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Monday 4 December 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 12 December 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

6: Better Care Fund

111 - 120

The Panel will be presented with details of the work that is being undertaken as a result of the Kirklees Better Care Fund Plan.

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

7: Work Programme 2017/18

121 - 132

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 16 January 2018.

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

Contact Officer: Helen Kilroy

KIRKLEES COUNCIL

OVERVIEW AND SCRUTINY PANEL FOR HEALTH AND ADULT SOCIAL CARE

Tuesday 3rd October 2017

Present:	Councillor Elizabeth Smaje (Chair) Councillors Richard Eastwood and Fazila Loonat Peter Bradshaw – Co-Optee David Rigby – Co-Optee Sharron Taylor – Co-Optee
Apologies:	Councillors Sheikh Ullah and Richard Smith
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 12th 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 Steve Ollerton, Ian Currell and Alan Turner from Greater Huddersfield CCG and Emily Parry-Harris from Kirklees Public Health to the meeting and considered proposals to introduce new criteria encouraging patients who were overweight or smoking to improve their lifestyles before undergoing routine surgery.

Steve Ollerton advised the Panel that evidence from America had shown that stopping smoking for just a few days could make a huge difference to a person's health. The Panel was informed that people who were overweight or smoked had poorer recovery rates following surgery.

Alan Turner advised the Panel that Greater Huddersfield and North Kirklees CCGs had moved to an outcomes-based programme to benefit the population as a whole and were engaging with clinical practitioners and GPs in North and South Kirklees to make sure all the transitional elements were in place and fit for purpose. The Panel was informed that the CCGs were planning to implement the Programme by January 2018, but would not go live until they had sought assurance that everything was in place accordingly.

Emily Parry-Harris advised the Panel that Public Health were working to protect the Wellness Model, but wanted to strengthen the relationship with CCGs and move more towards a prevention agenda. The Panel was informed that Public Health would like to see GPs having conversations with patients who smoked or were overweight at an early point and not just those people awaiting routine surgery. The Panel was advised that conversations were in the early stages between Kirklees Public Health and the CCGs, so that the Health Optimisation Programme could be incorporated within the Wellness Model.

Alan Turner advised that the CCGs were seeing a growing population of young people with increased BMIs due to the fact that they were not active enough. The Panel was advised that the BMI rates would rise over the next 10 years.

Steve Ollerton advised the Panel that the CCGs were not going to put people at risk as the Programme was only meant for people who were waiting for non-urgent surgery and that about 20% of people waiting for routine surgery could be helped by the Programme.

The Panel asked a question about other avoidable illnesses, for example the effects of alcohol, and whether other CCGs across the country had looked at this issue. Alan Turner

advised the Panel that most Trusts had started with smoking and obesity, but acknowledged there was potential within the programme to expand to other avoidable illnesses.

Emily Parry-Harris advised the Panel that the focus for Public Health was that a better approach to smoking cessation and obesity was needed, even if the person did not need an operation and that GPs should be having these conversations frequently and as early as possible.

Rory Deighton from Healthwatch asked a question regarding the timescales for both the Wellness Model (due to start September/October 2017) and the Health Optimisation Programme (due to start in January 2018). Healthwatch asked if assurance could be given that the Programme would be signed off as a joint integrated approach by the CCGs and Kirklees Public Health. Alan Turner responded to advise that the CCGs needed to ensure that mechanisms should be in place to ensure the right intervention approach across the CCGs to bridge the current gap. Emily Parry-Harris advised the Panel that Public Health expected to have come to a common understanding with the CCGs on what should be delivered, but that conversations were still at an early stage.

The Panel advised that outcomes should be about tackling health inequalities long term and were concerned that Kirklees Public Health and the CCGs were not yet in agreement in relation to the Health Optimisation Programme.

In response to a question regarding whether evidence was available that showed financial savings made by implementing this programme, Ian Currell advised that short-term a small amount of savings would be made by the Trusts, but long term savings would depend on the success of the Programme. The Panel was informed that the majority of freed up demand would be used to get people off the waiting list for routine operations.

Steve Ollerton advised the Panel that the Programme was for a period of 6-12 months and if at the end of that time the person had been unable to lose weight or stop smoking they would still get the surgery if required. The Panel was advised that only about 15% of people stopped smoking with a cessation programme and about 85% stopped smoking of their own accord. Steve Ollerton further explained that early conversations needed to take place between GPs, Clinicians and patients to encourage them to improve their lifestyles, as longer term this would reap benefits.

In response to a question regarding lifestyle rationing by the CCGs, Alan Turner advised that as part of the engagement process undertaken within Kirklees, a number of events and public meetings had been held. The Panel was advised that 500 questionnaires had been returned with very mixed views showing that some people felt the programme was what was needed to change the population culture, where-as others had said they felt it was about rationing or hitting the most deprived.

Rory Deighton asked a question regarding health inequalities and advised the Panel that some of the data showed stark health inequalities within different parts of Kirklees. Alan Turner advised the Panel that robust systems would be put into place by the CCGs to monitor the disparencies across the country.

In response to a question from the Panel regarding whether evidence was available from other Trusts across the country which showed improved outcomes following the

implementation of the programme, Alan Turner advised that the CCGs were working with Harrogate who had implemented the Programme in November 2016 and that an evaluation report was being finalised, but was not yet available for public view.

The Panel raised concerns regarding the fact that the report seemed to indicate the majority of engagement and consultation had been undertaken in Huddersfield and that not enough engagement had been carried out in North Kirklees. The Panel also felt that the report was not reflective of the ethnic groups in Kirklees. Alan Turner advised that engagement had been carried out within North Kirklees with a wide range of representatives from hard to reach communities and that some feedback had been positive.

The Panel advised that BMI levels in Asian men were high and felt that the report did not reflect this.

Alan Turner advised the Panel that the CCGs felt the Health Optimisation Programme complemented the Wellness Model and was not a duplication. The Panel was advised that the access pathways would be increased as a result of the Health Optimisation Model, whilst also pushing the prevention agenda.

Alan Turner advised that exclusions outlined within the report stated that if a patient was at risk they would not be referred to the Health Optimisation Programme. The Panel was informed that the deferral exclusions had been designed by clinicians.

Steve Ollerton advised that all the CCGs across West Yorkshire had been told to look at the issue of postcode lotteries and that Greater Huddersfield and North Kirklees CCGs would endeavour to minimise this within Kirklees.

In response to a question from the Panel regarding why the CCGs did not see this proposal as a significant variation to public service, Alan Turner advised that they had worked through the proposal and guidelines with their Legal Team who had advised this was not a significant change or variation to public service. Alan Turner further explained that the engagement and consultation carried out already had not been a statutory requirement and that other Local Authorities had implemented the Programme without any consultation or engagement.

Steve Ollerton advised the Panel that when a patient came off the waiting list for routine surgery to go onto the Health Optimisation Programme, they would return to the same place on the waiting list at the end of the programme.

In conclusion, the Panel made the following recommendations:-

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.

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

The Panel reviewed its activity and progress during 2017/18 and its agenda plan for 2017/18.

RESOLVED –
(1) That progress on the work programme for 2017/18 be noted.

7 **Date of the Next Meeting**

That the date of the next meeting will be 14 November 2017.

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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.

Name of meeting: Health and Adult Social Care Scrutiny Panel
Date: 12 December 2017
Title of report: Kirklees Joint Strategic Assessment (KJSA)

Purpose of report

The report provides a summary of the Kirklees Joint Strategic Assessment (KJSA) to describe how it is managed, developed, updated and utilised. The report will also identify how the KJSA can enable improved understanding of health inequalities and what can be done to address these.

This report is supported by a set of slides to be presented/ shared at the Scrutiny Panel meeting.

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?	**No**
Key Decision - 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 Strategic Director & name **Is it also signed off by the Service Director for Finance IT and Transactional Services?** **Is it also signed off by the Service Director for Legal Governance and Commissioning Support?**	**01/12/17** **Rachel Spencer-Henshall (Service Director Policy, Intelligence & Public Health)** **N/A** **N/A**
Cabinet member portfolio	**Cllrs Viv Kendrick and Cathy Scott, Adults and Public Health**

Electoral wards affected: N/A

Ward councillors consulted: N/A

Public or private: Public

1. Summary

- Local authorities and clinical commissioning groups (CCGs) have equal and joint duties to prepare Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs), through the Health and Wellbeing Board.
- In February 2015 the Health and Wellbeing Board approved a new approach to JSNA development in Kirklees. The re-named Kirklees Join Strategic Assessment (KJSA) continues to developed and updated on an ongoing basis to ensure that clear and comprehensive intelligence about local needs, assets and inequalities is available on a timely basis to support commissioning and planning decisions.
- The new web-based KJSA provides a number of useful place-based and over-arching intelligence summaries as well as detailed sections under the four themes of wider factors, health behaviours, health conditions and people and life events.
- The KJSA includes an increasing number of visual and dynamic elements and uses infographics and videos in place of narrative to bring content to life and highlight key messages.
- The 'Kirklees Overview' provides a high-level summary of the key issues and challenges affecting the health and wellbeing of the Kirklees population. This overview is refreshed annually and presented to the Health and Wellbeing Board for approval.
- A multi-agency KJSA steering group oversees the development of the KJSA and the health and wellbeing board is provided with updates on a regular basis. An updating schedule for KJSA sections is reviewed regularly by the KJSA steering group.
- A communications plan for the KJSA is in place and reviewed regularly. A blog has been developed to promote newly updated sections of the KJSA and to highlight how intelligence in the KJSA has been and can be used to inform commissioning decisions.
- The number of people looking at the KJSA is increasing. It has been positively received by the Health and Wellbeing Board and received national recognition, particularly for its dynamic format and shift to a more asset-based approach.

2. Information required to take a decision (please also see attached slides)

Background

The Health and Social Care Act 2012 introduced new duties and powers for health and wellbeing boards in relation to Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs). The statutory guidance on JSNAs states that the "purpose of JSNAs and JHWSs is to improve the health and wellbeing of the local community and reduce inequalities for all ages. They are not an end in themselves, but a continuous process of strategic assessment and planning".[i]

Local authorities and clinical commissioning groups (CCGs) have equal and joint duties to prepare Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs), through the Health and Wellbeing Board. JSNAs are "assessments of the current and future health and social care needs of the local community… The policy intention is for health and wellbeing boards to also consider wider factors that impact on their communities' health and wellbeing, and local assets that can help to improve outcomes and reduce inequalities. Local areas are free to undertake JSNAs in a way best suited to their local circumstances."[i]

In February 2015 the Health and Wellbeing Board approved a new approach to JSNA development in Kirklees. The re-named Kirklees Join Strategic Assessment (KJSA) continues to developed and updated on an ongoing basis to ensure that clear and comprehensive intelligence about local needs, assets and inequalities is available on a timely basis to support commissioning and planning decisions.

