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Monday 30 January 2017

Notice of Meeting

Dear Member

Overview and Scrutiny Panel for Health and Social Care

The **Overview and Scrutiny Panel for Health and Social Care** will meet in the **Reception Room - Town Hall, Huddersfield** at **2.00 pm** on **Tuesday 7 February 2017.**

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 Overview and Scrutiny Panel for Health and Social Care members are:-

Member

Councillor Elizabeth Smaje (Chair)
Councillor Andrew Marchington
Councillor Sheikh Ullah
Councillor Steve Hall
Councillor Fazila Fadia
Councillor Judith Hughes
Peter Bradshaw (Co-Optee)
David Rigby (Co-Optee)
Sharron Taylor (Co-Optee)
Christopher Horner (Co-Optee)

Agenda
Reports or Explanatory Notes Attached

Pages

1: Minutes of previous meeting

1 - 6

To approve the Minutes of the meeting of the Panel held on 10 January 2017.

2: Interests

7 - 8

The Councillors will be asked to say if there are any items on the Agenda in which they have been 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 interests.

3: 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.

4: North Kirklees CCG Transformation Programme

9 - 18

The Panel will consider an update on the development and implementation of the North Kirklees CCG Transformation Programmes.

Contact Officer: Richard Dunne, Principal Governance and Democratic Engagement Officer - 01484 221000.

5: Care Closer to Home

19 - 28

The Panel will consider an update on the implementation of the Care Closer to Home Programme in Kirklees.

Contact Officer: Richard Dunne, Principal Governance and Democratic Engagement Officer - 01484 221000.

6: End of Life Care

29 - 46

Representatives from Greater Huddersfield CCG, North Kirklees CCG, Locala and Kirkwood Hospice will be in attendance to present a report outlining the work that is being undertaken to develop an integrated approach for end of life care in Kirklees.

Contact Officer: Richard Dunne, Principal Governance and Democratic Engagement Officer - 01484 221000.

7: Work Programme 2016/17

47 - 62

The Panel will review its work programme for 2016/17 and consider its forward agenda plan.

Contact Officer: Richard Dunne, Principal Governance and Democratic Engagement Officer - 01484 221000.

8: Date of Next Meeting

To confirm the date of the next meeting as 7 March 2017.

Contact Officer: Helen Kilroy

KIRKLEES COUNCIL

OVERVIEW AND SCRUTINY PANEL FOR HEALTH AND SOCIAL CARE

Tuesday 10th January 2017

Present:	Councillor Elizabeth Smaje (Chair) Councillor Andrew Marchington Councillor Sheikh Ullah Councillor Steve Hall Councillor Fazila Fadia Peter Bradshaw David Rigby Sharron Taylor
Apologies:	Councillor Judith Hughes Christopher Horner (Co-Optee)
In attendance:	
Observers:	Richard Parry, Director of Commissioning, Public Health and Adult Social Care Sue Richards, Assistant Director for Early Intervention and Prevention Michelle Cross, Head of Service (All Age Disability) Sarah Carlile, Safeguarding Adults Partnership Manager Mike Houghton-Evans, Chair of Kirklees Safeguarding Adults Board Penny Renwick

1 Minutes of previous meeting

RESOLVED - That the minutes of the meeting of the panel held on 6th December 2016 be approved as a correct record.

2 Interests

The following members of the panel declared interests in agenda item 5 (Kirklees Safeguarding Adults KSAB 2015/16 Annual Report):

Cllr Smaje declared an 'other' interest on the grounds of being a member of the KNH Board.

Dave Rigby, Co-optee, declared an 'other' interest on the grounds of being a member of Health Watch.

Cllr Marchington declared an 'other' interest on the grounds of being a KNH Safeguarding Champion.

The following member of the panel declared an interest in agenda item 6 (Diabetes in Kirklees):

Dave Rigby, Co-optee, declared an 'other' interest on the grounds of being a member of Locala.

3 Admission of the public

The Panel considered the question of the admission of the public and agreed that all items be considered in public session.

4 Update on Early Intervention and Prevention (EIP)

The panel considered a report giving an overview of the complex work of the Early Intervention and Prevent (EIP) programme and to provide a current position statement. The Panel welcomed Sue Richards, Assistant Director for Early Intervention and Prevention and Michelle Cross, Head of Service for All Age Disability to the meeting.

The Panel discussed a report to Cabinet on the 17th January 2017 entitled "Proposal for Early Help Offer for Children, Young People & Families" and was informed that feedback from the consultation with members and the public was broadly supportive of the proposed model and in particular the need to focus council resources on those with most needs. Sue Richards further explained that there was a clear message from the consultation that the reach into communities and the more intensive people based interventions were more important than keeping council buildings. The Council had consulted on an option to include 17 delivery sites consisting of 4 Children's Centres and 4 central hub sites as part of a locality based model across the 4 early help areas. The Panel noted that there was some debate with members and comment from the public about whether the delivery sites were in the right buildings in the right place. Feedback from the consultation had raised concerns that the buildings would be too far from some communities.

The Panel received a copy of a presentation by Sue Richards entitled "Our New Council Early Intervention and Prevention (EIP)". Sue Richards advised the Panel that EIP continued to be arranged and further developed around the 3 tiers of intervention on Communities 'Plus', Targeted and Complex. The Panel noted the different EIP workstreams as outlined within the report and the draft EIP budget for period 2017-2020.

All Age Disability (Respite and Short Breaks)

Michelle Cross gave an update on the key issues of the AAD workstream and advised the Panel that a high level review of the Council's short breaks and respite

offer had been undertaken and an engagement exercise with families had concluded. The Panel was informed that over 225 responses had been received from families who currently received the service. Michelle Cross further explained that people value the service and feel that it bridges a gap in the market. The Panel noted that proposals were being developed for the Young People's Activity Team (YPAT), as whole service savings were expected as part of the Medium Term Financial Plan.

Michelle Cross advised the Panel that an AAD policy framework was being developed and a review of the Council's policies within the scope of AAD was planned.

Adults Targeted

Sue Richards advised the Panel that the Adults Targeted Workstream looked at the whole pathway for adults and that systems-thinking was being undertaken to explore different ways of working. The Panel was advised that officers were designing a digital front door online self-assessment form for adults that will enable the customer to 'self-serve' at the front door. Individuals could then see what support they may be entitled to, what there was locally in their community that could also meet their needs without the need for formal assessments and care and importantly whether they were likely to be able to get help towards costs of care. The Panel noted the key issues within the Adults Targeted offer as outlined within the report.

The Panel discussed how to help people to have a positive view about being healthy and noted that socially isolated people living in deprived rural areas could be disadvantaged in the level of support they have access to.

In response to a question from the Panel relating to how the Council will be evaluating outcomes of all the proposed changes, Sue Richards advised that the service will need to identify outcomes and measure what difference was being made.

The Panel agreed to receive future EIP reports for consideration, which directly related to Adult Social Care and agreed to receive further information with regard to the new corporate policy required to facilitate single corporate grant making strategy.

RESOLVED -
(1) That Sue Richards and Michelle Cross be thanked for attending the meeting and that the report on Early Intervention and Prevention be noted.
(2) That the panel receive further information with regard to the new corporate policy required to facilitate single corporate grant making strategy.
(3) That the panel receive future reports on EIP workstreams which directly relate to Adult Social Care – dates to be determined.

5 Kirklees Safeguarding Adults Board 2015/16 Annual Report

The Panel considered a report on the 2015/16 Kirklees Safeguarding Adults Board (KSAB) Annual Report and welcomed Mike Houghton-Evans (Independent Chair of Kirklees Safeguarding Adults Board (KSAB), Richard Parry (Director of Commissioning, Public Health and Adult Social Care), Penny Renwick, Lay Member (Kirklees Safeguarding Adults Board) and Sarah Carlile (Kirklees) to the meeting.

Mike Houghton-Evans advised that in 2015 KSAB had appointed its first Independent Chair and that the Board reported quarterly to the Council's Chief Executive on the work of the KSAB.

Mike Houghton-Evans informed the Panel that the Strategic Plan sat alongside the Annual Report and will be kept up to date and regularly refreshed. The Panel noted that the KSAB was supported by an infrastructure that oversees and enables delivery of the work programme, co-ordinates sub groups and task and finish groups. The infrastructure provides analysis and intelligence for the KSAB. Mike Houghton-Evans further explained that the Chair of KSAB must be independent to ensure challenge and scrutiny into the Partnerships. The KSAB noted that work this year had focussed on developing arrangements for the KSAB's new Delivery Group, which will co-ordinate the development and implementation of priorities outlined in the Strategic Plan and will ensure that the KSAB delivers. The KSAB had been well attended and partners on KSAB took their role seriously. The Panel was advised that members of the KSAB have sufficient delegated authority to effectively represent their agency and to make decisions on their agency's behalf. Mike Houghton-Evans advised the Panel of the agencies and organisations were members of KSAB, which was outlined within the report.

The Panel was advised on KSAB's vision which was outlined within the report and was based on the fundamental principles of the 2014 Care Act along with the Joint Health and Wellbeing Strategy (JHWS) and the Kirklees Economic Strategy (KES). Mike Houghton-Evans further explained that the principles of the national programme 'Making Safeguarding Personal' (MSP) underpinned the delivery of the KSAB's vision.

In response to a question from the Panel regarding a procedure to pick up common themes of individual Safeguarding Adult Reviews and if lessons to be learnt were shared, Mike Houghton-Evans advised that the KSAB Annual report was not a full performance report and information on Deprivation of Liberty (DOLs) was sent to the Chair of the Health and Social Care Scrutiny Panel. The Panel noted that performance information was reported to the KSAB's Delivery Group. Mike Houghton-Evans further explained that the KSAB uses tools available to them to scrutinise what agencies were reporting. The Panel was informed that Lay Members attended individual challenge meetings with members of the KSAB and the outcomes from these meetings would help to shape future KSAB agendas.

The Panel commented that Safeguarding Case Reviews were previously more visible within Kirklees amongst Councillors. Mike Houghton-Evans advised the Panel that Safeguarding Case Reviews were published and agreed to forward details onto the Panel.

Mike Houghton-Evans advised that analysis of the Kirklees Safeguarding Children's KSAB was undertaken by Sarah Carlile and shared with the KSAB. The Panel was informed that development days took place outside of the KSAB meetings to develop thinking of what should be in the Board's Work Programme and the agencies were involved in this work.

The Panel was advised that the KSAB now had 2 lay members, whose role was to critically challenge decision making and provide a lay perspective.

The Panel commented on the changes taking place within safeguarding and discussed how KSAB could try to ensure that the needs of the public did not get lost within financial constraints and have a negative impact on safeguarding. Mike Houghton-Evans advised that developing a locality model within Kirklees with joint teams would strengthen safeguarding and that outcomes should be improved. The Panel was informed that Early Intervention and Prevention was a standing item on KSAB so they could be kept up to date on how this work was progressing.

The Panel agreed that the KSAB 2015/16 was an encouraging report and that the Loan Shark Campaign undertaken early in 2014 (which had been supported by KSAB) was very positive.

RESOLVED –
(1) That Mike Houghton-Evans, Penny Renwick, Richard Parry and Sarah Carlile be thanked for attending the meeting and that the Kirklees Safeguarding Adults Board (KSAB) 2015/16 Annual Report be noted.
(2) That the Panel receive details of Safeguarding Case Reviews and when and where they are published.

6 Diabetes in Kirklees

The Panel received a report for information prepared jointly by North Kirklees and Greater Huddersfield CCGs and Locala, on the current position on Diabetes in Kirklees. The report provided an update on actions and planned work to support people in Kirklees living with diabetes.

The Panel noted the update regarding the variation in footcare pathway between Greater Huddersfield and North Kirklees. Locala have undertaken engagement work with service users of the podiatry service and were currently auditing wound care to inform the design of the new equitable pathway and were developing a consultation document on the proposed service changes. The Health and Social Care Scrutiny Panel had considered a report from Locala on the 1st November 2016 regarding proposed changes to podiatry services and had agreed that the proposed changes posed a significant change in public service and therefore agreed to scrutinise the proposals. The Panel noted that Locala would report back to an additional meeting of the Health and Social Care Scrutiny Panel on the 23rd March 2017 on the revised consultation proposals.

The Panel welcomed the update that Diabetes UK were recruiting a BME champion co-ordinator that will improve links between Locala and Diabetes UK.

The Panel noted that Public Health were commissioning a Wellness Model for the delivery of lifestyle interventions that will launch in 2018 and will contribute to the prevention of diabetes and link with the National Diabetes Prevention Programme.

RESOLVED – that the report on Diabetes in Kirklees be noted.

7 Work Programme 2016/17

The Panel discussed potential items for the 2017/18 work programme.

The Panel agreed that Art Psychotherapy be removed from the 2016/17 work programme as there was nothing further to report on this issue at the current time.

The Panel noted that Bradford Council were leading on a piece of work to scrutinise NHS Dentistry with particular regard to levels of tooth decay and access to NHS dentists and were liaising with both Kirklees and Leeds Councils on this matter. The Panel noted that this issue may also be looked at on a West Yorkshire basis and agreed to receive further updates when appropriate.

RESOLVED – that progress on the work programme for 2016/17 be noted.

8 Date of Next Meeting

RESOLVED - That the date of the next meeting be confirmed as 7th February 2017.

KIRKLEES COUNCIL

COUNCIL/CABINET/COMMITTEE MEETINGS ETC
DECLARATION OF INTERESTS

Overview & Scrutiny Panel for Health and Social Care

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.

