difference to people's lives. It celebrates innovation and excellence, while also providing honest reflection on the challenges we face and the inequalities that persist.

Across acute, primary care, mental health, community services, commissioning and Healthwatch, we see consistent themes emerge: the power of partnership working; the importance of culturally sensitive and inclusive approaches; the value of stories alongside data; and the impact that small, thoughtful changes can have when they are shaped by those who use services. Many of the initiatives described have been co-produced with patients, carers and communities, reinforcing our collective commitment to putting people at the heart of everything we do.

This report also highlights the pressures facing our system, including workforce challenges, increasing demand and financial constraints. Despite this, it is clear that teams across Calderdale and Kirklees continue to find creative and compassionate ways to improve experiences of care, often by working across organisational boundaries and learning from one another.

I would like to thank everyone who contributed to this report: the individuals who shared their stories, the staff and volunteers who led and supported improvement work, and the partners who collaborated openly and constructively to produce something genuinely system-focused. Your contributions provide both assurance and inspiration.

As we look ahead, this report offers a strong foundation for continued learning and improvement. By continuing to listen, to work together, and to amplify the voices of those with lived experience, we can further strengthen the quality, equity and compassion of care across Calderdale and Kirklees.

Ian Bennett
Director of Nursing and Quality
Calderdale and Kirklees Places
West Yorkshire Integrated Care Board

2. Introduction and background

Experience of Care (EoC) information and insight supports the health and care partnership to understand how services commissioned by West Yorkshire Integrated Care Board (WY ICB) feel for the population using them, including what matters most to people. Listening and acting on EoC insight supports and enables commissioners and partners to identify priority areas, celebrate excellence and act on opportunities for improvement in a way that truly reflects our populations voice.

Publishing the EoC report annually, although not a mandated requirement ensures the ICB operates on a continuous, evidence-based process for assessing needs, planning, commissioning, monitoring, reviewing and evaluating services. Including real-world EoC information and insight throughout commissioning cycles ensures commissioners decisions are driven by the holistic compassionate care that is delivered not just by clinical outcomes and efficiencies.

This approach aligns with the National Quality Boards (NQB) Improving experience of care: A shared commitment for those working in health and care systems expectations. This recognises peoples' experiences as one of the three key pillars of high-quality care (alongside safety and effectiveness) and emphasises co-production, EoC insight and embedding experience into core quality work. EoC is also a strong, continuous feature of the governments Fit for the future: 10 Year Health Plan for England (2025).

The annual Experience of Care (EoC) report has been produced for Calderdale and Kirklees since 2016. At that time, the report was shared with Quality Committees within each of the local Clinical Commissioning Groups. More recently, and with increasing partnership working, a collaborative approach has been encouraged with partners contributing content to a report that the West Yorkshire Integrated Care Board (WY ICB) Quality Team co-ordinated on behalf of the systems.

The annual experience report provides Calderdale Cares Partnership (CCP) and Kirklees Health and Care Partnership (KHCP) with the opportunity to demonstrate how our health and care system prioritises service user, carer and staff experiences to celebrate success and as a driver for change where required. Partners were keen to embrace a new way of presenting this information that would be engaging and innovative. Reasons for a new approach include:

- Previous reports were siloed and duplicated information that was already reported on by provider organisations experience reporting mechanisms.
- Desire to move towards a system-level, partnership-focused approach.

- Opportunity to create something radically different, such as a film, infographic, or story-based format.

A codesign group with representatives from health, care and Voluntary, Community and Social Enterprise (VCSE) sectors commenced development of the 2025 report in early September 2025. The group determined that the purpose of the report is to:

- Celebrate achievements.
- Provide a system-wide view of care experiences
- Demonstrate listening, action, and impact
- Avoid duplication of existing organisational experience of care reporting that is undertaken for assurance purposes.

The codesign group recognised that it was not practical for all providers to participate but made every effort to engage with a broad cross section of organisations. There remains however, some notable gaps in the submissions, specifically Calderdale's and Kirklees' Local Authorities and the Yorkshire Ambulance Service.

3. Organisational submissions

Each participating organisation was asked to complete a submission form. The remainder of this section contains the submissions from each organisation grouped together by type of organisation. The categories are:

a) Acute
b) Primary Care
c) Mental Health
d) Community and smaller independents
e) Commissioning and Healthwatch

a. Acute provider submissions

Organisation Name	Calderdale and Huddersfield NHS Foundation Trust
Organisation Description	Calderdale and Huddersfield NHS Foundation Trust (CHFT) deliver compassionate care to a diverse population of around 450,000 people from our two main hospitals, community sites, health centres and in patients' homes. A team of over 7,000 staff and 200 volunteers provide person centred care through a range of services to meet the individual needs and preferences of people and the local communities. 18% of our population are from an ethnic minority group, and 26% of our population live in a level of deprivation higher than the national average.
Description of experience of care initiative	**Strengthening Support for Unpaid Carers** The Chief Nurse (and executive lead for experience of care) raised the profile and commitment to improving support for unpaid carers in 2024 – 2025 across CHFT, establishing support for unpaid carers as a strategic priority for the Patient Experience and Involvement Group (PEIG). The aim was to strengthen support for unpaid carers through three objectives which were: • Improved identification of unpaid carers to increase signposting and support • Improved support for unpaid carers own health and wellbeing • Improved involvement of unpaid carers in the planning and care PEIG has an additional three strategic priorities which underpinned by our commitment to tackling inequalities in health, contributed to the design, implementation and impact of improving support for unpaid carers: • Using Insight for Improvement • Strengthening how we work in partnership with people and communities • Strengthening person centred care A working group was established with membership from colleagues, carers with lived experience, and system partners. Membership on both Calderdale and Kirklees local council strategic carers groups,

the West Yorkshire Integrated Care Board strategic carers group and NHS England Commitment to Carers group were formed to align, share and collaborate wherever possible.

A review of local and national insight initially informed how CHFT could improve support for unpaid carers.

In addition to insight from surveys, complaints and compliments CHFT developed a schedule of events to engage with unpaid carers, patients, partners and colleagues to inform priorities and co-produce improvement initiatives.