KJSA governance and timescales

A multi-agency KJSA steering group (please see here for Terms of Reference) oversees the development of the KJSA and the health and wellbeing board is provided with updates on a regular basis from the Public Health Intelligence lead.

A rolling updating schedule for all KJSA sections is in place (see slide 2 in the attached) and reviewed regularly by the KJSA steering group. Section updates are timed to coincide with the availability of new data/ intelligence. The Kirklees Public Health Intelligence team leads on KJSA development and engages with a wide range of stakeholders from Kirklees Council and partner organisations with topic or population expertise for specific section updates. Several KJSA steering group members and wider colleagues act as KJSA or asset 'champions' to support a more asset-based KJSA, facilitate wider engagement with the KJSA products and processes and ensure the KJSA captures relevant local voice and insights.

KJSA content

- The new web-based KJSA enables easy navigation via intuitive menus (see slides 3-4). It provides a number of useful place-based and over-arching intelligence summaries as well as detailed sections under the four themes of wider factors, health behaviours, health conditions and people and life events.
- All sections follow a life-course approach, where appropriate, and provide evidence and intelligence to describe the issue/ group, explain why the issue is important to health and wellbeing, what key inequalities exist, what local assets are helping to improve outcomes and what commissioners should consider. Sections include links to other KJSA sections and additional sources of evidence and intelligence to avoid duplication and enable people to find further information if required.
- The KJSA includes an increasing number of visual and dynamic elements (see slides 5-6) and uses infographics and videos in place of narrative, where appropriate, to bring content to life and highlight key messages.
- There is a strong emphasis on understanding local 'assets' (see slide 7) and embedding an approach which 'starts with what's strong not what's wrong'. This approach can be seen in the most recently updated KJSA sections and the latest Kirklees Overview 2017/18. The new 'Community Assets: People Helping People' section of KJSA describes what is meant by an asset-based approach, why it is important and how the content of the KJSA reflects this. The indicator tables described below include a balance of traditional 'deficit-based' indicators and more positive 'asset-based' indicators.
- The 'Kirklees Overview' provides a high-level summary of the key issues and challenges affecting the health and wellbeing of the Kirklees population. It is a useful starting point for people new to Kirklees. This overview is refreshed annually and presented to the Health and Wellbeing Board for approval (the 2017/18 Kirklees Overview was approved in Sept 2017).

Understanding inequalities

- Dynamic indicator tables which present clear information about inequalities between geographic and demographic groups in Kirklees are being embedded in the KJSA (see

slide 6). These will go live in the next few weeks. These will be improved on an ongoing basis to enable progress towards reducing inequalities to be clearly understood. Additional/ alternative population outcome indicators for Kirklees can be incorporated into the KJSA indicator tables to support the process of monitoring progress towards achieving outcomes.

- The 'Kirklees Overview' will continue to be a key resource for monitoring and understanding the local picture of health inequalities.
- All KJSA sections include a number of recommendations for commissioners and service planners to consider. These are based on the evidence and intelligence summarised elsewhere in the section and should be focused on what actions are needed to improve outcomes and reduce inequalities.

Communication & engagement

- In addition to the processes outlined above, a communications plan for the KJSA is in place and reviewed regularly. A blog (see slide 8) has been developed to promote newly updated sections of the KJSA and provides links to relevant campaigns/ activities (e.g. the blog to promote the updated KJSA Carers' section was linked to the communications on Carers' Week on the Council's intranet). The blog posts also exist to highlight how intelligence in the KJSA has been and can be used to inform commissioning decisions.
- Further communication and engagement work is needed to increase awareness and use of the KJSA and to ensure the connections between intelligence, actions, strategies and outcomes are promoted and understood.

Evaluation (see slide 9)

- The new KJSA has been positively received by the Health and Wellbeing Board and received national recognition, particularly for its dynamic format and shift to a more asset-based approach.
- Analysis of KJSA webpage 'visits' tells us that the number of people looking at the KJSA is increasing.
- The JHWS, the local Health and Wellbeing Plan and the Children and Young People's Plan are strongly underpinned by the intelligence in the KJSA. In addition, the KJSA has been the key intelligence resource for the commissioning of the Healthy Child Programme (now 'Thriving Kirklees') and the forthcoming Wellness Model commission. Intelligence in the KJSA has also supported the focus of the Mental Health Needs Assessment.
- The extent to which the KJSA directly influences commissioning decisions across Kirklees partners has not been formally evaluated.

References

i. Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies. Department of Health, March 2013. Available from: < https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/277012/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-20131.pdf> [accessed 29 Nov 2017].

3. **Implications for the Council (see slide 10)**

As the council becomes a commissioning organisation and works more closely with Kirklees partners to achieve shared outcomes, the KJSA will become an increasingly important component of intelligence-led commissioning for outcomes. It will be important to clarify the links between local intelligence (including the KJSA), action

plans and strategies and understand the progress we are making towards reducing inequalities and improving outcomes. The continued development of the web-based KJSA will support this process by enabling a better understanding of local needs, assets and inequalities.

4. **Consultees and their opinions**
Not applicable

5. **Next steps**
Not applicable

6. **Officer recommendations and reasons**
That this report be received.

7. **Cabinet portfolio holder's recommendations**
Not applicable

8. **Contact officer**
Helen Bewsher
01484 221000 helen.bewsher@kirklees.gov.uk

9. **Background Papers and History of Decisions**
- Health and Wellbeing Board 26 February 2015 (Item 7: Next Steps with the Joint Strategic Needs Assessment (JSNA) Development)
- Health and Wellbeing Board 29 October 2015 (Item 9: Joint Strategic Assessment Development)
- Health and Wellbeing Board 30 June 2016 (Item 8: Kirklees Joint Strategic Assessment)
- Health and Wellbeing Board 30 March 2017 (Item 7: Kirklees Joint Strategic Assessment Update)
- Health and Wellbeing Board 28 Sept 2017 (Item 8: Updated Kirklees Joint Strategic Assessment (KJSA) Overview 2017/18)

10. **Service Director responsible**
Rachel Spencer-Henshall (Service Director Policy, Intelligence & Public Health)

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Kirklees COUNCIL

KJSA

The Kirklees Joint Strategic Assessment

An overview for:

Health and Adult Social Care Scrutiny Panel

12 December 2017

Helen Bewsher

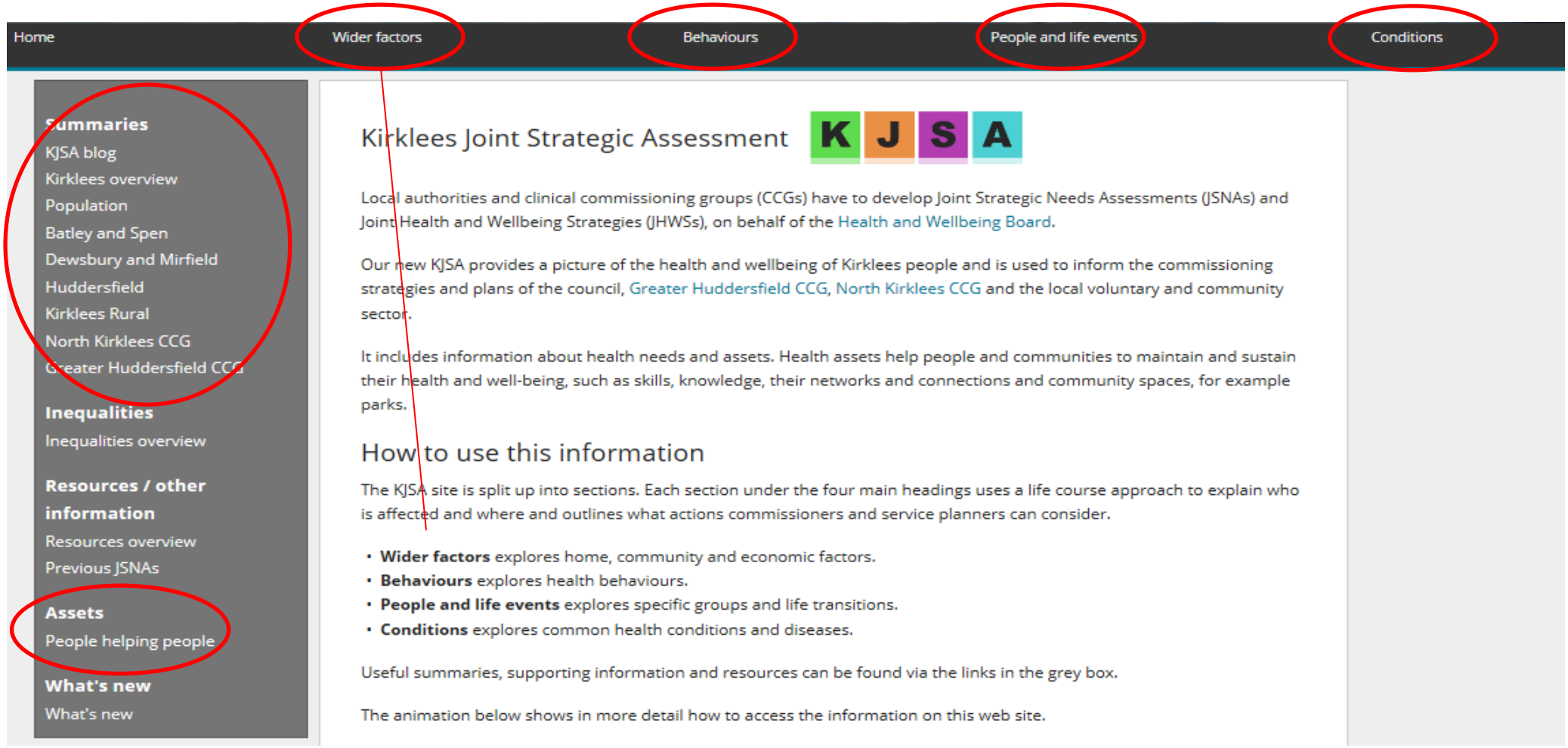
KJSA Section Progress

Key			
Completed or reviewed in past 24 Months	Due for review	To be completed	In Development

