Public Document Pack

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Wednesday 20 April 2016

# Notice of Meeting

Dear Member

## Health and Wellbeing Board

The **Health and Wellbeing Board** will meet in the **Meeting Room 3 - Town Hall, Huddersfield** at **2.00 pm** on **Thursday 28 April 2016.**

The items which will be discussed are described in the agenda and there are reports attached which give more details.

**Julie Muscroft**
**Assistant Director of Legal, Governance and Monitoring**

Kirklees Council advocates openness and transparency as part of its democratic processes. Anyone wishing to record (film or audio) the public parts of the meeting should inform the Chair/Clerk of their intentions prior to the meeting.

## The Health and Wellbeing Board Members are:-

Councillor Viv Kendrick (Chair)
Councillor Donna Bellamy
Councillor Jean Calvert
Councillor Erin Hill
Councillor Kath Pinnock
Kiran Bali
Rory Deighton
Chris Dowse
Dr David Kelly
Carol McKenna
Dr Steve Ollerton
Richard Parry
Vanessa Stirum
Rachel Spencer-Henshall
Sarah Callaghan

# Agenda
# Reports or Explanatory Notes Attached

**Pages**

## 1: Appointment of Chair

The Board will appoint a Chair for the meeting.

## 2: Membership of the Board/Apologies

This is where members who are attending as substitutes will say for whom they are attending.

## 3: Minutes of previous meeting

1 - 4

To approve the Minutes of the meeting of the Board held on 31 March 2016.

## 4: Interests

5 - 6

The Board Members will be asked to say if there are any items on the Agenda in which they have disclosable pecuniary interests, which would prevent them from participating in any discussion of the items or participating in any vote upon the items, or any other interest.

## 5: Admission of the Public

Most debates take place in public. This only changes when there is a need to consider certain issues, for instance, commercially sensitive information or details concerning an individual. You will be told at this point whether there are any items on the Agenda which are to be discussed in private.

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## 6: Deputations/Petitions

The Board will receive any petitions and hear any deputations from members of the public. A deputation is where up to five people can attend the meeting and make a presentation on some particular issue of concern. A member of the public can also hand in a petition at the meeting but that petition should relate to something on which the body has powers and responsibilities.

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## MATTERS FOR CONSIDERATION

## 7: Primary Care Strategy

7 - 72

To consider the Primary Care Strategies for Greater Huddersfield and North Kirklees Clinical Commissioning Groups.

**Contact:** Jan Giles, Greater Huddersfield CCG and Jackie Holdich, North Kirklees CCG

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## 8: Care Home Strategy

73 - 104

To consider the Kirklees Joint Strategy for Older People's Care Homes, which has been jointly developed between Kirklees Council, North Kirklees Clinical Commissioning Group and Greater Huddersfield clinical Commissioning Group.

**Contact:** Margaret Watt, Head of Commissioning & Quality Tel: 01484 221000

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## 9: Sustainability Transformation Plan update

To receive a verbal update on the Sustainability and Transformation Plan.

**Contact:** Rachel Millson, Business Planning Manager North Kirklees CCG and Natalie Ackroyd South Kirklees CCG

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## 10: Integrated Front Door Proposal (Multi-Agency Safeguarding Hub)

105 - 110

To consider a proposal for the remodelling of the Multi-Agency Safeguarding Hub (MASH).

**Contact:** Trish Berry, Interim Head of Service, Family Support & Child Protection Tel: 01484 221000

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## 11: Transforming Care Partnership Plan

111 - 158

To consider the draft Transforming Care Plan.

**Contact:** Kelly Glover, Transforming Care Partnership Programme Manager

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## 12: Special Educational Needs and Disability Ofsted Inspections

159 - 162

To consider a report about the focus and remit of the Area Special Education Needs & Disability OFSTED Inspections.

**Contact:** Mandy Cameron, Deputy Assistant Director, Learning & Skills
Tel: 01484 221000

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## 13: Health and Wellbeing Board Terms of Reference

163 - 166

To seek approval for the proposed revisions to the Terms of Reference for the Health and Wellbeing Board.

**Contact:** Phil Longworth, Health Policy Officer Tel: 01484 221000

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## TO NOTE ITEMS

## 14: North Kirklees Clinical Commissioning Group Operational Plans

167 - 214

To consider the North Kirklees CCG's Operational Plans which are being presented to the Board for information.

**Contact:** Rachel Millson, Business Planning Manager, North Kirklees CCG

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## 15: Minutes of CSE & Safeguarding Member Panel

215 - 222

To receive the minutes of the CSE and Safeguarding Member Panel meeting held on 3 March 2016 for information.

**Contact:** Helen Kilroy, Principal Governance Officer Tel: 01484 221000

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## 16: Date of next meeting

To note that the next meeting of the Health and Wellbeing Board will be on the 26 May 2016, Council Chamber, Dewsbury Town Hall.

**Contact:** Jenny Bryce-Chan, Governance & Democratic Engagement Officer Tel: 01484 221000

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Contact Officer: Jenny Bryce-Chan

**KIRKLEES COUNCIL**

**HEALTH AND WELLBEING BOARD**

**Thursday 31st March 2016**

| | |
|---|---|
| Present: | Councillor Viv Kendrick (Chair)<br>Councillor Erin Hill<br>Kiran Bali<br>Rory Deighton<br>Dr Steve Ollerton<br>Sarah Callaghan<br>Rachel Spencer-Henshall |
| Apologies: | Alison O'Sullivan |
| Observers: | Sharon Lowrie – Locala |

**107 Membership of the Board/Apologies**

The Board noted the following substitutions:

Catherine Riley for Owen Williams
Dr Nadeem Ghafoor for Dr David Kelly
Vicky Dutchburn for Carol McKenna
Helen Severns for Chris Dowse
Sharon Lowrie for Robert Flack
Cllr Gemma Wilson for Cllr Donna Bellamy

The Board welcomed Sarah Callaghan, Director for Children and Young People, Kirklees Council and Martin Barkley Chief Executive from Mid Yorkshire Hospitals NHS Trust

Apologies for absence were received from: Cllr Donna Bellamy, Cllr Jean Calvert, Dr David Kelly, Chief Superintendent Steve Cotter, Robert Flack, Adrian Lythgo, Vanessa Stirum, Cllr Gemma Wilson and Karen Taylor

**108 Minutes of previous meeting**

**RESOLVED –** That the minutes of the meeting held on the 25 February 2016 be agreed subject to the correction of a grammatical error on page 3.

**109 Interests**

No interests were declared.

**110 Admission of the Public**

All agenda items were considered in public session.

## 111 Deputations/Petitions

No deputations or petitions were received.

## 112 Domestic Abuse Strategy

Lee Thompson, Head of Safeguarding and Social Work and Alexia Gray, Service Manager Domestic Abuse and Safeguarding Partnerships attended the meeting to present the Domestic Abuse Strategy 2015-18. In summary, the Board was informed that domestic abuse is a complex and controversial issue with children being present in a third of local domestic abuse incidents. Victims are often affected by other factors such as poverty, drugs, alcohol, mental ill health and poor parenting. Forced marriage, honour based violence and female genital mutilation is included in the definition of domestic abuse.

Domestic abuse is a priority for Kirklees and the strategy has been developed in partnership with the Police, Health Service, Probation Service and the voluntary sector. It links to wider Kirklees strategies including the Safer Kirklees Plan, Joint Health and Wellbeing Strategy and the work of the Local Safeguarding Children's Board and Adults Safeguarding Board. Maintaining regular links into Safeguarding Boards and the Health and Wellbeing Board is important.

The Board was informed that important areas of focus are on early intervention and prevention and targeting services working with victims adults and children to reduce the impact. It is also important to understand what services are available, pathways to access and to identify where services are working in isolation or if there is any duplication.

Data from a number of sources has been collated to provide an indication of prevalence and to start to map demand for services although it is believed there is underreporting particularly in respect of some groups. There is also a growing incidence of domestic abuse by children against parents. There is still work to do on data collection.

The Domestic Abuse action plan is currently being reviewed for the year ahead, however much progress has been made. Recruitment to the Service Manager post finished in February 2016. A successful campaign to raise awareness with the launch of a video on the 1st of March called 'it's never ok' has had a positive response. The action plan to support the Strategy is due to be refreshed at the next Domestic Abuse Strategy Group to identify year two actions.

The Board was advised that the Multi Agency Risk Assessment Co-ordinator role only has funding in place until 2017. Whilst collective partnership efforts have ensured funding for five Independent Domestic Abuse Advocates longer term the service cannot be sustained beyond this.

Board members were asked to note the information presented and assist in the identification of partnership funding opportunities to support the implementation of the Strategy.

**RESOLVED -**
(a) That the Board notes the progress of the work undertaken to address priorities in the Strategy

(b) That the financial implications be noted

(c) That further updates will be received by the Board at timely intervals

**113 Kirklees Better Care Plan 2016/17**

Phil Longworth, Health Policy Officer advised the Board that the 2015/16 Kirklees Better Care Plan is being updated for 2016/17, and will include a high level narrative plan and a finance and performance template as required by NHS England.

The Better Care Fund is a national pooling of existing funding sources from within the Clinical Commissioning Groups and the Local Authorities. Preparation of jointly agreed Better Care Plans is a requirement of Better Care Fund (BCF).

The intention is to put some BCF money into Care Trak to pull together social care and NHS data flows. This is to understand how people are flowing through the system and to get a better understanding of who the lead accountable professional is.

Developments are being planned to:
- Improve integration across a range of services including reablement and intermediate care.
- Develop a consistent approach to accountable lead professionals, care plans and care management.
- Better co-ordinate the approach to Continuing Care across health and social care.
- Have a local work plan for reducing Delayed Transfers Care.
- Develop the local digital road map which will shape the digital elements of the plan.

Guidance on developing the BCF plans was published on the 23 February and the timing of submission is the 26th April 2 days before the next meeting of the Health and Wellbeing Board therefore the timescale will not allow the plan to be brought back to the board.

The Board was asked to delegate the sign off of the final version of the plan to the Director for Commissioning, Public Health and Adult Social Care in consultation with the Chair of the Board and nominated representatives from the Clinical Commissioning Groups.

**RESOLVED -**
(a) That the work under taken to update the 2015/16 Better Care Plan and develop the high level narrative be noted

(b) That delegated authority be given to the Director for Commissioning, Public Health and Adult Social Care in consultation with the Chair of the Board and nominated representatives from the CCG's

**114 NHS Planning Guidance Sustainability Transformation Plan**

Phil Longworth and Rachel Millson, Business Planning Manager, North Kirklees Clinical Commissioning Group updated the Board on the work that has been undertaken to date, to develop the Sustainability Transformation Plan (STP).

The Board was advised that Carol Mckenna, Chief Officer, Greater Huddersfield Clinical Commissioning Group had been nominated as the accountable officer responsible for the development of the local STP. A letters would be going out advising of this and the work required to develop the plan.

The Board was informed that guidance is being produced on a regular basis and the latest guidance poses 10 big questions that need to be addressed as part of developing the plan.

The intention is that there will be 6 place based, primary STP's for Calderdale, Bradford, Kirklees, Leeds, Wakefield and Harrogate and a West Yorkshire, Secondary STP. The West Yorkshire plan will have as its focus, Urgent and Emergency Care Networks, Mental Health, Cancer and Specialist Commissioning.

To date the following has been agreed:
- The footprint the plans will be developed across
- Development of a communication and engagement plan
- That Health and Wellbeing Board will be responsible for overseeing the STP and identifying key stakeholders from across all organisations

Work is progressing across Healthy Futures and a date for the workshop has been agreed.

The Board was advised that each STP area on a primary and secondary footprint is asked to make a submission by 15 April 2016, focusing on two specific questions. Submission of the full plan to national bodies must be by the 30 June 2016.

**RESOLVED -**
(a) That the update on the STP be received and noted by the Board.

(b) That the Board provide a response to the specific areas that the STP is required to address.

**115 Minutes of CSE & Safeguarding Member Panel**

The Board considered the minutes of the Child Sexual Exploitation and Safeguarding Panel held on the 3 February 2016.

**RESOLVED -**
That the minutes of the Child Sexual Exploitation and Safeguarding Panel held on the 3 February 2016, be received and noted by the Board.

**116 Date of next meeting**

**RESOLVED -** That the next meeting of the Health and Wellbeing Board will be held on 28 April 2016, in meeting room 3 – Huddersfield Town Hall.

# KIRKLEES COUNCIL

## COUNCIL/CABINET/COMMITTEE MEETINGS ETC
## DECLARATION OF INTERESTS
### HEALTH AND WELL BEING BOARD

**Name of Councillor**

| Item in which you have an interest | Type of interest (eg a disclosable pecuniary interest or an "Other Interest") | Does the nature of the interest require you to withdraw from the meeting while the item in which you have an interest is under consideration? [Y/N] | Brief description of your interest |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Signed:** …… **Dated:** ……

**NOTES**

**Disclosable Pecuniary Interests**

If you have any of the following pecuniary interests, they are your disclosable pecuniary interests under the new national rules. Any reference to spouse or civil partner includes any person with whom you are living as husband or wife, or as if they were your civil partner.

Any employment, office, trade, profession or vocation carried on for profit or gain, which you, or your spouse or civil partner, undertakes.

Any payment or provision of any other financial benefit (other than from your council or authority) made or provided within the relevant period in respect of any expenses incurred by you in carrying out duties as a member, or towards your election expenses.

Any contract which is made between you, or your spouse or your civil partner (or a body in which you, or your spouse or your civil partner, has a beneficial interest) and your council or authority -

- under which goods or services are to be provided or works are to be executed; and
- which has not been fully discharged.

Any beneficial interest in land which you, or your spouse or your civil partner, have and which is within the area of your council or authority.

Any licence (alone or jointly with others) which you, or your spouse or your civil partner, holds to occupy land in the area of your council or authority for a month or longer.

Any tenancy where (to your knowledge) - the landlord is your council or authority; and the tenant is a body in which you, or your spouse or your civil partner, has a beneficial interest.

Any beneficial interest which you, or your spouse or your civil partner has in securities of a body where -
(a) that body (to your knowledge) has a place of business or land in the area of your council or authority; and
(b) either -

the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or

if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you, or your spouse or your civil partner, has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

**KIRKLEES HEALTH & WELLBEING BOARD**

**MEETING DATE: 28th April 2016**

**TITLE OF PAPER: Primary Care Strategy for Greater Huddersfield CCG and for North Kirklees CCG**

**1. Purpose of paper**

To present the Primary Care Strategies for Greater Huddersfield and North Kirklees Clinical Commissioning Groups

**2. Background**

These documents are of strategic importance to the Health and Wellbeing Board. The strategies were developed during 2015/16 and have been agreed by the Governing Bodies of the respective organisations. The strategies are now presented to the Health and Wellbeing Board for information.

**3. Proposal**

The Board is asked to note and support the content of the Primary Care Strategies

**4. Financial Implications**

To be identified through the implementation of the strategies

**5. Sign off**

The Primary Care Strategies have been signed off by the Governing Bodies of the respective organisations

**6. Next Steps**

Systems and structures are in place to support the implementation of the Primary Care Strategies in the two CCG areas

**7. Recommendations**

The Health and Wellbeing Board is asked to note receipt of the Primary Care Strategies for Greater Huddersfield and North Kirklees CCGs

**8. Contact Officer**

Jan Giles, Head of Practice Support and Development

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07818065997

Jackie Holdich, Head of Primary Care

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**01924 504906**

NHS
Greater Huddersfield
Clinical Commissioning Group

**Greater Huddersfield Primary Care Strategy**

**Foreword**

*Dr Steve Ollerton, Clinical Chair, Greater Huddersfield Clinical Commissioning Group*

"Tough times never last, but tough people do" quoted Robert Schuller. He had nothing to do with primary care but I like the quote.

I think we can all agree that general practice is under pressure from a number of angles at the moment. We have dwindling resources (money), inequity in provision (for various reasons), recruitment and retention issues and a never ending surge of demand from an ageing population with multiple conditions. We have politicians telling us to work 7 days and providers buckling under pressure which ends up causing us more work. That brings me to another quote from Albert Einstein "insanity is doing the same thing over and over again and expecting different results".

If we want to continue to serve our patients and give them a high quality, timely service then we have to do things differently and we have to be tough. Our CCG is passionate about primary care, especially general practice. We are taking on full delegation from April 2016 and we need to make bold decisions to transform our primary care system. This strategy has been developed through extensive engagement with our patients, practices, federations and other stakeholders. They have told us the "what" and the "how" we should be changing. The "when" is the next 5 years.

General practice cannot undertake this transformation in isolation. We need to work with other primary care colleagues and allied providers e.g. local authority. Let's not forget the patients too - they will need to play their part in ensuring the future sustainability of general practice.

I hope we can all own this strategy and use it to inform our decision making over the coming years. The CCG will do all it can to see it come to fruition but we need our member practices to make it happen.

**Contents**

## 1. Case for Change

### 1.1. Why do we need a primary care strategy?

The central facets of general practice have not changed greatly since the inception of the NHS; whereas other parts of the NHS have seen large-scale change, this has not happened in general practice in the same way. What is clear is that the 'ask' of primary care and specifically of general practice has changed. Primary care has had to take on more responsibility, complexity and roles, often acting as the default provider of all services not seen as within the remit of other services. This has been within the context of growing demand through changing demographics with patients living longer with multiple co-morbidities.

The NHS is facing a challenge as in no other time. The Five Year Forward View makes the case for change nationally, with £22billion of savings expected to be made by 2020. The vision is that new models of care will be developed to deliver this, within which primary care will be central.

The challenge that we face locally and nationally to deliver these new models of care are demand, access, workforce, technology, finance and estates, especially with the national aspiration to 7 day working.

The CCG recognises these challenges and the potential impact it has on the local health economy and community. In order to prepare for these changes we have been developing strategies for primary, secondary and community health services.

From the 1 April 2016 Greater Huddersfield Clinical Commissioning Group (GHCCG) received full delegation to commission general medical services. In real terms this means that the CCG will gain much more influence to shape commissioning locally to support the needs of our population. This will enable us to work with local practices and stakeholders to develop ways of working and the better use of resources so that they will best meet the needs of our patients. This could involve reinvesting the funding from Directed Enhanced Services (DES), locally agreed practice based services and even aspects of the Quality and Outcomes Framework (QOF) into more appropriate, targeted schemes. To achieve this we have and will continue to seek input and involvement from local practices and other stakeholders so that the service that we develop together will work for patients and practices alike.

This strategy will focus on general practice with a view to working with wider primary care and other stakeholders as key partners in development and implementation.

### 1.2. What does this mean on the ground?

Through sessions we've done over the last 12-18 months, member practices have already told us that doing nothing isn't an option. Doing nothing will mean that:

- The service will become more reactive to crisis management
- There will be an increase in variation
- There will be a decrease in patient safety and quality
- Increase in costs (utilisation of locums etc.)
- Increased pressure to the rest of the health care system – particularly secondary care
- Increase in loss of GPs and practice staff
- Practice closures.

In Greater Huddersfield, the impact of this has already been seen with practices closing and merging, and positive steps have been made by practices in forming federations which enables collaborative working and strengthens the voice of primary care as providers of services. One example to date of successful collaboration amongst practices has been the development of the anti-coagulation service.

Authoritative sources such as the British Medical Association (BMA), the Kings Fund and Nuffield Trust have all reiterated that there needs to be a new model for primary care and that delivery of services on a bigger level 'primary care at scale' is the way to do this either through networks, federations or large super practices. Another fundamental is the delivery of care in partnership and integrated with other services. The Care Closer to Home (CC2H) model in Greater Huddersfield has strengthened the approach to delivering services to people in the community but fundamental to the success of this model is integration of primary care with community services. The workforce is finite, so to maximise resources, we will need work to collaboratively and breakdown traditional boundaries between general practice, secondary care, community services, social care, voluntary and community sector and community pharmacy to recognise a patient's physical, social and mental health needs.

### 1.3. Enablers

Technology has rapidly developed and is a significant part of our everyday lives, this is expanding into the delivery of health and social care but often in small pockets and limited to certain services. Barriers of different systems and information governance have led to a lack of information sharing to support patient care which needs to be considered and addressed. Working in an integrated way and at scale cannot be fulfilled without easy, secure access to the appropriate patient information held within clinical systems.
We recognise that the workforce challenge is felt keenly across all services and particularly in general practice. A lack of GP trainees, an ageing workforce and the challenges of being a clinician and a business owner pose difficult challenges for the profession.

As a General Practitioner, it is one of, if not the only business model where the chief executive is also the shop floor worker. As the pressures rise in terms of funding (the business) and clinically (as a medical practitioner) the profession is becoming a less desirable one. It is time to identify new roles, allow GPs to deal with the level of complexity they are trained to manage and utilise other practitioners with the skills to assess, diagnose and treat patients with certain conditions where appropriate. GPs will become the clinical leaders or 'primary care consultants' of their organisations much as consultants lead multi-disciplinary teams (MDTs) in secondary care.

Estates is another important enabler to the delivery of a new model of primary care, we have some knowledge about the estate in primary care and this is currently being reviewed and updated. We know that much of the estate is not fit to deliver services now and is limiting the potential of delivering new and advanced services in a primary care setting and in some cases even putting a barrier in place to delivering core services.

## 2. Stakeholder involvement in development

### 2.1. How we developed the strategy

As the strategy is centred around general practice and making it fit for a sustainable future, we established a programme structure to support the development of the strategy. This incorporated representatives of the CCG, both federations and the Local Medical Committee (LMC) at Programme Board and working group level. Based on the key areas of challenge and need for development, we established small groups to look at the following areas:

- Core offer
- Advanced offer
- Workforce and workforce development
- Estates
- IT systems and technology
- Engagement

These groups met regularly during the development of the strategy to shape the content and consider and incorporate themes from the feedback from our engagement activities.

### 2.2. How stakeholder engagement has shaped our strategy

**Patients and public**

Locally, we have proactively gathered patient and public views about primary care and the wider health and care system through a number of exercises (a full list can be found at Appendix 2). This information has been used to inform the development of this strategy. Some of the key messages that patients and public told us were:

- There needs to be better access to information and advice and better communication through a variety of channels
- Need for better working with other professionals including better knowledge of local voluntary sector and community groups
- Continuity of care is important when the patient has a long-term condition or ongoing need but for one-off needs, patients are happy to see any available clinician
- Better access to GP appointments
- Wider range of services and professionals within practices is desirable
- General practice should provide localised services.
- There is an appetite to expand the use of online booking, Skype and telephone consultations, email and text reminders
- We need to enable patients to care for themselves.

**Practice membership**

Engagement with, and gaining feedback from, the wider practice membership has been crucial to developing the right strategy for the future which is achievable, sustainable, evidenced and outcome based. Each group considered the feedback that had already been shared over the last 12-18 months through various exercises and meetings such as Practice Protected Time and the Business

Meeting. This was reflected on in developing the proposals for each area.

Further specific engagement exercises were undertaken and feedback has been incorporated into this strategy (included at Appendix 2).

**Wider stakeholders**

In addition, we held a session with wider stakeholders to discuss the development of the strategy and where there are interdependencies with primary care within their transformation plans. This supported identifying which areas we need to work on collectively and is reflected within the strategy.

A summary of all the engagement information utilised and the events and sessions held can be found at Appendix 2.

## 3. Vision

Our vision for this strategy is to create:

*'Thriving and progressive general practice with patients at its heart'.*

Our mission is all about:

- Patients being able to make appropriate choices and responsible decisions about their health and wellbeing
- Patients being able to expect a high standard and consistent range of primary medical services from every GP practice
- Primary care as a cornerstone of an integrated system of 'out of hospital' care
- Primary care accessible to patients 7 days per week
- An 'enhanced' level of service accessible to all patients as part of our Care Closer to Home model
- Strong and innovative workforce design and use of modern technology
- Education and training opportunities that cultivate professional excellence and high motivation
- A culture which promotes openness, transparency and the ability to make mistakes in a supportive and learning environment
- General practice at the heart of the health and social care system working collectively with partners and the wider community
- Greater Huddersfield being *the* place that clinicians choose to work.

## 4. Relationships

Strong relationships are fundamental to the success of this strategy. There is a shared intention to break down traditional silo working and foster effective partnerships. Relationship building is being encouraged and enabled across the health and social care system and local communities.

Through talking to our health and social care partners, we have identified examples of good integrated working, driven by the need to change and work differently to improve patient outcomes and system efficiency. Looking beyond the usual links between community services and secondary care, there is tremendous scope to work with the large numbers of voluntary/third sector organisations, community pharmacy (60 pharmacies in the Greater Huddersfield area), social care, and our 'out of hours' provider (Local Care Direct).

Opportunities to engage local schools and businesses in the promotion of health and wellbeing will champion healthy lifestyle awareness and ill health prevention, with potential to tailor for particular communities and community groups.

Whilst this strategy is focused on general practice, it is being progressed in the context of a much wider primary care service across Greater Huddersfield. Strong messages from our partners signal a shift towards an improved local system:

- We are keen to be involved early in the design phase when changing services
- There are huge opportunities to reduce inefficiency and duplication by working together and differently
- We need to work together to manage the workforce challenge, making sure patients are seen by the right person in the right place (with new opportunities to work with the VCS and community pharmacy)
- Improvement in communication channels will make a huge difference and allow us to work together.

## 5. Outcomes and measuring success

***Mattering most to the patients and service users we talked to:***

I'm seen by the right person at the right time

More of my care happens nearer to home

Me and my carers know how to manage my health and wellbeing

Everyone involved in my care knows my story

During the design of Care Closer to Home, which places primary care at the heart of community services, we worked with groups of patients and service users to understand the outcomes most important to them to achieve.

These outcomes provide the framework for the primary care strategy and measuring success. Whilst the outcomes translate across services, there are some particular priorities for primary care. These are identified in Table 1.

**Patients**

**Table 1**

| Outcome | Primary care priority | Measure |
|---|---|---|
| **I'm seen at the right time by the right person** | All patients are able to get same day access for urgent needs | % patients with an urgent need receiving same day access / consultation |
| **More of my care happens nearer to home** | Unplanned hospital admissions<br><br>More planned services delivered in a primary care setting | Unplanned admissions (primary care dashboard)<br><br>% patients accessing planned services in primary care setting |
| **Me and my carers know how to manage my health and wellbeing** | Care planning for patients with a long term condition (LTC)<br><br>All patients understand how to keep themselves healthy | % patients with an emergency care plan to manage exacerbation of their LTC(s)<br><br>Uptake of vaccinations and immunisations and screening |
| **Everyone involved in my care knows my story** | Improve communication and coordination between professionals and carers involved in a patient's care | For patients with a long term condition, Care Plans are reviewed by a MDT at least twice a year or more frequently as required |

**Strategy outcomes**

In addition to improving outcomes for patients, there are some key outcomes which will also help us to measure the success of our strategy. The key priorities are identified in Table 2 below.

**Table 2**

| Area | Outcome | Measure |
|---|---|---|
| **Workforce** | A strong resilient workforce | Staff survey (satisfaction levels)<br>Vacancy levels in practice |
| **IT** | Access to information through technology for clinicians and patients alike | % patients booking appointments online<br>% patients with access to, and viewing, their electronic record |
| **Estates** | Multi-purpose community facilities delivering comprehensive services to patients | TBC |

## 6. Core offer

| | |
|---|---|
| **Definition** | The core offer is the basic offer that every patient registered with a practice in Greater Huddersfield should expect from their practice. All practices will be required to provide the core offer and meet the minimum standards agreed. |
| **Where are we now?** | There is currently an inconsistency of access, provision and quality within general practice and limited description of the expectations of the core offer articulated by current contracts. |
| **What are we trying to achieve?** | Ensure people know what to expect from general practice and clarify expectations.<br><br>Ensure there is good access and high quality of service.<br><br>Define minimum standards of provision.<br><br>Encourage and facilitate appropriate use of services by patients. |
| **Vision** | Access to and provision of high quality general practice services to every patient registered with a practice in Greater Huddersfield. |

We know from talking to patients and professionals that there is still inequity of service provision for core GP services. In order to create sustainable general practice for the future, we need to create and implement some core standards and principles that patients are able to understand.

The GMS contract provides an outline of the core services all practices are expected to deliver but does not identify standards in detail which has led to differing interpretation of what is 'reasonable'. In defining the core offer, the CCG is not seeking to expand the core offer, rather provide a local agreed interpretation of those areas not defined in the GMS contract.

Some of the key principles and standards include:

- Promote self-management and patient education with patients
- Minimum scheduled appointment time for a routine GP appointment will be 10 minutes – this should support preventative and person-centred approaches
- Continuity of care where possible for both patients and clinicians
- All patients with an identified long-term condition (see appendix 3 for full list) will have a mutually agreed care plan in place where a patient agrees to take part in developing the care plan
- Personal development and an active appraisal system for staff will be provided by the practice
- Patient experience and feedback should be sought and acted upon
- All practices will have an effective patient reference group

A full list of the key standards and principles can be found at Appendix 3.

One of the most prevalent issues facing patients in primary care is the inequity of access to services. We know that the impact of this is to put pressure on other parts of the system, when patients cannot access a timely appointment within primary care, they are more likely to seek alternatives such as out of hours GP and attending local A&E services when their need would have been much better met by their local GP service.

In order to try to bring some consistency to access and provision of information, the following key requirements and standards have been identified as part of the core offer (a full list can be found at Appendix 3):

- Every practice should ensure clinical advice is available for all their registered patients from 8am - 6.30pm
- Access to same day requests, where appropriate, must be available and addressed for patients contacting the practice between 8.30am – 6pm on that day (this will be access to an appropriate clinician but will not necessarily mean a face-to-face appointment)
- Online access should be available and actively promoted for appointments and prescriptions
- All practices must offer telephone consultation / appointments
- All practices must have a regularly updated website with information sources for patients to access
- Unplanned routine appointments e.g. back pain / minor infection will be provided within 5 working days (this is with an appropriate clinician as determined by the practice)
- Planned routine appointments e.g. reviews are not subject to minimum timescales and should be made as appropriate for the individual patient
- All practices will enable, and promote to their patients, electronic access to their records (Patient Online).

**Case Study: Self-management of coeliac disease**

An increasing number of people are being diagnosed with coeliac disease and, for people who are diagnosed; knowing how to keep themselves healthy with the right food choices is an important issue. Greater Huddersfield CCG worked with the Coeliac Society and students from Huddersfield University to produce podcasts which support people who are newly diagnosed to make the choices that are best for their health. By filming in local supermarkets and restaurants, the choices available were easy to demonstrate in a format that was simple and reassuring. This is one example of using technology to support people to learn more about how to look after their health.

**Funding**

Core services are those which are defined within the GMS contract and will therefore be delivered through the payment made through the core contract, based on the registered list.

### 6.1. Support mechanisms

Whilst the CCG is able to influence locally decisions about the commissioning of primary care through full delegation from April 2016, it will not have the power to change or enforce breaches of the national GMS contract.

However, it is fundamental that all practices meet the core requirements over the lifetime of the strategy to ensure that patients get the services they need. Some practices have demonstrated and told us that they are already fulfilling all of these requirements and meeting these standards, however, we know that this is not the case for all practices and as such, the CCG will support these practices to meet the standards through the provision of:

- Learning and best practice from other practices and projects such as Breaking the Cycle
- Toolkit and resources
- Hands on support from personnel within the CCG.

Local federations have told us they are committed to providing peer support to their members to drive quality of primary care within Greater Huddersfield.

**Case Study: Patient Online accelerator site**

**The patient's perspective**

Adam was one of the first patients to trial the use of patient online.

Adam registered as a patient at the University Practice over 20 years ago when he first attended Huddersfield University. Over the years, Adam has had regular contact with the practice. 'Practice staff have taken good care of me and my family, from help when my partner and I had our child 11 years ago, to more regular care since I was diagnosed with type 2 diabetes three years ago.'

'I find it much easier to book and even cancel appointments online. It's so easy to log on via the app on my phone or on my computer and book an appointment when I need it. Ordering repeat prescriptions online also saves me a lot of time. If I realise I'm running low and the practice is closed on the Saturday, all I do is log on, request the relevant medication from the drop down list and then pick it up a few days later.'

Had these services changed the nature of his consultations with his GP? 'Absolutely! I realise my GP's time is precious therefore when I expect my blood test results to be in; I book an appointment for the week after. Once the result is in, I check it against past results and I check the notes of my last consultation to remind myself what was said. This results in me and my GP having a far more productive meeting as I am more prepared and I'm able to ask relevant questions.'

Would Adam recommend other patients to register for online record access? 'I certainly would. I can see appointments and repeat prescription ordering being really useful for most patients and record access useful for those, like me, who need to have more regular contact with their GP. In fact, I've already signed up my partner and my 11 year old son!'

**The GP's perspective**

The GP involved in the pilot, Dr Littlewood, was initially reluctant to share online test results and records with his patients but is now very much in favour.

'At first I was quite nervous about the prospect of patients accessing information that they may not understand, or that they may find upsetting. This all changed when one of my diabetic patients signed up for access. Almost immediately, I could see a positive change. My patient started preparing ahead of his consultation by accessing his latest test results and comparing them to past results. This has meant the 10 minutes we get together is very productive. 10 months down the line, I am even seeing this patient's diabetic controls are improving.'

## 7. Core plus offer

| | |
|---|---|
| **Definition** | The core plus offer should be available to all patients on a registered list but this may be delivered through formal arrangements with other providers within the patient's own practice. |
| **Where are we now?** | There is currently an inconsistency of access, provision and quality of services beyond a basic 'core' offer. Not all of our current enhanced schemes work for practices or provide good outcomes for patients. |
| **What are we trying to achieve?** | Ensuring good access to additional services beyond the basic core offer.<br><br>Ensuring that access to these services is available within a patient's own practice and therefore equitable. |
| **Vision** | Patients in Greater Huddersfield will have equitable access to a range of additional services at their practice. This may be delivered in collaboration with other providers. |

Existing enhanced services are variable in the impact they make on local populations, practices have told us that some schemes do not benefit local patients or work for practices.

Through the opportunities afforded by holding full delegated authority for commissioning general medical services, the current local practice based services and DES schemes will be reviewed and a new 'core plus' offer identified which will support local priorities and benefit patients.

A list of potential core plus services can be found at Appendix 3.

**Funding**

Core plus services will come with an additional funding stream to enable delivery of these services.

## 8. Advanced offer

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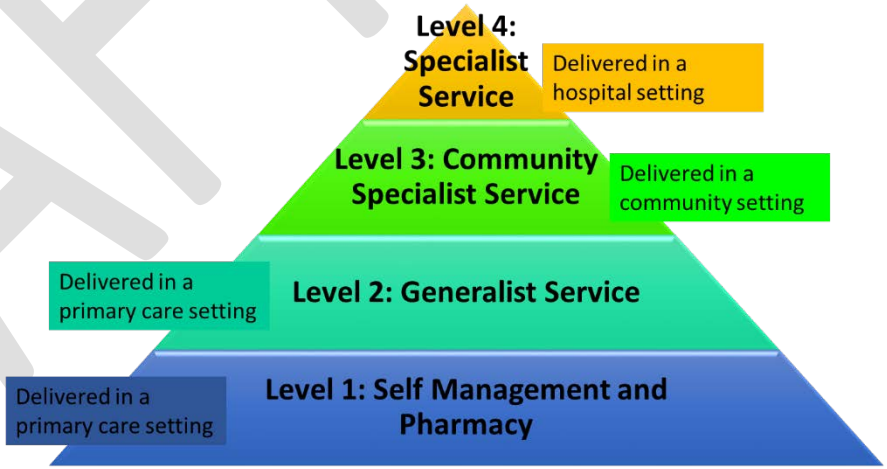
|---|---|
| **Definition** | The advanced offer is composed of services which will be available to all patients in Greater Huddersfield in a primary care setting. There is no expectation of practices to deliver these services, this is optional. |
| **Where are we now?** | There is an under-utilisation of skills in primary care and a large number of low-skilled low-tech interventions are taking place in secondary care which could otherwise be delivered in primary care. There are some existing examples of practices collaborating to deliver advanced services to patients in a primary care setting. |
| **What are we trying to achieve?** | Ensuring services are utilised appropriately and that patients can access appropriate services in primary care wherever possible. |
| **Vision** | Patients in Greater Huddersfield will have access to a wide-range of services closer to home in a primary care setting which are currently delivered in secondary care. This will be delivered through collaboration and partnerships between practices and other providers. |

The movement of planned services out of a hospital setting and into a community setting is in line with the aspirations for Care Closer to Home and as part of the acute hospital reconfiguration programme. It is intended that by 2020 the majority of tier 1-3 planned services will be delivered in a primary care setting where this is clinically appropriate, with collective working between professionals across primary, community and secondary care. Only specialist services will continue to be delivered in a hospital setting. In addition, there is opportunity to move some of these specialist services out into community with a movement of specialist staff from secondary care.




There are a number of services already delivered collaboratively and in a primary care setting, including the anti-coagulation service and the winter scheme to offer additional urgent appointments at weekends and over bank holidays working in hubs across Greater Huddersfield. A potential list of services which could be delivered in

a primary care setting is included at Appendix 3. It is proposed that these are commissioned and rolled out in a phased way.

**Funding**

Advanced services will come with an allocated funding stream to deliver the service to patients in Greater Huddersfield, not to a registered list.

## 9. Workforce

| | |
|---|---|
| **Where are we now?** | There is a national and local workforce challenge. GPs are in short supply and a large proportion of the nursing and practice management and support function workforce are approaching retirement. There are excellent staff within primary care but demand is rising, presenting a challenge to morale and retention of the current workforce. |
| **What are we trying to achieve?** | We aim to create a sustainable, engaged workforce to deliver a new offer in primary care including supporting patients to manage their own conditions, working efficiently whilst retaining a personal service for patients. |
| **Vision** | Greater Huddersfield will be seen as a place of choice to work, providing excellent opportunities to train, develop skills and for career progression for all roles, clinical and non-clinical. General practice will be driven by sustainable and efficient multi-disciplinary teams, led by GPs; ensuring patients receive high quality services delivered at the right time, by the right professional. |

Our focus for workforce and workforce development is:

- **Training the future workforce**

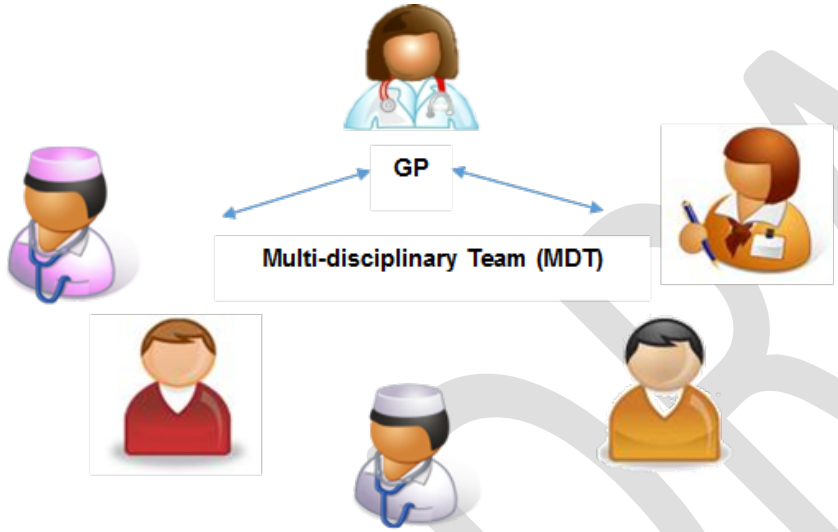
Engagement with practices identified that training and development opportunities are fundamental to the retention of existing staff and attracting new staff, making Huddersfield an attractive place to work. We will work with all ages of children and young people to offer work tasters and work experience within primary care and open the option of primary care as a career within a multitude of roles.

We know that attracting nursing staff in particular to primary care has been limited through the lack of pre-registration opportunities for new trainees before they undertake their training. We can quickly address this working with Huddersfield University and local practices to offer placements and to train nursing staff and Allied Health Professionals (AHPs) within practice as mentors to provide the required mentorship for this scheme. This will in turn provide professional development for those staff trained as mentors.

Fundamental to training the current and new workforce is to deliver lifelong learning and succession planning with opportunities to develop at all levels within primary care supported by proactive talent management. Through collaborative working, there is an opportunity for clinicians with different expertise to work across practices and develop enhanced skills in specific specialisms, creating professional development opportunities for staff, a wider-range of services for patients and efficiency for practices.

- **GP as the 'primary care consultant'**

A fundamental shift will be the role of the GP to one of a 'Primary Care Consultant' acting as a hospital consultant does, coordinating a team of professionals to deliver care to patients, offering clinical leadership and oversight to the team whilst seeing the most complex patients and retaining overall accountability for the care of patients as the accountable lead clinician.




In order to facilitate this, the workforce will expand to include new roles, some of which have already successfully been piloted in Greater Huddersfield (including pharmacists and OTs) creating capacity for GPs to undertake this role and deal with the more complex clinical interventions. Some of these roles are already embedded within other services delivered by partners such as Care Closer to Home, community pharmacy and voluntary and community sector and require closer working with these services to deliver services in a smarter way and achieve better outcomes for patients, ensuring they are seen by the right person at the right time. In other areas this may be specific recruitment of new roles as alternatives to existing roles, particularly where there are recruitment pressures.

**Case Study: Occupational Therapists in primary care**

*Is there a role for Occupational Therapy in Primary Care?*

*Could OT reduce the number of contacts/frequent attenders to GPs?*

Working with University of Huddersfield and two local GP practices, a 70 hour project has looked at these questions. A client group was identified that met the following criteria:

- Over 65
- More than 75 GP contacts per year
- Anxious, isolated, with health conditions impacting on role function and independence.

The pilot project found that:

- There was a clinical role for OT maximising the unique dual training in physical and mental health
- The service was not commissioned elsewhere or duplicating with other roles as these patients' needs were not severe enough to meet the criteria for secondary care or community services
- If OT intervention reduced these attendances by one-third over the year there would be savings to

- **Upskilling everyone**

The focus for primary care is to deliver more wide-range and complex services and manage the increasing demand for traditional services in general practice. There is a recognition by practices locally that many services and interventions are delivered by inappropriately qualified levels of staff for example, patients assessed by a GP who could be better seen by a nurse, Allied Health Professional or pharmacist or patients seen by a qualified member of staff who could be seen by a Health Care Assistant with the right skills and training.

By utilising a competency framework and upskilling staff, it ensures that patients are seen by the most appropriate professional and therefore achieve the right outcomes, capacity is created at the higher levels of qualification and professional, delivering a lower cost-base and creating time for senior clinical staff to lead, mentor and supervise the team and supporting personal development.

This will be supported by ensuring training and development opportunities are available for all roles and levels of staff within primary care and through working with local educational institutions to support learning throughout everyone's career.

It is important to recognise that this approach is inclusive of the wide-range of non-clinical roles within general practice. Practices, particularly our practice managers, have articulated a vision for the future management of general practice in which back-office and administrative functions are shared across practices to deliver economies of scale; requiring consistency of processes across these groups of practices. Operating at scale will also create opportunity for progression and demand for new roles within general practice including business and operations managers to manage integrated Human Resources, payroll and Organizational Development functions. This must be considered when identifying training and development needs.

- **Self-management and patient education**

Self-management is an over-arching ethos of this primary care strategy and fundamental to the core offer. Every professional should be considering how their involvement is enabling a patient to live as independent a life as possible. For the workforce, there will be a culture shift required to ensure that primary care professionals are embedding an ethos of self-management with patients and that this is reinforced at every level. This must be reinforced through training at all levels.

In addition, there will be a need to ensure patients understand that they do not always necessarily need to see a GP and understanding who is the best professional to meet their needs. The findings of the 'Breaking the Cycle' project (see Appendix 1) demonstrated that utilisation rates of roles other than the GP are significantly lower with patients still defaulting to the need to see a GP.

Underpinning this is a focus on reducing duplication with other professionals and making efficiencies within current roles and processes alongside a focus on patient education.

**Funding**

The funding for workforce and for training sits in a number of places; specifically with Health Education Yorkshire and Humber, the Deanery and within individual practice budgets. Practices have already indicated that there may be some opportunities to support

recruitment and training through collaboration and joining of resources between practices. The CCG will support this process and provide a central role in supporting development of initiatives such as the mentorship scheme and ensuring CCG funded training offered via forums such as PPT is targeted to support the priorities within this strategy. The CCG will also look to provide support to schemes which support workforce redesign and development in primary care e.g. the recent OT in primary care pilot, and work with Health Education Yorkshire & Humber and local educational institutions to support the creation of a workforce fit for the future.

**10. Information management and technology**

| | |
|---|---|
| **Where are we now?** | In primary care, technology is not currently being maximised and there is often scepticism or low levels of utilisation of technology. It is often as seen as an additional burden rather than an enabler. Sharing of records is limited by multiple clinical systems and the current equipment and infrastructure is not always of the required standard to allow use of the available innovations. |
| **What are we trying to achieve?** | We want to utilise the systems and technology available to us to maximise efficiency in primary care. We will ensure the foundations are laid through provision of appropriate infrastructure and equipment, training, a shared repository for information and support to migrate all practices to SystmOne. We will utilise these foundations and technological innovation to support patient care and communication with patients and other professionals. |
| **Vision** | Primary care will maximise the use of information management and technology where this directly supports patient care and allows clinicians in primary care to work more efficiently and effectively. |

Technology and systems are a huge part of the healthcare system and a focus for the NHS with the challenge for health and social care systems to become paperless by 2020.

There are some challenges to maximising the use of technology within general practice, however, where developments maximise benefits for patients, practices in Greater Huddersfield have embraced this; we are the national leader in facilitating access to Patient Online. There are five strands to our strategy relating to IT and technology:

- A shared care record underpinned by a single clinical system for general practice
- Infrastructure and equipment
- Training and support
- Patient facing technology
- Shared resources and repository

The diagram (diagram 1) below outlines our vision for IT and technology developments by 2020.

The pace at which technological developments occur must be taken into account and this is one area of the strategy which will require frequent review to ensure it takes account of the developments of the time e.g. cloud based technology, connectivity, security and encryption, and shared portals.

Access to clinical records across professionals is a national and local issue with many systems looking at different ways to tackle the problem. With further collaboration and integration, the need for visibility of patient information is crucial in order to be efficient and effective and manage clinical risk appropriately. Currently across

Greater Huddersfield we have 23 practices using SystmOne and 14 practices using EMIS as their clinical system, with a number of EMIS practices discussing migration; the next due to take place in July 2016. In addition a number of the key partner providers use SystmOne in the local area (including Locala, Kirkwood Hospice, and Local Care Direct as well as other partners using SystmOne viewer). We have reviewed options for system integration including portal solutions and believe that whilst this technology will develop in the long-term, it will not provide the level of visibility and functionality required to give us the most benefit in primary care.

Practices have the option to choose their clinical system under the core contract and this choice will remain. However, the majority of practices (75%) told us that having all General Practices on one clinical system would be beneficial to the whole health and social care system. Our partners have also reflected this as beneficial to integrated and collaborative working.

The benefits of doing this for the system and at a practice level have been outlined below (diagram 2). Whilst practices can continue to choose their clinical system, the CCG will support practices wishing to migrate to SystmOne to do so through project management, training and implementation support. There is funding available through our current budget to migrate practices from EMIS to SystmOne and we have learned valuable lessons from practices which have made the transition recently which can help make the process as smooth as possible with the right support offer.

In support of moving towards a shared care record, we will work to integrate with secondary care systems (EPR).

**Funding**

The CCG has a budget to support information management and technology for general practice which covers equipment, infrastructure, training and other resources. It is clear that some of the aspirations for this strategy will require further investment (e.g. mobile working) and we will continue to seek funding opportunities nationally to support our ambition (e.g. to submit bids for capital and national discussions on converting capital available for technology into revenue streams).

Practices have told us that training and support is fundamental to the best use of IT and clinical systems and there is a commitment to ensuring that this is implemented. To support the strategic intent, the CCG will only provide ongoing IT educational support for SystmOne. Training must be systematic and continuous to gain the maximum benefit.