Name of meeting: Health and Social Care Scrutiny Panel
Date: 7 February 2017

Title of report: North Kirklees CCG Transformation Programme

Is it likely to result in spending or saving £250k or more, or to have a significant effect on two or more electoral wards?	**No**
Is it in the Council's Forward Plan?	**No**
Is it eligible for "call in" by Scrutiny?	**Not Applicable**
Date signed off by Director & name **Is it signed off by the Director of Resources?** **Is it signed off by the Acting Assistant Director - Legal & Governance?**	**No – The report has been produced to provide the context to the Panel discussions.**
Cabinet member portfolio	**Adults, Health & Activity to Improve Health**

Electoral wards affected: All

Ward councillors consulted: N/A

Public or private: Public

1. Purpose of report

1.1 To provide members of the Health and Social Care Scrutiny Panel with the context and background to the discussions on the North Kirklees CCG (NKCCG) Transformation Programme.

2. Key Points

2.1 NKCCG are developing a number of initiatives as part of a wider transformation programme that is designed to help support the delivery of sustainable health and social care service across the district.

2.2 A key aim of the programme is to manage demand for hospital services by providing more services in community settings and ensuring more people are provide with care at or as close to home as possible.

2.3 Representatives from North Kirklees CCG will be in attendance to present an update on the transformation programme and a report that outlines the programmes of work that are being developed is attached.

3. Implications for the Council
None at this time.

4. Consultees and their opinions
Not applicable

5. Next steps
That the Panel take account of the information presented and consider the next steps it wishes to take.

6. Officer recommendations and reasons
That the Panel consider the information provided and determine if any further information or action is required.

7. Cabinet portfolio holder recommendation
Not applicable

8. Contact officer and relevant papers
Richard Dunne, Principal Governance & Democratic Engagement Officer, Tel: 01484 221000 E-mail: richard.dunne@kirklees.gov.uk

9. Assistant Director responsible
Julie Muscroft Assistant Director: Legal, Governance & Monitoring

North Kirklees CCG

Transformation Programmes

Update on the Development and Implementation of Transformation Programmes which support the Management of Demand for Hospital Services

1. Background/Introduction

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 integrated patient centred care and health and wellbeing, whilst reducing health inequalities for our local population. This will include the development of integrated models of holistic care pathways provided by a collaboration of organisations enabling and empowering patients and their carers to access proactive care, at the right time, provided by the right person, in the right place. This will result in a shift in activity out of hospital and into more appropriate community settings; ensuring patients are managed more effectively at or as close to home as possible.

Our 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 Model.

The implementation of this vision has been in progress for a number of years and is supported by a number of changes which we have implemented/are in the process of implementing. The first major step change in delivering this was the commissioning of an integrated model for community services through Care Closer to Home and the recent commissioning of an integrated model for children's services through the Healthy Child Programme. Both programmes support delivery of the Acute Services Reconfiguration at Mid Yorkshire Hospitals, 'Meeting the Challenge'.

We recognise that we need to do much more to deliver this vision by focussing on a more proactive, planned and preventative approach to care across North Kirklees. We have plans which are in place or in development to do this. These plans are described in the CCGs Operational Plan and the Kirklees Health and Wellbeing Plan which are currently in working draft status.

2. Identified Programmes: Progress and Next Steps

<u>2.1 Long Term Condition Management</u>

Using data from the Right Care Packs it has been identified that a number of key areas require whole pathway reviews, in particular Respiratory, Diabetes and Muscular Skeletal Conditions (MSK). Work is ongoing to review current provision and to identify and address any gaps. The respiratory work includes the prevention, management and care for; Chronic Obstructive Pulmonary Disease (COPD),

Asthma, Tuberculosis (TB) and Influenza (Flu) alongside reviewing the provision of the Oxygen service. Diabetes work is focussing on the prevention and reducing variation in primary care. The MSK pathway aims to standardise referral pathways; improve access and quality of care. This work is supported by the development of clinical threshold management across pathways. We are working with partners and clinicians across the system to develop and implement standardised pathways for a number of disease areas using a formulary developed in Devon as a baseline and adapting for local use. The clinical threshold management approach will be underpinned by the procurement of a clinical system which will support clinical decision making and on-ward referral, maximising patient choice of provider.

We are also looking to review how we partner with our patients who have long term conditions to consider their needs over the longer term. This links in closely with our frailty work as more of our older population has more than one long term condition and extends to incorporate those in the last 12 months of life, therefore helping people live well, age well and die well. We will do this by embedding the use of our care plan menu (self-management plans; personalised care plans; emergency care plans and end-of-life care plans) though early identification; annual reviews and holistic frailty reviews which seek to ensure person centred co-ordinated care supported through appropriate care planning.

2.2 A&E Improvement Group

A&E Improvement groups were set up at the request of NHS England and replace the old System Resilience Groups (SRGs). The groups cover acute hospital footprints with a focus solely on Urgent and Emergency Care, and are attended at the executive level by member organisations.

The A&E Improvement Group has been tasked by NHS England to deliver against the following 5 key areas:

1. Streaming at the front door – to ambulatory and primary care.
2. NHS 111 – increasing the number of calls transferred for clinical advice
3. Ambulances – code review pilots; Health Education England increasing workforce
4. Improved flow – ‘must do’s that each Trust should implement to enhance patient flow
5. Discharge – mandating ‘Discharge to Assess’ and ‘trusted assessor’ type models

Two task and finish groups have been established (Primary Care and Discharge) which have developed and implemented work plans.

Progress follows a ‘hospital reset week (12/12/16)’ where a number of Plan, Do Study Act (PDSA) cycles were tested resulting in significant improvements with regards to ambulance handover performance. As a consequence of the ‘reset week’,

the following changes have been made to improve the flow of patients through hospital services at Mid Yorkshire Hospital Trust:

- The Walk-In Centre at Dewsbury now accepts a wider referral criteria and a GP is available during the evening (until 11pm), 7 days a week.
- A new discharge model has been implemented which is intended to improve the quality of discharge planning and reduce length of stay.
- GPs are being asked to rapidly respond to and prioritise patients who require a home visit (usually through early telephone assessment and a duty doctor rota) with the rapid provision of an ambulance, if required.

The impact of these changes will be monitored via the A&E Improvement Group which links directly into CCG Governing Bodies for both North Kirklees and Wakefield.

The requirement to take a systems approach to improve the quality of care and flow of patients through hospital services, ensuring that people are seen by the most appropriate clinician for their needs, first time is an outcome within the Kirklees Health and Wellbeing Plan which is our local response to the delivery of the West Yorkshire and Harrogate STP. The measures being taken by the A&E Improvement Group to deliver this and key in delivering our ambitions.

2.3 Frailty

Across the North Kirklees 'place' (acute, community and primary care footprint) , all stakeholders have recognised that there is an increasing number of older people attending emergency departments and accessing urgent health and social care services with a rising demand due to the projected growth in the number of people aged 85 over the next twenty years.

There is a consensus that we need to change how we care for the needs of older frail people now which will lead to improvements in quality, outcomes and efficiency.

We are therefore working to develop a 'new model of care' for frailty bringing together the local health and care system to redesign care for our local population. A Frailty Steering Group attended by a wide range of stakeholders has been established and has been tasked with agreeing a joint Frailty Strategy. The emerging vision for this strategy is:

'Our frail population will be identified early and supported to live as safely and independently for as long as possible avoiding unnecessary admission to hospital through an integrated proactive approach to frailty across the health and social care system.'

Working collaboratively with Locala we have begun to develop a robust frailty identification and assessment process which is currently being used for the following cohorts of patients:

- Patients aged over 65 years and living in a Care Home
- Patients aged over 85 years and living in their own homes

Once assessed and diagnosed with frailty, these patients will undergo a holistic assessment and care planning review and will be supported by the Locala Single Point of Contact who will provide a reactive response service within 2 hours for moderate or severe frail patients who require an urgent review. We intend to expand the frailty work to include early identification of frailty risk in primary care and provision of specialist frailty assessment by April 2018.

An urgent care and frailty clinical summit is planned for the 1st February 2017 and will bring together partners with an aim to better understand current work plans for urgent care and frailty alongside aspirational plans from each organisation. We need to identify interdependencies and agree a joint vision for North Kirklees. We will seek to use the event to gain commitment from partners to work collaboratively to develop new models of care utilising resource differently to support transformation and change across the system. Following this, a new governance structure will be agreed which will likely include a Frailty Board made up of representation from each organisation, underpinned by the current Frailty Steering Group and identified task and finish groups.

The Frailty work is a key development in supporting us to deliver the Kirklees Health and Wellbeing Plan, which will deliver a number of ambitions set out in the West Yorkshire and Harrogate STP.

2.4 Review of the Urgent Care System across North Kirklees

Provision of Urgent Care services at Dewsbury Hospital has been under review by the CCG for some time. To meet the needs of our population a strategic outline case will be developed which will cover the whole care pathway for urgent and emergency care and will be in line with national guidance.

Current work (as identified in 2.1) includes a review of how the Walk-In Centre works with the A&E minor injuries team to provide a seamless team with extended roles, this is now being explored. We are also exploring the co-location of our GP out of hours provider within A&E at DDH.

Better use and development of the Ambulatory Emergency Care Unit at Mid Yorkshire Hospitals is a key requirement alongside the development and enhancement of the primary care offer for urgent care (extended access; home visiting; medical care home provision).

Discussion between Locala and Local Authority around how the current admissions avoidance teams (HAT and Locala In-Reach team) could work more collaboratively is ongoing.

We have also recently started a review of our flexible bed base; domiciliary care and reablement packages to better understand how we can ensure medically fit patients can be discharged from hospital sooner with the appropriate care to meet their needs.

Recent PDSA cycles within the Walk-In Centre based within the A&E Department at Dewsbury District Hospital has led to a review and extension of the referral criteria. This has resulted in an, increased the number of patients streamed into the Walk-In Centre from A&E from 13% to18%. The existing contract for the Walk-In Centre is currently being reviewed with plans for a new service to be in place by 1st October 2017. We are exploring how the current service can be merged with the minor injuries unit to provide a more expansive 'primary care stream'. Meanwhile this and the other initiatives mentioned, including the clinical summit, will inform a strategic outline case for urgent care which is in development and aims to implement a urgent care service for North Kirklees in-line with national guidance.

3. Meeting the Challenge: Hospital Reconfiguration at Mid Yorkshire Hospital Trust

Plans to reconfigure Mid Yorkshire Hospital services were approved by the Secretary of State in March 2014 following formal public consultation and referral by the Joint Health Overview and Scrutiny Committee. The plans are part way through implementation.

Reconfiguration of women's and children's services was completed in September 2016. As a result, Dewsbury Hospital now has a children's assessment unit open 10am to 10pm daily and children requiring admission to hospital are transferred to Pinderfields. Consultant led obstetric services are now centralised at Pinderfields, which also has a new midwife led birth centre. Dewsbury Hospital has a new purpose built midwife led birth centre.

Reconfiguration of surgical services also commenced in September 2016, as a result of which acute surgery is now centralised at Pinderfields, with the exception of some minor procedures which can be carried out in 'hot clinics'. Dewsbury will provide an increased range and volume of planned surgery.

When services are fully reconfigured all complex surgery will be centralised at Pinderfields. Currently bariatric and complex colorectal surgery is still being provided at Dewsbury.

The final phase of changes is currently scheduled to take place in May 2017. This will involve reconfiguration of acute medicine as outlined below:

- Dewsbury hospital will continue to have an emergency department (A&E) which will be open 24 hours a day, seven days a week
- The emergency department will be led by a consultant and will have senior specialist doctors working in it around the clock, who will have the right skills to be able to assess and stabilise any patient who turns up
- There will be consultants in the department during the daytime and early evening, which are the hours when attendances are highest. At other times the team will be supported by an on call consultant just as they are at night now
- Currently, about 70% of people who come to Dewsbury emergency department can be treated without needing to be admitted to a hospital bed. For those people the plans mean there will be no change
- People will notice a change if they are more seriously ill and need very specialist care which is likely to mean they have to stay in hospital
- This is because the plans will change the way specialist and inpatient care is provided to ensure people are seen more quickly by a clinician with the right skills.
- People who are very ill and are likely to need a stay in hospital will be taken directly to Pinderfields if they call a 999 ambulance
- If a person comes to Dewsbury Hospital and the clinical team find they need inpatient care, they will be stabilised and transferred to Pinderfields
- When the changes happen our advice will be that people should still take themselves to Dewsbury Hospital unless they need an ambulance: if they call an ambulance the paramedics will decide which is the best hospital for their needs
- Critical care services will be centralised at Pinderfields
- Bariatric and colorectal surgery will be centralised at Pinderfields.

Currently the Trust is undertaking a review of the original capacity assumptions in the Full Business Case to take account of changes in demand and length of stay, largely driven by an increased number of admissions of people with conditions that require longer lengths of hospital stay, such as frail older people, stroke and respiratory disease. If more beds are retained than originally planned this will result in an increase in the beds remaining at Dewsbury Hospital (as there is limited space to increase beds at Pinderfields).

Rigorous risk assessment of the implementation plans is being undertaken and a decision as to whether to proceed in May 2017 will be taken by the system (Trust, CCGs and local authority) at the end of February 2017.