This included:

- Speaking with carers about their experience through the weekly leadership assurance programme to understand how they have been involved in the planning and care of their loved one
- Working collaboratively with partners such as Healthwatch and Carers Count alongside regional and national partners to understand carers preferences, needs and experiences
- Engaging with unpaid carers at local carers groups in the community to understand what is working well and where we can improve support
- Recruitment of unpaid carers to the CHFT “Experts by Experience” volunteers
- Visits from the Executive, Non-Executive and CHFT Governor teams across clinical areas to speak with patients, carers and colleagues about support for unpaid carers

There have been multiple initiatives taken to improve the support for unpaid carers at the Trust through listening to the insight gained, and enriched by engagement, co-production and collaborative working. A sample of which can be seen below:

Initiative	**Impact**
• Support for Carers Leaflet reduced in length from 9 pages to 4. • Branding changed	• Less overwhelming and more user friendly

	• Removing “Keep carers caring” reduced the concern that carers may feel obligated to care when their loved one was in hospital
• Carers Charter co-produced with carers and in collaboration with both local councils	• Carers feel listened to, respected and valued as experts • Colleagues have a clear understanding of what carers can expect with one charter across organisational boundaries
• Digital stories developed with carers to share good practice and highlight the importance of involving carers as experts in their care	• Shared widely with partner support including nationally with Heads of Patient Experience; Picker Institute and NHS England to improve identification, involvement and support for carers in practice.
• Referral processes simplified in collaboration with Carers Count and Young Carers to increase referrals and access to support. This has included offering a non-digital solution for carers whose preference this is.	• Referrals to expert carers services have increased over the year with more carers now receiving support and advice • Colleague awareness of young carers increased
• Carers lanyards more readily available due to pooled funding arrangements developed locally with collaboration from both local councils	• Lanyards are now available at all times across CHFT, are increasingly offered by colleagues helping carers to be identified and supported

• Staff network for unpaid carers who are also colleagues at CHFT established and promoted	• Colleagues have greater awareness of unpaid carers, and colleagues who choose to can access additional support through the Trust
• Consistent messaging through various means including trust wide briefings; resources on the internet (public facing) and intranet; hospital appointment letters; use of digital stories; visits to clinical areas; banners and displays and joint training sessions with Carers Counts	• Increased awareness of how to identify and support unpaid carers • Information and displays in all clinical areas have enabled people who did not recognise themselves as an unpaid carer to consider this and be aware of support available • Carers report that they feel reassured and know that they will not be challenged when they attend appointments and visit their loved ones
• Identification of unpaid carers on the electronic patient record to enable greater flexibility in appointments to support carers own health and well-being and reduce inequalities in health	• Currently in the early stages, but early indications are that carers feel this would be really helpful in enabling them to schedule and attend to their own needs
• Standard Operating Procedure to ensure carers can receive support for their own nutrition and hydration	• Carers do not need to leave their loved one and are supported with their own health and wellbeing.

Success and improvement is measured through both qualitative and quantitative means such as the number of unpaid carers identified on the Electronic Patient Record or referrals to carers counts. Real

	time feedback from carers such as those who have shared their stories provides fantastic examples of the difference the initiatives are making in practice for patients, carers and colleagues.
Challenges	Reaching all our colleagues with information. We learnt that we need to use a variety of approaches and have a continued focus on delivering key messages.
Next Steps	To build on collaborative working and respond to carers feedback we are going to focus on improving the discharge experience for unpaid carers.
Future focus for Experience of Care	Unified approaches for unpaid carers to access and enable support with technology as there are currently multiple App developments and referral processes.
Contact details for further information about this submission	patientexperience@cht.nhs.uk
What one thing do you want people to remember about this submission?	Directly involving carers and working in collaboration with system partners has improved each initiative whether this has been pooling resources or carers spotting gaps such as people who do not know what a lanyard is.

Organisation Name	**Mid Yorkshire Teaching NHS Trust**
Organisation Description	Mid Yorkshire Teaching NHS Trust provides services from its three hospital sites in Wakefield, Pontefract and Dewsbury to a population of around 560,000, and also delivers a range of community services including virtual wards, primarily to the 370,000 population of Wakefield, Castleford and Pontefract. At Pinderfields Hospital, we provide specialist burns care and specialist spinal cord injury rehabilitation to a large population across the Yorkshire and Humber region.
Description of experience of care initiative	**Project Name:** Default to Decaf **Dates:** 3 March 2025 **Summary:** "Default to decaf" refers to the practice of automatically offering decaffeinated beverages as the standard choice, rather than caffeinated ones in order to improve patient safety by reducing falls, as caffeine can increase the urgency and frequency of bathroom trips, and to improve sleep and reduce anxiety. **Describe results and benefits achieved.** Following research and a pilot undertaken by an NHS Trust, it was identified that many slips, trips and falls within a hospital setting were due to toileting, especially at night. Therefore the "default to decaf" initiative was implemented to target those patients at risk of incontinence and falls. Once the pilot had been completed, the Trust's findings showed very positive results one of which was more than 75% reduction in falls on 2 wards. NICE Guidance (2019) recommends reducing caffeinated hot drinks are the default for patients within our care. Offering a hot beverage is widely recognised, effective method for helping to reduce agitation and promote a sense of calm. However, using a caffeinated beverage to calm patients down as a distraction previously may have exacerbated their behaviours. As a result of this pilot, Ward 2 at Dewsbury and District Hospital, staff started giving our patients decaffeinated tea and coffee from the beginning of March 2025 (unless they requested caffeinated). Patients have welcomed the change, and many have not noticed the difference. The Ward Manager

	and Matron engaged and involved staff, patients and carers in order to empower staff and improve patient experience and patient safety. Key measures of success were in the number of toileting related falls reducing, improving staff knowledge and understanding as well as advocating the benefits of switching to decaffeinated beverages. It was also important to uphold patient independence and choice whilst maintain a positive experience for both patients and staff, seeing improvements in sleep and reduced agitation. Although it is likely too soon to evidence a reduction, we have seen a reduction in falls (25%) and less during the night. Staff feel patients getting up at night and patient urgency to go to the toilet has reduced as well as a reduction in patient aggression. In terms of Acute Kidney Injury (AKIs) although this is not able to be audited, staff on Ward 2 feel that the number of AKIs have reduced. Staff do not want to limit people's choice, so hot drinks with caffeine are still provided on requested. However, once staff explained to patients the benefits of switching to decaf some were more than happy to switch with even some of our staff making the switch at home too! Increasing non-caffeinated fluid intake can improve hydration, enhance recovery and increase wellbeing. This project has only been made successful due to the involvement and engagement of staff, patients and carers working together with a common goal of ensuring our patients receive a positive experience in a caring and safe environment.
Challenges	Initially staff were only able to order single cup tea bags with string attached, but our Supplies team were able to source large packs of decaf tea bags and this has been much easier to make the switch to decaf.
Next Steps	Early signs show that by offering decaffeinated beverages, our patients have had positive outcomes in particular at night. Therefore, Ward 2 will continue to give decaf tea and coffee to our patients as we have seen positive results, and the patients cannot taste the difference. This has been rolled out across other medical wards across all hospital sites. Our Ward Manager from Gate 43 has submitted a Literature Review: The Benefits of Reducing or Eliminating Caffeine Consumption in Elderly Care Patients to the Nursing Times.