**Diagram 1 – Vision for information management and technology**

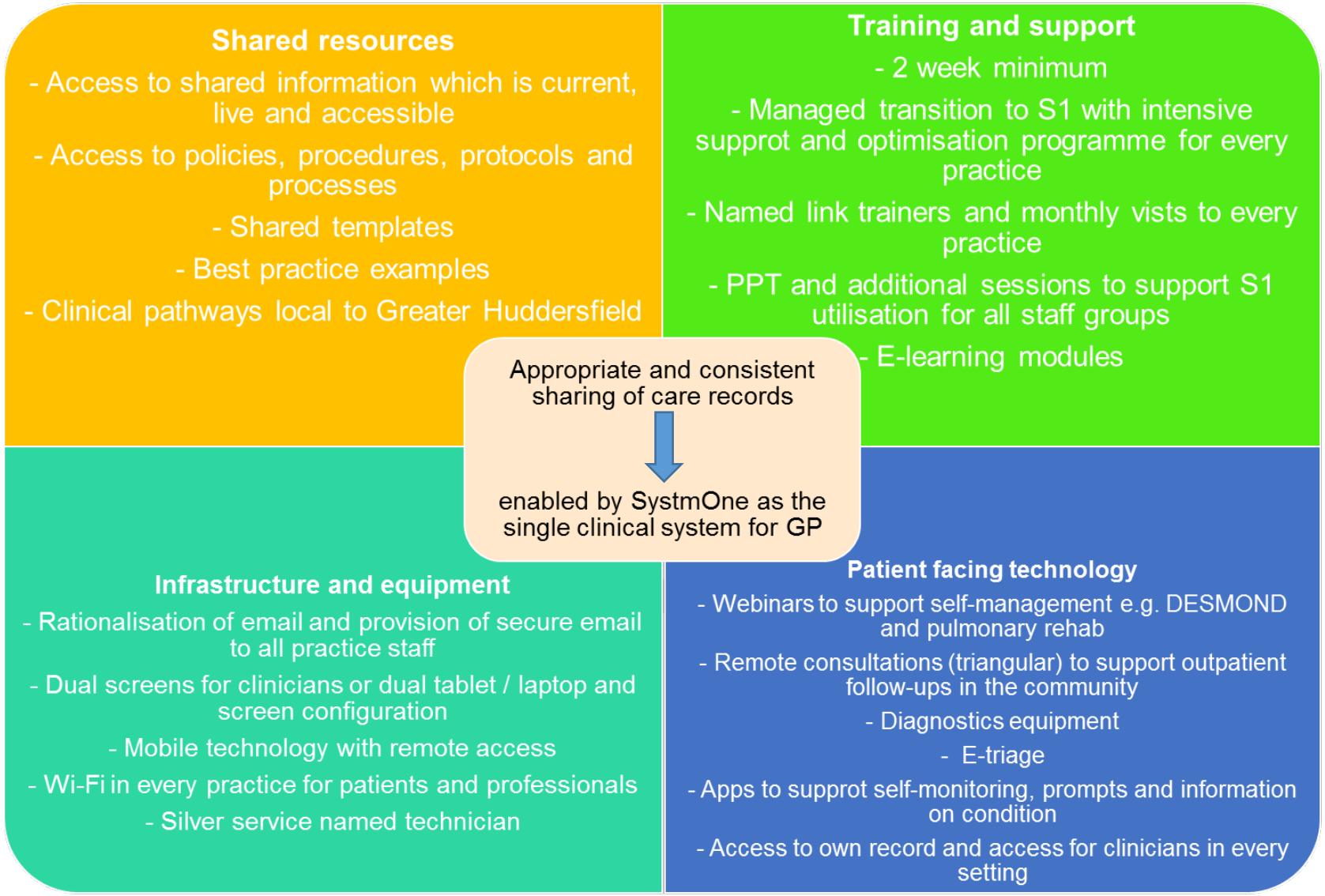


**Diagram 2 - Benefits of all practices moving to SystmOne**

| **Cashable benefits – CCG / system** | **Cashable benefits – Practice** |
|---|---|
| • Recurrent cost savings through running one system e.g. 'spoke' servers for EMIS which can be reinvested into other areas e.g. training<br>• Reduction in costs associated with supporting two systems | • Some 'extras' such as self check-in for EMIS are an additional cost for practices (this would not be a cost for S1)<br>• Using same system as community provider has shown to increase QOF points and financial reward<br>• Removal of costs for back-ups for EMIS |
| **Non-cashable benefits – CCG / system**<br>• Increased visibility of clinical records across providers (efficiency and clinical safety) Locala, Kirkwood Hospice, LCD all using S1 – CHFT, SWYFT and Barnsley FT also using S1 clinical record viewer<br>• Supports more integrated working across providers and practices<br>• A single system will support the national requirement to be paperless by 2020<br>• A single system will enable consistent reporting ensuring better information about the activity and demand in primary care (and better data quality support) and make contract monitoring seamless | **Non-cashable benefits – Practice**<br>• Time-releasing benefits* – using one system, the CCG could support practices by running reports centrally rather than required at practice level<br>• Time-releasing – CCG could centrally support the development of templates and protocols for use by practices<br>• Ability to view interventions of other providers e.g. community, hospice, specialist nurses, MSK and prison service<br>• Ability to work better with other providers and practices collaboratively e.g. hub working to support provision<br>***NB – time-releasing benefits may be converted to cashable benefits** |

**11. Estates**

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|---|---|
| **Where are we now?** | In a number of cases the current estate is not fit for purpose to deliver core essential services and will limit the ability to provide any additional services. There is inequity in the estate which patients access, with some receiving services in purpose-built state of the art facilities whilst others utilise premises of limited size and quality. Some of our estate is not sustainable for future use. |
| **What are we trying to achieve?** | We are aiming to ensure that primary care estate is sustainable and from that create a portfolio of estate within the community which meets the needs of patients and fulfils our ambition for general practice in the future. |
| **Vision** | We will deliver a primary care estate which is fit for the future, geographically coherent and efficiently-funded. |

The CCG has recently completed a strategic estates plan and this has been reviewed to ensure that it responds to the requirements of the full primary care strategy.

In order to appropriately plan our estate, this requires a much longer-term view beyond the next 5 years and operating within the constraints of limited budgets and revenue funding streams to support capital investment.

Our ambition for primary care estate is the following:

- Sustainable, efficient primary care estate in the right place
- A 21st century estate, featuring a new health centre to serve central Huddersfield, funded in the most efficient way, serving the needs of communities with a blend of hospital care and care closer to home
- Prioritised estate development according to greatest need
- Access to a large range of shared, community facilities – enabling integrated activities (including third sector, social care and mental health) to take place as locally as possible
- A network of appropriately located, functionally-suitable GP and community based premises – ensuring that all areas of the community are equitably served – based on need
- A number of appropriately located, functionally suitable health centres/large community clinics (treatment centres) – providing appropriate settings for specialist community based services
- That the Primary Care estate is regarded as a community asset. All sorts of wellbeing related activities are coordinated on behalf of the community. A diverse range of services, medical and non-medical are delivered from these community delivery points.

We are not currently utilising estate to maximum efficiency. For example, we have small practices in close proximity using estate which is not fit for purpose to support provision of core services. There are opportunities such as new shared premises which will

offer more efficient use of better estate for patients and the system and rationalisation of premises over time to improve the overall quality of the primary care estate.

To support the strategy in the movement of services from secondary care to primary care, and the need for greater collaboration with other practices and partners to deliver these services in a more integrated way, our estate will need to be big enough and well-enough equipped to deliver these services.

Our first priority is the completion and review of the six facet survey which will give an up-to-date view of the current primary care estate. There is then the potential to work with other local providers to review our collective estate and identify opportunities for collective working and rationalisation.

**GP infrastructure funding**

The CCG will need to access the GP infrastructure fund available from central government to support development of estate in line with this primary care strategy. The CCG will establish a structure which will ensure all bids and approvals are in line with the ambitions and principles outlined in this strategy and the information on the current primary care estate will inform the prioritisation process.

## 12. Communication and Engagement

Fundamental to successful implementation of this strategy will be engagement with member practices, our partner organisations and patients and carers.

### 12.1. Practice membership

Member practices have been engaged throughout the development of the strategy and this strategy addresses specific themes that have been highlighted. A summary of the feedback gained throughout the development of the strategy has been made available to all practices on the CCG's intranet. The practice membership is vital to the successful implementation of the strategy and a full communications and engagement plan will be developed to support this process.

Practices have told us that they access the intranet but this resource is not utilised to its full potential. We can improve this quickly by sharing more information through the intranet (linked to the IM&T objective to create a shared repository for practices) and highlighting new resources and information through our e-newsletter - "40fied".

Moving into implementation of the strategy, there will be opportunities for practices to stay up to date with and to contribute through the following mechanisms:

- Involvement in work streams and task and finish groups (once these are established for implementation)
- Engagement as more detailed plans develop for each area and the opportunity to shape these
- Regular intranet and 40fied updates
- Designated sessions at Business Meeting and Practice Protected Time.

### 12.2. Wider stakeholders

Building on the initial engagement with partner organisations during the development of the strategy, our approach to implementation will be to review and agree programme governance for implementation and widen the membership of work stream groups and establish task and finish groups with representation from partners where there is opportunity for joint development and implementation.

We will also continue to work with partners on a regional level through the development of the Sustainability and Transformation Plan (STP), our Healthy Futures priorities and the Urgent and Emergency Care Vanguard programme. All of these regional initiatives will have implications and important roles for primary care; we will ensure that these are aligned with, and supportive of, this strategy for primary care in Greater Huddersfield.

### 12.3. Patients and carers

Patients and carers will continue to be involved and engaged through the Patient Reference Group Network and other patient and community groups and forums. We will share our strategy in the public domain and identify where patients and carers can support us with the development of detailed plans and priorities during implementation.

We will continue to have active involvement with patient groups to understand how overall access, use and experience of primary care services is impacted by the implementation of the strategy. Patient

and carer feedback will be crucial to assessing whether the strategy has met the outcomes identified.

## 13. Commissioning and contracting

### 13.1. Impact of full delegation

The CCG received full delegated commissioning for general medical services from NHS England at 1 April 2016. This brings with it, responsibility for the following functions:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action, such as issuing branch/remedial notices, and removing a contract)
- Newly designed enhanced services (local practice based services and DES)
- Design of local incentive schemes as an alternative to QOF
- Ability to establish new GP practices in an area
- Approving practice mergers
- Making decisions on 'discretionary' payments (e.g. returner/retainer schemes)
- CCGs also have the option to pool commissioning and GMS/PMS funding for investment in primary care services

Full delegation requires the creation of a 'primary care commissioning committee' to oversee the exercise of delegated functions. This will be similar composition to the Joint Commissioning Committee in operation during 2015/16 with GP representatives from the Governing body, lay members, and open invitation to the LMC to attend these committee meetings.

### 13.2. Commissioning, contracting and procurement

The core offer will have no impact on current contractual arrangements as the existing contracts will still provide the framework for delivery of core services.

The core plus offer will redefine the current enhanced services and fund local priorities for these schemes which will have attached funding streams. These will largely be delivered to a registered list population so will unlikely require a procurement approach although each will be assessed on a case by case basis. This will be managed through the governance structure to support full delegated commissioning responsibility.

The advanced offer is predicated on delivery of services in a primary care setting to the whole population of Greater Huddersfield and not linked to the registered list. As such, each service will require review to determine the procurement approach required. The phasing of services will be determined through feasibility / market testing where required and timelines linked to decommissioning services where required.

**14. Market development**

There are currently 37 practices in Greater Huddersfield of which 30 are currently represented by one of two GP Federations in the area. Fundamental to the implementation of the strategy and vision and aspirations for primary care within Greater Huddersfield is the ability of a strong primary care provider market to respond at a practice level and more widely as a group of practices or part of a federation. We want to create a market which encourages and enables practitioners and service providers to innovate and work collaboratively.

Our partners have told us clearly that in order to work together, better, smarter and in a more integrated way, economy of scale is crucial. These organisations (large and small) cannot work in 37 different ways with 37 different practices, there is a critical mass which will enable change and thus a mechanism to engage with general practice collectively is required.

A key theme of the engagement work with practices has been the identification of collaboration between practices as the vehicle for change and the mechanism to deliver the vision for primary care.

Any new models of care discussed locally will heavily involve wider primary care and primary care will need the leadership and a strong unified voice to be a partner in this process.

The CCG will provide support to develop the primary care provider market, including strengthening the voice of collaborative general practice through facilitation of federation development.

**Appendix 1 - Case for Change**

**National Policy and drivers**

### The NHS Mandate

The Mandate renews the focus on improving patient outcomes and reducing health inequalities.

### The NHS Constitution

The NHS constitution sets out principles for what patients can expect from the NHS and what the NHS can expect from patients.

### The NHS Outcomes Framework

The indicators in the NHS Outcomes Framework are grouped around five domains:

Domain 1 Preventing people from dying prematurely;

Domain 2 Enhancing quality of life for people with long-term conditions;

Domain 3 Helping people to recover from episodes of ill health or following injury;

Domain 4 Ensuring that people have a positive experience of care; and

Domain 5 Treating and caring for people in a safe environment; and protecting them from avoidable harm.

For each domain, there are a small number of over-arching indicators followed by a number of improvement areas.

### Everyone Counts: Planning for Patients 2014/15 to 2018/19

The five offers as set out in NHS England's planning framework 'Everyone Counts:

Offer 1 NHS Services, Seven Days a Week;

Offer 2 More Transparency, More Choice;

Offer 3 Listening to Patients and Increasing their Participation;

Offer 4 Better Data, Informed Commissioning, Driving Improved Outcomes; and

Offer 5 Higher Standards, Safer Care.

### GP Contract

The GP contract 2015-2016 for England has been negotiated and agreed between the BMA general practitioners committee (GPC) and NHS Employers on behalf of NHS England. Changes to the current GP contract will be implemented over the lifespan of this strategy. Any change or increased flexibility should be fully utilised to help bring about the strategic change that is needed.

### Five Year Forward View

Outlines the vision for new models of care, introducing the concept of vertical and horizontal integration models including primary care – Primary and Acute Care Systems and Multi-specialty Community Providers.

### New deal for general practice

The Secretary of State described commitments to general practice linked to the Five Year Forward View on: a) workforce, b) infrastructure, c), reducing bureaucracy, d) helping to support struggling practices. He also outlined plans to review the way quality of care is assessed in general practice. In return he is asking GPs to work towards:

- Offering appointments seven days a week

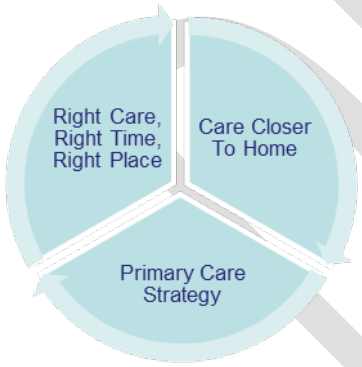
- Assuming social prescribing responsibilities
- Playing a more prominent role in public health
- Taking 'real clinical responsibility' for patients.

**Local drivers**

**Transformation**

Locally, Greater Huddersfield is undertaking three major transformation programmes, of which the primary care strategy forms one pillar with Care Closer to Home changing the way community services is delivered following the procurement of a lead provider and Right Care, Right Time, Right Place, currently at formal consultation stage on how hospital services will be reconfigured and provided in Greater Huddersfield.

It is recognised that all of these programmes are interdependent, if one of these fails to achieve its vision, goals and the required sustainability; all three will fail.




Care Closer to Home identified a vision for a community service wrapped around GP practice, supporting patients through locality teams. Close working between primary care and community services is essential to deliver outcomes for patients and support more care out of hospital settings.

Right Care, Right Time, Right Place focuses on reconfiguration of local hospital services of which several factors will impact upon primary care:

- Delivery of more planned services in a primary care / community setting
- Role of primary care in ensuring unnecessary attendances and admissions to hospital are avoided
- Role of primary care workforce in supporting the proposed Urgent Care Centres.

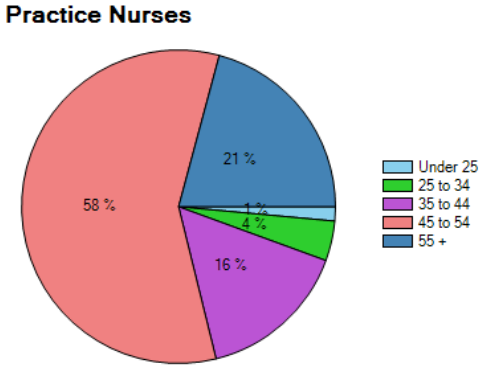
**Workforce**

The national workforce challenge within healthcare and primary care is well documented; in Greater Huddersfield the challenges are no different. We know that:

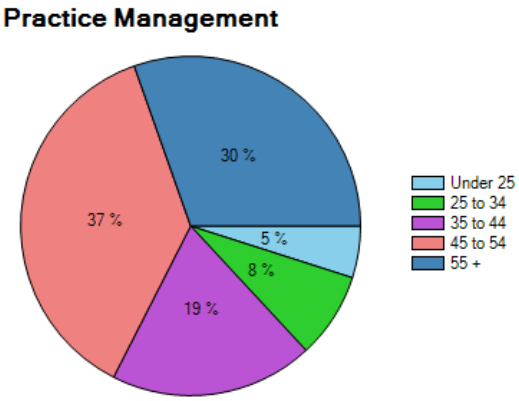
- 7% GPs in Greater Huddersfield are due to retire / leave general practice in the next 12 months (8-9 that we are aware of)
- 21% practice nursing workforce are at risk of retirement (55+) (see graph 1)
- 30% practice management / non-clinical staff are at risk of retirement (see graph 2)

- Health Education Yorkshire and Humber is concerned about workforce supply – not just GPs but also nursing staff and wider roles.

**Graph 1 - Age profile Practice Nurses in Greater Huddersfield, Health Education Yorkshire & Humber**




**Graph 2 - Age profile Practice Management in Greater Huddersfield, Health Education Yorkshire & Humber**




## Finances

Locally, 22 of the 37 practices in Greater Huddersfield are on a PMS contract, currently under review. This is posing some of these practices with a significant financial challenge, whilst other GMS practices are being impacted by the removal of funding through the Minimum Practice Income Guarantee (MPIG).

## Demand, activity and process

There is limited data and information available on the demand and capacity within primary care. During 'Breaking the Cycle' undertaken over three separate 5 day periods during 2015, 32 practices took part in an exercise with partners to look at new ways of working. A full analysis is underway but some key information has been taken from this exercise:

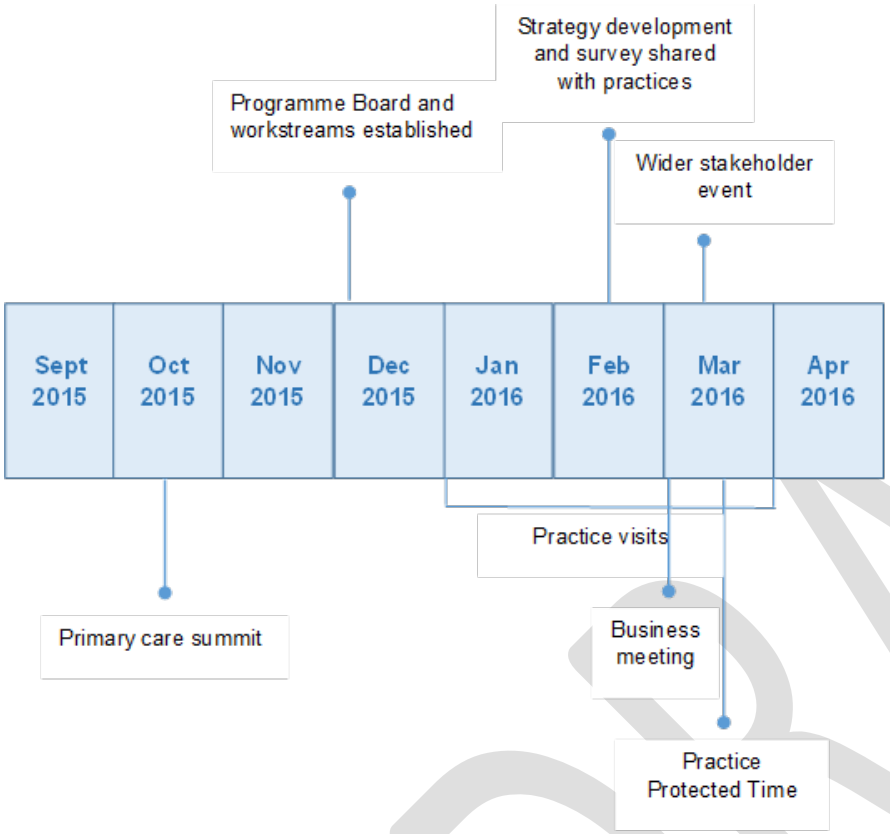
- Over the 5 day period 26 practices received 20,903 telephone contacts
- Approx. 50% were appointment requests

- Across 23 practices there were 3,456 requests for urgent appointments
- There is under-utilisation of appointments of some categories of health professional including practice nurses and health care assistants (see Table 3 below)
- Access to specialist opinions need to be rapid and reliable or the system backs up
- Cross-organisational appointment scheduling would be useful
- Real time information matters
- Soon but not urgent approach could help patients and YAS dispatchers
- A very small number of patients receiving a home visit go on to hospital showing the positive impact of clinicians in keeping people at home
- Utilisation of online booking is extremely low (1.1%) and resulting in a huge amount of time booking appointments by administrative staff
- Practices are willing to innovate and try new ways of working
- There is still inefficiency in process which is impacting on outcomes for patients which can be improved.

**Table 3 - Appointment utilisation rates by role**

| | Available | Booked | DNA | Utilisations | DNA% |
|---|---|---|---|---|---|
| GP/s | 4681 | 3959 | 152 | 85% | 4% |
| Advanced Nurse Practitioner | 1220 | 1011 | 28 | 83% | 3% |
| Practice Nurse | 1781 | 988 | 103 | 55% | 10% |
| Health Care Assistant | 1061 | 368 | 48 | 35% | 13% |
| Phlebotomist | 281 | 63 | 9 | 22% | 14% |
| Telephone Appointments | 71 | 62 | 0 | 87% | |
| Midwife | 40 | 20 | 3 | 50% | 15% |
| FY1 | 20 | 20 | 2 | 100% | 10% |
| Midwife: | 18 | 16 | 0 | 89% | 0% |
| Antenatal | 16 | 13 | 0 | 81% | 0% |
| Minor Surgery: | 12 | 12 | 0 | 100% | 0% |
| Counsellors: | 12 | 11 | 0 | 92% | 0% |
| Registrar | 11 | 10 | 1 | 91% | 10% |
| Health Visitor | 11 | 7 | 0 | 64% | 0% |
| Other - Shared Care | 4 | 7 | 2 | 175% | 29% |
| Other - Child/Minor Ailment | 104 | 0 | 2 | 0% | |
| ENT Outreach Clinic: | 7 | 0 | 0 | 0% | |
| Urology Outreach Clinic: | 10 | 0 | 0 | 0% | |
| Other - Midwife | 1 | 0 | 1 | 0% | |
| Other - OSDC | 1 | 0 | 2 | 0% | |
| Grand Total | 9362 | 6567 | 353 | | |

**Appendix 2 - Engagement**




**Engagement with practices**

Information utilised from practices:

- Practice Protected Time (PPT) (March 2015)
- GHCCG and Primary Care Commissioning, Developing our primary care strategy (July 2015)
- Member Practice Business Meeting (July 2015)
- Practice Managers' Reference Group, Future Management of General Practice (October 2015)
- Primary Care summit (October 2015)
- GP Registrars' session (November 2015)
- Survey to practices (February 2016)
- Member Practice Business Meeting (March 2016)
- Practice Protected Time (PPT) (March 2016)

**Engagement with wider stakeholders**

Session held on primary care strategy development on 3 March 2016 attended by:

- Calderdale and Huddersfield NHS Foundation Trust
- Locala Community Partnerships
- South-West Yorkshire Partnership NHS Foundation Trust
- Local Care Direct
- Third Sector Leaders
- Community Pharmacy West Yorkshire
- Kirklees Council

**Engagement with patients and public**

Patient and public engagement information utilised:

- CC2H stakeholder events (2014)
- Right Care, Right Time, Right Place stakeholder events (2015)
- Patient Reference Group Network (December 2015 and February 2015)

- Primary care engagement with Community Voices (community assets) (December 2015) which included the following groups:

    - The Denby Dale Centre
    - Kirklees Visual Impairment Network
    - Moldgreen United Reformed Church
    - The Basement Recovery Project
    - LS2Y
    - Mencap in Kirklees
    - Support to Recovery (s2r)
    - Volunteers Together
    - Honeyzz
    - PRJM Ltd.
    - Women's Centre
    - One Good Turn Charity MBE
    - Yorkshire Children's Centre
    - Royal Voluntary Service
    - Indian Workers Assn
    - Huddersfield Pakistani Community Alliance
    - Q 4 E
    - Huddersfield Mission



**Appendix 3 – Core, core plus and advanced offer**

**Core offer (list based)**

The key principles and standards for the core offer will be:

- Promote self-management with patients

- All practices will achieve CQC 'Good' standards in all domains, be legally registered and deliver core standards
- Minimum scheduled appointment time for a routine GP appointment will be 10 minutes – this should support preventative and person-centred approaches
- There will no minimum appointment time for practice nursing staff, recognising these will require great flexibility based on the individual patient's needs
- All patients identified and coded as having a long-term condition will be managed to meet the standards prescribed by QOF
- All patients with an identified long-term condition (COPD, diabetes, epilepsy, asthma (requiring regular inhalers / steroids), palliative patients) will have a mutually agreed care plan in place where a patient agrees to take part in developing the care plan
- Treatment should take into account individual needs and preferences, with patients having the opportunity to make informed decisions about their care, with a health professional. If the individual does not have the capacity to consent, guidance within the code of practice supporting the Mental Capacity Act should be followed
- Personal development and an active appraisal system for staff
- Patient experience and feedback should be sought and acted upon
- All practices will have an effective patient reference group

**Access**

The key requirements of the core offer which will address the current issues with inequity of access for patients are:

- All practices should be open from 8am – 6.30pm Monday – Friday
- Access to same day requests, where appropriate, must be available and addressed for patients contacting the practice between 8.30am – 6pm on that day (this will be access to an appropriate clinician but will not necessarily mean a face-to-face appointment)
- Patients living in care homes or nursing homes are included within the delivery of the core offer. The Carr Hill funding formula does account for this but we recognise that additional support and investment is required
- Online access should be available for appointments and prescriptions
- All practices must offer telephone consultation / appointments
- All practices must have a regularly updated website with information sources for patients to access
- NHS Choices should be kept up to date
- Unplanned routine appointments e.g. back pain / minor infection will be provided within 5 working days (this is with an appropriate clinician as determined by the practice)

- Planned routine appointments e.g. reviews are not subject to minimum timescales and should be made as appropriate for the individual patient
- All practices must use the Electronic Prescription Service (EPS) to make available to all eligible patients (noting the opt out on this for dispensing practices, of which there is one in the Greater Huddersfield area)
- All practices will enable their patients to have electronic access to their records (Patient Online)

The services listed have been identified through the development of the strategy and feedback from practices. Core plus and advanced services will be defined and agreed during implementation of the primary care strategy.

**Examples of core plus services (list based)**

The services listed are those commissioned by the CCG and does not include those services commissioned by the Local Authority / Public Health e.g. sexual health and drug and alcohol services.

| |
|---|
| Supporting training and placements for practice staff |
| Enhanced care home provision |
| Enhanced access models |
| Joint injections |
| Ring pessary fitting |
| Providing diagnostics in primary care above core offer |
| Complex leg ulcers and wounds |

| |
|---|
| Ears, Nose and Throat (ENT) GPwSI clinics/ outpatients |
| Enhanced diabetes provision |
| Endometrial biopsy |
| Peripheral vascular disease checks e.g. ABPI measurements and Doppler assessments of legs for ulcers and PVD |
| Minor surgery and some intermediate level surgery |
| Bladder scanning |
| ECG and spirometry |
| Minor injury service |

**Examples of advanced services (not list based)**

| |
|---|
| Dermatology outpatients |
| Audiology / hearing aids |
| Ophthalmology |
| Paediatric outpatients |
| Urology outpatients |
| Vasectomy |
| Mental health services |
| Step-up / step-down provision (consideration as to whether this could be extended to include patients in their own homes with a wrap-around intermediate tier service provision) |
| Cardiology GPwSI service |

| |
|---|
| Respiratory outpatients |
| Rheumatology outpatients |
| Physiotherapy |
| Podiatry |
| Some advanced diagnostic services |
| Anticoagulation above core offer |
| Dementia tier 2 service |
| Full allergy patch testing |
| DVT diagnosis and management service |



**Appendix 4 – Delivery plan**

| Action No | Action | Commences | Complete |
|---|---|---|---|
| CO1 | Assessing baseline of delivery of core services | Apr-16 | Jun-16 |
| CO2 | Develop support offer to practices to ensure every practice can deliver the core offer | Jul-16 | Oct-16 |
| CO3 | Promotion of patient online access - online booking, Patient Online, EPS via T&F group | Apr-16 | Jun-16 |
| CP1 | Review current local practice based services | Apr-16 | Jul-16 |
| CP2 | Commence review of current DES and QOF | Aug-16 | Nov-16 |
| CP3 | Implement new core plus schemes and revisions to locally based practice schemes / DES / QOF | Apr-17 | Apr-17 |
| CP4 | Commence review and assessment and refinement for core plus schemes | Jan-18 | Mar-18 |
| AO1 | Identify priority phase I services to move to or expand provision within primary care setting and subsequent phasing | Jul-16 | Sep-16 |
| AO2 | Identify procurement implications for each service and revise timescales | Sep-16 | Sep-16 |
| AO3 | Plan phase I implementation | Sep-16 | Mar-17 |
| AO4 | Implement phase I advanced services | Apr-17 | Sep-17 |
| AO5 | Evaluate phase I services and identify changes to implementation plan and approach for advanced services | Sep-17 | Dec-17 |
| W1 | Implement HEE competency framework | Sep-16 | Mar-17 |
| W2 | Develop work experience offer for primary care in Greater Huddersfield | May-16 | Sep-16 |
| W3 | Develop mentorship programme to train practice nursing staff to enable placements in primary care | Apr-16 | Sep-16 |
| W4 | Develop self-management support resources and training | Apr-16 | Sep-16 |
| W5 | Develop training opportunities with local university and colleges | Oct-16 | Mar-17 |
| IT1 | Commence planning to roll-out Wi-Fi to every practice in Greater Huddersfield | Apr-16 | Jun-16 |
| IT2 | Initiate task and finish group to support transfer of practices to S1 | May-16 | May-16 |
| IT3 | Commence planning and set-up for shared portal | Oct-16 | Mar-16 |
| IT4 | Develop educational support / training offer for S1 | Jul-16 | Dec-16 |
| IT5 | Review opportunities for bids to support equipment and infrastructure investment | Apr-16 | Ongoing |

| | | | |
|---|---|---|---|
| E1 | Complete six facet survey to understand the current estate in primary care | Apr-16 | May-16 |
| E2 | Undertake baseline exercise to understand the current ownership model in primary care | Apr-16 | May-16 |
| E3 | Identify options for development in central Huddersfield to create access to a quality primary care facility for patients and rationalise existing estate not fit for purpose | Mar-16 | Jun-16 |
| E4 | Create a task and finish group to review all available estate across primary care, community services and secondary care to identify options for rationalisation and facilitation of integrated working | Sep-16 | Mar-17 |
| CE1 | Develop plan to engage with member practices on completed strategy and plans for engagement | Apr-16 | May-16 |
| CE2 | Work with VCS partners to access updated directory of services for community organisations and make available to general practice | May-16 | Jun-16 |
| CE3 | Establish project to improve intranet resources for practices including: information available, intranet icon on the desktop of every practice computer, working with IT work stream to establish a shared repository | Apr-16 | May-16 |



**Glossary**

AHP – Allied Health Professional

APMS contract – Alternative Personal Medical Services Contract

CC2H – Care Closer to Home

CCG – Clinical Commissioning Group

DES – Directed Enhanced Service

GMS contract – General Medical Services Contract

GP – General Practitioner

GPwSI – General Practitioner with Special Interest

HCA – Health Care Assistant

LES – Local Enhanced Service

MPIG – Minimum Practice Income Guarantee

OT – Occupational Therapist

PMS contract – Personal Medical Services Contract

PPT – Practice Protected Time

QOF – Quality and Outcomes Framework



**References**

The following articles and case studies were reviewed during the development of this strategy in addition to the relevant national policy documents.

| **Author / Name** |
|---|
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| RCGP, 'An inquiry into patient-centred care in the 21st century' (2014) |
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| Primary Care Workforce Commission, 'Future of primary care: creating teams for tomorrow' (2015) |
| RAND Europe, New models of primary care to meet the future needs of the NHS: A brief overview of recent reports (2015) |
| Nuffield Trust, 'Transforming general practice: what are the levers for change?' (June 2015) |
| Case studies – Prime Minister's Challenge Fund (Wave 1 sites), Bolton Quality Contract |
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NHS
North Kirklees
Clinical Commissioning Group

# A vision for the transformation of healthcare in North Kirklees

## Primary Care Strategy 2016-2021

"The secret of **change** is to focus all your energy not on fighting the old, but on **building the new**"

Socrates

# Contents



This strategy sets broad parameters for the system as a whole, recognising that there are many contributors shaping the future of primary care in North Kirklees

# Foreword

As the Primary Care Support and Development Team for North Kirklees Clinical Commissioning Group, we are pleased to present the Primary Care Strategy for 2016-2021.

North Kirklees Clinical Commissioning Group recognises and accepts its responsibilities for assisting and supporting member practices and NHS England with a view to securing continuous improvement in the quality of general practice and primary care as a whole.

General Practice has been identified as one of the strategic work programmes for North Kirklees Clinical Commissioning Group's in 2015-16 and beyond, supporting along with a number of other programmes, the delivery of the strategic outcomes and overall vision for North Kirklees.

The Primary Care Transformation Programme very much builds on the arrangements and work already underway to commission improvements in primary care, within the context of General Practice in particular, and the main challenges posed by its pivotal role in delivering and supporting healthcare system reform through the NHS Five Year Forward View, both now and in the future.

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**CCG Governing Body Member**
**Clinical Lead—Primary Care**

**Rachael Kilburn**
**CCG Governing Body Member**
**Practice Manager Lead—Primary Care**

**Jackie Holdich**
**Head of Primary Care**

**Lindsey Bell**
**Programme Lead—Primary Care**

This document will guide and inform the response and future work plans of the Primary Care Transformation Programme plan and should be read in conjunction with:

- Joint Strategic Needs Assessment
- Joint Health and Wellbeing Strategy 2014-2020
- NKCCG Five Year Sustainability and Transformation Plan
- NKCCG One Year Operational Plan
- NKCCG Quality Strategy
- Care Closer to Home Strategy
- Urgent Care Strategy
- Planned Care Strategy
- Estates and Infrastructure Strategy
- Workforce Sustainability Strategy

# Our vision

**Our vision for healthcare in North Kirklees is one of seamless, high quality, accessible care delivered to all patients.**

The challenge for Primary Care in the coming years will be to work in collaboration with the Care Closer to Home and Urgent Care agendas, laying the foundations for total service transformation in line with the objectives of the NHS Five Year Forward View.

By breaking down the old boundaries we aim to deliver patient centred care, regardless of provider. We will explore new and innovative ways of delivering place based care through integrated budgets, designing services to meet the needs of specific geographic populations.

The overall objectives required to deliver the overarching vision for transformation of health in North Kirklees have been identified as:

- **Easily accessible primary care services for all patients**
- **Consistent, high quality, effective, safe, resilient care delivered to all patients**
- **Motivated, engaged and integrated workforce with the right skills, behaviours and training, available in the right numbers**
- **Premises and infrastructure which increases capacity for clinical services out of hospital and improve 7 day access to effective care**
- **Effective contracting models which are fairly and properly funded to deliver integration and positive health outcomes**

We recognise the need to be linked with the community, acute, mental health, social care and public health strategies, so that patient pathways are seamless and the health economy works well together.

"Our Primary Care Strategy is focused around the **care of patients**—the people doctors and nurses enter general practice to serve"

Improving health outcomes and significantly reducing inequalities remain a key focus. Access, clinical effectiveness and patient experience are key components of our direction of travel.

All General Practices will need to have a relentless focus on improving the quality of care to patients, supported by proactive use of data, information and patient feedback. Quality improvement needs to balance and combine external scrutiny and regulation with locally-driven, peer led approaches with the needs of the patient at the forefront.

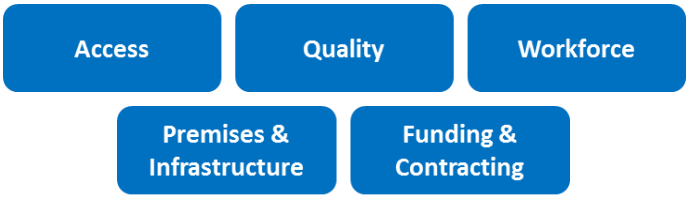
The key to achieving this balance is transparency. Reporting on quality indicators and service improvements to patients, between peers, to other care partners and to commissioners and regulators can help create a culture of continuous quality improvement.

General practice services should be outcome focussed, delivering health improvement and preventive care. By working collaboratively, sharing data on comparative performance, general practices are more motivated to drive each other to improve performance.

North Kirklees CCG member practices need to plan together and deliver together to achieve a better health service and be responsive to the challenge of providing a more efficient service. The CCG will support them to achieve this aim.

The overall objectives listed here stem from the key areas for improvement identified as part of the case for change through engagement with our member practices, stakeholders, patients and the wider public.

Having looked at the array of data available these overall objectives have been distilled into five key themes:



# North Kirklees Primary Care Strategy 2015-2020
## Themes for Action

| KEY THEMES | OVERALL OBJECTIVES |
|---|---|
| 1. Access to care | Easily accessible primary care services for all patients |
| 2. Quality of care | Consistent, high quality, effective, safe, resilient care delivered to all patients |
| 3. Workforce sustainability | Motivated, engaged and integrated workforce with the right skills, behaviours and training, available in the right numbers |
| 4. Premises and Infrastructure | Premises and infrastructure which increase capacity for clinical services out of hospital and improve 7 day access to effective care. |
| 5. Funding and Contracting | Effective contracting models which are fairly and properly funded to deliver integration and positive health outcomes. |

**More details about the objectives and specific projects that will support the achievement of the overall objectives can be found in 'Themes for Action' on pages 14-19.**

# National context

**The structure of the National Health Service and its approach to delivering healthcare is changing. This strategy is produced at a time of continued change, following the creation of Clinical Commissioning Groups (CCGs) which put general practice clinicians at the heart of commissioning healthcare services.**

The NHS Five Year Forward View released in October 2014 outlines objectives around focussing on preventative care, empowering patients and puts forwards a number of new innovative models of care which encourage integration and a patient centred approach to delivery of care across a geographic population.

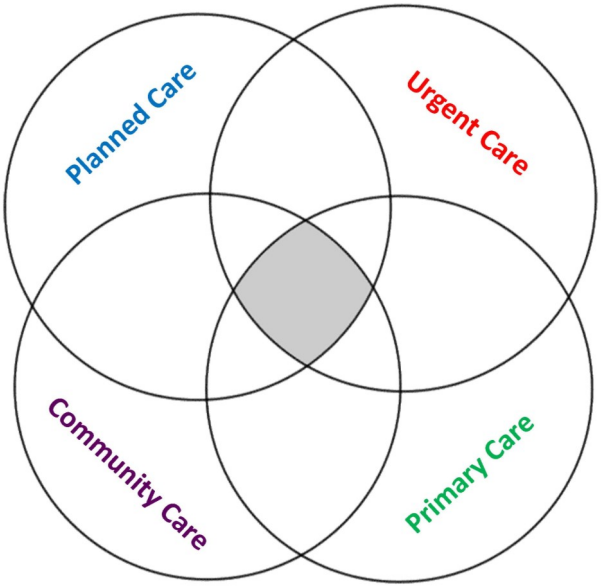
Prior to this the White Paper, Our Health, Our Care, Our Say: a new direction for community services started the process of reconfiguring community based services towards a more integrated model of working and has expanded to include a vision to transfer some hospital based care from the acute sector out into communities. This now forms part of our Care Closer to Home Transformation Programme.

More recently Sir Bruce Keogh published his report 'Safer, Faster, Better' into the transformation of urgent and emergency care calling for an integrated approach between providers and outlined the key role that primary care had to play as first point of contact.

Over the next five years, primary care providers are faced with significant change, new challenges to improve the quality of services provided, develop a highly skilled and sustainable workforce and deliver truly integrated care.

The timing of this strategy is therefore also important to support primary care and enable it to deliver the vision of the NHS Five Year Forward View, meet the governments aims around 7 day access to services and provide assurance that North Kirklees CCG is commissioning excellence in overall healthcare.

"General practice has been at the **heart of the delivery** of primary healthcare in England for decades"

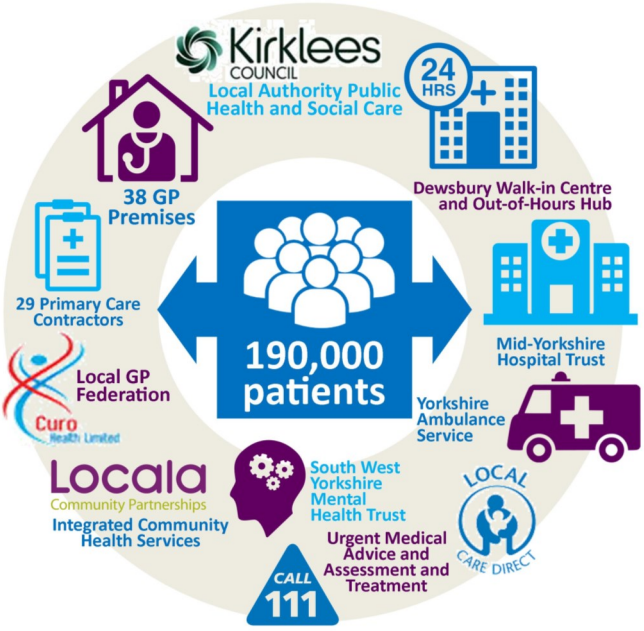



# Local context

**Here in North Kirklees and across the wider region of West Yorkshire there are significant programmes of transformation underway. The challenge going forward is to tie these together so that change becomes embedded.**

The North Kirklees CCG has a central role, working with stakeholder partners, Kirklees Council and NHS England, to ensure that our commissioning responsibilities are met in full. To certify that the care which we commission and provide is of the highest possible standard and quality, we will undertake constant review and scrutiny in order to achieve best practice, making sure we maintain a sustainable, safe and high quality local health service.

General Practice clinicians, our practice teams and our patients play an important role in influencing our strategy and we need to understand how a primary care strategy will affect commissioning decisions for local authority, acute, mental health and community services.



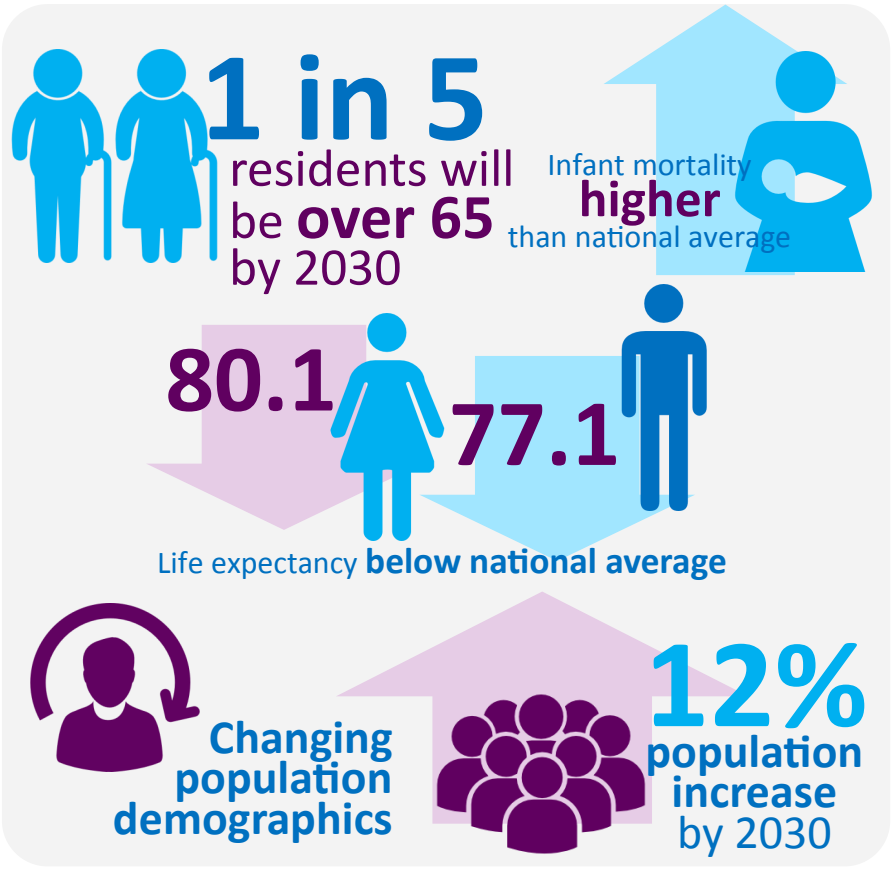

**Urgent Care Transformation**
The overall commissioning strategy for the CCG describes the significant changes being proposed across the Mid Yorkshire health economy through the 'Meeting the Challenge Programme' by consolidating services into specialist sites across the region aimed at improving productivity and sustainability of all health services. In addition to this the acute sector must also respond to the recommendations made in Sir Bruce Keogh's review of Urgent and Emergency Care and NHS England's call for new models of care.

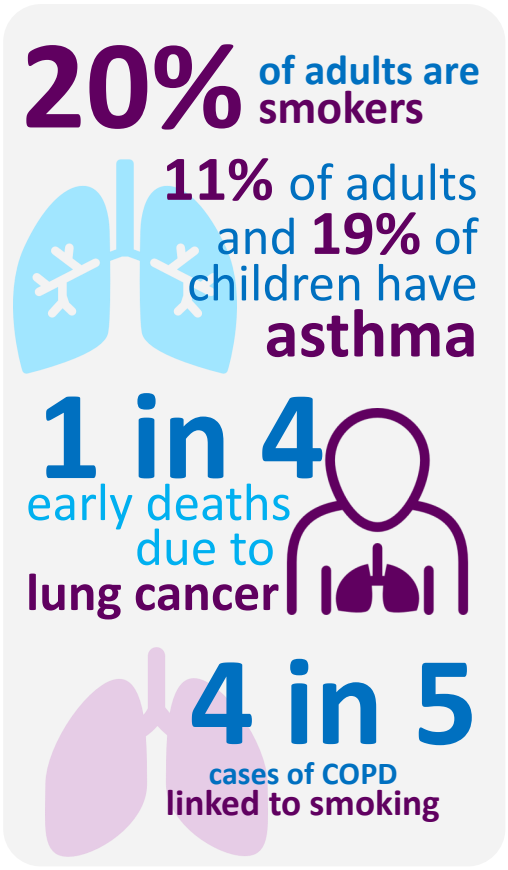
**Care Closer to Home and Planned Care Transformation**
There is a strategic shift of activity planned from hospitals to the community, preventing the need for hospital admission wherever possible. With enhanced integration of services for vulnerable patients, the aim is to ensure that people do not spend any longer in hospital than they need to.

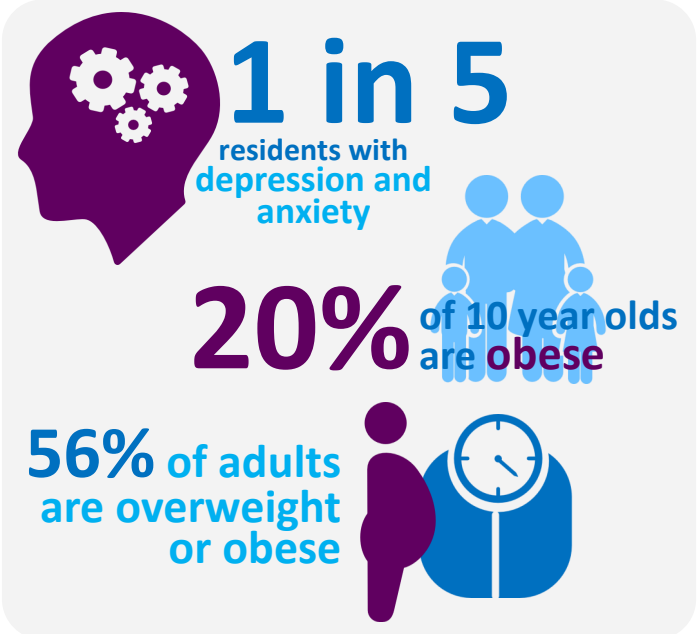
**General Practice Transformation**
North Kirklees CCG believes that general practice provides the foundation for all other healthcare services and that strong and sustainable general practice is crucial to securing health care services in the future. General practice has evolved significantly from its origins. Many practices have been at the forefront of innovation and quality improvement within primary care and the CCG will take the learning from these successes to implement further service improvements into general practice.

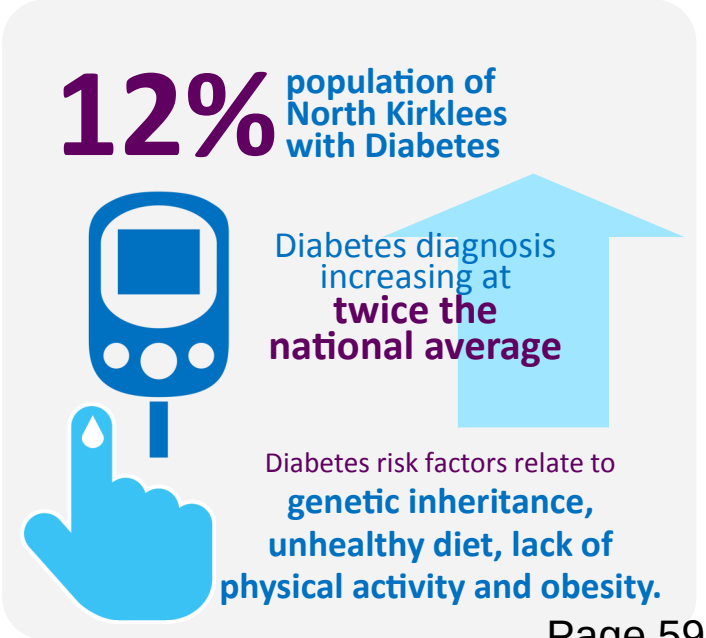
## Health challenges in North Kirklees

**North Kirklees has a population of 190,244 across Dewsbury, Batley, Birstall, Heckmondwike, Cleckheaton, Liversedge, Mirfield and Ravensthorpe. There are many communities with high levels of deprivation within the locality, with factors such as poor education achievement, unemployment, low income, and inadequate housing which increase the challenges of achieving positive outcomes for patients.**



# New models of care

Nationally, there is a growing consensus of the need to enable Primary Care to work at greater scale. New models of care should provide more proactive, holistic and responsive services for patients and some of these have been described in the NHS Five Year Forward View.

**Multi-specialty Community Providers (MCPs)**
While independent GP practices will remain where patients and GPs want that, the RCGP points out that general practice is entering its next phase of evolution. MCPs would provide a wider scope of services, making it possible for extended group practices to form through either Federations, Networks or single organisations and joining with community services to provide integrated care.

**Primary and Acute Care Systems (PACs)**
New contracting forms will allow a new variant of integrated care by allowing single organisations to provide list based GP and hospital services together, together with mental health and the community. This could be led by an Acute Trust or where there is a mature Multi-specialty Community Provider.

"Breaking down the old organisational boundaries, professional behaviours and political beliefs to **focus on what is right for patients**"

One possible result of the development of these new models could be an Accountable Care Organisation through integrated budgets across health and social care services which tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients.

In North Kirklees the view is to allow these models to evolve organically through increasing opportunities for collaborative working and the CCG will work with member practices to ensure that any new models are consistent with our ambitions for high quality, strengthened primary care. We will build on the clinical leadership that exists in our member practices to ensure clinicians are fully involved in decision making and new models of care across three service levels which are described below:

Level 1 – Individual General Practices
Level 2 – Cluster Networks
Level 3 – GP Federation

### Level 1 – Individual General Practices

In the NHS, the main source of primary health care is general practice, providing the first point of contact in the health care system. Primary health care is based on caring for people rather than specific diseases. Therefore, the aim is to provide an easily accessible route to care, tailored to the patient's health care needs. This may mean, continuity of care for frail older people; nurse-led seamless care for patients with multiple long term conditions and urgent access for patients when they need it.