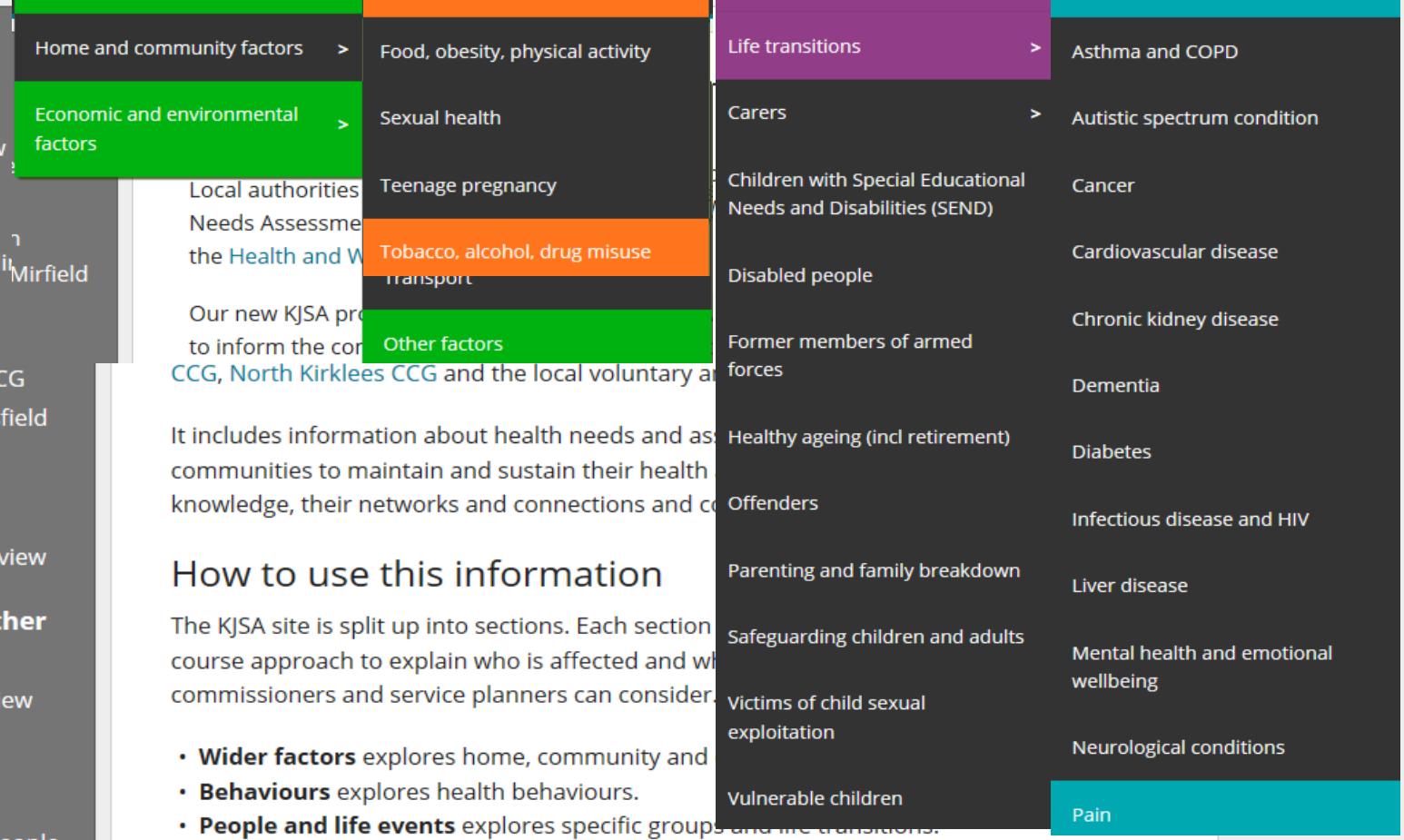
Section Title	Date Complete	Status
Assets overview	30/04/2016	Green
Batley and Spen summary[1, 2]	30/04/2016	Green
Victims of child sexual exploitation	30/04/2016	Green
Kirklees Overview	30/04/2016	Green
Inequalities overview	30/06/2016	Green
Poverty	30/06/2016	Green
Domestic abuse	30/06/2016	Green
Carers[1,2]	31/08/2016	Green
Safeguarding children and adults	31/08/2016	Green
Mental health and emotional wellbeing[1, 2]	30/09/2016	Green
Population summary	31/10/2016	Green
Dying & Bereavement	30/11/2016	Green
Former members of armed forces	30/11/2016	Green
Dementia (to link to DNA)	30/11/2016	Green
Huddersfield summary[1, 2]	28/02/2017	Green
Dewsbury & Mirfield summary[1, 2]	28/02/2017	Green
Kirklees Rural summary[1, 2]	28/02/2017	Green
Sexual health[2] and teenage pregnancy	28/02/2017	Green
Pregnancy & maternal health[1]	28/02/2017	Green
Community cohesion[1,2]	31/03/2017	Green

Section Title	Date Complete	Status
Offenders	30/04/2017	Green
Vulnerable children	30/06/2017	Green
Children with SEND	30/06/2017	Green
People helping people	31/08/2017	Green
Kirklees Overview	30/09/2017	Green
Joint CCG summary[1, 2]	In Development	Blue
Refugees and asylum seekers	In Development	Blue
Learning, skills and work	In Development	Blue
Crime and community safety	In Development	Blue
Food, Obesity, Physical Activity[1, 2]	In Development	Blue
Ageing Well (DPH Annual Report 2017)	In Development	Blue
Diabetes[1]	To Do	Amber
Disabled people (incl autism spectrum condition)	To Do	Amber
Cancer[1]	To Do	Amber
Transport	To Do	Amber
Infectious disease and HIV	To Do	Amber
Tobacco, Alcohol, Drug Misuse[1, 2]	To Do	Amber
Asthma[1] & COPD[1], CVD[1], CKD and liver disease	To Do	Amber
Parenting & family support?	To Do	Amber
Other wider factors (tbc)	To Do	Amber
Chronic pain[1]	To Do	Amber

Find the KJSA here: http://observatory.kirklees.gov.uk/jsna



Life-course approach
Links between sections and external resources
Visual and dynamic elements
Easy navigation via intuitive menus
Supports collaborative and agile working



Local authorities
Needs Assessme
the Health and W

Our new KJSA pr
to inform the cor
CCG, North Kirklees CCG and the local voluntary a

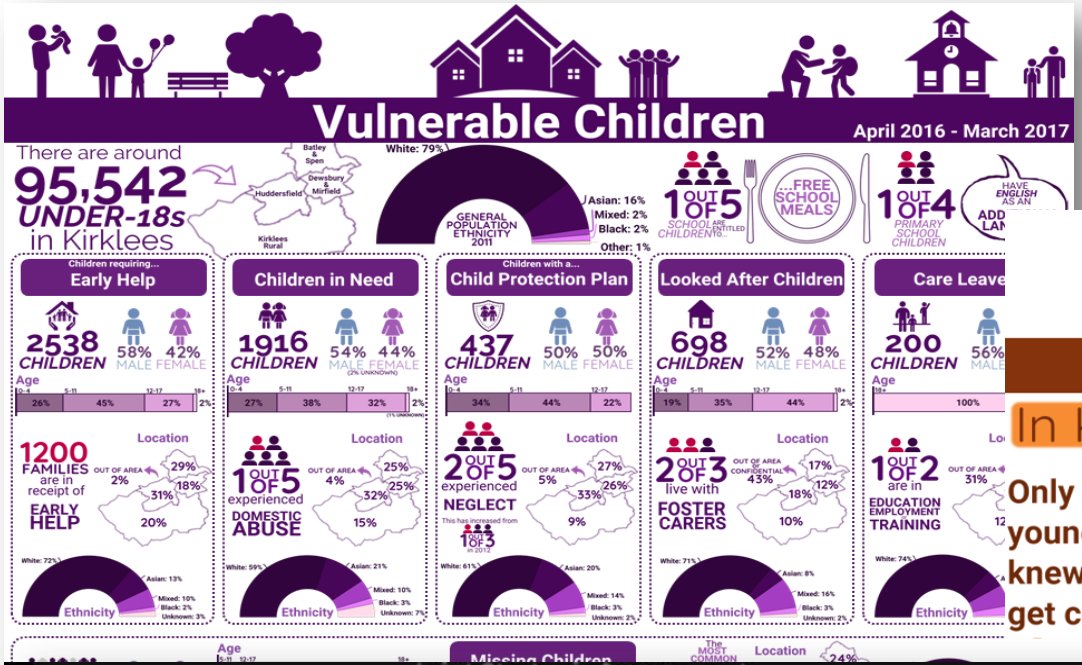
It includes information about health needs and as
communities to maintain and sustain their health
knowledge, their networks and connections and c

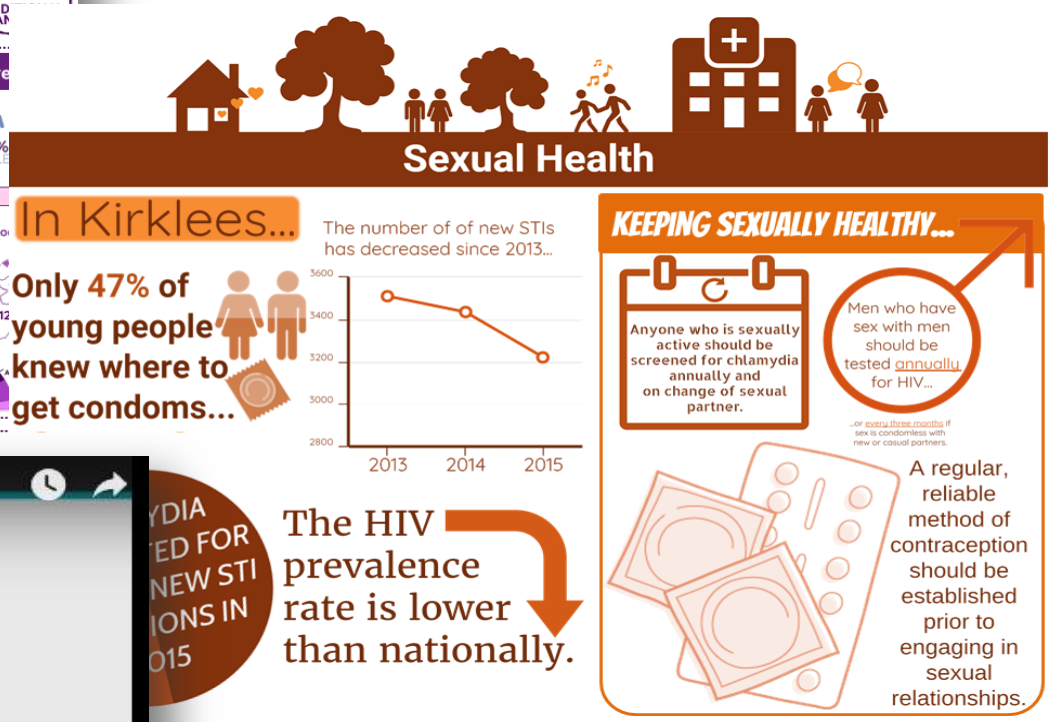
How to use this information

The KJSA site is split up into sections. Each section
course approach to explain who is affected and w
commissioners and service planners can consider.

