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Monday 25 September 2017

Notice of Meeting

Dear Member

Health and Adult Social Care Scrutiny Panel

The **Health and Adult Social Care Scrutiny Panel** will meet in the **Council Chamber - Town Hall, Huddersfield** at **10.00 am** on **Tuesday 3 October 2017.**

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

Julie Muscroft

Service Director – Legal, Governance and Commissioning

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

The Health and Adult Social Care Scrutiny Panel members are:-

Member

Councillor Elizabeth Smaje (Chair)
Councillor Richard Eastwood
Councillor Fazila Fadia
Councillor Richard Smith
Councillor Sheikh Ullah
David Rigby (Co-Optee)
Peter Bradshaw (Co-Optee)
Sharron Taylor (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 12 September 2017.

2: Interests — 7 - 8

The Councillors will be asked to say if there are any items on the Agenda in which they have disclosable pecuniary interests, which would prevent them from participating in any discussion of the items or participating in any vote upon the items, or any other 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: Robustness of Adult Social Care — 9 - 28

The Panel will receive a report that outlines the approach taken by Adult Social Care to improve the robustness of the Adult Social Care system.

Contact: Amanda Evans, Service Director for Adult Social Care Operations Tel: 01484-221000

5: Health Optimisation Programme — 29 - 84

Representatives from Greater Huddersfield CCG and North Kirklees CCG will present details of the proposals to introduce new criteria encouraging patients who are overweight and smoke to get fit before undergoing routine surgery.

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

6: Work Programme 2017/18

85 - 94

The Panel will review its work programme for 2017/18 and consider its forward agenda plan.

Contact: Richard Dunne, Principal Governance & Democratic Engagement Officer Tel: 01484-221000

7: Date of the Next Meeting

To confirm the date of the next meeting as 14 November 2017.

Contact: Richard Dunne, Principal Governance & Democratic Engagement Officer Tel: 01484-221000

Contact Officer: Richard Dunne

KIRKLEES COUNCIL

HEALTH AND ADULT SOCIAL CARE SCRUTINY PANEL

Tuesday 12th September 2017

Present:	Councillor Elizabeth Smaje (Chair) Councillor Richard Eastwood Councillor Sheikh Ullah Councillor Richard Smith Peter Bradshaw – Co-Optee David Rigby – Co-Optee Sharron Taylor – Co-Optee
Apologies:	Councillor Jean Calvert Councillor Fazila Fadia
In attendance:	Ruth Aseervatham – Locala Community Partnerships Clair Ashurst-Bagshaw – Kirklees Public Health Matthew Bardon – Kirklees Public Health Rory Deighton – Healthwatch Kirklees Alan Laurie – Kirklees Public Health Carl Mackie – Kirklees Public Health Rachel Spencer-Henshall – Kirklees Public Health Richard Dunne – Principal Governance and Democratic Engagement Officer

1 Minutes of previous meetings

RESOLVED - That the Minutes of the meeting of the Panel held on 25 April 2017 and 4 July 2017 be approved as a correct record.

2 Interests

Co-optee David Rigby declared an interest in agenda items 4 (Kirklees Integrated Wellness Model) and 5 (0-19 Healthy Child Programme, Thriving Kirklees) 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 Kirklees Integrated Wellness Model

Ms Spencer-Henshall outlined the elements of adult wellness services that were currently being delivered that included a mandatory service on health checks.

In response to a panel question on how people were targeted for health checks Ms Spencer-Henshall outlined the process that was followed that included details of the payments to GPs.

In response to a panel question regarding the numbers of people who had accessed the health check programme Ms Spencer-Henshall explained that a key issue for the programme was to target the right people and explained that if a person was already being seen by a GP for a specific illness they were excluded from the programme.

Mr Mackie informed the Panel that a key issue was getting people to take up the letter of invite for a health check and having looked at models elsewhere in the country Kirklees Public Health were considering introducing a mixed model that would include an outreach approach.

In response to a question on whether public health had a base position for understanding the outcomes of what it was looking for Ms Spencer-Henshall informed the Panel that the specification for the Wellness Model would include more details on levels of activity.

Mr Mackie informed the Panel that an early draft of the report on the public engagement work would be available in October and anticipated that the detailed specification would be available by the end of the year.

In response to a panel question regarding concern that the health check programme was focused on certain social groups the Panel was informed that public health wanted to ensure that the programme provided an universal invitation.

The Panel was told that professional and well educated groups were more likely to take up the health check offer than people in the lower socioeconomic groups.

In response to a panel question on whether the wellness model would pro-actively target people who didn't engage with health check invites Ms Spencer-Henshall informed the Panel that targeting of people would be informed by the engagement work provided by the Research Company.

Ms Spencer-Henshall explained that the Wellness Model was about behavioural change and outlined in detail how the model would look to address this.

In response to a panel question on how people who used services on the periphery of the model accessed the main services Mr Mackie informed the Panel of the holistic approach that would be taken to supporting people.

Mr Mackie explained that the Wellness Model would need to work more closely with the wider health and social care services.

Mr Deighton questioned how public health would measure the outcomes of the Wellness Model and how the objectives of the Model tied into the work of the Clinical Commissioning Groups (CCGs) such as the health optimisation programme.

Ms Spencer-Henshall informed the Panel that public health would base its outcomes on what they wished to change and this would lead to performance measures. Ms Spencer-Henshall stated that public health had spoken to CCGs to see how its offer could support the CCGs approach to health optimisation.

Ms Spencer-Henshall informed the Panel that public health did have some concerns that the health optimisation programme could impact on health inequalities and were trying to understand the implications of the programme.

Ms Spencer-Henshall explained that the pathway to surgery could be achieved through the Wellness Model although public health was concerned this approach could end up being a tick box exercise.

Ms Spencer-Henshall outlined in detail the skill set that public health wanted in the Wellness Model workforce.

Mr Mackie informed the Panel of the early findings from the Research Company that included good access to services; the importance of a good relationship with the health professional; and not being constantly passed from one service to another.

In response to a panel question on the costs of targeting relatively small groups of people like smokers and the efficiencies of programmes like weight management the Panel was informed that the Model would be more focused on the wider issues and supporting people.

Ms Spencer-Henshall explained that the Model would be about creating a relationship with individuals and helping people to improve their lifestyles and health.

In response to a panel comment that one way of improving access to the services would be to take the services to individuals the Panel was informed that a key aim would be to make people feel confident in having an honest conversation about their health and lifestyle.

In response to a panel question that there didn't appear to be any reference to alcohol related issues in the Model the Panel was informed the Model was about changing behaviours and alcohol would be an integral part of the programme.

Ms Spencer-Henshall informed the Panel that an element of the outcomes would be very personal to the individual and it would therefore make it difficult to provide explicit outcomes.

In response to a panel question on what pathway GPs would use when referring someone who needed support on weight management or smoking Ms Spencer-Henshall stated that the CCGs Health Optimisation programme had added a layer of complexity and public health needed to sell the Wellness Model's approach of behavioural change to GPs.

Ms Spencer-Henshall outlined the approach that would be taken in having a standard point of entry to the programme although public health had not yet identified how this would work.

Ms Spencer-Henshall informed the Panel that people would be able to self-refer into the programme and the Model would have to provide an easy route for people to access the services.

RESOLVED -
1) That attendees be thanked for attending the meeting.
2) That a further update be arranged at a date to be determined.
3) That the Panel's Supporting Officer be authorised to liaise with attendees to address the agreed actions.

5 0-19 Healthy Child Programme, 'Thriving Kirklees'

Ms Spencer-Henshall informed the Panel that the Healthy Child Programme (HCP) worked on the same principle as the Wellness Model which included a focus on providing a single pathway to a group of services without having to pass individuals from one service to another.

Ms Spencer-Henshall outlined the key areas of progress following the establishment of the HCP in April 2017. Ms Spencer-Henshall explained that mobilisation of the programme was still in the early stages and work was still being done to understand how HCP would fit with the wider work being done by the Council on its early help model.

Ms Aseervatham informed the Panel of the approach that Locala was taking in working with practioners on essential workforce skills. Ms Aseervatham explained how practioners were helping to identify workforce competencies and stated that although it was a time consuming approach it did provide a good base to develop the workforce.

Ms Spencer-Henshall stated that the HCP including a focus on the holistic needs of a family and any existing pathways of support would not be threatened.

In response to a panel question that some schools were being told that they had to buy into the services provided through school community hubs the Panel was informed that although some schools did buy services through the hubs the service provided by the HCP would not be a cost for schools.

Mr Laurie informed the Panel that collaboration of schools was included in the 49 priority areas of the Kirklees Future in Mind Transformation Plan.

The Panel was informed that the HCP was still in the early stages of the contract and although a lot had been achieved it was still too early to assess outcomes.

In response to a question on how existing health professionals who already worked with certain cohorts of children would integrate with the HCP services the Panel was informed that getting staff to integrate was not easy.

Ms Aseervatham explained that Locala had started to work with staff on a voluntary basis by encouraging staff to look at developing skills in other areas that included supporting staff to gain professional accreditations at university.

Ms Aseervatham outlined in detail the teams that were providing services in the community hubs and explained that the workforce was deployed on the basis of need.

Ms Aseervatham informed the Panel that the HCP workforce was working with Child and Adolescent Mental Health Services (CAMHS) and work was still ongoing to integrate more with social care.

Ms Spencer-Henshall stated that the Leeds City Council model of social care was similar to what public health and Kirklees Council were trying to achieve through the HCP.

Ms Spencer-Henshall informed the Panel that the HCP would be adapted to fit the emerging Kirklees children's offer although this would not include a specific focus on safeguarding.

In response to a panel question on how public health would ensure that there was a cohesive offer in Kirklees Ms Ashurst-Bagshaw informed the Panel that there was a work stream that was focused on ensuring that the re-design of children's services was developed in the right direction.

In response to a panel question on progress in reducing the waiting times to CAMHS in Kirklees Mr Laurie informed the Panel that no progress had currently been made. Mr Laurie explained that the focus on reducing waiting times had required changes in working practices which had been done and work was now taking place to prioritise reducing waiting times.

Mr Laurie informed the Panel that as part of the refresh of the HCP the 49 priority areas were likely to reduce to 20 and public health would be happy to provide more details on the priority areas once they had been agreed.

In response to a panel question about what happened to service pathways and the Single Point of Access for individuals who went through the transition from 0-19 services to adults services the Panel was informed that every service should provide the required support to help an individual with the transition.

Ms Spencer-Henshall informed the Panel that there was a need to ensure that there was a consistent pathway into both children's and adult services and the Council would need to be clear about the routes into the services.

In response to a panel question on the work that was being undertaken to develop a rigid cancellation policy as part of the actions to improve CAMHS waiting times Mr Laurie explained that every effort would be made to ensure that individuals that did not show for appointments were contacted in order to provide them with every opportunity to access to the service.

Mr Laurie informed the Panel that the referral service would receive details of individuals who hadn't attended appointments to see if they could try re-engage with them.

In response to a panel question on how public health intended to extend the Auntie Pams model into other localities Ms Spencer-Henshall outlined the work that would be done on peer and group support and training volunteers.

RESOLVED -
1) That attendees be thanked for attending the meeting.
2) That the Panel's Supporting Officer be authorised to liaise with attendees to address the agreed actions.

6 Work Programme 2017/18

The Panel reviewed progress of its work programme 2017/18.

Cllr Smaje outlined key areas of the Panel's planned activity which included the work that the Panel would need to undertake on reviewing the Kirklees Suicide Prevention Plan.

RESOLVED -
That progress of the work programme and forward agenda plan be noted.

7 Date of the Next Meeting

RESOLVED - That the date of the next meeting be confirmed as 3 October 2017.

KIRKLEES COUNCIL			
COUNCIL/CABINET/COMMITTEE MEETINGS ETC **DECLARATION OF INTERESTS** Health & Adult Social Care Scrutiny Panel			
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 Adult Social Care Scrutiny Panel

Date: 3 October 2017

Title of report: Robustness Of Adult Social Care.

Purpose of report: To describe the approach taken by Adult Social Care in order to continuously improve the robustness of the Adult Social Care system.

The report will:

- Describe and evidence the current developments and approaches in place to ensure the quality and sustainability of social care services and compliance with statutory duties contained within the Care Act 2014.
- Identify areas for further development and proposals to ensure continuous improvement.

Key Decision - Is it likely to result in spending or saving £250k or more, or to have a significant effect on two or more electoral wards?	**not applicable** **If yes give the reason why** .
Key Decision - Is it in the Council's Forward Plan (key decisions and private reports?)	**not applicable** **If yes also give date it was registered**
The Decision - Is it eligible for call in by Scrutiny?	**not applicable** **If no give the reason why not**
Date signed off by Strategic Director & name **Is it also signed off by the Service Director for Finance IT and Transactional Services?** **Is it also signed off by the Service Director for Legal Governance and Commissioning Support?**	**Richard Parry, 20 September 2017** **not applicable** **not applicable**
Cabinet member portfolio	**Cllr Cathy Scott and Cllr Viv Kendrick**

Electoral wards affected: **All**

Ward councillors consulted: **Not applicable**

Public or private: Public

1. **Summary**

Shaping the future of adult social care is a priority. There are some fundamental challenges including rising demand, aging populations, health inequalities and long term conditions. This is against a backdrop of reduced resources, budget challenges and the need to transform service delivery to ensure a sustainable care offer for the future.

This report provides an overview of new ways of working, what has been achieved to date and what is in view for the future. It aims to demonstrate the robustness of Adult Social Care.

2. **Information required to take a decision**

The report has been prepared for the Health and Social Care Scrutiny Panel as part of the annual programme cycle.

3. **Implications for the Council**

3.1 Early Intervention and Prevention (EIP)

The interface with EIP and Adult Social Care is integral to growing communities and encouraging self-care and resilience.

3.2 Economic Resilience (ER)

Adult Social Care promote wellbeing and resilience through growing opportunities for adults to benefit from education employment and training.

3.3 Improving Outcomes for Children

Adult Social Care promotes a think family ethos and works jointly with children's social care. Joint work has been promoted by the work of the Children and Adults Safeguarding Board and the Health and Wellbeing Board.

3.4 Reducing demand of services

The redesign of Adult Social Care has a key focus on reducing demand. Public perception around new ways of working requires focus.

The development of a sustainable market is a key priority to meet local need and reduce system pressures.

3.5 Other (e.g. Legal/Financial or Human Resources)

New ways of working impact positively on savings and efficiencies across adult social care, evident in the MTFP Transformation Programme.

4. **Background**

Adult Social Care is facing significant challenges in the context of rising demands, reflecting demographic growth, and reducing resources. The changing demographic means that we will see increasing demands for care for older and disabled people. The Council's approach to this has been to focus on early intervention and prevention. Our "Vision for Adult Social Care" (http://www.kirklees.gov.uk/beta/adult-social-care-providers/pdf/adult-social-care-vision-kirklees.pdf) highlights our approach which is to enable people stay independent for

as long as possible, reducing the need for or the length of time they may have to rely on state support

People who use services should be able to expect person centred care and support that is safe, effective, caring and responsive. This care should be supported by strong leadership and sustained by good use of resources. In order to achieve this a transformation programme is underway in Kirklees to redesign service delivery in Adult Social Care. This is being progressed through five work streams:

- Front Door
- Care offer
- Sufficiency
- Commissioning
- All Age Disability.

Each work stream seeks to redesign services to ensure optimum efficiency through making best use of technology and developing opportunities for people to self –serve wherever possible and appropriate. The principles of early intervention and prevention are key to maximising outcomes for people, managing future demand, meeting needs through proportionate, responsive services and through providing timely advice, information and signposting to alternative services to meet individual need.

Also see section 8.

As outlined in the previous Scrutiny report there are particular challenges in relation to the social care workforce, both for the council and for providers of services including care homes and domiciliary care. These challenges present risks associated with the quality of care and support which are monitored through robust performance management and contract monitoring arrangements.

5. New ways of Working

The Care Act 2014 requires Local Authorities to consider the person's own strengths and capabilities and what support might be available from their wider support network or within the community to help when determining their needs and how they may be met. This strengths based approach promotes independence through self-care, and enables individuals to make informed choices in relation to their health and wellbeing (SCIE-Strengths Based Approaches). The implementation of a strengths based approach requires cultural and organisational change. A number of Cultural Change events have taken place early in September 2017 with around 250 staff in attendance following the circulation of a paper outlining the intentions for future ways of working. These events helped communicate the next steps of our Adult Social Care Vision across our workforce. **See appendix 1; New Ways of Working Paper**

Leadership Development Days are scheduled for in September and October 2017 for Adult Social Care Team Managers and Deputy Team Managers. These development days will focus on Care Act Legal Literacy with a focus on how the Care Act promotes the need to work with strengths base approaches. It is felt that is timely to revisit the Care Act to ensure that middle managers maximise their opportunity to embed culture change. Thereafter we will explore the need for managers to lead culture change at team level.

In order to enhance partnership working in localities two operational Heads of Service have been appointed to focus on the North and South of Kirklees. This will strengthen partnership working, provide opportunities for strengthening multi disciplinary approaches through Place Based Models where integrated working enhances community services and customer experience. Opportunities for working as multidisciplinary, multi- agency teams

with co-terminus boundaries arranged around GP practices are being developed with Locala to co-ordinate care and support across services.

Teams are being reorganised into community hubs alongside colleagues from Community Plus. The Early Intervention and Prevention (EIP) focus in communities will focus on growing community capacity, accessing and developing specific community services that meet local need. A key priority is to map local services and need across each locality. An EIP structure will maximise this opportunity. **See Appendix 2; EIP Structure to be implemented.**

Two Heads of Service for Adult Social Care Operations, North Kirklees and South Kirklees, have been appointed to lead Adult Social Care Independent Living Services and the Community Wellbeing Social Care Teams. These posts will ensure strong interfaces with our partners and will work closely with Mid Yorkshire NHSTrust, North Kirklees Clinical Commissioning Group; Calderdale and Huddersfield NHS Trust and Huddersfield Clinical Commissioning Group. The Head of Service for All Age Disability provides a leadership focus on supporting children and young people, transitions into adulthood and adult learning disability. A Head of Safeguarding and Quality is appointed to lead strategic safeguarding, relationship management with partners and the Safeguarding Adults Board, quality and performance. **See Appendix 3; Head of Service Structure.**

The Community Wellbeing Social Care Teams in the North will move in to Batley Town Hall in October and Dewsbury Town Hall in December. The South teams will be based in the Civic Centre in Huddersfield initially with a number of practitioners moving into Slaithwaite Town Hall early in April 20l8.

In a move away from teams arranged around stages within a customer's journey, new teams will undertake assessment, reviews and safeguarding interventions, thereby reducing handoffs and providing greater efficiency and continuity of care. These new arrangements will be in place by Dec 2017.

6. The state and resilience of the various strands of the ASC market.

The Domiciliary Care Market

In common with many other Local Authorities, Kirklees Council is facing capacity challenges in relation to the availability of domiciliary care. All providers are reporting recruitment and retention issues as workers find alternative employment, often within the retail sector. The introduction of the National Living Wage (NLW) has seen salaries in other industries rise and so has had an overall negative impact on the care sector as a whole, as workers find alternative employment.