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Name of meeting: Health and Social Care Scrutiny Panel
Date: 7 February 2017

Title of report: Care Closer to Home and End of Life Care

Is it likely to result in spending or saving £250k or more, or to have a significant effect on two or more electoral wards?	**No**
Is it in the Council's Forward Plan?	**No**
Is it eligible for "call in" by Scrutiny?	**Not Applicable**
Date signed off by Director & name **Is it signed off by the Director of Resources?** **Is it signed off by the Acting Assistant Director - Legal & Governance?**	**No – The report has been produced to provide the context to the Panel discussions.**
Cabinet member portfolio	**Adults, Health & Activity to Improve Health**

Electoral wards affected: All

Ward councillors consulted: N/A

Public or private: Public

1. Purpose of report

1.1 To provide members of the Health and Social Care Scrutiny Panel with the context and background to the discussions on the Care Closer to Home (CC2H) programme and End of Life Care.

2. Key Points

2.1 Clinical Commissioning Groups (CCG's) in Kirklees, in line with the national agenda and planning guidance are shaping proposals that will provide integrated care that is delivered at or closer to home.

2.2 The proposals being developed by North Kirklees CCG (NKCCG) and Greater Huddersfield CCG (GHCCG) have been focused on delivering services across a Kirklees footprint.

2.3 The work is an important element of the wider transformation programmes that are being developed across the district that are based on the acute trust footprints.

2.4 CC2H is the vision for the development of integrated community based health care services across Kirklees which includes a focus on those in vulnerable groups and meeting the needs of individuals with palliative and end of life care needs.

2.5 GHCCG and NKCCG have set out integrated strategic priorities for end of life care in Kirklees that has included input from Kirklees Council, Kirkwood Hospice and Locala.

2.6 Representatives from GHCCG, NKCCG, Locala and Kirkwood Hospice will be in attendance to outline progress of the CC2H programme and work that is taking place on end of life care. Reports providing greater detail on these programmes of work are attached to item 5 (CC2H) and item 6 (End of Life Care).

3. Implications for the Council
None at this time.

4. Consultees and their opinions
Not applicable

5. Next steps
That the Panel take account of the information presented and consider the next steps it wishes to take.

6. Officer recommendations and reasons
That the Panel consider the information provided and determine if any further information or action is required.

7. Cabinet portfolio holder recommendation
Not applicable

8. Contact officer and relevant papers
Richard Dunne, Principal Governance & Democratic Engagement Officer, Tel: 01484 221000 E-mail: richard.dunne@kirklees.gov.uk

9. Assistant Director responsible
Julie Muscroft Assistant Director: Legal, Governance & Monitoring

CARE CLOSER TO HOME

Update on the implementation of the service for OSC February 2017

1. Background/Introduction

Plans to shift services and resources closer to people's own home originally began in 2012, culminating in the award of the contract by Greater Huddersfield and North Kirklees Clinical Commissioning Groups (CCG) to Locala. The service went 'live' on 1 October 2015 with Greater Huddersfield CCG taking the role of lead commissioner.

The Care Closer to Home (CC2H) programme has critical inter-dependencies with the Right Care Right Time Right Place and Meeting the Challenge hospital services programmes; the vision for CC2H is for an integrated community based health care service for all including the frail, vulnerable and older people and also end of life care. The vision for the service is a five year transition with community activity increasing over the lifetime via a planned and agreed, with commissioners, Service Development and Improvement Plan (SDIP); it is crucial that sustainable changes are made to our health and social care system to ensure that services are fit for purpose in the future and fully support developments of smaller, different acute hospital reconfigurations.

Key characteristics of CC2H are:

- Improved primary and community care providing the right care at the right time in the right place
- Provision of services in the community that promote independence and wellbeing for patients so they can support themselves by exercising self-management, choice and control
- Integrated high quality services at times required to meet the needs of the community
- Providing more planned care earlier thereby reducing reactive, unscheduled care
- Care provided as one coherent package, with a focus on individuals and helping people to get better

The main elements of the model are:

- Risk assessment to identify people who are most vulnerable and most likely to be admitted to hospital
- Proactive care management by multi-disciplinary teams
- High quality local information and support to enable people to manage their own condition and access the most appropriate care
- Person centred care delivered through a single assessment process and single care plan 24/7
- Care at or near home wherever possible

2. Where we are now/What are the issues?

An audit on where and what Locala are currently achieving against the service descriptors and Key Performance Indicators (KPIs) is underway, this will develop into a gap analysis and subsequent action plan to ensure that we, as a partnership, are on track with our overall five year vision.

Some issues have arisen over the life of the contract which are being worked through to achieve a satisfactory outcome, particularly in relation to patient care. For example:

- In relation to the Memorandum of Understanding between the individual GP practices and Locala. A round table discussion was held involving GPs, practice managers, Locala managers and front line staff as well as commissioners. A similar workshop has also taken place involving primary care practice nurses and Locala community nurses to review wound care pathways and improve patient care.
- A wider understanding of the issues and specific definitions (to avoid several different interpretations) of 'housebound' and 'communications and multi-disciplinary teams' for example was arrived at. Issues around the basic running of meetings and which patients would be discussed were raised.
- It transpired that therapists were not part of the MDTs – it was agreed that the invitation should apply to all staff.
- Some of the issues were very basic; however the opportunity to air them and discuss solutions was greeted positively by all.
- An under resource was identified within North Kirklees CCG to take the SDIP forward and a lack of engagement with some key partners. Additional resource has now been secured and a lead has been identified to develop the SDIP from a commissioning and contract management perspective. This piece of work has begun in collaboration with key partners.
- Single Point of Contact (SPoC), which is the 24/7 call centre for CC2H services is currently located alongside Gateway to Care in Civic Centre 3. SPoC is using the same telephony and IT system as the council which has led to a number of system failures since February 2016 when the service was set up. In addition, it is often difficult for SPoC call handlers to access Locala electronic systems through the Council's network. Back up arrangements have been put in place in case of any failure of the system in the future and Locala is working with Council colleagues to look at a long term sustainable IT and telephone system that is more reliable.

3. How has CC2H changed and impacted on patient pathways:

3.1 Many of the services which come under the umbrella of Care Closer to Home either directly or indirectly prevent avoidable hospital admission (a step-up service) or facilitate timely hospital discharge (a step-down service).

3.2 The Single Point of Contact ensures that ALL referrals are managed through one single point, for any professional, patient or carer. The service includes call handling, information gathering, and using that information to determine immediate next steps and appropriate onward referral.

3.3 Promoting self-care is inherent within all services; commissioners are working on a future development to promote self-care and support patients to manage their asthma/inhaler technique more effectively. This has not yet been fully mobilised through the contract and forms part of the SDIP.

3.4 At the start of CC2H, Locala developed a Maximising Independence strategy with a steering group and dedicated project lead and trainer. The project lead delivered a workforce development programme and rolled out training for colleagues working directly with patients to help them build confidence and promote self-care. This training included elements of motivational interviewing, the importance of a comprehensive and detailed first assessment and the development of a core assessment template that staff now complete for all patients. There is also a questionnaire at the start of patient care and on discharge where patients are asked to comment on how they feel their independence has been supported and maximised.

4. A patient story example of the above:

Locala's Colne Valley Integrated Community Care Team (ICCT) has made a difference to an 82 year old cancer patient after helping her to become independent on post-chemotherapy injections. The patient was diagnosed in February with high grade non-Hodgkin lymphoma, a cancer that develops in part of the immune system. Since then the patient has undergone six rounds of chemotherapy and was referred to the ICCT for post-chemotherapy injections to boost the white blood cells in the immune system.

Locala encourages patients to manage their healthcare whenever possible; the patient wished to go on a family holiday so was keen to learn how to inject herself independently. The patient was taught by one of the nurses and her confidence is growing. She has details of what to do if her temperature rises or she needs help and support.

She said, ‘All of the nursing staff were friendly and supportive when they were demonstrating how to do my injections. I felt I could ask them anything and they would always take time to listen. My day-to day life is more or less the same, I’ve just learned to pace myself. The team have helped me to keep my independence and for that I’m grateful’.

5. 7 day services

7 day services have been further developed in line with national work. For example Outpatient Antibiotic Therapy (OPAT) provides a 7 day service which prevents patients being admitted and provides the service within the community. Further work is in progress to enable more patients to receive all (including the first) doses within the community.

The OPAT team are qualified nurses who provide intravenous antibiotics to patient’s in their own homes across Kirklees. They assist in preventing an acute hospital admission or facilitating an early discharge for medically stable patients requiring intravenous antibiotics. Patients are accepted with a wide range of conditions, with referrals being made via the SPoC 24/7 365 days per year.

5.1 **OPAT supporting patients to go home earlier:**

Recent feedback provided to Locala, from a patient and his mother highlights what a difference the service makes to patients and their families; “A huge thank you for everything you have done these past weeks. Your compassion, empathy and friendliness is completely unrivalled. I almost want to keep my central line in! You have played a huge part in my recovery and I am forever in your debt”. Feedback from the patient’s mother reads: “We have had 21 days of impeccable visits from the IV Team. Every day the staff came to the house and provided not only excellent care but also emotional support, advice and reassurance. Nothing has been too much trouble for them. This is a 7 star service and the entire team are incredible, capable professionals as well as wonderful people. Without this service my son would still be in hospital, which would not have aided his recovery, being home has enabled his recovery more. Thank you for everything.”

Also clinician provision in SPoC in the evening and weekend promotes an efficient way of triaging patients, especially at weekends when there is a lack of external support from GP practices for example. This promotes keeping patients at home, following patient-specific emergency care plans.

6. In-Reach services

6.1 The In-Reach team facilitates patients being ‘turned around’ in A&E where previously they may have been admitted. There is a Locala nurse based in both A&E departments (Dewsbury District Hospital and Huddersfield Royal Infirmary) who is part of the In-Reach Service. The nurse works with the A&E clinical teams and the Hospital Avoidance Teams (HAT) commissioned to provide additional social care support by Kirklees Council to assess and source appropriate care in the community

to avoid unnecessary admission to hospital. To date, the In-Reach Service has avoided over 300 admissions to hospital for North Kirklees patients and 643 for Greater Huddersfield.

In-Reach works across 7 days, the service is currently analysing how best to link with and support the developing frailty approach. There are daily examples of patients being turned around in both A&E departments and how the In-Reach teams' ability to follow patients up once they return home provides additional reassurance to acute hospital colleagues in discharging rather than admitting patients.

The importance of having a multi-skilled team as well as shared competencies can be seen in In-Reach; having therapy and nurses, knowledge can be shared about patients who present as palliative as well as patients with fractures etc.

6.2 An example of the work of the In-Reach team supporting a patient to return home following reduced mobility:

1. SITUATION – Seen by the In Reach team in A&E HRI 26/12/17 , presented lower back pain unable to get out bed following fall 2/7
2. BACKGROUND – Male 87 years, lives with wife in bungalow, no care package in place .Normally independent with mobility. Dementia and prostate cancer.
3. ASSESSMENT – Lumbar spine x-ray NAD, transferred CDU assessment mobility and pain. Seen by CHFT physio, bed loop / combined toilet frame / wheeled Zimmer frame provided. Demonstrated use of towel as leg lifter, advice analgesia provided. Wife declined homecare support, returned home same day.
4. RECOMMENDATION – Home visit provided by Locala In-Reach team to reduce risk of re-admission

Locala In-Reach team home visit:
28/12/16, on arrival patient struggling with bed transfers, not taking regular analgesia, wife unable to assist as now has sciatica.
<u>Actions</u>

1. Mobility assessment – patient having difficulty using bed loop due to poor coordination. Sleeping in camp bed with thick mattress on top – bed too low and unable to raise, bed loop too big but stable when used. Wife reported 3 falls in December, 2 in shops and one at home, falls assessment completed. Chair at home good height suitable back rest and arms.
2. Wife reported cloudy urine – specimen obtained found to be clear. Plumbers present on visit fitting new bathroom / walk-in shower facilities.
3. Advise provided on bowel management and analgesia
4. Rapid response home care commenced 29/12/16 – support personal care
5. Pillow raiser and care phone ordered
6. Referred to chiropody

7. Referred wife to carer support – Sitting service, GP advised to take up yoga ease sciatica but unable to attend
8. Referred to falls practitioner
9. GP updated
10. Referred to community therapists - bed transfers and assess in new bathroom
11. Therapy follow up arranged through the Integrated Community Care Team and further equipment ordered

7. Workforce changes and developments

- In order to manage capacity i.e. the increases in demand produced through hospital avoidance and timely discharge, and the subsequent overall reductions in the bed-bases, the skill mix of the workforce and teams is changing.

- The transforming of the workforce is critical to ensure that Locala can deliver high quality community services effectively. Service reviews have been completed in November and December to review how effective the model for delivering CC2H is delivering care for patients one year on.

- Locala has instigated a working group to look at the workforce needs, including reviewing skills and training needs and has prioritised the Calderdale Framework to support colleagues working in community teams to help them meet the challenges associated with changing patient need and the complexity of patients now being managed in their own homes.

- The working group's programme of work includes; undertaking a Training Needs Analysis (TNA), developing competencies (using the Calderdale Framework) and promoting skill mix and integrated working across disciplines. This includes plans for using the opportunities presented by the new Apprenticeship Levy, with Apprenticeships available in a broader range of health and care roles.

- The review and outcomes will be completed by the end of March 2017 with an implementation plan to be in place from April.

8. Intermediate care

Work is also underway within the Intermediate Care bed bases to stream line the patient journey and develop a multi-disciplinary approach to assessment, provision and planning of care. Working with SystmOne to improve pathways and ensure right care, right time, right place, avoiding duplication and speeding up the discharge process.

