Public Document Pack

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Monday 6 November 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 14 November 2017.**

This meeting will be webcast live and will be available to view via the Council's website.

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 Loonat
Councillor Richard Smith
Councillor Sheikh Ullah
Councillor Habiban Zaman
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 3 October 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: Consultation Report of Findings - Proposed Changes to the Podiatry Service

9 - 68

The Panel will receive a report on the findings from the consultation on the proposed changes to the Podiatry Service in Kirklees.

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

5: Integration of Health and Adult Social Care

69 - 88

The Panel will receive a report that provides an update on progress of the integration of Health and Adult Social Care.

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

6: Interim Changes to Acute Inpatient Elderly Medicine, Cardiology and Respiratory Service Provision at Calderdale and Huddersfield NHS Foundation Trust (CHFT)

89 - 114

Representatives from CHFT will be in attendance to present details of the proposal for interim Acute Inpatient Elderly Medicine, Cardiology and Respiratory Service provision at CHFT.

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

7: Work Programme 2017/18

115 - 126

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.

8: Date of the Next Meeting

To confirm the date of the next meeting as 12 December 2017.

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

Contact Officer: Helen Kilroy

KIRKLEES COUNCIL

HEALTH AND ADULT SOCIAL CARE SCRUTINY PANEL

Tuesday 3rd October 2017

Present:	Councillor Elizabeth Smaje (Chair) Councillor Richard Eastwood Councillor Fazila Loonat David Rigby Peter Bradshaw Sharron Taylor (Co-Optee)
Apologies:	Councillor Richard Smith Councillor Sheikh Ullah
In attendance	Steve Ollerton, Alan Turner and Ian Currell - Greater Huddersfield CCG Emily Parry-Harris, Public Health (Kirklees) David Hamilton, Adult Social Care (Kirklees) Helen Kilroy, Principal Governance and Democratic Engagement Officer

1 Minutes of previous meeting

RESOLVED - That the Minutes of the meeting of the Panel held on 12 September 2017 be approved as a correct record.

2 Interests

No interests were declared.

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 Robustness of Adult Social Care

The Panel welcomed David Hamilton from Kirklees Adult Social Care to the meeting and considered an update on the approach taken by Adult Social Care in order to continuously improve the robustness of the Adult Social Care System.

David Hamilton advised the Panel that this report was a follow up to the update considered by the Panel in December 2016 on the Robustness of Adult Social Care and the progress made to date. The Panel was informed that there were still challenges and pressures around Adult Social Care, but felt hat the Service was moving in the right direction.

David Hamilton highlighted a number of new initiatives considered by the Panel in December 2016 which were being developed at the time, but had now been implemented, as follows:

- Quality Assurance Frameworks and Quality Clinics were now held on a regular basis and were embedded in the service, which had helped to ensure that

engagement with front line staff was ongoing to understand the pressures on the them and that staff understood the expectations in terms of performance;

- A number of culture change events had taken place in September 2017 attended by approximately 250 staff on the future ways of working; these events helped to communicate the next steps of the Adult Social Care Vision across the workforce;
- A restructure had taken place for both North and South Adult Social Care, which had helped to make a link to the CCGs and Trusts across Kirklees;
- Teams were being reorganised into community hubs in North and South Kirkles, alongside colleagues from Community Plus – the hubs would provide opportunities for staff from different agencies to work together to develop relationships and new ways of working;
- Introduced mobile and agile working across the service so staff could be more efficient within the community and better outcomes could be achieved for people;
- Kirklees had retendered for the homecare service, which was hoped would address some of the capacity issues that had been prevalent in the past;
- The Council worked closely with care providers to be sure that they understood their difficulties and the service was working jointly with CCGs to ensure that the right support was offered to providers to encourage them to remain in the market;
- The Panel was informed that the Transformation Board was chaired by David Hamilton and was focussing on performance, capacity and around doing things differently; the Council had invested some additional capacity, mainly from Deloitte and some new members of staff to focus on the redesign services in an appropriate way led by Kirklees Council;
- The Service was adopting a continuous improvement approach and the challenge was to keep moving in the right direction and keep assessing what has been done to make a difference and improve outcomes for people.

In response to a question from the Panel regarding performance management targets and how a shortfall in performance would be rectified, David Hamilton made reference to a performance tool showing targets used by officers. The Panel was advised that performance was a continuous challenge for the service. David Hamilton further explained that the performance targets would be used at the clinics with staff and also that appropriate challenges should be made to undertake regular temperature checks of performance. The Panel was advised that when bench marked regionally and nationally, results had shown that the service was performing well. David Hamilton acknowledged that there were areas within the service that were not performing as well as they could be but this had to be balanced against the level of resources available.

In response to a question from the Panel regarding the fact that the report indicated 6 out of 10 people did not feel the service helped them feel in control of their own care, David Hamilton advised that the service needed to be more people focussed and needed to do more to find out why this was the case. The Panel noted that the service had recently reviewed the direct payments policy, which could have had an impact on how people felt as direct payments were at the heart of people feeling in control of their own care. David Hamilton advised that more conversations were needed with service users and carers to try and identify why they do not feel in

control of their own care. The Panel was informed that the service would continue to drive direct payments and make it easier for people to access them.

In response to a question from the Panel regarding how engaged Kirklees was with the Care Closer to Home Strategy, David Hamilton advised that it was critical that Kirklees had a strong relationship with health colleagues and the new hub structure in North and South Kirklees would help this to ensure that strong links were established. The Panel was advised of a Winter Planning Event on the 5th October led by Kirklees Council which health colleagues had been invited to.

In response to a question from the Panel regarding performance records, for example dealing with the impact of delayed discharge, were savings being measured as the public perception was that hospital resources were often put under strain due to the fact that Social Care could not transfer people from hospital quickly enough. David Hamilton advised that Kirklees was performing well in terms of delayed transfers of care but that was not to say that performance in this area could not be improved. The Panel was informed that the figures for delays in transfers of care and length of stay in hospital, was monitored regionally and locally. David Hamilton advised that there was evidence that some people did need long term care in hospital, even though this was a last resort.

The Panel was advised that where it was established that a care home placement was required, one of the new initiatives would be that Trusted Assessors would assess people on behalf of care homes to speed up the process of transfer of care from hospital.

In response to a question from the Panel regarding evidence showing improvements made by the service and linking this to health providers, David Hamilton advised that evidence could be provided if required by the Panel and would link to health providers such as Locala.

In response to a question from the Panel regarding North and South Kirklees and the acute footprints and how was the service ensuring that social care provision in Kirklees was equitable across Kirklees and did not depend on where people lived, David Hamilton advised that Amanda Evans had overarching responsibility for this area and would monitor the quality and level of service provided in the North and South areas to ensure it was consistent and to the same specification. The Panel was advised that there could be some variation in service in parts of the borough where the needs were different.

The Panel asked a question relating to the hospital based teams and Health Care Lead Nurse at both HRI and Dewsbury hospitals. The Panel highlighted that Mid Yorkshire had moved services to Pinderfields from Dewsbury and vice versa, and would there be a Health Care Lead Nurse in Pinderfields and how were patients in need assessed at Calderdale. David Hamilton agreed to get this information for the Panel.

The Panel highlighted the fact that the report did not contain sufficient performance information to evidence the robustness of Adult Social Care and improvements within the service.

In response to a question regarding the state and resilience of the Adult Social Care market as a whole, relating to payments where got supported living where moved from paying a lump sum to paying the living wage on an hourly rate which was having a significant effect on the providers of supported living and the issues around people being able to pay for this service from within their own budgets, David Hamilton advised that the service was moving away from providing some services that were not absolutely necessary and providing them in a different way, for example where appropriate assistive technology had been provided rather than night working staff, which was a much more cost effective method in the right circumstances and was less intrusive therefore providing better outcomes for some people.

In response to a question regarding achieving excellence and quality assurance and events held for frontline staff
around improvement on audit results

RESOLVED –

1. That David Hamilton be thanked for attending the meeting.
2. That the update on the Robustness of Adult Social Care be noted.
3. That a report detailing performance and evidence that improvements were being made in the Adult and Social Care Service be considered by the Panel at a future meeting – date to be determined.

5 Health Optimisation Programme

The Panel welcomed Sue Richards and Michelle Cross from Kirklees to the meeting and considered a progress update on all the AAD Programme, including actions taken to address the Adults Learning Disability budget pressures.

RESOLVED -

1. That representatives from Greater Huddersfield CCG and Kirklees Public Health be thanked for attending the meeting and that the report on Health Optimisation Programme be noted.

2. That the Panel's supporting officer be authorised to liaise with attendees to address the agreed actions.

3. The panel agreed that the changes proposed within the Health Optimisation Programme were a significant change to public service and therefore agreed to scrutinise the proposals. The Panel requested that Greater Huddersfield CCG undertake a further 6 week period of consultation, particularly with hard to reach communities in North Kirklees, and report back to the Panel – date to be determined.

6 Work Programme 2017/18

That the progress of the 2016/17 Work Programme be noted and agreed the items to be carried forward into 2017/18.

1. The Panel agreed that the Health Optimisation Programme proposed a significant variation in service to the public and requested that the CCGs undertake a period of consultation for 6 weeks.

2. The Panel agreed that the engagement already carried out was not as robust as it could have been and that it had not sufficiently targeted hard to reach groups in North Kirklees.
3. The Panel would like to see a more robust consultation carried out so that the CCGs can clearly outline what is being proposed to the public and get their views.
4. That early conversations take place between the CCGs and Public Health as soon as possible so that they are 'on the same page' and commissioning services that will help people and achieve what was outlined in the report to the Panel.
5. The Panel would like to be reassured that the CCGs and Public Health ensure that what is being provided does not contradict one another and that the systems will be robust enough to deal with the numbers coming through.
6. The Panel requested that the CCGs also consult with Hospitals and asked for reassurance on who was being consulted and how the CCGs will reach both patients and clinicians on this proposal.
7. The Panel would like to see earlier conversations taking place with the Panel in future on issues they feel might be perceived as a significant variation in service.
8. Cllr Smaje agreed to meet separately with CCGs and Public Health following the Panel meeting to discuss the issues raised by the Panel in more detail – Scrutiny Briefing on the 26th October 2017.
9. The Panel requested that CCGs report back to the Panel with the results and outcomes of the 6 week consultation once it has been completed – date to be agreed.

7 Date of the Next Meeting

14th November 2017 at 10am in the Council Chamber, Huddersfield Town Hall.

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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.

Kirklees COUNCIL

Name of meeting: Health and Adult Social Care Scrutiny Panel

Date: 14 November 2017

Title of report: Consultation Report of Findings – Proposed Changes to the Podiatry Service.

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 findings from the consultation on the proposed changes to the Podiatry Service in Kirklees.

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 Service Director (Legal Governance and Monitoring)?**	**No – The report has been produced to support the discussions with Locala, Greater Huddersfield CCG and North Kirklees CCG**
Health Contact	**Sarah True – Engagement and Inclusion Manager Locala Community Partnerships**

Electoral wards affected: All

Ward councillors consulted: N/A

Public or private: Public

1. **Summary**

1.1 At the Health and Adult Social Care Scrutiny Panel meeting held 23 March 2017 representatives from Locala, Greater Huddersfield Clinical Commissioning Group (CCG) and Healthwatch Kirklees provided an update on the proposed changes to Podiatry Services in Kirklees that included an outline of the work that was still required to be undertaken prior to consultation and an indication of the consultation timeline.

1.2 The information that was presented to the Panel included the Consultation Plan and Document which detailed: the purpose of the Plan; the aims and objectives of the consultation; engagement and pre-consultation engagement activity; consultation process; consultation communication and activities; details of the proposed changes; the options under consideration; and the consultation questionnaire.

1.3 Panel members provided feedback on the consultation materials and document and reaffirmed an earlier Panel decision that the proposed changes represented a significant change to service provision.

1.4 The formal public consultation was undertaken for an eight week period during the months of June, July and August 2017.

1.5 Representatives from Locala, Greater Huddersfield CCG and North Kirklees CCG will be in attendance to present the outcomes of the consultation and a report of the findings 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

Proposed changes to the Podiatry Service

Consultation report of findings

October 2017

Contents

1.0 Executive Summary

This report summarises the responses of an 8 week consultation into proposed changes to the Podiatry Service in Kirklees.

Proposal 1: In Greater Huddersfield only, to reduce the number of locations where podiatry clinics are held.

Proposal 2: Across Kirklees, to apply the existing criteria to the all patients currently using the service. In the past this criteria has not been fully applied and there are patients within the service who are not eligible to receive podiatry care. This is being done to ensure our podiatry team can provide a quality service to patients with the greatest podiatry and medical need.

The consultation took place from 19 June to 11 August 2017. This report describes the range of communication and engagement techniques that took place to inform and consult with public, carers and colleagues.

Engagement techniques included:

- Online and paper surveys – we received 818
- Drop in sessions
- Text messages to existing patients
- Focus groups/outreach events
- Visits to GP clinics and health centres
- Emails from members of the public

The key themes from the consultation were as follows:

1.1 Proposal 1: Reduce the number of clinics available in Greater Huddersfield from 17 to 8.

People were asked to share their views on the proposed changes to clinic locations in Greater Huddersfield. 29% agreed or strongly agreed with this proposal, 64% disagreed or strongly disagreed and 7% didn't know/didn't respond. The key themes were:

Support for the proposal

- Some felt that the proposals would improve the service provided as those with the greatest need would be seen more quickly
- It was thought that 17 locations in Huddersfield was too many
- Some felt that there would be benefits from fewer locations that had better equipped facilities

- People commented that public transport links around the area were good and it wouldn't be a problem getting to the suggested locations

Concerns about the proposal

64% disagreed or strongly disagreed with this proposal. The key themes were:

- Many were concerned that it would mean travelling further for an appointment even if this didn't affect them they were concerned for vulnerable groups
- Some felt that this was a cost cutting exercise
- Some disagreed because this was not 'care closer to home'
- It was felt that too many sites were being closed
- A number of patients in Shepley were concerned about the public transport links to other locations

Suggestions from respondents

- Patients in Marsden suggested that Croft House GP be considered as the location for podiatry clinics instead of Slaithwaite Health Centre. When travelling by bus from Marsden the bus stops at the top of a hill and the walk up and down the hill is a concern. Croft House is better located.

1.2 Proposal 2: Applying eligibility criteria

People were asked to share their views on the proposal to apply the existing eligibility criteria across the whole service. 72% agreed or strongly agreed with this proposal, 23% disagreed or strongly disagreed and 5% didn't know/didn't respond. The key themes were:

Support for the proposal

- Most people in support of the proposal felt that care should be provided to those who are high to moderate risk
- Many supported the proposal as it would reduce waiting times
- There were a number of people who simply thought it made sense as it makes the service more efficient

Concerns about the proposal

23% disagreed or strongly disagreed with this proposal. The key themes were:

- The service should be there for anyone who needs it
- Older people who can't bend down and cut their nails will suffer and could end up back in the service because they can't look after their feet
- Some people thought this was a cost cutting exercise

Suggestions from respondents

- Lower risk/routine patients should be taught basic self-care that can be carried out at home
- There should be a low cost or no cost alternative for toe nail cutting

2.0 Introduction

The NHS is highly valued by patients and important to the general public. The NHS and the service it provides needs to change over time to ensure it can meet the needs of everyone now and in the future. People are living longer and have increasingly complex health and care needs.

Within Kirklees, the health economy is particularly challenged. Health care commissioners and providers have to do more with the money they have and make tough decisions about what they can and can't afford. It is recognised that to deliver the best care for local people money needs to be spent on things that will give the greatest benefit.

Demand for the Podiatry Service in Kirklees is growing and in order to meet the needs of the population now and in the future changes need to be made.

The podiatry service needs to support those patients with the greatest need. To be able to provide the right treatment for people with high clinical needs, such as those with rheumatoid arthritis, peripheral arterial disease and diabetes, we need to follow guidance which requires more specialist services. These patients have increased risk of developing complications of the foot such as foot ulcers or in worst case scenario, amputation.

3.0 Proposals under consultation

In 2015, podiatry services in Greater Huddersfield transferred from CHFT to Locala as part of the Care Closer to Home contract. Podiatry was already being provided by Locala to North Kirklees CCG patients. As the transfer proceeded it became clear to Locala that there were a large number of people on the caseload receiving care without having a specific clinical or podiatry need. This was impacting on the capacity available in the service and its ability to direct its resources to those most at risk.

Locala also reviewed the number of clinics where Podiatry clinics were taking place. In North Kirklees there are 6 locations and in Greater Huddersfield there were 21. This has now reduced to 15 after a number of GPs didn't renew contracts to use their premises for podiatry purposes.

Based on this review Locala are consulting around two proposals:

Locations in Greater Huddersfield

Locala are proposing to reduce the number of locations were clinics are provided. This would help improve the service by increasing the number of podiatry appointments that can be offered and patients could be offered more choice of appointments.

Applying eligibility criteria

Across Kirklees, the podiatry team uses a set of criteria to help decide who is eligible for treatment. This criteria has not been applied consistently throughout Kirklees and means that there are patients on the caseload who may not be eligible for care. By applying the criteria across the service patients who have the greatest clinical need for podiatry care will receive it when they need it most. This may mean that some patients will no longer be eligible for podiatry services.

4.0 Consultation process

The campaign was aimed at the public, carers, clinicians and colleagues as well as patient and community groups.

Locala was delegated the responsibility of carrying out this consultation by North Kirklees CCG and Greater Huddersfield CCG. The consultation was carried out in line with the CCGs legal obligations (appendix A).

4.1 Mechanisms

A consultation document was created a consultation document, electronic leaflet and dedicated web page and online survey (appendix B). This document was issued to:

- The 66 GP practices across Kirklees
- Health Centres across Kirklees
- Locala's colleague and community members
- Stakeholder and provider organisations
- Locala's colleagues providing home visits – Homecare, Podiatry and District Nurses
- Community Centres

Drop in Sessions

Date	Venue	Time	Attendees
Monday 3 July	Kirkburton Health Centre	9.30am- 12.30pm	0
Monday 3 July	Slaithwaite Town Hall	14.00pm-16.30pm	5
Wednesday 5 July	Cleckheaton Health Centre	9.30am-12.30pm	20
Wednesday 5 July	Dewsbury Health Centre	14:00pm-16.30pm	2
Thursday 6 July	Princess Royal Health Centre	9.30am-12.30pm	5
Thursday 6 July	Holme Valley Memorial Hospital	13:30pm-16.30pm	0

GP Visits

Visits were arranged at locations where it is proposed that clinics will no longer run. Conversations were carried out in GP waiting areas and in some locations our team spoke to people in the town centre. It was not possible to visit Honley GP or Waterloo GP.