Problems with recruitment and retention can have an impact on quality. We have been undertaking a range of activity to try to address the capacity issues and increase the availability of domiciliary care for those who need it most.

This work includes:

- Direct support for organisations in relation to the recruitment and retention of care staff – including the establishment of a Facebook Page – In2Care Kirklees – which directly links people seeking work in care with employers trying to recruit and is proving very effective.
- Reviewing and increasing the rates we pay for domiciliary care to better reflect the pressures providers are facing and enable better wages to be offered (see below).
- Introducing a "per visit" payment for visits to people living in more rural locations to take account of the longer travelling times between calls – these payments are transferred through to the care workers (see below).

- Introducing more “single handed care” – i.e. using newly available equipment to enable care workers to safely transfer and support people on their own, rather than having to have two workers as is currently the case. The current pilot is reducing the number of double-ups needed by over 50%. This not only frees up care workers to be used elsewhere but reduces the overall costs and supports family carers as well.
- Exploring opportunities to increase the availability of Personal Assistants (PAs) who people can pay for using their own money or a Direct Payment – this kind of work can be more attractive to some people as they are able to develop a relationship with a particular person or small group of people – and the Council is looking to increase the number of people who want to work as PAs.

New Contracts

The Kirklees’ contracts for domiciliary care have just been tendered and awarded. We used this exercise as a further way to address the capacity issues we are faced with.
The primary outcome we were aiming to achieve from this process is the delivery of high quality, reliable, domiciliary care to vulnerable people. Within the scope of the tendering exercise we were also aiming to achieve the following:

- **Sufficiency of Supply** – to avoid any waiting lists and to support the whole health and social care requirements
- **Have a range of provision** - to enable people who self-fund / use Direct Payments to have a choice of providers.
- **Equity of access** – so that no matter where people live in Kirklees they are able to access quality home care.
- **Sustainable quality** – ensuring that we are able to have close working relationships with our contracted providers to oversee quality and address any concerns early.
- **Best Value** – whilst paying a fair and sustainable price for care.
- **Ensure compliance with procurement rules** – local, national and international.
- **Least disruption for service users** – through encouragement of TUPE transfer of staff wherever possible.

Prior to tendering we undertook wide consultation with providers and people currently using services. Specific soft market testing with current providers and commissioners in nearby authorities has been used to inform our specification, pricing and overall approach. We have used feedback from service user quality visits and discussions via Partnership Boards to ensure we are aware of the priorities from a service user and carer perspective.
Based on this feedback and our local experience and knowledge, we took the following approach:

- Increasing the maximum number of hours we would purchase from any one provider (from 1,200 hours per week to between 2,000 and 3,000 hours) – with the aim of creating a more resilient team of staff in each organisation, making them less vulnerable to a sudden loss of workers and achieving economies of scale in relation to overheads
- Reducing the number of localities in which we are procuring / arranging care, from 12 to 6, with a principal provider in each delivering the bulk of the work and then a series of spot providers (on a framework contractual arrangement) delivering smaller amounts. This will enable us to balance the need for larger volumes of work with key providers which helps with ongoing resilience, whilst still encouraging the existence of other providers in the area to support choice to people who self-fund / use DPs and to offer some support if a provider fails or is unable to take on new work for a period. We also believe this will facilitate natural zoning of care staff, enabling more walking rounds and reducing the travel time between calls. This should also help with local recruitment as there will be fewer companies chasing the same number of potential staff.

- We have reviewed the price we pay per hour and it has been increased to reflect the costs that providers are facing, especially the travel costs.
- At the same time we are introducing compulsory Electronic Call Monitoring (ECM) to ensure we are only paying for the care delivered and so that we can spot check on delivery to our more vulnerable users
- We have shared with providers what prices we believe are fair in relation to staff wages, based on the rate we are paying. We intend to encourage them to pass on this price increase to front-line workers which in turn will improve recruitment and retention.

The new domiciliary care contracts have now been awarded and staff transfers are underway. In line with our stated aim of least disruption for service users, we are encouraging the TUPE transfer of staff where this is needed.

7. The State and Resilience of the Adult Social Care Market as a Whole

The situation in relation to domiciliary care, noted above, is also reflected in other areas of the social care market for similar reasons. It is a particular difficulty for domiciliary care as the added burden of travel can make recruitment and retention difficult. However, even in residential and day service provision the recruitment and retention of suitably able and qualified staff remains a challenge.

The care home market is facing significant pressures – the Care Quality Commission is changing its approach to regulation and we are seeing a number of care home owners decide to leave the market due to some of these changes. The recruitment of nurses is especially difficult for care homes and a number of homes have decided to stop offering nursing care as a result. This is a challenge for commissioners as the growth in demand for care homes, now and in the coming years, is specifically for nursing care and for dementia nursing care. The Clinical Commissioning Groups (CCGs) and the Council are working together to try to address this and the "Kirklees Older People's Care Homes Strategy" **(http://www.kirklees.gov.uk/beta/adult-social-care-providers/pdf/accommodation-strategy-op-care-home-strategy-2016.pdf)** includes details of actions we are taking to try to improve the situation.

Kirklees has had an approach in place, since 2002, to amend the rates we pay for older people's care homes annually. This takes into account the financial pressures faced by care homes such as National Living Wage, fuel costs and increased food prices etc. Whilst this has been very useful in keeping care home providers in the market, we are increasingly seeing care homes requesting higher fees and asking for top-ups from residents / families in order to remain sustainable.

The Council also works closely with care providers to be sure that we understand their difficulties. We are working jointly with the CCGs to ensure that we can offer the right support to providers to encourage them to remain in the market.

In an effort to prevent provider failure, and by way of support, we have established the CHESP meeting (Care Home Early Support and Prevention). This meeting has joint health and social care membership and is focussed on identifying early signs of provider failure. The CQC also attend and provide information relating to enforcement action taken. Issues that arise following health and social care staff visits are fed into the meeting then an action plan offering support is devised. Good practice events are held for all care home staff and training organised by Kirklees Council can also be accessed. The Independent Sector Care Home Meeting offers an arena in which to consult with, share and listen to providers.

We are further developing extra care and supported living for people which provides a genuine alternative to residential care for many, enabling people to be more independent but

in a safer environment and achieving some economies of scale by having care staff in one place.

The Council has also recently produced a revised "Market Position Statement" http://www.kirklees.gov.uk/beta/adult-social-care-providers/pdf/kirklees-adults-market-position-statement.pdf which provides information to providers and potential providers about the kind of support that residents will need and the likely demand. As more people opt to use Direct Payments (and their own funds) to commission their own care and support, having a range of choices for them to access is increasingly important.

The Council's "Connect to Support" E market place gives people access to 250 providers of care and support operating in Kirklees offering over 3,000 products and 600 services – the second largest in the region. The Kirklees Connect to Support website has approximately 500 registered users who have full use of the site including the facility to send information requests to providers and to purchase services directly (users don't have to register to use the site)

Whilst the situation in relation to social care remains challenging, we have good working relationships with our current providers and are well placed to attract new ones into the local market. We will continue to work, as commissioners, on maintaining and developing these relationships to deliver a sustainable social care market for the future.

8. Performance Management and Sector Led improvement in Adult Social Care

The Council is a key player across all regional ADASS Performance, Quality and Informatics networks with good representation across all Y&H sector led improvement activity. This supports a culture of transparency, peer review as well as peer learning and improvement. Through this process the Council has sought several opportunities for external challenge, support and review – this includes the recent LGA Peer Review on Integration.

Regional relationships also support a robust approach to benchmarking and an understanding of the Council's performance against other regional Councils.

A summary of Adult Social Care key performance areas are provided below:

Outcome	**Performance Summary**
People who may have an eligible need for social care have access to a range of support and networks, and are engaged in decisions, that help them live their lives	**Front Door Demand** (referral) trends at the front door highlight a significant reduction of almost 7% when compared with the same period last year. EIP approaches are highlighting some positive impact on parts of the system and the Council's understanding of the volatility of demand is increasing which helps mitigate the level of risk. **Assessment** activity through the last 20 weeks highlights a decline, with **Timeliness of Assessment** and **Outcomes from Assessment** remaining below expected levels. 73.1% of Assessments were completed within 28 days The service is actively taking action in this area through targeted operational improvement plans with social work teams. **Reviewing** performance remains below expected targets with data indicating 63% of service users receiving a review of their care during the year. The service is responding to this through the transformation programme.

Service Users and Carers feel in control of planning their care and support, with timely and accessible services that enable them to remain as independent as possible	**Reablement**: performance against KPI remains below the performance plan (outturn 80% against plan of 94%). Kirklees**' offer of reablement** also remains low (% of older people discharged from hospital are offered the service). The service is responding to this through the transformation programme sufficiency project. **Long Term Care:** Data shows growth in 18-64 admissions to residential/nursing care. Work is ongoing to understand if this is due to the Domiciliary capacity issues across the market or the complexity of demand. 6 out of 10 people in Kirklees who use social care services report they do not feel services help them feel 'in control'. The service is responding to this through the transformation programme. **Direct Payments and Self Directed Support** - Performance trends in this area remain stable/consistent with performance in line with other Y&H Councils.
Support to carers is effectively coordinated, co-operative and enables carers to continue to care for as long as they are willing and able to do so	**Carer Quality of Life:** some variation in QOL of carers (based on biennial Carer survey), further work being done through the Carers Strategy Group and Carer Networks to address this. **Carer and Service User Experience/Satisfaction:** it has been recognised that satisfaction of Carers and Service Users with ASC remains below expectations and this is being addressed via the Front Door workstream. **Carers Feeling Involved as Expert Care Partners:** feedback suggests carers in Kirklees feel less involved or consulted about the support provided to the cared for person. Pathway redesign work is focussed on ensuring both the culture as well as the social care pathway are conducive to identifying carers as key care partners, e.g. through more inclusive carer / service user assessments. **Service User and Carer Access to Info:** Kirklees' Front Door and broader information offer retained an overall 'Excellent' rating through the annual ADASS Mystery Shopper exercise, with some positive examples of mystery shopper experiences in the report (e.g. out of hours) along with areas of customer access/experience which will need further consideration (e.g. call waiting times, information/advice linked to safeguarding, info on the website).

9. Achieving Excellence and Quality Assurance

The quality assurance framework, "*Achieving Excellence in Adult Social Care Practice",* was produced in consultation with managers within the service. It reflects national Professional Capabilities Framework for social workers and Health and Care Professionals Council guidance. It sets out principles to improve social care practice and develop standards of excellence. The approaches included a Quality Implementation Group (now known as the Quality Impact Group), use of case file audits and Director's Audit Clinics. These were intended to highlight good practice and identify areas for improvement to feed into a quality improvement cycle overseen by Senior Leadership. The framework was launched in April 2016 with events for front line staff, managers and partner agencies.

Achieving Excellence in Social Care Practice update and looking to the future events took place in May and June 2017 for front line staff, managers and partner agencies. As well as updating on quality assurance these events included themes of working with people with dementia and mental capacity assessments. These are ever important areas of work in adult social care and had been identified as areas for improvement from audit results. The events were well attended and well received.

A review and recommendations for the QAF was to be completed in July. It was delayed as the new audit tool is intended to be based on an ADASS strength based peer audit tool which has been in development. The review and recommendations will therefore be submitted to Senior Leadership in September 2017.

Quality Audits

Quality audits in line with the framework commenced in May 2016. Compliance with the schedule has been good. Managers have had support around quality of auditing, analysis and well informed recommendations to promote a learning culture. Manager feedback has been used to inform improvements in the audit processes and tools.

During Year 1 there were 356 audits completed. In areas where work was completed (as some domains were not applicable in cases) there were largely positive results. The two domains needing most improvement were the Assessment, Determination of Eligibility, Support Plan and Review domain and the Assessment Mental Capacity Act and Deprivation of Liberty Safeguards domain. Audit results have been analysed to identify key themes and learning points which has informed QIG action planning and reports to Senior Leadership. Results from audits in Year 1 were disseminated at the quality events and had influenced the themes chosen.

Directors Audit Clinics

These have taken place on a quarterly basis since August 2016. They have provided the Strategic Director for Adults and Health, with insights into frontline practice. They have provided an opportunity to understand system pressures and inform strategic development. There has been positive engagement in these clinics from front line staff and managers. Individual feedback is provided to the attendees to commend good practice and identify any development needs. Outcomes also inform the QIG action planning.

The Quality Impact Group (QIG)

The QIG is attended by Service Managers and Team/Deputy Managers and is chaired by the Principal Social Worker. The QIG meets 8 weekly. It has monitored the implementation and embedding of the QA framework. QIG uses results from audits, clinics and other learning to influence practice at a team and individual level.
Learning from audits, complaints, serious adult/case reviews and quality and performance clinics is used to inform QIG action plans.

QIG meetings ensure good practice is shared and celebrated and identifies areas for development. It promotes good communication so all teams are informed of changes and new ways of working. Managers update their teams on the QIG and have their own action plans for the team to embed practice and demonstrate progress.

Examples of some of the actions taken around learning and development

- Results from the adult quality audits have been shared via the QIG and have informed the action plans for team development.
- Events took place with staff and managers to update them on the progress and keep them engaged in Achieving Excellence and Quality Assurance.
- Active involvement in the Teaching Partnership is providing opportunities for improved Social Work teaching, practice and professional development.
- Front line staff have presented cases to the Director's Audit Clinic and have received individual feedback.
- Updated MCA and Best Interest policy, tools and guidance.
- Sessions for managers taking place in September to embed the strength based approach and support them to lead development work on this for their teams.
- QIG has enabled managers to share updates on information governance, data management and risk and on data protection breaches and lessons learnt.
- Recording in Adult Social Care Good Practice Guidance produced.
- Updating of the Assessed Supported Year in Employment and Social Work progression processes sand guidance with the Learning and Organisation Development Team.
- ASYE forums have been set up to support staff and managers.

10. Working in Partnership with our NHS Trusts.

A&E Improvement Groups in Mid Yorks and Greater Huddersfield and Calderdale are working across systems to maintain safety and minimise harm for our patients / service users and ensure sufficient capacity within the health and social care economy to meet predicted demand during this period and to identify key risks and mitigations. Plans run alongside other plans including:

- Operational Pressures Escalation Levels Framework
- Mid Yorkshire A&E Improvement Plan 2016/17
- Greater Huddersfield and Calderdale Improvement plan
- Business Continuity Plans for organisations
- Infection Control Plans
- National Flu Plan
- Cold Weather Plan for England
- The West Yorkshire Resilience Forum: Adverse Weather Plan.

Kirklees Adult Social Care is actively engaged with the A&E Improvement Boards and it's sub-groups that support action plans to address capacity and quality issues.

Current arrangements to support patient flow and the delivery of the 4 hour A&E standard include:

Hospital Avoidance Team

The Hospital Avoidance Team ensures that people who are presenting at the Accident and Emergency Unit or are transferred to the Medical Assessment Units or Frailty Units have a pathway of services to avoid admission. Treatment or exploratory tests which can be carried out within the out-patients remit and support which can prevent re-presentation to A&E are

required. The service provides information and advice, practical support, avoids social admissions to the acute sector of the hospital. The team will explore preventative options, offer Assistive Technology, install care phones and transport patient's home when necessary. The Hospital Avoidance Team offer a 7 day working pattern across all hospital sites 9am until 9pm.

Hospital based teams

Social Workers are based with the hospital as part of a multi-disciplinary team to provide assessment of care and support needs for patients. This service is provided 7 days each week across all hospital sites. The assessment process provides a focus on the needs of carers. A continuing Health Care Lead Nurse is based at both HRI and DDH to work collaboratively around assessment of health needs. Reablement pathways support patients to return home with support to maximise their skills and continue to live independently. When patients require long term support their needs are identified through a Person Led Assessment which help to inform the support plan.

Adult Social Care work in partnership with the relevant NHS Trusts and other partners to manage Delayed Discharge of Care to reduce length of stay in hospital and support timely discharge.

Frailty Pathways

Frailty is recognised as a long term condition impacting on older people. The Frailty units across the hospital sites in Kirklees are focussed on integrated working to maximise independence and avoid admissions to hospital. If frail older people are supported in living independently and understanding their long-term conditions, and educated to manage them effectively, they are less likely to reach crisis, require urgent care support and experience harm. Work to embed pathways and support around Frailty is underway.

Red Bags

The Red Bag initiative aims to ensure better communication and more person centred care for people leaving care and nursing homes for hospital admission. As part of the NHS England, New Care Models Vanguard Program, it has been recognised for some time that communication between provider and acute settings has been unacceptably varied leading to confusion as to individual needs and expectations and delays in admittance and transfer. The scheme provides the opportunity to collate all relevant and standardised paperwork, medication and personal belongings for the individual to be handed over to hospital staff upon admission.
This approach has been successfully trialled and piloted locally (North Kirklees CCG) and there is the intention to roll this out further. Overall, this approach has demonstrably improved transfer between hospital and care home settings and has reduced those delays attributable to poor information and medication handover.

Trusted Assessors

The Home First principle is key in ensuring that people make decisions about their long term care needs at home having had the opportunity to fully recover and to optimise their independence. For the few for whom it is established that a care home placement will be required to meet their needs on discharge the Trusted Assessor (TA) role will be working to support this transfer in a timely way. It is envisaged that this should lead to more discharges at weekends. The TAs will collate and address issues raised by care homes regarding any poor discharges, which has historically impacted on their willingness to accept discharges leading into and over weekends. A measure of success with be a reduction in the number of Delayed Transfers of Care relating to patient choice and care home waits.

Recruitment is underway in the North which will see a Trusted Assessor working with Care Homes as part of the Discharge Team to avoid the duplication of assessment activity and facilitate timely discharges. Discussions are underway to implement a similar role within Greater Huddersfield and Calderdale.

Discharge to Assess

A Discharge to assess pathway, again supporting the home first principle, is being explored with an emerging model that will see delivery aligned with rapid response and reablement services. This will support timely discharge from hospital when patients reach their medical optimum enable them to be discharge to home assessment pathways. Funding of 600K, for additional reablement capacity has been identified as part of the Improved Better Care Fund (BCF) monies.

Winter Planning

The six months from November 2017 to March 2018 contain a number of significant challenges to the health and social care economy across the A&E Improvement Group and its ability to deliver safe, high quality patient care. These include but are not limited to:

- Winter and the challenges of winter illness
- Sustained increase in Emergency Department (ED) activity and the impact on delivery of emergency care standard and ambulance turnaround times.
- Referral To Treatment (RTT) and cancer waiting time performance
- Financial challenges

Kirklees Adult Social Care is actively engaged with the A&E Improvement Boards and it's sub-groups that support action plans to address capacity and quality issues. The plans ensure that our collective Winter Response plan describes the agreed local processes for ensuring a co-ordinated and effective response to increase demand for services.

This plan complements the current arrangements whereby a timely and effective approach to increased demand (across the local health and social care system) is driven by the OPEL system (Operational Pressures and Escalation Level). This is a proven approach to appraising key partners of demand and marshalling the required resources / response to manage demand and ensure patient flow with acute settings. It allows for a daily commentary and response to demand and provides a clear process for escalation and response.