9. Partnership working

- Major partnerships continue to be developed and worked on, particularly with primary care which is acknowledged as being challenging, acute trusts and social care.

- In order to facilitate these changes there is a need for greater integration, both internally to Locala and with teams/services from other organisations.

- The In-Reach team at HRI and DDH are working with the Frailty Team at HRI and HAT team at DDH on joint assessments. The team is also part of the High Intensity User Group (patients who attend A&E regularly) at both sites which has involved developing an inter-agency sharing protocol, and has shown excellent outcomes from the ambulance service. The group includes the Police, YAS, In-Reach, Community Matrons, A&E, Safeguarding, Social Services, Mental Health Services and Health Trainers.

- The In-Reach team is based on both hospital sites in Huddersfield and Dewsbury and is working with the Emergency Departments and key wards on both sites to ensure that patients are directed to care and support options in the community at the earliest opportunity.

- Locala has an Intermediate Care Matron liaising with wards to support assessment of patients prior to admission in to Intermediate Care beds. This has helped to ensure patients are placed in the right setting for rehabilitation and transfer is as smooth and timely as possible. Locala and social care staff work together to ensure there is joint working to the same aim for patients for discharge planning.

- The approach to integration includes more innovative use of partnerships with third sector organisations to ensure people are supported with more basis daily living needs.

- Locala has had a particular emphasis on developing partnerships with third sector organisations such as Age UK, Millen Care, Connect Housing and the Denby Dale Centre as they often work with people in different and innovative ways and can engage with people who may not use more mainstream services. This will help to identify and harness additional community capacity, knowledge and connections and avoid duplication of work across health and social care partners. For example, Locala ICCTs are already undertaking social care assessments as part of the care assessment where relevant.

10. Minimising Duplication

- Single Point of Contact (SPoC) being co-located within the council services, allows joint assessment of need, across social and health boundaries, identifying the best service to meet patient's needs. Carephones, mobile response, emergency social workers and out of hours social care all work together to best provide for the needs of Kirklees residents.

- SystmOne web based referrals are being developed and the launch of e-referrals gives smoother access to Locala services for GPs and other referral partners.

- SPoC clinicians link daily with care homes in North Kirklees to provide clinical advice (GHCCG commissions a specific Care Home Service).

- Through the night, social care and district nursing night service are an integrated team. This allows patients to get the best care they require, ongoing assessments by nurses are timely and capacity is increased as integrated working allows greater geographical coverage.

- Work is ongoing with Mid Yorks around discharge of patients, investigating making the patient journey smoother and sharing assessment information between teams to avoid duplication.

- The Intermediate Care bed bases are working with social care to ensure data entry is not duplicated and streamlined care is delivered.

- There is a partnership in place in relation to the Reablement service; Locala provides therapists to support Reablement carers working with patients awaiting a care package where an optimisation of their condition is undertaken for a period of six weeks. Locala assesses the patient and develops a reablement programme for the care staff to deliver as well as providing training and development for the care staff. This helps to ensure that the service is minimising the need for long term care packages.

Commissioners and Locala are working together to refine reporting and data collection with a specific focus upon hospital avoidance/avoiding emergency admissions are captured and reported each month. This is broken down to team level, it is anticipated that this will be complete by April 2017; this will be a major marker in demonstrating the effectiveness of the contract.

Developing an integrated approach for End of Life Care in Kirklees – February 2017

Kirklees Council, North Kirklees CCG, Greater Huddersfield CCG, Locala and Kirkwood Hospice

Introduction

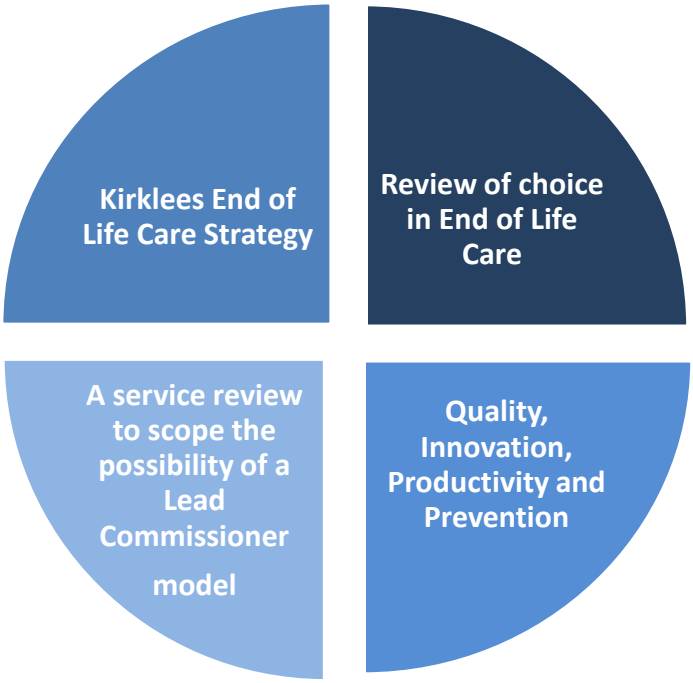
1. Work on End of Life Care has been undertaken to develop an integrated approach across Kirklees, with involvement from the Clinical Commissioning groups, the Council, Kirkwood Hospice and Locala. This paper provides:

   - An overview of the work that is being developed, with updates from key partners.
   - Assurance that the approach taken has ensured consistency in the standard of care and support across the district
   - Details of future plans

   The CCG's currently invest £1.6m across a range of services which include a sitting service, hospice services, the 24/7 helpline and fast track services. There is an acknowledgement that the wider cost of end of life care is much higher, taking into account the impact across the entire health and social care system, which is why collaborative working between partners is essential. Kirkwood Hospice is also a key commissioner of palliative and end of life services for people in Kirklees and commission £3m of services on behalf of the local population in partnership with CCGs, from their share of the above funding and their own fund raising activities.

Context

2. There are four key areas of activity currently being utilised to develop a Kirklees wide end of life offer. This work is taking place across all agencies linked to the provision of end of life care and includes the Local Authority, General Practice, the Clinical Commissioning Groups, Kirkwood Hospice and Locala. The four distinct areas of activity with the CCGs are:



- Kirklees integrated End of Life Care Strategy. (Local Authority / Kirkwood Hospice / GH & NK Clinical Commissioning groups)

- Review of choice in End of Life Care – the Governments response (Local Authority / Kirkwood Hospice / General Practice / GH & NK Clinical Commissioning groups)

- Provision of Comprehensive Care to meet the needs of those at End of Life (a review of services and to scope the possibility of the introduction of a lead provider model). (GH & NK Clinical Commissioning groups) **Note** as this develops all providers will be engaged and contribute to a full service specification.

- Quality, Innovation, Productivity and Prevention. – through admission avoidance and the roll out and use of the Electronic Palliative Care Co-ordination system. (GH & NK Clinical Commissioning groups, General Practice)

Although these are four distinct work streams they do not sit in isolation of one another, given that the objectives of the strategy are being incorporated into the service review; the choice at end of life recommendations have been incorporated into the strategy and that EPaCCS is referenced across both strategy and review of choice.

Both CCG's 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, while reducing health inequalities for our local population. This will include the development of integrated models of care provided by a collaboration of organisations, enabling and empowering patients and their carers to access care in the most appropriate place with a focus on integrated and holistic care pathways. This will be supported by population based budgets, with the intention of a resulting shift in activity out of hospital and into more appropriate settings, ensuring patients are managed more effectively at or as close to home as possible. This is in line with national imperatives to move to more integrated systems of care, with an evolving role and function of both Clinical Commissioning Groups.

Work stream activity

3.1 Kirklees integrated End of Life Care Strategy

The aim the integrated end of life care strategy and vision was to set out integrated strategic priorities for end of life care in Kirklees.

It has drawn on information from previous strategies, commissioning documents, existing knowledge, current work programmes and national guidance. Patients will be engaged in the implementation of the strategy making use of existing forums and reference groups.

This overarching set of strategic priorities is based on an underpinning Outcomes Based Accountability analysis. The action plan described below sets out the response to the shared Kirklees priorities.

It has been developed by lead representatives for commissioning bodies in Kirklees including Kirklees Council, Kirkwood Hospice, North Kirklees and Greater Huddersfield and in consultation with provider organisations such as Locala.

Under five categories a set of objectives was defined by commissioners as the aspiration for a comprehensive end of life offer. These are reproduced below:

3.1.1 Discussions as end of life approaches

- People, carers and their families are encouraged to discuss their end of life needs as early as possible with relevant professionals. Professionals need to feel able to broach this subject and have the skills to do this sensitively. This will facilitate the development of a timely co-ordinated care plan that most effectively meets their needs and wishes.
- Further steps are taken locally to tackle the taboo for the public and professionals around about discussing death and dying as a life event.

3.1.2 Assessment, care planning and review, co-ordination of care

- People nearing end of life are identified and recorded in GP Practices so that a co-ordinated care plan is in place that can be shared by those staff and professionals supporting patient/ carer/ family, both in and out of hours.
  GHCCG and NKCCG will continue to implement Electronic Palliative Care Co-ordination Systems (EPaCCS) (locality registers) or equivalent systems in Kirklees as a means of supporting this. Work is currently being undertaken to develop a frailty model within North Kirklees, of which a key component is earlier identification of those nearing the end of life.
- People at the end of life have a care coordinator identified.
- End of life care pathways are incorporated into the Care Close to Home model, paying specific attention to requirements as part of implementation of the Care Act.

3.1.3 Delivery of high quality care in different settings, care in the last days of life

- Improve were necessary, end of life care for those in residential and nursing homes by developing targeted information and training for staff within residential and nursing care homes.
- Improve were necessary, end of life care for those in acute hospitals by developing targeted information and training for staff.
- Ensure that people are not prevented from dying in a place of their preference by process/ systems barriers (e.g. lack of access to specialist equipment such as profiling beds).

3.1.4 Care after death

- Ensure that recently bereaved people have timely access to information about relevant services such as bereavement support.

3.1.5 The whole end of life pathway

- Ensure that individuals, carers and their families' experiences actively influence and shape local services.
- Ensure that non specialist staffs receive appropriate and effective education and training on an ongoing basis through a more co-ordinated approach across partners in Kirklees.
- Ensure that families and carers are supported through the whole end of life pathway**.**
- Develop use of End of Life Champions across Kirklees.

Under each of these criteria a set of actions was identified and has formed the basis to develop a consistent approach to end of life care. See table below.

3.2 Review of choice in End of Life Care – the Governments response- Document to be embedded

What's important to me? - A Review of Choice in End of Life Care was published in February 2015.

30 recommendations were made within this paper and the Government responded to those recommendations in 2016.

As a means to gauge the Kirklees offer each recommendation was considered by all partners and a position was recorded against the recommendation, this is now being cross referenced to the strategy to ensure that the strategy remains current, reflects best practice and continues to be fit for purpose.

The six ambitions contained within the 'Ambitions for Palliative and End of Life Care - A national framework for local action 2015-2020' have also been incorporated into the strategic view:

Ambition	**Description**	**Joint Strategy**	**Review of choice – local position**
Each person is seen as an individual	*I, and the people important to me, have opportunities to have honest, informed and timely conversations and to know that I might die soon. I am asked what matters most to me. Those who care for me know that and work with me to do what's possible.*	Roll out EPaCCS across Kirklees, noting when full coverage of all GP practices will be achieved and any follow-up and/or which will be necessary in the future. Baseline assessment of bereavement support options available in Kirklees to identify any gaps and look at how support can be made more consistently available across Kirklees. Ensure local information for people, family and carers is available at all stages of the EOL pathway to support people to be able to come to terms with and plan end of life care, understand services that are available both during end of life and following death.	EPaCCS evidences the conversations around choice and preferred priorities of care. Currently incompletely applied, but continue to promote EPaCCS. The challenge for local authorities and is being flagged up at strategic joint Health and Social care forums. Enhanced SCR to make sharing EoLC choices easier for our EMIS practices, could use codes for Personal care plan as a mark of these conversations having happened and look to monitor and improve. Need to be clear where to signpost carers to - carers count or other relevant agencies. Kirkwood service designed to support carers: • pressure area care • moving and handling • monthly Coffee retreat • peer support and that of the professionals. • Care and Share' group – info and networking for carer's • bereavement support Carers work within GP practices for up-to-date figures of identified patients. This is monitored via Carers Champions PPT meetings. Carers Count and the route to accessing Carers Assessments in line with the Care Act. Practices across Kirklees have been encouraged to identify and record patients who are approaching the last year of life.