- **Wider factors** explores home, community and
- **Behaviours** explores health behaviours.
- **People and life events** explores specific groups
- **Conditions** explores common health conditions and diseases.

Useful summaries, supporting information and resources can be found via the links in the grey box.





Kirklees COUNCIL

Indicator tables coming soon…

Indicator Table

How to guide | Data Download | Data | Kirklees Council

Welcome to the KJSA indicator page. This page provides Kirklees level data for a variety of key indicators. For more infomation please click the 'How to guide' button.

Information

Name Behaviours - Physically Active (% Adults)
Definition The proportion of people who achieve minimum recommended amount of physical activity
Numerator The proportion of people who carry out 30 minutes or more of at least moderate activity five times a week
Denominator Total number of respondants

Key

Comparison
- Significantly better than Kirklees
- No significant difference from Kirklees
- Significantly worse than Kirklees
- Kirklees value
- Kirklees confidence interval
- Indicator confidence interval

Trend
- Significant improvement
- Slight improvement
- No change
- Slightly worse
- Significantly worse

Indicator
- Asset
- Joint Health & Wellbeing Strategy

Expand/Collapse List | Indicator Tab

Indicator	Value	Lower Confidence Interval	Upper Confidence Interval	Kirklees	Trend	
Wider Factors - Confidence Managing Money (% Adults)						
Money Confidence - Male (2016)	87	84	90	87		none
Money Confidence - Female (2016)	88	85	91	87		none
Money Confidence - Age 18-44 (2016)	83	80	86	87		none
Behaviours - Physically Active (% Adults)						
Physically Active - Male (2016)	39	37	41	37		none
Physically Active - Female (2016)	35	33	37	37		none
Physically Active - Age 18-44 (2016)	35	33	37	37		none
Physically Active - Age 45-64 (2016)	38	36	40	37		none
Physically Active - Age 65+ (2016)	40	37	43	37		none
Physically Active - Ethnicity All BME (2016)	31	28	34	37		worse
Physically Active - Ethnicity White (2016)	38	37	40	37		none
Physically Active - Ethnicity Black (2016)	42	33	53	37		none
Physically Active - Ethnicity Mixed (2016)	20	13	30	37		worse

Approximately half of all the indicators will be '**asset**' indicators

Moving to an asset approach

Moving from JSNA to JSA

- An iterative, ongoing process
- Focuses equally on needs and assets
- Outlines medium and longer-term challenges for district

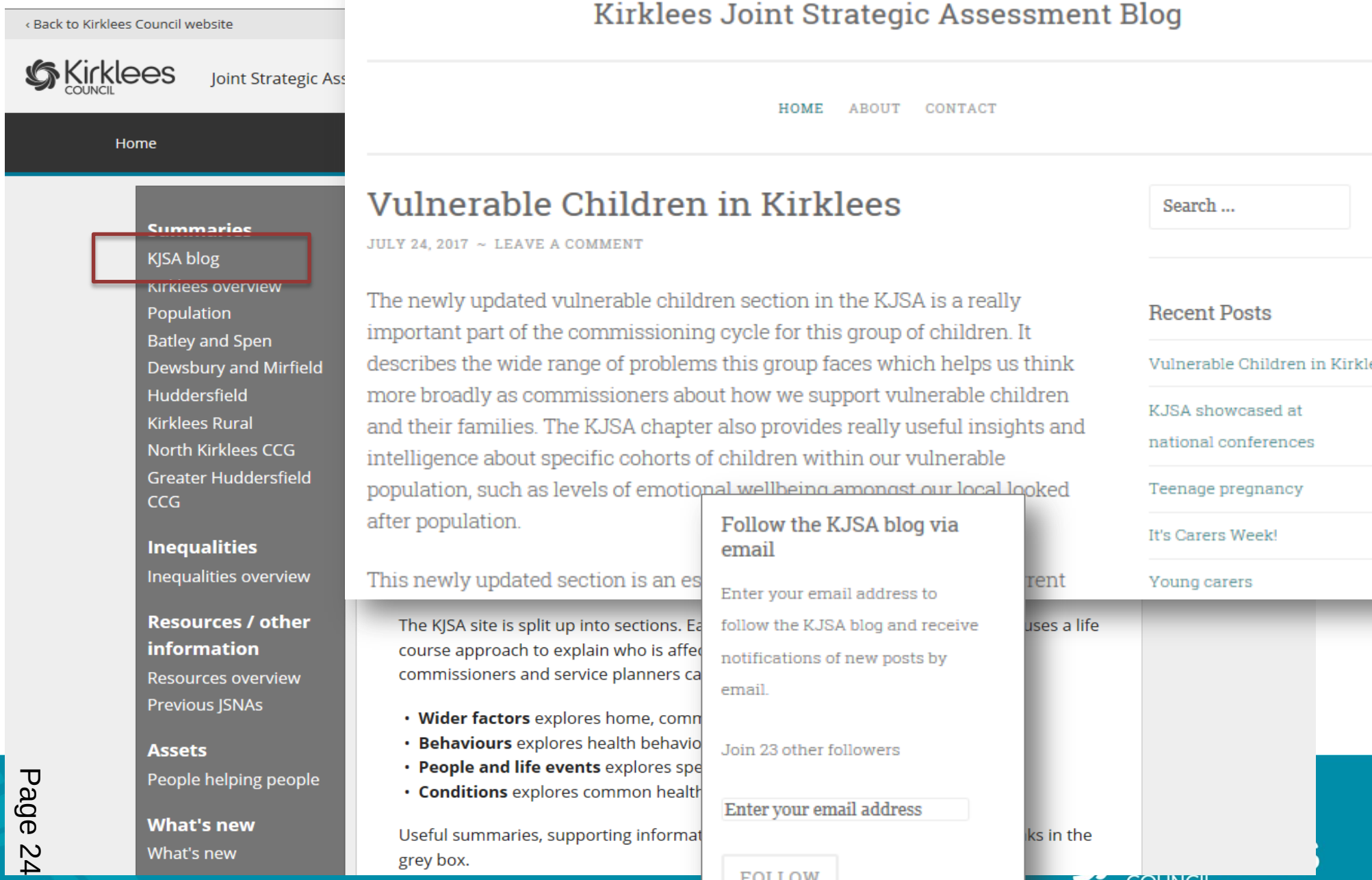
What is an asset?

- Things that help people and communities to maintain and sustain their health and well-being, including:
  Skills | Capacity | Knowledge | Networks and connections | Effectiveness of groups and organisations | Local physical and economic resources (such as green spaces and local businesses)

An asset approach starts by reflecting on what is already present:

- What makes us strong/ healthy/ able to cope in times of stress?
- What makes this a good place to be? What does the community do to improve health?

Kirklees COUNCIL


‹ Back to Kirklees Council website
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Huddersfield
Kirklees Rural
North Kirklees CCG
Greater Huddersfield CCG
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Inequalities overview
Resources / other information
Resources overview
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Assets
People helping people
What's new
What's new
Kirklees Joint Strategic Assessment Blog
HOME ABOUT CONTACT
Vulnerable Children in Kirklees
JULY 24, 2017 ~ LEAVE A COMMENT
The newly updated vulnerable children section in the KJSA is a really important part of the commissioning cycle for this group of children. It describes the wide range of problems this group faces which helps us think more broadly as commissioners about how we support vulnerable children and their families. The KJSA chapter also provides really useful insights and intelligence about specific cohorts of children within our vulnerable population, such as levels of emotional wellbeing amongst our local looked after population.
This newly updated section is an es
rent
The KJSA site is split up into sections. Ea
uses a life course approach to explain who is affe
commissioners and service planners ca
• Wider factors explores home, comm
• Behaviours explores health behavio
• People and life events explores spe
• Conditions explores common health
Useful summaries, supporting informat
ks in the grey box.
Search ...
Recent Posts
Vulnerable Children in Kirkl
KJSA showcased at national conferences
Teenage pregnancy
It's Carers Week!
Young carers
Follow the KJSA blog via email
Enter your email address to follow the KJSA blog and receive notifications of new posts by email.
Join 23 other followers
Enter your email address
FOLLOW
COUNCIL

Summary

- Creative and unconventional user engagement
- Effectively and memorably conveys key messages
- Flexibility to update sections separately
- Distributes burden of work
- Supports intelligence-led commissioning for outcomes

Success indicators

- Just under **5000** KJSA website viewing ‘sessions’ and over **15,000** page views since Dec 2016
- Over **2,200** users since Dec 2016 (55% returning & 45% new)
- Anecdotal feedback and testimonials from guest bloggers highlight ease of use
- Positively received by Health & Wellbeing Board
- Received Highly Commended award: LARIA 2017

Challenges/Learning

- Easier to engage some stakeholders than others
- Limited take-up of blog (to date)
- Time needed to update sections in new format
- Observatory may not be the best platform for the KJSA
- Updating schedule needs to be quite fluid…
  - We don't always get new data/ intelligence when we expect to
  - Sometimes political priorities take over
- How do we ensure that the KJSA is used to drive intelligence-led commissioning?
- How do we ensure that the KJSA helps us to understand health inequalities and what is changing?
- How do we communicate the links between the KJSA, the JHWS, the Local HWB Plan and the Kirklees outcomes?