GP Practice	Date	AM/PM
Dearne Valley Scissett GP & outside swimming baths	7 August	AM

Marsden GP & town centre	4 August	AM
Newsome GP & centre	2 August	AM
Shepley GP	1 August	PM
Kirkheaton GP	3 August	PM

Outreach Events/Community Groups

Date	Group/Organisation	Type of Activity
04/07/2017	Age UK	Informal weekly social event for over 50s. Discussed proposals with group.
05/07/17	Ravensthorpe Community Centre	Supporting completion of surveys
12/07/2017	Kirklees Dementia Awareness Association	Engagement Event for the public, representatives of community groups and healthcare professionals.
13/07/2017	The Basement Project (Drug and Alcohol support and awareness)	Supporting completion of surveys
13/07/2017	Connecting Communities – Pilgrim Estate Dewsbury	200 people from the area attended, local public services along with members of the public.
13/07/2017	Communities Who Can	Information to network of around 100 community organisations asking them to provide feedback
20/07/2017	The Huddersfield Over Fifties Forum	Monthly meeting - Discussed proposals with group and encouraged completion of surveys
24/07/2017	Milen Care – Asian Elderly Day Care Centre	Focus Group for female users of Milen Care
25/07/2017	Chart BAME event, Batley	Awareness event for Black African Minority Ethnic women in North Kirklees – stand and support completion of surveys
25/7/2017	Carers Count	Support with promotion of consultation to carers in Kirklees via Carers Count network.
26/07/2017	Milen Care – Asian Elderly Day Care Centre	Focus Group for female users of Milen Care
27/7/2017	Huddersfield Pakistani Community Alliance	Supporting completion of surveys

Other

News release	We issued a press release to local media including Dewsbury Reporter Series (approx. 9,000 circulation) and Huddersfield Examiner (approx. 11,000 circulation). The story was featured on Al Mubarak Radio to encourage listeners to participate.
Social media	We used our own social media channels including Facebook and

	Twitter. Encouraged stakeholders to include the information on their networks including GH and NKCCGs, Healthwatch, Carers Count, AgeUK.
GPs	Sent content for GP weekly newsletter to inform GP practices about Consultation
Text messages	Text messages were sent to patients that did not have appointments during the consultation period
Patient letters	All patient letters sent out during the consultation period had a paragraph at the bottom of the letter informing them about the consultation and how to participate.
Posters	Posters were sent to all GP clinics, health centres and selected community centres informing people about the consultation and the 'drop in session' dates.
Locala Colleagues	All Locala colleagues were informed via weekly newsletter and intranet.
Locala Members	All Locala colleague and community members were informed via email
Homecare	Locala's Homecare team took consultation papers out into the community
Website	A dedicated section for the consultation was created on the Podiatry pages of the Locala website
MPs/Councillors	Contacted by letter
Newsletter	North Kirklees CCG Summer Newsletter
Meeting	North Kirklees CCG Patient Participation Meeting – 18 June
Meeting	North Kirklees CCG Stakeholders Meeting – 12 July

4.2 Equality

We have used initial equality impact assessments to identify communities who could be affected by proposed changes. These will be reviewed using feedback from the consultation, which will help us make a more informed decision.

We made every effort to ensure our consultation reached a representative sample of the individuals who make up the Kirklees population.

Proposal	Possible impact on protected groups
Locations	There is a potential impact on these groups: Disability & Age - difficulty in accessing new locations Low income – paying for transport to new locations
Criteria	Disability & Age – not being eligible for the service could mean they don't access service elsewhere and foot conditions worsen. Race – South Asian people who are more prone to diabetes could be disproportionally affected. Low income – if not eligible for the service may not be able to afford to pay for podiatry services

We made every effort to ensure that our consultation reached a representative sample of the individuals possible affected by the proposals outlined in the consultation. This included:

- Attending Age UK and Older Peoples networks
- Attended specific venues used by South Asian people – Milen Care, Ravensthorpe Community Centre and Pakistani Community Alliance.
- Organised feedback used by low income groups – Ravensthorpe Community Centre, Basement Project

On the equality monitoring form we asked: Do you consider yourself to be disabled? The results were:

Answer Options	Response Percentage	Response Total
Yes	56.89%	442
No	35.26%	274
Prefer not to say	7.85%	61
Total:	Answered	777
	Skipped	41

5.0 Analysis of existing engagement

In December 2015 and July 2016 Locala carried out some engagement with service users about the current podiatry service. The objective of the engagement exercise was to:

- Understand what people thought of the current service
- Understand how local people want future services to be delivered
- Understand how the implementation of NICE guidance may impact on people
- Ensure that we use the findings from the engagement to inform our plans for future services including completion of an equality impact assessment.

The engagement was delivered in two sections, the first half of the engagement took place in December 2015 and the additional engagement took place in June – July of 2016. The two stage approach was to ensure that the engagement taking place picked up a broad range of views to support a whole system approach to podiatry services in Kirklees.

In summary the key themes from the engagement activity was as follows:

- **People are concerned about any change taking place** – people were worried about how changes would affect them and what alternatives would be in place.
- **Low responses to the NICE guidance** would suggest people may not have understood the implication of NICE guidance on the current service.
- **Happy with service** – most patients are happy with the service they receive. As an organisation we strive to improve where possible and ensure our patients always receive outstanding care at all times.
- **Appointments** – there are a number of comments in Patient Opinion, Friends & Family, complaints and face to face engagement about appointments within the Podiatry service. This varies from not being able to get an appointment, to wanting more choice and being seen more regularly. 52% of patients stated that they would like/might like a greater choice of appointments.
- **Patients are generally happy** but some would like to be seen before 12 weeks
- **A more efficient booking system** has been put in place recently and other plans are in place to make booking easier for patients.

6.0 Analysis of Consultation Feedback

We received feedback on the consultation via:

- Online and paper surveys (819)
- Drop in sessions held (6)
- Outreach sessions attended (7)

6.1 Profile of the survey respondents

Appendix A 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:

- **53.62% (422)** were female and **43.07% (339)** were male
- Respondents were aged between 17 and 91
- **67%** of respondents were from Greater Huddersfield, **26%** from North Kirklees and **6%** out of area or declined to state postcode
- **78.58% (598)** described themselves as heterosexual, **0.13% (1)** as lesbian, **0.66% (5)** as gay, and **2.89% (22)** as bisexual.
- The majority of respondents, **79.08% (616)** described themselves as White, **11.04% (86)** as Asian or Asian British and **2.7% (21)** as Black or Black British.
- **57.20% (445)** stated that they identified with Christianity, **14.65% (114)** no religion, **5.53% (60)** preferred not to say and **12.85% (100**) Islam
- **11.24% (87)** provide care for someone
- **56.89% (442)** 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.

The data has been analysed to understand if respondents were representative of the local population based on the 2011 census data.

	Kirklees Census 2011	Locala results	+/-
Gender			
Male	49.4%	43.07%	-6.33%
Female	50.6%	53.62%	+3.02%
Prefer not to say		3.30%	
Age			
Under 18	20.4%	0.64%	-19.76%
18-24	18.50%	2.82%	-15.68%
25-34	20.57%	3.72%	-16.85%
35-54	25.30%	12.18%	-13.12%
55+	64.40%	72.44%	+8.04%
Prefer not to say		8.21%	
Ethnicity			
White British	76.67%	75.87%	-0.8%
White Irish	0.62%	2.18%	+1.56%
White Gypsy / Traveller	0.04%	0.00%	-0.04%
Other white background	1.80%	1.03%	-0.77%
White and black Caribbean	1.22%	0.26%	-0.96%
White and black African	0.15%	0.00%	-0.15%
White and Asian	0.64%	0.00%	-0.64%
Other mixed	0.30%	0.00%	-0.30%
Indian	4.92%	3.72%	-1.2%
Pakistani	9.90%	9.24%	0.66%
Chinese	0.34%	0.00%	-0.34%
Other Asian	0.71%	0.26%	-0.45%
African	0.56%	0.00%	-0.56%
Caribbean	1.10%	2.44%	+1.34%
Other black	0.22%	0.00%	-0.22%
Arab	0.29%	0.00%	-0.29%
Other ethnic group	0.35%	0.51%	+0.16%
Religion			
Christianity	53.4%	57.20%	+3.8%
Islam	14.5%	12.85%	-1.65%
Buddhism	0.20%	0.51%	+0.31%
Hinduism	0.40%	0.26%	-0.14%
Sikhism	0.80%	1.03%	+0.23%
No religion	23.50%	14.65%	-8.85%
Prefer not to say		7.71%	
Other		5.53%	
Disability			
Yes	17.7%	56.89%	+39.19%
No	82.3%	35.26%	-47.04%
Prefer not to say		7.85%	
Carers			
Yes	10.4%	11.24%	+0.84%

No		84.24%	
Prefer not to say		4.52%	

In addition to the equality monitoring questions we also asked people who completed the survey to let us know if any of the following statements applied to them.

The questions 'Did you understand the proposals?' 'Do they have an impact on you?' and 'What do you use the service for?' have been further analysed against equality and diversity data which highlighted no issues. Appendix D.

After reading the information did you understand the proposals?

Understanding the Proposal	Response Percentage	Response Total
Yes, All of it	67.91%	529
Yes, some of it	30.30%	236
No	1.80%	14
Total:	Answered	779
	Skipped	39

Type of people responding to the proposed changes:	Percentage	Total
A carer of a patient that has used or is currently using the service	6.02%	48
A healthcare Professional	1.25%	10
A member of staff	0.88%	7
A member of the public that has not used the service in the past	16.04%	128
A patient that has used or is currently using the service	74.06%	591
	Answered:	798
	Skipped:	20

We asked people if they currently use or have used one of the podiatry clinics and to indicate which clinic they usually use.

Clinics used and how many respondents use them:		
Location	Percentage	Total
Dearne Valley HC Scissett	3.90%	24
Fartown Health Centre	15.58%	96
Honley GP Practice	5.84%	36
Kirkburton GP Practice	6.49%	40
Holmfirth (Holme Valley Memorial Hospital)	8.12%	50
Meltham The Cobbles GP Practice	6.17%	38
Marsden Health Centre	5.19%	32
Newsome GP Practice	2.11%	13

Princess Royal Health Centre	26.30%	162
Slaithwaite Health Centre	9.09%	56
Skelmanthorpe GP Practice	3.73%	23
Mill Hill Health Centre	7.95%	49
Waterloo GP Practice	3.57%	22
Shepley GP Practice	3.08%	19
Dewsbury Health Centre	9.58%	59
Batley Health Centre	5.36%	33
Cleckheaton Health Centre	7.14%	44
Lepton GP Practice	0.81%	5
Birkenshaw Health Centre	1.30%	8
Total:	Answered:	616
	Skipped:	202

We asked people to tell us how they usually travel to their podiatry clinics:

Transport to podiatry appointments		
Method	Percentage	Total
Public Transport	20.59%	132
Taxi	6.71%	43
Car	59.13%	379
Walk	10.30%	66
Other	3.28%	21
	Answered:	641
	Skipped:	177

Other methods of transport included relying on family to get to appointments, home visits or using a combination of the above methods.

We asked people to tell us what they currently use the podiatry service for:

Treatment method used by patients		
Treatment	Percentage	Total
Corns, painful hard skin	15.22%	100
Toe nail cutting only	41.86%	275
Wound Care	4.87%	32
Nail Surgery	5.48%	36
Biomechanics	4.41%	29
Diabetic Checks	21.31%	140
All	6.85%	45
	Answered:	657
	Skipped:	161

We asked people to tell us if they felt these proposals would have an impact on them:

Impact level	Response Percentage	Response Total
Yes, a big impact	37.23%	293
Yes, some impact	27.95%	220
No, no impact	15.50%	122
Do not know	12.83%	101
This does not apply to me	6.48%	51
Total:	Answered	787
	Skipped	31

We asked for reasons and the themes were:

- Some people felt that they and other patients will be at risk (10 Responses)
- It was thought that there will be fewer appointment times/podiatrist availability (17 Responses)
- A number of respondents were unhappy or felt that they would be unable to pay for another provider if they were not eligible for the service (24 Responses)
- Many felt that they would have problems with transport if clinic locations changed and they have medical conditions that would make cutting their own toe nails difficult (251 Responses)
- Some people said they don't want to travel to another location (47 Responses)

6.2 Location of podiatry clinics

To help us improve the podiatry service we have proposed reducing the number of clinic locations in Greater Huddersfield only. This would mean that some patients living in Huddersfield might need to use a different location to the one they currently use. Currently the service is in great demand due to the increasing number of people with long term conditions and an ageing population. If accepted this would help us improve the current service by increasing the number of appointments and offering more choice of appointments. Podiatrists are currently spending a significant amount of time travelling between locations when they could be spending time with patients.

6.2.1 Survey responses

Q: We are proposing to reduce the number of clinics available in Greater Huddersfield from 15 to 8. To what extent to you agree or disagree with the proposal?

Answer options	Response %	Response count
Strongly agree	3.9%	31
Agree	24.8%	195
Don't know	10.1%	80
Disagree	27.5	216

Strongly Disagree	33.50	263
Answered question		785
Skipped question		33

Q: Please explain your reason for your answer.

785 people responded to this question. The main themes were:

Support for the proposal

- It was felt that there would be improved efficiency
- Some felt that the proposals would improve the service provided because those with the greatest need would be seen more quickly
- It was thought that 17 locations in Huddersfield was too many
- Some felt that there would be benefits from fewer locations that had better equipped facilities
- People commented that public transport links around the area were good and it wouldn't be a problem getting to the suggested locations

Feedback theme	Example comments
Improved efficiency	Hopefully this will bring resources together and more patients can be seen.
	I can see from figures that some clinics have few attendees if they can attend the next nearest clinic it makes common sense.
	NHS can't afford everything, minor things should be cut.
	Whilst not happy about it I believe it is necessary to do so for better care for patients and realistically it is better financial sense.
People with more serious conditions will be seen more quickly	High/mod risk patients can be seen more often as more clinical time available.
	It will focus the service and resources you have to allow for better quality care for patients who need it the most.
	To make better use of facilities other than people just wanting toe nails trimming etc. And care for people who need really important treatment.
Locations	It looks like a lot of locations at the moment.
	Clinics too close together.

Concerns about the proposal

- Many were concerned that it would mean travelling further for an appointment even if this didn't affect them they were concerned for vulnerable groups
- Some felt that this was a cost cutting exercise
- There were many concerned that care will suffer
- It was felt that too many sites were being closed
- Some felt that clinics should be located nearer to peoples' homes

- A number of patients in Shepley were concerned about the public transport links to other locations

Feedback theme	Example comments
Vulnerable people will be affected	People with mobility problems use this service. It is a huge effort in some cases to attend an appointment. Some are in a great deal of pain (only they can feel it!) A local appointment is hugely important.
Care will suffer	Had severe foot pain and could not walk, podiatry helped me get back to it. If the service does not exist then people will be left destitute.
	Will put lives of people with low level needs at risk as they will get worse
Care should be closer to home	It is important services are provided locally with easy access to local people.
	'I do not agree that you should reduce the number of clinics, as I do not think I have the right to deny services to others, who like me need this service and are only able to get to a local clinic'.
Transport Shepley	'I can drive but there are buses in this location (Scissett) not so sure there is in Shepley'.
	'Agree but do think it could be hard for some people in Shepley- Buses not too good'.
	'Agree but do think it could be hard for some people in Shepley- Buses not too good'.

Suggestions

- Patients in Marsden suggested that Croft House GP be considered as the location for podiatry clinics instead of Slaithwaite Health Centre. When travelling by bus from Marsden the bus stops at the top of a hill and the walk up and down the hill is a concern. Croft House is better located.

6.2.2 Feedback from outreach sessions

Age UK Coffee Morning (weekly social event in Huddersfield)

- One person was unhappy that her local clinic may be closed and had already completed the consultation survey.
- Some felt that that public transport in some areas of Huddersfield was fine but weren't sure about some of the village locations.
- Generally the group were unhappy that these locations would be closed.
- One person was supportive and suggested that there were a lot of clinics and that the NHS had to make difficult decisions and this seemed to make sense

Huddersfield Over 50s Forum

- Some members of the group thought that it was unfortunate to have to make these decisions but it was a sign of the times
- A discussion was had about the ageing population and increase in long term conditions and that it was important to treat those people quickly
- There was concern that some isolated people many not be able to access care

Chart BAME event (event for BAME women in Kirklees)

- The majority of people at this event were from North Kirklees and weren't affected by the change in clinic locations. They did voice their concerns for people who might not be able to access services in the future
- It was suggested that people could pay a small charge for nail care similar to the service provided at Huddersfield University and that this community approach would be good for people who are socially isolated.

6.3 Applying eligibility criteria

The podiatry team use a set of criteria to help decide who is eligible for treatment. This has not been applied consistently throughout Kirklees and means there are many patients on the caseload who may not be eligible for podiatry care. The proposal means that some patients who currently see a podiatrist for dry skin removal, fungal infections or toe nail cutting will not be eligible for care in the future.

6.3.1 Survey responses

Q. We think it's important to redesign the service to ensure patients with high/moderate level needs get seen quicker and more frequently.

Answer options	Response %	Response count
Strongly agree	19.3%	152
Agree	52.8%	416
Don't know	5.8%	40
Disagree	14.1%	111
Strongly Disagree	8.6%	68
Answered question		787
Skipped question		31

Q: Please explain your reason for your answer.

787 people responded to this question. The main themes were:

Support for the proposal

- Most people in support of the proposal felt that care should be provided to those who are high to moderate risk
- There were many who supported the proposal but were concerned about the possible impact on elderly patients.