Ambition	Description	Joint Strategy	Review of choice – local position
Each person gets fair access to care	*I live in a society where I get good end of life care regardless of who I am, where I live or the circumstances of my life.*	Raise awareness to address public perceptions of the role of Hospices Review existing EPaCCS template and explore if necessary, whether the existing template meets the needs of all stakeholders. Develop central point of access for information and signposting on bereavement support.	24hr helpline for specialist palliative care advice. Kirkwood is now 'open' to admissions 7 days a week. Discussions and documenting the discussions, around preferred priorities of care is the key. Locally there is fast track funding approved. Fast track pathways manage and review for 8-12 weeks. Following this the service user will be allocated care via Brokerage. This function has been included within the Prior Information Notice- and will form a key element of the accompanying service specification. Locala End of Life Care Champions
Maximising comfort and wellbeing	*My care is regularly reviewed and every effort is made for me to have the support, care and treatment that might be needed to help me to be as comfortable and as free from distress as possible.*	Review assessment protocol for access to specialist equipment (e.g. profiling beds) for Fast track end of life care and amend if necessary to ensure appropriate and timely access to relevant equipment.	Although the commissioning of care co-ordinators differs across Kirklees, with North Kirklees commissioning care co-ordinators within Locala, the function is also covered by a variety of HCPs. Where these discussions take place they need to be documented and coded. Anecdotal information suggests that that this does happen, although is difficult to evidence. This will be influenced by using EPaCCS. Health care professionals need to have the skills and education to feel confident in having these conversations and also be able to recognise dying.
Care is coordinated	*I get the right help at the right time from the right people. I have a team around me who know my needs and my plans and work together to help me achieve them. I can always reach someone who will listen and respond at any time of the day or night.*	Explore access to EPaCCS template for all relevant health and social care across adult and children's services (including residential and nursing care), professionals including independent sector staff (dependant on access to SystmOne) Explore available data on conditions and care packages for people at the end of life. Explore which data could make up a meaningful 'Dashboard' on End of Life Care to inform commissioning, Map existing services, roles and responsibilities available to support end of life care across Kirklees Develop 'Dashboard' for ongoing monitoring of end of life care. Develop an integrated commissioning plan for training and education which looks at specific needs of different professionals. This will include the development of EOL Champions.	Included in EPaCCS as is the care co-ordinator information but not consistently completed. GP is usually the named responsible clinician and this overlaps with the requirement for all to have a named GP. Even though the GP is named responsible clinician, further work is required to develop co-ordinated care across different teams and workforces. Community services have a role to play, and this could be developed further Discussions and documenting the discussions, around preferred priorities of care is the key. Part of the EPaCCS template. In the core plus element of the primary care strategy we are looking to include EoLC in the LTC section especially for COPD, heart failure and dementia.

Ambition	Description	Joint Strategy	Review of choice – local position
All staff are prepared to care	*Wherever I am, health and care staff bring empathy, skills and expertise and give me competent, confident and compassionate care.*	Explore what training resources are currently available for professionals to help them to broach the subject and support people making decisions • Collate current resources. • Training leads to meet and share best practice. Identify variations in quality of end of life care across residential and nursing homes. Draw on any good practice to target training and other interventions where needed to improve quality. This will include: • Developing stronger links with Kirklees Residential Care team. • Exploring contract monitoring information in nursing homes. • Working with Kirklees Council to explore current issues and develop/source targeted information and agree how to disseminate • Reviewing training and education role of Kirklees Home Care Support Services. Links to wider piece of work on quality to be overseen by Physical Wellbeing, Ageing Well and Independence Integrated Commissioning Group. Links to training strategy.	Training is currently provided by Kirkwood who provide sessions on communications skills of varying length and depth. Also around care planning with the addition of HEE. There are ongoing training, monitoring and feedback to S1 practices relating to EPaCCS, its use and take up. The EOLC champions training for Locala is based on these core competencies and is underpinned by the Ambitions document Integrated End of Life Care action plan included an action to review existing training. This was completed and led by Kirkwood. The next step is to develop the integrated training plan which is also being led by Kirkwood. EoL community partnership funded groups exist. Taking training to practices. To work on opportunities for training – short courses / master class options / GP / junior doctor / locally.
Each community is prepared to help	*I live in a community where everybody recognises that we all have a role to play in supporting each other in times of crisis and loss. People are ready, willing and confident to have conversations about living and dying well and to support each other in emotional and practical ways*	Develop public information/ awareness-raising about end of life considerations to help to break down taboos etc. • Review existing national / local resources/ evidence available to explore what works. • b) Develop joint communications response and deliver as appropriate. Explore potential role of *Connect to Support online E Market place/ information resource and Gateway to Care as a means of raising awareness of end of life issues, breaking down taboos, providing information in one place. Identify, collate and share summary of existing feedback from individuals and their carers including the national voices survey, Kirkwood/ Forget Me Not Hospice/ Martin House patient engagement information, CCG patient engagement information.	EoL community partnership funded groups. List of voluntary organisations locally who have a particular role in EoLC are available. These are promoted via a poster within communities. Work has included setting up a dedicated EOL area on Connect to Support containing relevant info/ service etc. including bereavement services. Kirklees Community Partnerships have also been working on commissioning community contracts. Funding three organisations to establish community activity for people who have been diagnosed with a life-limiting condition and are within the last 12 months of their life.

Ambition	Description	Joint Strategy	Review of choice – local position
Each community is prepared to help - **continued**	*I live in a community where everybody recognises that we all have a role to play in supporting each other in times of crisis and loss. People are ready, willing and confident to have conversations about living and dying well and to support each other in emotional and practical ways*	Potential to link to development of Dashboard as noted above Reps on Stakeholder groups to advise on appropriate information sources	In June 16 for organisations already running activity and those which would like to start activity, along with other stakeholders including Kirkwood Hospice and potentially Locala. The aim was to look at what the Kirklees offer would be and how we could promote it, including discussion on any barriers and how these may be overcome. Community Partnerships have produced publicity (**Directory On-A-Page**, of activity groups for Kirklees residents living with life limiting conditions and illnesses.) for GPs and waiting areas/other public places has helped to get out and they are hoping that they will help with getting people into the activities. More info available, voluntary sector can be great help in bridging the gap Integrated End of Life Care Vision and Action Plan developed with Health and Wellbeing Board oversight.

3.3 Provision of Comprehensive Care to meet the needs of those at End of Life

Following a review of the end of life related grants it was decided that the scope to bring services across the whole of Kirklees under one commissioning arrangement be considered. This developed into the End of Life Prior Information Notice (PIN).

It was decided that a soft market test should be carried out to consider whether there were suitable provider/s and appetite within the market for this service area.

The purpose and content (abridged) of the PIN/RFI is articulated below, and was presented to market as follows:

- This is a Request for Information (RFI) published on behalf of the Clinical Commissioning Groups.
- The purpose was to gauge market interest and potential for introducing the development of a lead provider for End of Life services.
- The commissioners are seeking expressions of interest to meet the needs of the Kirklees community.
- The statutory duties of the CCG will remain with the CCGs with service delivery via a service specification and MOU.
- End of life care has been identified as a priority programme for the commissioning partners of Kirklees and any expression should reflect the objectives of the Kirklees strategy - 'High quality, person/family centred care for people at the end of life'.
- The service will operate, providing seamless high quality services to the population of Kirklees, demonstrating interdependencies with all sectors.
- Services will be delivered to meet the defined care pathway.

This exercise closed in November 2016, and resulted in 8 expressions of interest. A working group have met to discuss the results of the exercise. The next steps include making a recommendation to the joint SMTs to develop a collaborative approach to create a lead provider arrangement. The paper has been produced and will be on the agenda for 10th February 2017.

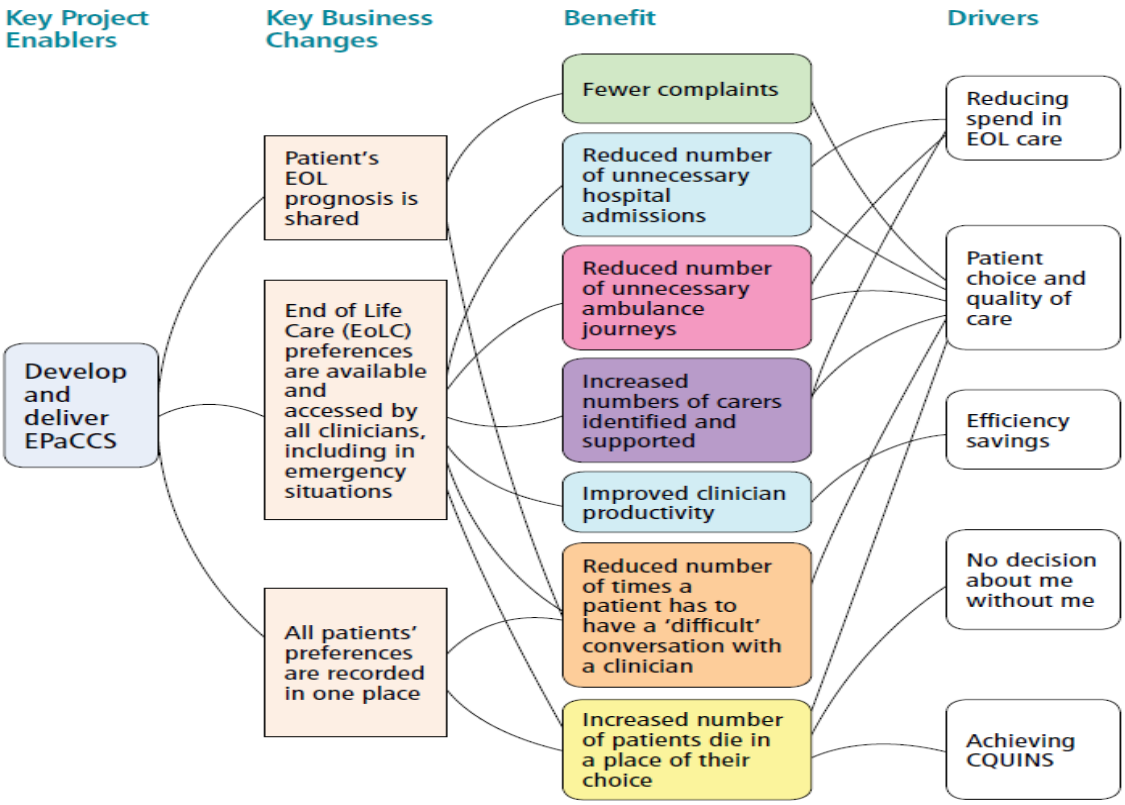
3.4 Quality, Innovation, Productivity and Prevention

3.4.1 EPaCCS

The End of Life Care Strategy (2008) identified the need to improve co-ordination of care, recognising that people at the end of life frequently received care from a wide variety of teams and organisations.

EPaCCS enable the recording and sharing of people's care preferences and key details about their care with those delivering their care. The systems support co-ordination of care and the delivery of the right care, in the right place, by the right person, at the right time.

Statement 8 of the NICE Quality Standard for end of life care for adults published November 2011, also recognises the potential of EPaCCS, highlighting the importance of effective care co-ordination and of standardised documentation. The standard identifies locality registers or other systems as a mechanism for facilitating effective care co-ordination.
Key outcomes that the EPaCCS can deliver:



3.4.2 Local implementation – GHCCG

The rollout for EPaCCS in Greater Huddersfield was carried out between February and April 2015 to all SystmOne Practices. All 23 practices received a practice visit from a multidisciplinary team.

EPaCCS records can be accessed by any professional who may be caring for a patient; including their GP, district nurses, specialist nurses, hospice services and some hospital services. The EPaCCS records are particularly useful for professionals such as out of hours doctors and night nursing services who may be less familiar with a particular patient. Recording this information in one place allows easy access to it, preventing repetition, duplication and aiding decision making. The EPaCCS also acts as a library for useful information that can be accessed by healthcare professionals either for their own use, or for patients and their carers to use.

Within Greater Huddersfield EPaCCS continues to be promoted within practices and a small increase (2.75%) in usage has been noted. The tool has also been marketed with Local Care Direct to ensure that the OOHs service is aware of and able to access the tool.

3.4.3 Local implementation- NKCCG

The EPaCCS rollout was launched at a dedicated Practice Protected Time in July 2014. All 29 practices received a practice visit from a multidisciplinary team and provided positive feedback on the benefit they felt EPaCCS would bring. The practice visits also provided the multidisciplinary team the opportunity to promote relevant services and signpost practices to training and education opportunities.

From the outset, the agreed aims for the project were:

•Improving communication across boundaries of care– including handover to Out Of Hours, and anticipatory prescribing
•Improving and supporting early identification and intervention of patients at end of life, to reduce unnecessary A/E attendances, admissions and length of stay and improve planning for transfer of care.
•Enabling reliable data for strategic and transformational planning
•Improving the consistency of recording of EOL QOF indicators and CQUINs measures
•Improving the quality and efficiency of existing Gold Standards Framework meetings

Data from EPaCCS has been promising, showing that compared to the baseline (deaths in the last 12 months on the QOF register) EPaCCS deaths show:

- Increased percentage for those with an Advance Care Plan documented
- Increased percentage of patients with OOH Handover form completed recorded
- Increased percentage for those with DNACPR recorded
- Increased numbers of those with a preferred place of death recorded

In addition, a positive impact on GSF reported by practices and district nurses. Training sessions have been held for LCD and Locala district nurses, with EPaCCS referred to positively in the Mid Yorkshire CQC report (2014) for Community End of Life Care.

The work to embed EPaCCS within North Kirklees has been supported by the lead GP for EOL care, who has visited practices to discuss ways of improving the recording of patients approaching their last year of life and to ensure practices are completing the EPaCCS template correctly. All practices have received targeted resources disseminated through locality cluster meetings, and 8 practices have requested a follow up visit from the lead GP for EOL care, with a further 6 visits scheduled in 2017. All practices visited have received a resource pack and have provided positive feedback as to the value of the visits.

3.4.2 Admission avoidance

North Kirklees CCG has undertaken a project with Kirkwood Hospice, to investigate the impact of the hospice's services upon unnecessary secondary care admissions. A monthly report is produced detailing the numbers of appropriate admissions prevented and patients supported to die in place of choice.

4. Locala update

4.1 Introduction

In Kirklees, approximately 3,800 people die each year. Based on national projections the number is expected to rise by 17% from 2012 to 2030. The percentage of deaths occurring in the group of people aged 85 years or more is expected to rise from 32% in 2003 to 44% in 2030.