In summary, the aim of this plan is to:

- Identify a shared understanding of responses to winter related issues across the health economy footprint
- Identify what role organisations within the health economy footprint will play in response to winter related risks.

11. Adult Social Care Transformation Programme

As outlined above there are a number of key work streams underway within the Adult Transformation Programme which aim to redesign services so they are more efficient, cost effective and deliver better outcomes.

Some of the key principles and new ways of working focus on early intervention and preventative approaches that align communities and statutory services to prevent and intervene early to make the biggest difference to outcomes for people. Moving away from time and task based care to outcomes for individuals will enable increased flexibility and

support people to be safe, independent and have control over their lives. Utilising a strengths based approach will empower people and reduce their dependency, alongside the use of technology to enable people to self-serve where appropriate. A key redesign principle will be a 'do it once' approach to ensure services are streamlined and as efficient as possible, thereby reducing handoff's across the system and delivering improved user experience.

Within the Front Door project work is ongoing to integrate and transform the Adults customer access points across health and social care, linking in with the corporate Front Door and Digital by Design Programmes.

Key objectives of this project are to resolve more contacts at the first point of contact, enable citizens and/or their representatives to self-serve on line and signpost demand as appropriate to other support networks and third party organisations.

Work undertaken to date includes data analysis of calls received into Gateway to Care to fully understand the demand and case tracking/journey mapping learning in order to inform the future redesign. A number of experiments are underway to test out different and new ways of working which will be evaluated, the learning from which will inform the redesign and future model.

Work is progressing well around the Care Offer project, of which key objectives include establishment of a review taskforce to ensure existing care packages are proportionate to needs, utilising a strength based approach, reducing handoffs and blockages within the system.

National evidence (Institute of Public Care) is clear that support packages are overprovided on discharge from hospital and at times of crisis. A review task force is now in place to right size care packages using strengths based approaches and promoting independence. This includes single handed care reviews which seek to reduce the need for second carers through the provision of improved equipment and adaptations. This approach results in a less intrusive and costly care package and releases capacity to support others.

A draft care offer model has been developed which utilises a tiered approach for identifying an appropriate response to individual need and facilitates strength based solutions to maximise independence. Further testing of the model is required before proceeding to implementation stage.

This Sufficiency project aims to enhance the current re-ablement offer and reinforce the step up/step down provision to improve service efficiency and effectiveness and improve outcomes for users. Alongside that the service is exploring opportunities to transfer its in-house residential care provision to the provider market.

Auditing of case files has taken place to determine the proportion of service users who would have benefited from reablement but did not. The outcome of this has highlighted that there are benefits to be gained from providing reablement, particularly to those people who move into a transitional bed as opposed to returning home. Analysis of data has supported the need to develop an improved decision making framework so that the service is targeting its resources to the right levels of need and abilities.

This project is strongly linked to work ongoing with partners to develop more streamlined Intermediate Care services and integrated models of care.

Conclusion

As already outlined social care is facing some fundamental challenges with rising demand, an ageing population and reduced resources. Whilst the transformation project work is

progressing well and at pace we also recognise there is still a lot to do to achieve the new vision for adult social care, whilst maintaining safe services and managing business as usual.

We recognise to embed these changes and in order to change social care practice there are a number of further activities required to make this happen around culture change and workforce development as well as embedding strong performance management, Quality Assurance and new governance arrangements.
We have a strong programme management structure and leadership team in place to support the transformation and help us towards achieving our new vision and the council outcomes.

12. Consultees and their opinions

This is a report prepared for members of the Health and Social Care Scrutiny Panel.

13. Next steps

Further focussed reports may be request by the Scrutiny Panel.

14. Officer recommendations and reasons

That the Scrutiny Panel acknowledge progress to date, the plans to shape the future service delivery and key challenges.

15. Cabinet portfolio holder's recommendations

Scrutiny note both the ongoing programme of work to continuously improve adult social care and the inherent risks that exist in the adult social care system locally and nationally.

16. Contact officer

Amanda Evans, Service Director for Adult Social Care Operations

17. Background Papers and History of Decisions

Robustness of Adults Social Care Report presented in December 2015.

18. Service Director responsible

Amanda Evans, Service Director for Adult Social Care Operations

Appendix 1

New Ways of Working

This paper sets out the approach to future ways of working that delivers responsive and proportionate interventions to local populations of people in need of care and support.

It is underpinned by the principles of ensuring that interventions are person centred and empowering, ensuring that people in receipt of services remain in control. This will be achieved through an asset based approach that moves away from a deficit based model, it will harness support available to individuals through families, friends and communities.

There will be an increased focus on preventative approaches that anticipate times of increased need and plan for such events through contingency arrangements. Support plans will be co-produced, with individuals and their carers, and will move away from time and task based care to outcomes which allow increased flexibility for the individual in negotiation with the provider.

In order to become streamlined and efficient we will embrace a 'do it once' approach. This will mean reducing handoffs both within Adult Social Care, the Council and across the Health and Social Care system.

The Customer Journey

It is established that if services are designed around the customer they will become efficient. Reflecting on our current pathways it is clear that there are many handoffs in the customer journey due to having specialist teams to undertake different elements of Care Act duties. This necessitates the customer repeating their narrative to each new worker and is a barrier to person centred support. Indeed SCIE has highlighted that good social care practice is to allocate work to a single, lead practitioner.

For that purpose we will seek to merge the assessment, support, reviews and safeguarding activity in place based teams across North and South Kirklees.

We know that it will take the whole system to change the way it works to empower customers, enabling them to access quality information, advice and guidance and proportionate, timely responses. This includes broadening the points of access and self-serve options for people in need of support. The digital by design work will see increasing numbers of people undertaking their own assessments and reviews through the online offer. We will be reviewing our approach to reviews including how frequently these are undertaken. We will also be exploring the ability for people to have appointments in the hubs to reduce the need for practitioners to travel out.

We cannot achieve an outcomes based support plan if we continue to commission task based services. We will be engaging with our providers to co-produce and trial new ways of working that will see the customer and provider relationship enhanced. Coproduction with customers will be underpinned by a Strengths Based Approach,

ensuring we maximise strengths. Where people have going complex needs there will be increased flexibility in the way that day to day care is delivered to the benefit of both the cared for and the provider. It will take account of fluctuating conditions, building in planning for resilience and contingencies and avoiding crisis management. The needs of carers will be a key, to help carers to continue caring, whilst ensuring they have the right advice and support.

Community Hubs

Community hubs are a place based approach to providing joined up services across Health, Social Care and communities that better supports local populations through more proactive, intelligence led and risk based interventions.

The community hub is more than a building – though physical assets are essential, the principle is that these are shared physical assets

We will absolutely need to work differently; staff won't use office space in the same way but will still need touch down space and space to link with colleagues. Mobile and Agile working will underpin this. Colleagues are not just people from the same organisation, colleagues are people who are trying to make a difference to the same population. Arguably it's more important for a Social Worker to work closely with a Community Nurse from the same patch than to work with a Social Worker from the other side of the borough. If all the people who can make a difference can come together a joined up solution is much more likely. This approach will underpin other outcomes focussed initiatives including the emerging Frailty Pathway.

Early Intervention and Prevention

EIP is a win/win. We want to support people to be safe, independent and to have as much control over their lives as is possible. If we can help people to be independent from the system we will be able to focus resources, both funding and the workforce, to support more vulnerable people with more complex needs.

If there is one thing that all statutory services and the third sector have in common it's this aspiration.

EIP though is complex – for individuals it's rarely about one particular solution or intervention. How communities and statutory services come together to prevent and intervene early will make the biggest difference to outcomes for people. As we move into our community hubs we will work increasingly closely with our Community Partnership Managers who will have a role to build community capacity and resilience, reducing the demand for statutory support.

Transformation

We are working with our transformation partners, Deloittes, to apply a programme discipline to work that has largely already commenced. This journey is covered within our journey map which we will describe at the "Shaping the Future" events in September.
The programme in Adults is organised into five, interdependent work steams:

- All Age Disability
- Care Offer
- Commissioning
- Sufficiency
- Front door

There is an absolute need to deliver significant savings, especially during this year and next. Our approach to this is to focus on designing services around the customer journey that are responsive and proportionate and seek to promote independence choice and control. Through reablement and the provision of equipment, adaptations and suitable housing we will promote independence. We will make best use of community assets and resources to support individuals and their carers to remain resilient.

We are developing a new approach to managing resources through panels that will enable budget managers to achieve parity of outcomes for people with similar needs. We will have greater ability to track budget spend in localities and a proactive approach to taking actions to address issues and escalate unmanaged risks through close monitoring at a local level.

Managing Demand

At times the pressure of demographic growth in the context of reducing resources can seem like an unachievable challenge. It is necessary therefore to manage demand as far as possible. Traditionally this has been through gatekeeping through criteria, prioritising until people are in crisis and through waiting lists.

As we move forwards, as an intelligence led organisation we are looking at ways of managing demand whilst maintaining responsive services. Initiatives to date are:

- Moving the financial assessment to the beginning of the customer journey. We know in the region of 25% of customers drop out of social care, following assessment, when they are made aware of their assessed contribution. We will now enable this to be known before a costly assessment takes place. Of course anyone has the right to continue to have an assessment if requested.

- Enabling other practitioners to undertake reviews. We know that often cases that are waiting for reviews have other practitioners involved such as the Accessible Homes OTs or BIAs. We will be developing ways to enable these practitioners to record reviews, following a trusted assessor model.

- Online offer: we will be enabling individuals and their representatives to undertake assessments and reviews on line.

- Providers as partners: We will be exploring opportunities for providers to collaborate more with customers around support planning and reviews.

- Improving the coordination of reviews in care homes in localities. This will enable any themes around quality of care concerns to be picked up earlier and addressed through the Early Warning meetings and will enable the contract monitoring teams to adopt a risk based approach.

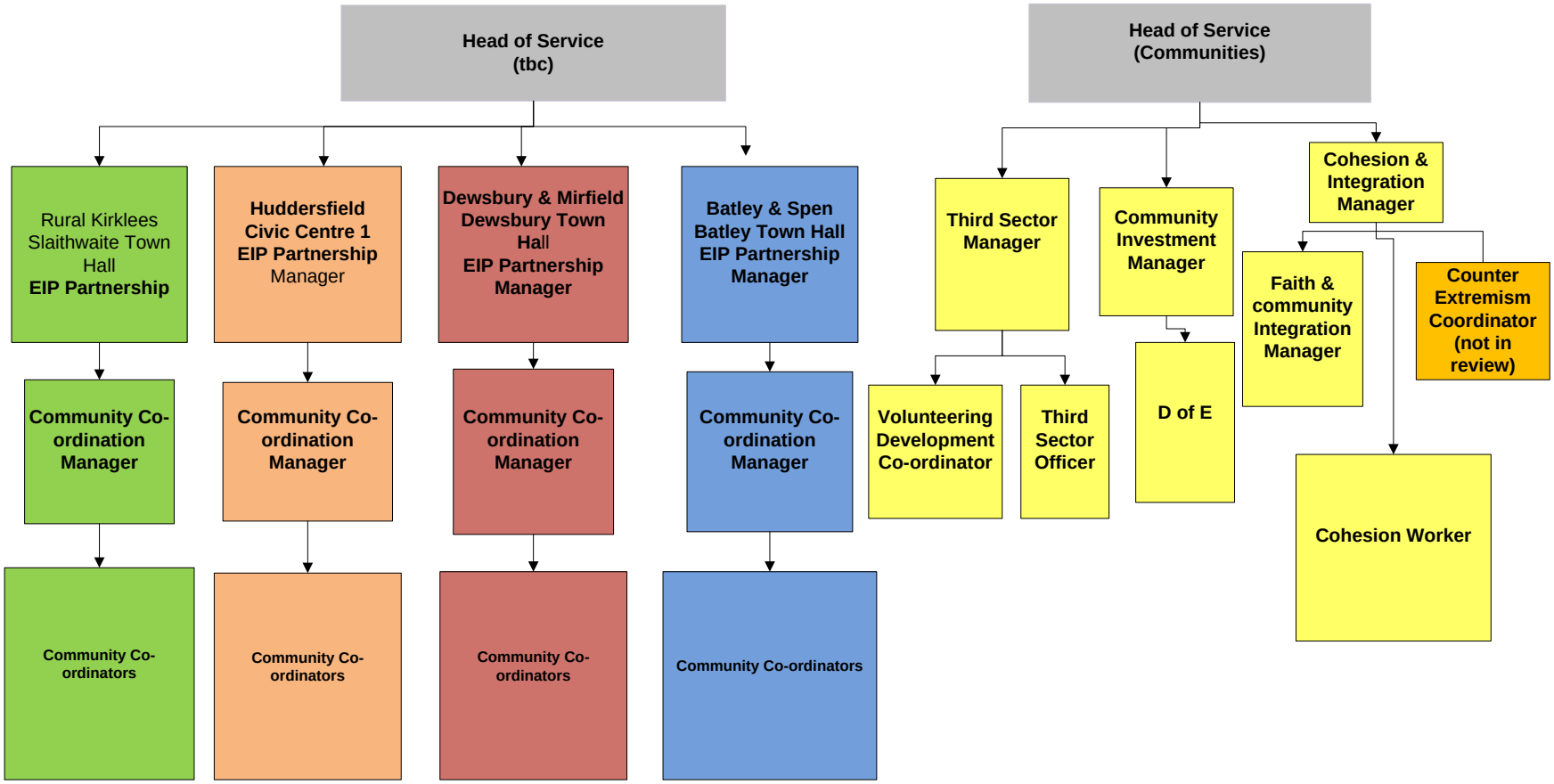
Safeguarding

Our Single Point of Access for Safeguarding is placed adjacent to Gateway to Care to ensure collaborative working at the point safeguarding concerns are raised. Here we are able to identify what needs to happen to ensure immediate safety of an adult at risk, whilst employing the principles of Making Safeguarding Personal. Safeguarding Consultants ensure effective decision making and manage identified risks. Three Senior Safeguarding Consultant will be aligned with the North and South Community Hubs, also supporting Mental Health and Learning Disability. Deprivation of Liberty Operational services will be aligned closer to the safeguarding service. Safeguarding is everyone's business and our new Safeguarding arrangements will provide the opportunity to support enable and challenge across the safeguarding partnership.

Amanda Evans
Service Director, Adult Social Care Operations

Appendix 2

EIP Structure to be implemented



Head of Service
ASC Operations NK
Lee Thompson

Service Manager
Operational Safeguarding & DOLs
Elaine Crossley

Service Manager
SPA, Care Navigation, Health Trainers & Sensory
(Vacant, pending recruitment)

Service Manager for Hospital, Community Social Work Teams & Extra Care **NK**
Gail Addinall

Social Work Practice & Education lead and Link to Emergency Duty Team Manager, Duncan Fairweather

Head of Service
ASC Operations SK
Debra Mallinson

Service Manager
AT/Carephones/Mobile Response & Dementia Homes
Integrated Nights and Out of Hours
Nigel Bunker

Service Manager
Short Term & Urgent Support Teams ICT Homes x2
Janette Robertson

Service Manager for Hospital, Community Social Work Teams & Extra Care **SK**
Alistair Paul

Manager
Brokerage & Movement/Handling
Denise Diskin

Business Partnership/Customer Service
Acting Manager
Damian Crowther

Head of Service
Safeguarding, Quality & Performance
Patrick Worthington - Interim
Saf Bhuta from 1st October

Safeguarding Adults Partnership Manager
Sarah Carlile

Service Manager
Domestic Abuse Safeguarding Partnerships
Alexia Gray

Principle Social Worker
(In the longer term)

Head of Service
Commissioning & Market Development
(Vacant) Korrina Campbell - Interim

Partnership Commissioning Manager
Mental Health
Tony Bacon

Partnership Commissioning Manager
Learning Disabilities
Gary Wainwright

Partnership Commissioning Manager
Older People
Sandra Croft

Partnership Commissioning Manager Phys Dis/SI
Amanda Foxley

Senior Contract & Procurement Manager
Emma Hanley

Directorate Lead-Business Intelligence, Systems, Performance
Saf Bhuta

Kirklees COUNCIL

Name of meeting: Health and Adult Social Care Scrutiny Panel

Date: 3 October 2017

Title of report: Health Optimisation Programme

Purpose of report:
To provide members of the Health and Adult Social Care Scrutiny Panel with the context and background to the discussions on the Health Optimisation Programme.

Key Decision - Is it likely to result in spending or saving £250k or more, or to have a significant effect on two or more electoral wards?	**N/A – Report produced for information only** .
Key Decision - Is it in the Council's Forward Plan (key decisions and private reports?)	**No**
The Decision - Is it eligible for call in by Scrutiny?	**No**
Date signed off by Director & name **Is it also signed off by the Assistant Director for Financial Management, IT, Risk and Performance?** **Is it also signed off by the Assistant Director (Legal Governance and Monitoring)?**	**No – The report has been produced to support the discussions with Greater Huddersfield CCG and North Kirklees CCG.**
Cabinet member portfolio	**Cllr Viv Kendrick and Cllr Cathy Scott Adults and Public Health**

Electoral wards affected: All

Ward councillors consulted: N/A

Public or private: Public

1. **Summary**

1.1 Greater Huddersfield Clinical Commissioning Group (CCG) and North Kirklees CCG have stated that in line with their ongoing commitment to improving the health of Kirklees residents, they plan to introduce new criteria encouraging patients who are overweight or smoke to get fit before undergoing routine surgery.

1.2 The CCGs have stated that people who smoke or are obese experience more complications during and after surgery and can take longer to recover.

1.3 The CCGs believe that the introduction of this new criteria will offer people the opportunity of the best possible clinical outcome as well as the longer term benefits of a healthier lifestyle.

1.4 Representatives from Greater Huddersfield CCG, North Kirklees CCG and Kirklees Public Health will be in attendance to present details of the proposed model which will include the planned pathways to surgery and the outcomes from the engagement work. The CCGs report together with the supporting information is attached.

2. **Information required to take a decision**
N/A

3. **Implications for the Council**
N/A

4. **Consultees and their opinions**
N/A

5. **Next steps**
That the Overview and Scrutiny Panel for Health and Adult Social Care takes account of the information presented and considers the next steps it wishes to take.

6. **Officer recommendations and reasons**
That the Panel considers the information provided and determines if any further information or action is required.

7. **Cabinet portfolio holder's recommendations**
N/A

8. **Contact officer**
Richard Dunne, Principal Governance and Democratic Engagement Officer, Tel: 01484 221000 Email: richard.dunne@kirklees.gov.uk

9. **Background Papers and History of Decisions**
N/A

10. **Service Director responsible**
Julie Muscroft, Legal, Governance & Monitoring

☐ ☒ ☒

Name of Meeting	Health and Adult Social Care Scrutiny Panel	**Meeting Date**	03/10/17
Title of Report	Health Optimisation – Proposal to introduce additional Thresholds for Non-Urgent Elective Surgery	**Agenda Item No.**	
Report Author	Alan Turner	**Public / Private Item**	Public
GB / Clinical Lead	Steven Ollerton, David Hughes, David Kelly	**Responsible Officer**	Vicky Dutchburn (GHCCG), Vicki Robinson (NKCCG)

Health Optimisation
Proposal to introduce additional Thresholds for Non-Urgent Elective Surgery

1. Executive Summary

Obesity and tobacco smoking constitute major causes of global morbidity and mortality; in the context of England, the 2015 Health Survey for England found that twenty-seven percent of adult males and adult females are obese[1]. Nineteen percent of adults smoke[2]. In 2014, the Chief Executive of the National Health Service in England stated, in his report The Five Year Forward View[3], "if the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded out by the need to spend billions of pounds on wholly avoidable illness." By 2017, however, the King's Fund[4] found that, "what is often missing is detail on the specific programmes that will be put in place to deliver these benefits and the evidence that lies behind them."