- Many supported the proposal as it would reduce waiting times
- Many people simply thought it made sense as it makes the service more efficient and was a better way to spend limited finances

Feedback theme	Example comments
Care should be for patients who need it most.	'I do agree that people with the most need should be prioritised but some people who still need podiatry services will lose out'.
	'If more frequent attention reduces the length of time for care that would be a benefit. You should be more ambitious and include self-care training for patients with moderate needs'.
	High risk should be seen quicker to avoid a worse situation.
	People who need the service should be given first priority. No one should waste anyone's time.
	People who need the service should be given first priority. No one should waste anyone's time.
Agree but have concerns about some patients.	'I agree, but I also think that many elderly or sick patients in particular need to be able to get to clinics within reasonable distance from their homes, because of their age, health problems and the expense of travelling and living on a fixed income e.g. pensions'.
It makes sense	Because it's logical...
	It could provide a more efficient service

Concerns about the proposal

- The majority who disagreed were concerned that they and others would suffer as a consequence of not being eligible for the service
- Many people were concerned about how they would cope if they were no longer eligible for the service

Feedback theme	Example comments
Vulnerable people will be affected	There are many people like me who need help with toe nails- Where else would I go. Please do not assume we all have transport.
	'You are looking at stopping people with less needs getting the service. This is wrong and will make healthcare worse'.
	'You appear to be excluding elderly people who have difficulty in caring for their own foot health but have no acute problems. For those who can afford a private podiatrist this won't be a problem but for those who can't you are leaving them to develop problems instead of providing free healthcare as the NHS should'.
Care will suffer	This service should not be interfered with. No need to redesign by reducing the patients will suffer. Where elderly will go they cannot cope themselves.

	Whilst accepting the premise this should already be happening and if not then management/appointments need to be adjusted. This proposal seems an excuse to decline some patients and reduce the numbers you already treat. This proposal seems to be about downsizing the service rather than meeting the needs of the public.

Suggestions

- Lower risk/routine patients should be taught basic self-care that can be carried out at home
- There should be a low cost or no cost alternative for toe nail cutting

6.3.2 Feedback from outreach sessions

Milen Day Care Women's Group (day care service for Asian elderly people)
The following comments were made by the 20 women at the outreach session:

- Most people didn't use the service and cared for their own feet
- They thought the proposals were acceptable and that people with serious conditions should be prioritised

Milen Day Care Men's Group (day care service for Asian elderly people)
The following comments were made by the 25 men at the outreach session:

- Most people did not use the service and looked after their own feet with the support of their family
- They thought the proposals were acceptable and that people with serious conditions should be prioritised
- It was suggested that local no cost/low cost toe nail cutting clinics should be organised

Age UK Coffee Morning (weekly social event in Huddersfield)

- Many were concerned that services could be taken away from them and felt that people might get worse if they don't find an alternative provider
- Some felt that there had been enough cuts to services and didn't want things to change.
- They did understand and support priority for people with serious conditions.

Huddersfield Over 50s Forum

- Some people already used a private provider and were in full support of the proposal
- Others felt this was another important service being taken away from older people

- Some didn't use the service now and felt that if the proposal went ahead they were more likely to be seen quickly

Chart BAME event (event for BAME women in Kirklees)

- Most people supported the proposal and thought care should be directed towards those in greatest need
- Two people were very concerned about people who may not receive the service in the future and what would happen if they couldn't self-care or pay for treatment.

6.4 Additional Support

For patients who are no longer eligible for treatment we want to offer a safe discharge from the service. We asked people what support they thought should be provided for people who would no longer be eligible for podiatry treatment.

Q: For those who may no longer eligible for the podiatry service because they have low level foot care needs such as nail cutting, verrucae or dry skin, what support to you think we should provide?

Suggestions	Response Percentage	Response Total
Foot healthcare from a qualified podiatrist	57.62%	344
Educational leaflet	26.80%	160
Video clips	15.91%	95
Information about other local services on offer	57.62%	344
Option to purchase approved tools at cost price	29.15%	174
Total:	Answered	597
	Skipped	221

When asked 'what else would you suggest', the key themes were:

- Additional Support at GP Practices, drop in sessions and self-care.
- Alternative low cost or no cost provision.
- 650 people didn't comment

Feedback theme	Example comments
Additional support	Consideration be given to running a once a month walk in for people who live alone and have disabilities that preclude them from carrying out effective care of their own feet!
	Would it not be possible for GP surgeries to always have a doctor or nurse who has some experience of podiatry to be in attendance at the surgery, say once or twice a week, to give helpful advice.
Alternative low cost/no cost	Provide a secondary service at a nominal cost. i.e. charge for

care provision	more frequent appointments and for "lower" risk patients to continue with their trusted clinician. Peer support networks. Establishing (even funding) volunteer and community support. - Signposting to community support.
	Make a small charge, some people can't hold the tools for clipping toe nails.
	Recommend private treatment at low, fixed cost.
	I would look elsewhere, if we don't look after our feet it's our fault in the first place and leaflets are a good idea.

7.0 Conclusion

The consultation process has provided Locala and the CCGs with the views and suggestions of the public on the proposals around podiatry care in Kirklees.

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. These findings of this consultation will be taken into consideration when planning future specification of the Podiatry Service. This will be shared with the public once decisions have been made.

Appendix A CCG legal requirements around consultation

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

Appendix B Consultation Survey

Have your say

We believe these proposed changes will benefit patients who have the greatest need for podiatry care, improve the service we are able to provide, and ensure that the service is able to support the growing number of people who need care in Kirklees.

We would like you to tell us what you think about these proposals. Your views are really important to us if we are to make the right decision about the future of podiatry services.

Could you tell us the first part of your postcode? e.g HD8

1. **After reading the information did you understand the proposals?**
   Yes, all of it ❑ Yes, some of it ❑ No ❑

2. **Are you:**

   A patient that has used or is currently using the service ❑

   A carer of a patient that has used or is currently using the service ❑

   A healthcare professional ❑

   A member of staff ❑

   A member of the public that has not used the service in the past ❑

   Other, please state

3. **Do you or someone you care for currently use/have used one of the 17 clinics in <u>Greater Huddersfield:</u>**
   Yes
   No (if no go direct to Q5)
   Don't know

   If yes, which clinic/s do you usually use?
   Dearne Valley HC Scissett tick boxes
   Fartown
   Honley GP
   Kirkburton GP
   Kirkheaton GP
   Holmfirth HVMH
   Meltham The Cobbles GP

Marsden Health Centre
Newsome GP
Princess Royal Health Centre
Slaithwaite Health Centre
Skelmanthorpe
Mill Hill Health Centre
Waterloo GP
Shepley GP
Dewsbury Health Centre
Batley Health Centre
Cleckheaton Health Centre
Lepton GP
Birkenshaw
Meltham The Cobbles GP
Marsden Health Centre

If you or someone you care for currently uses the service or has done in the past, tell us how you normally travel to podiatry appointments:

Public transport ❑
Taxi ❑
Car ❑
Walk ❑
Other (please state)

4. **What do you currently use the Podiatry service for?**

Corns, painful hard skin	❑	Nail Surgery	❑
Toe nail cutting only	❑	Biomechanics	❑
Wound care	❑	Diabetic checks	❑

5. **We are proposing to reduce the number of clinics available in Greater Huddersfield from 17 to 8. To what extent to you agree or disagree with the proposal?**

Strongly agree	Agree	Disagree	Strongly Disagree	Don't Know	
Please explain your reason for the above answer					

6. **We think it's important to redesign the service to ensure patients with high/moderate level needs get seen quicker and more frequently. Do you agree? To what extent to you agree or disagree with the proposal?**

Strongly agree	Agree	Disagree	Strongly Disagree	Don't Know	
Please explain your reason for the above answer					

7. **For those people who are no longer eligible for the podiatry service because they have low level foot care needs such as nail cutting, verrucae or dry skin, what support do you think we should provide?**

Foot healthcare training from a qualified podiatrist ❑
Educational leaflet ❑
Video clips ❑
Information about other local services on offer ❑
Option to purchase approved tools at cost price ❑

What else would you suggest?

8. **Do you feel the proposal would in any way have an impact on you?**

Yes a big impact	Yes, some impact		No, no impact	Do not know	This does not apply to me
Please explain your reason for the above answer					

9. **Is there anything else you think we should consider when making a decision about any changes to current podiatry services?**

Additional Information

This questionnaire can be completed on our website where regular updates will be available: www.locala.org.uk/tbc.

If you need this form in another language or another format (such as large print) please contact us at: podiatryconsultation@locala.org.uk Tel: tbc

(this information will be added in Urdu, Gujarati, Czech and Polish)

Please return this completed form to:
Locala Community Partnerships CIC
Freepost Plus RSTJ-EYJA-UCTB
First Floor, Beckside Court
Bradford Road
Batley WF17 5PW

Closing date

The consultation will end on 30 June 2017. All surveys must be received by midnight that day to ensure they are considered.

Data protection

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.

Appendix C Equality and Diversity Data

Postcode Areas	Percentage of total responses	Total responses
BD11	0.86%	7
BD12	0.12%	1
BD19	2.44%	20
BD24	0.12%	1
BD4	0.12%	1
BD9	0.12%	1
HD1	4.40%	36
HD12	0.24%	2
HD15	0.12%	1
HD2	10.15%	83
HD21	0.24%	2
HD22	0.12%	1
HD3	6.11%	50
HD4	5.99%	49
HD5	7.82%	64
HD6	0.37%	3
HD7	10.76%	88
HD8	12.10%	99
HD9	9.17%	75

LS11	0.12%	1
LS12	0.12%	1
LS17	0.12%	1
S36	0.12%	1
S75	0.12%	1
WF1	0.24%	2
WF11	0.12%	1
WF12	4.65%	38
WF13	4.16%	34
WF14	1.71%	14
WF15	2.81%	23
WF16	2.20%	18
WF17	5.37%	44
WF4	0.37%	3
WF5	0.12%	1
No Comment	6.23%	51
Total:		818

What sex are you?

Answer Options	Response Percentage	Response Total
Male	43.07%	339
Female	53.62%	422
Prefer not to say	3.30%	26
Total:	Answered:	787
	Skipped	31

How old are you?

Answer Options	Response Percentage	Response Total
Under 18	0.64%	5
18-24	2.82%	22
25-34	3.72%	29
35-54	12.18%	95
55+	72.44%	565
Prefer not to say	8.21%	64
Total:	Answered	780
	Skipped	38

Answers	Response Percentage	Total Responses
No Comment	8.80%	72
Australia	0.12%	1
Austria	0.12%	1
Bangladesh	0.98%	8
BURMA (Myanmar)	0.12%	1

Caribbean	0.12%	1
England	67.97%	556
France	0.12%	1
Great Britain	3.30%	27
Grenada	0.37%	3
India	2.57%	21
Ireland	0.98%	8
Jamaica	1.10%	9
Northern Ireland	0.49%	4
Not relevant	0.12%	1
Pakistan	3.55%	29
Poland	0.24%	2
Scotland	0.86%	7
Spain	0.12%	1
Trinidad	0.12%	1
UK	7.58%	62
Total		**818**

Do you belong to any religion?

Answer Options	Response Percentage	Response Total
Buddhism	0.51%	4
Christianity	57.20%	445
Hinduism	0.26%	2
Islam	12.85%	100
Judaism	0.26%	2
Sikhism	1.03%	8
No religion	14.65%	114
Prefer not to say	7.71%	60
Other (Please specify)	5.53	43
Total:	Answered	778
	Skipped	40

What is your ethnic group?

Answer Options	Response Percentage	Response Total
British	75.87%	591
Irish	2.18%	17
Other	1.03%	8
Indian	3.72%	29
Pakistani	9.24%	72
Bangladeshi	1.54%	12
Any other Asian background	0.26%	2
White and black Caribbean	0.26%	2
White and black African	0.00%	0
White and Asian	0.00%	0
Any other mixed background	0.00%	0

Caribbean	2.44%	19
African	0.00%	0
Any other black background	0.00%	0
Chinese	0.00%	0
Any other Ethnic group	0.51%	4
I do not wish to disclose my ethnic origin	2.95%	23
Total:	Answered	779
	Skipped	39

Do you consider yourself to be disabled?

Answer Options	Response Percentage	Response Total
Yes	56.89%	442
No	35.26%	274
Prefer not to say	7.85%	61
Total:	Answered	777
	Skipped	41

Type of impairment: Please tick all that apply

Answer Options	Response Percentage	Response Total
Physical or mobility impairment (such as using a wheelchair to get around and / or difficulty using their arms)	34.87%	257
Sensory impairment (such as being blind/having a serious visual impairment and / or difficulty using their arms)	12.35%	91
Mental health condition (such as depressions or schizophrenia)	7.73%	57
Learning disability (such as Downs syndrome or dyslexia) or cognitive impairment (such as autism or head injury)	2.04%	15
Long term condition (such as cancer, HIV, diabetes, chronic heart disease, epilepsy)	33.79%	249
Prefer not to say	8.68%	64
None	26.59%	196
Total:	Answered	737
	Skipped	81

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 Percentage	Response Total

Yes	11.24%	87
No	84.24%	652
Prefer not to say	4.52%	35
Total:	Answered	774
	Skipped	44

Are you pregnant?

Answer Options	Response Percentage	Response Total
Yes	0.26%	2
No	95.88%	745
Prefer not to say	3.86%	30
Total:	Answered	777
	Skipped	41

Have you given birth in the last six months?

Answer Options	Response Percentage	Response Total
Yes	0.00%	0
No	96.12%	744
Prefer not to say	3.86%	30
Total:	Answered	774
	Skipped	44

Please select the option that best represents your sexual orientation:

Answer Options	Response Percentage	Response Total
Bisexual (both sexes)	2.89%	22
Gay (Same sex)	0.66%	5
Heterosexual/straight (Opposite sex)	78.58%	598
Lesbian (Same sex)	0.13%	1
Other	1.05%	8
Prefer not to say	16.69%	127
Total:	Answered	761
	Skipped	57

Are you transgender? Is your gender identity different to the gender you were assigned at birth?

Answer Options	Response Percentage	Response Total
Yes	0.26%	2
No	91.02%	689
Prefer not to say	8.98%	68
Total:	Answered	757
	Skipped	61

Appendix D

Will these proposals have an impact on you? Analysed using E&D data.

What sex are you?	Total Response

Do not know	**101**
No Comment	1
Female	49
Male	47
Prefer not to say	4
No Comment	**31**
No Comment	7
Female	14
Male	9
Prefer not to say	1
No, no impact	**122**
No Comment	5
Female	47
Male	69
Prefer not to say	1
This does not apply to me	**51**
No Comment	2
Female	23
Male	22
Prefer not to say	4
Yes, a big impact	**293**
No Comment	9
Female	166
Male	106
Prefer not to say	12
Yes, some impact	**220**
No Comment	7
Female	123
Male	86
Prefer not to say	4
Grand Total	**818**

What age are you?	Total Response
Do not know	**101**
No Comment	1
18-24	11
25-34	8
35-54	13
55+	57
Prefer not to say	9
under 18	2
No Comment	**31**
No Comment	7
18-24	2

25-34	2
35-54	1
55+	16
Prefer not to say	3
No, no impact	**122**
No Comment	6
18-24	5
25-34	7
35-54	24
55+	70
Prefer not to say	7
under 18	3
This does not apply to me	**51**
No Comment	3
25-34	4
35-54	13
55+	24
Prefer not to say	7
Yes, a big impact	**293**
No Comment	10
18-24	2
25-34	4
35-54	27
55+	226
Prefer not to say	24
Yes, some impact	**220**
No Comment	11
18-24	2
25-34	4
35-54	17
55+	172
Prefer not to say	14
Grand Total	**818**

Do you belong to any religion?	Total Response
Do not know	**101**
Christianity	39
Islam	35
Methodist	3
No Comment	1
No religion	15
Prefer not to say	8
No Comment	**31**
Christianity	9

Church of England	3
Islam	2
No Comment	9
No religion	4
Prefer not to say	4
No, no impact	**122**
Christianity	53
Church of England	1
Islam	37
Methodist	1
No Comment	8
No religion	10
Prefer not to say	6
Protestant	1
Roman Catholic	1
Sikhism	2
Spiritualist	1
Weslyan	1
This does not apply to me	**51**
Christianity	25
Hinduism	1
Islam	6
No Comment	2
No religion	10
Prefer not to say	5
Rasta farina	1
Sikhism	1
Yes, a big impact	**293**
Agnostic	1
Baptist Church	1
Buddhism	3
C e	1
c of e	2
Catholic	4
Christianity	182
Church of England	2
COE	1
Hinduism	1
Islam	10
JEDEI	1
Jehovah's Witness	1
Judaism	2
No Comment	9
No religion	36

not relevant	1
Other (please specify):	4
Prefer not to say	24
Roman Catholic	1
Sikhism	5
What has this to do with podiatry?	1
Yes, some impact	**220**
Atheist.	1
Baptist	1
Buddhism	1
Christianity	137
Church of England	1
Islam	10
Jediism	1
jehovah's witness	1
Methodist	1
No Comment	11
No religion	39
Prefer not to say	13
Spiritualist	1
Totally irrelevant question	1
What as this to do with foot care	1
Grand Total	**818**

Row Labels	Total Response
Do not know	**101**
Bangladeshi	1
British	61
I do not wish to disclose my ethnic origin	3
No Comment	3
Pakistani	33
No Comment	**31**
Bangladeshi	1
British	18
Irish	2
No Comment	8
Pakistani	2
No, no impact	**122**
Bangladeshi	9
British	71
I do not wish to disclose my ethnic origin	2
Indian	13
Irish	2
No Comment	6

Other	1
Pakistani	18
This does not apply to me	**51**
British	35
Caribbean	1
I do not wish to disclose my ethnic origin	2
Indian	6
Irish	1
No Comment	2
Other	2
Pakistani	2
Yes, a big impact	**293**
Any other Asian background	2
Any other Ethnic Group	4
British	226
Caribbean	10
I do not wish to disclose my ethnic origin	12
Indian	6
Irish	9
No Comment	10
Other	3
Pakistani	11
Yes, some impact	**220**
Bangladeshi	1
British	180
Caribbean	8
I do not wish to disclose my ethnic origin	4
Indian	4
Irish	3
No Comment	10
Other	2
Pakistani	6
White and Black Caribbean	2
Grand Total	**818**

Do you consider yourself to have a disability?	Total Response
Do not know	**101**
No Comment	2
No	38
Prefer not to say	8
Yes	53
No Comment	**31**
No Comment	7

No	9
Prefer not to say	2
Yes	13
No, no impact	**122**
No Comment	9
No	74
Prefer not to say	5
Yes	34
This does not apply to me	**51**
No Comment	2
No	24
Prefer not to say	5
Yes	20
Yes, a big impact	**293**
No Comment	11
No	51
Prefer not to say	23
Yes	208
Yes, some impact	**220**
No Comment	10
No	78
Prefer not to say	18
Yes	114
Grand Total	**818**

Are you pregnant?	Total Response
Do not know	**101**
No Comment	2
No	97
Prefer not to say	2
No Comment	**31**
No Comment	7
No	24
No, no impact	**122**
No Comment	6
No	116
This does not apply to me	**51**
No Comment	2
No	44
Prefer not to say	4
Yes	1
Yes, a big impact	**293**
No Comment	14
No	263

Prefer not to say	16
Yes, some impact	**220**
No Comment	10
No	201
Prefer not to say	8
Yes	1
Grand Total	**818**

What best describes your sexual orientation?	Total Response
Do not know	**101**
No Comment	2
Bisexual (both sexes)	1
Heterosexual/straight (opposite sex)	81
Prefer not to say	17
No Comment	**31**
No Comment	8
Bisexual (both sexes)	2
Heterosexual/straight (opposite sex)	13
Other	1
Prefer not to say	7
No, no impact	**122**
No Comment	8
Bisexual (both sexes)	2
Heterosexual/straight (opposite sex)	99
Prefer not to say	13
This does not apply to me	**51**
No Comment	3
Bisexual (both sexes)	1
Gay (same sex)	2
Heterosexual/straight (opposite sex)	37
Prefer not to say	8
Yes, a big impact	**293**
No Comment	17
Bisexual (both sexes)	11
Gay (same sex)	1
Heterosexual/straight (opposite sex)	205
Lesbian (same sex)	1
Other	5
Prefer not to say	53
Yes, some impact	**220**
No Comment	19
Bisexual (both sexes)	5
Gay (same sex)	2

Heterosexual/straight (opposite sex)	163
Other	2
Prefer not to say	29
Grand Total	**818**

Are you transgender?	Total Response
Do not know	**101**
No Comment	8
No	88
Prefer not to say	5
No Comment	**31**
No Comment	8
No	20
Prefer not to say	3
No, no impact	**122**
No Comment	8
No	107
Prefer not to say	7
This does not apply to me	**51**
No Comment	2
No	40
Prefer not to say	9
Yes, a big impact	**293**
No Comment	19
No	245
Prefer not to say	29
Yes, some impact	**220**
No Comment	16
No	189
Prefer not to say	15
Grand Total	**818**

Do you understand these proposals? Analysed using E&D data.