Approximately three quarters of deaths are expected, which for Kirklees is 2,850 people, there is potential to improve the experience of care in the last year and months of life for these people, and those close to them, each year.

The approach to supporting patients, carers and professionals is multi– faceted to ensure we deliver quality evidence based care.

4.2 Integrated Community Care Teams (ICCTs)

The Locala ICCTs provide comprehensive assessment and planning throughout the individual's end of Life Care Pathway.
The principle of one co-ordinated care plan with a single professional care co-ordinator, co-ordinating care for end of life patients and their carers is in place. Specialist Palliative Care Nurses working with the hospice have access to Systm One and sharing modules between themselves and Locala colleagues, along with the implementation of the electronic palliative care co-ordination system (EPaCCS) will support improved communication.

4.3 Electronic Palliative Care Co-ordination system

Locala instigate the process of Advanced Care Planning by discussing the persons and their families end of life care needs. These discussions and wishes are recorded in the system. This ensures the individuals preferences are known and communicated.

4.4 Individualised care of the Dying Document (ICODD)

The doctors and nurses in our hospitals, hospices, care homes and in the community are dedicated to caring well for people who are dying. We also want to support their families/carers at what can be a very difficult time. It is vital that we get the important things right for the dying person, which will be different for each one, so we use an individualised care document for people in the last few days of life.
The individualised care of the dying document is used when the team of doctors and nurses have treated any reversible causes for a person's deterioration, and consider the person to be dying from their illness and in the last few hours or days of life.

The ICODD which was created around the five priority areas as described by the Leadership Alliance in March 2014. These priorities which are of equal value cover:

- The possibility that a person may die within the next few days or hours is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly.
- Sensitive communication takes place between staff and the person who is dying, and those identified as important to them.
- The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.
- The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.
- An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, coordinated and delivered with compassion.

The ICODD is being used with minor adjustments to each clinical setting across Kirklees and Calderdale within the hospice and acute setting and is being rolled out with in the Community/Primary care setting.

4.5 Verification of Expected Death

Nurse verification of expected death commenced in Jan 2015 within Kirklees/ Calderdale. This is fully supported by the current Coroner Martin Fleming. Nurse verification has impacted upon family and carers support and welfare at one of the most emotive and difficult times during a person's dying pathway. This encompasses the Commissioning Carers principle 3 of the right care, at the right time, in the right place. We have had some fantastic feedback stories around this for example:

Just to let you know I verified my first patient death last week, I was a bit nervous at first. The patient had died at 5.30pm and I attended at 6.30pm, the funeral director collected the person at 7.15pm. The family were really pleased that everything was done quickly and efficiently and they weren't waiting around for hours for an Out Of Hours GP to attend.

4.6 Care Homes Hospital Bag Scheme

The Care Home Transfer bags are used to transfer standardised paperwork, medication and personal belongings with the resident throughout their hospital episode and are returned home with resident. The standardised paperwork will ensure that everyone involved in the care for the resident will have necessary information about the resident's general health, e.g. baseline information, current concern, social information and any medications, on discharge the care home will receive a discharge summary with the medications
This is progressing to a trial pilot within Calderdale and Huddersfield Foundation Trust. The joint working of all health and social care colleagues will support transfer of residents from care home to acute trust setting.

4.7 Care Homes

Consultant clinics held in care homes where complex residents can be referred for assessment and plan of care put in place.
Collaborative working with the acute trust has resulted in improved discharge summaries ensuring the care home has a written plan of care.

The Care Home Support Team have created a personalised information booklet to support Advanced Care Planning.

Education and training in care homes include a guide to advanced care planning for care staff in residential and nursing homes.

4.8 Case Study

66 year-old resident with advanced dementia for 16 years, bed bound and reduced swallow reflex. History of weight loss - admitted with aspiration pneumonia.

Advice for care home and GP - After long discussion with the residents daughter and the medical consultant Dr Seebass, it was agreed that repeated hospital admissions are not in the best interests given the progressive and incurable nature of her condition. Admission to hospital causes unnecessary distress to her. In future if she exhibits new symptoms these should be managed by the GP. This includes oral antibiotics and symptomatic relief. Unfortunately the "111" service will not be aware of these complex care planning decisions and will in all likelihood call an ambulance, it is for this reason that she will always need to be reviewed by a GP (including out of hours) in order to treat her in the home and not in hospital. We have made the Care Home Support Team aware of this lady in the hope they can assist you with the management of this patient going forward. We have made a referral to the community Hospice team. If this lady develops symptoms we recommend that these are managed in the home with palliative care medicines and simple non-distressing medical interventions. Please ring the hospice hotline if you require help with this and cannot get advice from the GP.

4.9 MDT Collaboration

Care Home Support Team (CHST) arranged MDT – Daughter, care home and GP – agreed palliative plan. Resident died in care home peacefully
Daughter contacted CHST following relative's death to thank team for their input and professionalism – it made all the difference to ensure a peaceful death.
GP noted excellent, informative and clear discharge letter from CHFT (evolutionary process with working with consultants and being clear about escalation plan).
GP – without consultant support difficult to make decision about ongoing care, young age and time constraints.

4.10 Training

Macmillan Nurse Specialist provide Gold Standards Framework Training to designated care homes.
End of life Care training and support is provided to all care homes, these training sessions range from one off sessions to a structured programme.
EOL Champions training is available to 25 staff per year within Locala over a five year period.

EOL care training is offered to all Locala colleagues with a range of options.

Care Home Support Team provide training to the care homes in south on a range of subjects which includes EOL. This is linked to the Macmillan nurse specialist training.

5. Kirkwood Hospice update

Kirkwood Hospice (KWH) provides a broad, comprehensive range of services to people in Kirklees. The services which the Hospice delivers (and commissions) provide holistic care including practical, social and psychological, spiritual and religious support as follows (see Appendix One) for further details of these services and their impact:

- In-Patient Hospice Care - 16 beds at our purpose built site in the centre of Kirklees*
- Support and Therapy Centre for Day Attendance
- Support and Therapy Centre Drop-In service for patients and carers
- Educational / Support Programmes for those with life-limiting conditions
- Community Specialist Palliative Care Team including Admiral Nursing for people with dementia at end of life.
- Lymphoedema Follow-Up clinic
- Out-Patient Consultant Clinic
- Specialist 24/7 Advice Line for professionals, patients and carers
- Family Care Team - specialist emotional and psychological support including counselling for adults and children before or after bereavement

As well as providing outstanding care for people with life-limiting illnesses, their families and loved ones, we also support fellow professionals through education, training and advice. Whether colleagues are looking for information, advice, care or support, KWH is on hand to help.

KWH has been involved in the development of the Kirklees Strategy for End-of-Life Care and, having made significant contributions to the progress made to date, is very supportive of the direction of travel. In addition, KWH is committed to increasing the level of its voluntary funding to grow investment in local services. KWH believes that this commitment will create opportunities for service developments in the future in collaboration with its partner CCGs.

- KWH successfully coordinates the care of nearly 1400 people every year – nearly 90% are supported to die without requiring Hospital admission at the end of their life
- KWH has been leading the development and delivery of end-of-life care services in Kirklees for nearly 30 years
- KWH is held in the highest regard by the local community for the quality of care that we deliver. Local people are very protective of what is an important local charity
- KWH provides almost £3million of voluntary funding to commission our palliative and end-of-life care services for people in Kirklees
- KWH delivers significant social value in the local economy deploying a network of 800 volunteers (the largest in Kirklees) delivering benefits for people with life limiting illness

KWH continues to innovate and improve the quality of end-of-life care that is delivered and is completely embedded within the local system, working in partnership with all local providers and commissioners.

The KWH strategic plan Let That Moment Be Now illustrates the priority for the Hospice to reach more people who have palliative care needs before the end of life. The plans which are well underway are to reach more people with diseases other than cancer and to reach people from different parts of the community in Kirklees that have not traditionally accessed Hospice or palliative care services. One example is that In 2015 KWH commissioned a report from Healthwatch Kirklees regarding the understanding and perceptions of South Asian groups on end of life services in Kirklees.

KWH has continued to influence local services and strategy through its involvement, with other commissioning partners, in developing the Kirklees Integrated End of Life Care vision and also shaping the services offered through the Care Closer to Home contract. The Pathway objectives described in the CCGs' Prior Information Notice were developed as part of this vision, which we contributed to. Of all the organisations involved in providing End-of-Life Care in Kirklees, KWH is confident that it is achieving most of these objectives already, for the people that are known to us.

I. *People are informed as early as possible about the approach of end of life to enable informed decision making about their preferences.*

As a specialist provider KWH does this as standard. KWH is the local expert in Advanced communication skills and Advance Care Planning, we provide education to other professionals (e.g. Locala, CHFT and YAS) to enable improvement in the practice of generalist professionals.

II. *End of life care is timely, compassionate and reflects their needs and wishes as far as possible with respect to physical, social, psychological, cultural and spiritual aspects.*

This objective describes the ethos of Hospice care that Kirkwood has developed over the past 30 years. A comprehensive Multidisciplinary team (MDT) gives us the ability to meet the full range of needs more comprehensively than any other provider in Kirklees.

III. *People during end of life phase remain in a place of their preference where possible avoiding unnecessary hospital admissions.*

KWH continues to be successful in supporting people to avoid a Hospital admission at the end of life. In 2015-16 of all the people that KWH cared for, 725 died, all but 77 (11%) were supported to die away from Hospital.

IV. *Pain and other symptoms are managed as effectively as possible.*

KWH has developed a system of recording Patient Reported Outcome Measures (PROMs), which effectively capture symptoms and functional status of people accessing specialist palliative care services. This development is at the forefront of practice nationally and is not replicated elsewhere in Kirklees. Appendix six is a paper that provides a summary of this development and how it relates to pain and other patient needs.

V. *All people in Kirklees die with dignity and in a place of their preference.*

KWH leads the practice of advance care planning in Kirklees and as part of this establishes the preferred place of care for people at the end of life. At Appendix Eight there is information regarding the achievement of preferred place of care. 81% of the people we care for achieve their preferred places of care.

VI. *People and their carers feel supported both during end of life care and after the person has died.*

KWH provides support to everyone who is significant to the dying patient, this support is provided both pre and post bereavement. People are supported to continue to function as well as possible when they have been affected by the death of someone after a life limiting illness.

VII. *People and their carers are engaged in the co-production of services and service developments linked to end of life care.*

KWH was born out of the Kirklees community's desire to have high quality care for people at the end of their lives. Our board of Trustees are the representatives of the local community who direct and shape services to meet the needs of local people. In addition, every two months we hold the Kirkwood Future Forum, which invites service users to feedback and contribute to ideas for service development.

6. LA update

The joint work relating to the End of life Strategy has already been described above.

In addition to this the Council has supported a number of community grant funded initiatives to improve services to those people at the end of life and their carers.

Updating the connect to support and the Kirklees website to be an accurate reflection of the services available and an effective signposting service to the residents of Kirklees.

7. Future areas of work

- Continued implementation of EPaCCS- associated governance routes/joint working across Kirklees despite there being separate acute footprints for NK/GH
- Training and education
- Care closer to home
- Delivering against the strategy
- Lead Provider Framework

8. Other initiatives

- **Admiral Nurses**

  Jacqueline Crowther has recently been appointed at Kirkwood Hospice in a 2 year fix term post. The new service is a first of its kind in Yorkshire, made possible thanks to an innovative partnership between Kirkwood Hospice, Dementia UK and Kirklees Council. Jacqueline will work closely with GPs and Community Nurses across Kirklees to offer support when it is needed, when dementia advances or when end of life approaches. Training will also be offered to organisations that support people and families living with advanced dementia. There are currently 9 admiral nurses in the area (including Jacqueline's post,) 184 admiral nurses in total in the UK.

  The only other gap identified at the launch of this service was to have an admiral nurse within the acute setting, as we don't have this at the moment.

- **Learning Disabilities – EoL Care**

  The CCG commissioned St Anne's to produce a short video and training package 'Doing It My Way,' a comprehensive guide in End of Life Care for people with learning disabilities. The guide and DVD are part of an End of Life pack –also including the Probabilities of Life Expectancy tool and the Standards we aim to meet. I have attached the training document but as you know we are still 'looking' for the short film on the shared drive.

  There is also the LeDeR Mortality review process which has started recently – reviewing all deaths of people with a learning disability (4-74.) This is led by the University of Bristol and we have people within the CCG/SWYPFT who have been trained as reviewers. Further training is to be scheduled as the time capacity for reviews is quite demanding alongside peoples day jobs. I can give much more info on this if you need it.

Table of Progress and Amendments

Version	Date	Created by / Amendments made by	Comments
1 Initial draft	10th Jan 17	Peter Kirkman	Initial draft
2	11th Jan 17	Sadaf Adnan	Amends and NK additions Version circulated to partner organisations for input (12th Jan 17)
3	16th Jan 17	Peter Kirkman	To incorporate **Vicky Dutchburn's** comments and amendments.
4	19th Jan 17	Peter Kirkman	To incorporate **Rachel Foster's** input into the paper to reflect Locala activity.
5	19th Jan 17	Peter Kirkman	To incorporate additional info provided by **Nikki Gibson-Windle** on other initiatives.
6	19th Jan 17	Peter Kirkman	To incorporate **Michael Crowther's** input into the paper to reflect Kirkwood activity.
7	20th Jan 17	Sadaf Adnan	To incorporate **Dr Bilal's** comments and amendments from a NK perspective as well as minor formatting amendments.
8	20th Jan 17	Sadaf Adnan	To reflect appropriate elements of NKCCG's Operational Plan.
9 Final draft	23rd Jan 17	Peter Kirkman	Formatting and addition of Council references based on known activity and telephone conversation with **Phil Longworth**.