One specific area which has attracted attention is the move by some commissioners across the country to insist that patients change, or spend a specific period attempting to change, adverse lifestyle behaviours prior to surgery[5]. An increasing number of Clinical Commissioning Groups have decided to place restrictions on those receiving elective operations, requiring such patients to lose weight to below a specified body mass index threshold and/ or stop smoking prior to their surgery.

On the one hand, there is evidence that making these lifestyle modifications improves patients' primary outcomes from these operations and reduces their chances of site-specific or anaesthetic complications. After the operation, if these healthy behaviours are maintained, there would be reduced risk of mortality and morbidity. On the other hand, patients will have delayed access to treatments from which they might benefit. This paper describes some of the published evidence which pertains to the main arguments in this difficult issue for healthcare decision makers, but also to present to the Health and Adult Social Care Scrutiny committee an update on local intentions of Greater Huddersfield and North Kirklees CCGs to implement such a programme referred to as the 'Health Optimisation'.

Further to the decision at the Joint Quality Performance and Finance Committee in December 2016 to support further development of a Health Optimisation Programmes for patients that require routine elective surgery the Health Optimisation programme has been explored and scoped with both CCG governing bodies on the 14th June 2017 agreeing for the programme to move into implementation stage.

2. Introduction & Background

Effects of Smoking

In 2014, almost 80,000 deaths in England were attributable to smoking[6]. The Consortium on Health and Ageing undertook a metaanalysis of 25 cohorts across Europe and North America and found that former smokers had a lower relative risk of cardiovascular deaths than current smokers; it also calculated the risk advancement period, which is the average time by which the occurrence of an event (such as disease incidence or death) due to a risk factor is advanced in exposed people compared with unexposed people. For current smokers, this risk advancement period was 5.5 years, compared with only 2.2 years for former smokers. With non-smokers as the reference value, the hazard ratio for an acute coronary event is 2.0 in current smokers and 1.3 in former smokers[7].

For smoking, a systematic review recently found that smoking cessation programmes prior to hospitalised surgery overall had a success rate of 55%[8]. A recent systematic review found that a mixture of interventional studies and observational studies. In their meta-analysis, they considered the primary study outcome as total complications, consisting of secondary outcomes including any wound healing complications, pulmonary or respiratory complications, all-cause mortality, and all-cause length of hospital stay. Across the thirteen studies, there was a statistically significant reduction in the risk of total complications in former smokers compared with current smokers, with an average 22% of former smokers experiencing an event compared with 32% for current smokers[9].

Effects of Obesity

For any given individual, obesity will increase his or her risk of numerous diseases, in particular cardiovascular diseases such as diabetes, hypertension, heart disease, stroke, and several digestive diseases, including gastroesophageal reflux disease and its complications (e.g. erosive esophagitis, Barrett's oesophagus and oesophageal adenocarcinoma), colorectal polyps and cancer, and liver disease (e.g. non-alcoholic fatty liver disease, cirrhosis and hepatocellular carcinoma)[10].

Obesity in adulthood is a powerful predictor of death at older ages. For a forty-year-old female non-smoker, a body mass index of over 30 is associated with 7.1 years of life lost, and for a forty-year-old male non-smoker, 5.8 years of life lost[11]. The Framingham Heart Study also showed that a significant contributor to this lost life expectancy is mortality prior to the age of 70 (Figure 1).

Figure 1: Percentage Mortality between the Ages of 40 and 70 by smoking status, BMI[11]

	Female non-smoker	Female smoker	Male non-smoker	Male Smoker
BMI of 18.5 to 24.9 kg/m2	9.36 (7.56–11.59)	18.72 (16.10–21.74)	12.62 (8.73–17.75)	26.72 (23.58–29.73)
BMI of 25 to 29.9 kg/m2	13.85 (11.18–16.73)	13.85 (11.18–16.73)	17.43 (12.74–23.07)	29.74 (26.53–33.03)
BMI $\geq$ 30 kg/m2	20.09 (15.34–24.85)	34.35 (24.90–43.84)	22.86 (14.31–32.91)	45.03 (39.11–51.57)

The Organisation for Economic Cooperation and Development noted that in 2014, England had the second highest prevalence of obesity in Europe, after Hungary. Of particular note to clinicians, it estimated the potential impact of various interventions to reduce years disability

adjusted life years lost to obesity; of these, counselling by a combination of dietitians and physicians were the two interventions which could have the greatest impact at population level, ahead of food advertising regulation, fiscal measures, food labelling, worksite interventions, self-regulation, mass media campaigns and school -based interventions. Doctors therefore have the potential to play the most significant role in the control of the epidemic[12].

Medical triggers, for example a doctor telling a patient to lose weight, have been shown to promote long term behaviour change. The National Weight Control Registry of US is a registry of a self-selected population of more than 4000 individuals who are age 18 or older and have lost at least 13.6kg (30lb) and kept it off at least 1 year. They identified that most registry participants reported a trigger for their weight loss (83%). Medical triggers were the most common (23%), followed by reaching an all-time high in weight (21.3%), and seeing a picture or reflection of themselves in the mirror (12.7%). People who had medical reasons for weight loss also had better initial weight losses and maintenance. Medical triggers were also associated with less regain over 2 years of follow-up. These findings suggest that the period following a medical trigger may be an opportune time to initiate weight loss to optimize both initial and long-term weight loss outcomes[13].

Obesity at the time of surgery is associated with a very wide range of problems, which were categorised in a recent review into perioperative, intraoperative and postoperative. Problems in the perioperative management of obese patients are mainly related to their respiratory system, such as reduced lung volume with increased atelectasis; derangements in respiratory system, lung and chest wall compliance and increased resistance; and moderate to severe hypoxaemia. Intraoperatively, in addition to additional equipment and continued issues with airway management, obesity is associated with higher block failure and complication rates for regional anaesthesia, open approaches to general surgery where laparascopic techniques may be safer, and longer operating times. Obese patients have a significantly higher risk of postoperative myocardial infarction, wound infection, nerve injury, urinary infection and pulmonary embolism[14].

Data collated from survey data from CLiK local adult population survey 2016 demonstrating the levels of the population with a BMI 30+ and smokers :

	Greater Huddersfield	North Kirklees	Kirklees
Either regularly smoke or BMI 30+	57509	51042	108524
Adult population	196912	145596	342508
% of adult population	29.2%	35.1%	31.7%

BMI of 30+

Greater Huddersfield	% of survey sample	
Age	Male	Female
18-34	15.2%	12.3%
35-44	13.5%	9.1%
45-54	16.4%	12.0%
55-64	11.3%	10.9%
65-74	7.3%	9.0%
75+	4.2%	4.3%
Total adults		

North Kirklees	% of survey sample	
Age	Male	Female
18-34	14.4%	15.9%
35-44	24.8%	10.3%
45-54	16.4%	11.8%
55-64	20.0%	13.4%
65-74	11.2%	10.6%
75+	5.3%	5.5%
Total adults		

Current smokers (including occasional and regular smokers)

Greater Huddersfield	% of survey sample	
Age	Male	Female
18-34	20.7%	21.1%
35-44	14.9%	11.8%
45-54	20.0%	14.1%
55-64	14.3%	13.0%
65-74	8.9%	10.1%
75+	4.6%	4.3%
Total adults		

North Kirklees	% of survey sample	
Age	Male	Female
18-34	20.1%	20.4%
35-44	28.7%	12.8%
45-54	21.8%	13.7%
55-64	21.9%	15.1%
65-74	14.2%	12.1%
75+	6.3%	6.3%
Total adults		

Locally smoking rates vary across Kirklees with significant variations across social and ethnic groups. High level data provided by Public Health indicates that approximately 29% of the adult population in Greater Huddersfield are active smokers and / or have a BMI>30+ and rising to 35% of the adult population in North Kirklees; approximately 1/3 of the population fall within this populous across Kirklees.

3. What Might be a Reasonable Period for Attempting Lifestyle Modification?

Patients, clinicians and commissioners would need a sufficient length of time for lifestyle modification to have a reasonable chance of success. The messages would also need to be consistent with the current NHS patient information portal, NHS Choices, which notes that a number of smoking cessation interventions, such as nicotine replacement therapy and varenicline, last up to 12 weeks. The Office for National Statistics considers a smoker to have successfully quit smoking at the 4 week follow-up if he or she says they have not smoked at all since two weeks after the quit date[15]. As the above literature[8] described, pre-operative smoking cessation has a 55% chance of success. A six-month period would allow patients to undergo a full attempt of 16 weeks[16] with additional time for consideration of alternative methods and access to interventions available.

In the case of obesity, any policy would need also to be consistent with NHS Choices[16], and there is the additional dimension of ensuring that the period is not so short that a patient attempts to lose weight at an excessive rate.

A male of average 1.75m height who is morbidly obese, with a BMI of 40kg/m2, would weigh 122.5kg, but would weigh 30.6kg less if he reduced to a BMI of 30. Similarly, a female of average 1.61m height who is morbidly obese, with a BMI of 40kg/m2, would weigh 103.7kg, but would weigh 25.9kg less if she reduced to a BMI of 30. NHS Choices recommend that

patients lose weight at a rate of 0.5 to 1.0kg per week, so for this risk factor, a twelve-month period would also be considered as reasonable in this instance.

Most of the NHS material is however centred around a 12-week programme; a patient who lost 12kg in 12 weeks, amounting to 10% of BMI in a morbidly obese male, might be considered a relative success. Therefore, a policy consistent with the national literature would be that 10% reduction in BMI would be considered a successful weight loss attempt even if this did not bring the patient below 30[17].

4. The proposed model across Kirklees

Greater Huddersfield and North Kirklees CCGs have decided to look at how to implement such a scheme and following a significant scoping exercise decided on the following programme.

For patients 18 and above that have a BMI of 30 and above. They will have a period of up to 12 months' maximum prior to referral or an elective procedure, to reduce their BMI to less than 30 or achieve a weight loss of 10% of overall weight. At the end of the 12-month period or when the weight reduction target has been achieved, whichever is the soonest, the patient will come off the Health Optimisation element of the pathway and will re-join the original pathway for the relevant procedure. Patients will be expected to maintain their weight lose up to their procedure.

BMI is an established measure of weight though it is recognised that muscular people will have a higher BMI that is not thought to be a risk to health (muscle is denser than fat) and adults of Asian origin may have a higher risk of health problems at BMI levels below 25.

Waist circumference

Obesity can be measured by waist measurements but it is not yet established in UK clinical practice. NHS Choices website states individuals have a higher risk of health problems if waist size is:

- more than 94cm (37 inches) if you're a man
- more than 80cm (31.5 inches) if you're a woman

Risk of health problems is even higher if your waist size is:

- more than 102cm (40 inches) if you're a man
- more than 88cm (34.5 inches) if you're a woman

For patients18 and above that actively smoke. They will have a period of up to 6 months' maximum prior to referral or an elective procedure, to stop smoking, and/ or they must be smoke free for a minimum of 4 weeks. At the end of the 6-month period or after 4 weeks' smoke free, whichever is the soonest, the patient will come off the Health Optimisation element of the pathway and will re-join the original pathway for the relevant procedure. Patients will be expected to remain smoke free up to their procedure.

Clinical discretion should be used at any time by the GP or Secondary Care Clinician during the Health Optimisation pathway as to what is meant by urgent or non-routine.

If there is an anticipated safety concern should the patient not be referred or delayed, and this outweighs any benefits from a period of improving health and reducing risk factors prior to any routine operation, then referral should be made using the relevant referral template.

However, if there is more certainty in the diagnosis and routine surgery would be the outcome, and there is some other reason that the patient would not benefit from a Health Optimisation period, then the Individual Funding Request (IFR) process should be followed.

5. Engagement and Design

Health Optimisation Patient Pathway and Referral Exclusions

A Task and Finish Group (TFG) was formed, met with representatives from both CCGs (Clinical and Non-clinical), Public Health and Patient representatives to design and develop the initial Health Optimisation Pathways describing the journey from point of Patient contact through to either discharge and/or listed for surgical procedure. The Pathway was to be reinforced by an agreed Pathway Referral Exclusion.

The membership of this group included five lay representatives from the following organisations; S2R, Kirklees Local TV, Saathi, Honeyzz and Denby Dale Centre

In addition to this the TGF were asked to design and develop appropriate Patient Information Leaflet regarding Health Optimisation.

A draft pathway (Appendix 1) and a list of exclusions (Appendix 2) were subsequently developed based upon the input from all members of the TGF. These exclusions were further adapted to redress issues identified within the Quality and Equality Impact Assessments which continues to be refreshed as the programme develops further.

The pathway applies when making any referral to a surgical specialty. If the patient has a BMI of 30 or above AND/OR they are an active smoker, they should be offered a Health Optimisation period of 12 and 6 months and referral to weight management and/or smoking cessation service before the referral is made unless exclusions apply. If exclusions do apply, it is recommended as good practice to still offer lifestyle advice/support.

6. Primary and Secondary Care Engagement

Due to the sensitive nature of this particular programme we have engaged our primary care providers and GPs through our internal mechanisms through the use of such forums as Clinical Strategy Groups, Council of Members in turn ensuring full ownership from the Clinical Leads of the programme who in turn are GP.

This programme of work has raised a significant variety of opinions, inclusive of both opposition and support to its implementation. Some of the objections have included;

- The ethical element of the programme and its potential to be sighted as discriminatory
- The point at which the patient is informed (either within Primary or Secondary care)
- Lack of clinical evidence supporting the programme
- The appropriateness of the inclusion of children
- The reasoning behind the proposal for the programme being sighted as for financial gain
- The potential impact upon primary care

Some of the supping opinions have included:

- This being good practice to optimise patient's health
- Potential impact for demand management within secondary care
- A step in an attempt to create a population lifestyle change, within a population with significant levels obesity

- Recognition of timing of patient information being provided to generate greater impact of sustainable lifestyle changes

We have attempted to address a majority of the concerns raised and used the feedback to inform the developed pathways, exclusions and policy behind this programme.

One significant concern, that has been raised in a variety of forums, is that smoking and obesity have higher prevalence in socioeconomically deprived groups which already have poorer outcomes; it is, however acknowledged that it is these behaviours themselves which are significant cause, and reducing their prevalence has in fact been recommended by Department of Health as a means of reducing inequality[18].

Furthermore, work is underway with Public Health Kirklees to map currently provision of community interventions (smoking and weight management) so as to be able to identify gaps and proactively increase provision available within the areas of need.

We are continuing to work with both Trusts leadership teams to understand how best we can work together on this programme. Previous iterations of the Pathway have been shared with both Trusts for their comments with significant changes made accordingly (Appendix 3). The policing of the pathway raised concerns for the Trusts mainly due to the issues of the CCGs they also serve (NHS Wakefield and NHS Calderdale CCGs) are not currently at the same stage in implementation of Health Optimisation and therefore feel policing such a policy in its previous guise would require significant resource.

The Pathway has been designed to reduce the impact upon both Primary and Secondary Care, with and intention that an adapted referral and dedicated referral support will be able to reduce this initial concern.

7. Public and Patient Engagement

As part of the scoping exercise we needed to understand the needs of people that may be impacted by the introduction of health optimisation. Some initial work had been undertaken during September 2016 – February 217 by Health Watch Kirklees and both CCGs, which had provided some insight, but as these views were mainly from White British people they were not representative of our communities. And as such this work needed to focus on gaining the views from those people who are seldom heard and those within protected groups.

To support this work, we recruited 13 Community Voices to have conversations within their communities. To gain views on what support and information people would require to help them lose weight or stop smoking. The engagement commenced on 6th March 2017 and ran for 5 weeks. 584 surveys were collected via the Community Voices (Appendix 4)

Community Voices deliver conversations with targeted service users from a variety of local areas, protected groups and communities. Community Voices are individuals working in the voluntary and community sector who are trained to engage with the local population on our behalf. By working with volunteers in this way the response to our conversations has strengthened and increased, particularly amongst seldom heard groups.

8. Referral Management and Support

The Pathways Task and Finish Group (TGF) identified the need for a form of oversight and management of referral processes in and out of the Health Optimisation programme, highlighting the complexities of this element of the pathway which will include multiple community providers, primary care and secondary care with referrals potentially entering and leaving pathways at varying points.

A number of options were explored to deliver the required referral management and oversight which include;

A. Current providers of the Smoking and Weight Management services managing their referrals individually through an agreed mechanism
B. Public health, to undertake the management and oversight through the additional funding previously proposed to commission and develop the additional capacity required within the community
C. NHS Greater Huddersfield work in partnership with NHS North Kirklees in the development of an electronic referral support system (RSS) and service

Options A and B were discussed with Public Health as the commissioners of the current services to further understand the implications, requirements and feasibility. However, these options are deemed not to be viable due to the resource that would be required to deliver them. Therefore, the preferred approach being the implementation of Option C. It has been agreed, if possible to align the Health Optimisation programme with the implementation of RSS, and partnership work in now underway to align the programmes.

It is vitally important to ensure that the appropriate levels of monitoring and referral management process are robust and in place to enable a robust and efficient understanding of the programme, in particular its impact upon patents.

It has been agreed that if this programme was to be implemented that ongoing monitoring throughout the proposed 12 months period for this programme, will enable us to make further decisions if this has the desired effectiveness and viability to continue to be implemented, however it is further recognised that the desired outcomes and patient impact may not be immediately apparent, especially with regards to post procedural impact.

9. **Smoking and Weight Management Services Capacity**

For the successful implementation of this programme there is a potential need for substantial increase in current capacity within the Smoking and Weight Management services.

The service currently commissioned by Kirklees Public Health which could be offered to support those affected by Health Optimisation are;

- **Community Smoking Cessation (CSC)**; Currently provided by primary care and community organisations
- **Tier 2 Weight Management (T2WM**); Currently provided by Weight Watchers

The CCG governing bodies have agreed to the investment in additional capacity within the existing provisions available to account for health Optimisation related increase in uptake.

Capacity of the current interventions, provided by Public Health, are potentially able to cater for an additional 2500, recognising that, in addition, some patients may already be accessing the services, however there is this programme can potentially impact on approximately 18,000 patients.

Discussions have been held with Public Health and the CCGs Procurement Teams to identify methods of mitigation and ensure that capacity within the associated support services are available. The Public Health proposal to increase current capacity within the communities still did not meet the potential capacity, if all identified patients were to require Health Optimisation at this point. Following further investigation and analysis of the predicted patient capacity required has indicated (based upon data received from HaRD CCG) that there is a significant range to be catered for. This ranges from an approximate 17% increase up to the full potential patient uptake.

It is, therefore, proposed that the programme is implemented utilising the current capacity within Public Health services, concurrently undertaking a tender exercise for an 'Zero Value - Activity based' contract with additional providers via Any Qualified Providers (AQPs).