What sex are you?	Total Response
No	**14**
Female	7
Male	6
Prefer not to say	1
No Comment	**39**
No Comment	4
Female	21
Male	14

Yes, all of it	**529**
No Comment	17
Female	255
Male	238
Prefer not to say	19
Yes, some of it	**236**
No Comment	10
Female	139
Male	81
Prefer not to say	6
Grand Total	**818**

What is your age?	Total Response
No	**14**
35-54	3
55+	10
Prefer not to say	1
No Comment	**39**
No Comment	5
18-24	1
35-54	5
55+	27
Prefer not to say	1
Yes, all of it	**529**
No Comment	23
18-24	17
25-34	19
35-54	53
55+	367
Prefer not to say	45
under 18	5
Yes, some of it	**236**
No Comment	10
18-24	4
25-34	10
35-54	34
55+	161
Prefer not to say	17
Grand Total	**818**

Do you belong to any religion?	Total Response
No	**14**
Christianity	8
Islam	1

JEDEI	1
No religion	2
Prefer not to say	2
No Comment	**39**
Christianity	20
Islam	1
No Comment	7
No religion	7
Prefer not to say	3
Roman Catholic	1
Yes, all of it	**529**
Atheist.	1
baptist	1
Baptist Church	1
Buddhism	4
Catholic	3
Christianity	283
Church of England	4
Hinduism	2
Islam	76
jehovah's witness	1
Judaism	2
Methodist	5
No Comment	19
No religion	73
not relevent	1
Other (please specify):	4
Prefer not to say	36
Protestant	1
Rasta farian	1
Sikhism	7
Spiritualist	1
Totally irrelevant question	1
Weslyan	1
What as this to do with foot care	1
Yes, some of it	**236**
Agnostic	1
C e	1
c of e	2
Catholic	1
Christianity	134
Church of England	3
COE	1
Islam	22

Jediism	1
Jehovah's Witness	1
No Comment	14
No religion	32
Prefer not to say	19
Roman Catholic	1
Sikhism	1
Spiritualist	1
What has this to do with podiatry?	1
Grand Total	**818**

What is your ethnic origin?	Total Response
No	**14**
British	11
Pakistani	2
White and Black Caribbean	1
No Comment	**39**
British	27
Caribbean	3
Indian	1
Irish	2
No Comment	6
Yes, all of it	**529**
Any other Asian background	2
Any other Ethnic Group	4
Bangladeshi	11
British	378
Caribbean	4
I do not wish to disclose my ethnic origin	19
Indian	25
Irish	8
No Comment	20
Other	6
Pakistani	51
White and Black Caribbean	1
Yes, some of it	**236**
Bangladeshi	1
British	175
Caribbean	12
I do not wish to disclose my ethnic origin	4
Indian	3
Irish	7
No Comment	13
Other	2

Pakistani	19
(blank)	
(blank)	
Grand Total	**818**

Do you consider yourself to have a disability?	Total Response
No	**14**
No	4
Prefer not to say	2
Yes	8
No Comment	**39**
No Comment	5
No	12
Prefer not to say	2
Yes	20
Yes, all of it	**529**
No Comment	24
No	188
Prefer not to say	37
Yes	280
Yes, some of it	**236**
No Comment	12
No	70
Prefer not to say	20
Yes	134
Grand Total	**818**

Are you pregnant?	Total Response
No	**14**
No	13
Prefer not to say	1
No Comment	**39**
No Comment	6
No	33
Yes, all of it	**529**
No Comment	21
No	484
Prefer not to say	23
Yes	1
Yes, some of it	**236**

No Comment	14
No	215
Prefer not to say	6
Yes	1
Grand Total	**818**

What best describes your sexual orientation?	Total Response
No	**14**
Bisexual (both sexes)	1
Heterosexual/straight (opposite sex)	10
Prefer not to say	3
No Comment	**39**
No Comment	6
Bisexual (both sexes)	5
Heterosexual/straight (opposite sex)	22
Prefer not to say	6
Yes, all of it	**529**
No Comment	29
Bisexual (both sexes)	13
Gay (same sex)	3
Heterosexual/straight (opposite sex)	409
Lesbian (same sex)	1
Other	6
Prefer not to say	68
Yes, some of it	**236**
No Comment	22
Bisexual (both sexes)	3
Gay (same sex)	2
Heterosexual/straight (opposite sex)	157
Other	2
Prefer not to say	50
Grand Total	**818**

Are you transgender?	Total Response
No	**14**
No	13
Prefer not to say	1
No Comment	**39**
No Comment	8
No	30
Prefer not to say	1
Yes, all of it	**529**
No Comment	36

No	452
Prefer not to say	41
Yes, some of it	**236**
No Comment	17
No	194
Prefer not to say	25
Grand Total	**818**

What do you use the service for? Analysed again E&D data.

Do you belong to any religion?	Total Responses
All	**42**
Buddhism	1
Christianity	22
Islam	1
No religion	9
Other (Sikhism- 1, Judaism- 2):	3
Prefer not to say	6
Biomechanics	**28**
Buddhism	1
Christianity	14
No Comment	4
No religion	6
Other (please specify):	1
Prefer not to say	2
Corns, painful hard skin	**100**
Baptist Church	1
Christianity	72
Islam	2
Methodist	1
No Comment	1
No religion	13
Prefer not to say	7
Sikhism	2
Diabetic checks	**140**
Buddhism	1
Catholic	2
Christianity	81
Islam	17
Methodist	2
No Comment	6
No religion	16
Prefer not to say	15
Nail Surgery	**36**
Christianity	23

Islam	3
No Comment	4
No religion	2
Prefer not to say	1
Roman Catholic	1
Sikhism	2
No Comment	**161**
Christianity	51
Hinduism	2
Islam	62
Jedism	1
No Comment	8
No religion	24
Prefer not to say	11
Rasta farian	1
Spiritualist	1
Toe nail cutting only	**275**
Agnostic	1
Atheist.	1
baptist	1
Buddhism	1
Catholic	2
Christianity	172
Islam	11
JEDEI	1
Jehovah's Witness	2
Methodist	2
No Comment	17
No religion	40
Prefer not to say	17
Roman Catholic	1
Sikhism	2
Spiritualist	1
Weslyan	1
Wound Care	**32**
Christianity	22
Islam	4
No religion	4
Prefer not to say	1
Sikhism	1
Grand Total	**818**

What is your sex?	Total Response
All	**45**

No Comment	1
Female	19
Male	19
Prefer not to say	6
Biomechanics	**29**
No Comment	3
Female	18
Male	7
Prefer not to say	1
Corns, painful hard skin	**100**
No Comment	2
Female	73
Male	25
Diabetic checks	**140**
No Comment	5
Female	60
Male	67
Prefer not to say	8
Nail Surgery	**36**
No Comment	1
Female	23
Male	12
No Comment	**161**
No Comment	7
Female	61
Male	86
Prefer not to say	7
Toe nail cutting only	**275**
No Comment	12
Female	148
Male	111
Prefer not to say	4
Wound Care	**32**
Female	20
Male	12
Grand Total	**818**

What age are you?	Total Response
All	**45**
35-54	8
55+	31
Prefer not to say	6
Biomechanics	**29**
No Comment	3

35-54	6
55+	16
Prefer not to say	4
Corns, painful hard skin	**100**
No Comment	1
25-34	3
35-54	10
55+	81
Prefer not to say	5
Diabetic checks	**140**
No Comment	7
18-24	5
25-34	2
35-54	11
55+	99
Prefer not to say	16
Nail Surgery	**36**
No Comment	2
18-24	1
25-34	1
35-54	3
55+	28
Prefer not to say	1
No Comment	**161**
No Comment	8
18-24	14
25-34	16
35-54	41
55+	62
Prefer not to say	15
under 18	5
Toe nail cutting only	**275**
No Comment	16
25-34	6
35-54	13
55+	225
Prefer not to say	15
Wound Care	**32**
No Comment	1
18-24	2
25-34	1
35-54	3
55+	23
Prefer not to say	2

Grand Total	**818**

What is your ethnic origin?	Total Response
All	**45**
Any other Ethnic Group	3
British	31
Caribbean	1
I do not wish to disclose my ethnic origin	6
No Comment	2
Pakistani	2
Biomechanics	**29**
Bangladeshi	1
British	20
I do not wish to disclose my ethnic origin	3
No Comment	3
Other	1
White and Black Caribbean	1
Corns, painful hard skin	**100**
British	88
Caribbean	2
I do not wish to disclose my ethnic origin	2
Indian	2
Irish	2
No Comment	2
Pakistani	2
Diabetic checks	**140**
British	101
Caribbean	5
I do not wish to disclose my ethnic origin	5
Indian	1
Irish	2
No Comment	8
Other	3
Pakistani	15
Nail Surgery	**36**
Any other Asian background	1
Bangladeshi	1
British	27
I do not wish to disclose my ethnic origin	1
Indian	3
No Comment	2
Pakistani	1
No Comment	**161**
Bangladeshi	9

British	74
Caribbean	1
I do not wish to disclose my ethnic origin	2
Indian	16
Irish	6
No Comment	8
Other	4
Pakistani	40
White and Black Caribbean	1
Toe nail cutting only	**275**
Any other Asian background	1
Any other Ethnic Group	1
British	223
Caribbean	10
I do not wish to disclose my ethnic origin	4
Indian	5
Irish	7
No Comment	14
Pakistani	10
Wound Care	**32**
Bangladeshi	1
British	27
Indian	2
Pakistani	2
Grand Total	**818**

Do you consider yourself to have a disability?	Total Response
All	**45**
No Comment	2
No	6
Prefer not to say	5
Yes	32
Biomechanics	**29**
No Comment	3
No	10
Prefer not to say	3
Yes	13
Corns, painful hard skin	**100**
No Comment	2
No	27
Prefer not to say	8
Yes	63
Diabetic checks	**140**
No Comment	5

No	34
Prefer not to say	10
Yes	91
Nail Surgery	**36**
No Comment	2
No	15
Prefer not to say	2
Yes	17
No Comment	**161**
No Comment	8
No	116
Prefer not to say	7
Yes	30
Toe nail cutting only	**275**
No Comment	16
No	59
Prefer not to say	22
Yes	178
Wound Care	**32**
No Comment	3
No	7
Prefer not to say	4
Yes	18
Grand Total	**818**

Are you pregnant?	Total Response
All	**45**
No	39
Prefer not to say	6
Biomechanics	**29**
No Comment	3
No	25
Prefer not to say	1
Corns, painful hard skin	**100**
No Comment	3
No	94
Prefer not to say	2
Yes	1
Diabetic checks	**140**
No Comment	8
No	126
Prefer not to say	6
Nail Surgery	**36**
No Comment	2

No	34
No Comment	**161**
No Comment	6
No	147
Prefer not to say	7
Yes	1
Toe nail cutting only	**275**
No Comment	18
No	249
Prefer not to say	8
Wound Care	**32**
No Comment	1
No	31
Grand Total	**818**

Are you transgender?	Total Response
All	**45**
No	38
Prefer not to say	7
Biomechanics	**29**
No Comment	5
No	21
Prefer not to say	3
Corns, painful hard skin	**100**
No Comment	6
No	88
Prefer not to say	6
Diabetic checks	**140**
No Comment	9
No	120
Prefer not to say	11
Nail Surgery	**36**
No Comment	2
No	30
Prefer not to say	4
No Comment	**161**
No Comment	8
No	138
Prefer not to say	15
Toe nail cutting only	**275**
No Comment	30
No	224
Prefer not to say	21
Wound Care	**32**

No Comment	1
No	30
Prefer not to say	1
Grand Total	**818**

What best describes your sexual orientation?	Total Response
All	**45**
No Comment	1
Bisexual (both sexes)	2
Heterosexual/straight (opposite sex)	30
Other	1
Prefer not to say	11
Biomechanics	**29**
No Comment	4
Bisexual (both sexes)	2
Heterosexual/straight (opposite sex)	18
Prefer not to say	5
Corns, painful hard skin	**100**
No Comment	6
Bisexual (both sexes)	2
Heterosexual/straight (opposite sex)	75
Other	2
Prefer not to say	15
Diabetic checks	**140**
No Comment	8
Bisexual (both sexes)	3
Gay (same sex)	1
Heterosexual/straight (opposite sex)	103
Other	1
Prefer not to say	24
Nail Surgery	**36**
No Comment	3
Bisexual (both sexes)	2
Heterosexual/straight (opposite sex)	24
Lesbian (same sex)	1
Other	1
Prefer not to say	5
No Comment	**161**
No Comment	8
Bisexual (both sexes)	6
Gay (same sex)	4
Heterosexual/straight (opposite sex)	126

Other	1
Prefer not to say	16
Toe nail cutting only	**275**
No Comment	27
Bisexual (both sexes)	5
Heterosexual/straight (opposite sex)	196
Prefer not to say	47
Wound Care	**32**
Heterosexual/straight (opposite sex)	26
Other	2
Prefer not to say	4
Grand Total	**818**

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Name of Meeting: HEALTH AND ADULT SOCIAL CARE SCRUTINY PANEL

Date: TUESDAY 14 NOVEMBER 2017

Title of report: INTEGRATION OF HEALTH AND ADULT SOCIAL CARE

Purpose of Report:

This report presents for information a position statement on the integration of Health and Adult Social Care in Kirklees.

Key Decision - Is it likely to result in spending or a saving of £250k or more, or to have a significant effect on two or more electoral wards?	N/A
Is it in the Council's Forward Plan (Key Decisions and Private Reports)?	N/A
The Decision - Is it eligible for "call in" by Scrutiny?	N/A
Date signed off by Director and 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**	Richard Parry – 2 November 2017 N/A N/A
Cabinet member portfolio	Cllrs Viv Kendrick and Cathy Scott, Adults and Public Health

Electoral wards affected: All

Ward councillors consulted: Consultation with Ward Councillors is not applicable to this report

Public or private: Public

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1. Summary

The local vision and approach for health and social care integration

1.1 The Kirklees Health and Wellbeing Board reviewed and updated its vision in April 2017.

Kirklees 2020 Vision for our health and social care system is that –

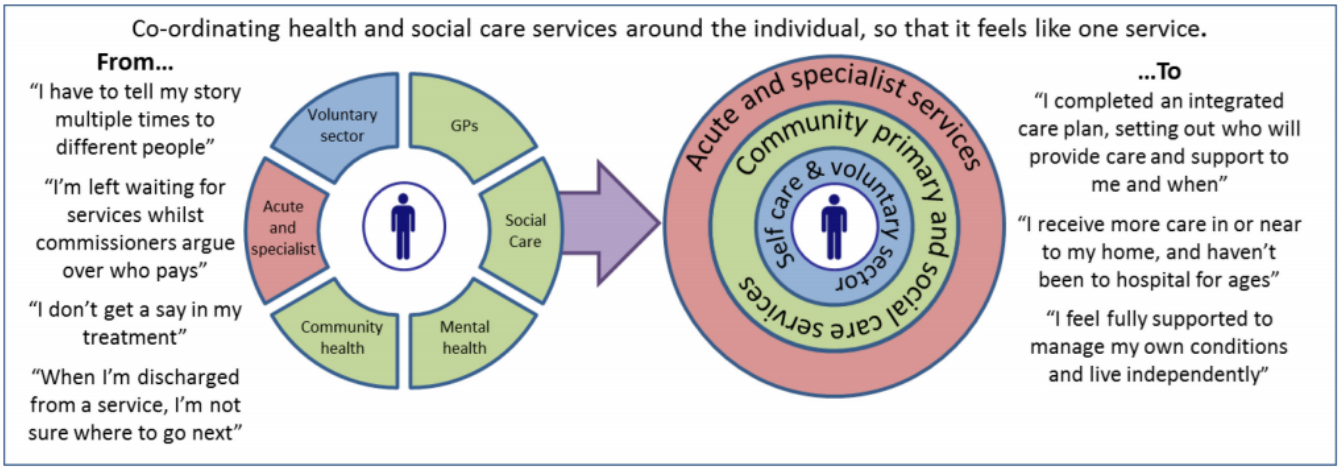
No matter where they live, people in Kirklees live their lives confidently and responsibly, in better health, for longer and experience less inequality.