Future focus for Experience of Care	By defaulting to providing decaffeinated drinks to our patients, this has shown an improvement in patient outcomes. Therefore, sharing this work across the system can only help to bring positive benefits to all our patients across the region.
Contact email for further information about this submission	myh-tr.palsmidyorks@nhs.net
What one thing do you want people to remember about this submission?	That even the smallest change can result in significant positive outcomes in patient care.

b. Primary care submissions

Organisation Name	**Pennine GP Alliance (PGPA)**
Organisation Description	Calderdale member-led organisation, ensuring GP services remain at the heart of our neighbourhoods, with core values of excellent, patient-centred care, where everyone's voice matters.
Description of experience of care initiative	**Serious Mental Illness (SMI) and Cancer Screening: Co-Produced Films** Summary of initiative: People with SMI die, on average, 15-20 years earlier than the general population. These stark statistics are partly due to low uptake of cancer screening; a health inequality we were determined to address. Through PGPA's SMI and Cancer Project work, collaboration with Calderdale and Kirklees Recovery College, local healthcare professionals and Verd de Gris Arts has resulted in two co-produced films aimed at tackling barriers and inequalities. West Yorkshire and Harrogate Cancer Alliance provided funding for the initiative. Design and implementation: In March 2025, PGPA hosted a workshop with Recovery College (College Principal and four lived-experience experts) and Verd de Gris Arts to explore key priorities/ messages. Conversation sparked the idea of two separate films: One would involve a natural conversation between healthcare staff and those with lived experience, discussing inequalities and adjustments. The second film, led by those with lived experience and including storytelling, facts and humour, would be aimed at the public sector (particularly those with SMI) to increase awareness of cancer screening and encourage uptake of screening. Filming began in April 2025 and the films were launched on 9 October 2025 at a dedicated celebration event. Attendees included those who had taken part, along with representatives from primary care, partner organisations, voluntary sector, stakeholders and West Yorkshire and Harrogate Cancer Alliance. Also present were the Mayor of Calderdale and the local MP, both of whom are actively supportive of this initiative. The Films: **A Right to Live** (https://bit.ly/RightToLiveFilm): designed primarily for health and care professionals, exploring how screening services can better support individuals with SMI, through inclusive practices and sensitivity to individual needs.

	Bits, Boobs and Poo (https://bit.ly/BitsBoobsandPooFilm): aimed at the wider public (especially people living with SMI), with personal stories, normalising screening and addressing fear, stigma and practical barriers. The impact: Direct impact on those involved in the co-production: • Reciprocal learning around the challenges of accessing and providing screening services • Benefits of working together and driving improvement • Some of those involved and members of their family have undergone cancer screening as a direct result of normalising and discussing the programmes. Launch event feedback from the local and West Yorkshire-wide audience was universally positive. The films have promoted discussions at training sessions and are now available as an accessible resource, for universal distribution. The expected outcomes include: • Increased awareness of the barriers and challenges facing those with SMI • Encourage conversation between healthcare providers and those with lived experience to identify individual needs and reasonable adjustments • Empower those with SMI to ask for further information, support and adjustments • Encourage them to make informed choices about cancer screening Measuring outcomes Short-term: “Views” from videos: YouTube and Bit.ly data will show the volume and reach of the films. Medium-term: Cancer screening uptake in those with SMI. Longer-term: Impact on health inequalities, demonstrated through evaluation of survival as a result of earlier cancer diagnosis.
Challenges	• Encouraging authentic discussions, brought the challenge of keeping focus on key priorities. Oversight from PGPA staff and the filming teams helped direct conversations appropriately. • 5-6 hours of a rich selection of facts, ideas and authentic conversation needed condensing into two short films. Collaboration between PGPA and Verd de Gris ensured this was done in the most impactful way.
Next Steps	• Films have already been widely shared across primary care, partner organisations and multiple social media platforms throughout Calderdale and in parts of West Yorkshire. The intent is to continue to circulate and promote the films as widely as possible so providers and public alike will benefit from the important health and equality messages.

	• Films to be promoted as personal development resources and used to initiate further discussions, encourage critical evaluation/adaptation of practice. • Consolidate the collaborative network and explore future co-production opportunities.
Future focus for Experience of Care	Use experience of working alongside those with lived experience to develop connections with other populations where inequalities exist (e.g. deprivation, homelessness, ethnicity and language). Collaborating across wider areas would give a broader view of the challenges and a bigger tool kit for addressing them.
Contact email for more information about this submission	Via the ICB Quality Team at wyicb-cal.quality@nhs.net
What one thing do you want people to remember about this submission?	Shocking health statistics and inequalities can (and should) be addressed through improved awareness a compassionate approach and working together.

Organisation Name	**Spen Health and Wellbeing Primary Care Network (Spen)**
Organisation Description	Spen is an alliance of seven practices collectively caring for patients within the Cleckheaton, Liversedge and Heckmondwike area. As a Primary Care Network (PCN) we offer a wide range of services to benefit our patient population.
Description of experience of care initiative	**Project Name:** Improved delivery of Social Prescribing and SMI Healthcare services. **Dates:** March 2025-present. **Summary:** A new PCN team was established March 2025. The team aimed to improve appointment utilisation and quality of PCN services across the board but with particular focus on the Social Prescribing Link Worker (SPLW) service and the SMI (Severe Mental Illness) Healthcare Facilitator (HCF) service as these were areas of concern re utilisation and effectiveness. This was in conjunction with improving patient experience. For the SPLW service the team worked in collaboration with Kirklees Council. And for the SMI HCF service the team worked with South West Yorkshire Partnership Foundation Trust (SWYFT). Meetings were held with the partner providers. Issues were raised and solutions explored to help improve the service delivery going forward. The following changes were implemented across the PCN; • Improving the System One (S1) rota's to correctly reflect the PCN practitioner, base and appointment types. • Clearer wording for SMS reminders to patients. • An automatic Feedback request sent via S1 to all patients when a consultation is started. • Monthly clinical reporting on S1 to gather appointment utilisation data as well as Did Not Attends (DNAs). • Re starting face to face monthly Practice Managers' meeting to review the PCN services among other relevant topics. • Regular check ins with practitioners/partner providers to ensure smooth running of services. Good communication between the teams has allowed for better collaboration. • Creating a Crib Sheet for all practice reception staff which displays all the PCN services along with referral criteria, practitioner working days and locations.

	• A focus on reasonable adjustments, eg providing more GP locations for patients to be reviewed and increased flexibility in appointments. Since these implementations, an improvement has been noticed in many areas. On request of the PCN, Kirklees Council now provide data on deprivation and how our SPLW is positively impacting the PCN's most deprived patients. Patients who are not on the SMI register but are on antipsychotics can now be reviewed by the PCN Mental Health Advanced Clinical Practitioner who will then refer to the SMI HCF for a physical health check. Relieving some of the burden on GPs. Utilisation data has improved, and DNAs reduced. The PCN practitioners are great and continue to make reasonable adjustments for patients. For example, the SMI HCF carried out a physical health check in the practice car park due to the patient being too anxious to leave their car. Patient feedback is received regularly through the protocol set up within S1 and has been very positive. **SPLW Feedback** "Rehana was kind and patient, understanding and knowledgeable." **SMI HCF Feedback** "It was as if I was on a day out with my best friend."
Challenges	Service uptake was often low at practices where the service practitioner was not based. Discussing utilisation monthly at the re-established practice managers meeting provided a constant reminder of the services available and informed practice managers if their staff were aware of the PCN services and were booking into the slots. The crib sheet was essential in displaying in reception and admin areas so staff could familiarise themselves with the services on offer and refer patients accordingly. The PCN invite practitioners and partner providers to attend and present at practice manager or board meetings to develop relationships and promote the excellent work being carried out. Organising S1 was challenging for a new team that was unfamiliar with the system. However, it was essential that it functioned in a way that benefited the PCN whether through comms annex protocols, correct wording on SMS reminders or accurate clinical reports. PCN S1 units are known to have issues with pulling through patient phone numbers when booked through remote booking. Despite this being flagged with senior members at the ICB and IT the issue remains, and the PCN continue to send SMS reminders manually.