To support this approach, the CCG will look to commission additional services from general practice that will support the role of the accountable GP and improve services for older people and provide additional access to service for patients with urgent medical needs. The CCG will work with practices to support new ways of working that respond to patient needs and benefit the practice in terms of time and skills. This may include different ways of providing urgent appointments, home visits and support to nursing homes in partnership with community services.

### Level 2 - Cluster Networks

Practice list sizes vary in North Kirklees, however, it is recognised that the current demands placed on individual practices is unsustainable and practices will need to work differently in the future to manage demand in new ways.

The CCG will support practices to work together through the cluster networks. This may be 'practice to practice' to encourage practices to provide more services on a locality basis or as part of integrated primary and community health and social care teams. The network will decide what services it wants to provide and how it will operate to deliver patient and practice benefits.

This may include how practices support housebound patients, inter-practice referrals or shared resources to improve outcomes for patients.
Patients have told us they want to see a flexible approach to health care and have greater access to the wider general practice team.

### Level 3 - GP Federation

General practice is largely based around independent contractors serving relatively small populations. It is envisaged that collaborative, general practice led services will go beyond the current scope of GP contracts, providing accessible and responsive out of-hospital care led in conjunction with other practices and provider organisations. Concepts, such as Family Health Networks, Neighbourhood Development Groups etc, describe a model of care whereby most forms of non-acute, non-specialist care are provided at scale by general practice, in the community setting, with GPs playing a coordinating role on behalf of their populations.

Pressures facing General Practice as providers, mean that practices are increasingly working together to share economies of scale. In North Kirklees, all 29 practices have formed a provider federation (Curo Health Limited) which will allow practices to work in a more collaborative way, sharing back room economies of scale and providing a vehicle to offer a wider range of services. The CCG will work with the federation to develop new models of care that provide a greater range of services in the primary care setting, while maintaining quality, efficiency and equitable access for all patients.

# Case for change

**The NHS Five Year Forward View sets out the case for change in healthcare. North Kirklees CCG aims to enable general practice to play an even stronger role at the heart of more integrated out-of-hospital services that deliver better outcomes, more personalised care, excellent patient experience and the most efficient possible use of NHS resources.**

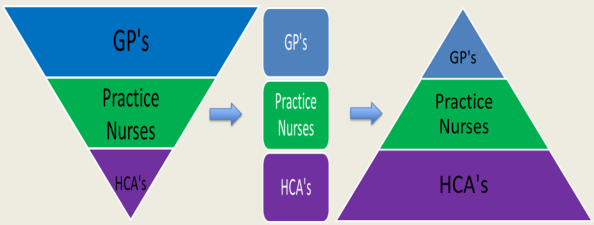
Our vision for transformation in primary care is built upon a compelling case for change with a clear set of reasons for improvement. In developing the primary care strategy, five key themes have been used to underpin our planning activities in the short to medium term and these build on the work already undertaken and the improvements achieved.

**Demand and Variation**
Feedback shows there is still room for improvement when offering a service which is accessible to patients. The increasing level of demand both from an aging population and raised patient expectations means that primary care needs to find new ways of both managing activity, whilst at the same time delivering services in ways that meet patient needs. It is well known that there are limited numbers of GPs available within primary care and so assessing skill mix to make the best use of the skills and expertise available should be a focus. Because there are many different contractors providing services variation is inevitable however primary care providers need to come together to make processes, and pathways more efficient and consistent across the whole of the service.

**Workforce challenges**
Challenges around sustaining a competent and motivated workforce are well documented through evidence from Health Education England's Workforce Audit Tool, and providers feedback around the pressures of recruiting and retaining staff. Added to this, North Kirklees has a significant number of GPs, Nurses and Practice Managers approaching retirement age and struggles as an under-doctored area compared to other CCGs. Staff development and succession planning are areas which need a joined up approach with other local partners to avoid the cycle of staff moving around the healthcare system.

**Premises and Infrastructure**
Whilst North Kirklees is fortunate to have a number of recently built PFI estates there are still some smaller practices in old converted residential buildings which are not fit for purpose. Ensuring that building are well used and fully occupied by the right services is an issue locally. Whilst primary care has 97% unified clinical systems, optimising the use of these systems to support wider access to care, increasing the use of digital systems such as Patient Online and e-consultation to improve clinical to patient and clinician to clinician communication still requires further work.

**Contracting and Funding**
Primary care contracting is complex and not always focussed on outcomes for patients. Providers and commissioners report that implementing, and monitoring contracts across so many providers offers challenges. With the shift of care into the community, effective and properly funded contracts are vital. Integrated approaches which are focused on the needs of the patient and improvements to the quality of care are needed to ensure that different groups of providers work better together.




*Changes to the skill-mix within general practice required to ensure effective distribution of the workload to more appropriate professionals.*

# Engagement

**As part of the development of the Primary Care Strategy the CCG held a number of engagement events with patients, the public, member practices and other local stakeholders.**

Our engagement team worked to undertake patient surveys. Existing data was collated and analysed as part of the engagement process. This included patient feedback from Patient Advice and Liaison Service (PALs) complaints, Freedom of Information requests, GP Patient Survey data and Patient Experience data. The CCG engaged with member practices through a number of different routes including feedback from a Membership Forum, a number of Governing Body development sessions, via the GP Federation and through a specially arranged Primary Care Summit. The comments gathered from this engagement activity included:

**General access to services**
Patient wanted more flexibility around opening hours and access to appointments outside of core hours, this was particularly important to working patients. Extended access to both same day and pre-bookable appointments was indicated. Patient surveys reflected a desire for increased access on Saturdays for routine care but the majority felt that most weekend appointments should just be for urgent medical needs. GPs felt that improving access to core primary care services would have positive impacts for patients.

**Networking practices to improve access**
For urgent appointments, patients were happy to see another clinician other than their own named GP and were willing to travel to other practices if necessary. For routine appointments patients were less likely to travel for an appointment and felt that where the patient was elderly, vulnerable or had a long term or complex condition, continuity of care and the reassurance of their own practice was important. This was also reflected in the comments from clinicians relating to more collaborative working.

**Use of effective signposting and triage models**
The use of a triage system whereby a healthcare professional could assess their needs and signpost them to the most appropriate service was seen as acceptable by patients. It was made clear though, patients preferred that triage be done by a healthcare professional and not a receptionist. Patients were happy to speak to their GP or a health professional via telephone but improvements would need to be made to any call back systems. The use of clinical triage was supported by clinicians and had been successfully used by some practices.

**Better use of online services**
An overwhelming number of patients reported that their practice had an appointment system where they had to ring at 8:00am to get an appointment which did not work and was frustrating. Patients wanted to be able to ring up or go online at any time to book appointments in advance.

Patients already using online services were keen for these to expand to include appointments with other health professionals. There was a general lack of awareness though of online services with both patients and primary care staff about what these could do and that these services are available via a phone app. Some patients and clinicians were not yet comfortable with the use of email or video consultations as they felt it may take longer than a phone consultation however they did suggest video consultation could be useful for patients requiring pre-booked reviews. These views were supported by GPs through a desire to make better use of technology generally.

**Provision, quality and information about services**
Patients were keen to see a wider range of services provided via their GP Practice such as physiotherapy, counselling, social care and hospital based services. They would be happy to access these services at another practice although concern was expressed again over the accessibility for vulnerable patients.

**Patient education**
A key message that came across from both the public and staff was the need for patient education both on the services available and how and when to access them. It was commented that information about different healthcare professionals and their roles would support patients to understand which clinicians to choose or why they had been signposted to particular clinicians.

# Themes for action overview

**The CCG Governing Board members are key to supporting the delivery of this strategy, by using their clinical expertise, skills in leadership and the co-operation of the member practices and health and social care partners to effect change.**

The delivery of the strategy will help address the challenges and opportunities presenting in shaping the local NHS in North Kirklees. The strategy will succeed with the clinical ownership by North Kirklees GPs and working in conjunction with Kirklees Council and other health partners.

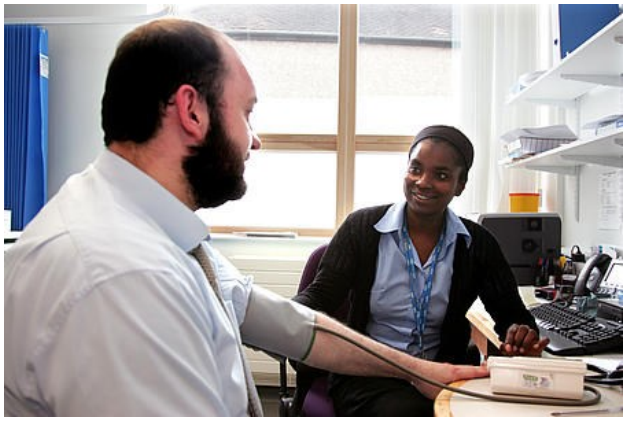
The strategy proposes several key objectives that are focussed on what North Kirklees CCG and its member practices need to plan and deliver together.

The need to have a proactive approach to planning and delivering health and social care services is vital, now more than ever. Our aim will be that we not only focus on developing preventative care pathways which ensure patient's are given the right care, at the right time, by the right person but also to think more medium and long term rather than only focussing on short term solutions.

We will encourage input, feedback and views from a wide range of stakeholders across the North Kirklees health economy and patient representatives, as part of our commitment to maintain continuous engagement with our member practices and health and social care partners.

We will publish an equality impact assessment on any proposed changes and the comments and views on specific issues will help to shape the final proposals for general practice transformation throughout the coming years.

"Primary Care is at a critical juncture. Whilst seen by the Government and NHS England as **the 'foundation' for the future delivery of healthcare** there are a number of significant challenges that must be overcome."



# THEME 1—Access to care

## Easily accessible primary care services for all patients in North Kirklees.

**CORE ACCESS**
Easy access to same day and pre-booked appointments within core hours Monday-Friday 8:00am-6:30pm at all GP Practices

**OVERNIGHT ACCESS**
Easy access to urgent medical advice and/or treatment 8:00pm to 8:00am 7 days a week

**EXTENDED ACCESS**
Easy access to same day and pre-booked appointments during extended hours from an efficient delivery model

**DIGITAL ACCESS**
Increased uptake of digital access to services via Patient Online, email and video consultation and tools to support self care.

Patients should be able to easily access routine general practice services from all providers during core hours, Monday-Friday 8:00am-6:30pm. Achieving this outcome is seen as a key enabler to deliver other parts of service transformation such as the Keogh recommendations around urgent care. By ensuring there is sufficient same day capacity within primary care this will allow patients to go to their GP as a first point of contact. We will also be looking at the quality of access available to patients not only the quantity.

The CCG wants to ensure that there is appropriate extended access to primary care services beyond core hours. This will support the Government's agenda on 7 day access to GP services. The CCGs view is that, whilst taking in to consideration patient's views on convenience, extended access to both urgent and routine care should be delivered from a model which is both efficient and accessible such as a hub and spoke model. A collaborative approach to service deliver also offers added resilience to smaller practices who struggle to offer extended services and will be implemented through collaborative working with the Care Closer to Home programme.

Rapid response to urgent medical needs and professional clinical advice should be available to all patients within North Kirklees 24 hours a day, 7 days a week. The challenge moving forward is to integrate and simplify services in a way which enables patients to understand where and how to access care when they need it.

In order to support wider access to primary care, adoption of digital ways of working will be promoted. This includes digital access to appointment booking, prescription ordering and medical records, digital consultations via email and video as well as encouraging patients to manage their health and wellbeing through easy access to advice and self care tools.

Demand is currently restricted in some cases by poor access, so management of the inevitable increase through increasing capacity is absolutely key if it is to remain sustainable.

Prevention, self care, meaningful chronic disease management and a comprehensive system of educating and empowering patients would all be part of this. Monitoring changes in demand and capacity will provide evidence to support any changes to service provision.

### Samira's Story

Samira is a 30 year old mother of 3 who is normally fit and well. On Friday morning as she was getting ready for work she developed an itchy rash near her right eye and is extremely worried that it might spread. She contacts her GP practice on Friday afternoon after finishing work as an early years teacher at the infant and primary school just around the corner.

Her GP practice offers her a telephone consultation with a GP on the same day, and Samira agrees. At 3:40pm she is contacted by a GP and is given advice on how to manage the rash.

She is still extremely worried and would prefer to see someone in person in spite of the advice given. Samira is offered a face to face appointment with and Advanced Nurse Practitioner at 7:30pm that day but with a neighbouring practice.

Although not her own practice, Samira accepts the appointment as the clinician will be able to see her medical records happy to attend and just wants to be seen and re-assured.

# THEME 2—Quality of care

## Consistent, high quality, effective, safe care delivered to all patients.

**CONSISTENT CARE**
Reduce or eliminate variation in the quality of core services across all practices.

**EFFECTIVE CARE**
Improved performance in patient reported outcome measures such as GP Patient Survey, satisfaction surveys and Friends & Family Test.

**HIGH QUALITY CARE**
Above threshold/national average performance in key quality areas such as QoF, CCG Outcome domains.

**SAFE & RESILIENT CARE**
Reduction in number of Patient Safety Incidents and increased use of Event Reporting Systems.

Our vision is that general practice providers will consistently provide high quality, accessible, safe and resilient care, as evidenced through appropriate assurance systems. This may include regular capacity and demand audits, Primary Care Assurance Tool, Primary Care Quality Matrix to demonstrate year on year improvements.

Overall quality of services will be assessed in conjunction with the CCG's Quality Strategy. The production of transparent, publicly available benchmarking data will allow patients and the wider public to see and provide feedback on the performance of local services.

All providers will be expected to participate in incident reporting to improve patient safety outcomes and be engaged in peer review to support a culture of continuous improvement. Practices should include advice, engagement and support from a wider clinical peer group across the health and social care system delivered through improved digital working such as web-conferencing, virtual meetings and e-consultation.

Working in collaboration with Care Quality Commission and NHS England, the CCG will ensure that all providers meet with contractual and regulatory requirements. An open approach will be adopted which encourages shared learning with examples of best practices from providers.

The CCG will encourage co-operative working between providers, community healthcare services and public health teams to deliver proactive, preventative, holistic and integrated services. This will mean that patients will be assured that their care and treatment in general practice is delivered to the same high standards regardless of which practice they are registered with and they can easily compare their service to others in North Kirklees.

### Doris' Story

Doris is 85 and suffers from hypertension, diabetes and arthritis. Her general health has been declining since her husband died three years ago. She hasn't been able to get to her doctors surgery for a blood test in a while as she does not have transport. Her GP surgery recently started to work with other neighbouring practices to offer routine care on Saturdays. Doris gets her son to take her to see a diabetes nurse who is shared between all the practices.

The nurse sees that Doris is struggling to manage her diabetes and often finds all the medication she is taking confusing. The diabetes nurse sits down with Doris and works out a treatment plan for her diabetes with some realistic goals around improving her mobility. To support her to achieve these the nurse refers her to the 'Better in Kirklees' social prescribing hub who arrange for her to join a local AgeUK exercise club and even arrange for a befriending service to drive her to the club.

The diabetes nurse also arranges for a care co-ordinator to visit Doris at home. The care co-ordinator talks with Doris about the different long term conditions she has, the medication she is taking and how to take it properly.

At her next appointment her diabetes is much improved, she feels more confident and happy as she is getting out more to the club. She has even made some new friends from the club who go for lunch together each week and her hypertension is also better after the care coordinator showed her the right way to take her tablets and why it was important.

# THEME 3—Workforce sustainability

## Motivated, engaged and integrated workforce with the right skills, behaviours and training, available in the right numbers.

**INTEGRATED WORKFORCE**
Integrated teams with GPs at the core, using a range of skilled professionals to deliver appropriate clinical care.

**EXTENDED WORKFORCE**
Use of non-clinical professionals, community and voluntary and patient groups to support recovery, self care and independence.

**MOTIVATED & ENGAGED WORKFORCE**
Staff who feel valued, involved and empowered to improve themselves, their colleagues and the services they work in.

**COMPETENT WORKFORCE**
All staff have clear career progression and remain competent and resilient through opportunities for professional and personal development.

**SUSTAINABLE WORKFORCE**
Roles which are sustainable through internal staff development and robust proactive succession planning.

**CHALLENGED WORKFORCE**
Staff are encouraged to innovate and improve through a culture of continuous learning, research and teaching opportunities.

Primary Care workforce is changing. We need a plan to ensure that we have a workforce to deliver this strategy. General practice workforce requires modernisation, still based around the GP practice holding responsibility for the care of its registered patients but with a stronger population focus and an expanded workforce. It will be important to support these changes through training, education and opportunities for professional and personal development.

A separate strategy will be developed which will focus on the four R's of sustainability; *recruitment* of new staff, *retention* of existing staff through expanded, enhanced roles and clear career development, *returning* staff to the workforce and *replacing* some roles with different ones to allow a more effective workforce.

We see the need for a modern, integrated general practice team which has the GP at the core but blends different skilled health and social care professionals together to ensure that patients are treated by the most appropriate person to meet their needs. This holistic approach will also look to utilise the skills of voluntary and community sector staff.

The CCG will address the need to embed general practice succession planning with a high proportion of practice staff approaching retirement. Staff development should be a high priority for all general practices.

"Only **29%** of GP Trainees want to become contractors or GP partners. Flexibility and work-life balance is a key consideration"

### Dr Smith's Story

Dr Smith has been a GP for 15 years. He has been struggling under the pressure of ever increasing demand from patients. Through collaboration, he and his four neighbouring practices have joined together to form an operational network. Patients from all five practices can access extended hours care up to 8pm on weekdays through a hub practice with access to shared medical records.

The practices have also agreed to share staff providing much needed nursing input around diabetes which his own nurse was not trained in. In exchanged for 1 day of ANP time from a neighbouring practice. Dr Smith is now able to offer a Dermatology clinic for all patients in the network, a skill which he had little time to use previously. The network also employs a full time Clinical Pharmacist who amongst many other things, responds to acute medicine requests, reviews patients on complex medication regimens, completes medication reviews with patients and processes prescription medicine requests in outpatient and discharge letters.

# THEME 4—Premises and infrastructure

## Premises and infrastructure which increase capacity for clinical services out of hospital and improve 7 day access to effective care.

To deliver the ambitions of primary care it is essential to have estates and infrastructure which are fit for purpose to deliver effective general practice services. Infrastructure including technology should support staff to deliver care in an efficient way. Premises, infrastructure and technology should support digital working, clinician to clinician interfaces and clinician to patient interfaces. To support this the CCG will look for unified clinical systems and integrated communications platforms.

The key to this will be to work with other partners for example the local authority, practice landlords and NHS Property Services to maximise premises within communities. The aim should be to deliver flexible multi-use premise that are adaptable to service needs and look for innovative and collaborative projects for health and social care provision.

The CCG will work in collaboration with local public sector partners on a proactive Estates and Infrastructure Strategy. To strengthen workforce development, premises and infrastructure should support a culture of teaching, learning and development for both staff and patients. An educational focus within estates will be key to this.

Infrastructure and technology should support patients to be involved in managing their own health and wellbeing and decisions about their care through information, advice and engagement.

### Terry's Story

Terry is 48 and works as a mobile breakdown mechanic for a small company in town. Terry is working longer hours than ever and having to cover a greater area. He feels like he is only home to sleep and then back out to work, free weekends are becoming less frequent. He is concerned that the extra stress is affecting his blood pressure. He does not have time to make an appointment with his GP surgery due to his unpredictable job.

His surgery uses a health pod in the reception area. Terry is able to pop in when he is free on his way home and take his own blood pressure. The pod is linked to his medical record. Terry's blood pressure is a little high so he calls the surgery the next day to speak to the GP over the telephone. His GP can see Terry's BP reading from the previous day and is able to offer him some advice without the need to come in to the surgery.

**ADAPTABLE INFRASTRUCTURE**
Purpose-built, flexible, multi use, premises which are adaptable to changes in services, capacity or demand.

**DIGITAL INFRASTRUCTURE**
Effective and efficient digital working which supports clinician to clinician and patient to clinician interfaces.

**EDUCATIONAL INFRASTRUCTURE**
Premises which support a culture of teaching and learning both for healthcare professionals and patients.

**WELL UTILISED INFRASTRUCTURE**
Integrated, multi occupancy premises which include a range of providers and services but with sufficient room for future growth/expansion.

**PLANNED INFRASTRUCTURE**
Pro-active estates and infrastructure plans , well managed which link whole health and social care systems.

**HEALING INFRASTRUCTURE**
Premises and infrastructure which support staff and patients wellbeing, relieve stress and support recovery.

**EMPOWERING INFRASTRUCTURE**
Premises and infrastructure which supports patients to manage their health and wellbeing and be involved in decisions about their care.

"**Four** out of **10 GP practices** felt their current premises were not suitable to deliver services to patients"

**BMA GP Survey 2015**

# THEME 5—Funding and contracting

## Effective contracting models which are fairly and properly funded to deliver integration and positive health outcomes.

In starting to explore how we can influence real transformational change in general practice across North Kirklees we need to consider some key principles, the main one being that "no work is moved without proper resource being moved with it" – i.e. workforce or finances. Member practices have already identified several key principles and areas which will form priorities in terms of service change throughout 2015-16 and beyond. These are:

- Supporting true equitable funding for core service provision across all general practice providers.
- Contract models which facilitate integration of services or close collaborative working.
- Proactive management of workload shift from secondary care to primary care, properly resourced and planned
- Effective contract management of all providers to ensure performance and activity levels remain affordable ensuring that poor performance does not negatively impact on other parts of the healthcare system
- Streamlining and simplifying enhanced service contracting and management based on improved health outcomes.

The introduction of co-commissioning is seen as a key enabler allowing the CCG an opportunity to take more strategic control over general practice budgets, thereby retaining any efficiency savings within primary care for future investment.

The purpose of this is not only to support further improvements to quality in general practice but also to provide additional investment where possible ensure the long term sustainability of general practice services in North Kirklees.

"**90% of patient contacts** in the NHS happen in primary care for only 8% of the total budget"

The aim should be the integration of all budgets both local authority, health and social care through either a multidisciplinary community provider (MCP) or primary and acute care system (PACS). One possible future could see the formation of an Accountable Care Organisation allowing for placed-based budgets, which truly deliver cradle to grave services for the entire population.

**PLANNED CONTRACTING**
Proactive management of activity shifts out of secondary care to ensure movement is properly planned and resourced.

**PROACTIVE CONTRACTING**
Use of co-commissioning to take strategic control of primary care budgets enabling new/enhanced service development.

**OUTCOMES-BASED CONTRACTING**
Simplified and streamlined contract and funding models which are easy to understand for providers and commissioners and are based on outcomes.

**EFFECTIVE CONTRACTING**
Effective contract management through prioritisation and sustainability to ensure performance and activity levels remain affordable.

**INTEGRATED CONTRACTING**
Contract models which facilitate close collaborative working and integration of services through place-based commissioning.

**FAIR CONTRACTING**
True equitable funding for core service provision to reduce variation between providers.

### Abigail, Practice Manager's Story

Abigail struggles with her role as Practice Manager, to reconcile all the different service payments the practice is due for the work it does beyond the core contract. Historically her practice was not as well equipped at negotiating as some others in the CCG and so finds wide variation between what she and her neighbouring practice receive for the same work. With an integrated primary care contract all additional services provided to registered patients are linked together as a single payment which is the same for every practice delivering the services making it much each for Abigail to and the CCG to process., leaving time to spend on improving the services in the future.

# Enablers to support transformation

## Co-commissioning of primary medical services

On 1st May 2014, Simon Stevens announced new opportunities for CCGs to co-commission primary care services in partnership with the NHS England. The NHS Five Year Forward View describes primary care co-commissioning as a key enabler in developing seamless, integrated out of hospital care based around the diverse needs of local populations. It will also drive the development of new models of care such as multi-specialty community providers and primary and acute care systems.

There are three models that the CCG could take forward:

**Level 1** - Greater involvement in primary care commissioning
**Level 2** - Joint commissioning
**Level 3** - Delegated commissioning

Co-commissioning would allow us to create a joined up, integrated out of hospital service for our local population with primary care leading and shaping the desired model. Helping to drive the development of an MCP model described by Simon Stevens 'Five Year Forward View', and building around groups of GPs combined with nurses and other community health services, mental health and social care.

The focus would be on a holistic, integrated approach to the individual and would be built around populations aligned with community and social care services. Co-commissioning is seen as an opportunity to collaboratively develop solutions around workforce, including exploring new models of working across health, for example Physician Assistants. Examples include supporting GP access arrangements and exploring seven day working by collaborative working.

Co-commissioning would allow the CCG strategic control of the primary care budget to protect and invest resources in response to healthcare challenges and advances in technology through a sustainable and resilient model. For example, digital working, such as video consultations, telemedicine and other solutions which would support general practice to work more effectively.

In January 2015, the CCG Member practices voted in support of the CCG to commission Level 1 - greater involvement in primary care commissioning for 2015/16. In October 2015 member practices again voted to remain at Level 1 - greater involvement in primary care commissioning.

"Transforming primary care needs to **maximise the use of enablers** available to shape a healthier future for patients and lead the out of hospital agenda."

**Clinical Leadership**
The CCG Governing Board members are key to the delivery of this strategy, by using their clinical skills, skills in leadership and the co-operation of the GP membership and health and social care partners to effect change. Every GP, Practice Nurse and the extended primary care team are essential to effecting positive outcomes for patients.

In addition, the CCG will work with individual Clinicians and the Membership board to strengthen clinical leadership within the CCG:

- Clinically led Peer review to promote individual learning through best practice
- Improved relationships with secondary care clinicians through Clinical Networks and pathway redesign

**Patient Education**
Throughout all the transformation programmes underway, patient education is seen as the core. Education empowers patients and puts them in the heart of services. It is about designing and delivering health and social care services in a way, which is inclusive and enables residents to take control of their health care needs. An empowered activated patient:

- Understands their health condition and its effect on their body.
- Feels able to participate in decision-making with their healthcare professionals
- Feels able to make informed choices about treatment.
- Understands the need to make necessary changes to their lifestyle for managing their condition.
- Is able to challenge and ask questions of the healthcare professionals providing their care.
- Takes responsibility for their health and actively seeks care only when necessary
- Actively seeks out, evaluates and makes use of information.

Empowered patients will better understand how to navigate between the many sectors in the healthcare system. When unsure about where to go or what to do next, the empowered patient will feel confident to ask for the information they need.

# Monitoring and evaluating

**Having the right governance and implementation structures in place to support achieving the objectives that will deliver our vision for general practice in North Kirklees is vital.**

Recently the CCG underwent an external review of its governance processes and a number of recommendations have been made.

To ensure that general practice is transformed in a way which ensures integration with the other key service transformation programmes around Care Closer to Home and Urgent Care an overarching governance structure has been proposed. This would integrate the existing Primary Care Strategy Group with the CCGs Clinical Strategy Group to offer a more holistic view of transformation. It was also felt that a working group aligned to each of the five key themes would be required to deliver real impact in these areas ensuring that the objectives outlined previously were being addressed.

By feeding back into the overarching governance structure the challenges faced in each of the five working groups can be looked at in conjunction with other projects running in the co-dependent transformation programmes. This is because many of the issued faced are similar across the three programmes.

The new structure highlights the view that in order to affect change, transformation must be delivered from the bottom up. The involvement of general practice contractors through the four cluster networks and the GP Federation will engage member practices so that they are able to take ownership of areas of work, get involved with trialling new ways of working themselves and support the development of grass roots innovation.

In addition to aligning a key theme to a cluster we are proposing that Clinical Leaders working in the Planned Care Transformation Programme identified in our commissioning intentions, are also able to work with an identified cluster of practices. Service development and pathway redesign can then be reviewed by local clinicians and have the benefit of wider input with member practices.

Clusters should take the lead in developing and supporting commissioning plans from the ground up, work on specific national and local performance areas where appropriate and collaborate with practices to provide a test bed for future service improvements.

# Acknowledgments

The CCG would like to thank the following people, groups or organisations for their input and support in developing the Primary Care Strategy:

North Kirklees CCG member practices
North Kirklees CCG Governing Body members
North Kirklees CCG Senior Management Team
Jackie Holdich, Head of Primary Care, North Kirklees CCG
Helen Severns, Head of Transformation, North Kirklees CCG
Lindsey Bell, Programme Lead, Primary Care
Deborah Turner, Head of Quality North Kirklees CCG
Kirklees Local Medical Committee
Healthwatch Kirklees
The patients and public of North Kirklees
North Kirklees Patient Reference Group
Kirklees Council
Locala Community Partnerships
Mid Yorkshire NHS Hospital Trust
South West Yorkshire NHS Foundation Trust
Kirklees Community Partnerships
Health Education England—Yorkshire & Humber
NHS England
Curo Health Limited

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**KIRKLEES HEALTH & WELLBEING BOARD**

**MEETING DATE: 28 April 2016**

**TITLE OF PAPER: Kirklees Joint Strategy for Older People's Care Homes**

## 1. Purpose of paper

The Kirklees Joint Strategy for Older People's Care Homes, has been jointly developed between Kirklees Council, North Kirklees Clinical Commissioning Group and Greater Huddersfield Clinical Commissioning Group. It outlines the shared approach that these three partner organisations will be taking to the ongoing development of care homes for older people within Kirklees.

## 2. Background

The attached strategy has been written in response to the difficulties currently being experienced within the older people's care home sector, both in Kirklees and across the country as a whole.

It has been jointly developed by commissioners in the Council and the two Kirklees Clinical Commissioning Groups (CCGs) in order to:

- clarify our shared vision for the role of care homes within Kirklees, now and into the future;
- recognise the role that care homes play in supporting older people;
- jointly agree actions that are needed to address the current pressures within the older people's care home sector.

It should be read in conjunction with the Council's Older People's Accommodation Strategy (referenced in the document) which takes a wider view of the accommodation needs of older people across Kirklees. Further products will be developed including a market position statement to guide providers and a detailed implementation plan to deliver the actions.

Key issues that the strategy highlights and aims to address are:

- recruitment and retention of a suitably skilled workforce;
- the need for greater co-ordination across health and social care organisations of the support / input to older people's care homes;
- the impending increases in demand for care arising from the ageing population;
- the scarcity of certain types of provision – in particular growing demands for, and diminishing supply of, nursing provision for older people with dementia;
- the context of diminishing resources within the public sector.

## 3. Proposal

- that the contents of the strategy are noted;
- that the strategy is endorsed by all partners; and
- that all partners consider their role in delivering the action plan within the strategy.

## 4. Financial Implications

No immediate resource implications – though the strategy refers to the ongoing issues concerning viability and fee rates.

## 5. Sign off

Both CCGs have contributed to the strategy and it is being signed off by the two Clinical Strategy Groups. Cllr Viv Kendrick has confirmed that she is happy for it to come to Health and Wellbeing Board.

## 6. Next Steps

As noted in the strategy, work is now progressing on the implementation of actions within the action plan. Work is also underway on the development of a shred Market Position Statement to help guide the older people's care home sector.

## 7. Recommendations

- that the contents of the strategy are noted;
- that the strategy is endorsed by all partners; and
- that all partners consider their role in delivering the action plan within the strategy.

## 8. Contact Office

Margaret Watt, Head of Commissioning & Quality, Commissioning & Health Partnerships, Kirklees Council
Contact No: 01484 221000

Helen Severns – North Kirklees Clinical Commissioning Group
Vicky Dutchburn – Greater Huddersfield Clinical Commissioning Group

# Kirklees

## A Joint Strategy for Residential and Nursing Care Homes for Older People 2016

Kirklees Council

NHS
Greater Huddersfield Clinical Commissioning Group

NHS
North Kirklees Clinical Commissioning Group

**A Message from the Kirklees Health and Wellbeing Board**

At their best, older people's care homes provide an enriching, safe and caring environment where we can be certain that our loved ones (and potentially ourselves in the future) can live fulfilling lives.

As our population gets older, it is increasingly challenging to make sure that we have enough of the right resources in place to make sure that all care homes are able to offer this.

We recognise that care homes in Kirklees, in common with the rest of the country, are facing very real difficulties – in recruiting and retaining the right workforce; in being able to support older people with increasingly complex needs; in having enough resources to remain viable as businesses; and in creating and sustaining a suitable environment to meet these changing needs.

We are committed to working together, across health and social care services, with the people of Kirklees and with care home providers, to address these challenges and to deliver our strong, shared vision for the role of older people's care homes now and in the future.

We endorse this strategy which has been prepared jointly by commissioners in the Council and the Clinical Commissioning Groups and in partnership with care home providers in Kirklees. We are committed to making sure that it is delivered, to the best of our joint abilities, so that we can be sure that our care homes are providing excellent places to live for older people in Kirklees. We will be reviewing the action plan at the Health and Wellbeing Board to monitor its progress.

Signed:

Cllr Viv Kendrick – Portfolio Holder for Prevention, Early Intervention and Vulnerable Adults, Kirklees Council

Steve Ollerton – Clinical Lead, Greater Huddersfield Clinical Commissioning Group

David Kelly – Clinical Lead, North Kirklees Clinical Commissioning Group

# Contents

## 1 Introduction & Approach

The Council and the Clinical Commissioning Groups have come together to prepare this strategy which outlines our plans for care homes for older people (including people with dementia) in Kirklees over the coming years.

This strategy complements the Council's Older People's Accommodation Strategy (published in 2010) and available here:

https://www.kirklees.gov.uk/community/careInKirklees/pdf/opastrategy.pdf

It has been prepared, along with additional publications **including a more detailed action plan and market position statement,** *(these documents are being drafted)* in order to give clear messages to our partner organisations and to the care home market about the role that we see care homes for older people playing in the future and what the priorities for development are.

This strategy focuses on the needs of older people (usually over 65) who need support due to frailty and vulnerability arising from older age. It also includes the needs of people who have dementia. There are separate strategies (and market position statements) which outline partners' approaches to accommodation for other groups of vulnerable people including those with learning disabilities, with physical and/or sensory impairments and with mental health issues.

We have taken a slightly different approach to developing this strategy, following the City Hall Innovation Team's guidance on how to arrive at innovative solutions to problems.

In summary, we have looked at responding to the following questions:

**Question 1: What difference are we trying to make for whom?**

***Response:*** *To improve the quality of life of older people who live in nursing or residential care homes.*

**Question 2: What are our specific challenges?**

**Response:** *Building a sustainable model of care home provision in Kirklees that is part of a wider set of systems that enables older people to live as independently as possible for as long as possible. We need to make sure that each care home is:*

1. *A good place to live*
2. *An effective part of a wider system*
3. *A successful business*

*Specific, shorter term issues that we need to address are:*

- *A shortage of the right type of care home provision (especially for older people with dementia and nursing care needs)*
- *Viability / costs – arriving at affordable business models that are sustainable*
- *Workforce – an overall shortage of people willing and able to work in the sector- both nursing and social care staff*
- *Estate / buildings – the need for environments which are fit for purpose to better meet people's changing needs*
- *Clarifying people's pathways into care*
- *The linked capacity / workforce problems within the domiciliary care sector that could limit our ability to support people in their own homes*

**Question 3: What are the causes of the problems / challenges?**

*Response: these are looked at in the strategy and reflect the national picture.*

**Question 4: What have we done so far?**

*Response: Appendix 2 lists the range of support / interactions with care homes – and the strategy and action plan highlight the need for better co-ordination of these to achieve better outcomes and efficiencies*

**Question 5: What do we need to do to meet our challenges?**

*Response: in summary, we have agreed that we need:*

- *A coherent strategy across health, social care and housing that sets out our shared approach and demonstrates the key interdependencies with other strategies.*
- *A workforce that is big enough, has the necessary knowledge, skills and attitudes and is flexible enough to meet current and future needs.*
- *An approach to co-production with all stakeholders – ie people who live or may live in care homes and their families; staff working in care homes; owners and regulators.*

The rest of this strategy aims to flesh out these responses, and begins with setting out a vision for the future of care homes, from the perspectives of the different stakeholders.

## 2 Our Vision for Care Homes in Kirklees

### 2.1 What Do We Want Our Care Homes to Be and Do?

We have looked at this from different people's viewpoints – first and foremost from the perspective of the **people who do and will live there and their families/friends**:

People who live, or are going to live, in care homes, and their friends and relatives say they want:

- **Choice**, about all aspects of my life, including: - moving into a home; where it is; what my room looks like and looks out on; how I live my life; how my care is delivered; how I spend my time; the food I eat, where and when I eat it; who visits me and when; when / if I go out and where; how / if I worship/pray; who I interact and spend my time with; when I get up and go to bed; who I have relationships with; where and how I die;
- **To live an interesting life –** continuing with my hobbies, having a choice of activities and having interesting people to talk to
- **Not to be lonely –** but to be alone when I choose to be
- **To be in control and as independent as possible -** I want to make my own decisions about everything that affects me – the little things and the big things
- **To be treated with dignity, respect and compassion** by everyone I come into contact with
- **To have my needs met** –my wellbeing, my social care needs and my health care needs
- **To be in a nice environment** – that helps me to be independent and find my own way around
- **To feel safe** and to take risks if I choose to
- **To be able to stay here for as long as I want**
- When my time comes, **to have a good death**

Carers:

- **To know that my loved one is being supported in a caring and compassionate way,** by skilled staff who have his/her best interests at heart
- **To be able to visit at any time** and feel welcome
- For **staff to contact me and keep me informed** about how my loved one is and to encourage me **to be involved** in caring for my loved one
- To be treated with respect and compassion

From the perspective of the **staff who work in the care home**:

People who work in care homes tell us they want:

- To be **valued and respected** for what I do
- To **work in an environment that helps me to look after people**
- To be paid **a fair wage** for the work I do
- To **feel confident that I have the skills to do my job** and feel that I know how to help people – even if they are challenging
- To be able to **develop my career** and gain / retain my professional registration
- To work **reasonable hours**

- To be **part of a good and supportive team**
- To be able to **have good relationships with the people I care for and their family** and friends
- To **feel trusted by my employers** – and supported if things go wrong
- To **feel trusted by the people I care for and the other professionals who support them** – doctors, nurses, hospitals, etc
- To **have people I know I can go to for timely support** if I need expert help
- To have **expert help quickly** when I need it
- To go home at the end of the day **knowing I have done a good job and made a positive difference to people's lives**
- To **be able to help provide a good home** for people
- When the time comes, to **help people to have a good death**

From the perspective of the **people who own the Care Homes**:

Care home owners tell us they want:

- to **run a good business that is popular** – for people to want to live in my home
- to **make a reasonable profit**
- to be **paid fees** that are **adequate to effectively meet the needs of** the **individual residents** and to allow the home as a whole to work well
- to **have a good, stable and loyal staff team** – with managers and care staff who I can trust to do a good job and who have all the right competencies, skills and abilities
- for **other systems that support me in recruitment** and upholding standards in the workforce (eg the Disclosure and Barring – DBS – scheme) **to work speedily, efficiently and effectively** and to be responsive to my requests
- to **be able to recruit and retain all the staff I need** and have a low turnover of employees
- to **feel that I am working in partnership with other professionals** who help older people – with the Council, hospitals, hospices, GPs, district nurses, therapists, etc
- to **make sure that my home is a good place for people to live** where I can meet people's needs and the people get on with each other – which means having a say in who moves in
- for my home **to deliver Gold Standards** in the way we care for people when they are **dying**
- the **people who inspect my home to treat me fairly and with respect** and to deliver consistent messages – so I am clear if / how I should improve
- any **support that is offered** to me **to be well co-ordinated** and helpful
- **business advice and support to be available** easily when I need it
- **to be creative in how my home develops in the future –** to find ways I can contribute to the wider community and offer different support to older people to meet their needs
- **to have a good relationship with commissioners** – both NHS and Council – so that I can work creatively and in partnership with them to develop my home to meet changing needs

- **commissioners to share risks with me** – so I can deliver what's needed without worrying that I may lose my business or end up very out of pocket

From the perspective of **hospitals and other healthcare providers**:

People working in hospitals tell us they want:

- to **feel that we are working in partnership with care homes**
- that **care homes recognise the pressure hospitals are under** and make sure that if they **send people to hospital that they really do need to be there**
- to be sure that there are **enough, good quality care homes** for people to move to, if they have to, when they no longer need to be in hospital
- for care **homes to be able to send care staff into hospital with people** if they feel that they would need this
- for **all the right information about a person's needs and conditions and medication to accompany someone** when they do come into hospital
- for there to be **a responsive contact we can talk to if we need some more information about someone** and they aren't able to tell us themselves
- for there to be **beds available for** people to move to for **rehabilitation and convalescence** – if they don't need to be in hospital any more

From the perspective of the **people commissioning health and social care (the Council and the CCGs)**

People who are responsible for commissioning care homes in Kirklees say they want:

- to have **a thriving local care home market** which meets people's current needs and choices and is able to change to meet future needs
- to be able **to work in partnership with care home providers** – so that the services they offer can vary and flex as demands fluctuate and the homes are seen as a fundamental part of the whole health and social care system
- **to be working in partnership with regulators** (CQC especially) so that we can work together to address any concerns and improve services
- to have **a wide range of choice available** for people who want and need to move into a care home
- to **pay a fair, affordable price for care**, **that delivers best value** for all Kirklees residents
- to have **a care home market that generates really positive feedback** from the people who live there and their relatives/friends
- to have **care homes which act as community hubs** – supporting both the people who live in them and those who live in the surrounding area
- to have a really **good range of choices of accommodation for people, including extra care, residential care and nursing care**
- **to have homes staffed by a skilled and dedicated workforce** – who want to be there and who see themselves as part of a wider health and social care team
- to have **care homes which can be flexible to meet the changing needs of their residents, so people don't have to move** if and when their needs change
- to have **sufficient, high quality care home places available** to **avoid people having to stay in hospital when their need to be there has ended**

- to have care **homes spread across Kirklees s**o that people are able to choose a home that is close to their local community
- to have a choice of **homes that can meet the varied cultural needs** of people in Kirklees
- to have care homes operating as local **businesses which contribute to the "Kirklees pound**" – investing profits into the local area and communities.
- For social workers **to be able to offer people a good choice of excellent quality homes** when they are helping them decide how best to meet their needs.

**2.2 Our Vision for the Future –** the outcomes we want to achieve

Our initial approach to developing this strategy suggested that there are three key things that we would want all care homes to be:

1. A good place to live
2. An effective part of a wider system that supports older people
3. A successful business

And the feedback we have received confirms that this is the right approach.

Having looked at what we want from our care homes from a range of different perspectives, and looked at examples of good practice and national research, there are some common themes that stand out for everyone. We have summarised our vision for care homes in Kirklees under these key themes:

**Choice**

- Enough care home places to meet current and future needs
- Location – to enable people to live in their local community
- Different models – so people can be cared for where they want (eg shared care, etc)

**Dignity, Respect and Compassion**

- These should run through all aspects of care
- People want to be cared for by people who themselves feel valued and who value them as individuals

We want to have care homes that:

- provide a safe and enjoyable place for people to live their lives
- welcome and involve families and carers in supporting their loved one
- support people to keep their own culture / faith / ways of life
- help people to have a good experience at the end of their life

**A Skilled Workforce**

We want a workforce that:

- is stable, capable and compassionate – able to meet people's needs and well supported by the wider health and social care system
- is sustainable for the future – with training and skills development to enable staff to meet people's changing needs
- has staff who know they are valued, supported and fairly paid

**Fair Price**

- for care home owners
- for people living there who are paying /contributing to their costs
- for the public sector – the Council and the NHS
- for the people who work there – to ensure they are paid a fair and living wage and to attract good staff

**Flexibility**

- to meet changing needs – of individuals and of the population / society as a whole
- to reflect changing choices of residents

**A Good Environment**

We need care homes:

- that are in the right place – where people want to live
- where the buildings and gardens are a good place to live
- which are well designed to help staff deliver care

- which enable people to be active members of their local communities
- which are good for the environment
- which act as community hubs – contributing to and supported by their local communities

**Enabling and Promoting Independence**

We want to see care homes:

- encouraging people to be as independent as possible
- making best use of new technology to help people to be independent
- enabling residents and relatives to contribute to the running of the home – so that people feel it is genuinely their home rather than a place they are staying.

## 3 Numbers Now & Trends for the Future

### 3.1 Care Homes in Context - our approach for accommodation for the future

In 2010 the Kirklees Older People's Partnership Board published "A Place to Live Life to the Full – an accommodation strategy for older people in Kirklees". The key messages from this document are, from an older person's perspective:

- Most older people want to retain maximum independence and control over their lives.
- Older people who are owner occupiers may be reluctant to move into rented sheltered accommodation or residential care because they do not want to erode their capital.
- If they have to move to alternative accommodation most older people want it to feel like ordinary housing, be reasonably spacious (with many preferring two bedrooms) and secure, within a neighbourhood where they feel familiar and safe.
- Older people are more economically active and if they are paying for services they want flexibility, quality and choice.

In relation to the types of accommodation needed the key messages are:

- Our ageing population means that there will be a need for an increasing amount of accommodation that is targeted at the needs of older people;
- There needs to be a wider range of accommodation choices for older people in Kirklees – rather than staying where they've always lived or moving to a care home
- There is a real shortage of extra care living options – which are a genuine alternative to care homes for older people and more likely to meet the changing aspirations of older people
- If we don't develop these alternatives the demand for care home places will rise significantly over the coming 5 to 20 years.

The strategy includes a chart (recently updated) which indicates the potential growth in demand for care home placements in Kirklees, if alternative options are not developed. [1].

The figures are presented for illustrative purposes as **a key part of the Council's accommodation strategy for older people is to move away from an over dependency on care home provision towards more, personalised support in people's own homes and to significantly increase the availability of other forms of more independent living for older people.**

Since the strategy was published the Council has opened three, Council run, extra care schemes targeted at older people and providing 142 flats.

These are popular and the Council is committed to supporting the development of more extra care – with a variety of tenure options – social rented, private rented and purchase – to meet growing demands. These will take time to develop and in the meantime, there will continue to be a reliance on care home provision.

[1] Projecting Older Peoples Population Information (POPPI) September 2015

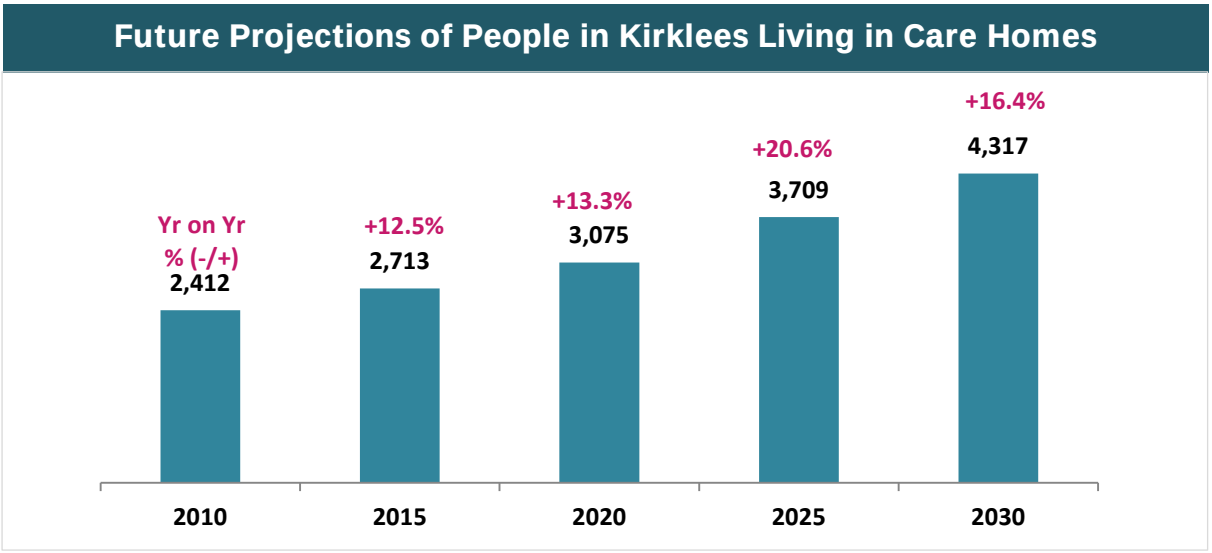



***Figure 1*** – Expected Number of Kirklees Citizens aged 65+ Living in a Care Home (With/Without Nursing)

There is a recognition that **there will always be a need for care home provision**. The Council's Market Position Statement for Older People highlights the **local shortage of high quality nursing home care for older people with dementia**. This shortage remains acute and demand for it is likely to grow as more people are developing and living with dementia.

More detail about the changes in the care home market over the past few years and the current situation in respect of care home beds is given in Appendix 2. The key messages from this information are:

- Whilst the Council's overall purchase of care home placements has decreased by 7% since 2010, there has been **a significant increase in the proportion of dementia beds purchased** (from 15% to 26%) – both nursing and residential. As expected, we are seeing **a shift in focus away from straightforward residential and nursing care and towards care homes able to support people with dementia**.
- **The availability of dementia nursing homes in particular is reducing and is not sufficient to meet current needs**.
- Current sources of data suggest there could be between 1,141[2]- 1,400[3] people with dementia living in care homes in Kirklees now, but only 820 registered dementia places. And prevalence estimates suggest that demand could double to between 2,326[4]-2,500 places by 2030. Over the past 12 months we have lost 47 nursing dementia beds in Kirklees.