Kirklees COUNCIL

Name of Meeting:	**Health and Adult Social Care Scrutiny Panel**
Date:	**12 December 2017**
Title of report:	**Kirklees Health and Wellbeing Plan**
Purpose of Report:	This report presents information about the Kirklees Health and Wellbeing Plan and the West Yorkshire and Harrogate Sustainability and Transformation Plan.

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**	**1 December 2017 - Richard Parry** **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

1. Background

1.1 A mandate to develop Sustainability and Transformation Plans (STPs) was announced by NHS England as part of the *2016/17 National Joint Planning Guidelines*. Organisations (Provider, Commissioner and Local Authorities) were tasked through this mandate to collaborate over an agreed geography (footprint) and develop plans which would address local challenges.

1.2 In response, the NHS and Local Authorities have come together in 44 areas covering all of England to develop proposals and make improvements to health and care. The focus of all top level STPs is addressing the three gaps set out in the NHS Five Year Forward View:

- health and wellbeing
- care and quality
- finance and efficiency.

1.3 The West Yorkshire and Harrogate STP (WY&H) was published in October 2016 here. The West Yorkshire and Harrogate STP is underpinned by 6 placed based

plans, including Kirklees. An update on progress with the West Yorkshire and Harrogate STP was presented to the Heath and Wellbeing Board in September. A copy of the report is in Appendix 1.

1.4 The Health and Wellbeing Board approved the Kirklees Health and Wellbeing Plan in June 2017. However, members were asked to note that the Plan is a live document and will continue to evolve. The current version of the Plan is attached.

2. Kirklees Health and Wellbeing Plan

2.1 The Kirklees Health and Wellbeing Plan sets out our vision for our health and social care system. The Plan draws on the Kirklees Joint Strategic Assessment and our analysis of our current challenges across the 'triple aim' of the Five Year Forward view; health and wellbeing, care and quality of services and finance and efficiency.

2.2 The Plan sets out a range of priorities for change:

Areas of Transformation

1. Early intervention & prevention
2. Improving services for children
3. Developing an adult wellness model
4. Capacity & quality of primary care
5. Sustainability of adult social care
6. Change the configuration of acute services
7. New model for continuing care
8. Transforming care for people with learning disabilities
9. Changing the commissioner landscape and new models of care

Supporting programmes

A. Health & Social Care Workforce
B. Digital Opportunities
C. One Public Estate
D. Kirklees Economic Strategy

2.3 The Plan encompasses a range of activity, including some that has been in development for a number of months, or in some cases years, and the planning and decision-making processes for those areas are well established. It also recognises that the Plan is supported by a number of existing organisation level plans and enabling strategies. As such the implementation of the Health and Wellbeing Plan will mainly be through these existing plans. Work is underway to ensure that these plans are responding to the priorities for change set out above.

2.4 The Plan identifies a range of measures of success against each of the challenges identified for the health and wellbeing gap and the care and quality gap. These proposed measures are currently being refined to create a more coherent dashboard of high level measures of success. The current draft of the indicator set is in Appendix 2. These indicators are intended to provide a high-level picture of progress towards the vision for our health and social care system. The existing organisation level plans and enabling strategies will provide additional levels of detailed performance information covering specific population groups and health and care issues in greater depth.

2.5 Starting in April 2018 the current proposal is that the new set of integrated governance arrangements that are being developed will take on responsibility for agreeing and monitoring the annual work programme to support the delivery of the Kirklees Health and Wellbeing Plan. The high level indicators and the integrated governance arrangements will be presented to the Health and Wellbeing Board for their approval early in 2018.

3. Information required to take a decision

This report is submitted for information only.

4. Implications for the Council

4.1 Early Intervention and Prevention

The Kirklees Health and Wellbeing Plan clearly recognises the central role that early intervention and prevention play in achieving our vision for the health and social care system, and as such it is one of the priorities for change in the Plan.

4.2 Economic Resilience

There will be no impact arising from this report.

4.3 Improving Outcomes for Children

Improving services for children is one of the priorities for change in the Plan.

4.4 Legal/Financial or Human Resources

There will be no impact arising from this report.

5. Consultees and their opinions

This report has been prepared in consultation with CCG partners.

6. Next steps

Not applicable.

7. Officer recommendations and reasons

That this report be received.

8. Cabinet Portfolio holder recommendation

Not applicable.

9. Contact Officer

Phil Longworth, Health Policy Officer, 01484 221000

phil.longworth@kirklees.gov.uk

10. Background papers and history of decisions

Not applicable.

11. Service Director responsible

Carol McKenna, Chief Officer, Greater Huddersfield and North Kirklees CCGs

Richard Parry, Strategic Director for Adults & Health, Kirklees Council

Appendix 1

West Yorkshire and Harrogate Sustainability and Transformation Partnership (WY&H STP) update for the Kirklees Health and Wellbeing Board
Thursday, 07 September 2017

1. Background

The approach we have taken to developing our STP in WY&H is based on the principle of subsidiarity – we do the work and make the decisions as close to the person as possible. The majority of the work therefore happens in each of our six places (Bradford, Calderdale, Harrogate, Kirklees, Leeds and Wakefield) which build on existing partnerships, relationships and health and wellbeing strategies.

Where we work collectively at WY&H level it is for one of three reasons:

- We need to look at how we best provide services across a wider footprint than place
- There is benefit in doing the work once and sharing
- We have a collective difficult issue and working together would help solve it.

The West Yorkshire and Harrogate Health and Care Partnership website www.wyhpartnership.co.uk/ includes a wide range of information about the WY&H STP including agendas, papers and minutes of West Yorkshire and Harrogate Joint Committee of the 11 Clinical Commissioning Groups (CCGs), the Cancer Alliance Board, West Yorkshire and Harrogate Local Workforce Action Board (LWAB) and the Lay Member Assurance Group

2. Recent developments

Finance

We are currently refreshing our financial plans, from those submitted in October 2016. The October submission was high level proposals that preceded the 2 year planning and contracting round. We aim to have this work completed in the next few months.

There are increasing resources going into health and social care in West Yorkshire and Harrogate - £5.7bn by 2020-21. We also know that need for care and services are growing at a faster rate than the money we have. If we delivered care in the way we do today, with no change and no efficiencies, the cost would be at least another £1billion by 2021. We need to make the best use of every £ we spend.

3. Joint Committee of the 11 Clinical Commissioning Groups

As we move to new models of delivery through the STP, the collaboration of the 11 CCGs across the area has been further strengthened by coming together as a Joint Committee.

We have recruited an Independent Lay Chair and two lay member representatives for the Committee.

The first meeting was held in public on the 4 July. The agenda, papers and recordings of the meetings are available online at www.wyh-jointcommiteeccgs.co.uk.

4. West Yorkshire and Harrogate priorities

Stroke

The stroke engagement work led by Healthwatch ended on 15 March 2017, with over 1500 comments received. Findings from our stroke engagement have been made public as part of our Joint Committee meeting on 4 July 2017. You can view this at http://www.wyh-jointcommiteeccgs.co.uk/.

This work is very much around the whole stroke pathway from prevention to after care. Further work is being considered and consultation will follow as appropriate

Cancer

The WY&H Cancer Alliance Delivery Plan was signed off at the end of March 2017. NHS England have announced that West Yorkshire and Harrogate Cancer Alliance are one of the first Alliances to have successfully been awarded £12.4 million investment over two years to transform services to speed up cancer diagnosis across the area. The work, which is part of the STP, will focus on working with GPs, community care providers and hospital services. Part of this work involves engaging the public and importantly patients, and carers over the coming months – this will be with the support of our including Healthwatch and leading charities, such as Macmillan and Breast Cancer Now.

Standardisation of Commissioning Policies

Healthwatch engaged with people across the whole of the area around 'follow up' appointments earlier this year. Although this is an independent piece of work, this will help inform the work of the WY&H STP. We are currently looking at improving elective care. Elective care is pre-arranged, non-emergency care, including scheduled operations.

Prevention

There are three gaps (health and wellbeing, care and quality, efficiency and finance) which we are addressing on our STP and tackling health inequalities is a priority. Public Health England, NHS England, and the Yorkshire and Humber Directors of Public Health are ambitious for our STP to lead the way nationally in reducing health inequalities across the region and within our local areas.

Urgent and emergency care

The Urgent and Emergency Care Board (UECPB) builds on a firm foundation of partnership working, shared learning and leadership to deliver the ambitions of WY&H STP. It connects all urgent and emergency care services together so the overall physical and mental health and social care system becomes more than just the sum of its parts.

UEC is one of four national service improvement priorities highlighted in the 'Next Steps' (the others being mental health, primary care and cancer). Targets for NHS 111 Online, 111 calls, GP access and urgent treatment centres. Key targets have also been identified for the Ambulance Response Programme, and ensuring people only stay in hospitals for as long as need be.

We delivered an 8% improvement in A&E performance between December 2016 and March 2017, e.g.

- GP streaming in A&E
- Strengthening ambulatory care models to reduce hospital admissions
- Introduction of the SAFER care bundle in ward areas to help aid the timely flow of patients
- Providing 24/7 telemedicine video links between clinicians and care homes to reduce unnecessary A&E attendances
- We want to sustain, embed and further improve A&E performance through 2017-18 to return to 95% achievement of the standard.

UECPB submitted a milestone tracker in June 2017 to NHS England. This sets out the expected milestones and achievements over the next two years in order to implement the national plan.

Mental health

Building on the work of the Vanguards and the blue print for the Mental Health Five Year Forward View, we have good collaboration across community and mental health trusts that provide mental health care, and what we see now is the sharing of expertise, and a shared vision to deliver consistent outcomes for people who need care and support. Providers are also working more closely together so people don't have to go out of area when they need specialist help. Work continues around improving child and adolescent mental health services, approaches to suicide and the scoping of autism specific care.

We have prioritised suicide prevention in our STP and our "zero suicide" approach will help reduce the toll on families and communities as we move from planning to delivery mode.

Colleagues are working on a number of work streams, including reducing out of area placements, and rehabilitation into the community. We are also looking at best practice nationally and how we can maximise funding opportunities, for example mental health liaison bids and there continues to be a huge challenge around the appropriateness of accident and emergency attendances – something we clearly want to address.

It is now well understood that mental and physical health conditions are not separate. Care and services need to focus on the whole person rather than isolated body parts. Historically there has been an artificial separation between physical and mental health, and mental health has tended to do worse in terms of the priority is has been given, and consequently the investment and focus on improvement it has received. There is strong evidence that tackling mental health problems early improves lives and can reduce subsequent problems.