	The new PCN team felt it was important that they meet all the partner providers and practices early on to make it known that the new team were open, willing and approachable to ensure collaboration would be positive and productive.
Next Steps	The PCN aim to make the most of any future IT implementations that will enhance patient communication. The PCN hope that the issue with the automatic sending of SMS reminders from the PCN S1 unit will be fixed in due course. Any support in addressing this would be appreciated. The PCN are in the process of setting up an Integrated Neighbourhood Team (INT). The INT involves different providers working together on a cohort of patients to deliver proactive care. We are confident that this will be a success as we have worked hard in the last year building strong relationships with other providers.
Future focus for Experience of Care	The INT will be new territory in terms of services coming together on this scale.
Contact email for further information about this submission	Spen.pcn@nhs.net
What one thing do you want people to remember about this submission?	That small changes and tweaks in different operational areas can collectively have a big impact in producing positive outcomes.

Organisation Name	**Upper Calder Valley (UCV) Primary Care Network (PCN)**
Organisation Description	PCN
Description of experience of care initiative	**Cancer Care Review, led by a Care Co Ordinator** Telephone call booked with patient March 2025, elderly man, living alone, very independent but isolated and has capacity but very hard of hearing. Difficult conversation due to hearing problems so a home visit was arranged. When the Care Co Ordinator attended she realised the patient had many additional needs but the patient had purposely avoided contact with his Practice or any health care provider. He was not eating properly He had been seen by Ageing Well Practitioner but he refused to engage as he had no trust at all in any health professional. He disclosed that he had an adult daughter but that this relationship had broken down. Over time the Care Co Ordinator visited the patient numerous times and established a level of trust which led to a more positive relationship. The patient began to contact the Care Co Ordinator when he had health concerns relating to his cancer diagnosis which was unprecedented. He eventually saw a GP and completed an Advanced Care Plan including Do Not Resuscitate (DNR) and a medication review. He also engaged with Overgate and the palliative care team. Again, something he was previously resistant to. The Care Co Ordinator suggested that the patient's daughter might want to know about her dad's illness, especially given the circumstances around his isolation. The patient agreed and the Care Co Ordinator contacted her. His daughter was very grateful as she knew something of his circumstances but not the extent. She became much more involved in his care and social circumstances. The patient was admitted to a care home, again something he had always resisted, following gentle reassurance from the Care Co Ordinator.

	The short time he was in the care home, he was clean, comfortable eating well, engaging with staff and fellow residents. He had rebuilt the relationship with his daughter and eventually had a good death The Care Co Ordinator could've carried out the initial review on the telephone, completed the template and thought little more about it. Instead, she recognised the patient's hearing difficulties and sensed there may be more that he needed. Over time, she built a positive relationship with him where he began to trust her, engaged with the care she offered and started to trust other health providers despite years of mistrust and suspicion. On his behalf she collaborated with Ageing Well, the Practice, the care home and his daughter. Together, they supported him and ensured that the end of his life was characterised by good care.
Challenges	The patient has communication difficulties due to being hard of hearing. He had a long-standing mistrust of health care providers, was isolated from his family and lacked self-care.
Next Steps	The approach of the Care Co Ordinator in this case is typical of the thorough and conscientious approach routinely taken by the team in the Upper Calder Valley. Patients are always at the heart of what we do.
Contact email for more information about this submission	Via the ICB Quality Team at wyicb-cal.quality@nhs.net
What one thing do you want people to remember about this submission?	The patient was always at the centre.

Organisation Name	**Upper Calder Valley (UCV) Primary Care Network (PCN)**
Organisation Description	PCN
Description of experience of care initiative	Medication review by clinical pharmacist with special regard to monitoring and review of dependence forming medication namely diazepam (a benzodiazepine) in a frail elderly patient. This patient was reviewed by a clinical pharmacist in the pharmacy team and her benzodiazepine medicines were discussed. Long term use of benzodiazepines is discouraged especially in the elderly due to side effects, safety concerns and dependence. These medicines must be reduced gradually and carefully in a controlled manner to precent withdrawal and adverse events e.g. seizures. The patient re-contacted the practice sometime later and a pharmacist with experience in benzodiazepine reduction took over the case. With the help of the patient's daughter, the pharmacist was able to very gradually reduce the benzodiazepine medicine to the point where this patient is now on a very low dose. She is much more alert and is not sedated in the daytime. Previously, she would get up in the morning for breakfast and then fall back to sleep. She is now able to engage in daytime activities with her daughter, is at a much lower risk of falls and therefore less likely to be admitted to hospital. This patient is housebound and is very anxious about leaving her house. All the appointments took place by phone as this was the patient's choice. A home visit was offered. The patient was also encouraged to attend her outpatient ophthalmology appointment which involved a stressful (for her) taxi ride to hospital 10 miles away; something she may have avoided in the past but was essential for continuing eye health. She described feeling more able to attend because of her improved health and alertness. We have developed a shared care, collaborative approach to this patient's care.
Challenges	Housebound, elderly and agoraphobic.

Next Steps	Continuation of regular review appointments as requested by the patient.
Future focus for Experience of Care	Continuation of reviews of the patient population on dependence forming medicines.
Contact email for more information about this submission	Via the ICB Quality Team at wyicb-cal.quality@nhs.net
What one thing do you want people to remember about this submission?	The patient's daughter telling me that she "had got her mum back". Mum was no longer sedated during the day and able to engage in daily life.

c. Mental health submissions

Organisation Name	**South West Yorkshire Partnership Teaching NHS Foundation Trust** **(SWYFT)**
Organisation Description	SWYFT exists to help people reach their potential and live well in their communities. We do this through our mental health, community, learning disability and wellbeing services across Barnsley, Calderdale, Kirklees and Wakefield. We also provide specialist secure mental health (forensic) services for the whole of Yorkshire and Humber.
Description of experience of care initiative	**Health inequality focus: Service evaluation - ethnicity, young mums and at risk of removal pathway** - Dr Estelle Verdi – Principal Counselling Psychologist and Service Lead **Experience of care work demonstrating compassion and dignity, and collaborative working across Place** This initiative focused on understanding and addressing inequalities in access to the Paths service for young mothers and women at risk of child-removal across Calderdale, Kirklees, Wakefield and the wider West Yorkshire system. Through compassionate, data-driven service evaluation and close collaboration with partners, we aimed to ensure that women experiencing pregnancy or baby loss, particularly those from ethnically minoritised communities, receive equitable, dignified and culturally appropriate support. A continuous dataset was developed using routinely collected information from the electronic patient record, including referral source, reason for referral, protected characteristics (sex, ethnicity, age), social and health inequalities (Index of Multiple Deprivation), and geographical location. These data sets were visualised in a newly created Paths PowerBI dashboard, providing a baseline for Quality Improvement (QI) work and enabling partners across the three Places to monitor trends and variation. **Collaboration**