Whilst the above information provides us with an indication of the likely numbers and types of beds needed to respond to current demand and to plan for future demographic growth, the following section which looks at gaps and opportunities will have an impact on both the amount and style of provision needed. Kirklees Accommodation Strategy for Older People is

[2] *Data from the Primary Care Web tool suggest that there are 743 people in GHCCG living in nursing homes and 887 in NKCCG, a total of 1630 people( Oct 2014). If 70% of these people have dementia that would equate to 1141 people.*

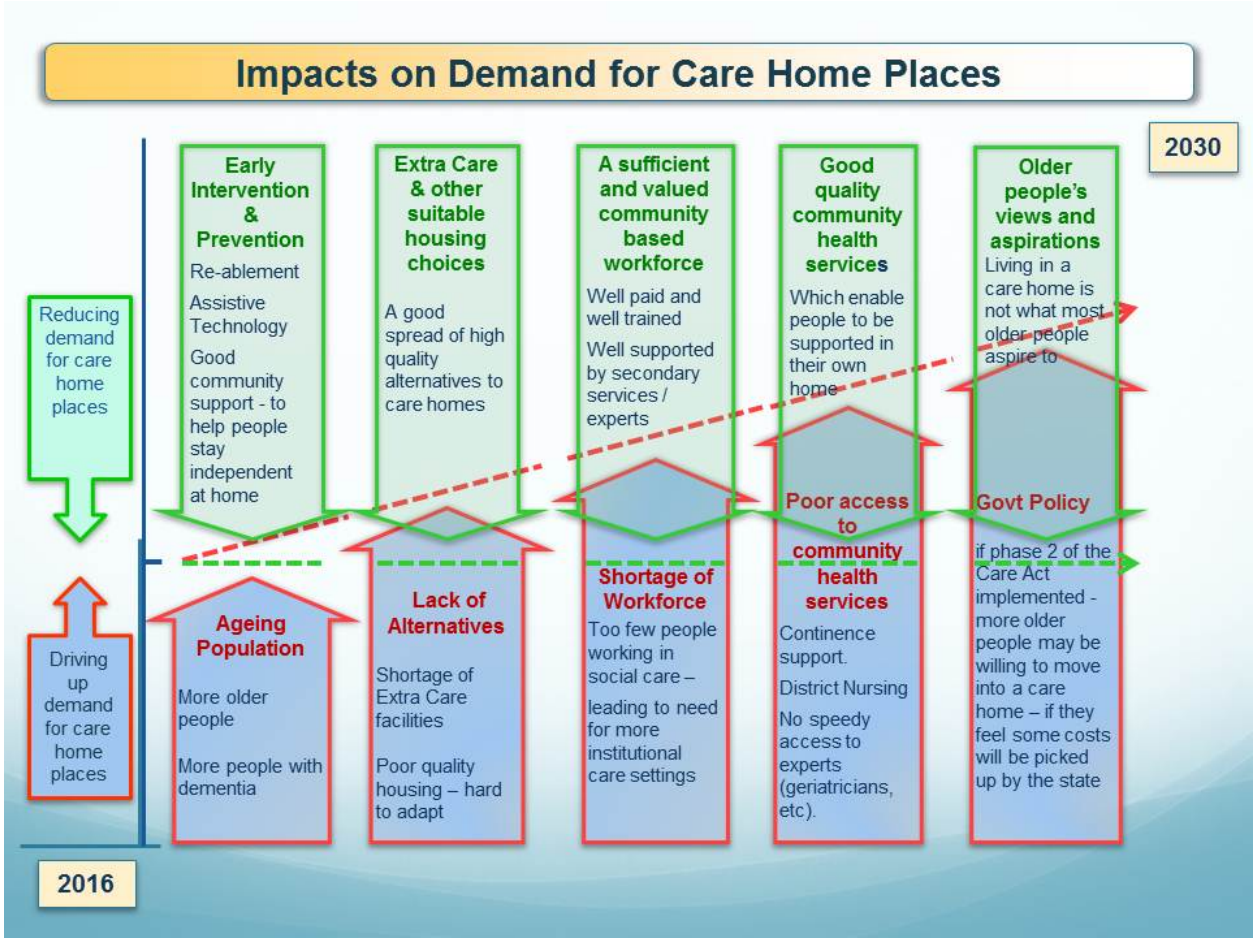
[3] *Data from www.poppi.org.uk (Oct 2014 ) suggests that there are currently 2001 people in Kirklees living in residential and nursing care- 70 % of this total =1400 people affected by dementia.*

[4] *Poppi data predicts that with demographic pressures, if treatment and provision of services remain the same, the numbers of care home places required will increase to 3323 by 2030, ( potentially 2326 of these people could need dementia care*

clear that more extra care is needed and the more of this that is available, the fewer care home places will be needed. Providing precise figures about likely numbers of beds needed, therefore, is not possible as it will be influenced by the range of other provision that is developed. We are aiming to provide more specific need forecasts in our Care Home Market Position Statement. However, there are some very clear messages that arise from this review work:

1) The **growing older population means that more care focused accommodation is likely to be needed;**
2) The changing demographic (ie **more older people** and fewer younger people) **means** that some degree of **communally based care,** which enables a smaller group of care staff to deliver support to larger numbers **will always be needed**, **alongside** the development of **assistive technology** wherever possible;
3) The **increasing number of people with dementia** means that any **accommodation** that is built **needs to be designed to meet the needs of people with dementia** and also to enable people to be as independent as possible; and
4) If we are developing new care provision, **whatever is built needs to be flexible to meet** the **changing aspirations** of older people.

The diagram below looks at the potential inflators and deflators iro changing demands for care home places.



## 4 How does the current care home situation compare to our vision?

### 4.1 Numbers

Section 2 highlights the current situation regarding the availability of care home beds in Kirklees and the shows the gap between what we need now and into the future and what is currently available. The **key immediate message is that there is an acute shortage of high quality nursing home placements for people with dementia**. And unless we address a number of issues within the care home market this gap is only likely to get bigger.

### 4.2 Quality

It is the role of the regulatory body, the Quality Care Commission (CQC) to inspect and rate the care homes. Currently the CQC website is showing the following ratings In Kirklees:-

<u>New Regulations</u>

11 – Good

20 – Requires Improvement

2- Inadequate

1- currently being inspected

<u>Old Regulations</u>

29 – Compliant

3 – Not complaint in all areas

The Council's Contracts and Monitoring Unit also visit care homes in Kirklees where they are funding places. The aim of the visit is to check that the care home operates safe, effective systems in order to deliver appropriate care. If a visit does identify issues these are followed up on with the care home to make sure they are addressed. Over the past few years, the main issues that we have found are:

- Inadequate support plans and risk assessments for residents which don't reflect current needs – and failure to adequately record the care and support that has been given;
- Environment Issues, including:-
    - a general lack of cleanliness in both communal areas and service users own bedrooms
    - a failure to keep up to a general maintenance plan for fixtures and fittings
    - a failure to repair/replace soft furnishings
- Medication administration records being inaccurate or incomplete
- Lack of stimulating activities
- Lack of support at mealtimes
- Inadequately trained staff particularly relating to the provision of dementia care

In summary, we are aware of a number of quality issues affecting care homes in Kirklees. It is clear from the feedback that we receive, and research undertaken both regionally and nationally, that the key factors that impact on quality are:

- The shortage of suitably trained and qualified social care staff;
- The shortage of nurses willing and able to work in care home settings;
- The state of the buildings – many homes are old buildings which do not lend themselves to the delivery of high quality care; and

- The mismatch between the cost of delivering high quality care and the resources that the NHS and Councils have available to pay for this care.

### 4.3 Workforce

A common theme emerging from the CQC inspections, the visits of the Council's contracting staff and feedback from providers and residents is the lack of a suitable workforce - both registered (nurses) and unregistered staff (care support staff) - which is both willing and able to work in the health and social care sector. This shortage of a suitable workforce is a key underlying cause of quality concerns affecting care homes. The shortage of registered nurses has many causative factors however it is the negative impact on care homes which is a grave concern. This complex concern has occurred due to many reasons which include the limited number of new nurses leaving university with often only one intake of students per year, many choosing to retire early and the potential to change their career or they decide to move abroad to nurse due to pay and conditions. Overall they do not see care home work as attractive or in line with their career plans.

This shortage of registered and unregistered staff, as well as care home managers, is recognised as a national problem and a challenge to those involved with recruitment. On the 17th December 2015 the Department of Health issued a statement of intent to create a new nursing support role. A consultation was launched at the beginning of 2016 to consult the health care sector about their views on a 'Nursing Associate'. Provisionally called nursing associates, they are described as being a role which will work alongside healthcare support workers and fully qualified nurses focusing on patient care.

The role, which could also be a new route for those wishing to become a registered nurse, has been recommended by nursing leaders and other healthcare professionals. The new addition to the care workforce will help bridge the gap between healthcare support workers, who have a care certificate, and registered nurses. The new nursing support role is expected to work alongside healthcare support workers and fully qualified nurses to deliver hands on care, ensuring patients continue to get the compassionate care they deserve. Nursing associates will support nurses to spend more time using their specialist training to focus on clinical duties and take more of a lead in decisions about patient care. Workshops nationwide lead by Health Education England are occurring to engage all health and social care sectors regarding our vision of this new role and if it can help to address the concerns about the workforce shortage. Discussions as to how this role can adapt to all our social and health care settings is ongoing as it is vital to use this opportunity to shape the landscape of our future workforce. We need to ensure that our population is looked after by the right person with the right skills at the right time and we have an opportunity to address this currently. The action plan (section 6) addresses what Kirklees will be doing to support the future workforce.

Significant short, medium and long term work is needed to address the other root causes which include:

- **low wages** – as the country's private sector economy improves, jobs are becoming available within a number of sectors – especially retail – which are seen as easier and more attractive to people and this is creating huge recruitment and retention problems in the care sector;
- **poor terms and conditions** – many care workers are employed on very poor terms and conditions with little job security; there is inconsistency in the pay and terms and conditions across different sectors;

- **lack of career pathways** – at present for younger people. This is causing significant concern as they cannot see any obvious career routes from front-line care work that will meet their longer term aspirations;
- **low value and negative images of care work in the media** - as press and media coverage highlights negative experiences of care, care workers are vilified for poor standards of care and service. There is virtually no coverage of the positive work that is done, day in-day out, and this has a very damaging long term impact on the willingness, of young people especially, to see care work as a valued and valuable career option.

### 4.4 Viability and Spending

As noted above, the care home sector is facing a crisis in terms of its ongoing sustainability. In the past 12 months Kirklees has seen 8 care homes close with a loss of 258 places. The reasons for these closures vary, but recurring relevant themes are:

- impending action by CQC over quality issues;
- difficulties in recruiting and retaining a suitable workforce – in particular nurses;
- issues to do with the state of buildings – ie, the current internal environment/layout is not really fit for purpose and the cost of upgrading is felt to be too high;
- age / health of care home owners – leading to decisions to retire from the business.

A number of national publications refer to the lack of profitability within the care home sector. Nationally care homes have seen a decline in fee rates paid by Local Authorities of 6% in real terms since 2011/12. In Kirklees fee rates have increased by 10.5% during this period, in line with the locally agreed formula. However, in spite of this we are seeing a number of older people's care home providers seeking additional uplifts which they say they need to remain viable. In particular the introduction of the national Living Wage is creating cause for concern and it is estimated (by Laing and Buisson) that this will require a 3.5% to 4.0% increase in fees to restore care homes' profitability status quo. [5] In response to this, Kirklees Council and CCGs have increased the care home fee rates by 4.4%.

In the same report one of the major reasons cited for why councils and providers have failed to engage effectively on market management issues in the past, and are likely to struggle in the future, is an apparent absence of understanding of the investment return requirements of care home operators

*"What is striking is that both sides (councils and providers) usually agree on the quantum of current operating costs (staff, utilities, consumables, etc.). Their disagreement nearly always revolves around an appropriate allowance for property costs (return on capital) and operator's profit."* [6]

Laing and Buisson, in their "Care Sustain" model indicate that investors are likely to expect a 12% per annum return on their capital investment in any new care home, though they note that existing care homes may well accept much lower profit margins, even operating at zero profit margins prior to closure.

This feels like an area which we need to do further work on within Kirklees so that we can come to some shared agreement on what we would see as acceptable profit margins which would encourage providers to both come into and remain in the care home market.

[5] LaingBuisson Paper – "Stabilising the Care Home Sector & Preparing for Implementation of Part 2 of The Care Act in 2020"
[6] Ibid

With the current problems arising from lack of availability of dementia nursing beds in particular, we are aware that the Council and the CCGs are facing additional costs. Additional 1:1 support is being provided, on a person by person basis. This approach is neither sustainable nor efficient and is wasteful of staff time.

If we are to have a thriving care home sector, we need to re-look at the cost models that underpin care homes, reviewing the price we pay, looking more creatively at the way money is put into care homes and looking creatively at the opportunities for additional income that could arise if we start to review the future role of care homes in our communities.

The care home market cannot be viewed in isolation and the current pressures facing domiciliary care (ie acute shortage of suitable workforce) are placing additional pressures on the care home sector – with demand for short term and intermediate care beds increasing as people find it increasingly difficult to secure support packages at home.

**4.5 Support for Care Homes, Clinical Input and Hospital Pressures**

There is a wide range of different support around for care homes in Kirklees. Successive health and social care commissioners have established a variety of teams aimed at offering specific input to improve the quality of care delivered in the homes. Appendix 2 shows a list of all the various teams and support services.

Whilst this is an impressive list, it is clear from care home provider feedback that:

- some of this support overlaps – and there is a danger, when a care home is struggling, that too many different organisations and individuals arrive to "help" and can be counter-productive;
- a review of this range of services is needed to create a more efficient and helpful support system.

Health care within care homes has its challenges, with a number of GPs telling us that they find delivering care to residents in care homes difficult, especially if there are a number of homes within their practice area and they struggle to meet the demands placed on them. Effective clinical input to care homes is critical in order to deliver our vision for the future of safe, well-cared for people who can have their health needs met speedily within the home wherever possible, avoiding the need for urgent trips to hospital. It is clear that improvements to clinical support to care homes are needed. If the range of support services is looked at strategically and reviewed, then it should be feasible to relieve the pressures on individual clinicians and improve the quality of healthcare available.

The number of urgent admissions into hospital from care homes is increasing and is placing a great deal of strain on our hospital services. Equally important is the damaging and disruptive effect this can have on people who live in care homes, especially those who have dementia who find the hospital experience bewildering and often unhelpful. Enabling people to get the clinical support they need within their home would deliver better outcomes for people and reduce the mounting pressures on NHS systems. A key aim from this strategy is to ensure that improved clinical support is made available to people in care homes and which enables care staff in the homes to deliver effective care without having to make unnecessary trips to hospital.

**4.6 Buildings**

In common with the rest of the UK, many of Kirklees care homes operate from large, old buildings which are no longer appropriate to meet the increasingly complex needs of the people who live there. Dementia care especially is best delivered in purpose built care homes which follow best practice in terms of dementia friendly design.

It is difficult for care staff to deliver the best quality of care in buildings which are not fit for purpose.
A significant amount of upgrading work has been carried out on care home buildings over the years to try to improve their suitability, however this remains an ongoing issue for some.

### 4.7 Locations & Opportunities for Changing Roles

The 66 care homes for older people are spread across Kirklees. Not surprisingly, location does not always match demand.

As noted earlier, Kirklees Council is aspiring to have many more extra care facilities available for older people. However, viewing the spread of care home provision across the area, and acknowledging the lack of larger sites available to build extra care at the scale required, it is worth considering the future role of care homes in offering some of the attractive features of extra care to their local older population, for example – access to daytime activities and company; help with bathing and personal care; restaurant facilities; outreach domiciliary care; etc. If these facilities were to be offered to people in the local community, in a way which is sensitive to the people already living in the home, it could bring benefits both to the home in terms of increased income and activity and to local older people in terms of improved facilities to meet their needs.

Some care homes already offer a number of these facilities and it is worth investigating if this approach can be extended.

## 5 Opportunities & Barriers

### 5.1 Funding Streams

The main bulk purchasers of care home beds in Kirklees are the Council and the NHS (primarily the CCGs via its Continuing Healthcare Budget but also the local community health provider iro intermediate care beds). Some collaboration between these organisations does take place, for example there is agreement on basic care home fees. However there remain further opportunities for closer collaboration in terms of a more unified approach to care home markets and, potentially, the pooling of budgets.

### 5.2 Working with the Care Quality Commission (CQC)

The shift in approach of the CQC to focus on regulation and inspection and moving away from supporting improvements in quality has had a significant impact on the local care home market. A number of care homes have now closed as a result of this and the speed with which this has happened has had a detrimental impact on the availability of nursing care beds in particular and placed a lot of pressure on both the CCG's and the Council's operational staff. Close working relationships between commissioners and the regulators are needed to ensure that an already vulnerable market is not made more vulnerable.

A more robust approach to quality within the care home sector is undoubtedly needed, and, properly managed, should help to shape the market in the right direction, with poorer quality homes in unsuitable properties closing and newer homes built to meet current needs filling the gaps. However, close partnership working is needed to make sure that the timing of this approach ensures that new provision is available as older, less appropriate homes close.

### 5.3 Resources – shrinking public sector budgets

All of these challenges appear at a time of severe pressures on both NHS and Council budgets which impact significantly on the ability of commissioners to address the viability issues of the care home sector.

Key to the success of a care home strategy for the future will be a more creative approach to income generation for care homes and a close focus on cost / benefit impacts of any proposed changes. Some ideas have been mentioned previously, eg care homes attracting income from opening up their facilities to local older people. More of this creative thinking will be needed to address the challenges we currently face.

Shared commissioning approaches across the Council and the CCGs will also help to reduce inefficiencies and create cost savings which can be redirected.

Having an ineffective care home sector has major cost implications for the NHS in terms of hospital beds and primary care support. Clearly, the cost of care home beds has to be seen alongside the overall NHS and social care budgets and any changes in fee structures need to be seen in the context of wider system savings that can be achieved.

## 6 Action Plan to Address the Gaps and Achieve the Vision

Having considered the range of issues outlined in this strategy, we have identified a series of actions that now need to be undertaken to address the current and future challenges that are facing the care home sector, and to work towards achieving the agreed shared vision for care homes in Kirklees. Reminding ourselves of our original aim, described in section 1 which is to:

***improve the quality of life of older people who live in nursing or residential care homes***

and we are aiming to do this through …

*building a sustainable model of care home provision in Kirklees that is part of a wider set of systems that enables older people to live as independently as possible for as long as possible.*

***We need to make sure that each care home is:***

- ***A good place to live***
- ***An effective part of a wider system***
- ***A successful business***

and acknowledging the specific, shorter term issues that we need to address which are:

- ***A shortage of the right type of care home provision*** *(especially for older people with dementia and nursing care needs)*
- ***Viability / costs*** *– arriving at affordable business models that are sustainable*
- ***Workforce*** *– an overall shortage of people willing and able to work in the sector- both nursing and social care staff*
- ***Estate / buildings*** *– the need for environments which are fit for purpose to better meet people's changing needs*
- ***Clarifying people's pathways into care***
- *The linked* ***capacity / workforce problems within the domiciliary care sector*** *that could limit our ability to support people in their own homes*

we are proposing the following set of actions for the Council and the CCGs to undertake, in partnership with a wide range of stakeholders including care home owners, managers and staff; NHS providers; the Care Quality Commission; education and training providers (including Skills for Care and the Local Education and Training Board); Healthwatch and, most importantly, residents, potential residents and their families and friends. A more detailed action and implementation plan will be drawn up to deliver these actions.

As a rule of thumb, when looking at timescales: short = 6 months (approx.); medium = 6 to 12 months (approx.) and long = 12 months plus.

| | ***Care homes should be:*** | ***Specific Challenges*** | **Actions** | **Outcome** | **Lead(s)** | **Timescale** |
|---|---|---|---|---|---|---|
| 1. | ***A Good Place to Live*** | *Estate / Buildings* | Review the care homes buildings / environment, consider their fitness for purpose for the future and develop an action plan to address any shortfalls. | A better understanding of the state of care homes across Kirklees – and the viability of them for changing roles in the future. | Care home owners and Council | Medium to Long |
| 2. | | *Quality* | Review approaches to quality oversight / monitoring within care homes to ensure the most appropriate support is offered if needed, via establishment of a quality framework. See also action below. | A better co-ordinated approach to quality monitoring and assurance leading to improved outcomes for residents | Council with CCG input | Short |
| 3. | | *Safeguarding* | Linked to the action above, review processes to support failing homes and ensure appropriate and co-ordinated responses are in place. | Residents are safeguarded. Care homes are enabled to continue if appropriate. | Council and CCG | Short to Medium |
| 4. | | *Medication* | Review the way medicines are managed within care homes. | Safe systems of medicine management are in place leading to better healthcare for residents | CCG | Medium |
| 5. | | *Workforce* | Link local authority, CCGs and partners including Locala and Care Home providers and Health Education England to agree a workforce strategy developing career opportunities for the registered and non-registered workforce. This would include exploring new and un-traditional role development such as clinical care worker. | A workforce that is fit for purpose with the potential to recruit and retain staff groups<br><br>Potential efficiency savings through considered skill mix review | CCGs, Council and Care Home providers | Medium to Long |

| | ***Care homes should be:*** | ***Specific Challenges*** | **Actions** | **Outcome** | **Lead(s)** | **Timescale** |
|---|---|---|---|---|---|---|
| 6. | | *Workforce* | Co-ordinate post qualification registered nurse professional development programme including coaching, peer support, rotation and revalidation, linking with University and other local providers re: pre-registration care home placements. | A broader supply of nurses willing and able to work within care homes. | CCGs & University | Medium to Long |
| 7. | | *Workforce & Dignity* | Consider role of new technology in helping to keep residents safe while enabling them to live in a freer environment | Less pressure on care staff and more freedom for residents to live in a safe environment. | Council and CCG | Short to Medium |
| | | | | | | |
| 8. | ***An Effective Part of a Wider System*** | *Shortage of the right type of care home provision & Market Intelligence* | Develop clear, joint Market Position Statement for older people's accommodation covering sheltered housing, extra care and care home options. | Clear message to providers and potential providers re what is needed | Council and CCG with input from Care home owners | Short to medium |
| 9. | | " | Work with specific providers to encourage provision of nursing dementia and dementia beds. | Increased availability of care home services for people with dementia | CCG and Council | Short |
| 10. | | " | Council, and external providers to progress option of transferring Council homes to become dementia nursing homes | Increased availability of care home services for people with dementia | Council, SWYFHT & Locala | Short |
| 11. | | " | Improve (and better co-ordinate) the range of support into residential care homes (including those for people with dementia who are challenging – see also below) | Better co-ordinated range of support to enable care homes to succeed | Council, CCG and NHS providers | Short to medium |

| | ***Care homes should be:*** | ***Specific Challenges*** | **Actions** | **Outcome** | **Lead(s)** | **Timescale** |
|---|---|---|---|---|---|---|
| 12. | | *Shortage of the right type of care home provision & Market Intelligence* | Consider development of alternative models of care home provision – where staff have additional training to meet the specific needs of people with dementia | Less dementia "nursing" care needed as residential care homes are better able to meet the needs of people with dementia | Council & CCG | Medium |
| 13. | | *"* | Improve support for all care homes to deliver care for people with dementia when they are are challenging. | All care homes are better able to support people with dementia | CCG & Council | Medium |
| 14. | | *"* | Develop the local provision of specialist provision for people with dementia who are challenging | The needs of people with dementia who have significantly challenging behaviour are met in Kirklees | CCG | Medium to Long |
| 15. | | *Clarifying people's pathways into care* | Map people's routes into care homes to ensure that we are making the best use of early intervention and prevention | People are supported in the least intrusive or disruptive way that best meets their needs | Council with CCG input | Medium |
| 16. | | *Clinical Support* | Consider approaches to GP support for care homes to ensure effective oversight and care is in place | Residents are receiving effective primary care | CCG | Medium |
| 17. | | *Clinical Support* | Consider how care homes can access wider NHS IT systems as necessary (eg SystmOne, EPaC) and develop improved connections | Residents information is easy to access from the home, leading to better co-ordinated care. | CCG | Medium |
| | | | | | | |
| 18. | ***A Successful Business*** | *Viability & Costs* | Develop the Care Home Provider Forum | More care homes attending and improved dialogue between commissioners and providers | Council and CCG | Medium |

| | *Care homes should be:* | *Specific Challenges* | **Actions** | **Outcome** | **Lead(s)** | **Timescale** |
|---|---|---|---|---|---|---|
| 19. | | | Engage care home owners with the Kirklees Business Hub | Care homes are seen as part of Kirklees Business community and have access to improved business advice / support | Council | Short |
| 20. | | | Assess the impact of the National Living Wage on care homes and develop proposals to mitigate the negative impact | Avoiding imminent care home closure | Council and CCG | Short |
| 21. | | | Collate and review the way we contract for care home places and develop proposals for changes including; fee rates, quality premiums, annual allowances, whole home costs for 1:1s, etc. | A fair charging system that is affordable and improves the viability of care homes. | Council & CCG | Short to Medium |
| 22. | | | Work with providers of care homes to look at opportunities for homes to become community hubs offering a range of outreach and in-reach support – eg short breaks, lunches, daytime activities, bathing, etc (link to 12 above) | Better range of local support for older people living in their own home and improved business model for care homes | Care Home Owners, Council and CCG | Medium to Long |
| 23. | | *Market Intelligence* | See action 8 above. | | | |

A detailed Implementation Plan for each of these actions will be developed alongside a Market Position Statement to help direct the care home market to meet local needs.

**Appendix 1**

**Current size of the Care Home Market in Kirklees**

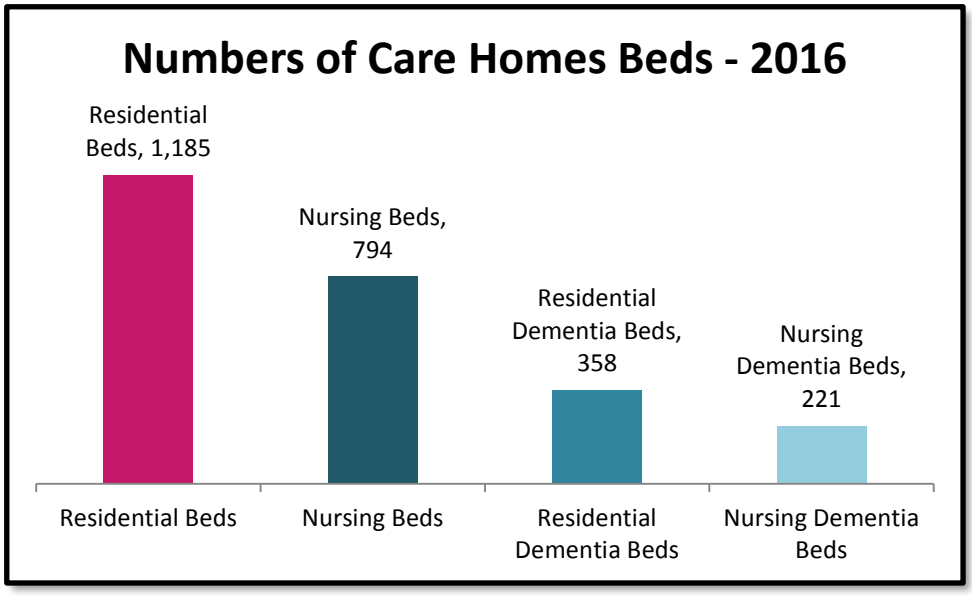
There are 67 Care Homes operating in Kirklees, 4 of which are directly managed by the local authority. Across all provision there are 2,750 beds, some of these are specialist beds which are detailed below.

The number of Care Homes has dropped from 71 in 2010 to 67 today. The total number of beds has been relatively stable, but it should be remembered that the older people population has increased by around 6,500 since 2010. In terms of what that means for the older population, there are currently 39 beds per 1000 older people, which is a decrease from 43 per 1000 older people in 2010.

**Shape and makeup of the current Care Home Market**

The Care Home market is complex, but is essentially consists of four different types of bed or placement; Residential Beds, Nursing Beds, Dementia Residential Beds and Dementia Nursing Beds.

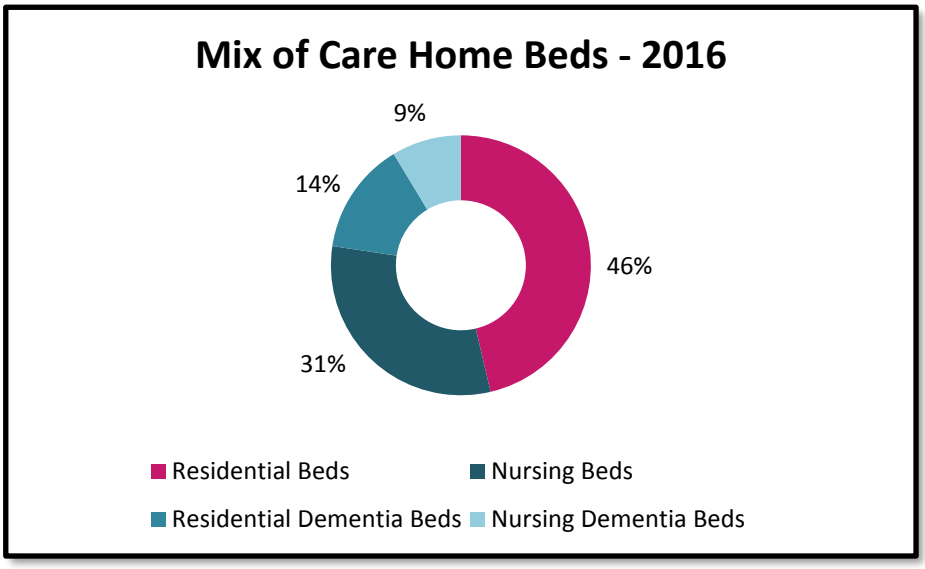
**CHART - Bed Types and numbers**




*Ref: Care Homes Beds Data 2016*

This shows the breakdown of broad types of bed current in the market. There are some beds counted in this data that are not solely used for older people, but are available for older people with specific needs.

The next chart shows the how these bed numbers look in terms of the whole market. This is currently dominated by residential beds which contains short stay and rehabilitation beds.

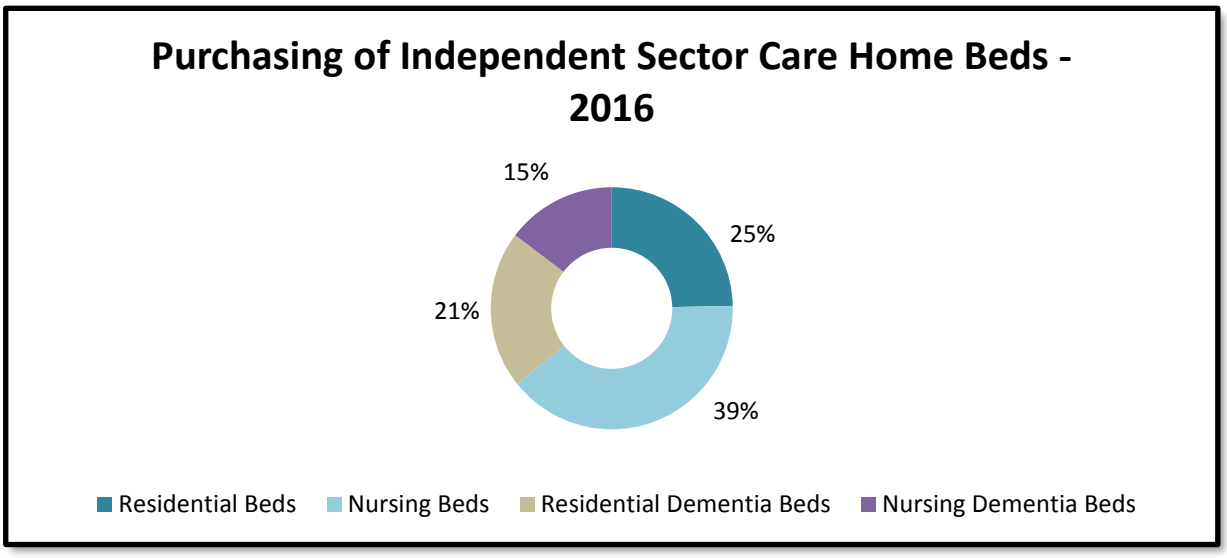



*Ref: Care Homes Beds Data 2016*

**Purchasing Information**

There are 2,750 beds that are in effect available for purchase; some of these are contracted for certain purposes or types of provision. When combined local authority and CCG's purchase around 1,650 (60%) beds, they also operate 6% of beds themselves. The remaining 940 (34%) could be a mixture of self-funders, residents from other local authority areas, or beds that are not in use for other reasons. It should be noted that some beds in Nursing Provision are jointly funded both LA and CCG's.

The funding of Care Home beds is not simple, there are a wide range of individual needs and circumstances that reflect the funding given to each Care Home bed. For instance some older people are eligible for support from the local authority for their personal care, others have to make a contribution and a further group are required to self-fund their personal care in Care Homes. There are similar complexities with how the CCG's fund Care Home beds such as eligibility for Continuing Health Care funding.




*Ref: Care Homes Beds Data 2016*

**Dementia Care**

The recent work on a dementia strategy for Kirklees has brought to the fore a wide range of accommodation requirements forecast to be needed by those suffering from dementia locally. It is estimated that 1 in 14 (4,807) older people have dementia to some degree. In terms of dementia beds there are currently 137 dementia beds for every 1000 dementia sufferers. It should be remembered that those with less complex dementia needs will be in accommodation across the care home and community sector.

There has been an increase in demand for dementia care home placements, a trend which is expected to continue as the demographics suggest significant increases in the 85+ age group and also an increasing in demand for nursing dementia placements, which the current market is not able to meet.

Please see the Kirklees Dementia Strategy for additional information. (LINK)

**Closures and changes in Care Homes**

Since April 2015 approximately 209 residential beds and 47 nursing beds were deregistered. Of these, 145 beds were situated in North Kirklees and 111 beds were situated in South Kirklees. The 47 nursing beds were also dementia beds and qualified for the Council's Dementia Payment Scheme. In addition, over the past 2 years nursing beds have been lost to the market due to care homes taking a business decision to continue operating but only providing residential beds. The main factor for this decision was the difficulty in recruiting and retaining quality nursing staff.

The majority of the home closures followed the Care Quality Commission taking regulatory action which, despite intense monitoring and support from numerous organisations, led to the owners taking the decision to close the homes and, in one case close other homes within the same group.

Of the 3 homes which closed which were not subject to or affected by regulatory action 2 of the homes were registered for less than 20 beds, with financial pressures being a primary factor in the decision to close.

## Appendix 2

## Improvement activity / support services for residential and nursing homes

**Contracting**

1. Agreed price and uplift formula
2. Joint contract monitoring process
3. Bought intermediate care beds in care homes
4. Assurance visits
5. Dementia Fee Scheme
6. Equipment list
7. Care home support included in CC2H specification

**Quality of service provided by the home**

8. Developed policies (induction, competency framework, medicines management, repeat prescriptions, anti-psychotics, distraction)
9. Good Practice Events (inc CQC inspection, Data Protection, IPC, Care Act 2014, Connect to Support , DNR documentation, Business Continuity Planning, Care of the dying documentation
10. Manager training
11. Manager forums
12. Access to Council training courses
13. Onsite training
14. Access to Online training resources (SCILS)
15. Co-ordinating nurse development and revalidation
16. Nurse coaching
17. Peer support (quarterly)
18. Rotation
19. IPC tools link
20. IPC Audit
21. IPC Training
22. @Home arts council funded pilot project
23. In2Care recruitment site

**External services that support the home**

24. Dedicated nurse support to individual homes
25. YAS 'pickup' protocol
26. Access to System One
27. Telehealth (Airedale)
28. EPAC
29. Care Home Support Service (Locala)
30. Primary Care Scheme
31. Admiral Nursing - educational and practical support into care homes
32. SWYPFT care home liaison team
33. Continence training
34. Support for Workforce NMDS completion
35. add Community Partnerships schemes

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**KIRKLEES HEALTH & WELLBEING BOARD**

**MEETING DATE: 28 April 2016**

**TITLE OF PAPER: Integrated Front Door Proposal (Multi-Agency Safeguarding Hub)**

## 1. Purpose of paper

This paper provides a proposal for the remodelling of the Multi-Agency Safeguarding Hub (MASH). It includes an outline of the current operational model and the opportunities available to strengthen the service by having a fully integrated front door. The Board are asked to consider the information within the report and ratify the proposed model.

## 2. Background

Local authorities have overarching responsibility for safeguarding and promoting the welfare of all children and young people in their area. They have a number of statutory functions under the 1989 and 2004 Children Acts which make this clear, and the Working Together Guidance 2015, sets these out in detail. This includes specific duties in relation to children in need and children suffering, or likely to suffer, significant harm, regardless of where they are found, under sections 17 and 47 of the Children Act 1989.

Whilst local authorities play a lead role, safeguarding children and protecting them from harm is everyone's responsibility. Everyone who comes into contact with children and families has a role to play. Local agencies, including the police and health services, also have a duty under section 11 of the Children Act 2004 to ensure that they consider the need to safeguard and promote the welfare of children when carrying out their functions. Under section 10 of the same Act, a similar range of agencies are required to cooperate with local authorities to promote the well-being of children in each local authority area. This cooperation should exist and be effective at all levels of the organisation, from strategic level through to operational delivery. An effective MASH operation facilitates joint inter agency working.

A joint letter from four government departments to all Local Authority Chief Executives and local safeguarding leads in March 2015 stated that their Secretaries of State were 'clear on the need for genuinely integrated multi agency approaches to underpin information sharing…every agency should commit to this approach.'

The first Mash's were developed in 2011 in response to the failure of agencies to work together to safeguard children and young people. This was documented in numerous serious case reviews and highlighted in national reports such as the Munro Review of child protection. Many of these early models were based on an approach developed by the Devon Local Safeguarding Board and rolled out across local authorities.

Kirklees have been operating a MASH since April 2015. It consists of co-located professionals from health, education, police and children's social care. The current structure of the MASH is outlined in Appendix 1.

Although the principles used to set up the Kirklees MASH were sound, it was always envisaged that the model would need to be reviewed and strengthened. In the last three months there has been a considerable amount of work undertaken within the service to understand the current practice, how it fits with the journey of the child through the system and what activity can be undertaken to improve outcomes for the children and young people of Kirklees. In relation to the MASH, the activity has highlighted that although there is evidence that the joint working is

improving information sharing, this is on a very limited basis. The MASH needs to have links to a larger network of agencies to improve information sharing.

One of the key findings from recent audit activity is that there is delay and drift in the completion of strategy discussions. The police who have responsibility for the discussions are based in Dewsbury and the social work staff are based in Central Huddersfield. The logistical difficulties have resulted In poor quality strategy discussions, which are usually done between the social work team and the police over the phone. This is not compliant with current statutory guidance.

Due to the limited way that the MASH has been set up, there are insufficient links to early help, and they do not have a presence in the MASH. This is a missed opportunity to share information and to ensure that children and families get the right help at the right time. There are limited links to key agencies that hold valuable information that would ensure a more robust assessment of risk, such as probation, housing, drug and alcohol services, youth offending services and adult services. This has diluted the effectiveness of the information sharing value of the MASH.

Recent research has shown that places, which have put such arrangements in place, are already starting to see positive results. Information sharing between partners leads to high quality and timely safeguarding referrals.

To safeguard children and young people effectively it is essential that the MASH is strengthened to improve information sharing in line with current practice expectations. The key role of the MASH is to share information in a multi agency way, jointly analyse risk and agree a multi agency response to referrals.

The integrating of the services also provides an opportunity for efficiencies by having a single entry point into a service, which reduces duplication and when effective prevents cases escalating to more costly interventions. This has beneficial budget implications for all agencies.

There is a need to have a single point of entry into the service as this ensures that there is no opportunity for children to 'slip through the net.'

In conjunction with the strengthening of the model, there are key supporting practices that need to be reviewed. This includes reviewing the continuum of need, the consent policy and the multi agency referral form. MASH is currently overwhelmed by poor quality referrals that are not on a referral form and where professionals have not gained consent of parents and children (where appropriate) to make a referral. A referral form that clearly outlines the issues of concern and lists all the family members should be completed in writing. Making a referral over the phone should only be done when there is a serious safeguarding issue that requires an urgent response. This ensures drift and delay are avoided and a decision about the next steps can be made within 24 hours which is in line with the statutory guidance. Currently, MASH receives referrals in the form of short emails, telephone calls and half completed referral forms. MASH social workers and admin staff have to spend an inordinate amount of time calling back professionals to gain a clear understanding of what the issues are and to clarify details. The information quality is very poor and as a result of this, MASH struggle to make a threshold decision in the best interest of the child within the required timescale. Often, professionals are unavailable to clarify the information and this causes delay to decision making.

Consent is an extremely important issue. MASH like every other children's service is governed by the data protection principles. It is therefore expected that unless gaining consent will negatively impact the circumstances of the child consent should always be gained for section 17 cases. Professionals in Kirklees do not routinely gain consent from parents and carers or from young people where it is appropriate. Research evidences that good practice stems from good engagement with families from the very start of the intervention. As you would expect, parents are extremely upset and angry to find out that professionals have made referrals without their knowledge and this is not a good starting point for future working relationships.

The continuum of need that is in place needs to be reviewed to provide absolute clarity about

where cases sit. It is recognised that it would assist professionals if the threshold document was clearer and also if the multi-agency referral form was more succinct and easier to complete.

**3. Proposal**

The future proposed structure of the MASH is outlined in Appendix 2. The key principle of this model is that there will be one entry point into the service and all agencies will fulfil their statutory responsibilities to safeguarding by working closely together to deliver an integrated front door. This will improve the response to risk and need and lead to better outcomes for children and young people.

Early help will have a team in the MASH to support the triage and information sharing function. This team will have strong links to the early help hubs that are being developed. When it is agreed that a family do not require a social care response they will be able to decide that wherever possible an early help offer is put in place. This will ensure that families get the right help at the right time, reduce the escalation of low-level cases and reduce re referrals.

It is unlikely that all agencies will be able to have a physical presence within the MASH, the structure outlines agencies (with broken lines around) that would have a virtual link to information share with the MASH. This would ensure that information sharing takes place with as many agencies as possible that might be working with a family. Having good quality information allows a full picture to be quickly gained to form the basis of a robust analysis of risk and need.

The addition of a Detective Sergeant from the police will allow strategy discussions to take place much quicker and reduce drift and delay. A joint multi agency response to risk can be managed at the point of referral and compliance will improve with statutory guidance. Considerable travelling time will improve the capacity for the social work teams and relationships with the police will be strengthened.

In the new model there will be a CSE and missing lead. This will allow one person to understand both cohorts of young people and provide a more robust response to intelligence and risk. In recognition of the importance of key work that needs to be undertaken in relation to the Prevent Agenda, the police representative will act as the lead professional in these areas of work and provide a link to key representatives to all agencies to ensure there is a robust response.

The numbers of staff from the Integrated Domestic Abuse Team (IDAT) have not yet been confirmed. It is really important to have a strong response to domestic violence given the high number of cases where this is a factor. The current IDAT function and impact is under review and when this is better understood the details of how they will integrate into the front door will be finalised.

There is a need for matrix management arrangements to be put in place. The MASH manager will have day-to-day line management responsibility for all agencies. This will allow holidays and low level staffing issues to be managed effectively. Clinical supervision will remain the responsibility of the relevant agency.

A review of the current accommodation has highlighted that there will be a need to move to alternative premises. There is a possibility that the police may have some suitable space in central Huddersfield and this is currently being considered alongside a proposal to relocate the MASH to the Civic Centre.

A multi-agency task and finish group has been set up to work on the remodelling and review the consent policy, the information sharing agreement and the multi-agency referral form. This group is linked to the group who are currently reviewing the continuum of need. The review of the threshold document will ensure that thresholds are clear. The managers in the MASH will be able to make clear decisions about whether the threshold requires an early help response or a social care response. This will ensure cases are not closed with no further action and that help is

provided at the right time for families. The clear processes that are in place will help the service to reduce re referrals by providing help that stops cases escalating. As part of the quality assurance framework, a threshold review meeting has been set up. This meeting will scrutinise all the MASH processes including re referrals and performance will be measured against the revised threshold document. One of the core functions of the task and finish group will be to review the systems and processes that support the function of MASH. There needs to be a clear process that outlines how cases will step up to social care and step down to early help when appropriate. It is proposed that the multi agency group is strengthened with some key senior representation from all agencies until the model and the review of associated documents and systems is completed.

The task and finish group will be producing an evaluation framework which can provide information on the difference the remodel has made to outcomes for children and young people.

It is envisaged that the implementation of the remodel could be done within twelve weeks as long as suitable accommodation was identified.

**4. Financial Implications**

Should the outline proposal be agreed, a further paper will be presented to the board, which will outline the full financial implications.

**4. Sign off**

This report was signed off by Assistant Director family support and child protection, Carly Speechley and Director of Children's Services Sarah Callaghan on the 18th of April.

**5. Next Steps**

- Multi agency partners to nominate key strategic leads who can work with the current task and finish group to deliver the remodel proposal. This will include each agency providing a paper on the financial implications.
- Outline proposal to be presented at the safeguarding board
- Review of supporting documentation (referral form, continuum of need, consent policy, step up/down process) to be completed through the task and finish group.
- Premises to be confirmed
- Detailed project plan to be put in place to outline the twelve week timeline from agreement to implementation. This will include information relating to the financial and HR implications.

**6. Recommendations**

The Board are respectfully asked to give agreement in principal to the suggested model.

**7. Contact Officer**

**Trish Berry 078975 299503**

# FRONT DOOR STRUCTURE
# AT 11th April 2016

**Police**

**Detective Sargent**
Giles Bradbury 40hrs

**Police Constable**
Linsey Levell 37.5hrs

**DIU Gangs Specialist (Researcher)**
Peter Appleby

**DIU Organised Crime Specialist (Researcher)**
Bryan Clark

These are 2 out of 7 Officers that work in MASH for one week at a time (37hrs) on a rotational basis

**Education**

**Attendance Improvement Officer**
Peter Jackson 37hrs

**Health**

**Specialist Safeguarding Officer**
Nicky Kelly 35hrs

**Social Work Team**

**Manager**
Tracey Swaine 1FTE

**Senior Practitioner**
Debbie Pearson 1FTE
Theresa Racz 1FTE

**Social Work Team**

**Manager**
Lisa Storey 1FTE

**Senior Practitioner**
Elsa Newall 1FTE
Yasmin Lawrence 1FTE

**MASH**

**Manager**
Mark Campbell 1FTE

**Deputy Team Manager**
Jenny Johnson-Cummings 1FTE

**Social Worker**
Deborah Osbourne 1FTE
Lydia Fell 1FTE

**EITS**
Maxine Wood 1FTE
Vacancy 1FTE

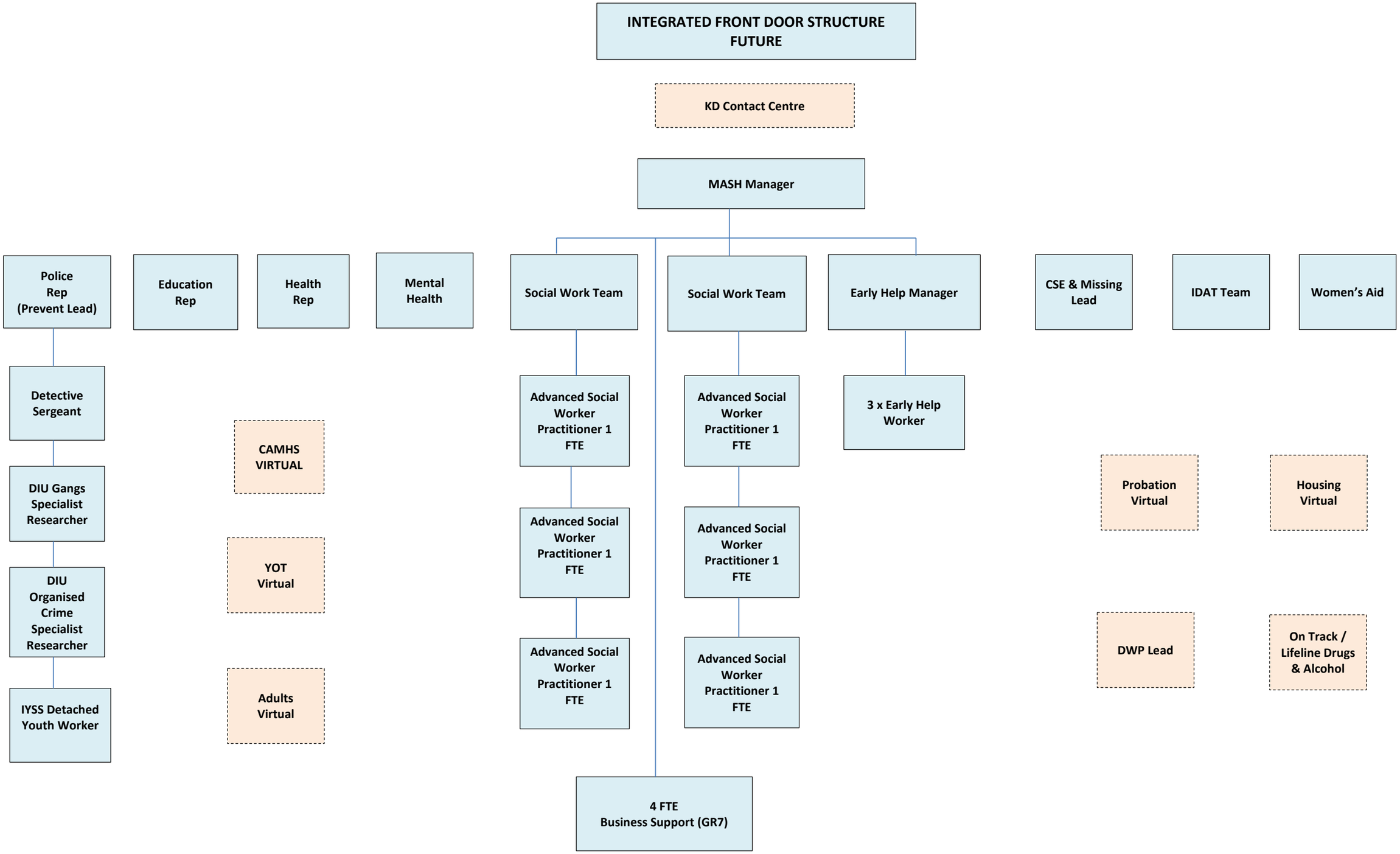
**IDAT Team**

**Social Worker**
Caroline Dawkins 18.5hrs

**Community Care Officer**
Lisa Moran 18.5hrs
Linda Hoare 1FTE
Jonathan Fell 1FTE

**Domestic Abuse Officer**
Angela John 1FTE
Dannie Denton 18.5hrs
Kirk Robinson 18.5hrs

# INTEGRATED FRONT DOOR STRUCTURE FUTURE



| KIRKLEES HEALTH & WELLBEING BOARD | |
|---|---|
| **MEETING DATE:** | **28th April 2016** |
| **TITLE OF PAPER:** | **Transforming Care Partnership Plan** |

**1. Purpose of paper**

The purpose of this report is to present the draft Transforming Care Plan so the Board can be cited on the direction of travel that the partnership is working towards to ensure we meet our requirements in line with the Transforming Care Agenda.