This approach allows for implementation to be undertaken without significant delay, at the same time as ensuring that intervention capacity could be met if there were to be significant increase in uptake. It is anticipated that the proposed approach would therefore have a period of up to a maximum of 6 weeks between commencement of the referrals and new providers being procured through the AQP framework.

The CCGs will continue to work alongside Public Health, through the use of programme monitoring, to ensure there is strategic alignment with future developments of programmes such as the Wellness Model. The recent draft commissioning intentions presented by Public health are being explored in partnership with the CCGs to identify the potential impact upon both current provision but also the gap that may be created via any new modelling of provision.

10. **Next Steps**

1. Finalise and dissemination of supporting literature
2. Agree referral mechanisms and process
3. Clinical Education – Primary and Secondary Care
4. Infrastructure and community interventions to meet patient needs – working with Public Health, in line with Equality Impact Assessment
5. Undertake AQP procurement
6. Continue to monitor impact through relevant governance structures
7. Continue to support neighbouring CCGs and feed into Health Futures agenda

Appendices

1. **Appendix 1 – Initial Draft Pathway**
2. **Appendix 2 – Intial Draft Exclusions**
3. **Appendix 3 – Latest draft Pathway**
4. **Appendix 4 - Health Optimisation - engagement report - May 2017 FINAL.**

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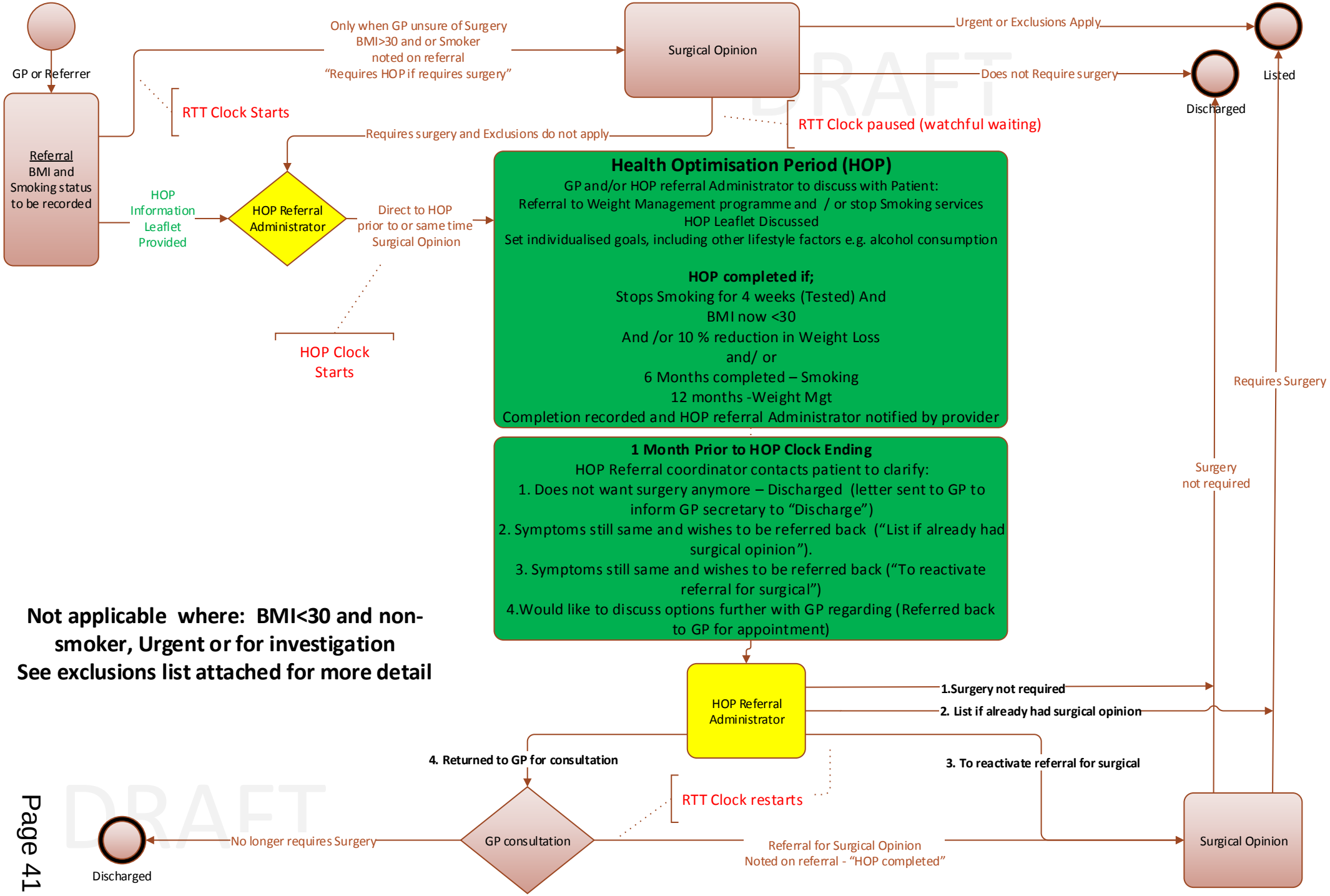
GP or Referrer
Referral
BMI and Smoking status to be recorded
Only when GP unsure of Surgery BMI>30 and or Smoker noted on referral "Requires HOP if requires surgery"
RTT Clock Starts
Surgical Opinion
Urgent or Exclusions Apply
Listed
Does not Require surgery
Discharged
RTT Clock paused (watchful waiting)
Requires surgery and Exclusions do not apply
HOP Information Leaflet Provided
HOP Referral Administrator
Direct to HOP prior to or same time Surgical Opinion
HOP Clock Starts
Health Optimisation Period (HOP)
GP and/or HOP referral Administrator to discuss with Patient:
Referral to Weight Management programme and / or stop Smoking services
HOP Leaflet Discussed
Set individualised goals, including other lifestyle factors e.g. alcohol consumption
HOP completed if;
Stops Smoking for 4 weeks (Tested) And
BMI now <30
And /or 10 % reduction in Weight Loss
and/ or
6 Months completed – Smoking
12 months -Weight Mgt
Completion recorded and HOP referral Administrator notified by provider
1 Month Prior to HOP Clock Ending
HOP Referral coordinator contacts patient to clarify:
1. Does not want surgery anymore – Discharged (letter sent to GP to inform GP secretary to "Discharge")
2. Symptoms still same and wishes to be referred back ("List if already had surgical opinion").
3. Symptoms still same and wishes to be referred back ("To reactivate referral for surgical")
4.Would like to discuss options further with GP regarding (Referred back to GP for appointment)
Requires Surgery
Surgery not required
Not applicable where: BMI<30 and non-smoker, Urgent or for investigation
See exclusions list attached for more detail
HOP Referral Administrator
1.Surgery not required
2. List if already had surgical opinion
4. Returned to GP for consultation
3. To reactivate referral for surgical
RTT Clock restarts
GP consultation
No longer requires Surgery
Discharged
Referral for Surgical Opinion
Noted on referral - "HOP completed"
Surgical Opinion

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Health Optimisation Period Exclusions Criteria v3

Exclusions apply to enable access to urgent care, but all patients must be offered access to smoking cessation and/or weight management concurrently regardless of urgency.

The following group/patients with the specified conditions would not be subject to this policy:

- The condition is immediately life-threatening
- Patients requiring emergency surgery or with a clinically urgent need where undue delay would cause clinical risk of harm
- Patients undergoing surgery for cancer;
- 2ww referral for suspicion of cancer;
- Patients under the age of 18 years
- Any procedures deemed as urgent by the surgical team
- The procedure needs to be performed within a strict timeframe as delay would result in it becoming ineffective
- Patients who despite having a BMI >30 have a waist circumference of:
    - Less than 94cm (37 inches) male
    - Less than 80cm (31.5 inches) female
- Referrals for interventions of a diagnostic or investigatory nature that do not require General Anaesthesia
- Patients previously completed Health Optimisation Period within the last six months
- Any surgical interventions that may be required as a result of pregnancy
- Frail Elderly
- Vulnerable patients who will need to be clinically assessed to ensure that, where they may be able to benefit from opportunities to improve lifestyle, that these are offered. (Please note that deferring elective interventions may be appropriate for some vulnerable patients based on clinical assessment of their ability to benefit from an opportunity to stop smoking/reduce their BMI/improve pre-operative fitness.) This includes patients with the following:
    - learning disabilities
    - significant cognitive impairment
    - severe mental illness**

**Adults with a serious mental illness are persons who currently or at any time during the past year, have a diagnosable mental, behavioural, or emotional disorder of sufficient duration that has resulted in functional impairment which substantially interferes with or limits one or more major life activities

Clinical discretion should be used at any time by the GP or secondary care clinician during the health optimisation pathway as to what is meant by urgent or non-routine. This could include, for example:

- If the patient has worsening, severe persistent pain not adequately relieved by an extended course of non-surgical management
- If there are any safety concerns about delaying referral (eg symptomatic gallstones)
- Significant functional impairment is defined as a loss or absence of an individual's capacity to meet personal, social or occupational demands

If there is an anticipated safety concern should the patient not be referred or delayed, and this outweighs any benefits from a period of improving health and reducing risk factors prior to any routine operation, then referral should be made using the relevant referral template.

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However, if there is more certainty in the diagnosis and routine surgery would be the outcome, and there is some other reason that the patient would not benefit from a health optimisation period, then use IFR. If a clinician felt that there were exceptional circumstances, the patient may be referred through the Exceptional Cases process for consideration.

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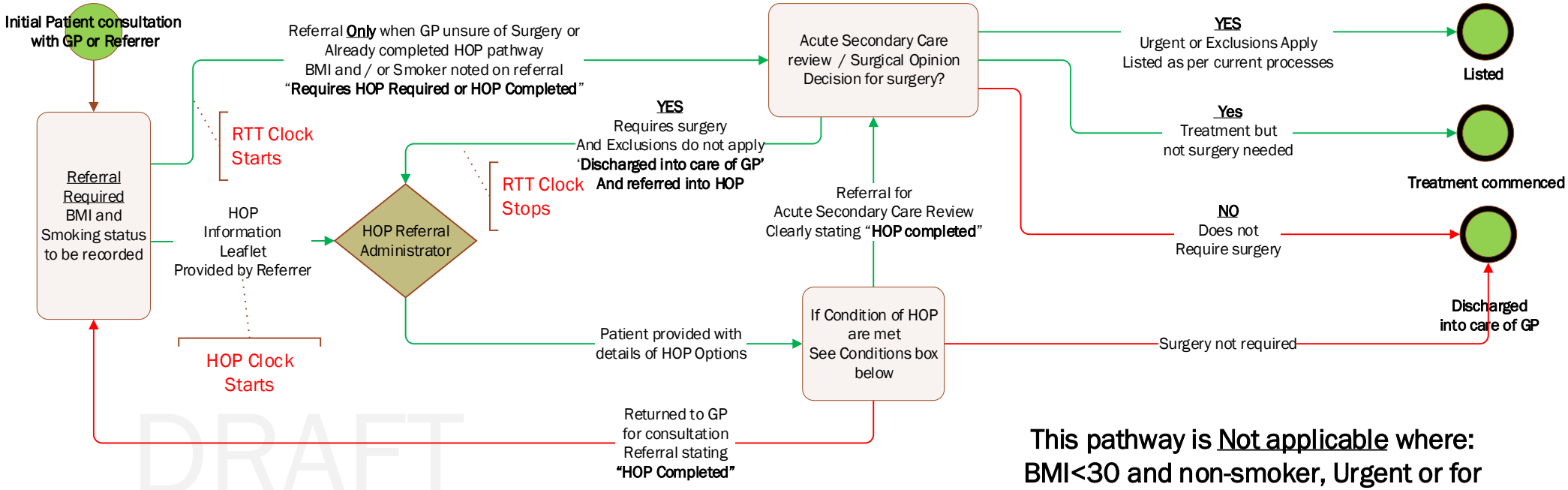

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This pathway is Not applicable where:
BMI<30 and non-smoker, Urgent or for investigation
See exclusions list attached for more detail

Health Optimisation Period (HOP)

GP and/or HOP referral Administrator to discuss with Patient:
Referral to Weight Management programme and / or stop Smoking services
HOP Leaflet Discussed
Set individualised goals, including other lifestyle factors e.g. alcohol consumption
Set review Date -1 month prior to time period (5 months / 11 months)

Completion Conditions

HOP completed if;
Stops Smoking for 4 weeks (Tested) And
BMI now <30
And /or 10 % reduction in Weight Loss
and/ or
6 Months completed – Smoking
12 months -Weight Mgt
Completion recorded and HOP referral Administrator notified by provider

Post HOP Completion

1 Month Prior to HOP Clock Ending
HOP Referral coordinator contacts patient to clarify:

1. Does not want surgery anymore – Discharged (letter sent to GP to inform GP secretary to "Discharge")

2. Symptoms still same and wishes to be referred back ("To reactivate referral for Acute secondary care review ")

3.Would like to discuss options further with GP regarding (Referred back to GP for appointment)

Note: All Patients who complete the HOP to be marked on system regardless of outcome, inclusive of date of completion

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NHS Greater Huddersfield CCG
NHS North Kirklees CCG

Health optimisation for non-urgent elective surgery

Engagement report

May 2017

Contents

Appendices

1.0 Executive summary

It had been agreed by NHS Greater Huddersfield and North Kirklees Clinical Commissioning Groups (CCGs) to scope the introduction of a Health Optimisation programme that would include new criteria which asks patients with a BMI over 30 to lose weight and smokers to quit before undergoing non-urgent elective surgery.

As part of the scoping exercise we needed to understand the needs of people that may be impacted by the introduction of health optimisation. Some initial work had been undertaken during September 2016 – February 217 by Healthwatch Kirklees and both CCGs, which had provided some insight, but as these views were mainly from White British people they were not representative of our communities. And as such this work needed to focus on gaining the views from those people who are seldom heard and those within protected groups.

To support this work we recruited 13 Community Voices to have conversations within their communities. To gain views on what support and information people would require to help them lose weight or stop smoking. The engagement commenced on 6th March 2017 and ran for 5 weeks.

Community Voices deliver conversations with targeted service users from a variety of local areas, protected groups and communities. Community Voices are individuals working in the voluntary and community sector who are trained to engage with the local population on our behalf. By working with volunteers in this way the response to our conversations has strengthened and increased, particularly amongst seldom heard groups.

In addition to the work undertaken by the Community Voices, a task and finish group was established to support the scoping of the health optimisation non-elective surgery pathway. The membership of this group included five lay representatives from the following organisations; S2R, Kirklees Local TV, Saathi, Honeyzz and Denby Dale Centre

584 surveys were collected via the Community Voices. The main themes raised from this engagement and previous engagement that has taken place are:

Views on asking people to lose weight or stop smoking prior to a routine operation

- Whilst this engagement did not ask people for their views on asking people to stop smoking or lose weight prior to a routine operation, previous engagement has. Although people were supportive of the idea to encourage people to give up smoking or lose weight prior to a routine operation. It was felt that these decisions should be made by the consultant on a case by case basis. And the decision should be based on the effectiveness of the treatment, impact on the patient if the surgery is delayed (there was some concern that delays in treatment could also lead to further health complications) and impact on the patient if the surgery goes ahead without them giving up smoking or losing weight.

- Many felt that BMI was not a useful indicator of how healthy a person is, many cited examples of people that were physically fit but had high BMI due to muscle mass.
- It was felt that people should be provided with realistic weight loss goals. Views on how much time people should be given to achieve these goals ranged from 2 weeks to 12 months. For smoking this ranged from 6 weeks to 6 months.
- Some questioned why this should be restricted to people who smoke or have a high BMI, and suggested that it should be extended to include people who drink alcohol or take drugs.

Prevention

- It was felt that there was a need to look at prevention by educating adults and children on healthy eating, not smoking and promotion of the benefits of exercise. This should start in schools and include teaching children how to cook.
- For many cost was seen as barrier to leading a healthy lifestyle, it was therefore suggested that people should be provided with reduced or free access to gym memberships, swimming, exercise classes and sport. And ensure these activities are available in local communities. Particular mention was made to enabling all children to be able to access activities for free. And provide fruit and vegetables for free or at a reduced cost. And educate people on how to eat healthily on a budget by running cooking workshops.
- GP practices should target 'at risk' patients to come in for regular health checks and advice. And run drop-in sessions where people can obtain support and guidance.
- Provide people with rewards / incentives if they lose weight or stop smoking, such as healthy food vouchers or subsidised recreational facilities.
- Reduce the number of takeaway outlets.
- Increase the number of free outdoor gyms in local parks.
- The Government should ban smoking and impose restrictions on fat and sugar levels in processed foods.

Supporting people to lose weight and / or stop smoking

- Many felt that the need to lose weight or stop smoking should have already been addressed by the GP prior to the need for surgery, through regular health checks. And support should be offered even if they are not waiting for an operation.
- People highlighted that it can be extremely difficult for some people to lose weight or stop smoking, as there may be an underlying reason as to why they are overweight or smoke. Therefore need to establish if there is any underlying cause and provide appropriate support to tackle this, such as counselling or CBT.
- Explain to people what the risks are if they don’t lose weight / stop smoking, and the benefits if they do. Use patient stories / case studies of people from Kirklees telling the benefits of losing weight / stopping smoking.

Supporting people to lose weight

- If patients were expected to lose weight prior to a routine operation, they should be provided with the appropriate support to enable them to do this. This should include a

referral to a weight management programme such as Slimming World and Weight Watchers. These support services should be provided for free. Some respondents had been referred to these programmes and spoke positively about them. However, many felt that 3 months was not long enough to make a change in lifestyle.

- Provide reduced or free access to gym memberships, personal trainers, swimming, exercise classes and sport. And ensure these activities are available in local communities. The support should be available at a range of times of the day and days of the week to enable people who work or have caring responsibilities to attend.
- Provide fruit and vegetables for free or at a reduced cost. And educate people on how to eat healthily on a budget by running cooking workshops.
- A few people suggested that should look at alternative ways to help people to lose weight, such as hypnotherapy, acupuncture, medication and herbal remedies.

Supporting people to stop smoking

- People who have been asked to stop smoking prior to an operation should be referred to a smoking cessation service and be provided with free counselling, online support, apps, group support, medication, nicotine patches, gum, e-cigarettes or hypnotherapy. The support should continue up to and after their surgery.
- Stop smoking sessions could be held in GP surgeries and community venues, where people could hear ex-smokers talk about how they did it and the benefits they have seen to their health and lifestyle. The sessions should be available at a range of times of the day and days of the week to enable people who work or have caring responsibilities to attend
- There was some concern by some people that if people give up smoking it may lead to them putting on weight, so it was suggested that as part of the support services provided to them this should also include healthy eating and exercise.

2.0 Background

As part of their respective recovery programmes, as well as being standard good practice, the Greater Huddersfield and North Kirklees CCGs have reviewed a range of commissioned services to test whether they are providing the best quality and outcomes, value for money, and that they are an effective and equitable way of using the resources available for the best benefit of the overall population of Kirklees.