	This work was achieved through partnership between: • Paths clinicians across Calderdale, Kirklees, Wakefield, Leeds and Bradford. • GP practices referring into Paths. • Muslim chaplaincy teams and community connectors. • A Patient and Public Involvement and Engagement (PPIE) group of women with lived experience from ethnic minority communities. • Academic partners supporting methodological development. This cross-Place and cross-sector collaboration ensured a shared focus on improving equity of access. Success was measured through: • Number and demographic characteristics of referrals across Places. • Patterns of Did Not Attend (DNA) activity. • Comparisons of service use against local population ethnicity using Office of National Statistics (ONS). • Qualitative insights from PPIE activity. • Evidence of improvement over successive 'Plan, Do, Study, Act' (PDSA) cycles. The ongoing PowerBI dashboard ensures sustainability, allowing continuous monitoring, early identification of emerging inequalities, and rapid testing of changes through repeated QI cycles. **Learning embedded into practice** The work directly informed practical improvements including: • Development and distribution of an information leaflet clarifying referral criteria and addressing identified gaps in GP understanding. • Strengthened engagement with Muslim chaplains to improve culturally sensitive referral pathways.

	• New approaches to community engagement following PPIE feedback, including enhanced confidentiality messaging and more flexible options for contact and support. • Increased awareness among staff of socio-cultural barriers and stigma surrounding loss in some communities, now incorporated into staff training and reflective practice. The service evaluation has been accepted for presentation at the British Psychological Society (BPS) Division of Counselling Psychology Annual Conference 2025 and has underpinned the award of a fellowship at Durham University for the project Illuminating Grief: Mental Health Support for Muslim Women Experiencing Baby Loss. **How patient and staff experience improved** **Patient experience** • Women involved in the PPIE event described historically low awareness of support services, fear of judgement, and concerns about confidentiality. Incorporating their insights improved: • Culturally appropriate communication about the service. • Clearer referral criteria ensuring women receive timely and relevant support. • Increased acceptance of the service within previously under-represented communities, resulting in a rise in referrals from minoritised groups in Kirklees. • Women reported feeling “heard,” “recognised,” and “understood,” highlighting increased dignity and compassion in service delivery and their community. **Staff experience** Staff now have: • More accurate referral information. • Better understanding of inequalities. • Access to real-time data to guide decision-making. • Increased confidence engaging with communities where stigma or gatekeeping may impact help-seeking.

	The dashboard and reflective approach have supported more responsive and person-centred practice. **Addressing health inequalities:** The core aim of this work was to identify and address inequalities linked to ethnicity, age, deprivation and vulnerability to child removal. The data revealed that: • 75–82% of referrals were from white women, not reflective of local population demographics. • No referrals were received from Black, Asian or mixed-ethnicity women in key localities despite higher levels of deprivation. • Additional socio-cultural factors were contributing to exclusion. The PPIE content analysis identified one overarching theme - Barriers to accessing support for pregnancy loss and related issues within a specific community, with five sub-themes: • Socio-cultural barriers and stigma • Family dynamics and control • Individual challenges and limitations • Practical barriers and service delivery • Strategies to improve access Actions taken included: • Tailoring communication to emphasise confidentiality. • Engaging trusted faith-based and community leaders. • Adapting referral information to be clearer and more inclusive. • Identifying practices with low or no referrals and initiating targeted GP engagement. This approach aligns with CORE20PLUS5 and Patient and Carer Race Equality Framework (PCREF) priorities, ensuring targeted action for populations disproportionately affected by loss, trauma and systemic inequity.

Challenges	Barriers encountered and how they were overcome **1. Gaps in referral data and recording** Early cycles identified inconsistent recording of referral reasons and acceptance data. Response: Process mapping, staff feedback and improved documentation templates corrected these issues. **2. Under-representation of minoritised communities** Referrals did not reflect population diversity. Response: Targeted engagement with community groups, faith leaders and local chaplains alongside culturally informed communication tools. **3. Stigma and cultural sensitivities** Women reported shame, fear of judgement and family pressures. Response: Community-led PPIE sessions shaped a more sensitive service model and strategies for safe access. **4. GP awareness and variability in referral practice** Some GPs lacked clarity about the service criteria. Response: Development of a referral information leaflet and Place-level GP liaison.
Next Steps	Using QI methodology and collaborative working, the project identified and addressed inequities in access to compassionate care following pregnancy and baby loss. Improvements in referrals from minoritised communities demonstrate early impact, and the learning is now supporting further research and service evolution. The service evaluation has identified notable variation in access to Paths for Black women across West Yorkshire. In Kirklees, access is above local population proportions, while in Calderdale and Wakefield

	it is below expected levels. In collaboration with the West Yorkshire Local Maternity and Neonatal System (WY LMNS), we reviewed stillbirth data for Black and Asian babies, which mirrors national trends: Black babies are twice as likely to be stillborn as white babies, and stillbirth rates for Asian babies are also significantly higher. Based on this risk profile, we would expect access to PATHs to be at least in line with population levels, if not higher, but this is not currently the case in several areas. To address this, Paths continue to work closely with key stakeholders, including faith representatives, to strengthen bereavement pathways and improve culturally informed engagement. In line with the recommendations from the National Motherhood Report (published for Black Maternal Mental Health Week 2025), we are exploring the development of dedicated spaces for Black women and expanding community engagement at Place. In Kirklees, ongoing work focuses on understanding the experiences of baby loss among Muslim women and exploring whether culturally and creatively shaped interventions can support mental wellbeing. As part of the research fellowship, we are collaborating with Happy Moments to deepen this understanding and evaluate impact. This work continues to shape an equitable, dignified and person-centred service for all women across our local system.
Future focus for Experience of Care	We propose establishing a West Yorkshire–wide Health Inequalities Network bringing together VCSE partners, health and social care services, academic colleagues, community leaders and experts by experience from each Place and focus area. This forum would enable us to learn from one another, share good practice, and coordinate system-wide action to reduce inequalities and improve experiences of care.
Contact email for further information about this submission	customerservices@swyt.nhs.uk

What one thing do you want people to remember about this submission?	What we want people to remember is that by working collaboratively across our Places, we are committed to raising awareness of the Paths service, reducing stigma around pregnancy and baby loss, and improving equitable access for all women, especially those from minoritised communities. By highlighting national and local data on perinatal inequalities and openly sharing our work, we aim to challenge the silence surrounding baby loss. We are committed to strengthening our partnerships, amplifying women's voices and driving meaningful change so that communities can more easily access and benefit from compassionate, culturally sensitive mental health support.