The Vision sets out our objectives for local people and local services:

- People in Kirklees are as well as possible for as long as possible, in both mind and body
- People take up opportunities that have a positive impact on their health and wellbeing
- Local people are helped to manage life challenges
- People experience seamless health and social care appropriate to their needs that is:
  - affordable and sustainable, and investment is rebalanced across the system towards activity in community settings
  - based around integrated service delivery across primary, community and social care that is available 24 hours a day and 7 days a week where relevant
  - led by fully integrated commissioning, workforce and community planning
  - clear about what difference it is making, and how it can improve

The Kirklees Ambition

1.2 Our ambition for the future is to move towards population based commissioning where the focus is on service user centred co-ordinated care, as demonstrated in the diagram below, that illustrates the aims and objectives of the Better Care Fund (BCF) Policy Framework (see here) which supports improvements to health and wellbeing and reduces health inequalities for our local population.



1.3 We will deliver this through the development of integrated models of care provided by a collaboration of organisations. We want to enable and empower patients and their carers to access care in the most appropriate place with a focus on integrated and holistic care pathways. Implementation of our vision will result in a shift in activity out of hospital and into more appropriate settings including communities; ensuring patients are managed more effectively at or as close to home as possible. The role and function of the Council and the CCGs will evolve as we move towards a more integrated system of care.

Care and Health Peer Challenge

1.4 In March 2017, Kirklees participated in piloting with the Local Government Association a new system wide care and health peer challenge. The focus of the challenge was:

- The strategic commitment of the Council and CCG partners to integrating out of hospital care for adults (i.e. adult social care, primary and community healthcare and public health).
- The shift to an integrated model 'care closer to home' for the delivery of care for adults outside of hospital.
- Leadership and governance for these shifts across the system, particularly from the Council, CCGs and the community services provider Locala.

A presentation which summarises the process, findings and recommendations is here (Agenda Item 9a). The key message was that 'n*ow is the time for action, with political, clinical and management leadership working together and the aim not joint working, but a single system working to enable you to do things once and better, with a single commissioning voice.*

The recommendations are being used to inform the work currently taking place on integration.

Progress on Integration – Priority Areas for Integration

1.5 Key elements of the work are already being progressed by the Integrated Commissioning Executive (whose membership comprises senior managers from the Council and the CCGs). The focus has been on the development of single integrated teams and plans for commissioning across the system for the following priority areas

- Aids to daily living including the Kirklees Integrated Community Equipment Service, minor adaptations, adaptations funded by the Disabled Facilities Grant, assistive technology*
- Intermediate care and reablement*
- Support to carers*
- Continuing care*
- Frailty*
- Quality in care homes and the Care Homes Strategy*
- Mental Health*
- Learning Disability
- End of Life
- Adult Wellness
- Healthy Child Programme/CAHMS Transformation**
- Children and Young People – SEN, sick /looked after/vulnerable children
- Schools as Community Hubs

There are currently two pooled budgets in place. The areas that are fully or partly in these pooled budgets are marked with asterisks:

* Better Care Fund	17/18 = £44,913k	18/19 = £48,974k
** Healthy Child Programme	17/18 = £10,757k	18/19 = £10,757k

Progress on Integration - A Single Commissioning System

1.6 The Care and Health Peer Challenge recommended that we proceed at pace on our integrated commissioning project, and that has been the focus since March.

1.7 The Health and Wellbeing Board agreed the 'Case for Change' for the development of a single commissioning system in June 2017 (the presentation is here, the covering report is here – Agenda Item 10).

1.8 Building on long standing partnership collaborative arrangements, the Council and the CCGs are working towards the development of a single strategic commissioning system that will use partners' combined skills, knowledge and resources to make more efficient use of scarce resources, ensure consistency of approach and be better prepared to deliver functions across a variety of footprints and move towards a new model of care organisation.

1.9 The Peer Challenge also recommended that '*It's not a plan until it's written down; when you've planned your work, you need to work your plan'*. To enable us to deliver this a Programme Board has been established with membership including CCG Clinical Chairs, Chief Officers, other senior management leads, governance manager, Council Directors for Adults and Health, Service Directors for Integration, Adult Care, Public Health and Finance. A sub-group has also been established to focus on specific issues relating to the coming together of the management and governance arrangements across the two CCGs. Steve Brennan has been seconded from his post as Director of Finance at North Kirklees CCG to act as the Senior Responsible Officer for the overall integration programme.

1.10 A critical step in the integration journey has been the decision by both CCGs to have a single accountable officer. Many other areas, including Leeds and Bradford, have taken the same step. Following the local process, which involved a range of stakeholders, the appointment was approved by NHS England who have the statutory power to appoint CCG accountable officers, and Carol McKenna took up the role across the two CCG on 1st November. Richard Parry has returned from his part-time secondment to his full time role as Strategic Director for Adults and Health in the Council.

1.11 The next steps are focussed on

- Establishing the Integrated Commissioning Governance Arrangements
- Developing the Integrated Commissioning Infrastructure

Establishing the Integrated Commissioning Governance Arrangements

1.12 The CCGs have already taken steps to start aligning their governance arrangements. For example, the Governing Bodies will be 'meetings in common' from January 2018, i.e. the meetings will run concurrently with the same agenda and separate decisions being made by each Governing Body. More detailed work on the streamlining of governance processes is underway.

One option is to establish a new set of integrated governance arrangements that are 'Delegation Ready' i.e. the relevant bodies (CCG Governing Bodies and Council or Cabinet) can delegate authority where appropriate and possible to the new integrated arrangements. It is expected that these powers will be limited at the outset, but will include being able to manage pooled budgets in due course. This will allow the 'committee' to run in 'SafeMode' for a period and then be stepped up to full running as and when ready and in more than one step.

During the initial phase of running in 'Safe Mode' the focus will be on:

- developing an integrated Commissioning Strategy and Implementation Plan
- overseeing the development of an outcomes framework, an integrated approach to quality and an integrated approach to engagement and public involvement
- agreeing the aspiration for pooling of budgets with size and scope to be determined
- receiving financial, performance and quality information on existing services
- agreeing the scope of integrated provision and manage delivery of early initiatives
- building working relationships, trust, mutual understanding and confidence.

Developing the Integrated Commissioning Infrastructure

1.13 There are already extensive integrated arrangements across the two CCGs and the Council. And these will be strengthened significantly over the next 6 months.

At the most senior level Carol McKenna will join the new executive leadership team for Kirklees. The integrated leadership arrangements for commissioning will be established ready to go live on April 2018. Following appropriate engagement and consultation with staff the transition to the new integrated arrangements will start from April 2018. There is a long standing commitment to enable staff to maintain their existing employer, but that their roles will be within the integrated arrangements and this might require them to work differently.

There is a recognition that embedding the new integrated arrangements will require new relationships and ways of working and that we cannot assume these flow naturally or quickly enough if left to develop entirely organically. Therefore an organisational development plan is being developed to support the transition. Key elements of this plan are likely to include investing time in staff getting to know each other, developing a common 'Toolbox' of approaches and language and a launch event across whole patch.

Progress on Integration – An Integrated Delivery System for Out of Hospital Care

1.14 Since the Peer Challenge earlier this year the discussions around integration of commissioning have led to a recognition that the development of an integrated delivery system for out of hospital care needs to run in parallel, rather than wait until next year. Consequently the Integration Programme has agreed a separate workstream to lead the development of our local model. This workstream is being led by Sue Richards, Service Director Integration. The workstream will be overseen by a working group with representatives from the Council, CCGs, primary care, Locala, South West Yorkshire Foundation Trust, Calderdale and Huddersfield Foundation Trust, Mid-Yorkshire Hospitals and Kirklees Neighbourhood Housing

The role of the group is to

- Agree the ambition for integrated ‘out of hospital’ provision with commissioners
- Develop a proposal for integrated ‘out of hospital’ provision with providers
- Develop and oversee implementation plans to realise the ambition

The programme plan is in the early stages of development but it is expected that it will set out a more structured approach to developing the leadership necessary to achieve a focussed set of expectations covering

- Establishing the baseline of services and resources currently in place across the system, the associated budgets, and current 'integration initiatives'

- Developing a shared understanding of what makes a difference and how, so that we can ensure these key features are present in our model as it is develop.
- Building the Leadership Approach to develop a shared commitment to developing a new model
- Developing the High Level Model of Care which sets out the key functions and structural elements of the model, including our approach to
    - population and geography
    - population health management and risk stratification
    - care co-ordination and management
    - record sharing and associated information governance
- Identifying some areas to make progress on now rather than wait for the new model to be fully developed. These will provide ways of testing out approaches, refining them and using the learning to inform our approach. The potential areas include
    - Local area/hub working (see below)
    - Single point of access/single point of contact
    - Single Trusted Assessor
    - Accountable lead professional/person
    - Common pathways
    - Digital by Design

The procurement phase will be lengthy and needs to recognise a range of key dependencies, including the end date on the current Care Closer to Home contract in 2020. Given the scale and complexity of the potential procurement it is expected that the Integrated Support and Assurance Process (ISAP) will be applicable (link). This Process has been developed by NHS England and NHS Improvement because the contractual arrangements through which some new care models will be implemented may mean contracting for new models of acre is 'novel' and that the bidder's organisational forms may be complex and can significantly affect incumbent NHS providers.

Locality hubs

1.15 The vision for Locality Hubs is to create a space that enables and nurtures a multi-disciplinary response to people who have vulnerabilities within communities – how this works in practice will evolve over time and will depend on the needs of each locality but it does need to be transformational. This means that what we start with will not be the final model; it will develop organically as we develop relationships with Partners and the local community. It is important that we do not simply pick up what we do currently and replicate it in the hub - the locality hubs are not a new front door/customer service centre. The offer in each area is likely to be different, as we know one size will not fit all. This is not about council services from council buildings – it's about utilising the locality hub as one of many community assets in an area where people live. The offer is about growing and encouraging community organisations to lead activities and events rather than council services being the provider.

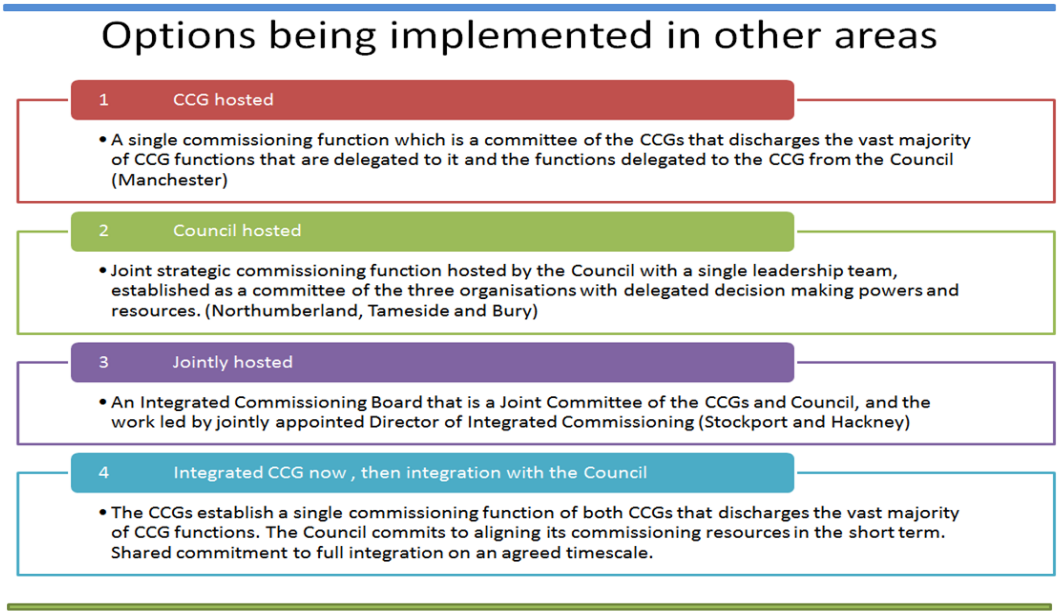
The locality hubs will be based in

- Batley Town Hall
- Dewsbury Town Hall
- Huddersfield Civic Campus
- Slaithwaite Town Hall

The development of the Locality Hubs is being led by Sue Richards (Service Direction for Integration). The detail of who will be working from the locality hubs is being worked through via Joint Hub Planning meetings (with representative from Adults and Children social care and Communities Plus Teams). Further work will be undertaken by the Early Intervention and Prevention Partnership Managers for each of the 4 localities to involve partners and VCSE organisations.

Integration Models being implemented in other Areas

1.16 The diagram below illustrates integrated commissioning models being implemented around the country. As set out above Kirklees is currently implementing Option 4, and could evolve into Option 3 subject to agreement around the integrated governance and infrastructure arrangements.



Kirklees Case for Change

1.17 There are also a wide range of models of integrated service delivery being developed around the country. These are all variants on the new care models set out in the Five Year Forward View and the recent Next Steps on the Five Year Forward View. There are two basic models for integrated out of hospital care:

- integrated primary and acute care systems – joining up GP, hospital, community and mental health services
- multispecialty community providers – moving specialist care out of hospitals into the community

Eight areas of England have now been identified to lead the development of 'accountable care systems' (ACSs) with recognition that these might become 'accountable care organisations' (ACOs) but only after 'several years'. They both share common core elements

- they involve a provider or, more usually, an alliance of providers that collaborate to meet the needs of a defined population
- these providers take responsibility for a budget allocated by a commissioner or alliance of commissioners to deliver a range of services to that population

- they work under a contract that specifies the outcomes and other objectives they are required to achieve within the given budget, often extending over a number of years.

Progress on the Primary Care Strategies

1.18 The Health and Wellbeing Board received an update on progress with the primary care strategies developed by Greater Huddersfield CCG and North Kirklees CCG. A copy is attached at Appendix 1.

2. Information required to take a decision

This report is submitted for information only.

3. Implications for the Council

3.1 **Early Intervention and Prevention**

Work to progress the integration of health and social care is in line with Priority 3 "As part of new Council we will work in partnership with lots of organisations, communities and people."

3.2 **Economic Resilience**

There will be no impact arising from this report.

3.3 **Improving Outcomes for Children**

There will be no impact arising from this report.

3.4 **Legal/Financial or Human Resources**

There will be no impact arising from this report.

4. Consultees and their opinions

This report has been jointly prepared by the Council and CCG Partners in integration.

5. Next steps

Not applicable.

6. Officer recommendations and reasons

That this report be received.

7. Cabinet Portfolio holder recommendation

Not applicable.

8. Contact Officers

Phil Longworth, Health Policy Officer, 01484 221000, phil.longworth@kirklees.gov.uk

Steve Brennan, Senior Responsible Officer, Working Together, 01924 504900 steve.brennan@northkirkleesccg.nhs.uk

9. Background papers and history of decisions

Not applicable.

10. Service Director responsible

Sue Richards, Service Director, Integration, 01484 221000, sue.richards@kirklees.gov.uk

APPENDIX 1

KIRKLEES HEALTH & WELLBEING BOARD	
MEETING DATE:	**28th September 2017**
TITLE OF PAPER:	**Primary Care Strategy update – Greater Huddersfield CCG/North Kirklees CCG**

1. Purpose of paper

This paper has been requested by the Kirklees Health and Wellbeing Board, to brief and update the Board on the Greater Huddersfield and North Kirklees Primary Care Strategies and what they mean for the rest of the Health and Social Care system.

2. Background

As highlighted previously by both CCGs there are significant pressures on primary medical care, both nationally and locally. The primary care strategic programmes aim to support and shape primary care provision to mitigate the associated risks. The sustainability of the system's ability to provide high quality primary care is dependent on the success of the programmes, both locally and nationally.

3. Proposal

The Board is asked to endorse and support the work of the primary care strategic programmes and to consider the interdependencies with other areas of its work.

4. Financial Implications

A programme of investment is included within the CCGs' financial plans.

For Greater Huddersfield this includes £735k investment from CCG core funds during 2017/18 and 2018/19 to develop an infrastructure to enable primary care providers to work together at scale and, in different ways so that more clinical time is released to care for patients. An additional £1.5m within core funding is supporting a range of work at individual practices including progress towards working at scale.

For North Kirklees for 2017/18 agreement was made and built into financial plans for a total of £1,581,500 to be invested in a number of additional services to be provided by General Practice. This includes a number of services provided from individual practices but also support to move further towards working at scale and the sharing of functions releasing clinician time to care for patients.

5. Sign off

Greater Huddersfield CCG: Carol McKenna; Chief Officer; 19 September 2017

North Kirklees CCG: Helen Severns; Head of Transformation and Integration; 19 September 2017

6. Next Steps

Implementation of the Primary Care Programmes are a strategic priority for both CCGs and the work will continue at pace.

7. Recommendations

The Board is asked to:

- Note the update;
- Endorse the strategic objectives and programme;
- Consider how to maximise the contribution through wider system interdependencies.

8. Contact Officer

Greater Huddersfield CCG:

Rachel Carter, Interim Head of Strategic Primary Care Projects,
Rachel.carter@greaterhuddersfieldccg.nhs.uk; Telephone 07786 065569.

North Kirklees CCG:

Nina Birt, Interim Head of Primary Care Support and Development,

Nina.Birt@northkirkleesccg.nhs.uk; Telephone **07584 138401**

1. Introduction

This paper has been requested by the Kirklees Health and Wellbeing Board, to brief and update the Board on the Greater Huddersfield CCG and North Kirklees CCG Primary Care Strategies and what they mean for the rest of the Health and Social Care system.[1]

The Greater Huddersfield Primary Care Strategy was shaped by engagement with patients and the public, local general practices and wider stakeholders. Our vision for primary care is "Thriving and progressive general practice with patients at its heart." We have 37 GP practices providing primary care to over 245,000 patients, with individual practice populations varying from about 1,400 to 15,800. In 2017/18 we will spend about £33m on primary care, which is about 10% of the CCG's total income.