Part of this review has looked at the scoping of the introduction of a 'Health Optimisation period' to improve outcomes for active smokers and those with a BMI>30 on a non-urgent elective surgery pathway

One of the many expectations in the NHS Five Year Forward View is that CCGs take action on smoking, obesity and diabetes. In Kirklees we have high levels of chronic obstructive pulmonary disease, cardiovascular disease, type-2 diabetes and cancer, which in many cases are linked to behaviours like smoking, lack of exercise and unhealthy diets. We are working with a range of partners including public health to encourage people to make healthier lifestyle choices and reduce preventable ill-health. The introduction of new criteria for surgery would support this work.

Within West Yorkshire and Harrogate Sustainability and Transformation Partnership, Harrogate and Rural Districts (HaRD) CCG has implemented a Health Optimisation period, effective from 1 November 2016.

Smoking

In England in 2011, an estimated 79,100 adults aged 35 and over died as a result of smoking (18% of all deaths) and nearly half a million hospital admissions for adults aged 35 (5% of all admissions) were attributable to smoking. Treating smoking-related illnesses costs the NHS an estimated £2.7 billion in 2006. The overall financial burden of all smoking to society has been estimated at £13.74 billion a year.

Locally smoking rates vary across Kirklees with significant variations across social and ethnic groups. High level data provided by Public Health indicates that 12% of the adult population in Greater Huddersfield are active smokers and rising to 14% of the adult population in North Kirklees.

It has been agreed by both CCGs to scope the introduction a health optimisation pathway for active smokers referred for non-urgent elective procedures.

BMI

Public Health England reported that the prevalence of obesity amongst adults has increased sharply in the 1990s and early 2000s. The proportion who were categorised as obese (BMI 30kg/m2 or over) increased from 13.2% of men in 1993 to 24.3% in 2014 and from 16.4% of women in 1993 to 26.8% in 2014. Today nearly a third of children aged 2 to

15 are overweight or obese, and younger generations are becoming obese at earlier ages and staying obese for longer.

Reducing obesity levels will save lives as obesity doubles the risk of dying prematurely. Obese adults are seven times more likely to become a type 2 diabetic than adults of a healthy weight, this may cause blindness or limb amputation. And not only are obese people more likely to get physical health conditions like heart disease, they are also more likely to be living with conditions like depression, which can have an impact on motivation, medication may cause weight gain etc.

The burden is falling hardest on those children from low-income backgrounds. Obesity rates are highest for children from the most deprived areas and this is getting worse. Children aged 5 and from the poorest income groups are twice as likely to be obese compared to their most well off counterparts and by age 11 they are three times as likely.

Locally 20% of the adult population is assessed as obese in Greater Huddersfield and 24% in North Kirklees. These rates vary significantly across social and ethnic groupings.

It has been agreed by both CCGs to scope the introduction of a health optimisation pathway for patients with a BMI over 30 referred for non-urgent elective procedures.

Kirklees Integrated Wellness Model

The support services that people would be referred to, as part of the health optimisation pathway are also currently being reviewed. Public Health, Kirklees Council, with partners in the NHS, social care and the voluntary sector, are leading the development of an Integrated Wellness Model to support and enable adults in Kirklees to lead healthier, happier lives and be more physically active. This is a major service redesign based on integration of a number of services and interventions covering health improvement, self-care and long term conditions. The new model will be in place by 1 April 2018. Support services will be provided by Primary Care until the Wellness Model is implemented in April 2018.

To support the development of the Wellness model, work is taking place with key stakeholders and service users. The research is scheduled to commence February / March 2017, with a summary by early May 2017.

As the development of the Kirklees Integrated Wellness Model will include gaining views on support services, such as smoking cessation and weight management, this intelligence will be used to influence the scoping of the Health Optimisation for the non-urgent elective surgery pathways, and the views and feedback from service users will be included in any re-design.

3.0 Our responsibilities, including legal requirements

3.1 Our responsibilities

Engaging people is not just about fulfilling a statutory duty or ticking boxes, it is about understanding and valuing the benefits of listening to patients and the public in the commissioning process.

By involving local people we want to give them a say in how services are planned, commissioned, delivered and reviewed. We recognise it is important who we involve through engagement activity. Individuals and groups play different roles and there needs to be engagement opportunities for both.

Engaging people who use health and social care services, and other stakeholders in planning services is vital to ensure services meet the needs of local communities. It is also a legal requirement that patients and the public are not only consulted about any proposed changes to services, but have been actively involved in developing the proposals.

3.2 Legal requirements

There are a number of requirements that must be met when discussions are being made about the development of services, particularly if any of these will impact on the way these services can be accessed by patients. Such requirements include the Health and Social Care Act 2012 and the NHS Constitution.

Health and Social Care Act 2012, makes provision for CCGs to establish appropriate collaborative arrangements with other CCGs, local authorities and other partners, and it also places a specific duty on CCGs to ensure that health services are provided in a way which promotes the NHS Constitution - and to promote awareness of the NHS Constitution.

Specifically, CCGs must involve and consult patients and the public:

- in their planning of commissioning arrangements
- in the development and consideration of proposals for changes in the commissioning arrangements, where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and
- in decisions affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact

The Act also updates Section 244 of the consolidated NHS Act 2006 which requires NHS organisations to consult relevant Overview and Scrutiny Committees (OSC) on any proposals for a substantial development of the health service in the area of the local authority, or a substantial variation in the provision of services.

The duties to involve and consult were reinforced by the NHS Constitution which stated: 'You have the right to be involved directly or through representatives, in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services'.

The Equality Act 2010 unifies and extends previous equality legislation. Nine characteristics are protected by the Act, age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

Section 149 of the Equality Act 2010 states that all public authorities must have due regard to the need to a) eliminate discrimination, harassment and victimisation, b) advance 'Equality of Opportunity', and c) foster good relations. To help support organisations to meet these duties a set of principles have been detailed in case law. These are called the Brown Principles;

- The organisation must be aware of their duty.
- Due regards is fulfilled before and at the time any change is considered as well as at the time a decision is taken. Due regards involves a conscious approach and state of mind.
- The duty cannot be satisfied by justifying a decision after it has been taken.
- The duty must be exercised in substance, with rigour and with an open mind in such a way that it influences the final decision.
- The duty is a non-delegable one.
- The duty is a continuing one.

An Equality Impact Assessment (EQIA) will need to be undertaken on any proposals for changes to services that are developed through the programme, in order to understand any potential impact on protected groups and ensure equality of opportunity. Engagement must span all protected groups and other groups, and care should be taken to ensure that seldom-heard interests are engaged with and supported to participate, where necessary.

The Gunning Principles of Consultation are recommended as a framework for all engagement activity but are particularly relevant for consultation and would be used, in the event of a judicial review, to measure whether the process followed was appropriate. The Gunning Principles state that:

- Consultation must take place when the proposal is still at a formative stage
- Sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response.
- Adequate time must be given for consideration and response
- The product of consultation must be conscientiously taken into account

4.0 Engagement process

As part of the scoping exercise we needed to understand the needs of people that may be impacted by the introduction of health optimisation. Some initial work had been undertaken during September 2016 – February 217 by Healthwatch Kirklees and both CCGs, which had provided some insight, but as these views were mainly from White British people they were not representative of our communities. And as such this work needed to focus on gaining the views from those people who are seldom heard and those within protected groups.

To support this work we recruited the following Community Voices to have conversations within their communities, using the survey (see Appendix B) as a template for discussion. Community Voices 'deliver conversations with targeted service users from a variety of local areas, protected groups and communities. Community Voices are individuals working in the voluntary and community sector who are trained to engage with the local population on our behalf. By working with volunteers in this way the response to our conversations has strengthened and increased, particularly amongst seldom heard groups.

The Community Voices were able to choose the most appropriate approach to engage with their community.

1. Auntie Pams
2. Carers Count
3. Huddersfield Pakistani Community Alliance
4. Kirklees Local TV
5. KVIN- Kirklees Visual Impairment Network
6. Mencap in Kirklees
7. Moldgreen United Reformed Church
8. PCAN
9. PRJM Ltd.
10. Raabani Matriach Support
11. RCCL
12. Saathi Community Enterprise Ltd.
13. Support to Recovery

The engagement commenced on 6th March 2017 and ran for 5 weeks.

In addition to the work undertaken by the Community Voices, a task and finish group was established to support the scoping of the health optimisation non-elective surgery pathway. The membership of this group included five representatives from the following organisations; S2R, Kirklees Local TV, Saathi, Honeyzz and Denby Dale Centre.

5.0 Analysis of existing engagement

A review of any existing engagement that had taken place about BMI and smoking took place. The following is a summary of the existing engagement:

Healthwatch Kirklees

During September 2016, Healthwatch Kirklees used social media to ask people their views on the approach being taken by the Vale of York CCG in introducing BMI and smoking thresholds for non-urgent surgery. They received back 203 survey, 63 for smoking and 140 for BMI.

- Whilst people were supportive of the idea to encourage people to give up smoking or lose weight prior to a routine operation. It was felt that these decisions should be made by the consultant on a case by case basis. And the decision should be based on the effectiveness of the treatment, impact on the patient if the surgery is delayed (there was some concern that delays in treatment could also lead to further health complications) and impact on the patient if the surgery goes ahead without them giving up smoking or losing weight.
- If patients were expected to give up smoking or lose weight prior to a routine operation, they should be provided with the appropriate support to enable them to do this. Such as referral to a weight management programme, smoking cessation, gym membership etc.
- People highlighted that it can be extremely difficult for some people to lose weight, as their weight may have been caused due to the side effects of medication, mental health conditions, or a medical condition that restricts their ability to exercise.
- Many felt that BMI was not a useful indicator of how healthy a person is, many cited examples of people that were physically fit but had high BMI due to muscle mass.
- It was felt that there was a need to look at prevention by educating adults and children on healthy eating and promotion of the benefits of exercise.
- Some questioned why this should be restricted to people who smoke or have a high BMI, and suggested that it should be extended to include people who drink alcohol or take drugs.

The report can be accessed here: https://www.northkirkleesccg.nhs.uk/wp-content/uploads/2014/05/Smoking-and-BMI-engagement-report-FINAL-1.pdf

North Kirklees CCG

In addition to the work done by Healthwatch Kirklees, North Kirklees CCG used their quarterly engagement event on 30th November 2016 to ask local people, voluntary and community sector organisations and key stakeholders about asking people to stop smoking and / or lose weight prior to a routine operation. The key themes raised were:

Smoking

- People were supportive of the idea to encourage people to give up smoking prior to a routine operation if it led to an improvement in health outcomes. However, they were concerned if it became mandatory and led to people being denied treatment.
- It was felt that the operation should still go ahead even if they are unsuccessful.
- It was suggested that the operation date should be confirmed, and whilst the patient is waiting for their operation they should be provided with support to stop smoking.
- Smoking was seen as an addiction, and that many people would not find it easy to stop without the appropriate support being provided.
- There was some concern about the impact on the patient if the surgery is delayed and if this could lead to further health complications.

BMI

- People were supportive of the idea to encourage people to lose weight prior to a routine operation.
- Many felt that BMI was not a useful indicator of how healthy a person is.
- People highlighted that it can be extremely difficult for some people to lose weight, as their weight may have been caused due to the side effects of medication, mental health conditions, or a medical condition that restricts their ability to exercise.
- If patients were expected to lose weight prior to a routine operation, they should be provided with the appropriate support to enable them to do this.
- There was some concern about the impact on the patient if the surgery is delayed and if this could lead to further health complications.
- It was felt that there was a need to look at prevention by educating adults and children on healthy eating and promotion of the benefits of exercise.

The report can be accessed here: https://www.northkirkleesccg.nhs.uk/wp-content/uploads/2016/11/Engagement-Event-30th-November-2016-Report.pdf

Greater Huddersfield CCG

Greater Huddersfield CCG held sessions with their Community Voices and their Patient Reference Group Network.

Community Voices session was held on 12th January 2017. The purpose of the session was to let them know about health optimisation and to ask them to:

- Think about how we can work with your local community to understand the impact of this change.
- Work together to identify what needs to happen to make the change work in our local area.
- Support a new ‘pathway design’

From the discussions the following comments were made:

- Raise awareness of campaigns such as self-care/ looking after yourself and have information as early as possible
- Leading conversations should be avoided, have less judgemental conversations. How do we shift people in conversation
- Appropriate techniques to support people
- Interlinked with mental health i.e. body image/ self esteem
- Behavioural change
- Understand the information i.e. criteria's & thereafter inform the community
- Positive benefits
- Promotional material- leaflets/videos
- Needing surgery is a stressful/triggers point, this need to be acknowledged.
- Success stories are good tool for people going on the journey
- Impact greater on vulnerable communities
- Quick/ easier and cheaper food options is more appropriate for some
- Different techniques for different communities (one size does not fit for all)
- Voucher schemes- incentive – difficult with NHS having to save money
- South Asian communities- go through mosques etc to engage a wider audience
- Go through churches & schools, early intervention.
- Utilising appropriate community venues
- Sign posting i.e. health trainers/ PALS/Overeater anonymous etc.

Patient Reference Group Network at their meeting on the 2nd February 2017. The main themes raised were:

- People should be told as soon as possible about the need to lose weight or stop smoking.
- People need to be given a clear explanation of what's happening, when and what the benefits and dangers are to their health
- Practical support on diet, nutrition and exercise should be provided, this shouldn't just be in the form of literature.
- Support needs to be provided before the operation and continue after the operation.
- Deliver consistent messages locally across the patch.
- Stopping smoking can cause weight gain – which is the most critical – stopping smoking or losing weight?
- Many felt that BMI was not a useful indicator of how healthy a person is.

6.0 Analysis of engagement feedback

We received feedback on the engagement via 584 completed surveys.

Appendix C provides a breakdown of the protected characteristics of the survey respondents. It should be noted that approximately 10% of people did not complete the equality monitoring form, however, in summary the survey respondents were:

- **62.1% (339)** were female and **36.4% (199)** were male
- **1.4% (7)** stated that their gender was different to the sex they were assumed to be at birth
- Respondents were aged between 10 and 90, with an average age of 40
- **85.5% (429)** described themselves as heterosexual, **1.2% (6)** as lesbian, **2.4% (12)** as gay, and **2.8% (14)** as bisexual.
- The majority of respondents, **60.4% (328)** described themselves as White, **25% (136)** as Asian or Asian British, **6.4% (35)** as Black or Black British; and **4.4% (26)** as mixed or multiple ethnic groups.
- **35.6% (191)** stated that they identified with Christianity, **29.6% (159)** no religion and **21% (113)** Islam
- **18.3% (93)** provide care for someone
- **14.8% (81)** described themselves as having a disability. With the majority having a long term condition and / or a disability that was physical or mobility or a mental health condition.

In terms of where people live, 540 (92.5%) people provided the first part of their postcode. Of these, 75.4% (407) were from Greater Huddersfield postcodes, 20.9% (113) were from North Kirklees postcodes, and 3.7% (20) were out of the area. As the majority of the Commuity Voices are organsiations that represent Greater Huddersfield, these results are not surprising.

Q1. Please tell us how we could encourage people in Kirklees to live a healthy lifestyle

578 (98.9% of all respondents) respondents provided a comment, the main themes raised were:

- Some people felt that there tends to be an underlying reason as to why people are overweight or smoke. Therefore need to establish if there is any underlying cause and provide appropriate support to tackle this.
- For many cost was seen as barrier to leading a healthy lifestyle, it was therefore suggested that people should be provided with reduced or free access to gym memberships, swimming, exercise classes and sport. And ensure these activities are available in local communities. Particular mention was made to enabling all children to be able to access activities for free. And provide fruit and vegetables for free or at a reduced cost. And educate people on how to eat healthily on a budget by running cooking workshops.

- Start in schools, educating children on the benefits of eating healthy and exercising, and teaching them how to cook.
- Provide access to weight loss programmes for free, such as Slimming World and Weight Watchers
- Provide support groups and buddying schemes to encourage people to maintain a healthy lifestyle and stop smoking.
- Raise awareness of what is already available and how people can access the support / services.
- GP practices should target 'at risk' patients to come in for regular health checks and advice. And run drop-in sessions where people can obtain support and guidance.
- Explain to people what the risks are if they don't lose weight / stop smoking, and the benefits if they do. Use patient stories / case studies of people from Kirklees telling the benefits of losing weight / stopping smoking.
- Some people felt that the onus is on the individual to want to lose weight / stop smoking.
- Reduce the number of takeaway outlets.
- Increase the number of outdoor gyms in local parks
- Provide people with rewards / incentives if they lose weight or stop smoking, such as healthy food vouchers, subsidised recreational facilities.

Q2. Please tell us what support you think should be available to help people lose weight before their surgery.

567 (97.1% of all respondents) respondents provided a comment, the main themes raised were:

- Some people felt that the onus is on the individual to want to lose weight.
- Many people highlighted that it can be extremely difficult for some people to lose weight, as their weight may have been caused due to the side effects of medication, mental health conditions, or a medical condition that restricts their ability to exercise. Need to establish if there is any underlying cause to them being overweight, and provide appropriate support to tackle this, such as counselling, CBT.
- Provide reduced or free access to gym memberships, personal trainers, swimming, exercise classes and sport. And ensure these activities are available in local communities.
- Provide fruit and vegetables for free or at a reduced cost. And educate people on how to eat healthily on a budget by running cooking workshops.
- Explain to people what the risks are if they don't lose weight, and the benefits if they do. Use patient stories / case studies of people from Kirklees telling the benefits of losing weight.
- Provide access to a weight loss programme such as Weight Watchers or Slimming World. Some respondents had been referred to these programmes and spoke positively about them. However, many felt that 3 months was not long enough to make a change in lifestyle.

- Regular check-ups to monitor progress and to provide encouragement and support. This support should continue once the person has lost the weight and after surgery.
- To look at alternatives way to help people to lose weight, such as hypnotherapy, acupuncture, medication and herbal remedies.
- Support groups provided in local community so they can meet people going through it together.
- Leaflets about how lose weight i.e. what foods to eat, exercise plan. A guide as to what is a healthy weight and how it impacts on your health i.e. heart disease and diabetes.
- Give rewards for losing weight e.g. shopping vouchers.

Q3. When and how do you think that support should be provided?

557 (95.4% of all respondents) respondents provided a comment, the main themes raised were:

- Many felt that the need to lose weight should have already been addressed by the GP prior to the need for surgery, through regular health checks. And support should be offered even if they are not waiting for an operation.
- Most people felt that if someone is told to lose weight just because they need surgery, they should be provided with free regular support immediately, and this should continue up to and after their surgery. They should be provided with realistic weight loss goals. Views on how much time people should be given to achieve these goals ranged from 2 weeks to 12 months.
- When advised that they need to lose weight they should be referred to a weight loss programme, such as Weight Watchers or Slimming World and be given free membership to a gym. In addition to this they should be provided with a range of information of what is available locally, such as support groups, walking groups etc. The support should be available at a range of times of the day and days of the week to enable people who work or have caring responsibilities to attend.
- Some people highlighted that it can be extremely difficult for some people to lose weight, as their weight may have been caused due to the side effects of medication, mental health conditions, or a medical condition that restricts their ability to exercise. Establish if there is any underlying cause to them being overweight, and provide appropriate support to tackle this, such as counselling or CBT.