d. Community and smaller independents submissions

Organisation Name	**Locala Health and Wellbeing**
Organisation Description	Locala Health and Wellbeing is a not-for-profit community healthcare provider delivering services across West Yorkshire and Greater Manchester. As a social enterprise, we have the flexibility to tailor our services to meet the needs of our communities – and any financial surplus is re-invested straight back into supporting patient care and our communities.
Description of experience of care initiative	**Project Name:** Diabetes Support Group Holmfirth – supporting people to support themselves **Dates:** April 2024 and ongoing Locala's new Diabetes Education Courses for Type 1 and Type 2 patients were launched in April 24. These sessions replaced the national DESMOND and DAFNE programmes. DESMOND stands for Diabetes Education and Self-Management for Ongoing and Newly Diagnosed. DAFNE stands for Dose Adjustment for Normal Eating. Helen from Holmfirth who has Type 1 Diabetes, attended one of the pilot sessions. After speaking to other attendees during the breaks, the overwhelming theme was the lack of support groups locally and how much people really wanted to share information, experiences and support each other. Helen mentioned this to her Diabetes Nurse, who put her in touch with Nicola Barber in Locala's Engagement and Involvement Team. Nicola contacted Helen to discuss her ideas and has gone on to work with her to establish a peer support group in Holmfirth. From the outset, the offer from Locala has been clear, we want to support local groups to grow and thrive but the groups need to be run and led by volunteers - good peer support should run alongside existing provision. The benefits of peer support groups are well documented. Self-management of diabetes or dealing with a new diagnosis can be tough. A key benefit of peer support groups is access to help from people who also deal with similar issues day in, day out. Evidence suggests that people who lack confidence to

	self-manage are more than 10 times more likely to access health and care services more regularly. Peer support provides a space where individuals openly share their experiences. Helen has worked hard to establish the group which now has 12 active members and numbers are growing. Nicola has supported with promotion, social media, local partnerships and reassurance. The group welcomes people with both Type 1 and Type 2 diabetes. They meet on a regular basis with sessions during the day and evening and there are plans to launch a walking group too. The group not only support each other, they are a valuable link for Locala with the Diabetes community, sharing their experiences to allow for improvements to be made. The relationship with Locala is hugely positive, providing the opportunity for two-way feedback, support and advice. Members of group have been involved in reviewing Diabetes patient information and will also be involved in website development work. Nicola has attended three sessions to meet the group and she experienced first-hand how valuable the meetings are. Someone was about to go on holiday and was worried about taking their medication through the airport – the advice and support the group gave that person, meant they left happy and reassured. Locala's Lead Diabetes Nurse attended a meeting in October to offer a Q&A session, which came from feedback from Helen, who said members were asking similar questions and they did not have the correct information so had started speculating. Helen felt it would be beneficial to hear from a nurse directly. Some questions included information about Insulin pumps, and clarity on how other health care professionals communicate with each other regarding patient care. The members said this session was very helpful as the nurse answered lots of questions which brought reassurance and understanding. The session was also beneficial to the Diabetes nurse who was able to gain insight into what patients are experiencing in their day-to-day life. The impact on individuals attending the group has been positive – feeling supported and listened to. Currently we are unable to measure the impact on the Diabetes Team – the hope is that by feeling

	supported and having direct links to the Diabetes Team it will lead to fewer calls and 1:1 appointments allowing for valuable time to be spent with other patients. As a result of this project, we offer people the opportunity to get in touch with the Engagement Team if they would like support to set up their own group using the Holmfirth group as an example. Helen has also offered to share her experiences and support other people to establish a group. Discussions are taking place with another individual about setting up a similar group. To add more traction, a PR campaign is being planned for early 2026 to showcase the success of the group and again, encourage people to contact Locala if they want to do something similar.
Challenges	Outline any barriers or difficulties encountered and how they were managed or overcome.
Next Steps	We will use the success of this group to encourage others to establish more groups across the area.
Future focus for Experience of Care	We have shared details of this group with the local Anchor organisations and PCNs to ensure they are able to support and signpost people to join the group.
Contact email for more information about this submission	Via the ICB Quality Team at wyicb-cal.quality@nhs.net
What one thing do you want people to remember about this submission?	Our vision is to encourage more groups to flourish across Kirklees and develop a network of well-informed people who can work with us to support people with Diabetes.

Organisation Name	PriDerm Community Dermatology Service
Organisation Description	Priderm is an innovative community service delivering rapid access to intermediate dermatology services across North Kirklees, with a strong focus on education and prevention. As a local service, it is agile and responsive, enabling it to quickly introduce service improvements/learning identified from patient insights and collaborative working.
Description of experience of care initiative	**Project Name**: Reducing health inequalities in dermatology, in-line with the Core20PLUS5 approach for adults **Dates**: 2024/25 **Summary**: Brief description of work and scope Through analysis of its caseload, Priderm identified 3 under-represented patient groups: • Learning difficulties • Nursing home residents • Disadvantaged young adults **Description** To address these inequalities, Priderm collaborated with patients and carers/staff in these community organisations • Kirklees Adult Learning Disabilities Health (ALDH) Service and two advocacy organisations, Kirklees Involvement Network/Men's Talk • All North Kirklees Nursing homes • 'Fresh Futures'**:** local charity supporting vulnerable/disadvantaged children, young people and their families.

	LD Collaboration: We discussed potential educational needs for the local Learning Disability (LD) population with Kirklees ALDH and related advocacy organisations. We held face-to-face training sessions on 'staying safe in the sun' and when to seek medical advice. Participants included people with LD/carers/support staff and a group from MensTalk. The interactive session used 'Easiread' content and leaflets. There were many questions resulting in very informative discussions. Learning ● Providing information in 'Easiread' format on our website and in written correspondence. ● To reduce anxiety, we added a video to our website to explain what patients can expect when patients when they see us ● We are exploring the usefulness/possibility of adding questions to the Annual Health Check, relating to mole-checking. ● It is not always easy to identify patients with Learning Disabilities from patient notes, so we now speak to all patients directly to arrange first appointments and ask about special requirements **Nursing-home collaboration** Reached out to all Nursing Homes (NH) in North Kirklees to get feedback on educational needs of its staff and carers, concerning subject matter and delivery methods. 'Care of skin in the elderly' was by far the most requested subject. Online training was preferred to face-2-face; ideally recorded training to allow flexible access.

	We piloted a webinar for 3 NHs. The interactive format was led by a Senior Clinician. The content included common age-related skin changes, the role of care-givers in early detection, the management of pressure issues, skin cancer and when to seek help. We found little awareness about the link between poor hydration, use of soap and dry skin/skin breakdown. There were misconceptions around the best washing strategies and the correct use of moisturisers. The training objective was to reduce skin issues/breakdown amongst residents and improve care experience. Learning ● Nursing home residents are particularly vulnerable to skin breakdown as there is a lack of understanding amongst nursing home staff on how to properly care for skin ● Our findings demonstrate the need for ongoing additional education for the elderly/carers in preventative skincare regimes, to reduce the risk of skin breakdown. ● Online pre-recorded training is the optimum delivery method. ● A check on learning, post-training, is useful **Disadvantaged Young Adults collaboration** We reached out to the Fresh Futures charity (FF) to explore ways we could help support their clients. Needs identified included: ● Fundraising ● Support to assist students into employment ● Provision of speakers

	We agreed to work towards creating a partnership supporting with ● Fundraising events/activities ● Priderm staff volunteering their time to FF ● Providing speakers ● Work experience with Priderm ● FF Employability Programme (CV writing, interview practice etc.) ● Promoting FF awareness The collaboration increased staff awareness of local inequalities and barriers faced by disadvantaged young people. Activities included: ● Attending a FF job fair, which gave Priderm a chance to talk about the service and how it can support work experience with FF attendees. ● Introduction of 'Freedom Dress Friday', where staff donate £1 each week to wear casual clothes. This has already raised around £400 for FF, fostering a team spirit, whilst supporting a worthy cause. ● Internal promotion of FF within Priderm, via posters/digital updates. Success was demonstrated by funds raised, staff participation in volunteering/fundraising and young people supported through employability initiatives. Feedback has been overwhelmingly positive. The partnership has strengthened relationships with the local community, enhanced our visibility and enhanced trust with patients/service users.