The North Kirklees Primary Care strategy, which was developed through extensive engagement with member practices, patients, stakeholders and the general public, sets out North Kirklees Clinical Commissioning Group's (NKCCG) vision for Primary Care and describes what outcomes the CCG expects to see from Primary Care over the next 5 years. The strategy is part of NKCCG's transformational vision for primary care services, and focusses on the key challenges that need to be addressed to ensure that primary care services deliver:

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

2. Primary Care Programme (Primary Care Strategy and General Practice Forward View)

The NHS Five Year Forward View was issued in October 2014. The more detailed national primary care approach was described in the General Practice Forward View (GPFV), published April 2016. The Greater Huddersfield Primary Care Strategy was in final stages of development when the GPFV was issued, and was itself published in June 2016. The final version of the North Kirklees strategy was ratified by the NKCCG Governing Body on 3 February 2016.

Key messages from the national and local strategies include:

- Funding in general practice has not kept pace with investment elsewhere in the NHS. The share of spend on general practice services now needs to be increased.
- There are major pressures on primary care capacity. Whilst there are national programmes to train more GPs, this is balanced by retirements, falling retention and increases in part-time working. A high proportion of nursing and practice management and support function workforce within primary care are also approaching retirement. The solution is a combination of recruiting, retaining and developing existing staff, together with using resource differently so that the role of a GP shifts to one of a "Primary Care Consultant", providing clinical

[1] CCG Primary Care strategies cover general medical services. The broader definition of "primary care" includes dental practices, community pharmacies and high street optometrists but these are outside CCG remits.

leadership and accountability, seeing the most complex patients and coordinating a wider team of professionals to deliver care to patients.

- There is also a clear national direction for GP surgeries increasingly to work together in primary care networks or hubs to provide enhanced services to combined patient populations of at least 30,000 to 50,000. This could be done (for example) by working collaboratively in groups, through federations, or via more formal contractual mechanisms. One of the key objectives is to provide more convenient patient access to general practice, including at evenings and weekends.
- We need to release time for primary care professionals to care for patients. This includes management of demand, diversion of unnecessary work, reduction in bureaucracy and more integration with the wider health and care system. Specific programmes include implementing 10 high-impact changes to release time for patients, and increased support to help patients to manage a greater proportion of minor self-limiting illnesses for themselves.
- There are opportunities for greater use of technology and infrastructure to enhance patient care and experience, as well as to streamline processes. This will include different ways of patients interfacing with their primary care professionals, for example through telephone or on-line consultations.

Funding mechanisms for primary care services are complex and include a variety of discrete routes. Both CCGs have received full delegation for the exercise of primary medical care commissioning functions from NHS England (GH from April 2016; NK from April 2017); this includes the delegation of core primary care budgets covering a range of funding streams. In addition there are various funding routes managed nationally or regionally against which CCGs can bid and both CCGs have successfully secured additional funding for practices via these routes. Over time each CCG has also developed investment strategies tailored to its local needs and these are reflected in overall budgets. A summary of investment is included below for each CCG.

3. Progress in Greater Huddersfield

The CCG is managing both implementation of the local Primary Care Strategy, and the requirements of the national General Practice Forward View, within an overarching Primary Care Programme. The objectives of the programme are in Appendix A.

Key Achievements so far include:

- Supporting practices to implement the 10 High Impact Actions identified nationally as proven innovations to release time for care.
- Success in funding bids for GP resilience, estate and technology, urgent and emergency care, and training.
- Clear approach to developing Core, Core Plus and Advanced offers to provide consistent and high-quality services to the Greater Huddersfield population.
- Professional Development frameworks developed for nurses, Health Care Assistants and receptionists and implemented in a number of practices.
- Programme to offer pre-registration nursing placements in practice, to support future recruitment.
- Increased uptake of patient online access.
- Programme of “Care Navigator” training to support patients in accessing relevant services.
- Progress in implementing the Local Digital Roadmap for Kirklees.

Innovation

There are a number of areas where Greater Huddersfield has achieved benefits for patients and/or recognition for innovative approaches. For example:

- Work to support vulnerable practices through sharing of knowledge and other resource and specifically targeting assistance.
- Provision of a specialist primary care services (achieving Outstanding CQC rating) for patients more likely to have chaotic lifestyles, including homeless people, asylum seekers, refugees and sex workers.
- Early implementer in providing online access for patients to their full medical record.
- Targeted support for patients that are unpaid carers, including provision of information and signposting as well as networking opportunities that are also open to the public.

Investment

Planned investment in primary care is summarised in Appendix B. This includes the allocation of £3 per head from core CCG funding to invest in supporting the sustainability of primary care. The investment is budgeted over two years (2017/18 and 2018/19) and utilisation will include developing infrastructure to deliver at-scale, and implementing high-impact actions to release time for care. The CCG is working with the My Health Huddersfield General Practice Federation on how benefits from this investment can be maximised.

Additional funding will be made available to the CCG from 2018/19 onwards to deliver improved patient access. This will include routine and same day appointments and evenings and weekends to meet locally-determined demand.

Every practice was offered the opportunity to apply for resilience funding in December 2016, with further bids in June 2017. The successful bids supported by NHSE include collective and collaborative support for sustainability for our smaller practices and short-term capacity to support further development of the GP federation.

The CCG has ongoing programmes of work related to, and intended to maximise opportunities from, additional funding streams. Examples include on-line consultation software and estates and technology developments.

Priority next steps include:

Service provision & development

- Strategy to enable sustainability and delivery at scale.
- Progress opportunities to test and refine working with Federation.
- Relaunch working group to agree and oversee primary care service development workplan.
- Implement plans to deliver extended access.

Workforce

- Continue to support implementation of High Impact Actions to release Time to Care.
- Support practices to work collaboratively to introduce wider workforce roles.
- Engage with practices to ensure consistent awareness of current and future workforce issues and progress potential solutions.

Workload

- Take opportunities to reduce bureaucracy and promote collaboration to “do things once”.

- Work with practices to assist patients in managing a greater proportion of minor self-limiting illnesses for themselves.

Infrastructure

- Progress existing priority estate schemes and exploit emerging opportunities.
- Continue to deliver against Local Digital Roadmap for Kirklees, ensuring practice engagement to maximise benefit and take-up of specific solutions.

4. Progress in North Kirklees

The CCG is managing both implementation of the local Primary Care Strategy, and the requirements of the national General Practice Forward View, within an overarching Primary Care Programme.

Key Achievements

Key achievements so far include:

- Support and progress of applications to the Estates & Technology Transformation Fund (ETTF). ETTF is just one of several programmes outlined in the General Practice Forward View aimed at supporting general practices across the country to increase capacity and transform care, focusing on investment, workforce, workload, practice infrastructure and care redesign. It is designed to accelerate investment in infrastructure to enable the improvement and expansion of joined-up out of hospital care for patients. Funds will specifically be targeted at increasing capacity in primary care to enable better access to general practice, widen the range of care and its associated community amenities, implement new technologies and help to reduce unnecessary demands on urgent care services. The CCG supported 9 applications, 8 of which progressed to the next stage and 2 of which have received funding to date.
- As part of the ETTF scheme the CCG supported the submission of a technology bid which included 12 practices which will enable practices to work together and differently by utilising new technology such as laptops and E-Consultation screens. The scheme was initially aimed at being implemented in 2017/18 but we secured partial funding of £37,548 in 2016/17 and were able to implement the service then.
- Supporting the development and sustainability of the GP Federation. Curo Health Ltd is a GP Federation which was created to enhance the delivery of health and care services to our local population. All 27 of the GP practices across North Kirklees are members of Curo and therefore they cover 100% of the 191,500 population of North Kirklees. Curo believe that community based services which are high quality, consistent and joined up must be the solution to many of the pressures on today's NHS and that General Practice is ideally placed to lead this community based provision. North Kirklees CCG has commissioned some services from Curo including the management of our Quality Access scheme (QAS) which aims to enhance patient access to primary care services.
- The Primary Care Quality Access Scheme (QAS) is an enabler to roll out the Clinical Threshold Management approach; through the scheme, practices are required to improve access for patients by increasing the capacity for routine and urgent appointments outside of core GP hours. For 2017/18 we have 25 of our 27 practices signed up and as a result we are delivering 94 hours a week of additional primary care appointments over and above the provision provided through the NHS England commissioned extended hours DES.
- We are ensuring a consistent approach to referrals through peer review on 6 identified pathway areas. The information is reviewed by practices and then shared and discussed at

cluster meetings. Through the clusters practices participate in pathway development and adhere to locally developed pathways and processes in order to improve quality and reduce variation in activity.

- Practices are also working towards achieving targets above the aims stated in the national GP contract with regard to E-Consultation, E-Referral, EPS2 and Ordering Prescriptions online and reducing ordering of medication via third parties.

- Implementation of OSCAR. OSCAR which stands for Online Support and Clinical Advice Resource was launched in May 2017. OSCAR is a locally developed website that will provide a central fixed point that hosts all care pathways, clinical guidance and commissioning policies across NHS North Kirklees and NHS Wakefield CCGs. OSCAR is an open website that requires no log in and can be accessed by all at https://my-oscar.nhs.uk/ It aims to:
    - Support clinical decision making at the point of care
    - To provide easy access to clear, concise evidence based clinical guidance
    - To ensure the patient receives quality health care at the right place, first time
    - To reduce variation, improve patient safety and support quality outcomes
    - To support the alignment of planned care across the two CCGs
    - To provide a resource that supports 'The Referral Support System Approach'
- Completion of the GP improvement leaders programme. A small cohort of a Practice Manager, Federation and CCG employees completed this programme in early 2017. We also have 6 practices attending the next programme scheduled in April 2018. The GP Improvement Leaders programme enables personal development on how to deliver change and engage people in the process, allows practices to build local capability and apply new skills and knowledge to support own practice and wider local area in achieving its goals. It also has the potential to accelerate change locally by working on a chosen improvement project focused around one of the 10 High Impact Actions for general practice and encourages **l**earning alongside others from general practice and become part of a wider improver's network.

Investment

Planned investment in primary care is summarised in Appendix C. This includes the allocation of £3 per head from core CCG funding to invest in supporting the sustainability of primary care. The investment is budgeted for 2018/19 and utilisation will include developing infrastructure to deliver at-scale. The CCG is working with Curo GP Federation on how benefits from this investment can be maximised.

Additional funding will be made available to the CCG from 2018/19 onwards to deliver improved patient access through the NHS England Extended Access scheme. This will include routine and same day appointments and evenings and weekends to meet locally-determined demand. Further patient engagement to support the development of the model will commence on 25th September and run until late November 2017. This will be delivered in partnership with Greater Huddersfield CCG.

NKCCG ensured every practice was offered the opportunity to apply for resilience funding in December 2016, with further bids in June 2017. The successful bids supported by NHSE include CCG-wide capacity & demand audit carried out via the GP federation and scoping and trial of a prescribing hub.

The CCG has ongoing programmes of work related to, and intended to maximise opportunities from, additional funding streams. Examples include on-line consultation software and estates and technology developments.

Priority next steps

Implementation of the Primary Care Programme is a strategic priority for the CCG and the work will continue at pace.

5. Implications for the overall Health and Social Care system

As many people's first point of contact with the NHS, around 90% of patient interaction is with primary care services.

The ability of primary care services to provide a holistic and high quality service for patients is highly interdependent with other services on which patients (and their carers and families) also depend.

Key areas where the support of the wider health and social care community are particularly critical to success include:

- The need to attract and retain people (clinicians and non-clinicians) to work in Kirklees.
- Increasing public awareness and support for changing models of care. For example willingness to see a healthcare professional other than a GP if appropriate.
- Enabling professionals to spend more of their time directly caring for patients by streamlining processes between organisations.
- Ensuring provision of care is consistent and equitable across the Kirklees population through clear and shared understanding of, and appropriate signposting to, the full range health and social care services available to Kirklees residents.
- Consistent and sustained support to help patients to manage a greater proportion of minor self-limiting illnesses for themselves.

Appendix A: Greater Huddersfield Primary Care Programme objectives

Investment

To plan and oversee investment in primary care, to:

- Develop and support primary care workforce
- Tackle workload
- Deliver care redesign, including working at scale
- Improve access
- Support infrastructure
- Ensure sustainability

Workforce

- To have in place training, skills development and career progression, for all roles, upskilling throughout primary care teams.
- Retain existing staff and attract new members of staff.
- Work collaboratively across Greater Huddersfield (between practices and with other partners)
- Develop new ways of working and new roles within primary care

Workload

- Embed within our community an ethos of self-management and responsibility for effective use of resources.
- Reduce bureaucracy
- Increase efficiency, resilience and sustainability through collaborative working

Infrastructure

- Create a primary care estate which is fit for the future, geographically coherent and efficiently-funded.
- Greater use of technology to enhance patient care and experience, and to allow primary care clinicians to work more efficiently and effectively.

Care redesign

- Strengthen and redesign general practice, improving access (bookable and same-day) in-hours and out of hours, and improving sustainability.
- Support working at scale
- Free up GP time.

To implement Core, Core Plus and Advanced primary care offers.

- (Core Offer): Access to, and provision of, high quality general practice services to every patient registered with a practice in Greater Huddersfield.
- (Core Plus Offer): Patients in Greater Huddersfield will have equitable access to a range of additional services. This may be delivered in collaboration with other providers.
- (Advanced Offer): Patients in Greater Huddersfield will have access to a wide-range of services (currently delivered in secondary care) closer to home in a primary care setting.

Appendix B: Summary of planned primary care 5 year spending: Greater Huddersfield

	16/17	**17/18**	**18/19**	**19/20**	**20/21**
Commissioning Schemes	£326k	£186k	£186k	£186k	£186k
Local Enhanced Services (subject to review)	£482k	£482k	£482k	£482k	£482k
Primary Care IT	£636k	£636k	£636k	£636k	£636k
Delegated co-commissioning	£31,097k	£31,669k	£32,281k	£33,217k	£34,579k
Additional Investment from core CCG funds	£0	£245k	£490k	£0	£0
Vanguard funding	£144k	£0	£0	£0	£0
Extended Access	£0	£0	£821k	£1,500k	£1,500k
GP Forward View funding					
Care Navigator/Medical Assistant training	£21k	£43k	£43k	TBC	TBC
On-line consultations	0	£64k	£85k	TBC	TBC
Retained GP scheme	£19k	£19k	£19k	£0	£0
GP Resilience	£46k	Subject to bids			
Estate & Technology Transformation Fund	Subject to bids				
Practice Manager development (details to be announced)	TBC	TBC	TBC	TBC	TBC

Subject to annual review and confirmation, and flex between areas to deliver national and local requirements.

Appendix C: North Kirklees planned investment in primary care

2016 / 17	
Quality Access Scheme - Curo Health Ltd	£774,190
Practice Support	£21,000
Care Coordinators	£124,500
Phlebotomy	£233,854
24 Hour Ambulatory Blood Pressure Monitoring	£71,096
Basket of Procedures	£204,727
Diabetes-Insulin	£46,000
Reception and care navigators training	£16,568
2017 /18	
Quality Access Scheme - Curo Health Ltd	£931,123
Practice Support	£21,000
Phlebotomy	£238,858
24 Hour Ambulatory Blood Pressure Monitoring	£72,617
Basket of Procedures	£209,108
Diabetes-Insulin	£46,984
Reception and care navigators training	£33,116
Online general practice consultation software systems	£49,673
2018 / 19	
Improving Access	647,664
Reception and care navigators training	£33,095
CCG allocations to support new ways of working	£577,936
Online general practice consultation software systems	£66,190
PMS Money *(Awaiting decision and governance on how this money will be invested)*	£906,440
2019/20	
Improving Access	£1,171,052
Reception and care navigators training	£33,081
Online general practice consultation software systems	£33,081
PMS Money (Awaiting decision and governance on how this money will be invested)	£892,234
2020/21	
Reception and care navigators training	£33,063
PMS Money (Awaiting decision and governance on how this money will be invested)	£877,562
Additional monies held by NHS England • GP resilience monies - £690K WY&H in 16/17. Further funding in 17/18 and 18/19 • Vulnerable practice funding • Estates, Technology and Transformation Funding • Transformation funding £290K across WY&H used by NHSE (10 high impact changes)	

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Kirklees COUNCIL

Name of meeting: Health and Adult Social Care Scrutiny Panel

Date: 14 November 2017

Title of report: Proposal for Interim Acute Inpatient Elderly Medicine, Cardiology and Respiratory Service Provision at Calderdale and Huddersfield NHS Foundation Trust (CHFT)

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 proposed interim changes to services at CHFT.

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 Service Director (Legal Governance and Monitoring)?**	**No – The report has been produced to support the discussions with CHFT**
Health Contact	**Anna Basford – CHFT Director of Transformation and Partnerships**

Electoral wards affected: All

Ward councillors consulted: N/A

Public or private: Public

1. **Summary**

1.1 CHFT currently provides inpatient Respiratory, Cardiology and Elderly Medicine services at both the Calderdale Royal Hospital (CRH) and Huddersfield Royal Infirmary (HRI).

1.2 One of the key drivers that has led to the proposed changes to the configuration of these services are the recommendations contained in The Royal College of Physicians Invited Service Review for Elderly Care Services June 2016 report and the Respiratory Medicine August 2016 report that include a strong recommendation that improvements could be made through centralising the services into a single site model.

1.3 The reports also highlight:

- The challenges in recruiting and retaining consultant respiratory and elderly medicine physicians due to the high volume of work and lack of speciality cover.
- Concerns that measures taken by the Trust to open temporary wards to cope with winter pressures could compromise the delivery of safe care due to a major reliance on locum and agency staff.

1.4 The services clinical and managerial leadership are keen to progress the changes before the start of winter to reduce risks to patients over the intensive winter period.

1.5 Representatives from CHFT will be in attendance to present the proposed changes. A detailed CHFT report on the proposed interim service model and a CHFT PowerPoint presentation are 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

Calderdale and Huddersfield
NHS Foundation Trust

INTERIM CHANGES TO ACUTE INPATIENT ELDERLY MEDICINE, CARDIOLOGY & RESPIRATORY SERVICE PROVISON AT CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST (CHFT)

Paper for Discussion at Kirklees Overview and Scrutiny Committee

14th November 2017

1 Introduction

This paper describes the case for change for the interim reconfiguration of inpatient Respiratory, Cardiology and Elderly Medicine Services. This change is a stand-alone change, and is important for reducing the risk of causing harm to patients now. The benefits of this change will be delivered to patients as soon as the change is made, the proposal does not pre-empt the full reconfiguration.