Q4. Please tell us what support you think should be available to help people stop smoking before their surgery

544 (93.1% of all respondents) respondents provided a comment, the main themes raised were:

- Many described smoking as an addiction and as such it is very difficult to stop. To support people in doing this it was felt that they should be referred to a smoking cessation service and be provided with free counselling, group support, medication, nicotine patches, gum or e-cigarettes. Other suggestions were hypnotherapy, reflexology, CBT and acupuncture.

- Stop smoking sessions could be held in GP surgeries and community venues, where people could hear ex-smokers talk about how they did it and the benefits they have seen to their health and lifestyle.
- Some people felt that there was a need to understand why they smoke and try to address any underlying issues.
- There was some concern by some people that if people give up smoking it may lead to them putting on weight, so it was suggested that as part of the support services provided to them this should also include healthy eating and exercise.
- Need to raise awareness of the impact smoking has on the body, and the complications it can cause when someone requires surgery. And the benefits of stopping smoking, both in terms of health and financial.
- Many felt that was already a lot of support available that people can access if they wish to stop smoking.
- Some people felt that cigarettes should be banned.

Q5. When and how do you think that support should be provided?

525 (89.9% of all respondents) respondents provided a comment, the main themes raised were:

- Many felt that the need to stop smoking should have already been addressed by the GP prior to the need for surgery, through regular health checks. And support should be offered even if they are not waiting for an operation.
- Many acknowledged that whilst it is difficult to stop smoking, surgery may be the incentive they need to stop.
- People who have been asked to stop smoking prior to an operation should be referred to a smoking cessation service and be provided with free counselling, online support, apps, group support, medication, nicotine patches, gum, e-cigarettes or hypnotherapy. The support should continue up to and after their surgery. Views on how much time people should be given to stop smoking prior to their operation ranged from 6 weeks to 6 months.
- Need to raise awareness of the impact smoking has on the body, and the complications it can cause when someone requires surgery. And the benefits of stopping smoking, both in terms of health and financial.
- Stop smoking sessions could be held in GP surgeries and community venues. The sessions should be available at a range of times of the day and days of the week to enable people who work or have caring responsibilities to attend.
- Many felt that there should be a real focus on prevention and reducing the number of young people that take up smoking.

Q6. Please use this space to provide any additional comments you have about supporting people to lose weight or stop smoking.

350 (59.9% of all respondents) respondents provided a comment, the main themes raised were:

- Many felt that the need to lose weight or stop smoking should have already been addressed by the GP prior to the need for surgery, through regular health checks. And support should be offered even if they are not waiting for an operation.
- Many people highlighted that it can be extremely difficult for some people to lose weight, as their weight may have been caused due to the side effects of medication, mental health conditions, or a medical condition that restricts their ability to exercise. To tackle their weight the underlying causes need to be addressed first. This was felt to be the same for people that smoke.
- Some felt that people are aware of the dangers of smoking and being overweight but don't believe that it will impact on their health.
- Some felt that there was a need for community groups to receive more funding to enable them to support their communities to lead healthier lifestyles.
- Many felt that people need a supportive environment to help them to lose weight or give up smoking. This could be provided through buddying, support groups, community groups etc.
- Some people felt that cigarettes should be banned and processed foods should be more expensive.
- Focus on prevention and start in schools, educating children on the benefits of eating healthy, exercising, not smoking; and teaching them how to cook.
- For many cost was seen as barrier to leading a healthy lifestyle, it was therefore suggested that people should be provided with reduced or free access to gym memberships, swimming, exercise classes and sport. And ensure these activities are available in local communities. Particular mention was made to enabling all children to be able to access activities for free. And provide fruit and vegetables for free or at a reduced cost. And educate people on how to eat healthily on a budget by running cooking workshops.
- Provide access to smoking cessation and weight loss programmes for free.
- Raise awareness of what is already available and how people can access the support / services.
- Some people felt that the onus is on the individual to want to lose weight / stop smoking.
- A few people commented that they had been asked to lose weight prior to surgery but had not been provided with the appropriate support to enable them to do this.

7.0 Equality

The data has been analysed to understand if the respondents were representative of the local population based on the 2011 Census data and to also understand if there were any trends or differences in responses by particular communities or groups.

Approximately 10% of survey respondents chose not to complete the equality monitoring form, and some were partially completed.

Sex

From experience of previous surveys we know that women are much more likely to respond to surveys and often take more responsibility for family health, so the increased response rate is somewhat expected.

	Census profile %	Respondents profile %	Differential
Male	49.4%	36.4%	-13.0
Female	50.6%	62.1%	+11.5

Age

	Census profile %	Respondents profile %	Differential
15 and under	20.4%	8.4%	-12.0
16-24	12.0%	15.2%	+3.2
25-44	27.1%	36.7%	+9.6
45-59	19.2%	22.1%	+2.9
60-64	6.1%	6.5%	+0.4
65-74	8.3%	7.9%	-0.4
75-84	5.0%	2.9%	-2.1
85 and over	1.9%	0.4%	-1.5

Given the programme will have an impact on children it is unfortunate that their views are not evident in the engagement, this will need to be considered going forward.

Ethnic group

It should be noted that:

- White British includes English, Welsh, Scottish, Northern Ireland, British.
- White Other includes Irish, Gypsy or Irish Traveller, any other white groups.
- Asian/Asian British includes Indian, Pakistani, Bangladeshi, Chinese and any other Asian background.
- Mixed/multiple ethnic background includes White and Black Caribbean, White and Black African, White and Asian and other mixed/multiple ethnic background.
- Other ethnic group includes Arab and any other ethnic group.

	Census profile %	Respondents profile %	Differential
White/White British	76.7%	57.8%	-18.9
White other	2.5%	2.6%	+0.1
Mixed/multiple ethnic group	2.3%	4.4%	+2.1
Asian/Asian British	16.0%	25.0%	+9.0
Black/African/Caribbean/ Black British	1.9%	6.4%	+4.5
Other ethnic group: Arab	0.6%	0.2%	-0.4

Religion

	Census profile %	Respondents profile %	Differential
Christian	53.4%	35.6%	-18.8
Buddhism	0.2%	0.4%	+0.2
Hindu	0.4%	1.5%	+1.1
Judaism	0.0%	0.0%	
Muslim	14.5%	21.0%	+6.5
Sikhism	0.8%	1.5%	+0.7
Other religion	0.3%	5.8%	+5.5
No religion	23.9%	29.6%	+5.7

Disability

It should be noted that census data collected asks people to identify if their day to day activities are limited a lot or a little, where as our equality monitoring asks people if they would describe themselves as disabled. This data has been combined to create an overall percentage of people that have some level of difficulty with day to day activities.

	Census profile %	Respondents profile %	Differential
Disability	17.7%	14.8%	-2.9

Carers

	Census profile %	Respondents profile %	Differential
Carers	10.3%	18.3%	+8.0

Lesbian, Gay, Bisexual and Transgender

It should be noted that accurate demographic data is not available for these groups as it is not part of the census collection. The most up to date information we have about sexual

orientation is found through the Office of National Statistics (ONS), whose Integrated House Survey for April 2011 to March 2012 estimates that approximately 1.5% of the UK population are Gay/Lesbian or Bisexual. However, HM Treasury's 2005 research estimated that there are 3.7 million LGB people in the UK, giving a higher percentage of 5.85% of the UK population.

Transgender and Trans are an umbrella term for people whose gender identity and/or gender expression differs from the sex they were assigned at birth. One study suggested that the number of Trans people in the UK could be around 65,000 (Johnson, 2001, p. 7), while another notes that the number of gender variant people could be around 300,000 (GIRES, 2008b).

Lesbian, Gay and Bisexual %	Transgender %
6.4%	1.4%

Under representation

As can be seen from the tables above the reach of the survey has met with a representative sample of most of our communities. However to understand what, if any, under representation existed between known demographic profiles and people responding to the survey, the section below highlights any difference of -2.5 or more. The underrepresented groups were;

- People aged 15 and under
- Males
- Christians
- White / White British
- Disabled people

However, it should be noted that in the previous engagement that has taken place, White / White British were overrepresented. The latter groups; men, Christians and White/White British whilst underrepresented were still represented in significant numbers so we can feel comfortable that we have heard their voices, albeit not at a representative level. For children and young people under 15 and possibly disabled people who are more likely to be impacted by the programme further activity would need to be considered.

Analysis

Utilising the themes identified across the survey in the open questions, analysis has been undertaken to understand if there is any difference in the responses to these questions by people from protected groups. Caution should be applied as some themes are raised by relatively few people.

Asian / Asian British

The following suggestions were made:

- That there should be healthy eating classes specifically focused on Asian food.

- Information that is provided should be in community languages and be culturally sensitive.
- Hold healthy living sessions in local communities and have members of the Asian community trained as health champions.
- Hold more women only exercise classes.
- The services provided need to understand Asian community culture and eating habits.

Disability

A couple of people mentioned that the sports facilities provided by Kirklees Active Leisure are not accessible for wheelchair users.

Carers

The following suggestions were made:

- It was felt by some that there was a need to provide support services specifically for carers, which would support them in being able to undertake exercise and eat a healthy diet. These activities would need to fit in around their caring responsibilities and should be provided for free. Suggestions made were gym membership, walking groups, weight management course, managing stress and support groups.
- Health professionals need to be more aware of the issues faced by carers, and how this can impact on their mental and physical health. Some felt that carers should have regular health checks to monitor their health so they are able to continue to be carers.

8.0 Summary of key themes from existing data and the engagement

The main themes raised from existing data and the engagement are:

Views on asking people to lose weight or stop smoking prior to a routine operation

- Whilst this engagement did not ask people for their views on asking people to stop smoking or lose weight prior to a routine operation, previous engagement has. Although people were supportive of the idea to encourage people to give up smoking or lose weight prior to a routine operation. It was felt that these decisions should be made by the consultant on a case by case basis. And the decision should be based on the effectiveness of the treatment, impact on the patient if the surgery is delayed (there was some concern that delays in treatment could also lead to further health complications) and impact on the patient if the surgery goes ahead without them giving up smoking or losing weight.
- Many felt that BMI was not a useful indicator of how healthy a person is, many cited examples of people that were physically fit but had high BMI due to muscle mass.
- It was felt that people should be provided with realistic weight loss goals. Views on how much time people should be given to achieve these goals ranged from 2 weeks to 12 months. For smoking this ranged from 6 weeks to 6 months.
- Some questioned why this should be restricted to people who smoke or have a high BMI, and suggested that it should be extended to include people who drink alcohol or take drugs.

Prevention

- It was felt that there was a need to look at prevention by educating adults and children on healthy eating, not smoking and promotion of the benefits of exercise. This should start in schools and include teaching children how to cook.
- For many cost was seen as barrier to leading a healthy lifestyle, it was therefore suggested that people should be provided with reduced or free access to gym memberships, swimming, exercise classes and sport. And ensure these activities are available in local communities. Particular mention was made to enabling all children to be able to access activities for free. And provide fruit and vegetables for free or at a reduced cost. And educate people on how to eat healthily on a budget by running cooking workshops.
- GP practices should target 'at risk' patients to come in for regular health checks and advice. And run drop-in sessions where people can obtain support and guidance.
- Provide people with rewards / incentives if they lose weight or stop smoking, such as healthy food vouchers or subsidised recreational facilities.
- Reduce the number of takeaway outlets.
- Increase the number of free outdoor gyms in local parks.
- The Government should ban smoking and impose restrictions on fat and sugar levels in processed foods.

Supporting people to lose weight and / or stop smoking

- Many felt that the need to lose weight or stop smoking should have already been addressed by the GP prior to the need for surgery, through regular health checks. And support should be offered even if they are not waiting for an operation.
- People highlighted that it can be extremely difficult for some people to lose weight or stop smoking, as there may be an underlying reason as to why they are overweight or smoke. Therefore need to establish if there is any underlying cause and provide appropriate support to tackle this, such as counselling or CBT.
- Explain to people what the risks are if they don't lose weight / stop smoking, and the benefits if they do. Use patient stories / case studies of people from Kirklees telling the benefits of losing weight / stopping smoking.

Supporting people to lose weight

- If patients were expected to lose weight prior to a routine operation, they should be provided with the appropriate support to enable them to do this. This should include a referral to a weight management programme such as Slimming World and Weight Watchers. These support services should be provided for free. Some respondents had been referred to these programmes and spoke positively about them. However, many felt that 3 months was not long enough to make a change in lifestyle.
- Provide reduced or free access to gym memberships, personal trainers, swimming, exercise classes and sport. And ensure these activities are available in local communities. The support should be available at a range of times of the day and days of the week to enable people who work or have caring responsibilities to attend.
- Provide fruit and vegetables for free or at a reduced cost. And educate people on how to eat healthily on a budget by running cooking workshops.
- A few people suggested that should look at alternative ways to help people to lose weight, such as hypnotherapy, acupuncture, medication and herbal remedies.

Supporting people to stop smoking

- People who have been asked to stop smoking prior to an operation should be referred to a smoking cessation service and be provided with free counselling, online support, apps, group support, medication, nicotine patches, gum, e-cigarettes or hypnotherapy. The support should continue up to and after their surgery.
- Stop smoking sessions could be held in GP surgeries and community venues, where people could hear ex-smokers talk about how they did it and the benefits they have seen to their health and lifestyle. The sessions should be available at a range of times of the day and days of the week to enable people who work or have caring responsibilities to attend
- There was some concern by some people that if people give up smoking it may lead to them putting on weight, so it was suggested that as part of the support services provided to them this should also include healthy eating and exercise.

9.0 Conclusion

The engagement process has provided the CCGs with the views and suggestions of the public and voluntary and community sector organisations, on what support and information people would require, to help them lose weight or quit smoking. These views will be considered as part of the scoping of a Health Optimisation programme.

This report will be made publically available and feedback provided to those respondents who have requested it.
We would like to thank all respondents who have given their time to share their views.

Appendix A – Engagement action plan

Activity	9/1	16/1	23/1	30/1	6/2	13/2	20/2	27/2	6/3	13/3	20/3	27/3	3/4	10/4	17/4	24/4	1/5	8/5	15/5	22/5	29/5	June onwards
Develop and agree engagement action plan																						
Recruit community assets to undertake engagement																						
Recruit lay reps for Health Optimisation Task and Finish Group																						
Develop and agree patient survey																						
Engagement by Community Assets takes place																						
Inputting of surveys online																						
Analysis of both existing and data from current engagement.																						
Production of engagement report.																						
Present the report to Health Optimisation Task and Finish group																						
Feedback to the public																						

Appendix B – Survey

NHS North Kirklees Clinical Commissioning Group
NHS Greater Huddersfield Clinical Commissioning Group

Survey

Greater Huddersfield and North Kirklees CCGs have decided to ask people to improve their health before undergoing surgery.

What was the decision?
Patients with a BMI over 30 and smokers will be asked to try to lose weight or quit smoking before undergoing routine, non-urgent surgery.

What are the reasons for the change?
There is evidence that people who smoke or who are obese experience more complications during and after surgery and can take longer to recover.

The NHS Five Year Forward View asks CCGs to take action on smoking, obesity and diabetes. In Kirklees we have high levels of chronic obstructive pulmonary disease, cardiovascular disease, type-2 diabetes and cancer. In many cases these are linked to smoking, lack of exercise and unhealthy diets. We are already working with a range of partners to encourage people to make healthier lifestyle choices and reduce preventable ill-health.

This is not a ban on surgery and people who do not wish to access support services or fail to lose weight or stop smoking will not be denied their operation. .

We would welcome any thoughts or suggestions you have about how we support people to stop smoking and / or lose weight before a routine non-urgent operation.

Please insert organisation name

Q1. Please tell us how we could encourage people in Kirklees to live a healthy lifestyle

Support services to help people to lose weight

Q2. Please tell us what support you think should be available to help people lose weight before their surgery.

Q3. When and how do you think that support should be provided?

Support services to help people to stop smoking

Q4. Please tell us what support you think should be available to help people stop smoking before their surgery

Q5. When and how do you think that support should be provided?

Q6. Please use this space to provide any additional comments you have about supporting people to lose weight or stop smoking.

Equality monitoring

In order to ensure that we provide the right services and to ensure that we avoid discriminating against any section of our community, it is important for us to gather the following information. No personal information will be released when reporting statistical data and data will be protected and stored securely in line with data protection rules. This information will be kept confidential.

1. What is the first part of your postcode?

Example	HD6
Yours	

☐ Prefer not to say

2. What sex are you?

☐ Male ☐ Female

☐ Prefer not to say

3. How old are you?

Example	42
Yours	

☐ Prefer not to say

4. Which country were you born in?

☐ Prefer not to say

5. Do you belong to any religion?

☐ Buddhism
☐ Christianity
☐ Hinduism
☐ Islam
☐ Judaism
☐ Sikhism
☐ No religion
☐ Other (Please specify in the box below)

☐ Prefer not to say

6. What is your ethnic group?

Asian or Asian British:

☐ Indian
☐ Pakistani
☐ Bangladeshi
☐ Chinese
☐ Other Asian background (please specify)

Black or Black British:

☐ Caribbean
☐ African
☐ Other Black background (please specify)

Mixed or multiple ethnic groups:

☐ White and Black Caribbean
☐ White and Black African
☐ White and Asian
☐ Other mixed background (please specify)

White:

☐ English/Welsh/Scottish/Northern Irish/British
☐ Irish
☐ Gypsy or Irish Traveller
☐ Other White background (please specify)

Other ethnic groups:

☐ Arab
☐ Any other ethnic group (please specify)

☐ Prefer not to say

7. Do you consider yourself to be disabled?

☐ Yes ☐ No

☐ Prefer not to say

Type of impairment:

Please tick all that apply

☐ **Physical or mobility impairment**
(such as using a wheelchair to get around and / or difficulty using their arms)

☐ **Sensory impairment**
(such as being blind / having a serious visual impairment or being deaf / having a serious hearing impairment)

☐ **Mental health condition**
(such as depression or schizophrenia)

☐ **Learning disability**
(such as Downs syndrome or dyslexia) or cognitive impairment (such as autism or head-injury)

☐ **Long term condition**
(such as cancer, HIV, diabetes, chronic heart disease, or epilepsy)

☐ Prefer not to say

8. Are you a carer?

Do you look after, or give any help or support to a family member, friend or neighbour because of a long term physical disability, mental ill-health or problems related to age?

☐ Yes ☐ No

☐ Prefer not to say

9. Are you pregnant?

☐ Yes ☐ No

☐ Prefer not to say

10. Have you given birth in the last 6 months?

☐ Yes ☐ No

☐ Prefer not to say

11. What is your sexual orientation?

☐ Bisexual (both sexes)

☐ Gay (same sex)

☐ Heterosexual/straight (opposite sex)

☐ Lesbian (same sex)

☐ Other

☐ Prefer not to say

12. Are you transgender?

Is your gender identity different to the sex you were assumed at birth?

☐ Yes ☐ No

☐ Prefer not to say

Thank you for taking the time to complete this survey.

Please return to:
FREEPOST RTEJ-AGSA-UAZL
NHS North Kirklees CCG
4th Floor
Empire House
Wakefield Old Road
Dewsbury
WF12 8DJ

Please return no later than Friday 7th April 2017. Unfortunately, we cannot accept any responses after this date.