	Learning: Key learning embedded into practice includes ● the value of cross-team collaboration, ● contributing to meaningful community work enhances staff teamwork and morale ● the effectiveness of small, consistent engagement initiatives ● the recognition that employment support is vital in reducing health inequalities in this group
Challenges	An open, exploratory and collaborative approach, without pre-conceived ideas, avoided barriers.
Next Steps	Priderm has drawn up ambitious plans to build on its achievements of improving care experience in these under-represented groups
Future focus for Experience of Care	Effective collaboration with other services has improved patient care experience. This approach is transferrable to other services.
Contact email for more information about this submission	rachel.singh2@nhs.net
What one thing do you want people to remember about this submission?	Education is a powerful tool in optimising patients' skin health. Priderm has demonstrated that effective collaboration with other community organisations can enhance patients' care experience and reduce health inequalities, (in-line with **Core20PLUS5).**

e. Commissioning and Healthwatch submissions

Organisation Name	**Healthwatch Kirklees and Healthwatch Calderdale**
Organisation Description	Healthwatch Kirklees and Healthwatch Calderdale is the local health and social care champion. We gather people's experiences of using GPs and hospitals, dentists, pharmacies, care homes or other care and support services. We help people to find reliable and trustworthy information and advice. We are entirely independent and have the power to make sure NHS leaders and other decision makers listen to local feedback and improve standards of care.
Description of experience of care initiative	**Empowering Voices: Improving outcomes through compassionate listening, information and signposting** Healthwatch Kirklees provides an information and signposting service that people often turn to when they feel they've reached the end of the line. Many come to us after trying every avenue without success, feeling exhausted, unheard, and unsure where else to turn. Here's what people can rely on when they contact us: • We answer the phone. • We call back when we say we will. • We listen - properly. People have the time and space to offload and tell their story. • Kindness and compassion run through every conversation. • We deliver on our promises. If we say we'll do something, we do it - and we keep people updated. • If we don't immediately know who can help, we find out. • We don't just hand out phone numbers. We make sure the service we signpost to is appropriate and will genuinely assist—and if it doesn't, we follow it up. • We support people when they need us and empower them whenever possible. • We help prevent formal complaints. Often, we can resolve issues quickly and informally, sparing people additional time and stress.

Below are two examples of how our information and signposting service has made a difference:

Janine's story

Janine reached out to Healthwatch feeling overwhelmed. She lives with an eating disorder and poor mental health. Although she had a care package, it wasn't meeting her needs as her carers didn't fully understand her condition, relationships frequently broke down, and she was often left at risk without support. Mental health services were unable to offer the help she needed at the time.

One of our engagement colleagues spent time listening to Janine and strengthened her voice within the services she was accessing. Healthwatch worked with her GP practice, the mental health social care team at Kirklees Council, South West Yorkshire Partnership Teaching NHS Foundation Trust, several care companies, and Cloverleaf Advocacy to help her access coordinated, appropriate support.

Janine is now moving forward with renewed confidence. She told us:

"Thank you for your help. Honestly, you have been absolutely amazing… It's just been so hard—really hard—and mentally exhausting. But thank you for being there on my journey and being such a lovely person, because it really does help."

Ruby's story

Ruby contacted us six months after her husband passed away at Calderdale Royal Hospital. She was burdened by unanswered questions about his care and felt deeply let down by the lack of compassion she had experienced. Her grief had become stuck; she couldn't move forward without understanding what had happened.

An engagement colleague from Healthwatch visited Ruby in person to listen to her concerns. We then liaised with a senior nurse at Calderdale and Huddersfield NHS Foundation Trust, who agreed to meet Ruby face-to-face, along with our colleague and Ruby's advocate, in a place where Ruby felt comfortable to talk, rather than having to visit the hospital.

During the meeting, Ruby had the time and space to ask every question she needed answered. She was met with genuine empathy. Following the meeting, the Trust provided a thorough explanation of

	her husband's care, acknowledged where things could have been better, and shared what had changed as a result of her feedback. This reassurance helped ease some of Ruby's worries and gave her comfort that others would not have the same experience. We then signposted Ruby to bereavement support, helping her begin to process her grief and move forward. Ruby reflected: "I appreciate them [Calderdale and Huddersfield NHS Foundation Trust] meeting with me and saying sorry. I needed to feel heard and understood…speaking up can make a difference. If people don't do that, nothing will change." Our information and signposting service provides compassionate, personalised support for people struggling to navigate complex health and social care systems. Our work reduces distress, prevents unnecessary complaints, and improves people's experiences of care across Kirklees and Calderdale.
Challenges	The main challenge is occasional lack of responsiveness or clarity from services, which can delay progress for the people we support. Some issues require repeated follow-up, often across multiple organisations. Despite this, we persist, respectfully but firmly, until people receive the support they need.
Next Steps	We plan to write more 'stories' to highlight examples of where our information and signposting service has supported people effectively.
Future focus for Experience of Care	Future collaborative work could include joint training on listening skills and compassion, and system-wide learning events based on real lived-experience stories
Contact email for more information about this report	info@healthwatchkirklees.co.uk
What one thing do you want people to remember about this submission?	That taking time to listen with compassion is not a "nice-to-have" - it is transformative. When services invest in listening, kindness, and clear communication, people feel safer, problems are resolved sooner, and the whole system benefits