If you are a man with a severe mental illness in West Yorkshire and Harrogate you are three times more likely to die of circulatory disease and twice as likely to die of cancer than someone without mental illness. This is equally true across a range of other common conditions, and the combined result of this that your life expectancy is 18.6 years lower. This is why we need to improve mental health services, and crucially, remove boundaries that exist between mental and physical health services.

Our mental health work across the STP footprint aims to redress this imbalance. Here in WY&H we are developing a Local Service Framework for mental health and strong collaboration on child and adolescent mental health services, forensics and suicide. Our ambitions include:

- A 40% reduction in unnecessary A&E attendance

- A zero suicide approach to prevention (75% reduction in numbers by 2020-21)
- A reduction in Section 136 place of safety episodes both in police and health based places of safety
- Elimination of Out of Area placements for non-specialist acute care within 12 months
- A reduction in waiting times for autism assessment.

To help ensure that we meet these ambitions the four NHS trusts (South West Yorkshire Partnership NHS Trust, Leeds and York Partnership NHS Foundation Trust, Bradford District Care NHS Foundation Trust and Leeds Community Healthcare NHS Trust) are working collaboratively, alongside clinical commissioning groups, to strengthen partnerships and share delivery of specialist mental health services. Through these closer working arrangements, we will share best practice across the region, for example reducing out of area placements for non-specialist hospital care over the next 12 months. We are already achieving this in some areas across the STP. Our aim is to ensure that people are supported in the least restrictive environment, ideally in a community setting close to home, rather than in hospital.

Specifically, this includes:
- Ensuring there are effective 24/7 crisis services in place across the region and where possible developing more consistency in the way these operate. Working with partners in the police, local authorities, third sector, Yorkshire Ambulance Service and acute trusts to develop new ways of working and services that ensure that people are seen in the most suitable environment and that people don't end up in A&E and police cells unnecessarily.
- The development of a WY&H suicide strategy ensuring all organisations are working together to prevent suicidal behaviour
- Working together across the region sharing best practice to keep people close to home reducing and eventually eradicating the need for out of area placements.
- CAMHs – improving the care pathway for CYP, providing as much care as possible in the community and ensuring people can access a bed close to home when needed.
- Exploring how we can work together to make improvements to the time people have to wait for the assessment and diagnosis of autistic spectrum disorders (ASD) and Attention Deficit Hyperactivity Disorders (ADHD).

In Harrogate we are piloting a project with a local 3rd sector organisation of social prescribing for people will long term mental health problems with the aim of reintegrating into communities, reducing reliance on mental health services and working towards employment. Harrogate has also introduced an all age mental health crisis response through single point of contact.

Bradford's crisis care partnership and first response services have received national recognition and they have had no mental health out of area placements in over a year. Being part of the WY&H partnership will help strengthen the work to improve mental health and wellbeing through shared learning across our area.

The service offers mental health crisis support 24 hours a day, seven days a week, to vulnerable people needing urgent crisis support. A single phone number means that people can self-refer.

Since its launch in March 2015, there have been no out-of-area placements and people are now getting the help they need within their own communities rather than travelling long distances. The service is run by the Care Trust in partnership with the Bradford Council

and West Yorkshire Police, and voluntary partners - Mind, Creative Support and the Cellar Trust - that provide three 'safer spaces' for people of all ages, 24/7, as an alternative to A&E. Trust mental health professionals in police control rooms, custody suites and A&E, and council social workers working in the First Response team, means that people in mental health crisis get the right support, with the right professional, when they need it. Intervening early and signposting to the right service, has reduced demand on the police, ambulance services and A&E departments, and achieved a 50 per cent reduction in people detained under section 136, which gives police the power to take someone to a place of safety.

NHS Greater Huddersfield CCG and Kirklees Council, North Kirklees CCG have worked to improve access to children's mental health services. This included agreeing additional funding for autistic spectrum condition assessments, launching a one-stop-shop phone service for children and young people with emotional and mental health needs, developing a regional eating disorder service and piloting a scheme to provide support to school pupils with autism and mental health needs.

Primary care

Strong primary and community services are an essential part of the STP. This means broadening the definition of primary care and changing the model to build resilience for professionals and the public. The programme of work is taking shape to address and make links to local plans and GP access. There is also a strong a focus on the GP Forward View and workforce.

This programme has brought together strong leadership across the STP footprint, and is developing an ambitious programme of work focused on addressing the challenges we face, identifying and sharing good practice for high quality care in community settings, and supported self-care. This is the biggest area of care delivery and small, positive changes will make the biggest difference to local people. Bringing together local authorities and NHS perspectives, boosted by the independent and 3rd sector, is essential.

Hospitals working together

One of the other key areas of progress in WY&H has been how our hospitals are working together. The Acute hospitals do this through the West Yorkshire Association of Acute Trusts (WYAAT). The board of each of the WYAAT trusts agreed to form a Committee in Common which is responsible for leading the work programme to deliver this ambition. Any case for change will be considered by the Committee in Common before being recommended to each of the individual trust boards for approval.

- Airedale NHS Foundation Trust
- Bradford Teaching Hospitals NHS Foundation Trust
- Calderdale and Huddersfield NHS Foundation Trust
- Harrogate and District NHS Foundation Trust
- Leeds Teaching Hospitals NHS Trust
- Mid Yorkshire Hospitals NHS Trust

WYAAT has a joint work programme which includes four work streams:

- Specialist services
- Clinical standardisation and networks

- Clinical support
- Corporate services.

WYAAT is driving forward nine different projects which are all at different stages of development. This includes:

- Developing a West Yorkshire Vascular Network - Clinical representatives from each Trust have been working together to develop a model for how we can develop a West Yorkshire vascular team and network. Developing the service as a single network will improve recruitment to local services and provide opportunities for staff to specialise in different aspects of vascular surgery.
- Improving the pharmacy supply chain - pharmacy teams from acute trusts in west, north and east Yorkshire (covering WYHSTP and Humber, Coast and Vale STP) are working collaboratively to explore opportunities for optimising efficiency and value by establishing a shared medicines supply chain from the point of ordering to the point the medicine is available for use in clinical areas. Not only will the project bring efficiency savings, it will bring about supply chain performance improvement, release clinical time for patient care and support in managing any risk around supply shortages.
- Programme management and governance - Matt Graham, Programme Director joined WYAAT this month taking over from Caroline Griffiths. The WYAAT programme management office has been developing a range of governance and assurance processes to support the progression of the different programmes of work.

Specialised services

The responsibility for commissioning specialised services remains with NHS England. Specialised services are those provided in relatively few hospitals, accessed by comparatively small numbers of patients but with catchment populations of usually more than one million. These services tend to be located in specialised hospital trusts that can recruit a team of staff with the appropriate expertise and enable them to develop their skills.

The role of the STP is to work closely with colleagues in NHS England on local place based plans to ensure connectivity. This includes working in partnership in order to improve the quality and outcomes of specialised services across the North of England.

Specialised Services North will link with STP footprints to develop a whole system, pathway led approach to provision and commissioning of services, particularly where transformational change is required.

Maternity services

In support of NHS England's National Maternity Review, we have developed the West Yorkshire and Harrogate Local Maternity System Board. The Board's vision for maternity services is to further improve safety for mum and baby, personalisation, choice and family friendly care. We believe every woman and their partner should have access to information to enable them to make decisions about care; and every woman and baby should be able to access support that is centred around their needs and circumstances.

We also believe that all staff working in maternity care should be supported to deliver care which is women centred. They should work in high performing teams, in organisations which are well led, and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries.

To achieve this, we will be:

- Developing a local vision for improved maternity services in order to ensure that there is access to services for women and their babies, regardless of where they live
- Ensuring women and their babies can access seamlessly the right care, in the right place at the right time
- Making sure that providers in West Yorkshire and Harrogate, such as NHS hospitals and other health services, work together so that the needs and preferences of women and families are paramount
- Putting in place necessary infrastructure to support services to work together effectively
- Making sure that women, their partner, their families and local communities are involved in designing maternity services
- Supporting a learning culture between NHS staff, partners and fostering workforce co-ordination and training.

Next steps

- We will be producing and publishing our response to the national 'Next steps on the five year forward view' document later this year. This will describe our plans to improve health and outcomes for the people in our region, and the governance and capacity arrangements we are putting in place to deliver them – reflecting the good progress that we have made since publishing our draft proposals in November 2017.

- We are developing a WY&H Finance Strategy. This is a really important piece of work, building upon the work that has already taken place by our Finance Directors across WY&H, providing a coherent summary of the actions we will be required to undertake to deliver financial sustainability as one of the three key aims set out in the Five Year Forward View. The continuing ownership of the agenda and numbers will help ensure the success of the STP.

- We have recently established a programme of work to understand how we can best work together to develop a better understanding of our estates and capital requirements to meet the requirement of changing clinical service models. Owen Williams, Chief Executive at Calderdale & Huddersfield NHS FT has agreed to lead this piece of work.

Throughout everything we do we will continue to:

- Develop and support our staff
- Have conversations with people who use services and their carers
- Work with our politicians, council leaders, WY&H Local Authorities Consultative Group, Joint Health and Overview Scrutiny, Health and Wellbeing Board Chairs
- Work at pace to implement positive change.

Appendix 2

Kirklees Health & Wellbeing Plan headline indicators

(DRAFT November 2017)

Health and Wellbeing Gap)

1. inequality in life expectancy for men and women
2. healthy life expectancy for men and women compared to the England average
3. infant mortality rate
4. proportion of people who feel socially connected (especially those with a long-term condition)
5. proportion of children and adults who are obese (greatest improvement in the areas with the highest levels)
6. drinking at sensible levels or physical activity
7. smoking prevalence in routine and manual occupations
8. proportion of people with 3 or more long term conditions who feel confident that they can manage their health
9. cancer screening rates (greatest improvements in groups with the lowest rates)
10. proportion of people with common mental health conditions who access early help

Care & Quality

1. non-elective admissions
2. avoidable admissions for frail elderly population
3. admission rates for respiratory conditions and/or admission rates for CVD and/or admission rates for all cancers
4. 18 weeks referral to treatment (NHS Constitution measure)
5. cancer treatment in 62 days (NHS Constitution measure)
6. delayed transfers of care (NHS Constitution measure)
7. social care related quality of life for people receiving social care
8. variability in long term condition management (measure tbc)
9. people achieving their preferred place of death
10. late/emergency presentations (mental health)
11. self-reported quality of life for carers

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Kirklees Health and Wellbeing Plan 2017

Final v 1.03
7 November 2017

Kirklees Health and Wellbeing Plan 2017 - 2021

Foreword

The mandate to develop Sustainability and Transformation Plans (STPs) was announced by NHS England as part of the *2016/17 National Joint Planning Guidelines*. Organisations (Provider, Commissioner and Local Authorities) were tasked through this mandate to collaborate over an agreed geography (footprint) and develop plans which would address local challenges.