The plan will be further developed with key stakeholders to ensure true co-production and an engagement event has been planned for the 25th May 2016 and a draft plan of the event is included within the plan.

**2. Background**

NHS England's planning assumptions were based on areas of £1m population and this is what they based the Transforming Care Partnerships (TCP's) on. Across the North and Humber region, 7 TCP's were asked to work together. Calderdale, Kirklees, Wakefield and Barnsley (CKWB) Transforming Care Partnership was one of these TCP's and they have worked collaboratively to develop a programme that will transform our community infrastructures and reshape services for people with a learning disability and/or autism. The plan will be framed around Building the Right Support and the National Service Model October 2015 and it will be developed to ensure the needs of the five cohorts identified are included as well as the wider population when transforming services.

The CKWB region was rated as the 6th highest for CCG commissioned in-patient beds (including all assessment and treatment beds and locked rehabilitation beds) in July 2015 and, although work has been ongoing and the number has reduced, we are still well over the national planning assumptions for in-patient beds. For NHS England commissioned beds (including all low, medium and high secure beds), the region was mid table, but following several discharges since July 2015 the numbers are now within the national planning assumptions.

The key aims for our plan will be:

- Reduction of CCG commissioned in-patient beds, delivering a 60% reduction across the partnership by 2019
- Developing better/new/broader range of specialist community services that are flexible and responsive to manage crisis better and prevent admission
- Developing capable communities to enable people to live in their own homes
- Developing a better understanding of our local populations with complex needs and how best to support them in a crisis
- Ensure people with a learning disability and/or autism have the opportunity to live meaningful and fulfilled lives

**3. Proposal**

Endorse and support the Transforming Care Plan.

**4. Financial Implications**

Assurance that the financial section (Section 7) of the plan meets the Transforming Care Agenda requirements.
Assurance that any financial implications within the plan will be maintained within the existing financial envelope along with the match funding application to NHS England.

**5. Sign off**

Carol McKenna – Chief Officer

Vicky Dutchburn – Head of Strategy, Business Planning and Service Improvements

**6. Next Steps**

The plan is continually being developed and the final submission to NHS England is the 1st July, with check points at 20th May and 24th June. The mobilisation date was the 1st April 2016, but it is acknowledged that the plan will evolve once we have engaged and moved towards a co-production approach to shape the future of the learning disability provision.

- Engagement Day with key stakeholders to enable real co-production
- Set up all work streams with the right membership
- Further develop the plan and move to mobilisation

**7. Recommendations**

It is recommended the Health & Wellbeing Board:

- Agree they are assured that the CCG's and the LA are meeting the requirements of the Transforming Care Agenda
- Endorse and support the Transforming Care Partnership

**8. Contact Officer**

Kelly Glover, Transforming Care Partnership Programme Manager,
kelly.glover@greaterhuddersfieldccg.nhs.uk, 01484 464126

NHS
Greater Huddersfield
Clinical Commissioning Group

# Calderdale, Kirklees, Wakefield and Barnsley (CKWB)

# Transforming Care Partnership Plan

## Table of Contents

# 1. Executive Summary

The Calderdale, Kirklees, Wakefield and Barnsley (CKWB) Transforming Care Partnership has been formed to collaboratively develop a programme that will transform our community infrastructures and reshape services for people with a learning disability and/or autism. The plan will be framed around Building the Right Support and the National Service Model October 2015 and it will be developed to ensure the needs of the five cohorts below are included as well as the wider population when transforming services.

- A mental health problem, such as severe anxiety, depression or a psychotic illness which may result in them displaying behaviours that challenge
- Self-injurious or aggressive behaviour, not related to severe mental ill-health, some of whom will have a specific neurodevelopmental syndrome with often complex life-long health needs and where there may be an increase likelihood of behaviour that challenges
- 'Risky' behaviour which may put themselves or others at risk (this could include fire-setting, abusive, aggressive or sexually inappropriate behaviour) and which could lead to contact with the criminal justice system
- Lower level health or social care needs and disadvantaged backgrounds (e.g. social disadvantage, substance abuse, troubled family background), who display behaviour that challenges, including behaviours which may lead to contact with the criminal justice system
- A mental health condition or whose behaviour challenges who have been in in-patient care for a very long period of time, having not been discharged when NHS campuses or long-stay hospitals were closed

The CKWB region was rated as the 6$^{th}$ highest for CCG commissioned in-patient beds in July 2015 and, although work has been ongoing and the number has reduced, we are still well over the national planning assumptions for in-patient beds. For NHS England commissioned beds, the region was mid table, but following several discharges since July 2015 the numbers are now within the national planning assumptions.

Each area within the partnership had already developed programmes locally to transform services, but it has been acknowledged that the partnership will prove invaluable to harness the collective knowledge and experience to further build on progress already made and to use our resources more effectively and efficiently to gain more momentum in the delivery of new models of care and support for the most complex people.

**The key aims for our plan will be:**

- **Reduction of in-patient beds, delivering a 60% reduction across the partnership by 2019**

- **Developing better/new/broader range of specialist community services that are flexible and responsive to manage crisis better and prevent admission**
- **Developing capable communities to enable people to live in their own homes**
- **Developing a better understanding of our local populations with complex needs and how best to support them in a crisis**
- **Ensure people with a learning disability and/or autism have the opportunity to live meaningful and fulfilled lives**

# 2. Mobilise communities

## 2.1 Governance and stakeholder arrangements

### 2.1.2 Governance arrangements for this transformation programme

There are strong partnerships in place across the CKWB region and these have enabled many of the key partners to be brought together and engage in the development of this plan. NHS and Local Authority commissioners and a wide range of other stakeholders are committed to developing and delivering the new models of care and support for people with learning disabilities with complex needs. This will be achieved working closely with all key partners and people with learning disabilities, their families and advocates and will be provided through more detailed co-produced plans.

The CKWB Transforming Care Partnership Board has been established to oversee the development and delivery of the transformation programme across the region. This Board has endorsed the draft plan and during the next two months the final draft will be completed and formal endorsement will be sought from Health and Wellbeing Boards within the region. Partners represented at the CKWB Transforming Care Board include:

- Kirklees Council
- Calderdale Council
- Wakefield Council
- Barnsley Metropolitan Borough Council
- Calderdale Clinical Commissioning Group
- Greater Huddersfield Commissioning Group
- North Kirklees Clinical Commissioning Group
- Wakefield Clinical Commissioning Group
- Barnsley Clinical Commissioning Group
- Specialist Commissioning Services
- Learning Disability Partnership Boards

Representation is from senior leaders from each organisation who have the authority or lead role to deliver the transformation programme.

### 2.1.2 Internal Governance

**Transforming Care Plan**

Each CCG will also feed the TCP plan into their respective quality and safety groups to ensure the clinical governance is met; these will also go to their Governing Bodies for information.

**Local Plans**

Each area has currently got its own governance structure for reporting their local plans; these joint groups (listed below) will also be used to feed the TCP plan progress.

Calderdale – Joint Transforming Care Steering Group
Barnsley – Adult Joint Commissioning Group
Wakefield – Connecting Care Executive
Kirklees – Integrated Commissioning Executive

The terms of reference for the Board and further details regarding programme governance are embedded below.

CKWB TOR V 5.doc

**Health and Wellbeing Boards – Dates of next meeting for sign off**

Kirklees Health and Wellbeing Board – 28th April 2016
Calderdale Health and Wellbeing Board – TBC
Wakefield Health and Wellbeing Board – 24th March 2016
Barnsley Health and Wellbeing Board – 5th April 2016

### 2.1.3 Describe stakeholder engagement arrangements

There have been multiple engagement events across the partnership around learning disability services and although the key stakeholders that have been identified above are actively working on the development of the transformation plan, it is recognised that much wider and targeted engagement needs to happen to develop a fully co-produced transformation plan and one of the key work-streams will be to develop a detailed communications and engagement strategy ensuring input from other stakeholders including:

- People with Learning Disabilities, Carers and their Families, all ages including those with lived experience of secure services
- Patient Reference Groups – Kinfo

- NHS service providers including
  - Primary Care
  - Community Services
  - Acute Care
  - Specialist learning disability service providers
- Voluntary and Community Sector
- Public Health
- Criminal Justice System
- Private Providers
- Health Education England
- Inclusion North

### 2.1.4 Describe how the plan has been co-produced with children, young people and adults with a learning disability and/or autism and families / carers

There have been numerous engagement events across the four areas in the TCP over the last three years which have focused on building better services in the community, including enhanced community team pathways with 24/7 coverage, accommodation, provider frameworks for community provision and crisis services. South West Yorkshire Partnership Foundation Trust has also delivered several engagement events around their transformation for LD community and in-patient services that covered the TCP region.

## 2.2 Engagement with Children and Young People

There has been lots of engagement across the TCP following on from the Future in Mind Report with children, young people and their families and carers. The feedback from this engagement has helped develop a 5 year strategy to improve access to services, developing new and innovative ways to meet mental health and learning disability needs whilst building up resilience in children, young people and their families in their schools and wider communities to improve outcomes.

Significant consultation and engagement has also taken place with children, young people and their families, specifically in relation to services for ASD / ADHD and LD. The purpose of the consultation was to develop a new pathway for accessing services and improve engagement, and develop a more integrated delivery model for these services. A transformation group has been working together for two years, including practitioners and parent reps, developing and consulting on the pathway and changes to the services. There have been numerous engagement events with children, young people and their families and carers which have further helped shape the proposals, and update on progress to date. This work is continuing currently.

Following engagement, recovery plans have been developed for the ASD / ADHD pathway which are being redesigned to reduce waits, and increase capacity for

undertaking assessments. The referral process has also been reviewed in line with the local transformation plan. This includes referrals direct from universal and early help services to improve information and develop a more multi-disciplinary offer. The pathway development also includes a non-clinical offer with the Educational Psychology team within the Local Authorities SEND service undertaking assessments.

The SEND Service have worked with the Community Paediatric service to develop an early intervention offer and package of support for ASD / ADHD / LD which aligns with the new pathway being developed, and fits in the recommendations in the transformation plan.

The developments for LD and ASD align with the transformation to develop an early response and support for children and young people, and will support a reduction in in-patient services and minimise the impact of pre-admission CTR (care and treatment review).

The consultation undertaken for Future in Mind is listed below:

- Education and Schools partnership group
- Third Sector partner engagement
- Listen to ME(ntal Health)
- Young Healthwatch Mental Health Forum
- Risk-taking Behaviours
- School Counselling Support
- New Technologies / Social Media
- Support for LGBT young people (Lesbian, Gay, Bisexual and Transgender)
- Emotional support for younger people
- Transition in to adult services
- Access to services through the hubs
- CAMHs Friends and Family Questionnaires
- Perinatal Mental Health user survey

The common themes from engagement, whether that be from the learning disability transformation programmes, the care closer to home programmes or the future in mind transformation, are the same, people want to be empowered and to have more control. This plan is about enabling people to be more resilient, providing them with the skills and tools and developing a robust community infrastructure that will be flexible and able to deliver high quality services as and when people need them.

### 2.3 Feedback from Engagement Events

- Easy access to services and information that is easy to understand
- Care closer to home, but do not want homes turned into hospitals
- Bespoke housing - right housing / environment for the individual

- Personalisation needs to include people with challenging behaviours
- Families should be recognised as being part of the workforce, could support be provided in the family home whilst Mum and Dad take a break elsewhere?
- Training does not just have to happen in a 'room'. Sometimes it's about sharing information and good ways of doing things
- Using people's communication plans and person-centred plans helps us understand what they want. It helps us make sure the Mental Capacity Act is being applied effectively
- We need to get the voice of families in the JSNA
- We need to make sure people who are away from home get access to advocacy
- We need to make sure that people are not isolated. People need those who love them in their lives and support should be given to visit family and friends
- We need to invest in prevention to prevent families breaking down
- Having access to the internet
- Accessible leisure activities e.g. swimming, football, drama group and other groups are important to our wellbeing and support to be able to do these
- LD champions who work in general hospitals to ensure the nursing staff understand our needs
- Keep our Activity centre, and have more groups
- Reasonable adjustments should be included within all health and social care contracts
- Very important to have efficient caring help. Priorities for carers; plenty of help and more facilities for good respite care
- Supporting people who use services is critical to maintaining their care / wellbeing
- Independent support such as advocacy is highly valued by users and carers
- People also find support in other ways such as community groups, voluntary organisations, friends and social groups
- Social connections and a sense of belonging is important to wellbeing and coping
- Staff can be caring and compassionate, basing their care around the person's needs as much as they can in the restrictions that they work in
- Hospital / bed based care does work for some people; it is often very much like a house or flat not like a ward – it is home for some people and should be recognised
- Visits to doctors are helped if the doctor or nurse knows the individual and their history and has time to listen carefully, it is important that if referring to hospital the right information is passed on
- Local register needs to include all people with challenging behaviour
- Still too many people in high cost placements out of district
- Access to Mental Health Services is sometimes difficult

- Barriers to accessing universal services within the community
- Short breaks tend to be building based
- Too much investment in specialist services and high cost placements without understanding the quality of these placements
- Not all GP practices offer health checks
- Lack of hydrotherapy services – time limited / cost
- Landlord / housing issues – not responding to repairs quickly, chasing up responses from housing
- Withdrawal of service bus and general bus services reducing
- The negative impression of hospitals that have been given since Winterbourne, and other hospital scandals
- More supported work placements / job opportunities - We do not want to just walk round shopping centres all day
- Speech and Language Therapy and support in school, needs resourcing
- There needs to be raised awareness at all levels of learning disability and autism
- More communication is needed with the people who use services, their families and carers. This needs to be ongoing genuine consultation resulting in recommendations that are acted upon and resourced
- We need more learning disability and autism champions – on the Clinical Commissioning Group Board, in general practice, at the council and other providers of health and care services
- Not getting diagnosed early enough - underlying conditions or co-morbidities not being addressed in a holistic way
- Confusion of where to go for services / help and understanding what is available - no single point of access
- Transitions are problematic (children's services to adults, hospitals to community, from one provider or funder to another)
- Too much focus on risk and not enough thought given to independence
- Lack of understanding of MHA / Consent, some people noted that Sections are being used or managed inappropriately
- Not enough independent / advocacy support to help explain and challenge restrictions / out of area decisions that take the person far away from family
- Professional workloads / processes are not well designed to meet needs for this group – e.g. GP appointments too short, LD Community teams have too broad a remit, support workers are isolated / low wage based, specialist providers are few
- Care plans are often not complete or up to date or well followed; reviews are often infrequent or not robust; health action plans in primary care not being used

- There is a lack of networking across the system to wrap care around people – reports of arguments between agencies and refusals to accept cases e.g. Autism
- When communications are poor, people with learning disabilities feel they are not listened to and not understood – their views are not taken into account and changes in care are being made 'to them'
- Professionals noted the lack of integration in systems, partnerships and funding leading to delayed decisions, particularly in relation to judicial requirements: 'people are getting stuck in the system'

### 2.4 Describe the Health and Care Economy covered by the plan

There are various providers, including NHS providers, private sector and the voluntary sector that are providing services across the region and most are under single commissioner contracts, either block, frameworks or spot purchased. There is a mix across the TCP where some joint commissioning between local authorities and CCGs and pooled budgets are in place but not with all. The partnership is committed to further exploring ways of joint commissioning, pooled budgets and alternative ways of commissioning to support the delivery of the transformation plan.

The current model of provision, albeit slightly different in each area, is generally the 'traditional' model that is dependent on care home provision and 24/7 supported living services. It is recognised there is a need to develop new bespoke models of provision to be able to care and support people with learning disabilities and/or autism with behaviour that challenges.

The arrangements below are for **all ages** including children and young people.

### 2.5 Current Commissioning Arrangements

**Clinical Commissioning Groups** – A range of local commissioning arrangements exist across each area but are not all consistent across the partnership:

- Personal health budgets are offered to enable personal choice and flexibility, this allows people to purchase their own support Block contracts are in place for community services from SWYPFT
- Block contracts are in place for some A&T beds and some are purchased on a spot purchase basis
- Spot contracts are in place for all in-patient rehabilitation beds
- Block and spot contracts are in place for respite services and day care services
- A mixture of Frameworks, spot and block contracts are in place for residential / nursing placements

**Local Authorities** – A range of local commissioning arrangements exist within each authority, but are not all consistent across the partnership:

- All local authorities offer personal budgets, enabling individuals to choose a managed budget, a direct payment or a mixture of the two. A range of support services are offered to people who chose a direct payment to help them identify and secure the support they need and to help manage the direct payment. In most authorities such options are supported by approved provider lists or a system for accrediting providers. Many of these are now featuring joint care and health budget elements
- Regarding provision of supported living services, accommodation and day care, most authorities have a Framework Agreements or Approved Provider mechanisms in place covering provisions for different levels or types of need.
- Provision of highly specialised services or tailored individual packages may involve traditional tenders outside of those arrangements if they do not fall under the supported living framework agreement
- The community support and supported living framework agreement, offers 3 levels of funding for specialist social care funded services, that enables individual bespoke packages of social care provision to be commissioned
- For respite provisions, authorities use a mixture of block and spot purchase contracts within traditional building based services and also provide personalised respite provisions via direct payments that focus on individual outcomes
- Residential care is usually on a block or spot-contract basis, but mainly spot as personalisation has meant a shift in commissioning block residential care.

**NHS England Specialised Commissioning** – Services such as Child and Adolescent Mental Health services (CAMHs) and Adults are commissioned for patients from England. These services meet the four factors for specialised services as described in the prescribed services manual. (NHSCB 2013). The services are commissioned and contracted for using the NHS standard contract. Services are contracted on a block basis with an all-inclusive price. Currency for payment is usually by occupied bed day for impatient services and by activity for community services. CQUIN schemes are in place for all services and monthly contract monitoring meetings are held to manage performance against the contract.

### 2.6 Provider geography, natural alignments and collaborative arrangements

The partnership is committed to further exploring ways of joint commissioning, pooled budgets and alternative ways of commissioning to support the delivery of the transformation plan and there is one key area where this is already happening.

South West Yorkshire Partnership Foundation Trust currently provides the specialist community service and some of the assessment and treatment beds across the TCP. The partnership is already working on a joint service specification for the

community services including the new enhanced community service and discussions are taking place for most of the CCGs to commission the in-patient assessment and treatment beds.

It is recognised there are benefits from further joint working with providers and this will be incorporated within the overall plan for further scoping to identify key areas where changes can be made at provider level, especially where care providers are present across all four partner regions.

### 2.7 System and market engagement

There are several provider forums across the partnership, which bring a range of social care, health care, private and voluntary sector providers together to share best practice, work in partnership to address key issues and challenges, make clear local priorities / need and give clear strategic messages on market development. This needs to be further developed to bring this together across the partnership and mechanisms put in place to ensure a strong collaborative approach to deliver the system wide changes.

### 2.8 Geographical boundaries and organisational considerations

There is a natural grouping across our TCP as we all commission from the same partnership trust for specialist learning disability services. However there are considerations to be taken into account when further developing the plan including:

- Local variation in the need for market transformation
- Geography and deprivation
- Extremes of in-patient numbers
- Determining ordinary residence
  - Our TCP has 36 secure beds and this can be an issue when stepping people down due to ordinary residence rules
- People from out of area currently in our transformation area or people from our transformation area placed ‘out of area’
  - Our TCP is a net importer for residential placements and London is one of the main areas who export into our area
  - Our TCP is an exporter for college placements are there are not enough locally
  - Prison population is high in Wakefield
- Commissioning of specialised services
- Different pathways
- Transition from children to adult services
- Data and information sharing across transformation region
- Contracts
- Vanguards and Integrated Care Pilots

One of the key actions on our route map is to undertake an in-depth review of our current baseline considering all the above factors.

## 3. Understanding the status quo

### 3.1 Baseline Estimates

| Baseline estimates - LD | | | | |
|---|---|---|---|---|
| **Age Band** | **2015** | **2020** | **2025** | **2030** |
| 18-24 | 2,788 | 2,586 | 2,541 | 2,781 |
| 25-34 | 3,839 | 3,994 | 3,977 | 3,772 |
| 35-44 | 3,757 | 3,709 | 3,960 | 4,122 |
| 45-54 | 4,157 | 4,042 | 3,638 | 3,608 |
| 55-64 | 3,289 | 3,634 | 3,901 | 3,774 |
| 65-74 | 2,637 | 2,823 | 2,829 | 3,152 |
| 75-84 | 1,374 | 1,575 | 1,942 | 1,571 |
| 85 and over | 498 | 590 | 729 | 914 |
| **Total** | **22,339** | **22,953** | **23,517** | **23,694** |

Information has been gathered from various sources and analysed to provide a baseline assessment of needs and services. This has included the Learning Disability Self-Assessment Framework, Joint Strategic Needs Assessment's, Joint Health & Wellbeing Strategies, Transforming Care Data, Projecting Adult Needs & Service Information System, Projecting Older People Population Information System, Future in Mind Strategy and internal databases.

#### 3.1.1 Population and Demographics

| Area | Total population | Adult population | LD/Autism Population | LD/Autism known to services |
|---|---|---|---|---|
| North Kirklees / Greater Hudds | 423,000 | 335,826 | 7,912 | 1,530 |
| Calderdale | 203,000 | 169,798 | 3,827 | 672 |
| Wakefield | 332,000 | 287,379 | 6,180 | 1,374 |
| Barnsley | 231,200 | 199,749 | 4,420 | 1,106 |
| **Total** | **1,189,200** | **992,752** | **22,339** | **4,682** |

#### 3.1.2 Analysis of in-patient usage by people from Transforming Care Partnership

The national plan 'Building the Right Support' published on 30th October 2015 sets out a planning assumption that each TCP will reduce reliance on in-patient care, and where they are currently above this level, will plan to reach an in-patient rate within the range 20-25 in-patients per million population for NHS England commissioned

services and 10-15 in-patients per million for CCG commissioned services by March 2019. The CKWB partnership has a population of approx. 1.2 million and is basing the plans on the following:

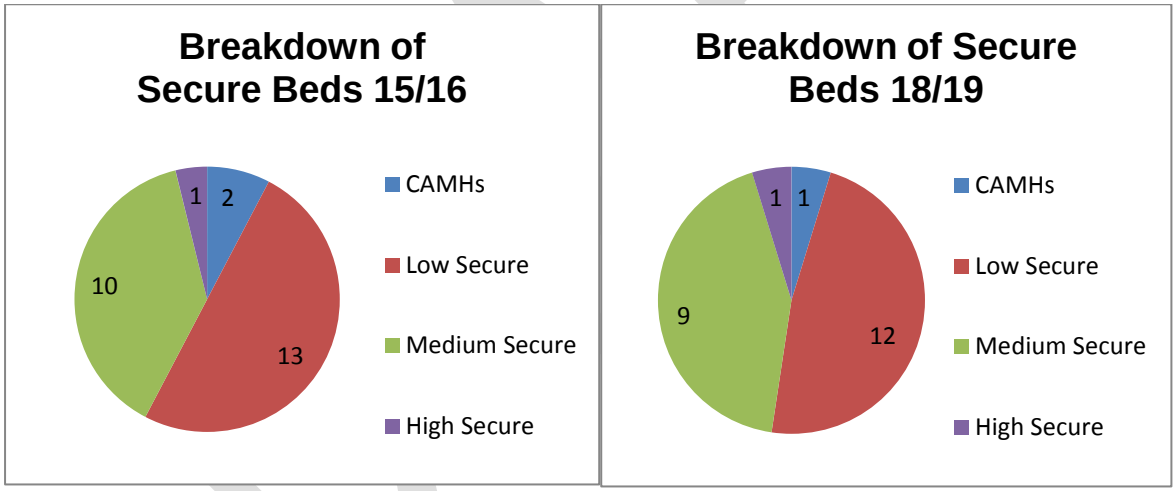
NHS England commissioned - 30 in-patient beds

CCG Commissioned - 18 in-patient beds

### 3.2 NHS England Commissioned Services

There are currently 26 people in secure services and the breakdown of type of bed is shown below. This number is already within the 20-25 planning assumption range, however work is ongoing to reduce these numbers and it is forecast that this will be 21 in 18/19 which will be lower than the planning assumptions.

| Secure Beds | Actual 15/16 | Forecast 18/19 |
|---|---|---|
| Adults | 24 | 22 |
| Children | 2 | 1 |
| **Total** | **26** | **23** |




Attached is NHS Specialised Commissioning narrative to support this plan.

Spec Comm Narrative for YH TCPs

### 3.3 Clinical Commissioning Group Commissioned Services

There are currently 38 people in in-patient beds, this is more than double the national planning assumption level, however by the end of year 1 this will have reduced by 45% and by the end of year 2 we will have achieved better than the levels suggested of 18 in-patient beds across the partnership. It is worth noting that although the numbers are quite high for year 0, there has only been 4 people out of

the 38 that have been in longer than five years. See below table for forecast in reduction of beds over the next three years.

### 3.3.1 Numbers and Projections for CCG Commissioned In-patient Beds

| Year | Year 0 (2015/16) | Year 1 (2016/17) | | | | Year 2 (2017/18) | | | | Year 3 (2018/19) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Period** | **31/03/16** | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
| CCG In-patient Beds | 38 | 31 | 28 | 26 | 21 | 16 | 16 | 16 | 15 | 14 | 14 | 14 | 14 |

### 3.3.2 Annual spend of in-patient beds commissioned by the CCGs and NHS England Specialist Services

| | Annual cost (£) 2015/16 | Annual cost (£) 2016/17 | Annual cost (£) 2017/18 | Annual cost (£) 2018/19 |
|---|---|---|---|---|
| CCG commissioned patients | £6,365,346 | £4,529,910 | £2,844,699 | £2,532,525 |
| NHS England Specialised Commissioned patients | £5,980,476 | £5,370,223 | £5,004,406 | £4,760,305 |
| **Total** | **£12,345,822** | **£9,900,133** | **£7,849,105** | **£7,292,830** |
| **Cumulative Reduction in spend** | | **£2,445,689** | **£4,496,717** | **£5,052,992** |

The current spend is in excess of £12m and the planned reduction of spend in in-patient beds is over £5m with the largest reduction coming from CCG commissioned beds which will be used to reinvest into community provision.

## 3.4 Describe the current system Current Services and Provision

### 3.4.1 Learning Disability Community Teams

All 5 CCGs commission their local specialist learning disability service from South West Yorkshire Foundation Partnership Trust (SWYPFT) at an annual cost of approx. £7.7m. In some of the areas Social Workers and Community Nurses work together as part of the integrated Community Teams for Learning Disabilities (CTLDs) which is managed by the Local Authorities, but this is not consistent across the TCP as some have moved away from this approach.

### 3.4.2 Assessment and Treatment Units

SWYPFT provide assessment and treatment beds across two units. Fox View has 4 beds and is in Kirklees and Horizon is an 8 bedded unit and is in Wakefield. Assessment and Treatment beds are currently block commissioned by three of the CCGs and these services include a number of therapies including psychology. Of the other two CCGs, one commissions a block bed from another trust and the other CCG commissions from the private sector on a spot purchase.

### 3.4.3 In-patient Rehabilitation

All in-patient rehabilitation beds are spot purchased by all CCGs from private providers who all offer a similar service.

These placements are mainly out of area of the TCP, see table below showing current position.

| Provider | Total of Beds either commission or used | No of beds in TCP area | No of beds out of TCP area |
|---|---|---|---|
| Priory Group | 5 | 5 | 0 |
| Cambian Healthcare | 15 | 2 | 13 |
| Lighthouse Group | 5 | 0 | 5 |
| Other Provider | 4 | 2 | 2 |
| Turning Point | 1 | 0 | 1 |
| St George's Healthcare | 2 | 0 | 2 |
| **Total** | **32** | **9** | **23** |

### 3.4.4 Respite and Short Break Services

Across the TCP there are different respite services and short break services commissioned by both health and social care including joint commissioned services. Demand continues to grow for these services.

A recent trend since the introduction of personal budgets has seen a steady increase in the number of people taking a direct payment as an alternative to traditional, building-based short break services. A direct payment / PHB can be used to create an individually designed person-centred short break, possibly visiting a place of interest, friends or extended family, staying in ordinary accommodation with a personal assistant or paid carer. This more personalised, creative approach still gives carers a break from caring but also enables the cared for person to have a new life experience.

We expect to see continued demand for short breaks services grow, but expect more people to take up direct payments / PHB to purchase an individually designed short break. We also expect individuals to join together personal budgets to collectively purchase short break services with friends.

### 3.4.5 Residential / Care Home

Learning disability care home provision for individuals with challenging behaviour and complex health needs represents a significant cost pressure within the overall care home provision expenditure. The TCP all commission care home provision via spot purchasing arrangements to promote user choice. The local authorities all work in partnership with its independent sector market and has developed 'fair rates for care' where the Council is statutorily required to implement 'usual rates' in an attempt to balance local market conditions, the strategic aim to promote and support

independence, organisational pressures and to provide reasonable levels of stability and sustainability within the local care home market. The Council has an approach of working with providers to raise standards of care through its contract monitoring and annual review processes and provider forum mechanisms. Each area within the TCP has an accommodation strategy in place which clearly states the intentions to reduce the use of care home provision and develop supported living, this is a more cost effective provision and also support the move towards more independent living.

### 3.4.6 Supported living

There are various levels of supported living across the regions and this is one of the largest provisions currently commissioned by all areas.

Intensive care and support provided on a 24 hour - 7 days a week basis (where the Council typically commissions both the care and support service plus the accommodation).

Support and enablement services for people with lower levels of need who have their own living arrangements in place (e.g. living with parents etc.).

### 3.4.7 Support and Enablement / Care at Home

There are many packages of support offered in a person's home across the area, this is also significant spend for all areas.

### 3.4.8 Day Care

There are several day care facilities commissioned by both local authorities and CCGs across the TCP, these range from dealing with low to high complex people with a learning disability.

### 3.4.9 Other services commissioned include the following

- Shared Lives
- Advocacy Services
- Transport Services
- Housing Related Support
- Information and Advice Support

**Current spend on LD Services**

| Provision | Annual cost to CCG(s) in 15/16 (£) | Annual cost to local govt in 15/16 (£) | Total |
|---|---|---|---|
| Community Teams | £7,646,832 | £3,242,000 | £10,888,832 |
| Other Community Teams | £62,002 | £0 | £62,002 |
| Day Care Facilities | £1,601,353 | £9,704,025 | £11,305,378 |

| Provision | Annual cost to CCG(s) in 15/16 (£) | Annual cost to local govt in 15/16 (£) | Total |
|---|---|---|---|
| Domiciliary/Home Care | £3,486,537 | £1,252,310 | £4,738,847 |
| Educational Establishment | £525,562 | £0 | £525,562 |
| Care Home | £16,639,562 | £26,606,000 | £43,245,562 |
| Respite Services | £954,182 | £1,107,621 | £2,061,803 |
| Shared Lives | £137,952 | £1,067,000 | £1,204,952 |
| Supported Living | £2,827,027 | £31,303,183 | £34,130,210 |
| Short Breaks Service | £0 | £570,000 | £570,000 |
| Housing Support | £0 | £0 | £0 |
| College Transport | £0 | £221,860 | £221,860 |
| Support / Advice Services | £28,500 | £651,500 | £680,000 |
| Other Costs requires further breakdown | £9,801,216 | £18,810,000 | £28,611,216 |
| **Total** | **£43,710,725** | **£94,535,499** | **£138,246,224** |

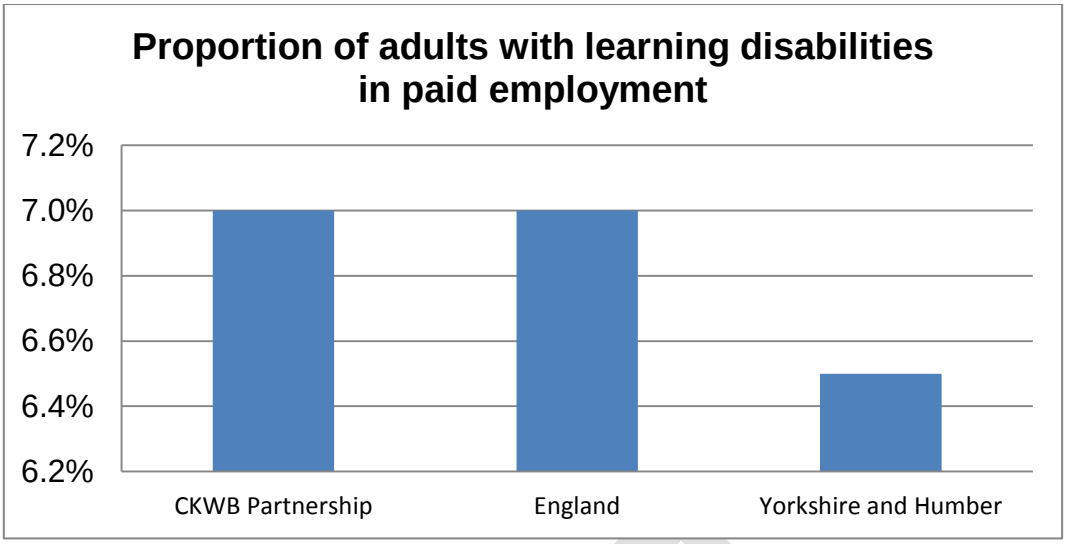
## 3.5 How does the current system perform against current national outcomes?

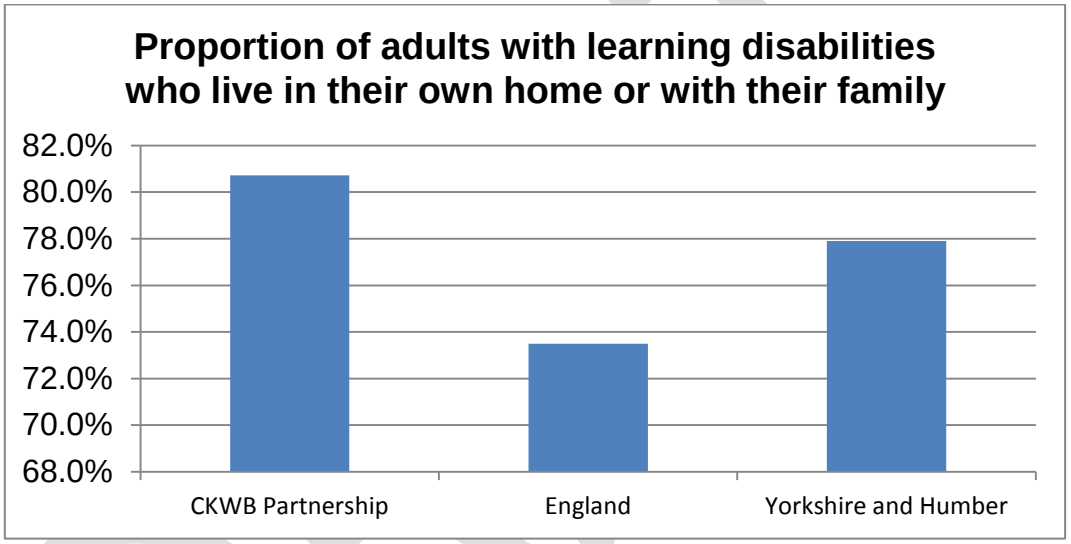
### 3.5.1 In-patient Bed Commissioned v National Planning Assumptions

When 'Building the Right Support' was published, the CKWB partnership was ranked 6th in the country for the highest number of in-patient beds commissioned by the CCG by population. Since this data was taken based on July 2015, we have already reduced our in-patient beds by 6, with a further 7 by the end of quarter 1 in 16/17. The current position of secure beds commissioned is already aligned to the upper planning assumption.

### 3.5.2 Adult Social Care Outcomes

The two key measurements which relate to people with a learning disability on the Adult Social Care Outcomes Framework (ASCOF) are shown below. The performance for the CKWB Partnership for both outcomes, is equal to or greater than the England average, and both outcomes are greater than the average for Yorkshire and Humber region.




### 3.5.3 What does the current estate look like? What are the key estates challenges, including in relation to housing for individuals?

Each of the partner areas has a range of accommodation provision through, in house, independent and voluntary sector provision locally. Wakefield for example has over 60 supported living establishments for individuals and up to 12 people living together and Calderdale has a 12 bed short stay, emergency and respite provision. This estate is reviewed locally on an ongoing basis for its quality, usage and relevance to the overall need of the LD population.

There will be a full consolidated review of the estates for all areas included in the TCP and a full update will be provided in the next plan.

## 3.6 What is the case for change?

### 3.6.1 Challenges within the current care model

- Lack of specialist enhanced or crisis support teams over 7 days per week that support parents and care providers in the individual's home

- No step up ‘safe places’ for people to go when a crisis occurs, the default is an in-patient bed
- Lack of a preventative approach to people in crisis and clarity about action / support needed.
- Lack of support / training for carers to manage family members with complex needs behaviours that challenge
- Lack of understand of numbers ‘at Risk’ potential to need crisis support to prevent admission
- Not enough robust specialist respite provision
- Lack of highly skilled providers across the area to manage challenging people in a community setting
- Availability of specialist-designed suitable premises for people with behaviours that challenge / autism
- Lack of positive risk taking across the board
- Lack of partnership working in the wider community to assist in safe discharge of people with history of offending behaviours
- Lack of good information systems and sharing data, forward planning
- A lack of robust outcome measures (possibly a knock-on effect from poor information systems) means that progress had been hard to measure and is a key element that needs to change
- The length of time required to develop sustainable community-based alternatives to admission. Particularly housing, architectural based solutions
- A lack of systems / capability to identify people at risk of poor outcomes / potential admission
- Commissioning for specialised services is done on a system wide basis rather than sub regional basis
- We have no control over admissions directed by the courts
- The need to change the culture across the board / re-shape the current market provision, by giving clear messages
- The health and social care system faces unprecedented funding pressures and significant future challenges. More focus on individual outcomes and value for money
- Although direct payments are well established, there is still a lot of work to fully roll out and implement personal health budgets further

### 3.6.2 How can the current model of care be improved?

Due to the challenges within the current system, we must transform to increase the efficiency and quality of our local services which requires new thinking and radical changes across the system. Our services need to be organised and aligned to deliver high quality and evidenced based care. We need to ensure we have the right people delivering the right service in the right setting at the right time. We need to develop a clear understanding of the type and volume of specialist service required now and in the future.

- Person-centred planning ensuring choice and control is the key to all service provision and planning
- Promotion of personalised budgets to provide more control to people, better planning and co-production
- Together with our partners we need to make sure the needs of people with learning disabilities are fully met with timely and appropriate care that is planned, proactive and coordinated and evidenced-based
- Systematic early identification and intervention and detailed complex needs prevention planning
- Effective prevention from a young age, especially as young people prepare for adulthood, addressing or reducing the impact of challenging behaviours. Helping people to stay out of trouble and supporting people who enter the Criminal Justice System
- Development and retention of a consistently highly skilled, confident and value driven workforce
- Create and support capable communities ensuring families and carers are trained and supported utilising organisations such as Kinfo to deliver specific training around learning disabilities
- Clear and concise service specifications to ensure providers are clear of their roles and responsibilities and better contract monitoring, with a focus on developing outcome specifications
- Clear criteria around the threshold for admission into an in-patient bed
- Further development of the CTR process to improve the process from pre-admission to discharge along the pathway
- Standardised performance measures for all providers to allow regular reporting of performance and activity
- Agree a set of minimum outcome measures to allow benchmarking and tracking of performance, (NDTi Community Inclusion Web, Triangle - Outcome Star)

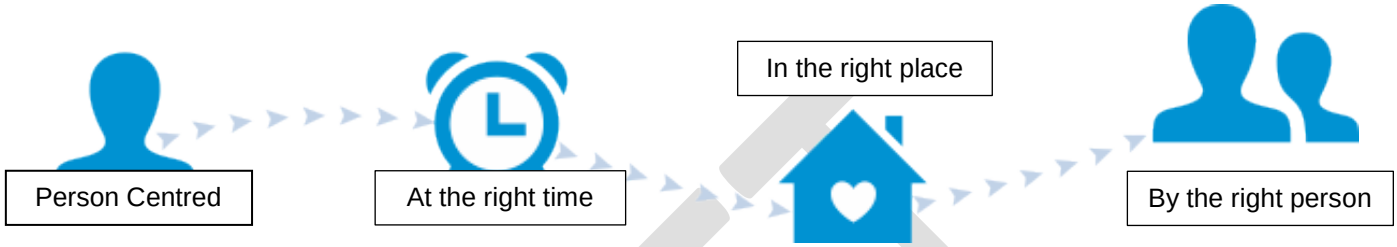
# 4. Develop your vision for the future

## 4.1 Vision, strategy and outcomes

Our vision is to radically change the parts of the system that are not working well and become an area of best practice in which each locality is able to meet the needs of its complex needs population locally in all but the most complex cases. We will do this by building upon what we know works well and identifying gaps in service and areas for improvement. We will then invest in a model of care and support that meets the needs of the LD population now and in the future. It is worth noting that we are already doing well at managing people in their own homes and exceed the national average by 7% and we will build on this to ensure the five cohorts can also be managed in their own homes. We will work collaboratively and innovatively to look at the way we commission and deliver future care and services. We will ensure that

the change is system wide and encompasses the cultural shift that is required to succeed.

The core strategy will be to develop capable communities, a highly skilled workforce and more quality accommodation options across the pathway, with a clear focus on personalised care at the right time in the right place by the right person. It will be aligned to our care closer to home strategy which encompasses the wider determinants of health and social care, enabling people to be independent, living in their own homes and communities with access to all services when required.




### 4.1.1 Describe your aspirations for 2018/19

The partnership will work together to achieve positive outcomes for people with a learning disability and/or autism, ensuring they have the same choices and control to have a meaningful and fulfilling life. We will support individuals to use mainstream services and participate in their local communities whenever possible and when problems arise, people will be supported by specialist services and facilities to prevent crisis, and if a crisis situation does occur it will be managed well.

**As a result of the changes covered in this plan we will ensure:**

- Good quality learning disability services delivered by highly skilled, multi-disciplinary staff will have an approach based on strong community support services, planned around people in the environment that they are in, focussing on person-centred care, and looking at each individual's needs and where appropriate the family needs. This approach should be applied to all, including people with very complex needs
- People with a learning disability and/or autism, including people with complex and challenging behaviour, will sometimes have physical or mental health problems and will be supported to access mainstream health services whenever possible that will make reasonable adjustments to the provision of their care
- More people with learning disability and/or autism will be supported to live in the community / in their own at home and when people display challenging behaviours, the appropriate support will ensure that they will be kept safe within their communities wherever possible
- We will become centres for excellence in supporting people with learning disabilities and/or autism in the community. We will develop and apply best

practice and evidence based interventions to ensure we facilitate the most successful outcomes for people

- We will ensure that population data is kept up to date and use this to better understand the needs of our population ensuring flexible and intelligent commissioning practices that make the right services available and at the right time
- All generic health and social care services will be encouraged to extend the range and provision Learning Disability / Autism champions to improve the care experience
- There should be provision for those people who have low level needs, who may not currently meet the criteria for services, through appropriately accessible local prevention and wellbeing services.
- We will build community capacity to encourage co-production based choice and control. Where they need more specialist support, including specialist support arising from complex and challenging behaviour, individuals will have access to skilled support staff and where necessary the support of specialist professionals to assist assessment and help plan more effective support
- The service will be committed to achieving the outcomes of 'rights, inclusion, independence and choice', and to ensuring that it 'sticks with' individuals in spite of the difficulties experienced in meeting their needs
- Services should ensure that those with learning disabilities and their carers are able to access the right level of information, advice and advocacy support.
- Carers should be provided with support in accordance with the national and local Carers Strategy and the Care Act, and services should ensure that appropriate attention is given to meeting the needs of older carers and people with learning disabilities and/or autism who are carers themselves
- A named single point of contact who will lead on co-ordinating all professionals involved in support the individual.

### 4.2 How will we know if we have succeeded?

There are a number of different tools and frameworks that are being used or developed to measure outcomes and the TCP will be including this as a key action within the plan to review what is available and align this to the overall outcomes that this plan is working towards.

When all the national measurements have been published from NHS England, we will identify any gaps that we feel needs to be captured from an outcomes perspective to ensure we are not duplicating work by using many different methods. This is about streamlining the process to implement a framework that everyone can use across the system that is easy to use, whilst providing meaningful information.

#### 4.2.1 Improved quality of care

- I get the right treatment and medication to keep me well
- I am cared for by people who are well supported

- I get the additional support I need in the most appropriate setting
- I get good quality general healthcare
- I have regular care reviews to assess if I should be moving on
- I am involved in decisions about my care

#### 4.2.2 Improved quality of life

- I am safe
- I am supported to live safely and take an activity part within the local community
- I have a choice about living near to my family and friends
- I am protected from avoidable harm, but also have my own freedom to take risks
- I am treated with compassion, dignity and respect
- I am supported to make choices in my daily life
- I am helped to keep in touch with my family and friends

#### 4.2.3 Reduced reliance on in-patient services

- Reduction in in-patient services
- Reduction in secure in-patient beds
- Reduced length of stay
- Delayed discharges will be minimised

### 4.3 How will improvement against each of these domains be measured?

**Our SMART objectives are as follows and denominators will be included in all contracts to ensure these can be measured through contract monitoring:**

#### 4.3.1 Improved quality of care

- Quality review of care plans via contract monitoring
- Use of quality initiatives such as ‘quality checkers’ using the experience of people who use services.
- Service user / Carer feedback
- Increased % of people with health checks and health action plans
- Increased uptake of screening and immunisation
- Improved management of long term conditions e.g. diabetes
- Improvement in health lifestyle indicators e.g. smoking, BMI, etc.
- Reduction in A&E attendances
- Reduction in avoidable emergency admissions

#### 4.3.2 Improved quality of life

- Reduction in avoidable and premature deaths
- Reduction of unplanned respite
- Reduction of placement breakdowns
- Number and % of people in their own homes

- Number and % of people in settled and secure accommodation of their choice
- Number and % of adults in employment

#### 4.3.3 Reduced reliance on in-patient services

- Reduction in in-patient services by 50%
- Reduction in secure in-patient beds by 10% bringing the number lower than then national expectation
- Reduction in length of stay
- Delayed discharges will be minimised
- Any hospital stays will be closer to the individual's home and support networks

# 5. Implementation planning

## 5.1 Proposed service changes

### 5.1.1 Overview of your new model of care

The proposed model will be based on the principles described in the national service model and will be developed across the life span taking into consideration the changing needs and requirements of people with learning disabilities.

## 5.2 Key themes for implementing the Transformation Programme:

- Choice and control at the heart of all service provision and planning
- Systematic Early Identification and Intervention
- Planned, proactive and coordinated care in the community
- Effective Prevention and Management of Crisis
- Helping people to stay out of trouble and supporting people who enter the Criminal Justice System
- A consistently highly skilled, confident and value driven workforce
- Equitable service provision and high quality evidence based care in the community

## 5.3 What existing services will change or operate in a different way

### 5.3.1 Community Service Model – Enhanced Pathway

Across the TCP we are working jointly with SWYPFT to develop a more robust community service including an enhanced pathway in line with the national service model. A new service specification has been designed and is currently under review with all organisations for sign off. This service specification encompasses the principles within the national service model and the aims and objectives are below:

- Ensure people with a learning disability are included as equal citizens, with equal rights of access to equally effective treatment enabling a purposeful and fulfilling life

- Provide a robust care coordination framework (CPA) with an underpinning principle to provide a single integrated health and social care process to deliver continuity of care
- Implement person-centred practice and individual service design including the following principles:
  - Prevention and early intervention
  - A whole systems life course approach
  - Family carer and stakeholder partnerships
  - Behaviour that challenges is reduced by better meeting needs and increasing quality of life support for communication
  - Physical health support
  - Mental health support
  - Function based holistic assessment
  - Support for additional needs
  - Positive behavioural support
  - Safeguarding and advocacy
  - Specialist local services
  - Workforce development
  - Monitoring quality
- Ensure care and support is proactive, planned and coordinated and the individuals and families have more choice and control over what this looks like
- Ensure better and quicker identification and treatment of mental health problems within the learning disability or autism community
- Ensure that any hospital admission needed is as short as possible, part of the integrated pathway and in a local generic mental health or specialist in-patient service
- Ensure individuals are resettled in the community with a highly personalised health, care and housing package put in place through careful planning with the individual, their family and independent advocate
- Ensure personal health budgets are promoted and offered where appropriate and the required support to be provided to individuals and their families to manage this
- Development and implementation of a risk register to ensure early intervention and to prevent unnecessary admissions

### 5.4 What new services we will commission

#### 5.4.1 Crisis response capacity

A key element of the new service spec is that community teams should be ensuring that patients identified as ‘at risk’ have the necessary care plans, relapse prevention and contingencies in place so that crisis occur as rarely as possible. We will also build on current work to know who is at risk within the community and manage this group more successfully.

However, even best managed plans cannot avoid all crisis situations. The first point of contact for developing crisis should be the CLDT who will work though the care and contingency plan to try and avoid escalation and to de-escalate the situation. However, if a full crisis occurs in an unforeseen way or when the CLDT is not available it is essential that services can respond to their needs with appropriate and effective advice and support 24 hours a day, 7 days a week. This service will be delivered by an intensive support team. As well as improving service accessibility and responsiveness this will positively impact on the number of out-of-hours admissions to in-patient units. It would be consistent with current commissioning guidance to develop this service through investment in the existing mental health crisis response service with the caveat that it is also suitable for people with learning disability and/or autism who experience behavioural crises. Linkage to services such as appropriate short break facilities and to the out of hours management system for local learning disability residential / supported living services could provide some flexible options to lessen immediate pressures and provide 'holding solutions' until the day-time services can resume responsibility. Where the person in crisis is in the 'core group' they should have in place a well thought out contingency plan, which should assist the effective management of the situation.