Appendix C – Equality monitoring data

Q1. What is the first part of your postcode? e.g. HD1, WF10, BD4, LS13, HX6. If you would prefer not to say, please leave the box blank

Answer Options	Response Percent	Response Count
BD1	0.2%	1
BD6	0.2%	1
BD8	0.2%	1
BD9	0.2%	1
BD11	0.2%	1
BD13	0.2%	1
BD19	0.6%	3
DN8	0.2%	1
HD1	11.9%	64
HD2	12.0%	65
HD3	9.4%	51
HD4	12.0%	65
HD5	13.0%	70
HD6	0.9%	5
HD7	4.4%	24
HD8	4.4%	24
HD9	7.2%	39
HX3	0.6%	3
HX5	0.2%	1
HX6	0.4%	2
LS7	0.2%	1
OL4	0.2%	1
OL14	0.2%	1
WF3	0.2%	1
WF5	0.6%	3
WF6	0.2%	1
WF12	2.2%	12
WF13	3.1%	17
WF14	2.2%	12
WF15	1.1%	6
WF16	0.6%	3
WF17	10.9%	59
answered question		**540**
skipped question		**44**

Q2. What sex are you?

Answer Options	Response Percent	Response Count
Male	36.4%	199
Female	62.1%	339
Prefer not to say	1.5%	8
answered question		**546**
skipped question		**38**

Q3. How old are you? e.g. 42

Answer Options	Response Percent	Response Count
16 and under	9.6%	50
17-25	15.4%	80
26-35	18.0%	94
36-45	18.8%	98
46-55	15.4%	80
56-65	13.4%	70
66-75	6.5%	34
76-85	2.5%	13
86 and over	0.4%	2
answered question		**521**
skipped question		**63**

Q4. Which country were you born in?

Answer Options	Response Percent	Response Count
Africa	0.4%	2
America	0.2%	1
Barbados	0.2%	1
Britain	1.2%	6
Canada	0.2%	1
China	0.2%	1
EU	0.2%	1
England	57.7%	280
France	0.2%	1
Great Britain	0.6%	3
Germany	0.4%	2
Grenada	0.2%	1
Hong Kong	0.2%	1
India	1.9%	9
Ireland	0.2%	1
Jamaica	1.2%	6
Jordan	0.2%	1
Kashmir	0.2%	1
Nigeria	0.2%	1
Pakistan	4.3%	21
Peru	0.2%	1
Poland	0.4%	2
Scotland	0.6%	3
South Africa	0.2%	1
Syria	0.2%	1
The Netherlands	0.2%	1
Trinidad and Tobago	0.2%	1
Turkey	0.2%	1
UK	24.9%	121
Wales	1.0%	5
Yorkshire	1.2%	6
Zimbabwe	0.2%	1
answered question		**485**
skipped question		**99**

Q5. Do you belong to any religion?

Answer Options	Response Percent	Response Count
Buddhism	0.4%	2
Christianity	35.6%	191
Hinduism	1.5%	8
Islam	21.0%	113
Judaism	0.0%	0
Sikhism	1.5%	8
No religion	29.6%	159
Prefer not to say	4.7%	25
Other (please specify)	5.8%	31
answered question		**537**
skipped question		**47**

Q6. What is your ethnic group?

Answer Options	Response Percent	Response Count
Asian or Asian British: Indian	7.0%	38
Asian or Asian British: Pakistani	16.0%	87
Asian or Asian British: Bangladeshi	0.7%	4
Asian or Asian British: Chinese	1.1%	6
Asian or Asian British: Other Asian Background	0.2%	1
Black or Black British: Caribbean	4.6%	25
Black or Black British: African	1.5%	8
Black or Black British: Other Black background	0.4%	2
Mixed or multiple ethnic groups: White and Black Caribbean	2.4%	13
Mixed or multiple ethnic groups: White and Black African	0.6%	3
Mixed or multiple ethnic groups: White and Asian	1.5%	8
Mixed or multiple ethnic groups: Other mixed background	0.0%	0
White: English, Welsh, Scottish, Northern Irish, British	57.8%	314
White: Irish	1.5%	8
White: Gypsy or Irish Traveller	0.2%	1
Other white background	0.9%	5
Arab	0.2%	1
Any other ethnic group	1.7%	9
Prefer not to say	1.8%	10
answered question		
skipped question		

Q7. Do you consider yourself to be disabled?

Answer Options	Response Percent	Response Count
Yes	14.8%	81
No	82.6%	451
Prefer not to say	2.6%	14
answered question		**546**
skipped question		**38**

Q8. Types of impairment:

Answer Options	Response Percent	Response Count
Physical or mobility impairment (such as using a wheelchair to get around and / or difficulty using your arms)	28.8%	23
Sensory impairment (such as being blind / having a serious visual impairment or being deaf / having a serious hearing impairment)	16.3%	13
Mental health condition (such as depression or schizophrenia)	36.3%	29
Learning disability (such as Downs syndrome or dyslexia) or cognitive impairment (such as autism or head-injury)	16.3%	13
Long term condition (such as cancer, HIV, diabetes, chronic heart disease, or epilepsy)	37.5%	30
Prefer not to say	2.5%	2
answered question		**80**
skipped question		**504**

Q9. Are you a carer? Do you look after, or give any help or support to a family member, friend or neighbour because of a long term physical disability, mental ill-health or problems related to age?

Answer Options	Response Percent	Response Count
Yes	18.3%	93
No	77.6%	395
Prefer not to say	4.1%	21
answered question		**509**
skipped question		**75**

Q10. Are you pregnant?

Answer Options	Response Percent	Response Count
Yes	2.6%	14
No	96.0%	509
Prefer not to say	1.3%	7
answered question		**530**
skipped question		**54**

Q11. Have you given birth in the last 6 months?

Answer Options	Response Percent	Response Count
Yes	3.0%	15
No	95.8%	484
Prefer not to say	1.2%	6
answered question		**505**
skipped question		**79**

Q12. What is your sexual orientation?

Answer Options	Response Percent	Response Count
Bisexual (both sexes)	2.8%	14
Gay (same sex)	2.4%	12
Heterosexual/straight (opposite sex)	85.5%	429
Lesbian (same sex)	1.2%	6
Other	0.6%	3
Prefer not to say	7.6%	38
answered question		**502**
skipped question		**82**

Q13. Are you transgender? Is your gender identity different to the sex you were assumed at birth?

Answer Options	Response Percent	Response Count
Yes	1.4%	7
No	96.5%	496
Prefer not to say	2.1%	11
answered question		**514**
skipped question		**70**

HEALTH AND ADULT SOCIAL CARE SCRUTINY PANEL - WORK PROGRAMME 2017/18

MEMBERS: Cllr Liz Smaje (Lead Member), Cllr Richard Eastwood, , Cllr Fazila Fadia, Cllr Richard Smith, Cllr Sheikh Ullah, Peter Bradshaw (Co-optee), David Rigby (Co-optee) , Sharron Taylor (Co-optee)

SUPPORT: Richard Dunne, Principal Governance & Democratic Engagement Officer

FULL PANEL DISCUSSION		
ISSUE	**APPROACH**	**AREAS OF FOCUS/OUTCOMES**
1. Financial position of North Kirklees CCG and Greater Huddersfield CCG	The Panel has received an update on the CCG's financial position and agreed to continue to monitor the CCG's finances through further updates at panel meetings. The Panel has also agreed to include the CCGs Primary Care Strategies in this item to consider if there are any specific elements that contribute to the innovation and efficiency of primary care services	• Consider the wider transformation programmes being undertaken by both Greater Huddersfield CCG & North Kirklees CCG to include assessing their contribution to increasing efficiencies and impact on services. • A focus on the work being undertaken to reduce costs and increase efficiencies to include: o Monitoring the impact of the 'Talk Health Kirklees' campaign. o Assessing the various CIP's and reviewing the impact of any proposed changes to the commissioning of services.
2. Kirklees Health and Wellbeing Plan (Sustainability and Transformation Plan) and Kirklees Joint Strategic Assessment (KJSA)	To maintain an overview of the Kirklees Health and Wellbeing Plan and the KJSA through discussions at panel meetings. This item has been included in a themed discussion at the meeting 12 December 2017 that will cover the work of the Health & Wellbeing Board and include the Better Care Fund.	Key outcome/aim for the Panel will be to assess the impact of changers to service users and consider ways that these could be mitigated. Areas of focus to include: • Keeping tracks on progress of the implementation of the plan; • Monitoring impact of changes; • Assessing how local changes fit/link with the wider transformational changes taking place across West Yorks • How the local plan links to the West Yorks Sustainability and Transformation Plan (STP)

FULL PANEL DISCUSSION		
ISSUE	**APPROACH**	**AREAS OF FOCUS/OUTCOMES**
		• 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
3. Healthwise Optimisation Programme An initiative being considered by the CCG's that will support people prior to surgery who are deemed to be at higher risk of complications that can occur during or after surgery. Initial areas of focus will cover obesity and smoking.	The programme will be discussed at the meeting scheduled for 3 October 2017.	The Panel will consider how the programme will operate to include the planned timescales for implementation of the programme. Aim/outcome will be for the Panel to understand the impact of these changes ; identify if there are any groups that will be adversely affected by the changes; and make recommendations to CCGs on ways to reduce the impact of these changes.
4. Integration of Health and Social Care The integration of Health and Social Care is at the centre of government reforms and with the introduction of STP's there is a clear expectation for there to be significant measurable progress in health and social care integration by 2020	To maintain an overview of progress of the Integration of Health and Social. This item will be discussed at the meeting scheduled for 14 November 2017.	• Consider how performance will be measured; assessing the pace of change; and reviewing the impact on the standard and quality of services being delivered in Kirklees. • Assess the overall impact of reductions in budgets across the whole of the health and social care economy. Aim/Outcome will be for the Panel to: assess if there is any disproportionate impact on certain groups; highlight impact on service users to relevant providers and ensure steps/measures are being taken to support affected groups.

FULL PANEL DISCUSSION		
ISSUE	**APPROACH**	**AREAS OF FOCUS/OUTCOMES**
5. CQC Inspections	To maintain an overview of the progress of the Action Plans developed by a number of local providers following a CQC inspection either through written updates/ Feedback from Lead Member /presentations at panel meetings.	Review progress from the following provider action plans : • Calderdale and Huddersfield NHS Foundation Trust • Locala Community Partnerships • South West Yorkshire Partnership NHS Foundation Trust • Mid Yorkshire Hospitals NHS Trust
6. All Age Disability and Adult Pathways	The Panel to receive updates on the work that is being done on developing the All Age Disability and Adult Pathway workstreams.	<u>Panel meeting 4 July 2017</u>. The Panel received an update on the work that is being developed on Adult Services Pathways that included an overview of the key areas of transformation The Panel has requested further information that provides: • An overview of the timescales and key milestones for the various transformational work streams and redesign of the Adult Services pathways • The headline financial figures that outline where the projected savings will be achieved.
7. The Healthy Child Programme (0-19 services) The Kirklees Integrated Healthy Child Programme (KIHCP) is seen as a catalyst for transforming work with children and young people across a range of systems, interventions, sectors and services over the next 5 -10 years.	In March 2017 the Panel was presented with an update on the KIHCP procurement process; the approach being taken to implementing the programme; and progress of implementation. Further updates will be presented at panel meetings during 2017/18. This item has been scheduled for discussion at the meeting 12 September 2017.	At the March meeting the Panel agreed to: • Maintain an overview of the development of the service to include progress on implementation • Receive an update on how the key risks/issues have been managed as outlined in the March meeting. <u>Panel meeting 12 September 2017.</u> The Panel received an update covering the areas identified from the March 2017 meeting. The Panel has agreed to : • Receive an overview of the priority areas in the

FULL PANEL DISCUSSION		
ISSUE	**APPROACH**	**AREAS OF FOCUS/OUTCOMES**
		Kirklees Future in Mind Transformation Plan. • Maintain an overview of progress of the implementation of the programme to include feedback from practioners. • Include an additional area of focus on the transition from HCP to adult services. • To monitor work being done to Improve engagement with Social Care within the mobilisation processes with the aim of improving integrated working. • To monitor the Panel's concerns on the work being developed to develop a rigid CAMHS cancellation policy with the aim of gaining assurance that robust communication systems are in place.
8. Integrated Wellness Model 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**.**	In March 2017 the Panel received an update on the progress of work that has taken place to develop a Kirklees Wellness Model. Further updates will be presented at panel meetings during 2017/18. This item has been scheduled for discussion at the meeting 12 September 2017.	At the March meeting the Panel agreed to keep the issue on the Work Programme with a focus on: • Scoping out the detail of the Wellness Model's functions; • Developing the details for the Service Specification • Producing a timeline to include key milestones and decision making; • Understanding the outcomes and impact for service users; and • Clarification on what services/provision will align virtually or work on the periphery of the model. Aim/outcome will be to understand how this model integrates with work being developed in other areas of the health and social care economy; the impact this will have on service users; and ensuring measures are put in place to support equitable access to services.

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ISSUE	**APPROACH**	**AREAS OF FOCUS/OUTCOMES**
		<u>Panel meeting 12 September 2017.</u> The Panel received an update on the progress of the design and commission of the Kirklees Integrated Wellness Model. The Panel has agreed to: • Receive the outcomes from the engagement/public insight work and the draft service specification. The Panel has also identified a number of additional areas of focus to include: • Assessing how the model will integrate with the work of the CCGs (such as Health Optimisation) • Getting a clearer indication of the approach that will be taken by Public Health in identifying outcomes and developing an evaluation strategy. • Assessing how Public Health will assess value for money. • Reviewing: the numbers of people accessing the services; and the initiatives to 'scale up' services, increase the numbers of service users and target areas of inequality.
9. Robustness of Adult Social Care	To maintain an overview of the work being done to support a robust adult social care service through updates at panel meetings. This item has been scheduled for discussion at the meeting 3 October 2017.	Areas of focus to include: • The new contract for homecare provision. • State and resilience of the adult social care market. • Update on preparations for winter.

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10. Attention Deficit Hyperactive Disorder (ADHD) – Adults	In April 2017 the Panel was presented with an update on waiting times and numbers for Adult ADHD and an overview of the work that was being developed to enhance the capacity of service and improve the consistency of the service delivered across West Yorks. The Panel has agreed to receive a further written update.	Maintaining an overview of progress.
11. Quality of Care in Kirklees	In April 2017 CQC presented to the Panel an outline of its activity and an overview of the outcomes of the inspections in Kirklees. It was agreed that a further update be arranged towards the end of the 2017/18 municipal year with a focus on adult social care.	General update report and discussion.
12. Suicide Prevention The House of Commons Health Committee has recommended to Government that health overview and scrutiny committees should be involved in ensuring effective implementation of local authorities' suicide prevention plans. This should be established as a key role of these committees. Effective local scrutiny of a local authority's suicide prevention plan should reduce or eliminate the need for intervention by the national implementation board.	The Panel will need to view and assess the Kirklees Suicide Prevention Plan and agree its approach to monitoring the effectiveness of the Plan.	Areas of focus and outcomes to be confirmed.

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13. Changes to Podiatry Services – outcomes of consultation	A report on the outcomes of Locala's consultation on the Changes to Podiatry Services has been scheduled to be considered by the Panel at the meeting 14 November 2017.	To be determined following presentation of consultation outcomes report.
14. Mental Health Services – Transformation Programme SWYPFT are continuing to work through a major service transformation programme with a focus on: recovery; putting more people in charge of the care they get; providing 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 at a future meeting on progress of the programme.	Areas of focus to include: • Overview of the key services that are/have been transformed. • Details of where implementation has taken place • Overview of emerging outcomes including lessons learned.
15. Care Closer to Home (CC2H) CC2H remains a key transformational change for Clinical Commissioning Groups (CCG's). A key aim of CC2H is to develop an integrated community based health care service for all including the frail, vulnerable, older people and end of life care. The programme has critical inter-dependencies with the two hospital services programmes (Righty Care Right Time Right Place and Meeting the Challenge). The CC2H contract is delivered by Locala and GHCCG is the lead commissioner.	In February 2017 the Panel considered an update on the implementation of the programme and received the February 2017 copy of the Locala Quality Dashboard. The Panel agreed to continue to maintain an overview of progress of the programme.	Areas of focus to include: • Assessing the effectiveness of CC2H in supporting the two hospital services programme with a particular focus on the changes taking place across Mid Yorkshire Hospitals Trust and the progress being made in reducing demand in hospital services provided by Calderdale and Huddersfield NHS Foundation Trust. • Undertaking a further review of the Locala Quality Dashboard to identify if there are any themes that the Panel may wish to focus on.

FULL PANEL DISCUSSION		
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16. Health and Wellbeing Board – Better Care Fund (BCF) The BCF provides a significant financial incentive for the integration of health and social care. CCG's and LA's are required to pool budgets and agree an integrated spending plan on how they will use their BCF allocation.	This item has been included in a themed discussion at the meeting 12 December 2017 that will cover the work of the Health & Wellbeing Board.	Areas of focus to include: • Current position of the BCF and improved BCF (iBCF). • Assessing any plans to use iBCF to improve local targets and services including: meeting adult social care needs; reducing demands on hospital services including improved discharged times from hospital; and supporting the local social care provider market. • Planned BCF outcomes. • How the funds will be used to support the integration of health and social care.
17. Interim Changes to hospital services To scrutinise any interim changes to hospital services that the Calderdale and Huddersfield NHS Foundation Trust (CHFT) are considering prior to reconfiguration	The Panel will need to monitor the reviews that CHFT are currently undertaking on inpatient provision of Cardiology, Respiratory and Elderly Medicine. CHFT has advised the Panel that it will be looking to make changes to the above services in November. A presentation explaining the plans and the clinical urgency to make the changes before the anticipated increase in demand in winter will be discussed at the meeting 14 November 2017.	Areas of focus to be determined.

LEAD MEMBER BRIEFING ISSUES	
ISSUE	**AREAS OF FOCUS**
18. Care Act 2014	Lead Member to maintain an overview of the implementation of the reforms on the Council including impact of financial challenges and rising demand; and workforce challenges Update report on the implementation and impact of Care Act 2014 received 21 September 2017. Lead Member will review and update the panel.

19. Deprivation of Liberty Safeguards	Lead Member to receive an update report and subject to information received consideration to be declaring this item complete. Update report received 21 September 2017. Lead Member will review and update the Panel.
MONITORING ITEMS	
ISSUE	**AREAS OF FOCUS**
20. Tuberculosis (TB) in Kirklees	Following an update in April 2016 the Panel agreed to continue to monitor TB in Kirklees to include arranging a further update to cover: • Looking at the work being undertaken to reduce TB rates in Bradford and Leeds and to highlight examples of good practice. • Getting clarification on staffing ratios for the current TB nursing establishment as per the recommendations from the Royal College of Nursing. • Receiving an action plan on the work being undertaken in Kirklees to reduce the high levels of TB in the borough
21. Review of Mental Health Assessments	The Panel will need to agree a time line for reviewing progress of the recommendations of the Ad-hoc Panel following the presentation of the report that to Cabinet at its meeting that was held 25 July 2017.

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