In response, the NHS and Local Councils have come together in 44 areas covering all of England to develop proposals and make improvements to health and social care. Our local footprint is the West Yorkshire and Harrogate STP which is underpinned by six place-based plans built around the needs of the local population.

Kirklees Health and Wellbeing Plan is a clearly articulated vision for the Kirklees health and social care system which is supported by a number of existing organisation level plans and enabling strategies. It supports delivery at a local level of the NHS England *Five Year Forward View* and recently published *Forward View Next Steps* documents.

The commissioner/provider geography in Kirklees is complex in that it crosses a number of organisational boundaries. This provides us with the opportunity to collaborate with a number of organisations over a number of footprints to deliver change. Further detail on this is included in appendix 3 of this document. Working across organisational boundaries is not a new concept in Kirklees, collaboration and integration is well established and has already started to deliver change in a number of areas. The work streams identified within the Kirklees Health and Wellbeing Plan build upon this work and aim to take the principles of collaboration and integration further in the future to deliver better quality outcomes for people in Kirklees.

We know that NHS organisations and Local Councils are operating in an increasingly complex environment, coupled with less resource. This is something that locally we need to be mindful of as we continue to collaborate and re-focus our efforts on achieving the best outcomes for our population with the reducing resources we have available to us.

To ensure we do not lose sight of the needs of local people in this complex commissioner/provider environment, a set of principles to support system change have been developed. These principles will be used as a tool to support decision making and the development of new models of care.

Please note: This is a live document and therefore will be refreshed as our plans evolve and develop. We are awaiting the West Yorkshire STP delivery plan which is due for publication in next 2-3 months, following its publication we intend to produce a local delivery plan for Kirklees .

Kirklees 2020 Vision for our health and social care system:

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

The principles underpinning the Kirklees 2020 vision are that:

- ✓ 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

- ✓ To support the achievement of this Vision we will need to work with a wide range of partners who can influence the wider determinants of health and wellbeing, including housing, learning, income and employment.

Kirklees Joint Strategic Assessment

KJSA provides a picture of the health and wellbeing of Kirklees people and is used to inform the commissioning strategies and plans. The latest overview approved by the Health and Wellbeing Board in 2017 highlights the key health and wellbeing challenges for Kirklees, and how we should tackle them. (link)

Key challenges

- The need to prevent and intervene early
- Enabling people to start, live and age well
- Achieving healthy communities, homes and work
- Improving resilience and enabling healthy behaviours (e.g. diet and physical activity)
- Narrowing the inequality gap

How do we tackle them?

- Redouble efforts to shift activity from reacting to preventing and intervening early
- Ensure access to healthy housing, decent work and strong community
- Create environments that enable healthy behaviours
- Ensure interventions are designed and targeted to reduce inequalities
- Promote independence and resilience to start well and age well
- Ensure changes are driven by community assets and strengths to achieve positive and sustainable outcomes

Delivering the Vision Together

We can only deliver the vision if all health and social care partners work together and turn the commitments in this plan into reality. Achieving our ambitions for the future also depends on local people playing their part too.

Our Part

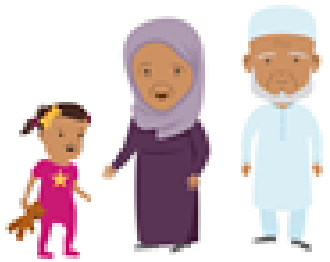
Local health and social care organisations will work together across Kirklees to:

- Keep people as well as possible for as long as possible
- Ensure services are accessible, sustainable, safe and care is of a high quality
- Help communities to support each other
- Support the local economy to grow
- Listen to our communities, be honest and open

Your Part

As a local resident you can play your part by:

- Taking responsibility for your own health and wellbeing
- Getting involved in your community
- Being as healthy and active as possible
- Helping protect children and the vulnerable
- Supporting your local businesses
- Having your say and telling us if we get it wrong



Alignment with Other Plans and Strategies

Kirklees Health and Wellbeing Plan is an overarching plan which is supported by a number of existing organisation level plans and enabling strategies.

West Yorkshire and Harrogate STP

Kirklees JHWS

Kirklees JSA

Kirklees Health and Wellbeing Plan

- CCG 2 Year Operational Plans
- GPFV Transformation Plans
- MHFV Transformation Plans Inc. LD Transforming Care Plans
- Financial Recovery Plan

- Corporate Plan & New Council
- Medium Term Financial Plan
- Vision for Social Care
- Children & Young People's Plan

- Right Care, Right Time, Right Place
- Meeting the Challenge
- NHS Provider 2 Year Operational Plans
- CHFT 5 Year Plan

- Economic Strategy
- Skills Strategy
- Housing Strategy
- Community Safety Plan
- Local Plan
- Local Transport Plan

Involving local people

We will involve local people and key stakeholders in any proposals which involve the design, development and delivery of services. This includes:

When proposals are being developed and designed *to ensure that local people/stakeholders have the opportunity to shape them*

When we are thinking about changing the way a service is provided *which may be as part of co-production, engagement and formal consultation*

Our approach to involvement is to always use what we already know, including any patient/user/carer experience intelligence prior to embarking on further involvement. Our ambition for the future is to upskill our local population to co-produce any changes or new models of care where they can influence design and development. We have an established multiagency Patient Engagement and Experience (PPE) Group who are responsible for working as a partnership to ensure our engagement activities are aligned and robust. This work is undertaken at an organisational level but we continue to work on projects together to ensure we don't duplicate conversations or over consult our local population. Part of our involvement approach is to work with trained Community Voices representatives in delivering our conversations. These representatives are local people from Voluntary and Community Sector (VCS) Groups and Patient Reference Groups (PRG) . These people are paid to deliver engagement and consultation on our behalf ensuring we reach the most vulnerable members of our local population.

Any proposals outlined within this Kirklees Health and Wellbeing Plan will be subject to the usual engagement processes . Some examples of how we engage are detailed below:

Partnership work with providers, Healthwatch Kirklees and the Kirklees Overview and Scrutiny Committee.

Well-established links with local VCS and PRG groups including our trained assets as part of our 'Community Voices' programme.

Provide the wider public with information about commissioning plans and publicise opportunities to get involved.

Use our website, local media, Twitter and Facebook to promote engagement opportunities, plans and decisions to a wide audience.

Use a range of methods and approaches to involve local people in specific service change programmes including surveys and patient representation on panels.

Get involved by visiting the following websites:

http://www.kirklees.gov.uk/ https://www.greaterhuddersfieldccg.nhs.uk/ https://www.northkirkleesccg.nhs.uk/

Local Challenges

The triple aim: Closing the gaps
There are three gaps outlined in the Five Year Forward View these relate to health and wellbeing, care and quality of services and finance and efficiency.

Our approach is to ensure that we can improve outcomes in health and wellbeing and care and quality whilst delivering within the resources available.

The following slides summarise the local challenges that we face in Kirklees, our plans focus on closing these three gaps.

The detailed milestones and targets will be included in the implementation plan which will be published later in the year.

Local Challenges – Health and Wellbeing Gap

Local Challenge	Ambition for the Future	How will we Measure Success?
Whilst life expectancy for men and women is increasing there is still a significant difference in life expectancy at birth between our least deprived areas and most deprived areas of 6.8 years for men and 5.3 years for women. Healthy life expectancy is lower than the England average for both men and women.	We want to enable people to live long and healthy lives no matter where they live .	Reduce the inequality in life expectancy for men and women in Kirklees (Marmot indicator) Increase healthy life expectancy for men and women to the England average
Good housing, work with prospects, green infrastructure and social mobility all influence the social capital of an area. In turn this generates a more confident, independent self sustaining culture that promotes further social and economic development and personal wellbeing.	All Kirklees residents are able to live in a home that meets their needs. Reshaping our environment to promote health, volunteering, active travel and physical activity and use of our green spaces and cultural facilities helps shape how we feel about ourselves and communities. Confident cohesive communities are healthy communities.	Increase the proportion of people living in suitable housing Increase in the proportion of people who feel socially connected, especially those with a long term condition
Too may people experience living and working conditions that have negative impacts on their health and wellbeing. Our response is often not focused on preventing issues occurring, or we do not intervene early enough so issues become more embedded and complex.	If we are to transform our approach to health and social care we need to prevent and better manage conditions at all ages by encouraging self care and deliver brief, early and targeted interventions.	Increase the proportion of people with 3 or more long term condition s who feel confident that they can manage their health.

Local Challenges – Health and Wellbeing Gap

Local Challenge	Ambition for the Future	How will we Measure Success?
Kirklees has one of the highest infant mortality rates in West Yorkshire, although a lot of progress has been made in previous years, more needs to be done.	The reduction in infant mortality rates continues, especially amongst those groups with the highest rates	Infant mortality rate has reduced to the England average, with the greatest improvement in areas with the highest rate
Uptake of cancer screening programmes in Kirklees is amongst the worst in West Yorkshire. This is a particular issue in North Kirklees in bowel and cervical screening. Kirklees is also higher than the England average for cancers diagnosed as emergency presentations. These cancers are on average more advanced (stages 3 and 4) than those detected earlier and the outcome for the patient is poor.	Cancer screening uptake improves , especially in groups with the lowest rates, to support early identification of cancers and to help reduce the number of cancers detected as emergency presentation.	Kirklees cancer screening rates are in line with the England average, with the greatest improvements in groups with the lowest rates Increase of 4% of cancers diagnosed at stages 1 and 2.
Not enough people who have a common mental health condition gain access to early help.	In line with the Mental Health Forward View we are aiming to transform services to ensure they are more preventative and proactive. Increase in the number of people who receive help for common mental health conditions earlier in the pathway.	Increase to at least 25%, the proportion of people with common mental health conditions who access early help .
Too many women experience poor mental health during pregnancy and in the first year after the birth of their child.	More women to gain timely expert help in their local community. To foster development of local networks with providers of maternity services and community groups thus aiming to increase community resilience and build awareness.	Launch of a new specialist perinatal mental heath service in 2017 which will provide timely, expert help for up to 260 women per year in Kirklees experiencing moderate to severe mental health problems during pregnancy and during the first year after the birth of a child. Work in partnership with primary care and other providers of perinatal care to make a difference to the 1040 women per year with less serious mental health problems during pregnancy and after the birth of their child. Improved access, reduced crises/incidents, satisfaction.