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HEALTH AND SOCIAL CARE SCRUTINY PANEL (V18)

Members: Cllr Liz Smaje (Lead Member), Cllr Fazila Fadia, Cllr Steve Hall, Cllr Judith Hughes, Cllr Andrew Marchington, Cllr Sheikh Ullah, Peter Bradshaw (Co-optee) , Christopher Horner (Co-optee), David Rigby (Co-optee), Sharron Taylor (Co-optee),

Support: Richard Dunne, Principal Governance & Democratic Engagement Officer & Helen Kilroy, Principal Governance & Democratic Engagement Officer.

POTENTIAL ISSUES IDENTIFIED FOR INCLUSION IN THE WORK PROGRAMME 2016/17	
ISSUE	**APPROACH AND AREAS OF FOCUS**
FULL PANEL DISCUSSION ISSUES	
<u>Early Intervention and Prevention (EIP)</u> Investing early in prevention and early intervention of adult social care can reduce or delay the need for costly crisis intervention or care service and improve the outcomes for individuals <u>All Age Disability (AAD)</u> The All Age Disability offer refers to people with lifelong disabilities and the key aim of the programme was to ensure the best start in life, promoting health and resilience throughout life by implementing a more flexible and personalised approach with few age barriers for people with a disability.	A progress checkpoint on the EIP and AAD was considered by the Panel on the 6th September 2016 which included: • Timeline and overview of the EIP programme and the work that has been undertaken • Focus on Learning Disability • An opportunity for scrutiny to have input into the draft strategy • An update on EIP Early Help consultation and engagement • An update on YPAT and what starting to find out from consultation so Panel can have an input into what is being developed • That the report include progress on AAD and a summary of the implementation plan <u>Panel meeting 10th January 2017</u> The Panel considered a report giving an overview of the complex work of the Early Intervention and Prevention (EIP) programme and a current position statement. The Panel also received a presentation showing the draft EIP Budget 2016-19 and EIP workstreams and decision timelines. The Panel agreed to receive updates on a number of EIP workstreams, namely:- • Learning Disabilities for Adults and Children – to include Learning Disability budget; recruitment and retention and AAD – scheduled for consideration by the Panel on the 25th April 2017; • Adults Pathway (to include supporting carers, volunteering, community capacity building, grant funding) – scheduled for consideration by the Panel in July 2017;

	• YPAT – short breaks and respite care – scheduled for consideration by the Panel in June 2017.
<u>Mental Health Services – Transformation Programme</u> South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) provides community, mental health and learning disability services to the people of Barnsley, Calderdale, Kirklees and Wakefield. SWYPFT is currently working through a major service transformation with a focus on : recovery; putting more people in charge of the care they get; provided more support to people when they need it; helping people to leave hospital when they are ready; and ensuring that GP's stay at the heart of care.	Panel to receive an update on the progress of the wider Transformation programme with a focus on specific strands of the programme to include: • Acute and Community (early in new municipal year to include milestones and timescales for change) • Rehabilitation and Recovery. • Specialist Adult Learning Disability Health Services. • Older People (early in new municipal year as per Acute and Community) The Panel will also consider the feedback from the recent CQC inspection to include the CQC action plan. <u>Quality Summit – 14 July 2016</u> CQC presented key findings from inspection and was followed by the Trust's response. A plan outlining the actions that will be taken to address the issues highlighted by the inspection will be submitted to CQC by 9 August 2016. A copy of the plan will be circulated to panel members and a decision on next steps will be taken at the Panel meeting in September. 23 September 2016 - the CQC Action Plan was circulated to the Panel, next steps to be discussed a next meeting. 10th January 2017 - the SWYPFT CQC Inspection Core Service 'Must Do' action plan was circulated to the Panel for comments.
<u>Yorkshire Ambulance Service</u> During 2015/16 the Panel received a presentation from YAS on performance, demand and quality of services. This was followed by a more detailed analysis of performance data in Kirklees which highlighted an issue on the response times in the rural areas of the district. YAS NHS Trust has been working on a transformation agenda with stakeholders. The negotiations have seen	The Panel will continue to focus on the performance, demand and quality of services with a particular focus on: the red call response times; an evaluation of the impact on any actions taken to address performance; consider the performance of NHS 111 service; and relevant workstreams from the West Yorks Urgent & Emergency Care Vanguard Programme. <u>Panel meeting 1st November 2016</u> The panel considered a presentation from YAS regarding their Transformation Programme.

some major changes to the service based on the challenges being faced by YAS.	The Panel agreed to receive a further update from YAS on the 25th April 2017 covering the following areas:- • A more detailed analysis of the response times (tail end of performance); and • The outcomes of the YAS Transformation Programme in relation to the whole of Kirklees.
<u>Diabetes in Kirklees</u> Concerns were raised by the Panel in September 2015 regarding prevalence and impact of diabetes in Kirklees. Key areas of work being undertaking by Public Health, CCGs and Locala include prevention, supported self-care/education, primary care, foot care and specialist diabetes services – and on a shared equality objective on improving access, experience and outcomes for South Asian people with diabetes	<u>Panel meeting on 8th March 2016</u> The Panel considered an update report on Diabetes work in Kirklees and agreed to receive:- • Progress update on the level of amputations in North and South Kirklees, including statistics (NKCCG and GHCCG – Vicky Dutchburn to lead); • Report from Locala on the Gold Standard foot care in Kirklees; • That officers from Greater Huddersfield CCG and North Kirklees CCG investigate the Panel's suggestion that the Diabetes's Networks in both North and South Kirklees work together for the benefit of Kirklees, rather than being on Acute Footprints alone, and provide a progress report to a future meeting of the Panel. <u>Panel meeting on 12th April 2016</u> The Panel considered a briefing note on Diabetes related food disease and Amputations in Kirklees and agreed to consider a future report giving more detail on minor amputations. Panel has agreed to schedule a discussion on the 4th October 2016 to include: • More information on minor amputations to include an update on actions being taken to improve outcomes in Kirklees and reduce the incidence of diabetic foot disease and amputations; • The approach and work that is carried out across Kirklees on eye screening; • The role of Locala in developing a care closer to home model for diabetes; • An update on the diabetes networks with a focus on how the networks in North and South Kirklees are working together. • Incident statistics for Diabetes <u>Panel meeting 4 October 2016</u> The Panel presented with an update and information on actions and planned work to

	support people in Kirklees living with diabetes. Actions agreed at the meeting include: • Update on actions to improve diabetic foot health to include timescales to be submitted as soon as possible – this will provide a baseline for progress at next full update. • CGGs to provide a written update for discussion by the Panel. • Public Health to confirm availability of diabetes app when MyHealthtools module on diabetes is launched later in the year. <u>Panel meeting 10th January 2017</u> The Panel considered an update report prepared jointly by North Kirklees and Greater Huddersfield CCGs and Locala on the current position on Diabetes in Kirklees. The Panel noted that some of the issues included within the report would come up in the discussions with Locala on the Changes to Podiatry Services – due to be considered by the Panel in March 2017 (date to be determined).
<u>Attention Deficit Hyperactive Disorder (ADHD) – Adults</u> Attention deficit hyperactivity disorder (ADHD) in Adults is a neurodevelopmental disorder which presents with symptoms of inattentiveness, hyperactivity and impulsiveness	Update reports on this issue to be considered by the Panel (briefing paper saved in Informal Meeting folder for H&SC on 9.2.16) focussing on the re-commissioning of Adult Services. Panel have agreed to schedule a report to be considered on the 4th April 2017.
<u>KJSA Development</u> KJSA is seen as the local foundation of priority setting, informing commissioning strategies and plans and helping local people to hold providers and commissioners to account. The strategy provides the framework for joint commissioning plans and specific, detailed commissioning plans for the NHS, social care and public health. The JSA was being refreshed during 2015/16.	Panel has agreed to schedule a discussion at the December meeting to include: • An overview of the process that is followed in the development of the KJSA • Presenting an example of the work that is carried out on updating a section of the KJSA • Outlining the approach that is taken to implementing actions to address the issue(s) and monitoring progress. <u>Panel meeting 4 October 2016</u> Panel has agreed to drop the item from the December meeting and reschedule at a later date. Panel have agreed to schedule a report to be considered on the 7th March 2017.

Care Closer to Home (CC2H) Clinical Commissioning Groups (CCG's) in Kirklees, in line with the national agenda and planning guidance are shaping proposals that will provide integrated care that is delivered at or closer to home.	Panel meeting 12th April 2016 – North Kirklees CCG to provide evidence on the activity that has taken place to support the plans to reduce bed capacity by 44 at Mid Yorkshire Hospitals NHS Trust. Panel to maintain an overview of the operational and strategic aspects of the programme across the whole of Kirklees to include: • Assessment of capacity • Monitor progress of the implementation of the CC2H programme. Panel have agreed to schedule a report to be considered on the 7th February 2017.
End of Life Care Greater Huddersfield CCG and North Kirklees CCG have set out integrated strategic priorities for end of life care in Kirklees that has included input from Kirklees Council, Kirkwood Hospice and Locala.	Panel to maintain an overview of the work to develop an integrated approach for end of life care in Kirklees to include: • Assessing the consistency of standards of care and support across Kirklees. • Monitoring progress of the strategic priorities. The Panel have agreed to schedule a report to be considered on the 7th February 2017.
North Kirklees CCG (NKCCG) Key transformation programme NKCCG are currently developing a number of initiatives as part of a wider transformation programme that will be designed to help support the delivery of a sustainable health and social care service across the district.	The Panel will focus on a number of elements of the transformation programme to include: • Planned care – plans to undertake more planned activity at the Dewsbury & District Hospital • Urgent care – Work being done to manage more effectively referrals into hospital by looking at whole pathway of care and identifying patients that could be supported and seen by primary care. • Specific focus on plans to utilise the capacity of the Walk-in Centre in Dewsbury to help alleviate pressures in A&E. Panel have agreed to schedule a report to be considered on the 7th February 2017.
Proposed changes to the Podiatry Service in Kirklees Locala Community Partnerships won the contract to provide podiatry services in Greater Huddersfield and are	Lead Member will have initial discussions with CCG's and Locala and decide if the issue should be escalated to the wider Panel to consider if the changes are deemed to be a substantial development or variation in health service.

currently developing proposals that will: reduce the service locations; provide daily clinics with longer opening hours in the new locations; and review the pathway of care.	28 April 2016 – Lead Member has met with Locala and CCG's. Panel meeting 1st November 2016 The Panel considered an update from Locala and Greater Hudds CCG on the proposed changes to the Podiatry Service. The Panel agreed that the proposed changes posed a significant change to public service and agreed to scrutinise the proposals. In November 2016, the Panel requested that the Public Consultation document be amended to take account of the Panel's comments before it was sent out to the Public, as follows:- • The Consultation Document to advise that the CCGs have delegated the responsibility to consult to Locala; • The information included in the consultation document should refer to the 2011 Census; • Proposal 1 should advise that the proposed changes affect the whole of Kirklees; • The proposals do not make any reference to people with mechanical mobility problems and this should be outlined, including information relating to what impact the changes will have on people which needs to be clearly explained within the proposals and consultation document; • The Consultation document refers to making some changes to Podiatry Services, but should 'set the scene' of what the proposed changes are early on in the document. • The proposals should make a connection between the early engagement and the proposed consultation. The Panel agreed to hold an additional meeting of the Panel to scrutinise the proposed consultation on the changes to podiatry services in Kirklees.
Pre-Payment Cards and Direct Payments The introduction of pre-payment cards is a new initiative being explored by the Council as a potential way to address some of the issues and challenges arising from Direct Payments to people who choose to manage their own personal budgets for arranging adult support and care.	A report was considered by the Panel on the 6th September 2016 giving an update following the introduction of pre-paid cards as a method of administering Direct Payments (DP) to Service users. The Panel agreed to receive an information report on the 7th March 2017 on the Review of Direct Payments, to include information regarding the Audit.

<u>Quality of Care in Kirklees</u> During the 2015/16 municipal year the Panel met with CQC to discuss ways it could strengthen their working relationship and to receive an update on the inspections of health and social care providers that had taken place in Kirklees.	The Panel has agreed to continue to focus on the work and activity of CQC to include: • Looking at the quality of provision of Care homes in Kirklees with a focus on those homes that have been rated as 'requires improvement' • To establish if the inspections highlight any common areas for improvement. • To arrange a further update from CQC once all initial inspections in Kirklees have been completed (projected for September 2016) and assess the overall state of care in the district. Panel have agreed to schedule a report to be considered on the 4th April 2017.
<u>Primary Care Strategy</u> Greater Huddersfield CCG (GHCCG) and North Kirklees CCG (NKCCG) have developed Primary Care Strategies which are seen as being key elements of their respective strategic work programmes.	The Panel will review both strategies to include: • Establishing if there any specific elements from the strategies that require a more detailed assessment • Monitoring the implementation of both primary care strategies • Include development of GP Federations (initial discussions to be carried out informally) and performance indicators. Panel have agreed to schedule a report to be considered on the 4th April 2017.
<u>Kirklees Sustainability and Transformation Plan</u> NHS England is requiring every health and care system to come together, to create its own ambitious local blueprint (Sustainability & Transformation Plan) for accelerating its implementation of the Forward View. The local NHS planning process will have significant central money attached and Sustainability and Transformation Plans (STPs) will become the single application and approval process for being accepted onto programmes with transformational funding for 2017/18 onwards.	Panel to maintain a close overview of the development of the Kirklees and West Yorkshire STP and provide regular feedback to the wider Panel. Panel to consider a report on the 4th October 2016, to include:- • An explanation (background and context) of the plan; • Details of performance indicators and how they will be monitored. • Context of how fits in with West Yorkshire Transformation Plan <u>Panel meeting 4 October 2016</u> The Panel were presented with an update on the process for developing Kirklees and West Yorks STPs which includes the current financial position of CCGs. The update included details of a consultation called 'Talk Health Kirklees' which will outline plans to reduce costs and provide better value for NHS spending. Actions agreed: • Outcomes of the Talk Health Kirklees consultation to be discussed at the meeting 6 December 2016.