Organisation Name	**West Yorkshire Integrated Care Board (WY ICB)** **Calderdale and Kirklees Place Quality Teams**
Organisation Description	WY ICB commissions health and care services for the population of West Yorkshire. Responsibilities of the ICB Quality Team includes monitoring experience of care and supporting improvements.
Description of experience of care initiative	The ICB Quality Teams in Calderdale and Kirklees (CK) have continued to drive experience of care improvements across the system. Our submission focuses on three areas of work: 1 Quality in General Practices 2 Care Homes 3 Story Facilitators Network **1 Quality in General Practices** We continue to prioritise understanding and improving the experience of care in General Practice (GP). The 'Quality in GPs' group provides a forum for sharing insight and identifying unwarranted variation across our area. Work to date has focused on experience insight, governance processes, and Care Quality Commission (CQC) readiness. A WY baseline assessment in July 2025 mapped current processes for gathering experience insight. Its purpose was to highlight good practice, identify gaps and pinpoint opportunities to streamline by doing things once across the system. Consistent practices across WY included: • Collecting data through the Friends and Family Test (FFT), GP Patient Survey, Healthwatch feedback, and local engagement methods, • Use of Primary Care Dashboards to review experience metrics, and • Systems and processes for escalation of issues through ICB governance structures at each Place and across WY. At CK Places the Quality Teams continue to strengthen the use of experience insight beyond the contractual requirements for general practice ie. surveys, complaints and FFT, by supporting the use of

	stories in general practice. This includes an offer to deliver training as well as mentorship for practices new to these methodologies. **2 Care Homes** The quality of care delivered in Care Homes continues to be monitored in a range of ways by the Providers themselves, the ICB, the Local Authorities and by the CQC. Two homes were identified as models of good practice: one achieved a CQC rating of 'Outstanding' and the other progressed from 'Requires Improvement' to 'Good'. We worked with the homes to capture their stories to share the learning across our system. You can watch the story films using the links below. Wendy's Braveheart Story (Rose Lodge) - Calderdale Cares Partnership Change the Problem into a Positive Story (Birch Park) – Kirklees Health and Care Partnership **3 Story Facilitators Network** A key mechanism for progressing against our Experience of Care ambitions is gathering and sharing stories. The CK Quality Teams have continued to facilitate the CK Story Facilitators Network (SFN). This is a digital group that brings together story facilitators from health, care and VCSE sectors to share ideas, resources and learning. The network has been running for over two years and membership thrives with professionals from across the system coming together to: • Build collective awareness of stories being shared within organisations, • Amplify the reach of stories and maximise impacts by sharing across organisations, and • Learn from each other about different methods of story capture. An example of the stories shared and used across organisational boundaries as a direct result of the SFN is 'Ron's Story: Don't Put the Spoon in the Pudding'. This was created by Mid Yorkshire Teaching NHS Trust and has been shared across multiple organisations for training purposes. You can view the story at: https://www.youtube.com/watch?v=dllKCwB5678

	We asked SFN members for feedback about their experience of the group. A selection of responses are below. **Question 1. How has the use of stories impacted experience of care in your organisation?** “Interesting to hear from people about what matters to them. Sometimes this is different to what a clinician would expect.” “Many patients … have gone on to become involved in how we develop our services, benefitting them, us and the wider community.” “Data is useless without stories and stories are useless without data” **Question 2. What difference has the SFN made to you and your practice?** “Helped me to reflect on the different methods used when capturing a story.” “Able to challenge ourselves and how we work.” “Story Facilitators Network is … a place to feel inspired as well as allowing us to share our achievements and stories.” A key objective of the SFN was also its biggest challenge: to create a central story library and enable stories to be shared easily across organisational boundaries. The group has progressed this by establishing a members’ SFN workspace on NHS Futures. After some initial hurdles the group engaged with colleagues with specific expertise in this area and the new space is now starting to be used. The space will enable further amplification and tracking of the impact of stories. By engaging with the WY Involvement Team we have also been able to link the SFN workspace with the WY Insight Library which will support greater triangulation of insight across our systems. Next steps for the SFN include: • Continue to expand and build the network, • Enhance and promote the SFN NHS Futures workspace, • Refine story gathering consent principles for use in relation to the Futures workspace,

	• Promotion and delivery of story training modules, and • Pilot use of the Story Impact Framework for evidencing impact and amplification.
Contact email for further information about this submission	wyicb-cal.quality@nhs.net
What one thing do you want people to remember about this submission?	That stories have power and enable richer conversations to support people focused decision making. In the words of one of our Story Network members “data is useless without stories and stories are useless without data”.

4. System summary (including themes, risks and challenges)

This report highlights and celebrates some of the exceptional achievements delivered across the system over the past year. It demonstrates a powerful commitment to putting people first by delivering care that is compassionate, person centred and inclusive. Staff have worked collaboratively across health, social care, councils, VCSE, faith leaders as well as alongside people with lived experience to successfully co-produce solutions, share expertise and raise awareness. This provides the partnership with awareness that services reflect the needs and preferences of those who use them.

Submissions demonstrate the range of creative, flexible and culturally sensitive initiatives across our health and care partnership. They showcase a focus on reducing health inequalities and removing barriers to accessing care by tailoring communication, engagement and education.

System wide learning is further strengthened through collaborative working and the progress of the SFN enabling the sharing of stories across a variety of partners to inform education, quality improvement and decision making.

Across the submissions several common risks and challenges were identified. These included:

- Workforce shortages and recruitment difficulties - impacting on service delivery and increased pressure on existing staff.
- Financial constraints - limiting the ability to invest in new initiatives.
- Growing demand for services, particularly in mental health and community care - creating additional capacity pressures on services.
- The use and reliance of volunteers - this can affect service continuity and must be carefully balanced.
- Digital transformation - including issues around system integration, data quality and cyber security.
- The identification mechanisms for identifying people with a learning disability – Impacted further by inconsistent referral data.

The report illustrates that when we listen to patients, carers, staff and volunteers, collaborate across organisations, champion inclusive practice and embed shared learning, we create a system where people feel heard, respected and empowered to make informed decisions about their care. In the future, this portfolio of work offers a platform for continued collaborative working and strengthening the partnerships across Calderdale and Kirklees.

5. Opportunities for further work

The report outlines a number of collective opportunities that could be explored to drive improvement and innovation. These opportunities reflect areas where collaboration, resource alignment and shared learning could enhance service delivery and address common challenges building on existing strengths, reducing duplication and creating solutions to benefit people both working in and accessing services. These opportunities could include:

- Develop simple, consistent measures to track impact and/or outcomes that could be developed and agreed for use across different providers and/or organisations.
- Continue to strengthen system-wide collaboration to share at scale what has worked well to spread successful models of work.
- Consideration could be given to having a CK EoC learning forum. This could accelerate collaborations, foster partnership working, share ideas, resources and training and promote peer support and networking.
- Standardise inclusive communications: Exploring and sharing materials system wide. For example, Easy Read, short explainer videos, plain English letters and texts and education and awareness campaigns.
- Continue to champion, amplify and use peoples' stories to support service design, improvement and decision making throughout the commissioning cycle.
- Ensure patients and carers can be supported via digital and non-digital options to further reduce inequalities.
- Continue to build strong partnerships with VCSE organisations and faith leaders via system forums such as SFN.

6. Next Steps

Following submission of the report to committees the ICB Quality Team will obtain feedback from the design group members on the process of collaboration and codesign. Learning will be used to inform future proposals for EoC reporting.

Following formal receipt of the reports and the story at committees the Quality Team will share the bundle across the CK system to a variety of fora including:

- Calderdale Communications, Involvement, Equality and Experience Collaborative
- Kirklees Health and Care Communications and Engagement Network
- Staff workshops at Place

- WY System Quality Group and/or WY Quality Committee (if applicable)
- North, East and Yorkshire Experience of Care Group

Contributing organisations will also be able to share the reports and the learning via their own mechanisms.