Kirklees Overview and Scrutiny Committee have requested the following points be addressed in the paper regarding this proposal:

- An explanation of the planned changes including clarity/emphasis on how the changes will result in patients receiving better care; to include quantifying the numbers of people who will be impacted by the changes; and an overview of the relevant performance indicators and what the Trust expects to achieve.
- A focus on the work that is being done to reduce the numbers of patients being admitted to hospital by providing increased support in the community.
- Highlighting the difference in the length of stays between the two sites for respiratory patients.
- More detail on the work that has been carried out on patient engagement to include where events were held and numbers (if known).

The service leadership, both clinical and managerial, are keen to progress the changes before winter begins, to reduce risks to patients over the intensive winter period. Through the document we describe clearly the recommendations of the Invited Service Reviews of the Royal Colleges which describe how making the changes will mitigate quality and safety risks that we are currently managing. We received these reports in 2016, and have spent time engaging with staff and patients, developing an implementation plan to address the recommendations. We have already taken actions in response to many of the recommendations, this reorganisation is one of the final steps we need to take, it is important we do it now to reduce the potential of harm to our patients.

In March 2016 the CQC inspected Calderdale and Huddersfield NHS Foundation Trust. Overall the trust was given a rating of Requires Improvement. Medical Care was one of the core services inspected. Overall Medical Care was rated as good. The CQC rated Medical Care as good in the domains of Effective, Caring, Responsive and Well-led. The CQC rated Medical care as requires improvement in the domain of Safe. These service changes are planned to reduce the risk of harm to patients.

We provide some patient stories to illustrate the potential risks to patients with the current service model, and the benefits the new model will provide. These are attached at appendix A. Both the CQC and Royal Colleges have identified that safety does require improvement, through these changes we can reduce risk of harm.

We have undertaken experience based design workshops and focus groups with patients, looking at ways in which we can improve our inpatient services. Their feedback has been used along with the information in the Report of Findings from the CCG's public consultation on the overall reconfiguration of clinical services in 5 years' time to ensure we address the two main public concerns about potential service change. These concerns are:

Travel time to the appropriate acute site in an emergency	Concern about time to access the hospital site in an emergency has been a theme coming through all engagement and consultation with the public. We recognise this is something the public are concerned about. We reiterate the significant benefit of arriving at the right site, with increased consultant input, and that this is a model already used in many of our specialties and in regional services.
Travel and transport - Opportunity to visit patients when the services are on one specific site.	The CCGs have a travel and transport group working on improving links between the two hospitals. Visits from family and friends are a critical part of recovery, and we are really keen to work with families to make this as easy as possible. The shuttle bus is available for relatives who want to transfer between the two sites. More shuttles have been put on at peak times to improve the opportunity to travel. Relatives are also able to book taxis from the main reception (payable by them). Age UK volunteers will be supporting patients with companionship. One of the key benefits of the reconfiguration is that the patient's stay in hospital will be shorter.

Scrutiny are asked to note that whilst we are making internal changes to specific specialties, the overall bed numbers remain consistent on both sites and patient access to acute services remains through an ED on both sites. Scrutiny are further asked to note the contents of the report and the proposed start date of the service reorganisation: end of November 2017. Scrutiny are asked to provide any comments on the report for the Trust's review.

Not making this change now will mean we continue to carry the risks identified by the invited service review and CQC. These include:

- Inequality to access acute frailty service, respiratory hot service and cardiology diagnostics and interventions depending on which site patients are admitted to
- Potential harm to patients through;
  - Avoidable admissions
  - Increased length of stay
  - Delay in investigations
  - Need to outlie into non-specialist beds
  - Open extra capacity
  - CQC review of NIV (non-invasive ventilation) provision
- Resulting in HCAI (health care acquired infection), harm falls, PU (pressure ulcer), delirium, deconditioning, increased dependency

Of course we continue to work to minimise these risks in the current service configuration.

2 Background

2.1 The proposal

- The current dual site model of hospital services provided by CHFT does not, and cannot, meet national guidance.
- This paper describes the case for change for the interim reconfiguration of inpatient Respiratory, Cardiology and Elderly Medicine Services. The Hospital Reconfiguration is at Full Business Case stage. If it progresses as planned all three inpatient services would be consolidated at CRH in 2022.
- In 2016 the Trust's care of older people and respiratory medicine services were reviewed by the Royal College of Physicians (RCP). The RCP recommended that action should be taken to enable cardiology and respiratory services to be co-located on the same hospital site and for the care of older people to be located on a single hospital site. The RCP queried whether the Trust could afford to wait five years for these services as proposed in the wider reconfiguration of hospital services particularly given immediate concerns over the fragility of the services and workforce
- In the interests of protecting and improving quality, safety and patient outcomes the Trust has therefore been working to develop proposals for the interim reconfiguration of cardiology, respiratory and elderly care services across the two hospital sites. Since early 2017 there have been a number of discussions and meetings with CCGs and YAS to discuss development of these plans.
- The interim proposal is to consolidate all inpatient Respiratory and Cardiology Services at CRH and Elderly Medicine at HRI.
- The proposal does not affect outpatient and diagnostic services; they will continue to be provided on both hospital sites.

2.2 The current service

- The trust currently provides inpatient Respiratory, Cardiology and Elderly Medicine services on both hospital sites, Calderdale Royal Hospital (CRH) and Huddersfield Royal Infirmary (HRI).
- The Trust faces considerable workforce challenges which undermine the resilience of clinical services and includes intense fragile clinical rotas, and recruitment and retention challenges resulting in a heavy reliance on locum and agency staff. Compared to the total WTE establishment for these three specialties 7 out of 25 posts i.e. 28% of posts are vacant and require agency / locum staffing. These challenges arise specifically due to the current dual-site service model.
- Details of consultant workforce and beds numbers is:

Speciality	Workforce (WTE) Consultants	Calderdale Royal Hospital	Huddersfield Royal Infirmary
Elderly Medicine	establishment: 8 actual in post: 4 agency / locums: 4	47 beds	47 beds
Cardiology	establishment: 10 actual in post: 10	24 beds 13 Coronary Care beds 2 Angioplasty / Pacing labs	12 beds on shared ward
Respiratory	establishment: 7 actual in post: 4 agency / locums: 1 vacancy: 1	16 beds 5 day Consultant 'hot clinic'	12 beds on shared ward

- Activity:
    - In 2015/16 there were 4,880 medical admissions with acute respiratory conditions.
    - In 2015/16 there were 3,232 medical admissions with acute cardiology conditions.
    - In 2015/16 there were 6,982 acute medical admissions for patients aged 75 years or older (excluding patients with a primary cardiac or respiratory condition).

2.3 The drivers for change

- Recommendations from the Royal College of Physicians (RCP) Invited Service Review (ISR) for Elderly Care Services report date June 2016 and Respiratory Medicine report date 26th August 2016.
- There was a strong recommendation that improvements could be made through centralising the services into a single site models. "*Overall, the review team were firmly of the opinion that the respiratory team would benefit from having inpatient services located on one site as they considered this would*

improve cover arrangements of patients (particularly at weekends), would facilitate a sharing of skill sets and a move to 7-day service" (Respiratory ISR) "*The review team did consider the Trust should give serious consideration as to whether the CoE services are able to move to one site sooner than presently planned [in 2022]"* (Care of the Elderly ISR)

- Cardiology and respiratory specialist services should be co-located "*The review team concluded that in an ideal situation the cardiology and respiratory services should be co-located on the same site so that the pathway for the breathless patient would be clearer, and patients with mixed cardio-respiratory disease could access both specialist services on one site"* (Respiratory ISR)
- Failure to recruit or retain consultant respiratory and elderly medicine physicians due to high volume of work and lack of a specialty rota. "*The Trust needs to take steps to understand the reasons why they are struggling to recruit to substantive consultant positions. The review team considered that if the Trust had a document, which clearly outlined the vision for the future delivery of the elderly service, then they could use this as part of their recruitment materials to attract new staff"* (Care of the Elderly ISR)
- The need to open additional capacity for winter pressures results in large number of overspill beds being opened which are predominantly for older people. "*We understand delays in transfer of care affect flow of patients during the winter, but these temporary wards raised concerns about the delivery of safe care due a major reliance on locum and agency staff"* (Care of the Elderly ISR). The centralisation of services will create additional capacity to cope with winter pressures (bed optimisation)
- The current configuration of dual services on two acute sites and the challenge to fund and recruit senior clinical staff limits the ability to offer continuity of care for patients or provide consultant led 7 days services.
- Specialist services are increasingly inequitable and due to the challenges of recruitment and retention of staff can only be delivered on one acute site; for example the respiratory admission avoidance hot service is only available at CRH and the acute frailty assessment and management service is only available at HRI.
- The Cardiology service has inequitable access to diagnostic and therapeutic procedures (cardiology interventional laboratories based at CRH) leading to increased length of stay for patients at HRI and an inability to deliver the PCI (Percutaneous coronary intervention) target within 72 hours.
- Work prior to this project through patient's focus groups (respiratory) and site visits (Leeds Teaching Hospitals Trust) and other initial scoping has indicated there is a case to explore in greater detail the actual benefits of amalgamation of resource onto single site provision for all three Specialties.
- Current pathway issues which lead to confusion for wider clinical teams within the hospital and delays in diagnostic and therapeutic tests for patients. For example in appendix A we provide case studies for 4 patients who have been

treated in our hospitals. There are 2 Frailty patients in these case studies. Both studies describe confusion for the wider clinical team in the best way to support these patients. The reorganisation of services will consolidate the frailty service, and ensure patients get the care they need from the right team in a timely way.

- The need to create a foundation for 7 day Specialist review to avoid clinical variation.
- The Trust continues to be a regional outlier where neighbouring trusts have developed services to have standalone specialist elderly medicine, respiratory and cardiology models of care.

The case for urgent change:

- Patients are not admitted to specialty bed base
- Patients do not receive appropriate/timely specialty review
- Unable to provide consistent 7 day senior review of patients
- Unable to provide Respiratory or Elderly medicine specialty rota
- Unable to substantively recruit to meet the rotas of the two sites, difficult to recruit Consultant workforce
- Challenges to staff retention and need to increase Consultant numbers
- Expert peer review (RCP, Royal College of Physicians) has told us the current service model is fragile and needs to change quickly
- ECIST (Emergency Care Intensive support Team) feedback has raised concern regarding lack of Comprehensive Geriatric assessment & LOS impacts
- CQC (Care Quality Commission) identified the medicine service as good. Under the safety domain it identified the service requires improvement.
- Old fashioned Model, outlier regionally and nationally - most hospitals have consolidated services
- Significant variation in service between sites
- Longer length of stay has negative clinical and organisational impact
- PCI & Day case rate is inefficient and risks adverse clinical impact
- There are adverse outcome risks for patients that need to be admitted to additional flexible inpatient bed capacity
- Impact on nursing workforce capacity from additional demand for services (across all specialties)
- Changes are essential to strengthen the resilience of the hospital and the wider system services for Winter 2017/18

3 Patient engagement:

To ensure any interim service model met the needs of patients, the project teams actively engaged patients for information

- In February 2014 the service leads organised an Experience Based Design for cardiology and respiratory patients at Calderdale Royal Hospital to listen,

understand and learn from what our patients had experienced through their admission, inpatient stay and discharge. This was repeated in May 2017 at Huddersfield Royal Infirmary.

- A Patients focus group for frailty was held at Huddersfield Royal Infirmary on the 10th August 2017. In addition, the physiotherapy lead did interviews with 5 patients, separate to the focus group. This information was used to supplement/triangulate the feedback from the focus group session.
- Each of these sessions was attended by between 10-12 patients and relatives, allowing for in depth views to be obtained and included.
- Learning from the public engagement and Report of Findings from the Right Care, Right Time, Right Place consultation on overall service reconfiguration have been considered where they apply to these services for example travel and transport.

Overall there was positive feedback about both the current services and the proposed consolidated services. The key points raised in the sessions are listed below, together with our response:

Patient feedback	Our response
Patients were left concerned and confused about being on the Coronary Care Unit at HRI having been admitted with a respiratory condition (HRI Ward 11 is a mixed cardiology/respiratory ward).	We recognise this concern. The reorganisation of services will mean patients are on the right ward for their needs and will eliminate this issue.
Patients saw clear benefits in seeing a specialist and being in a specialist bed	We note this point. The reorganisation of clinical services is designed to maximize this benefit.
Good affirmation and agreement from patients about how the frailty service at HRI is currently running	We welcome this feedback. Through reorganising services we look to expand this benefit at CRH through the provision of rapid access geriatrician out-patient appointments and a nurse led frailty team at CRH (pilot) to support admissions avoidance
Concerns around the additional time taken to travel across sites and clinical impact in an emergency	Concern about time to access the hospital site in an emergency has been a theme coming through all engagement and consultation with the public. We recognise this is something the public are concerned about. We reiterate the significant benefit of arriving at the right site, with increased consultant input, and that this is a model already used in many of our specialties and in regional services.
Additional travelling time for family and friends to visit	The CCGs have a travel and transport group working on improving links between the two hospitals. Visits from family and friends are a critical part of recovery, and we are really keen to

Patient feedback	Our response
	work with families to make this as easy as possible. The shuttle bus is available for relatives who want to transfer between the two sites. More shuttles have been put on at peak times to improve the opportunity to travel. Relatives are also able to book taxis from the main reception (payable by them). Age UK volunteers will be supporting patients with companionship. One of the key benefits of the reconfiguration is that the patient's stay in hospital will be shorter.

The project Workstreams were asked to consider concerns through development of the models.

4 Community Services

Scrutiny requested a focus on the work that is being done to reduce the numbers of patients being admitted to hospital by providing increased support in the community. This work includes:

- A focus in community services on case finding through primary care access to the GP Dashboard developed by THIS. As well as providing a view (updated every 24 hours) of patients discharged or admitted to hospital, it also provides a tool for risk stratifying patients on the basis of their current utilisation of planned and unplanned hospital care. – identifying those who are frail and who at risk of unplanned admission, and then co-ordinating care through community matrons, general practice, social care or the third sector; depending upon the needs of the person. This builds on the current national evidence base related to the use of electronic frailty indices. The intention of the work is to avoid the need to admit patients to hospital for unplanned and episodic care, or into permanent residential care.
- New models of care to reduce admissions from care homes. These models; provide MDT (multi-disciplinary team) approaches, access to technology, and education and support to staff.
- A range of services to support those who people who arrive at the hospital and who need interventions to prevent an admission. These services include; frailty and ambulatory care services on both sites – accelerating diagnostic and clinical assessment to reduce the need for admission. Hospital Avoidance Teams and Seamless Home from Hospital Services (provided by the third sector) provide practical support and transport to enable the patient to go home rather than being admitted.
- Reduction in the length of time elderly patients are in hospital – thereby reducing the harm related to deconditioning. We are implementing 8 national high impact changes to strengthen our discharge planning – particularly links with social care. This has been a key feature of the investments made under IBCF (Integration and Better Care Fund) this year.

5 Proposed service change

5.1 Service model:

- A model of care consolidating the three clinical services onto single site provision was developed using clinically led processes and programme management methodology.
- All stakeholders were informed and had opportunity to input into the model and recommend options
- The views of patients were sought and shaped the model
- Out-patients services are NOT affected by the proposal. The changes are to acute in-patients services only.
- *Elderly services:* The proposal increases the bed base by 10 beds consolidated onto the HRI site with enhanced support for front end frailty review by specialist nurses and Consultants. This will be 6 frailty beds on AMU and additional frailty ambulatory services. Rapid access geriatrician out-patient appointments and a nurse led frailty team at CRH (pilot) will support admissions avoidance. There will be daily Geriatrician presence at CRH to review patients in other specialty beds who require expert advice and review. A Geriatrician will be available by phone 9-5pm Monday to Friday for support to YAS/GP's on queries re ED/AMU attendance.
- Cardiology and respiratory services will be co-located at CRH. The Royal College of Physicians recommended these services be co-located.
- The *Cardiology* bed base will change. By consolidating the specialty onto one site we will reduce the length of time Kirklees residents are in hospital (as they will no longer need to be transferred between sites to receive diagnosis or treatment in the catheter labs). This means we will be able to reduce the number of Cardiology beds from the current 51 beds across the two sites to 37 beds consolidated at CRH and then reduced further to 29 beds. This is in line with capacity planning for the service. The phased approach is to ensure patients safety and to test the assumed reduction in in-patients stay with increased day case procedures. HRI wards and departments will be supported by daily in-reach by Cardiologists and Specialist Nurses. A Consultant of the week model will ensure continuity of care and consistency of review.
- The *Respiratory bed* base is to be consolidated and increased in line with the recommendations of the ISR team. The proposal for Phase 1 increases the bed base from 28 to 32 beds consolidated at CRH which includes 4 monitored beds. Phase 2 will see a further increase to 48 beds. The phasing is to ensure patients safety and appropriate number of Consultants in post. A Consultant of the week model will ensure continuity of care and consistency of review.

- To note: the bed changes do not impact on the total bed numbers and is a bed neutral position . Beds are however, being appropriated into the correct specialty bed base from General Medical wards and Short Stay wards.
- Clinical input from YAS (Yorkshire Ambulance Service), ED (Emergency Department) and AMU (Acute Medicine Unit) have allowed development of admissions criteria to ensure patients present and are treated on the most appropriate sites. YAS will expect to transfer between 2-4 patients across site per day.
- Numbers of patients attending each ED site is not expected to be significantly impacted. The type of patients will of course change with more frail elderly patients attending HRI. This will be supported by more ambulatory services and 6 AMU frailty beds. CRH will be supported by an in-reach nurse led frailty team (pilot)
- Self-presenters will experience no change and will present to the nearest hospital site. Patients will be treated on site and transferred across site if clinically indicated
- Collaboration with Local Authority to ensure safe and timely discharge of patients on the 'opposite' hospital site to avoid increases in DTOC (delayed transfers of care) cases and subsequent bed blocks have been agreed. New models of working started to take effect in September 2017.
- A collaborative approach with Locala has developed pathways where community in-reach teams support patients regardless of postcode origin.

Supporting services in the Trust were engaged and support the proposal.