Community services across the partnership generally operate on a traditional working day pattern, Monday to Friday 9.00-5.00. Outside these hours Social Services Emergency Duty Teams provide the principle crisis response. Those caring for somebody with a learning disability and/or autism often describe the challenges posed are when individuals get up preparing to leave for a day centre or in the early evening once they have returned to the family home. Services need to be flexible enough to offer some support during these periods. Each person identified as 'at significant risk' in receipt of care should have a crisis plan, accessible to the individual and their carers outlining what actions they can take and who to contact.

The focus of all crisis responses should be:

- Providing specialist support in the most familiar setting, their own home, family home, care home via providing specialist advice and additional support to the people who know the person best
- Provide support in a specialist 'safe, calming therapeutic unit' that enables the contingency plan to be implemented in a safe environment, ensuring whenever possible the least restrictive intervention is used and the individual returns home on a night whenever possible
- As above but with the addition of short term overnight stay.

### 5.4.2 Respite Care and Short Breaks

It is recognised by health and care commissioners that respite care and short breaks are an important part of the current provision available to users and carers. This

provision can help to avoid the need for admissions to bed based care or the escalation of difficulties that could lead to care breakdown.

Whilst it is accepted that it will be carried forward into the new model, there is also an opportunity to refresh the approach and leverage any new benefits that integrated working will bring. At the most basic level, respite can mean different things not only to different people using services but also to different commissioners. This plan recognises that respite may not be fully maximised at present because it will inevitably be bounded by where it is commissioned from and by whom.

In particular the focus on personalisation will enable personal budgets as well as direct payments to be used for care that is designed and controlled by the users and carers – which will mean that respite provision can be more responsive, more innovative and fit with the individual's interpretation of what respite means to them and works for them.

Opportunities for short breaks tailored to individual needs are available to every family supporting a person whose behaviour presents a challenge at home. Providing carers with a break when they are under pressure will prevent crises developing and help to prevent placements from breaking down.

### 5.4.3 An Effective Response to Challenging Behaviour

Learning disability services should give priority to people with complex needs and challenging behaviour. They are the people with the greatest need for services and marked improvements can be achieved by the provision of quality services. The adoption of a challenging behaviour policy by all providers will underpin this and ensure that there is a consistent response across all services. It should commit staff to maintain input and contact with service users to resolve problems.

The group of people whose behaviour is complex and presents a serious challenge to services should be identified, and logged on the 'At Risk Register' and the services that are assessed as necessary to meet their needs developed through a person centred planning process. The plans should be clear about environmental risk factors, triggers, warning signs and contingency arrangements and ensure that back-up resources can be made available to sustain arrangements through difficult periods, and that services are put in place to support this.

The new service specification for SWYPFT includes the need for access to specialist staff that have the appropriate skills and knowledge about complex and challenging behaviour that can provide specific support to individuals, their carers and families, providing specialist assessment, supporting development of proactive support plans giving advice and information and provide training.

Further modelling is required whilst the Programme is in implementation and cohorts are migrating to optimised care options, so that we can test and refine our assumptions on capacity and demand and match these with the quantity of staff and caseloads in the model.

The CLDT should have an adequate workforce with appropriately accredited training to equip them with the specialist knowledge and skills required to work with people with learning disabilities who have complex challenging behaviour. All staff working with people with learning disabilities should receive appropriate training in relation to challenging behaviour commensurate with their role.

Services should use a competency framework to oversee staff training and competency based on Skills for Care Guidance for Employers (2013). A positive behaviour service will need to be embedded within and alongside other services by establishing working protocols that are communicated and agreed with relevant stakeholders. Ensuring effective links with other key services are created by amenable working practices and appropriate formal arrangements.

### 5.4.4 Specialist Providers

This will be a key area the partnership will be working together on in the market development work-stream. There is a need for providers to support people with very complex needs and it is recognised that a regional framework will be beneficial for economies of scale. As mentioned, existing frameworks are in place for learning disability provision and these frameworks could be used as a basis to extend into a more specialist and bespoke service across the partnership.

### 5.4.5 Safe Place Accommodation

At times people with learning disabilities may need access to short term residential care to provide a safe environment. This service should include access to day facilities as well as overnight accommodation and should only be utilised in the short term with the expectation that it would be no longer than 4-6 weeks before moving back into their own community setting or returning home. This facility would be used to support individuals that live in the community and are either approaching a crisis or have reached crisis and require a safe environment where the enhanced community team can work with the person undertaking assessment and treatment to prevent admission to an in-patient facility.

### 5.4.6 Bespoke Homes in the Community

It is acknowledged that some people (the most complex and challenging) stepping down from in-patient settings will require more bespoke person-centred homes designed to the individual needs to live in that will keep them safe and they will be supported by personalised packages of care that will be flexible according to their needs. Whenever possible these bespoke individual homes will provide long term assured tenancies whilst balancing the need to ensure active engagement with

ongoing therapeutic care and support. It is expected that there may need to be a period of relatively intensive support, together with focused rehabilitation work to successfully manage their transition. These individual homes will be smaller developments in community settings and the key to their success will be co-produced planning with people with a learning disability and their families, providers and other stakeholders. It is also really important that when identifying people who would like to live in these homes, they are matched appropriately to the other people that will be living in the development.

Calderdale has already developed a number of houses able to support up to 4 people with similar needs in the community and this has facilitated the return to area of a number of people, learning will be shared from this across the partnership.

Within Kirklees we currently have a property that we are considering for the development of four to six individual homes which would cater more towards the five cohorts of people identified in 'Building the Right Support' and we are in discussions with providers regarding the delivery of care. This is something that as a partnership we have discussed and we will be reviewing our current cohort of people in an in-patient bed to ensure we have the right mix of people in these individual homes. We have also got some potential funding from the sale of two properties with the release of the legal charge and are currently developing a PID to submit to NHS England for approval to reinvest into this service.

### 5.4.7 Supported Living Services

There are many supported living services across the partnership and a review of these will be undertaken to identify if some of these can be redesigned to meet the needs of the five cohorts that this plan refers to. We will work with providers to identify what the gaps are in terms of training and building viability to see if any existing services can be adapted or whether we need to look at building new provision to meet the needs of people with more intensive needs and forensic backgrounds.

### 5.4.8 Positive Behavioural Support

Across health and social care, statutory and the independent sector, the workforce plan will specify the use of the Positive Behavioural Support Competency Framework This will underpin the development of a Positive Behavioural Support Hub. This will be a coordinated, planned network for the development and delivery of accredited training and bring together local expertise to develop full range of training, supervision and coaching for front line staff including personal assistants, their supervisors, managers and families. We will be discussing with local universities and Health Education England how this can be scoped and delivered.

### 5.4.9 Personalisation

In keeping with the national personalisation agenda, we will work to increase the numbers of people on self-directed forms of care and support. In support of the roll out of personalisation, commissioning and contracting arrangements have already been evaluated and amended with the specific purpose of encouraging and enabling providers to offer choice and flexibility not only to those seeking control over support, but to all individuals in receipt of services, including self-funders. This has been supported by a dramatic reduction in block or cost and volume contracts, with a continued migration to framework and spot contracting arrangements.

The table below shows the numbers of people receiving a direct payment or personal health budget and whilst the numbers look quite high, it only reflects 16% of the overall LD population known to services. The expertise of local authorities on direct payments is being utilised for further roll out of personal health budgets across health and this will be another key action within the plan to further analyse the position and identify how we can work collaboratively to further roll out personalisation across the TCP.

| **People receiving personal health budgets/Direct payments** | **Number** | **Value** |
|---|---|---|
| Personal Health Budgets | 61 | £ 2,642,734 |
| Direct Payments | 711 | £ 11,598,285 |
| **Total** | **772** | **£ 14,241,019** |

Local offers are currently being developed in each area for expanding the implementation of PHBs and the partnership will take the opportunity to review the viability of extending these across the region and it will consider how and what can be done as part of the overall plan together. Our plan is to offer individuals and families ongoing support to identify a personalised solution via taking control of a direct payment and the responsibilities within that. Some of the areas that will be included will be:

- Individual service funds / pooled funds to enable people with a learning disability to work closely with providers and user led organisation to co-produce a personalised plan – it is felt that these could be a good option for the five cohorts identified
- We will also work with the voluntary sector such as Mencap to utilise their expertise and support for the further development and implementation of PHBs focussing on the five cohorts identified
- We will develop the local market place to ensure quality, creative and flexible services and support available including specialist support for people with more challenging behaviours. This should lead to increased local choices for individuals and increase take up of such budgets

- Commissioning and contracting arrangements will be evaluated and amended with the specific purpose of encouraging and enabling providers to offer choice and flexibility not only to those individuals seeking absolute control over the support provided but to all individuals in receipt of services. This anticipated outcome will be a reduction in block or cost and volume contracts and a continued migration to framework and spot contracting arrangements.

### 5.5 How will people be fully supported to make the transition from children's services to adult services?

Young people with behaviour that is complex and challenges should be the subject of focused attention and support and recorded in EHC plans. The arrangements will specify that no young person be placed in a distant residential school or other distant placements (including respite and short breaks) when their needs can be met effectively nearer to home. Commissioners will ensure that the necessary work is undertaken to build the capacity and confidence of local communities to support young people with more complex needs.

Effective transition support is based on person-centred planning and partnership working and place young people's needs and aspirations at the centre of the transition process. This will help the processes of consolidating identity, achieving independence, establishing adult relationships and finding meaningful occupation. Transition planning should start at the age of 14 years and adult services should become increasingly involved from this age and remain involved during a planned and coordinated handover.

Transition planning will start at a very early age with raising people's hopes and aspirations, we have a statutory duty to start formal planning from 14 years of age (Year 9) for those with an Education Health and Care plan in place or transitional assessment. Preparing for adulthood must focus on:

- Higher education and/or employment – this includes exploring different employment options, such as support for becoming self-employed and help from supported employment agencies
- Independent living – this means young people having choice, control and freedom over their lives and the support they have, their accommodation and living arrangements, including supported living
- Participating in society, including having friends and supportive relationships, and participating in, and contributing to, the local community
- Being as healthy as possible in adult life (SEN Code of Practice 2014 – page 122)

Draft protocols have been developed to ensure all parties understand each other's roles and the statutory duties placed upon them. For the most complex young people this is and will always be a challenge. Having a clear preparing for adulthood

multi-agency protocol and pathway in place will help make the transition a more positive experience.

Preparing for
Adulthood Multi-Agen

In Kirklees they are developing an All Age Disability approach which will bring together key disabled children services and adult learning disability services into one single lifelong planning approach, this is a key theme that will be reviewed across the TCP as part of the early intervention and prevention work stream.

### 5.6 How will you commission services differently?

There will be an increased focus on outcomes when commissioning services, notably around the quality of care and support, and the quality of life enjoyed by those with a learning disability and/or autism, and their family and carers. The outcomes measures will also encourage care settings to be in the community and away from in-patient services unless they are appropriate.

Local commissioners have a commitment to work with the independent and third sector to ensure there is a vibrant and high quality market to support the needs of people with complex needs. One way this is achieved is via the production of Market Position Statements, they are aimed at care providers giving them clear messages regarding need and strategic market priorities. Attached is Kirklees as an example of how this is being approach, but each area has their own and we will work on developing a market position statement across the TCP.

KIRKLEES MPS LD
AUG 2013 final (2).pd

A significant amount of work has already taken place developing a framework for complex community care for learning disabilities in some of the areas within the TCP and this will be reviewed to look at extending across the partnership for health and social care to ensure economical consistency and sustainability of the provider market.

Greater understanding of the children's and autism population will mean commissioning arrangements may need to change. Market development activities will be required where providers do not currently provide the capability required. Market position statements will be key in signalling new and changed commissioning intentions to the market, and commissioners are likely to need to follow this up by working with the market closely to encourage and support these commissioning intentions being addressed.

The increase in complexity of needs and also the increased use of personal budgets and personal health budgets means that small niche providers are likely to be required to address some of the accommodation requirements. Therefore commissioning mechanisms, as well as market development activities, are likely to need to encourage a much smaller type of provider. There may also be a need to encourage social enterprises as a good way to deliver services. This will require additional market development effort to ensure suitable social enterprises are developed that can take on such services. Collaborative commissioning will be considered wherever appropriate and this will be one of the key discussions when further work has been done around new services that will be commissioned.

**Resettlement of long term hospital people**

There are currently 12 people who have been in hospital longer than five years, split into the following:

| | |
|---|---|
| CCG Commissioned | 4 |
| NHS England Commissioned | 8 |

It is recognised that these people may find it difficult to resettle back into a community setting and the TCP will use progression modelling to ensure this is done successfully.

The Care and Treatment reviews will ensure a clear and co-produced pathway and personalised and flexible packages will be available to ensure the transition is appropriate to meet the individual's needs. Personal health budgets will be offered whenever appropriate as the default choice for procuring a package to support the individual.

The funding of these packages in 16/17 has been included in the transformation funding following confirmation that the dowries will not be transferred with the person. It is anticipated that future dowries will transfer down once NHS England specialist commissioning have decommissioned beds. However, this has been included on the TCP risk register.

### 5.7 How does this transformation plan fit with other plans and models to form a collective system response?

- This plan is being developed based on local strategies and in line with national guidance. We will ensure that as the plan is further developed the following plans and guidance are all aligned to ensure we meet the requirements of these. Local Transformation Plans for Children and Young People's Health and Wellbeing
- Local action plans under the Mental Health Crisis Concordat

- The ‘local offer’ for personal health budgets, and Integrated Personal Commissioning (combining health and social care)
- Work to implement the Autism Act 2009 and recently refreshed statutory guidance
- The roll out of education, health and care plans as part of the SEND agenda

# 6. Delivery

## 6.1 What are the programmes of change/work streams needed to implement this plan?

The key work-streams including themes have been agreed by the board as follows. The identified leads are included in the terms of reference embedded in this document. These are subject to change following the engagement event with stakeholders:

- **Early intervention and prevention**
  - Develop excellent Case Management / Care and Treatment Reviews processes
  - Standard Risk Registers
  - Children’s Transformation Plan including Transition
  - All age approach
  - Develop better links with Youth offending and probation services, police, Safeguarding, etc.
- **Data Sharing and Intelligence**
  - Further information gathering on current baseline
  - Review of current systems / databases
  - Information Sharing Protocols
  - Benchmarking and peer reviews
  - Develop an agreed quality and standards framework
- **Finance and Contracting**
  - In-depth analysis at how current monies are spent
  - Mapping exercise – current external providers, contracts and framework agreements
  - Personal health budgets / Direct payment
  - Co Commissioning
  - Framework agreements
  - Co-funding opportunities, e.g. DCLG grants
- **Market Development including estates**
  - Looking at people’s needs and what services we currently have. CKWB market position statement
  - Aim to develop new services, support choice and control and helping people into work or activities
  - Develop more housing and social care options

- Reducing the reliance on care homes
- Developing a better community LD / Autism team
- Be aware and mindful of future legislative changes

- **Workforce Development and Training**
  - Supporting the development of a suitable workforce
  - Improving training for staff across different services
  - Training and supporting carers
  - Rolling out Positive Behavioural Support
  - Work jointly with external providers
- **Communications and Engagement**
  - See plan attached in section 6.4

### 6.2 Workforce Development Plan:

Each area within the partnership currently has its own initiatives within workforce development around overall quality of support, specific training requirements such as MCA and Safeguarding, provider engagement to assess current and future workforce needs, as well as management and leadership support. Local authorities have a responsibility to ensure that an adequately trained workforce is available to meet the social care need and each area is meeting that requirement. Support for learning disabilities provision forms part of this overall workforce development.

As a TCP we will review the current work happening in workforce development and identify the gaps relating to this plan. It has been discussed that we may build on the existing workforce development strategies and ensure representation is appropriate from a Transforming Care perspective, rather than creating another work-stream to deliver this. However, the principles will be followed on the attached workforce development plan below.

CKWB Workforce Plan.xlsx

It is recognised that in order to deliver the outcomes required through transforming care, the learning disabilities workforce needs to have a range of the right skills, capability and capacity to deliver personalised and high quality support. Services along the spectrum from secure down to universal and community need appropriate skills to be able to support and intervene effectively, and importantly know how to access higher levels of support if required. So someone who works in a job centre, for example, who is trying to support an individual with autism may have a basic awareness of the condition but may need to ask a CTLD nurse or other professional for advice if the level of skill required exceeds their knowledge. Likewise a supported living provider for learning disabilities would have skills to deliver the designated care plans of the individuals within their service but may need to draw upon psychological

support from a clinical professional if an aspect of behaviour was causing concern at the time.

By achieving this, the TCP will not only be able to deliver appropriate support but achieve effective use of resources. Positive Behavioural Support training is specifically mentioned in the Building the Right Support (Oct 2015) documentation as best practice for people with LD/Autism and who display behaviour that challenges and the partnership needs to respond to this in particular. However, a model of up-skilling community services will enable more people to remain as independent as possible and in effect 'raise the bar' to which community services can safely operate.

Under pinning this is the principle that people with learning disabilities and/or autism can learn, develop and become more independent, hence a new requirement; that of progression planning, innovative service design and improved commissioning skills will also be required.

As a result, the priority is to develop a comprehensive workforce strategy including individual local and TCP wide requirements. Adequate resourcing will need to be identified to not only deliver the work-stream but also keep existing staff through professional development and recognition both financially and personally that the role they do is valued (the NMDS-SC states that there is a 22.8% turnover rate within Y&H region). This will also include the key roles of care management, integrated working and collaborative commissioning.

Internal financial constraints through austerity measures within the LA and external cost risks through examples such as the living wage need to be incorporated into the workforce plan as direct staffing costs are the largest percentage of spend across both health and social care.

### 6.3 Estates Plan

Where there are gaps identified then the TCP will develop provision collectively or where there is a commissioning case for change. What is acknowledged across the partnership is a need for a flexible accommodation options and work has and will continue to be carried out working with providers of support and accommodation to enhance the range of accommodation provision.

As a partnership we have agreed that estates will be a key theme that sits under the market development work-stream.

## 6.4 Engagement Plan

A draft plan is embedded below:

TCP LD Engagement Equality and Commun

A draft plan for the first event is embedded below:

DRAFT - My Health Day - Transforming C

## 6.5 Key Enablers to success

**Shared Vision** – It is essential that all organisations within the partnership have the same vision to change the system and deliver better services for people with a learning disability and/or autism.

**Commitment** – There needs to be the appetite to deliver from each organisation and this needs to be supported from the top to ensure it is deemed a priority for the people involved.

**Public Support** – Engagement is a key factor to ensure the public fully support the principles of the transforming care plan across our partnership

**Funding** – To be able to deliver better services in the community, there will be a requirement to pump prime and there will be times where organisations are double funding whilst the transformation is ongoing. There are already huge constraints across health and social care with funding cuts, so it is essential that agreed funds are made available and match funded to succeed.

**What are the key milestones – including milestones for when particular services will open / close?**

CKWB Route Map v3.xlsx

**What are the risks, assumptions, issues and dependencies?**

## 6.6 Key Risks

CKWB Risk issue logs.xls

### 6.7 Key Dependencies

There are other partner agencies that need to be more involved in discussions and they will be included within the stakeholder engagement plan:

**Criminal Justice System** - we recognise that they will need to be involved in the transfer of people being placed in the community. Need to be aware that there will be some people living in the community that may need additional support and resource.

**Primary Care** as there will be individuals being supported in the community accessing mainstream services. Raise awareness of the individuals and their circumstances. They may need more intensive support and care management.

**Police** so that we raise awareness of the individuals living in the community and provide additional education to the workforce. Police could potential be involved in MDT discussions. In Kirklees we have worked with West Yorkshire police to roll out National Mencap 'Stand by Me Police Promise', one element has been to link PCSO with local care service provision. This is an area that we will look at sharing across the TCP.

**Council Services** to raise awareness with them that include housing, employment services and leisure providers to ensure people are supported to access services.

### 6.8 External policies / External changes

The shift of responsibilities from NHS England to CCGs needs to be understood and factored into commissioning arrangements. NHS England and all CCGs are represented within the governance structures for the programme of work.

**What risk mitigations do you have in place?**

Please see the risk register in section 6.6

## 7. Finances

### 7.1 Activity finance tracker data

#### 7.1.1 LD Patient Projection Tab

The numbers of inpatient beds commissioned by the CCG from 31st March 2016 onwards are based on projections made as at the 31st January 2016 and are best estimates based on current pathway timeframes taken from both the most up to date CTRs or the most up to date CPAs whichever was undertaken at the latest date.

The SCG commissioned beds are taken from the data submitted by SCG on the 28th January 2016 and have not been amended in this plan as the target reduction is in line with the national planning numbers.

### 7.1.2 Finance and Activity Tab

As a TCP a decision was made to only include people that had been in an inpatient bed and discharged after the 1st April 2009 and all Children's packages. However, it is acknowledged that not all areas submitted numbers for children and this will be picked up in the further analysis of baseline data.

The decision to not populate the 'at risk of admission' section was agreed across our TCP because every other person receiving a package of care would not necessarily be at risk and it would actually only be a small percentage of people that would be at risk. There was a concern by stating that all other packages were at risk, we would have to undertake CTRs on everyone in line with the CTR guidance and it would not be practical or beneficial to undertake these for several hundred people.

As part of this plan a draft service specification has been developed for LD community services and there is a requirement within this specification to maintain the at risk register. This has been built into our CQUINS for 16/17 and it has been agreed that we will agree specific criteria for the risk register, to ensure there is a consistent approach across our TCP to manage people at risk more effectively.

To enable us to consolidate all spend across the TCP into meaningful information, it was agreed to look at what services we are currently spending our budgets on. The focus will be to review spend in each area and understand where we can decommission services to enable monies to be released to reinvest into better community services.

finance and activity plan v3.xlsx

## 7.2 Estimated costs to deliver the programme

| Cost | Costing assumptions | Funding | TCP Funding | Matched Funding |
|---|---|---|---|---|
| Programme Manager | This plan requires a full time experienced programme manager to enable the plan to be delivered in a timely manner | £210,000 | £105,000 | £105,000 |
| Project Support | The programme manager will require full time project support to deliver the plan | £75,000 | £37,500 | £37,500 |

| Cost | Costing assumptions | Funding | TCP Funding | Matched Funding |
|---|---|---|---|---|
| Case Managers x 2 | To facilitate the discharge of people currently in CCG commissioned in-patient beds, two dedicated case manager will be required | £266,658 | £133,329 | £133,329 |
| Communications and Engagement | A budget has been calculated in the comms and engagement plan, albeit this is not yet fully scoped | £122,000 | £61,000 | £61,000 |
| PBS Training | The extent of this training is so significant the TCP will require dedicated funding to enable this to be successful Estimate | £100,000 | £50,000 | £50,000 |
| Double funding of packages | This is an estimate as full mapping has not yet been undertaken, it is assumed no dowries will be passed down in 16/17 | £750,000 | £375,000 | £375,000 |
| Enhanced Community Pathway Service | The indicative costing provided by SWYPFT to deliver the enhanced pathway in line with new service specification drafted | £1,000,000 | £500,000 | £500,000 |
| **Total** | | **£2,523,658** | **£1,261,829** | **£1,261,829** |

## 7.3 Match funding requirements by year for the transforming funding from NHS England

| | | | Breakdown of match funding requirements | | | |
|---|---|---|---|---|---|---|
| **Cost** | **Funding** | **TCP Funding** | **Matched Funding** | **Year 16/17** | **Year 17/18** | **Year 18/19** |
| Programme Manager | £210,000 | £105,000 | £105,000 | £35,000 | £35,000 | £35,000 |
| Project Support | £75,000 | £37,500 | £37,500 | £12,500 | £12,500 | £12,500 |
| Case Managers x 2 | £266,658 | £133,329 | £133,329 | £66,665 | £66,665 | |
| Communications and Engagement | £122,000 | £61,000 | £61,000 | £20,333 | £20,333 | £20,333 |
| PBS Training | £100,000 | £50,000 | £50,000 | £25,000 | £25,000 | |
| Double funding of packages | £750,000 | £375,000 | £375,000 | £375,000 | | |
| Enhanced Community Pathway Service | £1,000,000 | £500,000 | £500,000 | £500,000 | | |
| **Total** | **£2,523,658** | **£1,261,829** | **£1,261,829** | **£1,034,498** | **£159,498** | **£67,833** |

## 7.4 Transforming Care Partnership funding

The table below highlights the reduction in spend forecast for the next three years for both CCG commissioning and NHS England commissioned inpatient beds. It is anticipated that 10% of this money will be available after repatriating people into a community setting to reinvest into the delivery of this plan. The CCGs within the TCP are currently in contract negotiations with SWYPFT and the predicted uplift to the contract is £500,000.

| | **Annual cost 2015/16** | **Annual cost 2016/17** | **Annual cost 2017/18** | **Annual cost 2018/19** |
|---|---|---|---|---|
| CCG commissioned patients | £6,365,346 | £4,529,910 | £2,844,699 | £2,532,525 |
| NHS England Specialised Commissioned patients | £5,980,476 | £5,370,223 | £5,004,406 | £4,760,305 |
| **Total** | **£12,345,822** | **£9,900,133** | **£7,849,105** | **£7,292,830** |
| **Cumulative Reduction in spend** | | **£2,445,689** | **£4,496,717** | **£5,052,992** |

| **Cost** | **Funding** | **TCP Funding** | **Year 16/17** | **Year 17/18** | **Year 18/19** |
|---|---|---|---|---|---|
| Programme Manager | Kirklees CCG have recruited a full time PM for this work and are contributing the 50% cost | £105,000 | £35,000 | £35,000 | £35,000 |

| Cost | Funding | TCP Funding | Year 16/17 | Year 17/18 | Year 18/19 |
|---|---|---|---|---|---|
| Project Support | The TCP will be funding this role equally across all CCGs and LAs | £37,500 | £12,500 | £12,500 | £12,500 |
| Case Managers x 2 | Kirklees CCG have committed a FTE within the SWYPFT contract for a dedicated case manager. Barnsley have just had funding signed off to recruit a FTE dedicated case manager | £133,329 | £66,665 | £66,665 | |
| Communications and Engagement | The 10% saving on in-patient beds will fund this | £61,000 | £20,333 | £20,333 | £20,333 |
| PBS Training | The 10% saving on in-patient beds will fund this | £50,000 | £25,000 | £25,000 | |
| Double funding of packages | The 10% saving on in-patient beds will fund this | £375,000 | £375,000 | | |
| Enhanced Community Pathway Service | All CCGs within the TCP are currently in contract negotiations with SWYPFT, it is anticipated that the uplift will cover the £500,000 | £500,000 | £500,000 | | |
| **Total** | | **£1,261,829** | **£1,034,498** | **£159,498** | **£67,833** |

With regards to capital monies, this requires a full audit of current estates across the region to identify if we can reinvest in these assets or whether we need to build new provision across the partnership. This work will be one of the key deliverables and will also require input from funding organisations, providers and architects although discussions are already taking place in individual areas.

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**KIRKLEES HEALTH & WELLBEING BOARD**

**MEETING DATE:** **28th April 2016**

**TITLE OF PAPER:** **Area Special Education Needs & Disability OFSTED Inspections**

## 1. Purpose of paper

From May 1st 2016, OFSTED will begin their timetable to carry out an area Special Education Needs & Disability (SEND) inspection. The purpose of this paper is to inform Board members about the focus and remit of these inspections.

## 2. Background

The area SEND inspections follow on from the implementation of the Children and Families Act, part 3, and are intended to measure progress against the reforms. The Board has received previous reports about implementation.

## 3. Proposal

In order for Kirklees to respond strongly to this inspection, all key partners must understand what is required of them during the process. It should be noted that, as yet, the OFSTED handbook and framework for this inspection has not been published. However we have received strong indicators through the consultation documents that have been circulated.

The inspection will focus on two areas:

- How effectively does the local area identify children and young people who are disabled and/or have special educational needs?
- How effectively does the local area meet the needs and improve the outcomes of children and young people who are disabled and/or have special educational needs?

Although the framework and handbook have not yet been published, we understand that the inspection team will meet with a broad range of people including:

- Key Managers from education, health and social care services
- Visits to Early Years, School and Post 16 providers to talk to leaders and governors, and to study a sample of student files/information about their progress
- Visits to health settings for a discussion with managers and practitioners, with a review of health files and information about how health practitioners contribute to assessments and Education Health and Care Plans (EHCPs)
- Meetings with children and young people, and their parents/carers to gain their view of how effectively the area fulfils its responsibilities.

Any recent inspection outcomes for the local area carried out by OFSTED and CQC will be taken into account. In addition, the following information will be used to inform the inspection:

- Outcomes for children and young people in national assessments, and their destinations when leaving school
- Performance towards meeting statutory timescales for statutory assessment
- Any information about the use of disagreement resolution services, mediations, and appeals to First Tier Tribunal (SEND)
- Complaints made to OFSTED or CQC relating to SEND.

OFSTED will publish an inspection report in the form of an outcome letter. This will be shared with schools and settings, and any service involved in meeting the needs of children with SEND. It will also be sent to the Chief Executive of the CCG with a request that it be circulated to healthcare services and settings as appropriate.

The report will outline what inspectors looked at and give a summary of findings based on strengths and areas for development. Due to the breadth and complexity of the aspects of the area's accountability, there will not be a graded judgement.

We are working with colleagues across Learning, Social Care and Health to develop our joint response to this inspection. There has been a detailed implementation plan in place since 2014 and this incorporates our evidence for OFSTED. We have also developed a brief, overarching self – evaluation.

**4. Financial Implications**

Kirklees has received an SEN Reform Grant for the past 3 years, and this has been used to implement the Children and Families Act. Part of this funding has been used to second colleagues from Learning, Health and Social Care into temporary posts to support reform development, in particular the alignment of systems to support the EHCP process, and the development of the Local Offer.

**5. Sign off**

Sarah Callaghan, Director for Children & Young People

**6. Next Steps**

During 2014, there were a number of whole service briefings and more bespoke development sessions to help colleagues understand their responsibilities and duties in relation to the Children and Families Act. Our priority now is to ensure that all relevant teams across Learning, Health and Social Care are aware of their responsibilities in relation to this inspection, and we are developing a communications plan to support this.

**7. Recommendations**

That the Health and Wellbeing Board:

- share this information within their respective organisations
- encourage and support teams across Learning, Health and Social Care to prepare themselves for the inspection by taking note of briefings, information sessions, etc.

**8. Contact Officer**

Mandy Cameron, Deputy Assistant Director, Learning and Skills

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01484 221000

**Additional Information: SEND Area Inspection**

**Context**

The Children and Families Act was introduced in September 2014, and the implementation of part 3 of the Act has been progressing since then. The Children and Families Project Board has overseen implementation and includes representation from Learning and Skills, Children's Social Care, Adult's Social Care, Health, and Commissioning. The Project Board reports to the SEND Strategy Group. In addition to these representatives, this Group also includes parent/carer representatives, and colleagues from the Voluntary Sector.

The Implementation Plan is linked to the SEND Code of Practice 2014, and details all activity so far, its impact, and areas for development. Work streams have focused on specific areas of development work:

- The Child and Family Centred Approach
- Education Health and Care Plans (EHCPs), and statutory process
- Preparing for Adulthood (14 – 25)
- The Local Offer.

**SEND Area Inspection**

From May 2016, and over the next five years, all Local Authorities will be subject to an area inspection. This inspection will focus on:

- An evaluation of how effectively the local area identifies disabled children and young people and those who have special educational needs
- An evaluation of how effectively the local area meets the needs and improves the outcomes of disabled children and young people and those who have special educational needs.

Early guidance suggests that a wide range of information will be used in this evaluation process, alongside methods to gather the views of identified children and young people, parents and carers, leaders within the local area, and then providers (through visits).

**Proposed Inspection Arrangements**

Inspection teams will include an HMI (lead), a CQC inspector and a Local Authority inspector. Inspectors will review available national data as part of their preparation, including within area inspection outcomes from CQC and Ofsted. There will be a narrative evaluation report following the inspection, but not an overall effectiveness grade. Local areas may need to produce an action plan following the inspection, and there may be follow up inspection activity. The findings of the area inspection may be considered as part of other CQC and Ofsted inspection activity.

The fieldwork will include discussions with elected members, key local area officers from health, education and social care, and meetings with leaders of Early Years settings, schools and colleges, and specialist services. Visits will be made to a range of providers and services. These visits will not inspect the provision, but focus on their understanding of and

participation in meeting the areas' responsibilities. Inspectors will look at children and young people's files to contribute to their evaluations. There will be a strong emphasis on gathering the views of young people, and parents and carers, including meetings during visits to Early Years settings, schools and colleges, meeting with established parent and carer groups, meeting with any reference groups established in the area, a webinar for parents and carers during the inspection.

**Evidence of Successful Implementation**

Inspectors will be looking for the following:

- How we work in partnership with children and young people, and their parents and carers to understand their needs so that outcomes can improve
- How Early Years providers, schools and colleges work in partnership with the local authority and social care and health services to identify and meet these needs effectively
- How education, health and social care services work together to jointly commission the support and services their children and young people require, including out of area support
- That focusing on the needs of children and young people who have an EHCP is not at the expense of providing for those others who require support but do not need a plan
- Evidence of early intervention and support activities that prevent some children and young people from needing an EHCP at a later stage
- An accessible Local Offer that sets out the support it expects to be available.

Above all, local areas must know whether their provision is improving outcomes for children and young people or not. They must agree aspirational yet realistic targets for young people and monitor their progress towards achieving them. The setting and reviewing of goals or targets must involve children and young people, and their parents and carers.

| KIRKLEES HEALTH & WELLBEING BOARD | |
|---|---|
| **MEETING DATE:** | **28 April 2016** |
| **TITLE OF PAPER:** | **Proposed revisions to the Terms of Reference for the Health and Wellbeing Board** |

**1. Purpose of paper**

The purpose of this report is to seek approval for the proposed revisions to the Terms of Reference for the Health and Wellbeing Board.

**2. Background**

2.1 On the 24 September 2015, board members participated in a development session led by the Local Government Association.

2.2 One of the outputs from the session was that the Board would clarify its role and purpose, and improve understanding of the purpose and role of other boards and organisations and how to build constructive relationships across these bodies.

2.3 The proposed revisions to the Terms of Reference (see attached) are intended to reflect the outputs from the development session.

**3. Proposal**

That the Board:

- Considers and agrees the proposed revised Terms of Reference
- Agrees it progress through Corporate Governance and Audit and Annual Council.

**4. Financial Implications**

None.

**5. Sign off**

**6. Next Steps**

That once the revisions to the Terms of Reference have been agreed by the Board it will progress through Corporate Governance and Audit and then to Annual Council in readiness for the 2016/17 municipal year.

**7. Recommendations**

That the Board:

- Accepts the proposed revisions.

**8. Contact Officer**

Phil Longworth, Health Policy Officer

# Health and Wellbeing Board

## Membership

Membership of the Board includes Councillors, NHS Clinical Commissioning Group representatives, Healthwatch and Council Directors.

**Voting members**

- Three Members of Kirklees Council's cabinet, one of whom may be the Leader
- One Senior Councillor from the main opposition group
- One Councillor from a political group other than the administration and main opposition group
- Director for Children and Young People
- Director for Public Health
- Director for Commissioning, Public Health and Adult Social Care
- One representative of local Kirklees Healthwatch
- Three representatives of North Kirklees Clinical Commissioning Group
- Three representatives of Greater Huddersfield Clinical Commissioning Group

**Non-voting members**

- Chief Executive Kirklees Council
- Member of NHS England ( Statutory requirement: to participate in the board's preparation of JSNA / JHWS and if requested to participate in exercise of the commissioning functions of the Board in relation to the Kirklees HWB Area)

**Invited observers**

Chief Executive or nominated representative of significant health partners:

- Mid Yorkshire Hospitals Trust
- Calderdale and Huddersfield Foundation Trust
- South West Yorkshire Partnership Foundation Trust
- Current community health provider

## Terms of Reference

The Health and Wellbeing Board is a statutory Committee of the Council. The Board brings together the NHS and the Council to provide leadership in ensuring a strategic approach to providing integrated working in relation to arrangements for providing health and social care services.

## Purpose and Functions of the Board

- To be responsible for the health and wellbeing of the people of Kirklees, using collective resources to ~~reduce~~ improve health and wellbeing, reduce health inequalities and tackle variations ~~address variances~~ in the quality of health and social care.

- To develop, publish and own the Joint Strategic Needs Assessment for Kirklees (JSNA) to inform local planning, commissioning and delivery of services and meet the legal responsibilities of Kirklees Council and the Clinical Commissioning Groups.

- To develop, publish and own the Joint Health and Wellbeing Strategy for Kirklees, based on the JSNA and other local intelligence, to provide the overarching framework for planning, commissioning and delivery of services ~~including consideration of the pooling of budgets~~

- To provide the structure for overseeing local planning and accountabilities for health and wellbeing related services and interventions and the development of integrated sustainable health and social care systems.

- To promote ~~an ethos of~~ integration and partnership working with the NHS, social care, public health and other bodies in the planning, commissioning and delivery of services to improve the wellbeing of the whole population of Kirklees.

- To ensure the involvement ~~involve~~ and engagement of service users, patients and the wider public in ~~order to influence and inform the broader work of the Board~~ planning, commissioning and delivery of services to improve the wellbeing of the whole population of Kirklees.

- To provide leadership and oversight of key strategic programmes, such as the Sustainability and Transformation Plan, Better Care Fund, and to encourage use of associated fund arrangements where appropriate.

- To provide assurance that the commissioning and delivery of plans of partners have taken sufficient account of the Joint Health and Wellbeing Strategy and the Joint Strategic Needs Assessment.

- To publish and maintain a statement of needs for pharmaceutical services across the Kirklees area.

- To ensure that the Council's statutory duties in relation to health protection arrangements and plans are delivered though the work of its sub- committee, the Kirklees Health Protection Board.

- To exercise any other functions of the Council delegated to the Board by the Council.

- ~~To bring together key NHS, public health and social care leaders across the Kirklees area~~

- ~~To consider how best to ensure more collaborative working to reduce duplication and improve productivity within health and social care services, with appropriate reinvestment within this economy.~~

- ~~Have the flexibility to go beyond its minimum statutory duties to promote joining up of a much broader range of local services (i.e. further integration of health with more services around the wider determinants of health and wellbeing).~~

## Voting Rights

All statutory members of the Health and Wellbeing Board have voting rights.

In accordance with The Local Authority (Public Health, Health and Wellbeing boards and Health Scrutiny) Regulations 2013, if the Council's wishes to alter the voting rights and membership the board must first be consulted on any proposed amendments.

## Substitute Members

Voting Board Members can send a substitute to represent them should they be unable to attend and if appropriate cast their vote.

## Quorum

The quorum for the board will be attendance by 50% of the accountable bodies and 50% of the membership.

| KIRKLEES HEALTH & WELLBEING BOARD | |
|---|---|
| **MEETING DATE:** | **28 April 2016** |
| **TITLE OF PAPER:** | **North Kirklees CCG – One year Operational Plan 16/17** |

**1. Purpose of paper**

NHS England's vision for the future, '*The Five Year Forward View*' sets out a number of ambitions which require a response. '*The Five Year Forward View*' recognises that improvements must be made in the way NHS services are commissioned and provided and to do this challenges the organisations to close a number of gaps over the by 2020. These are:

1. The Care and Quality Gap
2. The Health and Inequalities Gap
3. The Finance and Efficiencies Gap

This document outlines North Kirklees CCG's response to contributing to closing these gaps locally.

**2. Background**

The mandate within the 2016 NHS England planning guidance *'Delivering the Five Year Forward View'* describes a challenged NHS which requires investment, a period of recovery and transformation to ensure sustainability in the longer term. The two stage approach to planning for 2016/17 is also linked to the requirement for local systems to collaborate and develop a Sustainability and Transformation Plan (STP). This document outlines the local ambitions in responding to this mandate and describes the first year of the STP developed over a Kirklees footprint.

**3. Proposal**

The focus of the work in 2016/17 will be on putting measures in place to inject stability in the system whilst progressing our longer term vision through three main transformation programmes:-

1. Transformation of planned care pathways with a view to sustainably managing demand for services in different ways
2. Transformation of our urgent care services
3. Transformation of primary care services to respond to national directives and integrate into the wider system.

The ambition is to work in a more collaborative and integrated way with partners to improve patient outcomes has been and will continue to be at the forefront of all the work undertaken. In 2016/17 the intention is to collaborate and integrate further building, expanding on work that has already commenced.

The development of commissioning plans for 2016/17 has been informed through engagement with GP membership, the voluntary sector and wider patient community. The Plans have been presented at a number of forums, including North Kirklees Patient Reference Group, GP Forum and specific engagement activities focused on commissioning priorities. The feedback received at these events had helped to shape and develop the information within this document.

This is a live document and therefore it will be refreshed as plans evolve over the coming year. This will also be refreshed as the Sustainability and Transformation Plan is developed to reflect that it represents the first year of implementation.

| |
|---|
| **4. Financial Implications** |
| **5. Sign off**<br><br>North Kirklees Clinical Commissioning Group Governing Body on the 6th April 2016. |
| **6. Next Steps** |
| **7. Recommendations**<br><br>The Health and Wellbeing Board are asked to receive this document for information. |
| **8. Contact Officer**<br><br>Rachel Millson, Business Planning Manager, North Kirklees CCG |

# 2016/17

# NHS North Kirklees One Year Operational Plan


NHS North Kirklees Clinical Commissioning Group

Report Author:
Rachel Millson: NHS North Kirklees CCG

Published: FINAL DRAFT v 8.0

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## Document History

| | |
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| **Version:** | **FINAL DRAFT v8.0** |
| **Date:** | |
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## Change Control

| Version: | Date: | Author(s): | Summary of Changes: |
|---|---|---|---|
| DRAFT v1.0 | 26.02.2016 | Rachel Millson | Content added |
| DRAFT v2.0 | 29.02.2016 | Rachel Millson | Content added |
| DRAFT v3.0 | 09.03.2016 | Rachel Millson | Content added |
| DRAFT v4.0 | 16.03.2016 | Rachel Millson | Content added |
| DRAFT v5.0 | 22.03.2016 | Rachel Millson | Content added following feedback from NKCCG Governing Body Members and Senior Management Team |
| DRAFT v6.0 | 24.03.2016 | Rachel Millson | Content added following feedback from NKCCG Governing Body Members |
| DRAFT v7.0 | 30.03.2016 | Rachel Millson | Amendments following feedback from NKCCG Governing Body Members |
| FINAL v8.0 | 18.04.2016 | Rachel Millson | Amendments to Quality Section following NKCCG Governing Body Meeting |
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Welcome to our operational plan for 2016/17 which sets out our ambitions for improving outcomes for the population of North Kirklees over the next year and is the first year of the Kirklees Sustainability and Transformation Plan.

We are an innovative and forward thinking organisation who has come a long way since our establishment as a Clinical Commissioning Group (CCG) in 2013. We undertook a major transformation of our community services in 2015, taking a system wide approach which focused not just on community provision but also on how our local urgent care and primary care services need to change to support a more integrated model of care. Initial changes which strengthen out of hospital services are now in place and we are now supporting local providers to work in collaboration to develop a place based model of care for patients in North Kirklees in line with the principles outlined in the Kings Fund Paper.

To help us in this, internally we have adopted a process of outcomes based commissioning to ensure that the changes we make are supported by sound evidence, good practice, meet the key outcome measures as described in the various national frameworks and mandates and are consistent with the vision of what we plan to achieve for the population of North Kirklees. We are also a pioneer site for the national RightCare programme and are embracing this methodology by embedding it into our business processes.

The NHS is operating in an increasingly complex environment, with a growing population and demand on services, increasing availability of new and more innovative technologies and with less resource. This is something we and other organisations are experiencing locally and we will be actively supporting measures to recover and bring stability to the system over the next 12 months.

In light of this, doing nothing is not an option; we need to work with partners, including patients and the public to look for opportunities to work at scale and in different and more integrated ways to secure sustainability for the future. We need to have an increased focus on prevention and commission services which deliver proactive rather than reactive care. We also need to empower patients to take responsibility for their own care and start changing behavior through care planning and self-care initiatives.

The challenges which are described above mean that we need to re-focus our efforts on achieving the best outcomes for our population with the reducing resources we have available to us, this means facing up to the reality that we may not be able to do everything. We also need to think about future proofing services and developing the market to ensure we are able to respond to the changing environment we are working within. The challenges we face now will get tougher therefore we must take action now. We started some of this work and have engaged in discussions with the public at various engagement events over the past 12 months which produced the commissioning principles we use in our decision making. This is only a small step forwards however and this work now needs to progress and develop at scale and pace.

Our operational plan outlines some of the measures we will put in place to progress this work over the next year.

# Executive Summary

NHS England's vision for the future, '*The Five Year Forward View'* sets out a number of ambitions which we are required to respond to. '*The Five Year Forward View'* recognises that improvements must be made in the way NHS services are commissioned and provided and to do this challenges the organisations to close a number of gaps by 2020. These are:

1. The Care and Quality Gap
2. The Health and Inequalities Gap
3. The Finance and Efficiencies Gap

This document outlines North Kirklees CCG's response to contributing to closing these gaps locally.

The mandate within the 2016 NHS England planning guidance *'Delivering the Five Year Forward View'* describes a challenged NHS which requires investment, a period of recovery and transformation to ensure sustainability in the longer term. The two stage approach to planning for 2016/17 is also linked to the requirement for local systems to collaborate and develop a Sustainability and Transformation Plan (STP). This document outlines our local ambitions in responding to this mandate and describes the first year of the STP we will develop over a Kirklees footprint.

The focus of our work in 2016/17 will be on putting measures in place to inject stability in the system whilst progressing our longer term vision through three main transformation programmes:-

1. Transformation of planned care pathways with a view to sustainably managing demand for services in different ways
2. Transformation of our urgent care services
3. Transformation of primary care services to respond to national directives and integrate into the wider system.

From this work there are a number of key themes emerging in terms of outcomes:-

- ✓ Commissioned services which are of a high quality, equitable in access, safe, cost effective and value for money
- ✓ Collaborative integrated commissioning which is inclusive of all key stakeholders, including patients
- ✓ Care provided by the right person, at the right time, first time
- ✓ Better use of enablers, for example, self-care and technology
- ✓ Make changes to address emerging workforce issues taking into account wider regional challenges
- ✓ Reduction in emergency and elective activity though earlier intervention and more effective management of long term conditions

Our ambition to work in a more collaborative and integrated way with our partners to improve patient outcomes has been and will continue to be at the forefront of all work we undertake. In 2016/17 we will collaborate and integrate further building and expanding on work we are already doing.

The development of our commissioning plans for 2016/17 has been informed through engagement with our GP membership, the voluntary sector and our wider patient community. We have presented our plans at a number of forums, including our North Kirklees Patient Reference Group, our GP Forum and specific engagement activities focused on our commissioning priorities. The feedback we have received at these events has helped to shape and develop the information within this document.

Please note: This is a live document therefore will be refreshed as our plans evolve over the coming year.

# Kirklees 2020 Vision for a joined up health and social care system:

*No matter **where** they live, **people in Kirklees** live their lives **confidently**, in **better health**, for **longer** and experience **less inequality.***

**Objectives for local people**

- ✓ People in Kirklees are as well as possible for as long as possible, both physically and mentally
- ✓ People can control and manage life challenges and are able to do as much for themselves and each other as possible
- ✓ People have a safe, warm, affordable home in a decent physical environment within a supportive community and a strong, sustainable economy
- ✓ People take up opportunities that have a positive impact on their health and wellbeing
- ✓ People who are informal carers are identified, supported and involved
- ✓ People experience high quality seamless health and social care that puts their individual needs, choices and aspirations at the heart of their care and support

**Objectives for local services**

- ✓ The local health and social care system is affordable and sustainable, and investment is rebalanced across the system towards activity in community settings
- ✓ Integrated service delivery across primary, community and social care focusses on prevention and early intervention, and are available 24 hours a day and 7 days a week where relevant
- ✓ Strategic planning, commissioning, intelligence, technology, workforce and community planning are fully integrated
- ✓ New solutions are created through innovation and creative collaboration locally, regionally and nationally.

# NKCCG Vision

*"Enabling the population of North Kirklees to live longer, healthier and happier lives"*

**The principles of this vision are;**

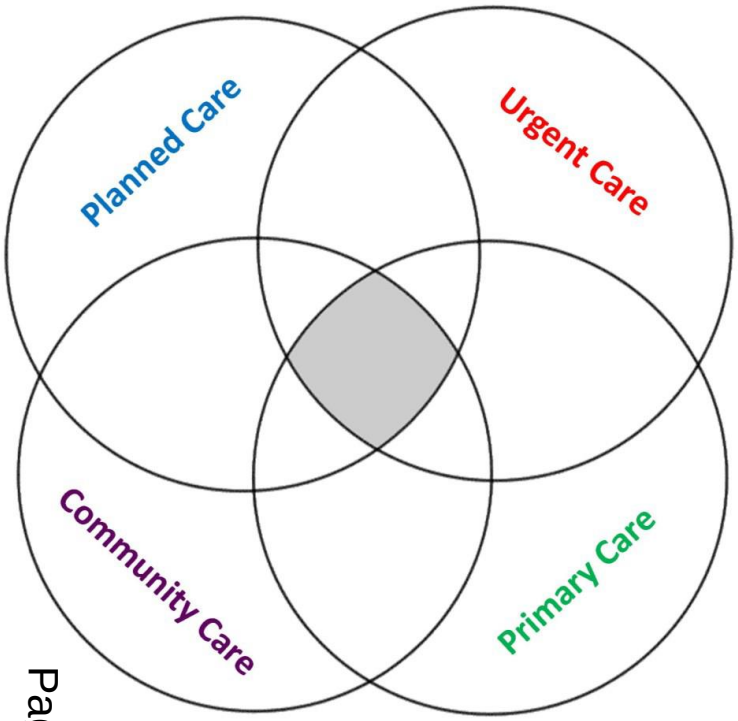
- ✓ Commissioned services which are sustainable, cost effective, safe, of a high quality and equitable in access
- ✓ Collaborative, integrated and person centred commissioning, which is inclusive of all key stakeholders, including patients
- ✓ Ensuring care is delivered in the right place, by the right person, first time
- Better use of enablers, for example, self-care and technology
- Make changes to address emerging workforce issues

# Our Vision

## What will service delivery look like in the future?

Our ambition for the future is to move towards population based commissioning where we break down silos in current service delivery so the focus is on patient centred care and health and wellbeing rather than specific services/providers and organisational structures. Our aim for the longer term is to develop population based budgets which enable patients to be treated in the most appropriate place for their condition with a focus on integrated and holistic care pathways. This will result in a shift in activity out of hospital and into more appropriate settings, so that patients can be managed more effectively.