	• Panel to receive revised version of electronic copies of the Health and Wellbeing presentation on STP following the presentations at the CCGs Governing Bodies meetings.
<u>Talk Health Kirklees Campaign</u> Outline plans from Greater Huddersfield and North Kirklees CCGs to reduce costs and provide better value for NHS spending.	<u>Panel meeting 6 December 2016</u> The Panel considered a report on the 'Talk Health Kirklees' Campaign outlining the current consultation process. In December 2016, the Panel agreed to comment on the Consultation report on findings and fed back to Greater Huddersfield CCG. The Panel made the following recommendations to be considered by the CCGs:- • That the CCGs consider the response of the Health and Social Care Scrutiny Panel and that the above issues raised by the Panel are taken into account as part of the CCGs decision making process. • That the CCGs provide a proposal for the Scrutiny Panel which gives assurance that future consultation will be as robust as possible. In January 2017 the Panel received a copy of CCGs response to the Panel's comments on the Talk Health Kirklees Consultation report on findings. The Panel noted that a further report would be provided by the CCGs outlining the implementation timescales – date to be determined.
<u>The Healthy Child Programme (0-19 services)</u> Responsibility for commissioning 0-5 children's public health services transferred to Local Government on 1 October 2015. The service specification was protected until the end of March 2016 which Public Health (PH) has extended for a further 12 months. As part of a review of the services PH will be developing a new 0-19 services model.	Panel to maintain an overview of on the development of the service. <u>1 November 2016</u> Panel has received information that provides an overview of the Healthy Child Programme (HCP) specification; an explanation of the procurement process; and overview of the programme works; and the process that will follow the award of contract. An update of progress has been scheduled for the 7 March 2017 meeting

<u>Wellness Model for Adults</u> The wellness approach goes beyond looking at single-issue, healthy lifestyle services with a focus on illness, and instead aims to take a whole-person and community approach to improving health. Based on self-care and intervening as early as possible but as late as necessary, it is clear that individuals who manage their own lifestyles are healthier, more productive, have fewer absences from work, and make fewer demands for medical and social services. Kirklees currently commissions separate services for smoking, physical activity, obesity, self-care etc. such as PALS, Health Trainers and a variety of third sector/NHS providers. The skills needed to promote behaviour change are broadly similar and some areas (Durham, Leeds, Derby, Halton) are redesigning integrated wellness services that are able to react more flexibly to the problems presented by people and also better react to emergent concerns such as type II diabetes and cancer prevention. The Wellness Model will support the aims of New Council to empower people to live their lives to the fullest possible potential by enabling people to increase control over their health through making changes to their lives. It will support the NHS 5 Year Forward View and Sustainability and Transformation Plans by diverting people from primary and secondary healthcare services towards prevention pathways, helping to contain rising healthcare costs. Pathways will be streamlined and consideration will be given to self-referral, drop-in and outreach approaches.	The Panel will consider a report on the 7th March 2017 focusing on the following areas:- • Review of emerging evidence in relation to Wellness models and evidence from the Joint Strategic Assessment about levels of need and community assets that might influence the design of the model. • Review of design principles for Wellness Model. • Understanding possible approaches to integration of provision, including strategic and operational delivery structures. • Review of collaborations and partnerships across public health commissioned services. • Understanding how services outside public health commissioned services might engage with new models (social care, NHS, community engagement, third sector etc) as they emerge. • Substance Misuse Services - Local Authorities are now responsible for commissioning substance misuse services to meet the needs of their communities. Kirklees Council will be re-commissioning these services during 2015/16. Panel to receive updates on the re-commissioning of services; an overview of the work of this service and how this will link to the work being undertaken in developing the Wellness Model.

Re-Procurement of the Whitehouse Centre The Whitehouse Centre is a general practice run by Locala under an Alternative Provider Medical Services (APMS) contract and provides services for vulnerable groups who have difficulty in accessing mainstream health services. The centre is commissioned by Greater Huddersfield CCG who are currently embarking on a tendering process to re-procure the services provided at the centre.	Initial briefing to Panel to outline the process that is being followed.
CQC Inspection of Calderdale and Huddersfield NHS Foundation Trust CQC carried out an inspection of the Trust in March 2016 as part of CQC's comprehensive inspection programme. In addition to this planned programme the CQC also undertook two unannounced inspections on the 16 and 22 March 2016. The Trust received an overall rating for both hospital sites as 'Requires Improvement'.	6 September 2016 - Representatives from Greater Huddersfield Clinical Commissioning Group briefed the Panel on the key findings of the inspection and outlined the next steps. A quality summit is likely to be scheduled for October 2016 and an action a plan developed by the Trust to address key issues highlighted by the inspection. A copy of the plan will be circulated to panel members to help inform a decision on next steps. 10th January 2017 – copy of the action plan circulated to Panel for comments.

LEAD MEMBER BRIEFING ISSUES	
Robustness of the Adult Social Care System The Care Act 2014 sets out local authorities duties to assessing people's needs and their eligibility for publicly funded care and support. The process for assessments can be complex and the speed, efficiency and robustness of the approach will determine the quality of the service and the level of care and support that an individual receives.	The Panel will consider a report on the 6th December 2016 which will focus will focus on a number of areas of the process that is followed in Kirklees to include: • Timescales from initial request to assessment being carried out to include volumes. • Looking at the experience and qualifications of staff carrying out the assessments • the approach/process that is followed in providing the ongoing support including how work is distributed between qualified adult social care workers and non-qualified case workers • Look at national guidance/examples of good practice. Panel meeting 6th December 2016 The Panel considered a report on the 6th December 2016 which outlined the approach taken by Adult Social Care to improve the robustness of the Adult Social Care system. The Panel agreed to receive further information on the following areas:- • Staff shortages within Learning Disabilities; • Milestones on how the new Quality Assurance Framework was working. The Chair of the Health and Social Care Scrutiny Panel agreed to keep a watching brief on this issue and report back to the Panel when appropriate.
Integration of Health and Social Care The integration of Health and Social Care is at the centre of government reforms and there is a greater focus and duty by health and wellbeing boards and clinical commissioning groups to promote integration between health and social care. The focus on integration is strongly linked to the development and guidance indicates that there is an expectation that the STP must cover better integration with local authority services, including, but not limited to, prevention and social care, reflecting local agreed health and wellbeing strategies.	Lead Member to keep watching brief on the development of the Integration of Health and Social Care.

Changes to the GP Contracts and implications for Kirklees GP practices operating in the GHCCG area currently hold different contracts with NHS England and are paid different amounts for providing core GP services. PMS (Personal Medical Services) contract (which is locally agreed) includes a premium for providing additional services (over and above 'core' primary services). As a rule practices who have PMS contracts are better off than those with GMS contracts. Following a review of the PMS contract all practices will be moved onto a core funding contract and to ensure equitable funding the additional funds from the PMS contracts will be more fairly distributed across all practices.	8th March 2016 – The Panel agreed to receive an update at a future meeting on the Changes to the GPs Contracts to include: • The implications for GP Practices in Kirklees • Outlining the practices that will suffer the largest loss of funding • An overview of the overall budget 5 July 2016 – Panel has considered a report from Greater Huddersfield CCG on the changes to GP contracts, funding and implications for practices in Greater Huddersfield. Panel has agreed to schedule an update at a future meeting to include the views of those practices that will be disadvantaged by the changes.
The Care Act 2014 (to include Client Financial Affairs) The Care Bill received Royal Assent on 14 May 2014 and introduces major reforms to the legal framework for adult social care. There will be major implications for the Council arising from the implementation of the Care Act 2014.	Lead Member to maintain a watching brief on the Care Act to include: • Impact of the reforms on the council. • Challenges and barriers to change. • Workforce challenges. • Client Financial Affairs
Art Psychotherapy (AP)_ Art Psychotherapy combines psychodynamic theories and techniques with an understanding of the psychological aspects of the creative process.	The AP service is currently not offered in Kirklees and the Panel has received a request to review the service and consider the benefits of establishing the service in Kirklees. Lead Member to receive details from Greater Hudds CCG on what services are commissioned by them instead of AP. The Panel agreed in January 2017 that there is no requirement for any further action at this stage.

<u>NHS Dentistry</u> This is an issue referred to the Panel by Healthwatch Kirklees who identified an issue with people in Kirklees struggling to get access to NHS Dental Services.	Lead Member to keep watching brief during 2016/17 municipal year. (Healthwatch Report to Health and Wellbeing Board in October 2015 on the experience of patients using NHS dentist.
<u>Deprivation of Liberty Safeguards</u> Deprivation of Liberty Safeguards (DoLS) are part of the Mental Health Capacity Act 2005. Last year the Panel noted that the number of DoLS applications being received by the Council was increasing. The increase has been due to the result of a Supreme Court Ruling which has widened the pool of those who might be considered to be deprived of their liberty.	Lead Member to keep watching brief and monitor figures.
<u>Developing a working protocol with Healthwatch Kirklees and Kirklees Health and Wellbeing Board</u> A working together protocol has been developed in recognition of the importance of the three independent bodies (Kirklees Health & Social Care Scrutiny Panel, Kirklees Health & Wellbeing Board & Healthwatch Kirklees) working together effectively.	Wait until Health & Wellbeing Board has completed its development session with the LGA which will include developing effective working relationships.

Mid Yorkshire NHS Hospitals Trust – Cancer Peer Review (of Unknown Primary) The NHS England Cancer Peer review, now known as the Quality Surveillance Team (QST) is a quality assurance programme for NHS Cancer Services. It is aimed at reviewing clinical teams and services to determine their compliance against national measures, as well as the assessment of quality aspects of clinical care and treatment. In March 2016 Mid Yorkshire NHS Hospitals Trust received a letter that formally detailed a number of serious concerns that were identified during a NHS England Cancer Peer review visit.	The Trust has responded to the QST with a plan that includes actions that are designed to address the serious concern. Next steps to be agreed by the Panel but could include reviewing the concerns identified and monitoring progress and delivery of the action plan. Panel has agreed that Lead Member will liaise with the Scrutiny lead at Wakefield Council and report back to the Panel on proposed way forward for monitoring the actions developed by the Trust. The Panel has also agreed to look at the work that is being developed by CCGs across the West Yorkshire to improve cancer services which include improved access to diagnostics and early diagnosis and increased screening. North Kirklees CCG submitted a written update which was shared with the Panel in December 2016 covering the following areas: • Cancer work across Yorkshire and Humber including achievements; • Commissioning Cancer services across North Kirklees and Wakefield Clinical Commissioning Group; • Quality Surveillance Team (QST) Visit – Cancer of the Unknown Primary • Trust's response and action.
SCRUTINY AD-HOC PANELS **(being monitoring by the Health and Social Care Panel)**	
Review of Adult Mental Health Assessments To understand the pathway for Adult Mental Health Assessments in Kirklees from the initial need for referral to assessment and onto treatment. In particular, to explore the current approach and effectiveness of Adult Mental Health Assessments in Kirklees.	The Ad-hoc Panel held their first meeting in April 2016 and agreed to focus on the following areas:- - Access and service provision, eg Single Point of Access (SPA); - Demands on services and capacity locally to respond; - Waiting times and performance for adults accessing the services including those that are provided at home; - Undertake research as part of the remit and seek feedback from providers of support for adults with mental health issues. Progress updates have been provided as and when appropriate to the Health and Social Care Scrutiny Panel. A final report is scheduled for consideration by the Panel on the 7th

	February 2017 and approval by the Overview and Scrutiny Management Committee on the 6th March 2017.
MONITORING ITEMS **Routine follow up to previous recommendations to demonstrate Scrutiny outcomes**	
ISSUE	**FOCUS**
Sexual Health – Chlamydia Screening in Kirklees A report by the Wellbeing and Communities Scrutiny Panel report on Chlamydia Screening in Kirklees was endorsed by Cabinet in April 2014.	The Panel have agreed to consider an update on the monitoring of recommendations on the 25th April 2017.
Tuberculosis (TB) in Kirklees In October 2014 the Panel completed a review of TB in Kirklees in response to the high rates of TB in the district. .	In April 2016 the Panel received an update on TB in Kirklees and progress of the recommendations. The Panel has agreed to continue to monitor the situation in Kirklees to include arranging a further update to cover: • The work being undertaken to reduce TB rates in Bradford and Leeds and to highlight examples of good practice; • Clarification on staffing ratios for the current nursing establishment as per the recommendations from the Royal College of Nursing; • An action plan on the work being undertaken in Kirklees with regard to action being taken to reduce the high levels of TB in the borough. An update report will be considered by the Panel during the 2016/17 municipal year.

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