5.2 Impact on patients

Based on analysis of 2016 figures high level modelling indicates the following impacts (*Figures are high level upside downside based on current YAS/CHFT analysis)

Greater Huddersfield Patients:

- Between 2180-2840* patients per annum who attended HRI by ambulance would go to CRH
- 1160-1510 patients who were in-patients at HRI would be admitted to CRH
- 1-2 patients per day would be transferred to CRH

Calderdale Patients:

- 1880-2260 patients who attended CRH by ambulance would go to HRI
- 840-1010 patients who were in-patients at CRH would be admitted to HRI
- 1-2 patients per day would be transferred to HRI

5.3 Benefits and Risks

Key benefits identified through the workshops, workstream meetings and clinical analysis of the proposed service:

- The proposed service model either fully meets the aims of the project and/or provides a platform for further service improvements and efficiency gains in the future such as 7 day provision of services. (Whilst of course inpatients are in hospital for 7 days a week the staff available on site changes on Saturdays and Sundays and out of hours). This reconfiguration would allow us to have more staff groups working across the whole 7 days.
- Patients will have quicker access to Specialist review improving time for diagnosis and treatment. Improving outcomes and patients experience.
- Whilst we are unable to forecast specific improvements in mortality data, we can point to evidence from previous service changes where mortality has improved following reconfiguration. Here a review of mortality data demonstrates that mortality has improved in all specialties that have moved to single site provision. The table below illustrates the improvement in mortality rates for three specialties following reorganisation to single site provision. These are Stroke (acute cerebrovascular disease), Hip fracture (fractured neck of femur) and acute GI bleed (gastrointestinal haemorrhage).

Mortality Rate						
	2012/13	2013/14	2014/15	2015/16	2016/17	Var 2016/17 v 2012/13
						%
Acute cerebrovascular disease	19.7%	19.2%	16.8%	21.1%	15.4%	-4.3%
Fracture of neck of femur (hip)	8.2%	5.5%	8.1%	6.7%	4.1%	-4.1%
Gastrointestinal haemorrhage	3.7%	2.7%	3.1%	2.4%	2.6%	-1.1%
Total	**10.5%**	**9.1%**	**9.3%**	**10.1%**	**7.4%**	**-3.2%**

- Supports winter resilience by creating capacity in current bed base.
- Admission avoidance from frailty teams at CRH & frailty ambulatory chairs at HRI. The frailty model at HRI implemented in February 2017 is already demonstrating an average of 165 avoided admissions per month. The extension of this service at CRH, with rapid access geriatrician appointments and an in-reach frailty team at CRH to support admissions avoidance would enable us to extend this reduction in admissions further.
- Reduced LoS (length of stay). The table below describes the current length of stay and discharges before midday on each site. The difference in length of stay is driven by the difference in service provision on each site. For example Huddersfield Cardiology patients have to wait for a transfer to Calderdale if diagnostic intervention is required. Calderdale in-patients have access to 7 day access to senior respiratory opinion commissioned through the ‘hot clinic’. Consolidation of the specialties will allow these clinical variations to be removed, ensuring all patients can benefit from the shorter length of stay. The improvements in reducing LoS are expected to deliver additional 1,577 bed days for cardiology and 1,789 bed days for respiratory patients. For elderly care the improvements will support winter resilience and avoiding opening additional beds.

- Meets the 72 hour PCI diagnostic target (95%). Negates the need for 220 cardiology patients per annum to transfer across site for diagnostics/treatment.
- Consultant of the week model for Cardiology/ Respiratory to reduce length of stay and outcomes. Platform for 7 day working
- Increased move from in-patients to day case rate
- Reduces inequality in access to diagnostics

The table below described key performance indicators for the current services. This includes PCI in 72 hours (Percutaneous coronary intervention, also known as coronary angioplasty), day case rate, spend on agency staff and also the difference in los (length of stay) and % of discharges before midday.

	PCI in 72 hours (standard 60%)	Day case rate (12.2 % national average)	Agency Spend YTD	Activity increase 15/16-16/17	SITE	LoS (2016 or 16/17)	% of discharges before midday (w/c 25/09)
Elderly Care			£585k	3%	**HRI**	15.4	9%
					CRH	13.1	25%
Cardiology	53%	8.1%	£455k	5%	**HRI**	9.1	9%
					CRH	5.3	3%
Respiratory			£67k	3%	**HRI**	11.0	9%
					CRH	7.7	18%

Alongside reducing the number waiting over 72 hours for PCI the number of Respiratory patients waiting for specially beds (outlying) will fall; number of elderly patients waiting for specially beds (outlying) will fall.

Key risks:

Key Risks	Mitigation
The high number of current vacancies: Consultant workforce, Nursing Workforce, therapists and Social Services, engagement workers	Creating more attractive clinical roles may increase recruitment success. Consolidation of nursing workforce will increase role opportunities. Working in larger teams will reduce the risk of agency staff and locum staff working unsupported by substantive staff. Leavers from the Trust have confirmed one reason for leaving was that the service had not been consolidated.
The benefits from the reconfiguration can only be achieved with excellent triage and easy cross site transfers and safe bed occupancy rates on both sites	YAS agreed site decision criteria will be audited and tested for compliance. Patients flow team continuously monitor activity levels across sites and make clinically informed judgement calls about safe capacity

Key Risks	Mitigation
Patients may have less access to Specialist staff (medical/ nursing/ therapists). This is because each specialty is single site, for example geriatric patients at HRI may have reduced access to respiratory or cardiology opinion.	Patients assessed as requiring a specialist bed will be transferred across site. Acute physicians at CRH and HRI will be supported by in-reach geriatricians, respiratory and cardiology medical teams on both sites. Specialist nursing teams to work on both sites
The skill mix of nursing and therapy staff will not be adequate to support the increased speciality bed numbers without further training.	A phased approach to the increase in respiratory specialist bed numbers to ensure safe staffing levels. Training requirements are being addressed to minimise this risk.
Patients on the non-specialist site receive poorer or delayed services as a result of service being on the 'other' site	Both hospitals have full acute service support through ED/AMU/ICU (intensive care unit) to ensure patients safety. Patients will be transferred across site when clinically appropriate
Relatives and carers will have longer to travel. Patients may not have carers/ relatives/visitors to support them during in-pts stays	Relatives and carers of in-pts can use the cross-site shuttle bus. This information will be shared on admission and on the wards. Information on quieter times to use the shuttle bus to be published & held on the wards. Taxi bookings are available at the security desks (payable by user)

(fully analysed in the QIA excel document)

5.4 Implementation

The implementation would be phased over several weeks to ensure patients safety. The proposal is to commence November 2017 over a 2-3 week period subject to full approval

Appendix A

Patient stories

Here are four patient stories, describing how the planned changes will improve patient safety and the inpatient experience. All these incidents have been investigated rigorously through Trust internal processes and the outcome discussed with patients or families in line with the Trust's Duty of Candor obligation.

Respiratory patient

Patient A was a lady in her 60s with chronic chest disease. She was admitted with increasing breathlessness and was being treated for a chest infection. She was admitted to the short stay unit and looked after by the general medical team. On the

Saturday of her admission she was assessed as ready for home and discharged later that day. At home she became more short of breath and needed re-admitting the next day. She was admitted to another ward and because of her breathlessness and the unfamiliar environment of the new ward she suffered a fall and fractured her ankle. This caused her to be bed bound and as a consequence she developed a hospital acquired pneumonia and sadly died.

With the service changes proposed she would have been seen and assessed by the respiratory specialist team on admission and cared for on the respiratory ward. She would have had daily specialist reviews including at the weekend and would have only been discharged when recovered from her respiratory condition.

Cardiology patient

Patient B was a man aged in his 90s who was admitted to HRI with a heart attack. He was transferred to the cardiology ward where his heart rate dropped rapidly. Emergency heart pacing is only available at CRH and he needed emergency equipment to keep his heart rate from dropping further. Staff at HRI were unfamiliar with the specialist equipment and struggled to use it. Medication was given instead to try and keep his heart rate up but he deteriorated and died.

With the proposed service changes planned patient B would have been admitted directly to CRH. Staff would be more familiar with the specialist equipment and he would have had access to emergency pacing. Although Patient B might not have survived he would have had a greater chance with the best treatment options available to the doctors.

Frailty patient

Patient C was a frail elderly gentlemen living in a residential home. He had a complex mental health history and the residential home had raised concerns about an acute change in his behaviour; he was becoming withdrawn and had lost his appetite. He was assessed in the home and it was recommended that he be referred to hospital for an acute medical assessment. In the acute medical unit the doctors had little detail on his condition and the recent concerns from the home and felt that admission was necessary as the only way to investigate and exclude a medical problem. He was admitted to an elderly care ward overnight where, because of the unfamiliar environment and staff, he became more withdrawn and stopped eating and drinking. Because of this he was started on a drip for hydration. His deterioration continued and in spite of good nursing and medical care he developed a hospital acquired pneumonia and died.

On review of his case no medical condition was identified as a cause for his change in behaviour in the residential home; the change in behaviour was due to his mental health condition. With early intervention by the specialist frailty team he would have had a comprehensive assessment and been discharged back to the home that day with a plan of care including increased support from the community team.

Frailty patient

Patient D was a frail elderly woman who was brought to the emergency department having suffered a fall at home. Investigations confirmed a small fracture of a pubic rami (a small bone in the pelvis; these are managed conservatively with pain relief and mobilisation). She was admitted for pain relief and therapy assessment. From ED she was referred to the acute medical unit and then transferred to a non-specialist medical ward before being moved to the short stay unit. Because of her pain and confusion with moving wards patient D became increasingly delirious and could not be discharged home. Sadly she died 2 days later in hospital from a heart attack.

Had she been assessed in ED by the frailty team they would have put a plan in place for analgesia and early mobilisation. She would have needed one night in a specialist frailty bed and have gone home the following day with a plan of care and community support package in place. Although she may still have suffered her heart attack, early intervention from the frailty team would have allowed her to be well, at home and enjoy have quality time with her family.

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Proposal for the Reconfiguration of Cardiology, Respiratory & Elderly Medicine Hospital Services

Scrutiny Briefing November 2017

Introduction / Background

- The current dual site model of hospital services provided by CHFT does not, and cannot, meet national guidance.

- In 2016 the Trust's care of older people and respiratory medicine services were reviewed by the Royal College of Physicians (RCP). The RCP recommended that action should be taken to enable cardiology and respiratory services to be co-located on the same hospital site and for the care of older people to be located on a single hospital site. The RCP queried whether the Trust could afford to wait five years for these services as proposed in the wider reconfiguration of hospital services particularly given immediate concerns over the fragility of the services and workforce.

- In 2016 the Care Quality Commission (CQC) inspected Medical Services as part of their inspection of the Trust. Medical Services were designated as good in all domains excluding Safety. For the Safety domain medical services were designated as Requires Improvement

- In the interests of protecting and improving quality, safety and patient outcomes the Trust has therefore been working to develop proposals for the interim reconfiguration of cardiology, respiratory and elderly care services across the two hospital sites. Since early 2017 there have been a number of discussions and meetings with staff, patients, CCGs and YAS to discuss development of these plans.

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Information provided

The briefing document provided to Scrutiny in advance of this meeting covers the following:

- Current Service Model
- Case for Change, including the case for urgent change
- Staff and Public Involvement & Engagement
- Community Services
- Proposed Service Model
- Impact & Benefit of the Proposed Interim Configuration
- Benefits & Risk
- Patient stories

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Proposal developed & strategic narrative agreed:

'We give good care, but we know we can give better to patients and want to do this as soon as possible. Working with patients, families and care providers changing these services will allow us to:

- *Make sure we can offer the same high standard of care to every patient, where ever they live.*
- *Get better at assessing and supporting patients to avoid admitting and keeping them in hospital unnecessarily*
- *Give the best care for patients by making sure they are admitted into the most appropriate specialty bed or day case area*
- *Ensure patients receive same care and input wherever they enter the service, whatever day of the week'.*

The Case for Urgent Change

- We were told in 2016 by the two Royal colleges and CQC to address issues of Safety. We have developed an action plan to address this, the reorganisation of services is one of the final steps.
- Patients are not admitted to specialty bed base
- Patients do not receive appropriate/timely specialty review
- Unable to provide consistent 7 day senior review of patients
- Unable to provide Respiratory or Elderly medicine specialty rota
- Unable to substantively recruit to meet the rotas of the two sites, difficult to recruit Consultant workforce
- Challenges to staff retention and need to increase Consultant numbers
- Expert peer review (RCP) has told us the current service model is fragile and needs to change quickly
- ECIST feedback has raised concern regarding lack of Comprehensive Geriatric assessment & LOS impacts
- Old fashioned Model, outlier regionally and nationally - most hospitals have consolidated services
- Significant variation between sites
- Longer length of stay has negative clinical and organisational impact
- PCI & Day case rate is inefficient and risks adverse clinical impact
- There are adverse outcome risks for patients that need to be admitted to additional flexible inpatient bed capacity
- Impact on nursing workforce capacity from additional demand for services (across all specialties)
- Changes are essential to strengthen the resilience of the hospital and the wider system services for Winter 2017/18

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Assumed Quality / Service Benefits - KPIs

Quality Improvement	Target	Benefit
Reduced LoS: Reduced to best Av LoS 16/17 :	Cardiology: 5.3 days Respiratory: 7.7 days	1577 bed days 1789 bed days Avoids additional bed capacity in winter – safety and financial benefit
Improved time to diagnostic/ intervention. • % of NSTEMI patients receiving a coronary angioplasty within 72 hours of admission • Patients do not have to travel for PCI	60% all pts (BPT) 95% medically fit pts (NICE) 0 pts requiring cross site transfer	Patients outcomes improved Improved pts safety.
Improved patients flow: • Increased planned discharges before 12pm. • Reduce DTOC	Average 30% across each discipline 3.5% of overall delays or patients who are deemed medially fit-	Improved flow through ED/ AMU & access to Specialist bed
A sustainable workforce: • Less reliance on agency staff as the roles become more attractive • Establishment of specialty Rota	Reduce agency Reduce vacancy rates Elderly rota Q4	Stability of staffing and consistency of review improves patients outcomes (ISR) CGA within 48hrs of admission, reduced LOS, improved outcomes
Admission Avoidance	Increase activity through frailty & ambulatory care	Reduced admissions, improved outcomes

Recommendation

The proposed interim reconfiguration of cardiology, respiratory and elderly medicine inpatient hospital services will improve clinical outcomes and deliver a better patient experience of care.

These changes are essential to strengthen the resilience of the hospital and the wider system services for Winter 2017/18.

Scrutiny are requested to note the proposed changes and that these are implemented at the end of November 2017.

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

MEMBERS: Cllr Liz Smaje (Lead Member), Cllr Richard Eastwood, , Cllr Fazila Loonat, Cllr Richard Smith, Cllr Sheikh Ullah, Cllr Habiban Zaman, 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. <u>Panel meeting 3rd October 2017</u> The Panel considered a report by Greater Huddersfield and North Kirklees CCGs on Health Optimisation and the proposal to introduce additional thresholds for non-urgent elective surgery. The Panel agreed that the Health Optimisation Programme proposed a significant variation in service to the public and requested that the CCGs undertake a period of consultation for 6 weeks. The Panel highlighted a number of key areas for further consideration and agreed that the Lead Scrutiny Member would meet with reps from GHCCG, NKCCG and Public

FULL PANEL DISCUSSION		
ISSUE	**APPROACH**	**AREAS OF FOCUS/OUTCOMES**
		Health to follow up the issues highlighted. The Panel requested that CCGs report back to the Panel with the results and outcomes of the 6 week consultation once it has been completed – date to be agreed.
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 Adult Social Care. 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.
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

FULL PANEL DISCUSSION		
ISSUE	**APPROACH**	**AREAS OF FOCUS/OUTCOMES**
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 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

FULL PANEL DISCUSSION		
ISSUE	**APPROACH**	**AREAS OF FOCUS/OUTCOMES**
		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. <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

FULL PANEL DISCUSSION		
ISSUE	**APPROACH**	**AREAS OF FOCUS/OUTCOMES**
		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. <u>Panel meeting 3rd October 2017</u> The Panel considered a report describing the approach taken by Adult Social Care in order to continuously improve the robustness of the Adult Social Care system. The Panel agreed to consider a report to a future Panel meeting detailing performance and evidence that improvements were being made in the Adult and Social Care Service – date to be determined.

FULL PANEL DISCUSSION		
ISSUE	**APPROACH**	**AREAS OF FOCUS/OUTCOMES**
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. <u>Lead member briefing 24 October 2017.</u> Public Health will present the Kirklees Suicide Prevention Plan at the Panel meeting 13 February 2018. Areas that will be covered will include: • Assessing the Plan; • Clarification of who is/has been involved in developing the Plan; • What partnerships are involved in overseeing and implementing the Plan; • Who monitors the effectiveness of the Plan and what are the expected outcomes.

FULL PANEL DISCUSSION		
ISSUE	**APPROACH**	**AREAS OF FOCUS/OUTCOMES**
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		
ISSUE	**APPROACH**	**AREAS OF FOCUS/OUTCOMES**
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 <u>Lead Member briefing 24 October 2017</u> Public Health will submit a written update for the January 2018 Panel meeting that will cover: • The points above. • Details of the implementation of the latent TB screening pilot; • An overview of the key work streams in the TB work programme; and • A general update of the numbers of TB cases in Kirklees
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.

NEW EMERGING ISSUES FOR POTENTIAL INCLUSION ON THE WORK PROGRAMME		
ISSUE	**APPROACH**	**AREAS OF FOCUS/OUTCOMES**
22. Wheelchair Services Wheelchair services in Kirklees are provided by a private company Opcare which is one of the UK's largest prosthetic, orthotic and wheelchair	Lead Member will undertake a short initial fact-finding study to assess the scale of the issues that have been highlighted before presenting to the wider panel to agree next steps.	Areas of focus and outcomes to be determined.

service providers. The Panel has been made aware of a number of issues that relate to the standard and quality of service that is being provided by Opcare.		
NEW EMERGING ISSUES FOR POTENTIAL INCLUSION ON THE WORK PROGRAMME		
ISSUE	**APPROACH**	**AREAS OF FOCUS/OUTCOMESARE**
23. Carers in Kirklees A recent adult safeguarding review undertaken by Healthwatch Kirklees focused on the feedback of the experience of people with dementia and their carers. The report highlighted the important role of carers and the challenges they faced when trying to help a family member or friend with dementia navigate the social care support pathways.	Lead Member has identified this issue as having the potential for being a focused pieced of work that could potentially be undertaken as a task oriented (ad hoc) review. An initial scoping exercise will be carried out to identify the key areas of focus.	Areas of focus and outcomes to be determined.

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