This vision is based on the principles of the new models of care within the NHS Five Year Forward View and the Kings Fund, Place Based Commissioning Paper.




Our progression towards this vision will be undertaken in a managed approach. We are in the early stages of this change management process working in collaboration with local providers and Kirklees Council.

Our intention is to approach the implementation of a new model of care for North Kirklees in the following stages:

1. Work with our membership to develop the primary care future model of service delivery
2. Integrate with community services
3. Integrate with social care services and mental health services
4. Integrate with acute hospital services

**Clinical Standards for 7 Day Services**

- ✓ We are working over a Systems Resilience Group (SRG) footprint to ensure compliance with four of the clinical standards relating to 7 day services by March 2017. The Mid Yorkshire footprint has been selected as an early implementer of this work.

**NHS Five Year Forward View**

The NHS Five Year forward View challenges organisations to focus on closing the gap between:

- ✓ Care and Quality
- ✓ Finance and Efficiency
- ✓ Health and Inequalities

We understand the above gaps at a local level and are working to understand the gaps at a 'place' level across Kirklees as part of the development of our Sustainability and Transformation Plan (STP).



What are the national conditions which drive this plan?

**Local Response to 9 National Drivers**

- ✓ Meet the requirements of the mandate to the NHS
- ✓ Development of a local Sustainability and Transformation Plan (STP)
- ✓ Plans to address the sustainability of General Practice
- ✓ Plans for financial stability
- ✓ Have plans to recover the constitution standards
- ✓ Have plans to meet the new mental health access standards
- ✓ Deliver on actions set out in the transforming care plan for learning disabilities

**Right Care Programme**

- ✓ Pioneer site for the Right Care Approach.
- ✓ Use the pioneer programme to establish the best way to adapt the methodology into our commissioning approach

**NHS Mandate**

- ✓ We endorse the NHS mandate for the future and understand how we contribute to its delivery at a local level.

*'Developing the Forward View'* sets out a clear direction of travel for systems in 2016/17 which can be broken down into two stages (see below). Whilst we recognise the importance of both these stages, locally we are advancing with our plans to transform local services whilst the system is in a period of recovery, we believe that change needs to happen to enable the system to recover in the longer term.

## Recovery

STAGE 1

### What does this mean?

- Return to financial balance
- Recovery of NHS constitution and quality standards
  - A&E 4 hour wait standard
  - Cancer treatment standards
  - YAS response targets
  - 18 Weeks RTT
  - Mental Health access standards

### Local Response

- ✓ Emergency Care Improvement Plan (ECIP)
- ✓ Action plan relating to the Good Governance Institute Report
- ✓ Local trajectories for improvement/recovery
- ✓ Development of commissioning principles
- ✓ Quality, Improvement , Prevention and Productivity (QIPP)

NHS
North Kirklees
Clinical Commissioning Group

## Transformation and Sustainability

STAGE 2

### What does this mean?

- Implementation of new models of care
- Working with the RightCare Programme
- New and innovative ways of working
- Improving quality and patient experience while also making necessary efficiency savings

### Local Response

- ✓ Transformation programmes at a local and regional level
- ✓ Development of a new model of care for Kirklees based around place based principles
- ✓ Pioneer for the RightCare Programme
- ✓ Advancements in technology through the Digital Roadmap
- ✓ Collaboration and integration with partners
- ✓ Clinical Standards for 7 day services

NHS
North Kirklees
Clinical Commissioning Group

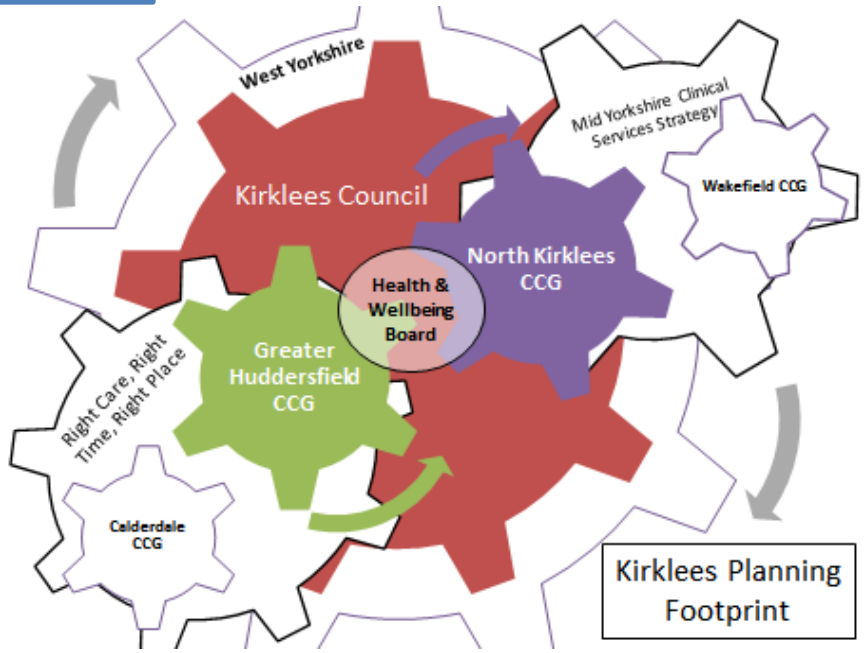
As NHS organisations we are required to produce a Sustainability and Transformation Plan (STP) in 2016/17. This plan is an overarching umbrella plan where Commissioners, Providers and Local Authorities are asked to come together over a defined footprint to agree a shared vision and outline plans for transforming the system to ensure sustainability of services in the future. The STP will be delivered over the next five years and the CCG operational plans represent the interventions which will be delivered locally during the first year of this plan.

The focus of the STP must be considered at a population level, therefore North Kirklees CCG will develop an STP over a Kirklees footprint which will be referred to as the 'Kirklees Place'. Six 'Place Based' plans will be developed in West Yorkshire. While this local focus is important we also need to ensure that we are developing plans which are truly sustainable. To do this we must look outside our immediate boundaries and consider what we can progress jointly at a regional level. All STP plans in West Yorkshire will therefore be part of a secondary STP which will be referred to as 'Healthy Futures'. Figure 1 below outlines the different STP footprints in West Yorkshire and how they link together under the Healthy Futures Programme Board.

Figure 1

The Kirklees Place consists of North Kirklees CCG, Greater Huddersfield CCG, Kirklees Council and our provider organisations. Over the coming months we will work together to agree a joint local vision for Kirklees. This vision will build on work which has already been undertaken in previous years and the direction of travel set out in the Kirklees Five Year Strategic Plan which was developed in 2014/15. The development and implementation of the Kirklees STP will be overseen by the Kirklees Health and Wellbeing Board. The work we have already undertaken to integrate on this footprint will support the development of the STP. Figure 2 below shows the complexities of the environment we are working within and illustrates some of the mechanisms in place which we will build on to deliver transformation across a Kirklees Place.

Figure 2




Kirklees Planning Footprint

**Digital Roadmap and Integrated Approach to Business Intelligence**

A joint approach to data sharing and business intelligence will enable us to design and deliver services which are wrapped around the patient.

**Integrated Commissioning Executive**

The Integrated Commissioning Executive (ICE) is the vehicle for operationalising integration across Kirklees (GHCCG, NKCCG and Kirklees Council)

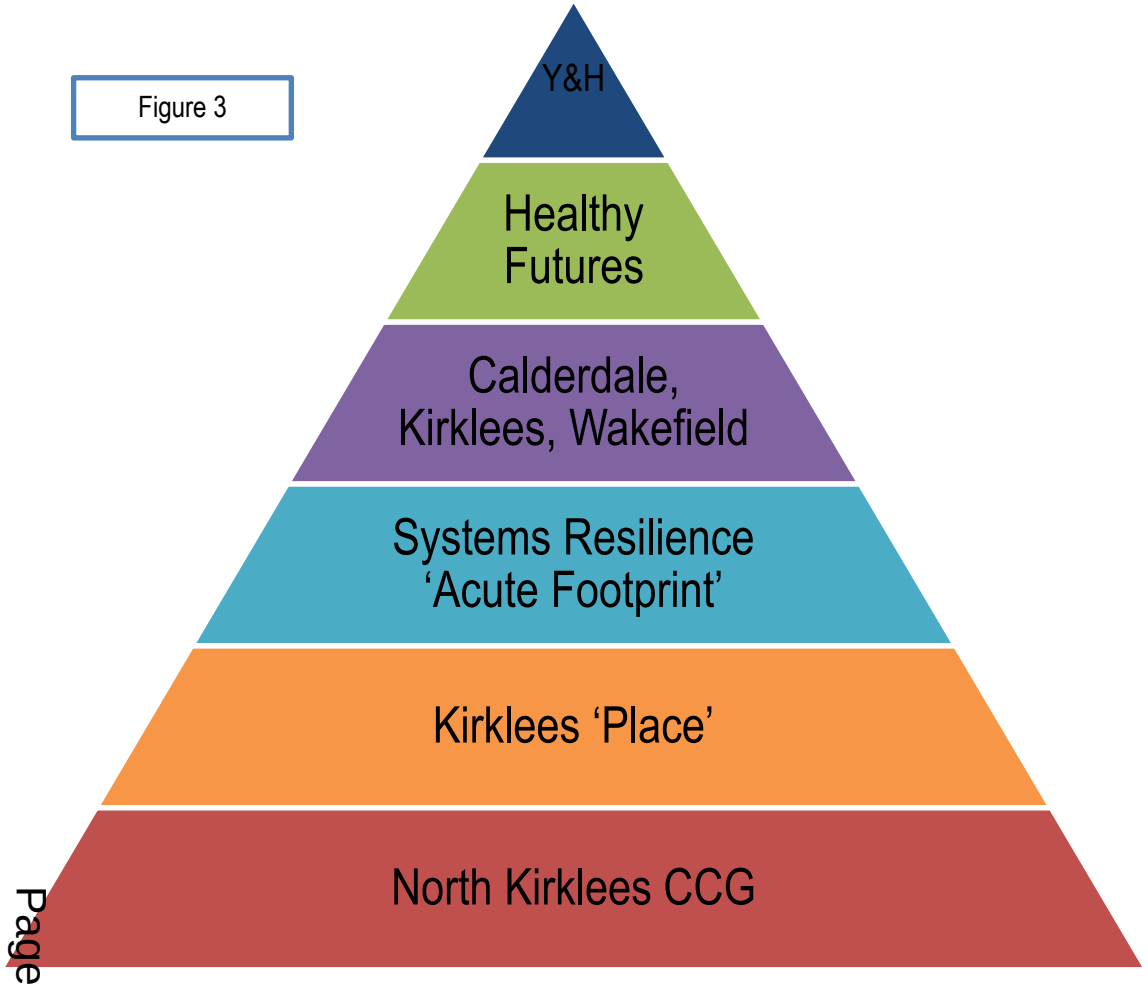

**Better Care Fund (BCF)**

Pooled budget which supports integrated commissioning across the Kirklees health and social care economy

The commissioning environment in which this CCG operates within is very complex. North Kirklees sits within a number of different footprints and works with a number of commissioner and provider organisations to ensure services are available to patients locally. Figure 3 below, provides a summary of the collaborative working relationships which are in place across the wider system. Between each of these levels of commissioning and collaboration we have processes in place to ensure transparency and alignment. All the levels are interdependent to ensure we commission services to meet the needs of our patients

The subsequent chapters to this provide a more detailed narrative of the plans which will be progressed over each of these footprints.

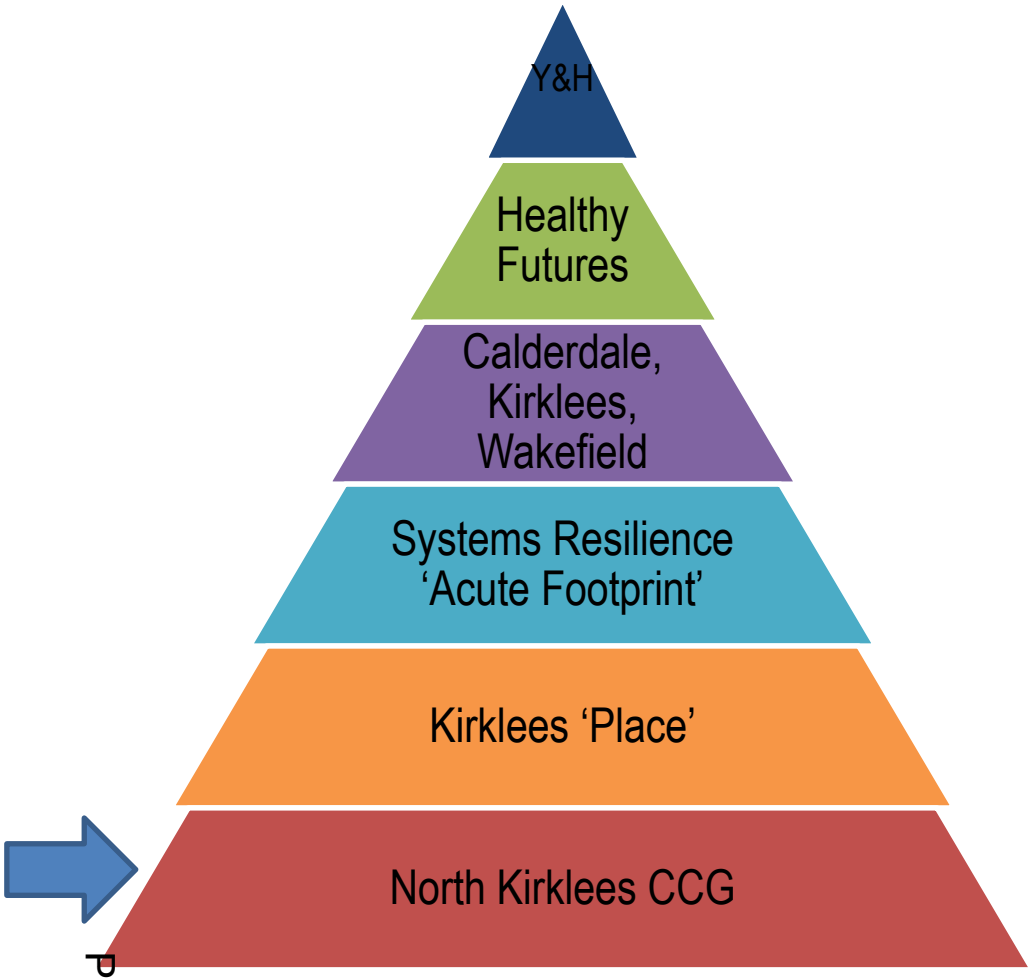
Figure 3




Across each of the different footprints there are a number of themes which are cross cutting. These are:

- Collaboration and integration to break down silos in the way we commission services and move towards a 'matrix way of working
- Providers working together to provide seamless integrated care wrapped around the patient.
- Breaking down barriers between health, social care and different care providers.
- Sharing learning and best practice 'not reinventing the wheel'
- Improving quality
- Reducing variation and creating efficiencies
- Sustainability
- Addressing workforce issues
- An innovative approach to technology

## North Kirklees




**Key Workstreams:**

- Transformation of Primary Care

**Partners:**

- GP Membership
- Health Education Yorkshire and Humber
- NHS England Regional Team North of England
- Community provider, Locala
- Other independents, e.g. Pharmacy
- Voluntary organisation e.g all together better
- Supported by Kirklees Council and Public Health

**Governance Overseeing Implementation:**

The implementation of the North Kirklees CCG Primary Care Strategy is overseen by the CCG Governing Body and the Council of Members. There are a number of working groups which link into these bodies who are responsible for progressing elements of the strategy over the next 12 months.

Link to the North Kirklees Primary Care Strategy

## Transformation of Primary Care Services

What are we trying to achieve?

**Our vision for healthcare in North Kirklees is one of seamless, high quality, accessible care delivered to all patients.**

By breaking down the old boundaries and working in collaboration with community and hospital services we aim to deliver patient centred care, regardless of provider. We will explore new and innovative ways of delivering place based care through integrated budgets, designing services to meet the needs of specific geographic populations.

The overall objectives required to deliver the overarching vision for transformation of health in North Kirklees have been identified as:

- Easily accessible primary care services for all patients
- Consistent, high quality, effective, safe, resilient care delivered to all patients
- Motivated, engaged and integrated workforce with the right skills, behaviours and training, available in the right numbers
- Premises and infrastructure which increases capacity for clinical services out of hospital and improve 7 day access to effective care
- Effective contracting models which are fairly and properly funded to deliver integration and positive health outcomes

What will we deliver in 2016/17?

- Progress towards full delegation for co-commissioning.
- Provide analytical and business development support to practices to help them create and implement business plans for working with other practices and develop sustainability
- Estates strategy for North Kirklees linked to the primary care transformation funding
- Development of a workforce sustainability strategy linked to other providers and Health Education Yorkshire and Humber
- Development plans to address some of the variation identified in quality across practices, linking into the clinical threshold management work being undertaken by the planned care programme.
- Improve incident reporting systems in primary care which include review and sharing of learning
- Establish a baseline of demand and capacity in primary care and develop an average and acceptable minimum level of access. Implement 7 day working scheme.
- Pilot a “hub and spoke model” across a number of practices which provides an integrated care model”.
- Extended use of clinical triage across a wider number of practices and introduce use of flexible clinic structures
- Better use of technology to support new ways of working

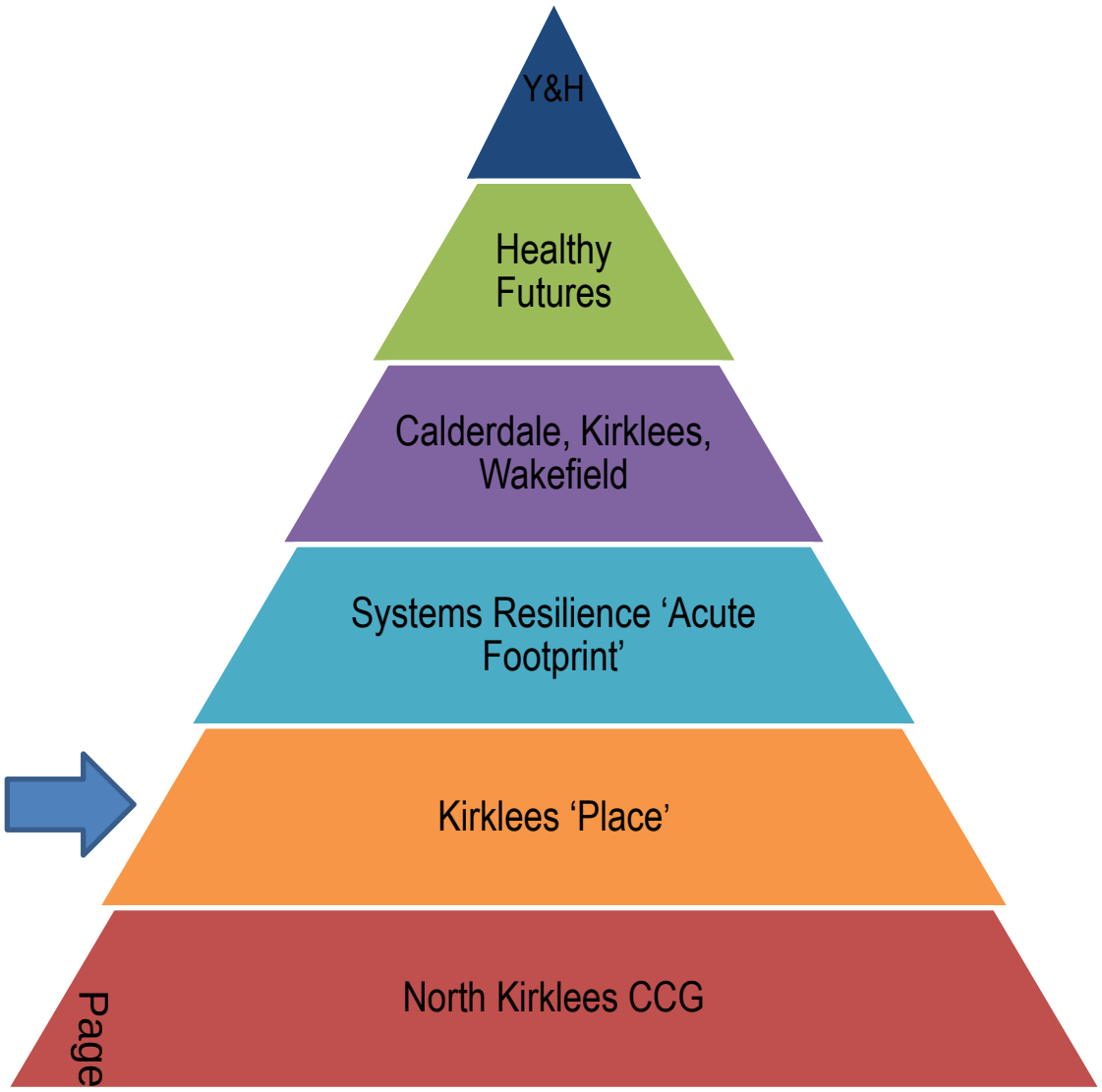
Risks to delivery:

- Pace of change required
- Pressures within general practice to make transformational change

Interdependencies with other workstreams:

We recognise that there are some barriers to achieving this vision which we will not be able to overcome on our own and we will be required to collaborate on larger footprints to ensure our vision is achievable and sustainable, for example, limitations around workforce. These discussions are already taking place; however the STP will formalise and drive this going forward.

## Kirklees "Place"




**Key Workstreams:**

- Care Closer to Home – Transformation of Community Services
- Priorities for Integration - Continuing Healthcare, Children, Mental Health and Maternity Services
- Better Care Fund
- Prevention

**Partners:**

- North Kirklees CCG
- Greater Huddersfield CCG
- Kirklees Council
- Locala
- South West Yorkshire Partnership Foundation Trust (SWYPFT)
- Voluntary Organisations

**Governance Overseeing Implementation:**

The Integrated Commissioning Executive (ICE) and its relevant sub-groups oversee our plans for integration. This group reports into the CCG Governing Body and the Health and Wellbeing Board.

The Care Closer to Home Programme is overseen by the CCG Governing Body.

## Care Closer to Home

What are we trying to achieve?

Care Closer to Home is the vision for the development of integrated community based health, social, primary care and mental health services across Kirklees for children and young people, the frail and older people specifically targeting those vulnerable groups who have identified health needs.

We are aiming to:

- Commission integrated care across a number of services (physical and mental health, social care, education) breaking down the current silos which exist
- Proactive approach which optimises wellbeing and independence and promotes self-care;
- Prevent emergency admissions through early intervention which includes a planned response to crisis
- Expedite timely and safe supported transfer/discharge
- Optimise a range of skills and encouraging flexible working across the workforce to meet the needs of patients.
- Work with the voluntary sector to enhance support that is tailored to individual need;
- Reduce the need for complex and expensive care packages – proactive case management to prevent escalation;
- Actively support parents/carers by ensuring their needs are assessed.

What will we deliver in 2016/17?

Working jointly with Greater Huddersfield CCG we commissioned an integrated community service model in October 2015. This work was supported by Kirklees Council. The implementation of the integrated service model is phased across the duration of the contract. Our ambition is to continue to expand the scope of services provided within the model and to further integrate health and social care services using the better care fund as a lever.

In 2016/17

- We will continue to develop an integrated approach to managing frailty which is a key function within the service model.
- We will continue to ensure that fundamental principles of the model underpin the care for patients in care homes, with integration between planned, proactive care, core primary care and responsive approaches to crisis and early supported transfer.
- We will continue to expand the range of services to support patients with palliative and end of life care needs.
- Support the community provider to work with primary care, mental health provider, acute provider, hospice and voluntary organisations to co-deliver services
- Deliver services to housebound patients

Risks to delivery:

- Pace of change required
- Pressures within the system to make transformational change
- Workforce to deliver the change

Interdependencies with other workstreams:

- Interdependencies to the Mid Yorkshire Clinical Services Strategy
- Primary Care Transformation
- Urgent and Emergency Care
- West Yorkshire Urgent Care Vanguard

## Mental Health Services

What are we trying to achieve?

Mental health services will be designed specifically for people who require access for services that will deal with their mental health needs in both hospital and the community. We will build on previous mental health and learning disability pathways and the work of Kirklees partnership to develop a holistic long term strategy which encompasses a preventative, anticipatory and whole person approach to managing care. This will include a focus on emotional health and wellbeing and resilience.

- To value mental health equally with physical health or "Parity of Esteem"
- To enable more people to live independently in their home communities, including helping more people to live in their own homes where possible with appropriate packages of care in place of a residential placement
- To gain greater assurance that the optimum package of care is being provided for each individual
- To achieve a reduction in out of area placements,
- An enhancement of community rehabilitation services building a local network of providers contributing to the rehab pathway including third sector organisations.
- Equity of access to high quality talking or psychological therapy services, especially where early intervention can avoid the escalation of issues and their impact on people's lives.
- Improve access to CAMHS and improve the quality of experience of using services to ensure they meet the expectations of children, young people and families.

What will we deliver in 2016/17?

- Progress the year one objectives within the CAMHS Transformation plan, working closely with the Healthy Child Programme
- Continuation of the joint work to transform Mental Health Rehabilitation services that support people with longer term mental health rehabilitation needs.
- Work with our mental health provider to ensure that the current needs of people with learning disabilities are fully understood and reflected in the right package of care for each individual. Implement the Transforming Care Plan.
- Improving IAPT services through exploration of self-referral routes and testing of new ways of delivering psychological therapies such as the Big White Wall online support service.
- Mental Health access standards
- Acute and community mental health pathway will be transformed to improve access to high quality care based on the needs of individuals as indicated by mental health care clusters
- Further development of a community-based dementia diagnostic service
- Improving dementia diagnostic rates, promote Dementia Friends and becoming a dementia friendly community.
- Develop social prescribing model for early intervention/prevention, work with Kirklees Council on mental wellbeing.
- Working with the police on the care-concordat.
- Review of current perinatal mental health provision in view of refreshed national guidance

Risks to delivery:

- Ability to identify additional capacity for repatriation
- Current payment & service model stifles change
- Lack of capacity in community and primary care to support service models

Interdependencies with other workstreams:

- Healthy Futures acute mental health workstream
- Psychiatric Liaison elements within the Meeting the Challenge plans
- Care closer to home community mental health services

## Integration Agenda

What are we trying to achieve?

To achieve the best possible outcomes for our population we must integrate services and break down the silos which currently exist within different NHS services and between health and social care, inclusive of physical and mental health services. We recognise that, whilst different organisations have overall responsibility for delivery of services in different elements of the system, it will take a partnership approach to truly transform and improve services in North Kirklees.

Integration was a key priority for us in 2015/16 will continue to be in 2016/17. Our focus on integration will be formaised through the development of our STP over a Kirklees place. Changes to the CCG leadership structure will also support collaboration with Kirklees Council and drive the integration of health and social care through the appointment of an joint interim Chief Officer for North Kirklees.

We plan to build on the work we have already undertaken and the relationships which have been developed using the Integrated Commissioning Executive and the Better Care Fund as the mechanisms and levers to drive this agenda forward

What will we deliver in 2016/17?

- Development of commissioning of the Healthy Child Programme in Kirklees
- Reducing inequalities plan
- Local response to the national maternity strategy
- Children's pathway development working with the acute trust
- Integrated business intelligence model
- Robust Better Care Fund plans for 2016/17
- Support the roll out of the national Fit for Work Programme
- Development and implementation of the Children with a Disability Strategy
- Continue to deliver continuing healthcare services for children and adults. Delivering quality care packages which also demonstrate value for money.

Risks to delivery:

- Delivering services in reducing health and social care budgets.
- Ensuring changes to health services do not have any unintended consequences on social care budgets
- Pace and scale of change required

Interdependencies with other workstreams:

- Interdependencies to the Mid Yorkshire Clinical Services Strategy
- Care closer to home
- Digital Roadmap

## Prevention

Prevention includes a wide range of activities aimed at reducing risks or threats to health. It is often described in 3 levels:

- *Primary prevention*: preventing the onset of ill health i.e. stopping people from smoking, better diet, increasing levels of physical activity, immunization
- *Secondary prevention*: early identification of ill health and slowing or stopping its progression i.e. screening, NHS Health Checks programme
- *Tertiary prevention*: reducing the level of disability experienced by people with existing health problems i.e. rehabilitation

The Wanless report (2004) emphasised the importance of public health and ill-health prevention, arguing that local-level public health activities needed to be prioritised in order to develop long-term sustainable action to improve population health. Many of the benefits of engaging people in living healthier lives occur in the long term but there are also immediate and short-term benefits when demand for health services can be reduced, especially in those areas such as acute services where capacity is seriously constrained.

Individuals are ultimately responsible for their own and their children's health but they need to be supported more actively to make better decisions about their own health and wellbeing. Some of the challenges include providing the right amount of information to facilitate decision-making, attitudes not conducive to individuals pursuing healthy lifestyles and addictions. There are also significant inequalities related to individuals' poor lifestyles and they tend to be related to socio-economic and sometimes ethnic differences.

Many of the most important health behaviors significant to the development of chronic diseases follow the social gradient such as smoking, obesity, lack of physical activity and poor nutrition. Action in these areas requires evidence-based programmes that focus interventions on reducing the social gradient, and programmes that address social and economic factors which are the causes of ill health.

***Preventable causes of ill-health***

We know that people continue to live with and die from diseases that are largely preventable. Living Well for Longer (PHE 2014) identifies the most common and biggest killer diseases being cancer, heart disease, stroke, respiratory and liver disease. The greatest causes of ill health and disease in Kirklees are smoking, poor diet, physical inactivity with too much alcohol becoming increasingly important (JSNA, 2014). These are all modifiable risk factors linked to these common diseases.

Currently Kirklees delivers a number of different lifestyle services designed to increase levels of physical activity, improve diet (including reducing obesity), stop smoking and reduce alcohol consumption. While these interventions have had varying levels of success we have recognised that people rarely have just one aspect of their lifestyle they want to change and many are closely linked, for example, people who need to lose weight are also likely to need to increase their activity levels and excessive alcohol often leads to weight gain. In order to increase effectiveness and make most efficient use of our resources in 2016/17 we will recommission services under one provider as an integrated Wellness Service to:

- improve service outcomes and quality of service delivery for our residents
- place a greater emphasis on prevention and early intervention by promoting a holistic approach to health and wellbeing
- empower individuals to maintain and improve their own health and remain independent for as long as possible
- take a whole-person and community approach to improving health

**Tackling Obesity**

One in three children (32%) and two out of three adults (66%) are overweight and/or obese in Kirklees (Public Health England, 2016). In Kirklees we know that tackling obesity requires a multidimensional approach because the risk factors driving obesity and obesity related conditions such as type II diabetes include diet, lack of physical activity and behaviors linked environment. It is acknowledged that as BMI increases, so does health costs. Severely obese people are three times as likely to require social care as people with a healthy weight.

Kirklees Council currently commissions a range of weight management services including Weight Watchers vouchers (tier 2) and a multidisciplinary weight management services based in the acute sector (Tier 3) linked into bariatric surgery pathways. Our aspiration in the future is to integrate our weight management services with the wellness model outlined above, reduce the number of people needing tier 3 interventions and ensure the right people access an evidence based pathway into tier 4 bariatric surgery. Bariatric surgery commissioning is transferring from NHS England to CCGs on the 1st April 2016; therefore we will have more scope locally to commission a service which aligns with this model.

We believe tackling obesity requires system-wide interventions and the reshaping of food and physical activity cultures to better promote healthy choices. Our actions reflect this view and focus not just on reviewing current weight management services but the risk factors highlighted above. Current actions that we will continue to build on locally include:

- Working with local planners to create healthier environments. One example is the development of an Integrated Impact Assessment framework which so far has been used to make decisions about new housing developments, a particular focus on active travel opportunities for example has been really important.
- The Kirklees Food Charter provides the direction of travel for local food policy and procurement across public services and wider. It outlines a series of measures to promote food that is good for people, the environment, the local economy and health. Almost all Kirklees schools now provide excellent 'Food for Life Standard' locally for procured food.
- The Physical Activity and Sport Strategy outlines a number of measures and interventions to promote 'everyone active Kirklees'.
- We will continue to build on our provision of a range of services promoting healthy food through cooking and food skills training
- Get Fit with the Giants and Terriers uses local professional sports teams to run a 12 week programme for men in sedentary occupations with higher BMI.

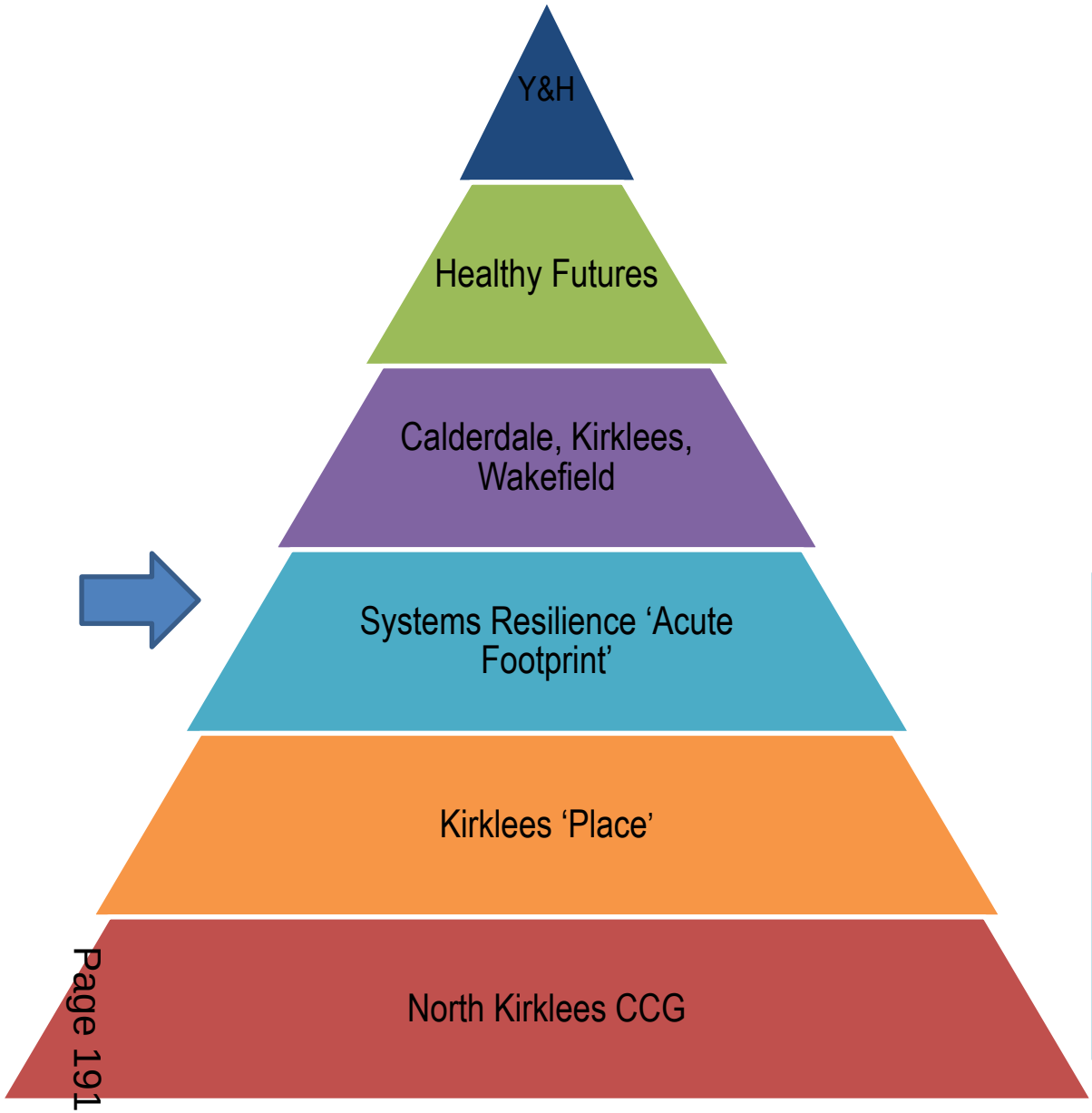
**Diabetes Prevention**

When diabetes is not well managed it can lead to serious complications including heart disease, stroke, blindness, kidney disease, nerve damage and amputations leading to disability and earlier death. We know diabetes is an issue for us locally, especially in our South Asian Communities.

Kirklees applied to be a Wave 1 pilot for the implementation of the National Diabetes Prevention Programme and although unsuccessful is hopeful of being successful in wave 2. In North Kirklees we are committed to preventing Diabetes and this is reflected in our current plans and strategies, Diabetes is one of the areas we have identified to make improvements on as part of the RightCare Programme.

We recognise that diet and exercise are risk factors to diabetes. We will work in partnership with Public Health to ensure services are available to support people to lose and manage their weight better and to help people become more physically active. Better local use will also be made of the NHS check to help identify people at increased risk of cardiovascular diseases and diabetes and to use it as a lever to promote local health improvement services and encourage patients to attend the services on offer. For individuals not attending services, the we will also work with Public Health to make sure that relevant and easy to understand information is available for individuals who may be willing to make some small changes to their lifestyle in order to have a big impact on their health'.

## Systems Resilience 'Acute Footprint'




**Key workstreams:**

- 'Meeting the Challenge' Acute Reconfiguration
- Planned Care Transformation
- Cancer
- Urgent and Emergency Care Transformation

**Partners:**

- North Kirklees CCG
- Wakefield CCG
- Mid Yorkshire Hospitals NHS Trust
- General Practice
- Kirklees Council
- Locala
- YAS
- SWYPFT

**Governance Overseeing Implementation:**

The Systems Resilience Group oversees the performance of the metrics which monitor the effectiveness of the system, e.g. constitution measures and delayed transfer of care. This group reports into the CCG Governing Bodies.

There are also Executive Quality Boards and Contracting Boards which hold the system to account.

The implementation of the 'Meeting the Challenge' Acute Reconfiguration is overseen by the Programme Executive and an Implementation Group., these groups reporting into CCG Governing Bodies and Health and Wellbeing Boards.

## 'Meeting the Challenge' Hospital Reconfiguration

What are we trying to achieve?

Our local Trust, through the implementation of the 'Striving for Excellence' Strategy aims to be an integrated care organisation, delivering comprehensive and seamless services across community and hospital pathways. Working closely with the wider health and social care economy, the overarching aim is to develop care pathways that provide services to patients in the right place, at the right time by the right people.
Successful delivery of this vision requires increased efficiency in both hospital and community services achieved by reducing duplication, optimising use of resources and ensuring people are cared for in the most appropriate setting by the most appropriate clinical team. Locally there is an appreciation that the current service model in Mid Yorkshire is neither clinically sustainable, able to ensure high quality of service nor financially viable and that transformational change at scale across the system is required to ensure services are sustainable locally in the future. In turn this programme contributes to closing the finance and efficiency and care and quality gaps identified in the Five Year Forward View.
There is a strong emphasis placed on care closer to or at its closest point to home. The planned hospital reconfiguration across the Mid Yorkshire footprint, 'Meeting the Challenge' and its interdependencies with the integrated models of care for community services across North Kirklees and Wakefield will deliver this vision. The key system changes which underpin this vision are:

- The re-profiling of A&E services provided from the three hospital sites;
- An integrated approach between acute, primary care and community services;
- Delivering services 7 days per week;
- Centralising some services to improve quality and safety; and
- Greater reliance on delivery of urgent services outside of hospital and providing elective services, outpatient, day case and inpatient surgery, at the closest hospital to where a patient lives.

Interdependencies with other workstreams

'Right Care, Right Time' Acute Reconfiguration of Calderdale and Huddersfield Foundation Trust
West Yorkshire Urgent and Emergency Care Vanguard/South Yorkshire acute vanguard

What will we deliver in 2016/17?

The hospital reconfiguration programme is in year three of implementation having successfully removed a number of hospital beds from across the three sites in line with the planned changes. The pace of change is under review in light of recommendations from the CQC. Tthe Trust in partnership with Commissioners and other key stakeholders are reviewing the timescales of delivery to assess the feasibility of accelerating implementation. A decision on this is expected in April 2016.

The planned key interventions which will be progressed in the third year of the programme are:

- Opening of the Midwife Led Unit at Dewsbury Hospital. Consultant led deliveries will be at Pinderfields Hospital or other Hospitals of the womans choice.
- Centralisation of children's inpatient services to Pinderfields Hospital
- Continued phased migration of planned day case and short stay surgery to Dewsbury Hospital from Pinderfields Hospital

If the decision is made to accelerate the hospital reconfiguration plans additional changes will be brought forward from 2017/18 to 2016/17.

Risks to delivery:

To be added following decision regarding early implementation

## Planned Care Transformation

What are we trying to achieve?

- Move towards proactive/preventative services which will reduce demand on acute provision and create capacity for those who require a higher more specialist acute intervention.
- Manage patient expectation by being clear about what we can deliver within current resource
- Ensure transformation is sustainable and not just shifting activity from one provider to another
- Reduce demand on elective care services from a provider and referrer perspective
- Improve patient education and encourage patients to take ownership of their own condition
- Patients receive treatment in a seamless, timely manner from the most appropriate clinical for their needs
- Prevent patients from being overtreated or treated too early in the pathway
- Look at different ways of addressing demand and other ways of meeting patient need
- Reduce variability in referral processes ensuring pathways are protocol driven and clinically effective

Risks to delivery:

- Pace of change required
- Current system pressures not allowing scope for transformational change or investment in alternative services
- Estates
- Workforce

What will we deliver in 2016/17?

- Develop the Clinical Leaders Forum to support joint working between primary care and secondary care clinicians with a view to reviewing and improving pathways. This Forum will ensure that the transformation is owned by both commissioner and provider with patients at the core.
- Implement sustainable measures and strategies to reduce demand on elective services and support the Trust in recovery of the 18 Weeks RTT access standard.
- Supporting secondary care clinicians to initiate e-consultations with primary care, as an appropriate alternative to an outpatient referral;
- Re-looking at services which require provision in a hospital environment and those that do not;
- The potential to minimise hospital face-to-face outpatient follow-ups by primary and secondary care clinicians adopting shared-care protocols and revised care pathways.
- Implementation of clinical threshold management systems and principles to reduce variation and ensure patients are seen by the right health professional for their needs first time.
- Review of children's pathways and maximise the benefits of the acute well child project
- Review use of diagnostics, particularly radiology and pathology to reduce variation and maximise capacity
- Work with the RightCare Programme to implement the methodology and make improvements in the following areas:
  - MSK
  - Respiratory with a focus on asthma
  - Diabetes

Interdependencies with other workstreams:

- Implementation of the primary care strategy
- Healthy Futures work relating to cancer
- Prevention agenda

## Cancer Services

What are we trying to achieve?

For the population of North Kirklees we want to ensure access to high quality and safe cancer services which improve patient experience and clinical outcomes for patients living with and beyond cancer. We also want to support patients at the end of life. We want to ensure that the cancer services available to our local population are resilient to manage the challenges within the system, for example, the increasing incidence of cancer and increasing cancer survival rates. Our aim which aligns with the wider objectives of the Strategic Cancer Network is for our services to be comparable with other wealthy countries in Europe in terms of the need for earlier diagnosis and higher treatment rates with curative intent.

We recognise the challenges and opportunities which are identified within the National Cancer Strategy and are in the process of developing an action plan to implement locally. This work is being led by the Mid Yorkshire Cancer Locality Group.

Risks to delivery:

- Limited dedicated resource to support improvement of cancer services
- Financial pressures
- Manpower – Specialist Consultants, Clinical Nurse Specialists, Radiographers
- Increasing demand and capacity reducing/remaining stable
- Competing demands on diagnostic capacity
- Complex pathways and more complex patients with multiple co-morbidities
- Access to diagnostics
- Public awareness
- Integration across whole of cancer pathway i.e. primary, secondary, tertiary, commissioning and specialist commissioning

What will we deliver in 2016/17?

- GP education regarding prevention and early diagnosis
- Increase screening uptake – enhanced screening programmes
- Increase public awareness of factors that reduce and increase the risk of cancer
- Implementation of the NICE Cancer Guidelines
- Review of diagnostic provision for cancer pathways
- Working with the acute provider to support streamlining of operational cancer pathways to ensure achievement of the national standards with a stretch target of booking within 7 days of receipt of referral for all tumour sites. This will support the recovery and sustainability of cancer access standards.
- Embed changes in primary and secondary care for Upper GI and Lower GI
- Managing growth for non-urgent, non-cancer referrals from primary care
- Understanding and tackling any unexplained variation in non-urgent, non-cancer referrals from primary care;
- Explore the feasibility of implementing cancer follow up clinics in the community, where clinically appropriate and where links to cancer CNS specialists are available.
- Supporting the work being undertaken at scale through the Strategic Cancer Network. This is inclusive of the review of cancer clinical pathways.
- Roll out National LWABC – Phase 3 Programme
    - Every patient to have access to recovery package

Interdependencies with other workstreams:

- Healthy Futures work relating to cancer
- Prevention agenda
- Planned Care Transformation Programme

## Urgent and Emergency Care

What are we trying to achieve?

For patients in North Kirklees we want to commission a simple, sustainable, high quality and patient focused urgent and emergency care service, which provides 24/7 access and ensures that patients are seen by the most appropriate health professional for their needs at the right time, in the right setting. (Keogh review 2014, Route Map 2015)

To ensure sustainability we recognise that all parts of the system need to function cohesively and be integrated with the wider health and social care economy, making best use of out of hospital services, at not just a local but a regional level.

There are a number of objectives which will enable delivery of this vision:

- Provide highly responsive urgent care services out of a hospital setting.
- Ensure that those services provided in the acute setting are sustainable.
- Help people with an urgent care need get to the right advice from the right clinician, first time
- Ensure those with a life threatening and serious need receive treatment in centres with the right facilities and expertise to maximise survival and recovery
- Connect all urgent and emergency care services together so the overall system becomes more than just a sum of all the parts
- Provide better support for people through the promotion of self-care
- Substantial progress against the ECIP action plan in line with the concordat arrangements.

Risks to delivery:

- Pace of change required
- Current system pressures not allowing scope for transformational change
- Estates
- Workforce

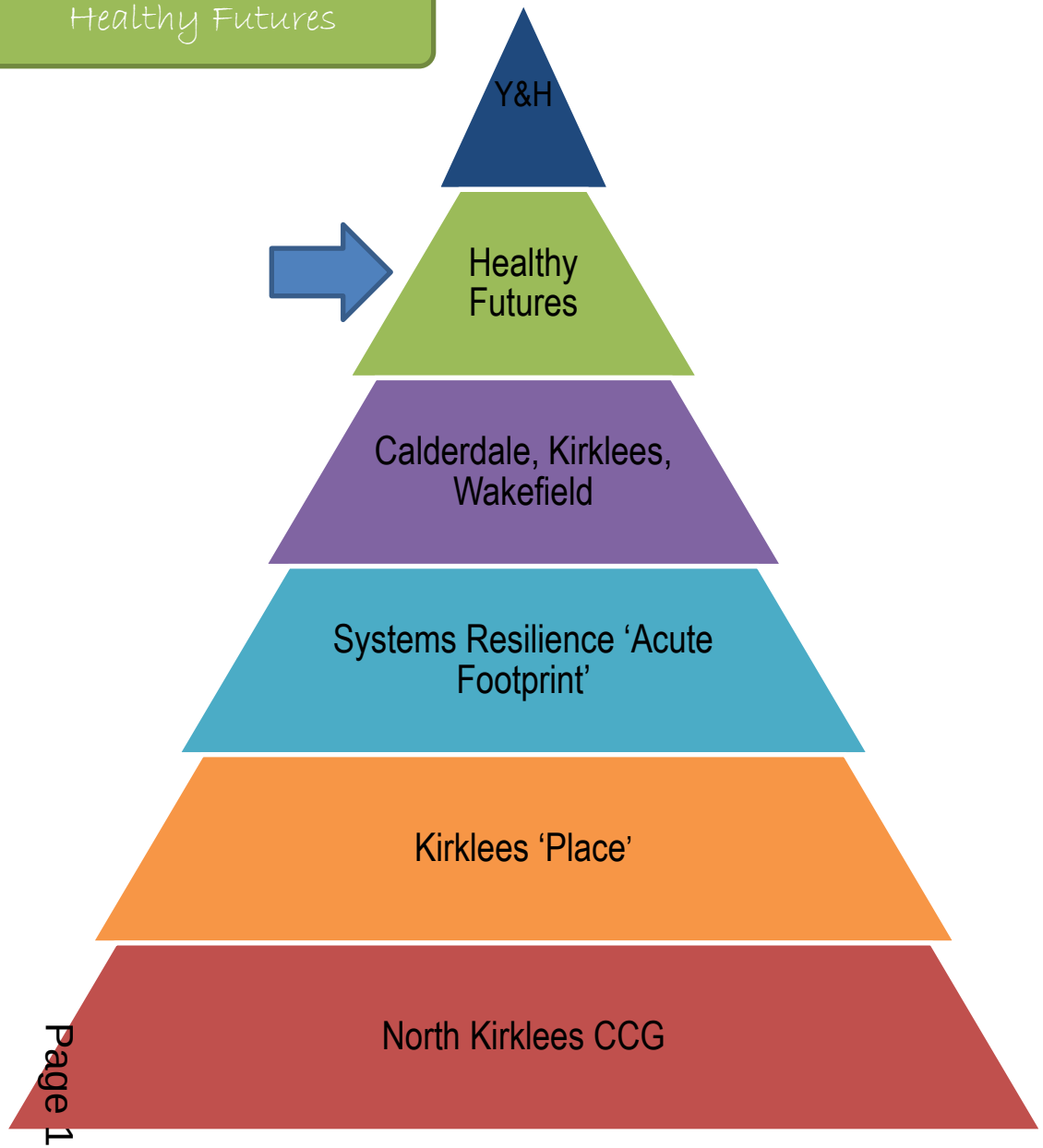
What will we deliver in 2016/17?

- Further develop and deliver an integrated Emergency Department where patients are seen by a health professional most appropriate to their need, first time.
- Continue to maximise and develop local out of hospital services to reduce demand on urgent and emergency care in a hospital setting
- Integrate pharmacy and primary care services into the urgent and emergency care system and develop facilities to offer a wider range of support services
- Support and develop local and regional models in the implementation of the 4 key urgent care work streams as outlined in the West Yorkshire Vanguard : Primary Care, Hear, See & Treat, Mental Health, Acute Service models
- Deliver the recommendations of the ECIP action plan to enable recovery of the system.
- Progress the priority actions of the 7 day working standards to reduce variation: action plan for implementation to be developed.
- Develop the community/primary care pathways to ensure alternative provision to an acute hospital bed is in place, including early supported discharge.
- Better use of technology to provide timely access to relevant patient and clinical data across the system. This will be progressed through the digital roadmap.

Interdependencies with other workstreams:

- West Yorkshire Urgent and Emergency Care Vanguard
- Implementation of the Primary Care Strategy
- Systems Resilience Group and the West Yorkshire Urgent Care Network
- The Mid Yorkshire plans for acute reconfiguration.
- Combined mobilisation of the integrated community services model
- Objectives of the Better Care Fund relating to the local plans for reduction in avoidable admissions and delayed transfers of care

## Healthy Futures




**Key workstreams:**

- Specialised Services
- Urgent and Emergency Care
- Cancer
- Mental Health (Acute)

**Partners:**

- 10 CCGs in West Yorkshire plus Harrogate
- Acute Providers across West Yorkshire
- Academic Health Science Network
- South West Yorkshire Partnership Foundation Trust (SWYPFT)
- NHS England
- YAS

**Governance Overseeing Implementation:**

The Healthy Futures Board oversee implementation of work progressed on this footprint. This group report into the respective CCG Governing Bodies.. The role and function of the Healthy Futures Board has been under review to ensure its link to the STP and a programme management team is being put in place to progress work undertaken at this level.

## Healthy Futures

What are we trying to achieve?

We are aware that in order to commission services which are sustainable within the reducing resources available to us, we need to look outside of our immediate boundaries and look to undertake work at scale. The Health Futures programme across West Yorkshire was established to facilitate this work.

This document has outlined in previous chapters a number of challenges the NHS faces nationally and which we are experiencing locally. There is a recognition that these challenges cannot be overcome by single organisations, instead we need to come together over a wider footprint to collaborate, work more effectively, share best practice and resources. The Health Futures work also provides a mechanism to review the provision of some services across West Yorkshire to establish if the existing arrangements are still providing the best outcomes for patients.

The Healthy Futures Board was established in 2015 and evolved from the existing 10CCG collaborative working arrangements in West Yorkshire, inclusive of Harrogate CCG.

Risks to delivery:

- Pace of change require
- Current system pressures not allowing scope for transformational change or investment in alternative services.

What will we deliver in 2016/17?

Priorities identified as being:

- Urgent and emergency care, linking to the work of the Urgent and Emergency Care Vanguard. A number of project areas have been agreed as part of the vanguard, work on these projects will move at pace during 2016/17 once the value proposition has been signed off.
- Cancer
- Specialised services
- Acute mental health, linking into the workstream identified as part of the Urgent and Emergency Care Vanguard.

Work is been undertaken to understand the scope for change in each of the priority areas, building on work which was undertaken by 10CCG and incorporating best practice in terms of new models of care.

This work will move at pace in 2016/17 and this section of the North Kirklees CCG Operational Plan will be updated as this work progresses.

Interdependencies with other workstreams:

- North Kirklees CCG Primary Care Strategy
- Improvements to cancer services which is being undertaken over an SRG footprint.
- Acute services reconfiguration 'Meeting the Challenge'

As work in each of the priority areas progresses this section of the North Kirklees CCG operational plan will be updated.

**Digital Roadmap**

In accordance with the Five Year Forward View we are required to produce a roadmap which demonstrates how we will ensure that services operate as paper free at the point of care delivery by 2020. This involves working with other CCGs, providers and the Local Authority to create a plan for how we will maximize the use of technology and overcome barriers with data sharing. North Kirklees CCG is working over a Kirklees footprint to develop this digital roadmap plan which will be ready for submission to NHS England by June 2016. To move this forwards a Kirklees ICT Group has been established, which includes representatives from provider and commissioning organisations across Kirklees.

We recognise the importance of working at scale and ensuring work progressed in the Kirklees ICT Group is aligned with neighboring roadmaps and work being progressed at a regional level. The Kirklees ICT Group will link to groups across Calderdale and Wakefield and into the West Yorkshire Urgent and Emergency Care Vanguard.

**Medicines Optimisation**

The focus for the Medicines Management Team in 2016/17 will be the delivery of efficiencies through projects to improve how medications are prescribed and used more effectively in primary care and hospitals. We will also continue to progress the national mandate to reduce antibiotic prescribing.

**Personalisation Agenda**

Personal health budgets offer choice and inform patients of all services available to them. Personal health budgets are part of the standard core offer for adults and children receiving continuing healthcare in North Kirklees. Locally, our existing offer also includes people in residential care and those who are at the end of life and meet specific criteria.

In addition to the existing offer above and in response to the mandate in the Five Year Forward View and Sir Stephen Bubb's Review, we will offer personal health budgets to people with learning disabilities from 1st April 2016.

From the 1st April 2016 please contact the CCG to be considered for a personal health budget:

NHS North Kirklees CCG
4th Floor, Empire House
Wakefield Old Road
Dewsbury, WF12 8DJ

We will undertake further work to roll out the offer of personal health budgets to people with a mental health need who are under a section 117, people with long term conditions and children with an EHC need during 2016/17. We will do this by working with providers to respond to the personalisation agenda and through the influencing of contracts for 2017/18. This work will build on the engagement we have undertaken to determine the level of need for personal health budgets outside of continuing healthcare and people with a learning disability.

We are also committed to the introduction of personalisation for maternity services in North Kirklees and will look to include this within our local offer during 2016/17.

**Estates Strategy**

To be added at a later date

**Self-Care**

Kirklees has a comprehensive self-care programme, developed over 10 years that supports people with long term conditions to improve their health and better manage their condition. Our local self-care offer includes:

- Health trainers
- Expert Patient Programme - A range of generic and specific self-management courses run by volunteer "expert patients"
- DAFNE and DESMOND for patients with diabetes
- Safer Ramadan - A programme to raise awareness amongst key communities/Professionals of the evidenced based advice and support to give to people fasting at this time in relation to their management of diabetes.
- Looking after me - An EPP style course to support carers looking after someone with a long term condition
- Help yourself to better health - 15,500 resources that cover self-management of a range of long term conditions and are available in libraries across Kirklees.
- Bibliotherapy - The use of reading creatively: books, stories and poems to make people feel better about themselves.
- Healthy Living Pharmacies scheme – 20 pharmacies have trained health champions to promote wellbeing, self-care and optimise medicines usage.
- Penny Brohn Living Well with Cancer programme - This course provides cancer survivors with a tool kit of self-care techniques that can help support physical, emotional and spiritual health.
- My Health Tools – a locally developed web based tool to support people with long term conditions to access high quality information, improve their health and better manage their condition through goal setting and behavior change

As well as individuals being able to access the support they need we recognise that it is also important that the practitioners they come into contact with have the right skills to be able to help them maximise their independence and feel they have the right knowledge and skills to manage their long term condition. All of our front line staff working in the community, from both health and local authority settings, have had access to training that focuses on developing those skills so that they can work differently with their patients. The commitment to working in a way that promotes self-care was a key component of our specification for our Care Closer to Home services that we successfully went out to tender for in 2015. The new provider of these community services now has a Maximising Independence Strategy and ability to promote self-care is reflected in the new performance measures we have agreed.

The Marmot Review acknowledged that many people die prematurely each year as a result of health inequalities. Marmot talks about a social gradient in health – the lower a person's social position, the worse his or her health and the action we take should focus on reducing this gradient in health. Past actions to reduce inequalities have focused solely on improving things for the most disadvantaged but this will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage (called proportionate universalism). We know that health inequalities result from social inequalities so any action needs to take this into account to increase chances of success.

Our Joint Health and Wellbeing Strategy was developed and supported by all partners and its implementation is overseen by the Health and Wellbeing Board. Given the link between health, inequalities and the wider determinants of health there are clear links between our Joint Health and Wellbeing Strategy and our Economic Strategy. The recognition of this link led to the development of a set of shared actions for both the Joint Health and Wellbeing Strategy (JHWS) and Kirklees Economic Strategy (KES). These actions can be accessed via the link below

**INSERT LINK ONCE SIGNED OFF**

In addition to these shared actions making the link between health, inequalities and wider determinants of health the Joint Health and Wellbeing Strategy contains a "Strategic Thinking Framework. This is a tool to use in developing robust plans that meet the health and wellbeing needs of local people and identifying gaps in current plans.

Tackling local health and wellbeing inequalities as public sector funding decreases is a significant challenge. In Kirklees we recognise that to best support local people and their needs, this challenge needs to be owned across the partnership to achieve our outcomes. Both Local Authority and Clinical Commissioning Groups jointly report performance against the delivery of the Joint Health and Wellbeing Strategy outcomes into the Health and Wellbeing Board.

While the Strategic Thinking Framework is a useful tool to ensure we all consider health, wellbeing and health inequalities when planning, redesigning or developing services we recognise the need to combine that with further actions that focus on the 6 policy objectives outlined in the Marmot review.

We are working with Public health on an action plan that will go to the Health and Wellbeing Board with the aim of getting all partners to sign up to delivering it. If agreed the plan will be monitored by the Health and Wellbeing Board as part of the delivery of the Joint Health and Wellbeing Strategy. This will be a key element of the delivery of the STP in relation to closing the health and inequalities gap.

As an organisation we understand the importance of improving quality of care and this is reflected within all of our key strategies and embedded in each piece of work we undertake. We align quality from our organisational objectives to the point of care delivery, ensuring that quality is not some abstract concept or theoretical pursuit but a relentless focus on how we can positively transform the lives of the people of North Kirklees. We routinely undertake quality impact assessments on all newly commissioned, de-commissioned services and where we are implementing changes to a service to ensure quality throughout decision making.

Quality is at the centre of discussions with our providers through the Contract and Quality Boards. We use these forums to assure us that providers are meeting minimum standards in all areas of quality. This includes an action plan to respond to the recommendations of the Francis Report and. that safeguarding policies are embedded in operational processes

We have developed a quality strategy which takes into account the key drivers and national requirements from the following sources and provides a local response for improvement,

*Francis Report, The Keogh Review, The Berwick Review, The Cavendish Review, Compassion in Practice*

This strategy is underpinned by 5 interdependent and interconnected messages. These are:-

1. Listen to the voices
2. Triangulate data and intelligence
3. Make use of all commissioning levels available
4. Walk the service – look and see
5. Share concerns and take action

This strategy and associated action plan can be accessed via the link below;

**LINK TO BE ADDED ONCE SIGNED OFF**

We have considered the *Berwick Review* in patient safety alongside our Francis implementation plan and are working in partnership with providers to enhance the strong work done locally for patient safety. This includes a focus on a reduction in harm using the safety thermometer to support an increase in patient safety, incident reporting and a review of how lessons are learnt and disseminated across all partners. We are committed to learning in this area and are active members of the Local Patient Safety Collaborative and the Quality Surveillance Group. As an organisation we have implemented a number of approaches to improve patient safety and reduce avoidable harm. During the next 12 months we will be developing safety thermometers for use in care homes and other domiciliary providers.

Commissioner led assurance visits such as Patient Safety Walkabouts with a number of our provider organisations, inclusive of acute, community and mental health providers will be strengthened over the next 12 months with plans to expand further into care homes and primary care which is in line with the our CCG Quality Strategy. This enables closer working relationships between all our commissioned providers to ensure that a robust, transparent, supportive and a constructively critical dialogue can take place.

Where issues or concerns are identified with providers we will continue to follow NHS England's quality concerns trigger tool and use the risk profile to 'deep dive' into practice.

Post infections reviews continue to identify the origination of infections and supporting providers to reduce the number of avoidable health-care acquired infections. In addition we have robust processes for the monitoring of MRSA and C Difficile infections

As an organisation we have signed up to the 'Sign up to Safety Campaign' and committed to our pledges to improve patient safety.

A local Sepsis action plan is being developed as response to a serious incident in Primary Care in another part of the UK. Locally this plan crosses all health care boundaries to ensure education, training and learning is achieved to minimise future harm to our local patients.

We will continue to improve incident reporting in primary care and promote a culture of evaluation and learning through the quality issues log. We will continue to embed this throughout 2016/17 and take action to improve services as part of lessons learnt exercises through assurance visits with practices.

The system work that North Kirklees led on during 15/16 with Locala and supported by the Academic Health Science Network will to continue to decrease the number of pressure ulcers. Other work continuing will be the work with Mid Yorkshire Hospitals Trust on their falls work stream and implementation of safety huddles.

A system wide Falls Strategy group has been formed after our Falls Summit last year. This will focus on the action plan delivery. This has which has developed to create a cohesive, integrative and collaborative pathway across Primary, Secondary and Community across a wider footprint which has Quality at the heart of its outcome. This includes a cost effective and clinical proven service which demonstrates positive patient outcomes

Working collaboratively with continuing healthcare colleagues and care homes we are developing quality assurance mechanisms which will reflect and mirror the principles of the safety thermometer in the acute providers. This will aid in monitoring of quality care in care homes and domiciliary care and help with quality improvement initiatives planned through collaborative approaches.

The safeguarding of children and adults at risk of abuse and neglect is an obligation for all of us who work in the NHS and partner agencies, and one in which NKCCG takes very seriously. We recognise safeguarding those who are vulnerable or at risk is a key principle which is embedded in the work we undertake as commissioners and is promoted in our engagement with all providers. As part of our commitment to safeguarding work, North Kirklees CCG has a combined children and adults safeguarding policy that reflects both the national guidance and local Multi-agency Safeguarding Policies and Procedures. We are key members of local Safeguarding Adults Boards and Safeguarding Children's Board arrangements and engage fully with the work of each of the Boards. We are committed members of NHS England's Yorkshire and Humber team safeguarding network and engage in the work plan of the network (this includes engagement by the CCG Safeguarding team on some NHS England national subgroups). We have an agreed combined work plan for safeguarding children and adults that demonstrate that we meet our statutory duties and responsibilities. The work plans also include learning from local, regional and national Serious Case Reviews/Safeguarding Adults Reviews/Domestic Homicide Reviews and taking relevant learning into the CCG and seeking the assurance from providers that they are committed to the same.

Continued areas of work in 2016/17 to protect children and young people include: child sexual exploitation, looked after children; human trafficking and female genital mutilation.

Continued areas of work in 2016/17 to protect adults include: health leadership and a strong health voice in complex safeguarding investigations, delivering a systematic approach to embedding the Mental Capacity Act (2005) as a key aspect of safeguarding, along with partnership working to support the delivery of effective Deprivation of Liberties Safeguards arrangements.

New areas that we are currently working to deliver include advertising and supporting the national health process for Female Genital Mutilation reporting, and work to raise the profile of Human Trafficking and Modern Slavery.

There are a number of key objectives which are included within the quality schedule as an addition to the standard national contract, this includes seeking assurance that providers are engaged not only with local Safeguarding work, but also are delivering the national PREVENT strategy. These objectives are monitored via the contracting boards.

We use a process of regular checking and reporting to seek and deliver assurance that safeguarding principles and work is embedded in the organisational culture of providers from whom we commission care, and this is reported via an established internal governance mechanism within the CCG.

During 16/17 we also aim to integrate safeguarding duties and responsibilities to be an integral part of the business development process. This is to ensure that any issues are highlighted at the beginning of the commissioning process and are considered throughout the development or review of services.

At the centre of the work we undertake is a drive to improve patient outcomes and deliver care which gives an individual as positive an experience as possible of receiving care and recovery – including being treated with compassion, dignity and respect this is reflected in the Quality Strategy. To remind us of this, we start all of our Governing Body meetings with a patient story. We are considering how we can share our patient stories with our other colleagues in order to make sure their impact is felt by anyone who works for our organisation. We have developed a Carer's Charter that had been developed in partnership with the Greater Huddersfield CCG and Kirklees Council and is being adopted by other providers across the Health and Social Care economy. This has been shortlisted for the HSJ awards. Patient experience is an element of care we consistently monitor through active contribution to the assessment of 'are local people getting good quality care?' domain of the CCG Assurance Framework. This is supported by learning from national and local survey results and the friends and family test as well as Patient Opinion results. This feeds into our Governance arrangements to share the learning and that we are kept informed.

As a CCG that lives its values of putting patients first we ensure that patients are involved with all aspects of the commissioning cycle and we have actively included patients and carers in the procurement of new multi million pound provider contracts.

North Kirklees CCG also recognises that staff satisfaction has a direct impact on the quality of patient care and patient experience. We proactively monitor the staff satisfaction survey results of our provider organisations and our own organisation and ensure regular dialogue is in place to understand how our providers are making improvements in this area.

As a CCG we use all of contacting levers across the commissioning cycle to ensure that the best evidence for patient safety, patient experience and clinical effectiveness in line with best practice guidelines and research. This evidence is considered and utilised through quality governance mechanisms to have a positive impact on our patients' lives and health outcomes.

We ensure that our service redesign and sustainable transformation programmes are based on 'best' available clinical evidence and utilise 'hard' data and 'soft' information to triangulate this quality intelligence to influence commissioning decisions. We use the Quality Impact Assessment processes to help support clinical decision making. We will continue to play an active role in driving clinical standards with all our providers and will assist where necessary through the overseeing CQC recovery plans in partnership with regulators such as the TDA, CQC. Through our sustainability and transformation planning we are increasingly focusing on workforce in our commissioned services and transformational plans to ensure that services are fit to deliver high quality care and respond to the changing demographics' of tomorrow.

We are supporting our CCG nursing workforce to meet the future challenges through continuing clinical supervision and supporting CCG, Local Authority and General Practice staff with the revalidation process. The quarterly Care Home Forum for the registered workforce which has been launched through a collaborative between the CCG and the Council will help to support, develop and educate care home staff and help to work more closely with our care homes. This links in with our Kirklees Footprint Strategy for care homes and our work on the future workforce resilience within care homes.

Over the next year we will be working closely with the primary care and transformation teams to lead, focus and drive the Quality element of the Primary Care Strategy. This initiative and partnership supports our CCG Quality Strategy about bringing consistent high quality safe care which is patient focused and resilient in practice and reducing variation where possible. The team plans to explore the possibility of patient safety walkabouts (Clinical Assurance Visits) in care homes and primary care as part of the CCG Quality Strategy Implementation Plan. Engagement across a 'place based' and 'acute' footprint engagement is reflected in our nursing strategy which aims to bring about closer working and building a closer rapport between provider teams.

NKCCG prides itself on the use of innovation and training to enhance commissioning, service delivery and ultimately high quality care, and this is a key element of our plans over the next year. We have enlisted the expertise and are working with a number of improvement organisations to ensure that innovation is embedded in the work we undertake, and that we remain at the forefront of modern service redesign going forward. This includes working with the Academic Health Science Network to lever positive redesign such as minimising falls across North Kirklees and piloting GP involvement with Safety Huddles in primary care/community services.

We continue to work with Wakefield CCG and Greater Huddersfield CCG in collaboration with providers to develop the CQUINS scheme to ensure that we are focused on incentivising new innovative practice pathways of care and quality patient care for all our patients. We are also currently working with the following organisations:

- Health Education Yorkshire and Humber, have assisted us in undertaking a profile analysis of our primary care workforce to help us establish training needs and risks in terms of gaps or staff shortages. They are also working to support the development of the new 'Nursing Associate' role which will drive the new vision of our workforce in all care settings including care homes and primary care. This work will be continuing to look to plan and develop a future workforce in all care settings which meets the needs of our patients and service and is reflected in our Nursing Strategy.
- Yorkshire and Humber Academic Health Science Network through the Improvement Academy: Working collaboratively on Falls Prevention and Safety Huddles with providers in different settings. The West Yorkshire Audit Consortium have also recently tested and evaluated our governance and Quality practices to ensure that they comply with the Francis Action plan to ensure that our arrangements are robust and compliant with best practice, and are significantly assured by our mechanism's.

Our embedded Quality Issue Log used across primary care acts as an Early Warning Sign to identify and variation in patient care. We have a robust Quality Impact Assessment process which helps us make effective commissioning decisions.

# Patient & Public Participation and Engagement

Engagement with patients, carers, general public and the organisations that represent their views and interests are central to our commissioning process. Our aim is for people to become partners in service re-design, active participants in their own healthcare and able to contribute to improving and developing local health care services.

We have strong and productive working relationships with Healthwatch Kirklees, neighboring NHS Greater Huddersfield CCG, Kirklees Council, the third sector and other stakeholders. Over the coming year we aim to improve our Your Health, Your Say programme, develop more opportunities to engage with community and voluntary sector organisations, and strengthen links with GP patient reference groups. More details can be found in our Communications and Engagement Strategy and Action Plan.

We have a programme of regular meetings with community and voluntary sector organisations each year.

We use our website, local media, Twitter and Facebook to promote engagement opportunities, plans and decisions to a wide audience.

We hold quarterly public engagement events to showcase commissioning intentions and listen to public views about service change and expectations.

We have well-established links with GP practice patient groups.

**Patients at the Centre of Everything we do**

We work closely with Healthwatch Kirklees.

Our Your Health, Your Say programme provides the public with information about commissioning plans and opportunities to get involved. This year we will be expanding the membership and looking at ways to make it more representative of our local population.

We use a range of tactics to involve local people in specific service change programmes including surveys and patient representation on panels.

We engage in regular dialogue with local health scrutiny functions and are members of the Health and Wellbeing Board

# Staff Health and Wellbeing

As an organisation we are committed to supporting the health and wellbeing of all our staff. As part of this commitment we offer an Employee Assistance Programme (EAP). The service is free to staff and offers confidential 24/07 support, information and advice on a range of both work related and non-work related topics such as stress management, bullying, coping with change and legal / financial advice. The service includes podcasts and reading material on a variety of other issues such as stress management, healthy eating.

Staff health and wellbeing features high on the Agenda for the Staff Forum and in April 2015 a Health and Wellbeing Calendar was launched across the organisation drawing attention to a specific topic each month such as Men's Health, Healthy Eating and Mental Health. A number of successful staff events have been held over the year and regular information is provided to staff in 'Empire News', at the weekly staff huddle and by means of screen savers.

Our health and social care system has the challenge of delivering more and better quality care for its population within increasingly tight financial constraints. In order to invest in new services we need to firstly make efficiency improvements to free up funds for investment. We will then prioritise our investment into services which support self-care, increase individuals physical and emotional wellbeing through prevention and self-management and support people to remain at home for longer. This will reduce the need for intensive, unplanned and crisis response services. In doing this, we will over time shift the health and social care system towards more sustainable ways of delivering care and support to our population.

**Financial Position for 2015/16**

We are on track to deliver a surplus as required of £3.7million by the end of this financial year. There are however a number of pressures surrounding the delivery of this surplus

- Negotiation and reconciliation of the acute services contract with Mid Yorkshire Hospitals
- The increasing level of prescribing spend
- Continuing Care costs are showing an increase month on month
- Under delivery of in year QIPP schemes against plan

The risks these pressures pose to the sustainability of the organisation have been mitigated by the application of a number of financial adjustments and the releasing of reserves to the value of £2.6million.

**Financial Plan for 2016/17**

The draft planned financial position for 2016/17 has been produced based upon and in accordance with the NHS Planning Guidance issued in December 2015.

Offsetting the above cost pressures the plan includes a QIPP programme to the value of £9.8million. The CCG has an historic QIPP achievement of around £7million per annum; therefore the 2016/17 plan represents a stretch target of £2.8million.

The overall plan should enable the CCG to achieve an overall surplus of £3.7million (1.5%) as stipulated in the guidance.

**The QIPP Challenge facing the CCG in 2016/17**

*QIPP is a national requirement for all NHS commissioning organisations.*

The 2015/16 Financial Plan was based on a QIPP delivery of £10.2million. It is predicted that we will achieve delivery of £8.0million of this target; this figure is inclusive of financial support which has not been delivered by the identified QIPP schemes.

For 2016/17 the QIPP plan for North Kirklees CCG is £9.8million. This figure takes into account planning guidance constraints being placed upon the CCG and the 2015/16 shortfall in achievement and includes a stretch target of £2.8million.

QIPP plans to the value of £18.3million are under development to support the delivery of the 2016/17 target and to allow for any programme slippage and part year effect due to varying start dates of the respective schemes.

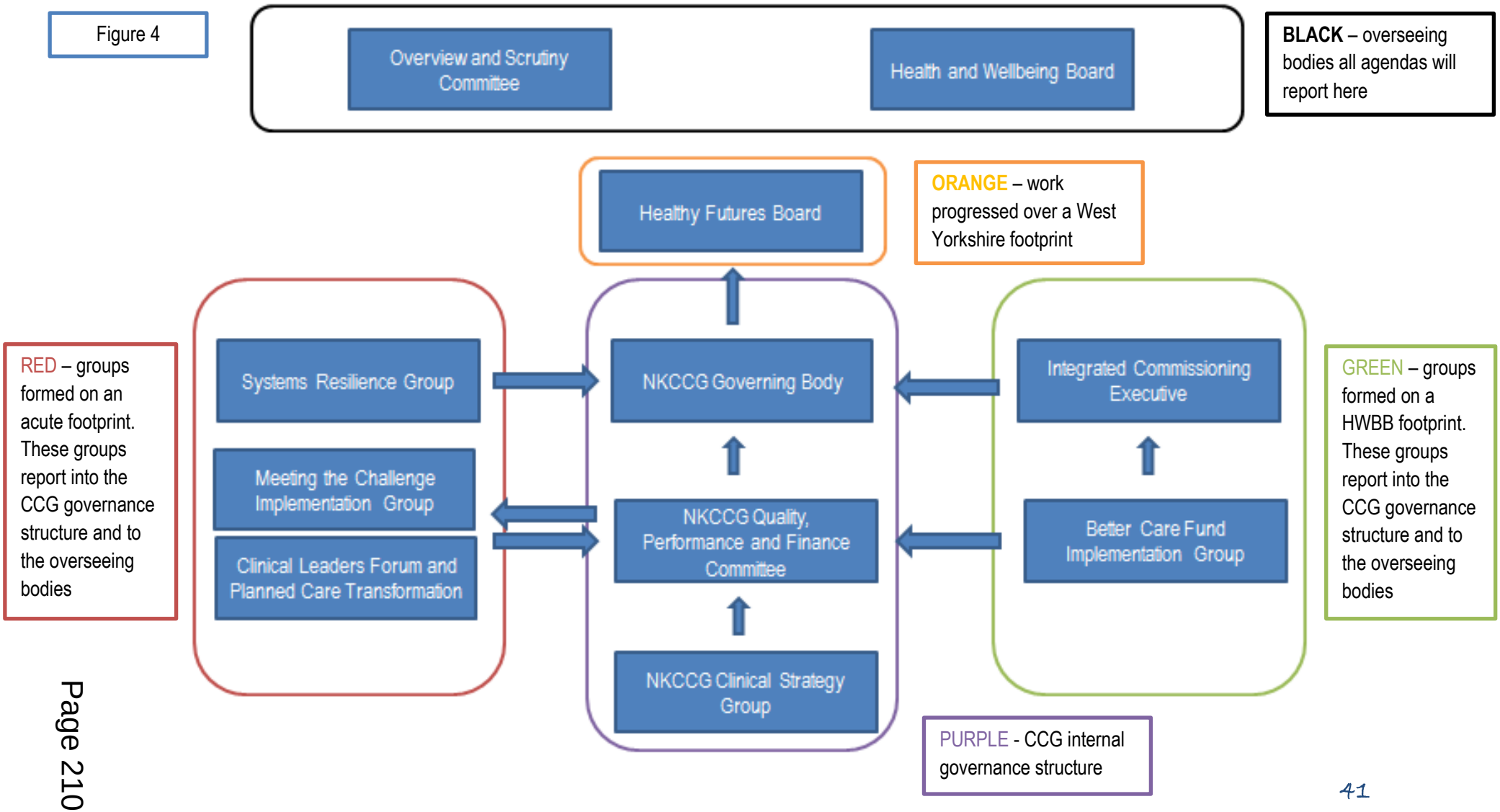
**Addressing the Future**

To address the future business requirements of the CCG it has been agreed through the Governing Body that the following approaches need to be adopted in developing strategy and modes of operation of the CCG.

- Financial benefits will flow from improving the quality of patient care.
- We need to focus on pathway re-engineering across the whole system of care.
- Recognise that we are in the health care business.
- As a Directors of a business we are responsible for the whole business not just our individual parts.
- We must demonstrate that we are in control and taking responsibility for our financial development and sustainability.
- The financial plan for 2016/17 is extremely challenging therefore we have to make sure that we deliver the QIPP savings targets and operate within our planned financial envelope.
- The CCG must operate through a strong and robust process of good governance.
- We need to look at other businesses and industries to see how they have reacted to their changing and challenging business environments.

The diagram below, (Figure 4) illustrates the governance processes in place for progressing the transformation agendas within this plan:

Figure 4



**Performance/Risk Management Framework**

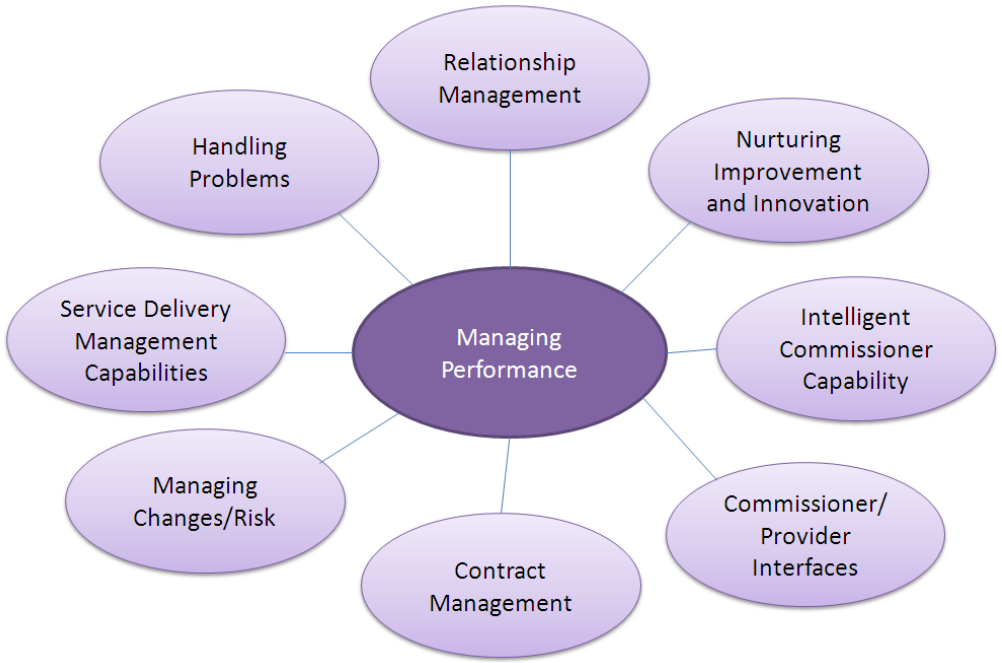
The CCG is a clinically led membership organisation made up of general practices (the members). The members have developed the governance arrangements which are set out in detail in the CCG's Constitution. The Constitution also sets out the principles of good governance which will be followed and the accountability arrangements.

The CCG is accountable for exercising the statutory functions of the group. It may delegate authority to act on its behalf to any of its members, its Governing Body, its employees, or any committee or sub-committee of the Group. Any such delegation would be described through the Scheme of Reservation and Delegation and the Committee terms of reference. The CCG remains accountable for all of its functions, including those which it has delegated.

NKCCG has developed a robust performance management framework which consists of a number of elements. A copy of the framework for 2015/16 is available in appendix X. Performance against the indicators and measures in the NHS outcomes framework and constitution is monitored at the Quality, Performance and Finance Committee and the Governing Body on a monthly basis. Figure 5 illustrates this framework and its key components.

NHS England has a statutory duty to conduct an annual assessment of every CCG. For 2016/17 a new CCG Improvement and Assessment Framework will be introduced. This new framework will align with NHS England's Mandate and planning process, with the aim of unlocking change and improvement in a number of key areas. This new approach aims to reach beyond CCGs, enabling local health systems and communities to assess their own progress.

Figure 5



## What do we use to inform decision making?

There are a number of information sources which influence and inform our strategic thinking and decisions as commissioners. Locally we call these tools within our commissioning toolkit. Further details are provided below:

**NHS Outcomes Framework and Constitution measures:** Performance/quality indicators which provide us with intelligence on how our system is performing.

**JSNA:** An in depth analysis of our local population needs.

https://www.kirklees.gov.uk/you-kmc/partners/other/jsna.aspx#anchor4

**Kirklees 5 year strategy:** Our strategic ambitions for Kirklees.

http://www.northkirkleesccg.nhs.uk/wp-content/uploads/2014/05/NHSNKCCG-five-year-strategic-plan.pdf

**NKCCG Commissioning Toolkit**

**NHS England 5 Year Forward View and its supporting strategies:** give us a steer on the direction of travel nationally.

http://www.england.nhs.uk/ourwork/futurenhs/

**Commissioning for Value:** Benchmarking information by condition and pathway comparing us with our 10 most similar CCGs. Links to the Right Care programme.

http://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/

**JHWS:** Vision and overall focus for improving health and wellbeing in Kirklees.

http://www.kirklees.gov.uk/you-kmc/deliveringServices/jointHealthAndWellbeingStrategy.aspx

An action plan for reducing health inequalities is being developed which will underpin the JHWS. We will play an active role in this work through the Health and Wellbeing Board and the Integrated Commissioning Executive.

As NHS organisations we are required to submit each year our local level of ambition for a number of national and local metrics. We are formally monitored by NHS England throughout the year to ensure we meet the standards set. The metrics we are monitored against are markers of quality and accessibility of services locally. The metrics we will be monitored against in 2016/17 and our associated ambitions are detailed below.


We plan to meet national minimum standards for all NHS constitution measures in 2016/17. This applies to:

- ✓ 18 week referral to treatment targets
- ✓ Cancer 62 day target
- ✓ Emergency Department 4 hour wait standards
- ✓ Ambulance response time standards
- ✓ Mental health access standards

We also plan to:

- ✓ Meet all national minimum standards relating to cancer
- ✓ Meet the national minimum standards relating to diagnostic waiting times

## Our other commitments for 2016/17

We plan to:

- ✓ Have no more than 38 C.Difficile infections in our acute trust
- ✓ Maintain a national minimum standards for dementia diagnoses
- ✓ Maintain national minimum standards for IAPT access and recovery

## Quality Premium - Local Measures

We plan to:

To be added following sign off by NHS England

Risks and Mitigations:

- System pressures and capacity in provider organisations to meet the constitution measures and waiting time standards. Recovery trajectories and action plans are in place.

End of Document

Contact Officer: Helen Kilroy

**KIRKLEES COUNCIL**

**CHILD SEXUAL EXPLOITATION AND SAFEGUARDING MEMBER PANEL**

**Thursday 3 March 2016**

Present: Councillor E Hill (in the Chair)
Councillors Ahmed, Allison, Holmes, Bellamy (Observer)

In attendance: Chris Walsh, Safer Kirklees Manager (Safe and Cohesive Communities)
Joanne Bartholomew, Assistant Director (Physical Resources and Procurement)
Catherine Walter, Licensing, Local Land Charges & Highways Registry Manager
Michael Bunting, Passenger Transport Manager (Physical Resources and Procurement)
Helen Kilroy, Principal Governance and Democratic Engagement Officer

Apologies: Councillor Kath Pinnock, Alison O'Sullivan, Carly Speechley and Pauline Martin

**1 Minutes of previous meeting**

The Panel considered the minutes of the meeting held on Wednesday 3 February 2016 and the Panel noted that Jackie Bolton from the Children's Society had been given the opportunity to comment on the Minutes.

Councillor Hill informed the Panel that she would be meeting with officers in Learning and Skills to discuss rolling out of the work of the children's society on the partnership project to other schools within Kirklees and would report back to the Panel.

**AGREED** –
(1) That the minutes of the meeting on 3 February 2016 be agreed as a correct record.
(2) That Councillor Hill to meet with Officers in Learning and Skills to follow up the issue of rolling out of work of the Children's Society on the Partnership Project to other schools within Kirklees and report back to the Panel.

**2 Safeguarding in relation to School Transport Policies and Procedures**

The Panel welcomed Joanne Bartholomew, Assistant Director (Physical Resources and Procurement), Catherine Walter (Licensing, Local Land Charges & Highways Registry Manager) and Michael Bunting, Passenger Transport Manager (Physical Resources and Procurement) to the meeting and considered an update on Safeguarding in relation to School Transport Policies and Procedures.

Joanne Bartholomew advised the Panel that she was the Assistant Director responsible for Safeguarding in relation to School Transport Policies and Procedures and that work had been undertaken in the passenger transport area to ensure it was well placed to manage risk. The Panel were informed that Kirklees Council had a statutory duty to provide home to school transport arrangements in accordance with Section 508B and 508C of the Education Act 1996. Under the Policy for home to school transport arrangements 2015-2016, approximately 800 children with Special Educational Needs (SEN), ability problems

or a disability were in receipt of transport arrangements to and from schools within Kirklees and out of area. Joanne Bartholomew further explained that transport was provided by 54 approved operators employing 586 drivers covering approximately 300 routes per day. The Council employed around 150 Passenger Assistants who were supported by 2 Escorts Supervisors, 4 Transport Officers and a Senior Transport Officer. It was hoped that 3 independent travel trainers would be recruited by the end of May 2016.

Michael Bunting advised the Panel that the Council was working with parents and the wider community on the transportation of children to and from school.

The Panel was informed that Passenger Assistants attended mandatory training as part of their initial induction, which included escort responsibilities, health and safety, safeguarding, challenging behaviour, and childhood conditions. All Passenger Assistants received regular 1 to 1 'job talks' in which the Council's Statutory Duty on Safeguarding and Standard Procedure for dealing with safeguarding concerns was discussed.

Michael Bunting further explained that in March 2015, the Home Office approved 'Workshop to Raise Awareness of Prevent (WRAP)' training which became mandatory for all Passenger Assistants. The Workshop was delivered by West Yorkshire Police Prevent Engagement Officers and aimed to give staff an understanding of the National Prevent Strategy and the Prevent Duty. All licensed drivers must attend Safeguarding Training provided by the Licensing Department, whilst all PSV drivers received the Safeguarding Training provided to Passenger Assistants.

Michael Bunting confirmed that information was sent to Escorts and parents to provide updates on developments within the service, including a Newsletter. The Panel agreed to receive examples of the Newsletter. Joanne Bartholomew further explained that the service had regular communication with parents, both verbally and in writing. Parents, whose children were transported to and from school, were in regular dialogue with the service.

Communications were maintained with parents for the duration of the time that the Council was providing Transport Service to their child and formal links were made via the parents Newsletter. The Panel were informed that complaints regarding drivers and Escorts were dealt with appropriately and that there was a robust process in place to deal with complaints in this area. Michael Bunting further explained that the service had good links on information sharing with the Police. When a complaint had been made against a driver they were removed from service, pending the outcome of a full investigation.

The Panel noted that Passenger Assistants and drivers were trained to recognised the signs and symptoms of safeguarding and CSE issues. They were also trained in what to do in the event of such an incident. Safeguarding matters were immediately reported to the Senior Transport Officer in order that an operational response could be implemented under the supervision of the Passenger Transport Manager. This could include contacting the child's social worker, reporting the matter to Referral and Response and/or the Police. It could also be necessary to liaise with schools. The response of other agencies was monitored and all actions were logged. Passenger Assistants were appropriately briefed and relevant information and communications were maintained with them in order to obtain feedback.

Joanne Bartholomew advised the Panel, however, that removing the driver/Passenger Assistant could be very distressing both for the employee and for the children. A range of support would be provided to ensure the staff member did not feel ostracised and isolated, whilst still maintaining appropriate safeguarding of the child. Joanne Bartholomew advised

that when allegations were found to be unfounded the employee would be put back on route as soon as possible and every effort made to restore parents confidence.

Michael Bunting advised the Panel that if complaints were made against a taxi driver, their approved transport badge would be removed. Intelligence would be shared with the Licensing Team who would then discuss the incident with the driver and a decision would be made as to whether the license should be removed.

Michael Bunting informed the Panel that where possible work was undertaken by the Council to help children with special needs to increase their independence, for example, independent travel training was undertaken where appropriate to enhance life chances in future for children. The Panel were informed that the service had a firm commitment to 'stranger danger' and that this was built into the independent travel training. Michael Bunting informed the Panel that an independent travel training pilot was undertaken at Ravenshall School in January 2016 with 8 children. This pilot included educating parents and engaging with them, and assisting to encourage opportunities. Class room sessions were carried out which hopefully resulted in the child receiving a bus pass that they could use on public transport, in place of taxis, to get to school or college. The Panel agreed that the independent travel arrangements for children with special needs gave them an opportunity for a different life and opened doors for them.

**Changes to Regulatory Panel**

Catherine Walter advised of the constitutional changes made to the Regulatory Panel in January 2016, in that officers were now responsible for decisions on license applications for taxi drivers. The Panel were informed that enforcement procedures were now in place in Leeds Council and other West Yorkshire Local Authorities would be up and running by April 2016. Catherine Walter advised the Panel that the mop up training for taxi drivers had been undertaken with only 100 drivers still outstanding. The Panel was informed that those drivers who had not had the training had been told that their license would not be renewed until they had undertaken the training.

Michael Bunting informed the Panel that if taxi drivers do not show their badge when transporting children, the Escort would report it and that the procedures in place for dealing with this were very robust. However, a reasonable approach was adopted to dealing with incidents where drivers had forgotten to show their badge. Michael Bunting further explained that if the service was not satisfied with the drivers response, they would be removed immediately.

Joanne Bartholomew informed the Panel that there were 2 badges given to taxi drivers and they were:-

- A Taxi Driver License; and
- A Kirklees Badge that authorises a taxi driver to deliver School Transport for Kirklees.

All drivers transporting school children were required to show their badge and if they were unable to, the company would be required to provide another 'badged' driver with immediate effect.

The Panel were informed that in order to carry out spot checks on safeguarding measures, 2 Escorts were sent out without notice to undertake an 'unannounced audit' of school transport and observe the whole of the journey.

Catherine Walter advised that where a taxi driver license had been removed and not returned by the driver, officers from the Council would visit the driver to retrieve the license.

**AGREED**:-
(1) That Joanne Bartholomew, Michael Bunting and Catherine Walter be thanked for attending the meeting and that the update on Safeguarding in relation to School Transport Policies and Procedures be noted.
(2) That Michael Bunting provide copies of the parent Newsletter to the Panel for information.

3. **Hate Crime Reporting**

The Panel considered an update on Hate Crime reporting, which included on-going work within Kirklees and the need to raise awareness of Hate Crime and CSE within communities. Chris Walsh, Safer Kirklees Manager (Safe and Cohesive Communities) was welcomed to the meeting.

Chris Walsh advised the Panel that the main areas of his responsibilities were Community Safety, Anti-Social Behaviour and Preventing Violent Extremism. The Panel were informed on the difference between a hate incident and a hate crime, as follows:-

- Hate Incident - any incident which was perceived by the victim or any other person to be motivated by hostility or prejudice based on personal characteristics, disability, gender identity, race, religion/faith and sexual orientation.

- Hate Crime - had a criminal or common law element. Should the necessary evidential threshold be met and the case went to court, if the defendant was found guilty there would be an appropriate punishment which could secure an increased punishment compared to the stand alone offence.

Chris Walsh advised the Panel that the Kirklees Hate Crime Strategy was based on 3 core principals which were:-

- Preventing Hate Crime, by challenging the attitudes that underpin it and early intervention to prevent it escalating.

- Increasing reporting and access to support, by building victim confidence and supporting local partnerships.

- Improving the operational response to Hate Crime by better identifying and managing cases and dealing effectively with offenders.

The Panel was informed that there were degrees of under reporting of hate crime incidents. There were more incidents of hate crime in the north part of the district, however, the Panel were informed that the increase could be to do with confidences and reporting mechanisms currently in place.

The Panel were informed that Hate Crime was one of the themes that sat under the Community Safety Partnership Priority to "protect people from serious harm". In order to achieve this overall outcome, it was essential that there was close collaborative work between the Community Safety Partnership and Safeguarding Board for Adults and Children by reducing harm at the earliest possible opportunity. Chris Walsh further

explained that the delivery of Kirklees Hate Crime Strategy and its action plans were driven and managed by the Hate Crime Strategic Group and reviewed on an annual basis.

The Panel were informed that online reporting of Hate Crime made for easier and quicker communication with the appropriate agencies. Chris Walsh further explained that the actions included:-

- effective and accessible reporting centres were in operation across Kirklees;
- online reporting via Council's website; and
- clear links with victim support agencies.

Chris Walsh advised the Panel that one of the areas of focus of the Strategy was to raise awareness within communities and part of this work included displaying posters in public places, for example, bus stations, railway stations, the university and Council buildings. The Panel received a copy of the poster entitled 'Stopping Hate Crimes in Dewsbury Starts Here' and also a leaflet entitled 'Hate Hurts - Report It, Sort It, Say No To Hate' which was a useful communication tool for road shows and events.

The Panel were informed of publicity events intended to raise awareness, for example, 'Transgender Day of Remembrance' held on 20 November 2015, which was an annual observance that honoured the memory of those whose lives had been lost in acts of anti-transgender violence. Chris Walsh further informed the Panel of the Hate Crime Awareness Week, was an annual event. The purpose of the Hate Crime Awareness Week was to encourage all Local Authorities, including the Police and other partners, to work in partnership with local groups and organisations to host a series of Hate Crime awareness events around the UK and abroad. The Panel were informed that briefings for staff and members on awareness of Hate Crime were arranged including, frontline worker briefings in libraries and children's centres with the intention of spreading the message as widely as possible.

Chris Walsh explained that the ability to report Hate Crime via the internet was useful as it gave an anonymous element if necessary and also increased the range of ways people could report incidents and was available 24 hours a day. The other places to report incidents were via third party centres, such as libraries and housing offices which was in line with the recommendation to increase the range of places people could report hate crime, other than police stations. The Panel were advised that community centres used the online form for reporting Hate Crime. Chris Walsh further advised that Kirklees Council had dedicated a page on its website on Hate Incident reporting, which included the incident reporting form.

Chris Walsh advised the Panel that Kirklees was not aware of CSE hate related crime and that there had been no increase of a link to CSE in any of the incidents reported.

The Panel agreed to receive a breakdown of Hate Crime data to a future meeting.

Chris Walsh advised the Panel that the Hate Crime Strategy had been in place for 3 years, however, there was a long history of partnership working on Hate Crime. Chris Walsh further explained that there were a number of centres within Kirklees where Hate Crime could be reported. An audit of the centres had resulted in significant reductions to ensure the support being provided at the remaining centres was effective and fit for purpose.

Chris Walsh advised that Hate Crime data in the North and South Kirklees was provided in the strategic intelligence assessments, broken down Ward by Ward. The Panel noted that some Wards had higher figures due to better reporting mechanisms. Chris Walsh agreed

that the data he would provide on Hate Crime would include the different types of incidents reported.

**AGREED:-**
(1) That Chris Walsh be thanked for attending the meeting and that the update on Hate Crime reporting in Kirklees be noted.
(2) That Chris Walsh provide data on Hate Crime to a future meeting, which would include a breakdown of the different types of incidents reported.

4. **CSE Management Information**

The Panel considered an update on CSE Management Information.

The Panel noted that the Management Information on Kirklees Young People showed cases increasing from December 2015 to January 2016. Councillor Hill agreed to raise this issue with the Assistant Director for Children and Young People and report back to the Panel.

The Panel discussed the Management Information for residential homes for Looked After Children and a number of Members were concerned at the high numbers. Councillor Hill agreed to discuss this issue with the Assistant Director for Children and Young People and report back to the Panel.

**AGREED:-**
(1) That the update on Management Information be noted.
(2) That Councillor Hill discuss the issues raised by the Panel on the Management Information relating to residential homes for Looked After Children and Kirklees Young People, with the Assistant Director for Children and Young People and report back to the Panel.

5. **CSE and Safeguarding Member Panel agenda plan for 2015/16**

The Panel considered the agenda plan for the CSE and Safeguarding Member Panel for 2015/16.

Councillor Hill suggested to the Panel that Chris Porter from Public Health could attend a future meeting of the Panel in the 2016/2017 municipal year to give an update following implementation of the CSE Victim and at Risk Individuals Strategy.

The Panel discussed the agenda items for the April meeting and noted that Jackie Bolton would be attending from the Children's Society to give an update on the partnership project taking place within Kirklees. The Panel also noted that Osman Khan, Superintendent of the West Yorkshire Police, (who had replaced Ged McManus), would also be attending the meeting to give an update on historic CSE cases.

The Panel agreed to have a discussion at the April meeting regarding the future focus and work programme of the Panel and agreed to receive a summary of work of the Panel during 2015/2016.

Councillor Holmes advised the Panel that she had met Alison O'Sullivan, Director of Children and Young People, along with Councillor Patrick, to discuss the information provided by the West Yorkshire Police to the CSE Panel and whether this could be provided in such a way that it could be shared with Groups. Alison O'Sullivan had agreed to discuss the matter with Councillor Hill.

Councillor Hill informed the Panel that a final draft of the report on the questions from Leading Members should be available shortly. The Panel noted that the report would be shared with Leading Members in due course.

**AGREED** –
(1) That the agenda plan for CSE and Safeguarding Member Panel for 2015/16 be noted and amended as agreed.

6. **Date of next meeting**

**AGREED** –
(1) That the date of the next meeting of the CSE and Safeguarding Member Panel be held on Thursday 7 April 2016 at 10.30am til 12.30pm in Meeting Room 3, Huddersfield Town Hall.

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