Local Challenges – Health and Wellbeing Gap

Local Challenge	Ambition for the Future	How will we Measure Success?
A third (33%) of children age 10/11 and two thirds (66%) of adults are overweight and obese. Physical activity and emotional health and wellbeing are connected to this, and are a toxic trio leading to poorer outcomes and increasing risk of costly long term conditions. Our high obesity levels locally result in a higher than average prevalence of health conditions like diabetes.	Our services must make every contact count and support positive changes that promote health at all stages of the life course. A partnership of providers will deliver an integrated approach to emotional and physical health through the Health Child Programme. (This incorporates Tier 2/3 CAMHS) Reduction of people at high risk of developing diabetes by 2020 and increase in the number of people referred to Healthy Living Services.	Reduce the proportion of children and adults who are obese to the England average, with the greatest improvement in the areas with the highest levels. Reduce the proportion of adults with diabetes , with the greatest improvement in the groups with the highest levels.
People who live in poorer areas and/or have lower educational attainment/lower skills have, in general, worsened health behaviours and outcomes at all points in the life course. More affluent groups are increasingly heeding messages about healthy eating, exercise and smoking and so the gradient of inequality worsens. Smoking rates are falling in line with national trends. There are still a number of vulnerable population groups however where smoking rates are high, including pregnant women and people in routine and manual occupations.	We continue to see improvements in the health related behaviours and take up of opportunities, but we want to see the fastest improvements in those neighbourhoods and communities with the worst rates currently and where there are low levels of motivation to change.	Improvement in key healthy lifestyle indicators including • drinking at sensible levels • physical activity Reduce the proportion of women smoking at delivery in our most deprived Wards (>25%) to current Kirklees average (13%) Reduce smoking prevalence in routine and manual occupations from 25% to the lowest in the region (21%)

Local Challenges – Care and Quality Gap

Local Challenge	Ambition for the Future	How will we Measure Success?
Some people in Kirklees wait too long to be seen/for diagnosis/treatment/discharge: ➢ MYHT are not currently meeting the national access standards relating to 18 weeks RTT, A&E and some cancer targets. ➢ Some patients have an unnecessary admission and an extended LoS in hospital ➢ Currently none of our GP Practices offer extended access outside of what is funded by the national enhanced scheme. ➢ Timely access to choice appointments in CAMHS has significantly improved locally however there remains more work to do in respect to access to specialist elements of CAMHS such as ASD. ➢ Around 1 in 4 adults who are referred for a social care assessment have to wait too long	All patients/service users will be seen/assessed/diagnosed/treated /managed and discharged by the right clinician/professional for their needs in a timely manner. This ambition is for all care sectors in Kirklees.	Sustainable achievement of all NHS Constitution measures by 2018/19. Including 18 weeks RTT, Cancer, DTOC 100% of GP practices offering extended access at evenings and weekends by 2018/19. Timeliness of adult social care assessment
As the age profile of our population changes we will also see more and more people needing help to live at home, We expect to see demand for social care for people aged over 65 grow by 30% in the next 10 to 15 years.	We will improve the quality of care and sustainability of adults social care and develop a wider range of types of place to live for people with care needs.	Improve the social care related quality of life for people receiving social care to at least the regional average No adult social care providers are rated inadequate by CQC
Workforce crisis amongst both acute hospital consultants and trainees resulting in a high agency spend on medical and nursing roles.	TBC – Acute Trusts to confirm	Reduce agency spend Improve staff turnover rates
Workforce crisis among primary care, community care. High proportion of primary care workforce nearing retirement age.	Diverse and skilled workforce to deliver care in community and primary care settings. Introduction of collaborative new and transient roles to support this. Succession planning for the future Improve reputation of Kirklees as a good place to work	Increase in the number of training practices in primary care Introduction of new roles and new ways of working

Local Challenges – Care and Quality Gap

Challenge	Ambition for the Future	How will we Measure Success?
The local adult social care workforce is predicted to increase by up to 40% over the next 10 years due largely to an ageing populations., and the roles of these staff are becoming increasingly complex as the needs of service users become more complex.	We want to make adult social care an attractive career which recognises the critical role care staff play in enabling some of our most vulnerable citizens to lead independent and fulfilling lives	Reduce the vacancy rate across adult social care Increase the skill levels across the care workforce, particularly in residential and domiciliary care
Compared to our peers within the NHS England RightCare data packs we have higher than average emergency admission rates for respiratory conditions and CVD conditions. We also have than average admission rates for all cancers. RightCare also shows variability in the way long term conditions are managed locally, for example diabetes management. Deferential outcomes for patients dependent on the management approach.	We will develop clinical resource centres to manage patients in primary care which will enable us to offer a wider range of services to meet the needs of local people and better access to services whilst using the workforce available to us more effectively. There is a strategic shift of activity planned from hospitals to the community, preventing the need for hospital admission wherever possible. With enhanced integration of services for vulnerable patients, the aim is to ensure that people do not spend any longer in hospital than they need to. Proactive management of activity shifts out of secondary care to primary care need to be properly planned and resourced.	Reduction in admission rates for respiratory conditions, CVD and all cancers. Reduced variability in long term condition management.
In Kirklees, approximately 3,800 people die each year. This number is expected to rise by 17% from 2012 to 2030. There is more which could be done to coordinate different services to ensure patients and their families receive the highest quality of care at the end of life.	Improve co-ordination of care for people at the end of life. Focus on better informed decision making for patients, holistic care planning/management and delivery which ensures people during end of life phase remain in a place of their preference where possible and are supported to die with dignity.	Increase in the numbers of people achieving their preferred place of death through earlier identification, proactive management, development of Advanced Care Plans and recording of preferences on the EPaCCS register.

Local Challenges – Care and Quality Gap

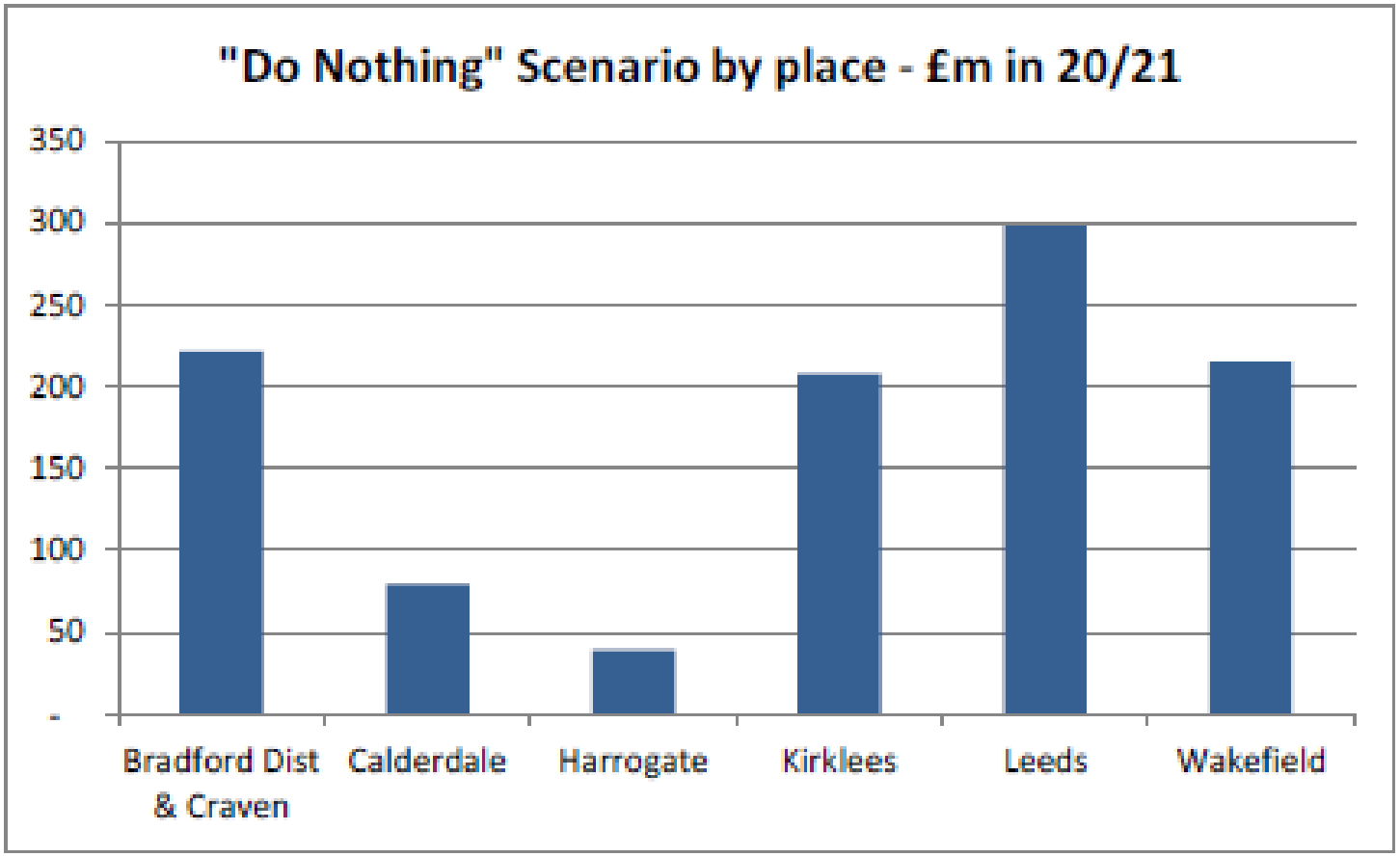
Challenge	Ambition for the Future	How will we Measure Success?
People with severe and enduring mental health needs die on average 15-20 years sooner than their neighbors in similar socio-economic circumstances.	Address this issue proactively through improved health screening in conjunction with primary and community care.	Reduction in late/emergency presentations Reduction in excess mortality
Carers are critical to an effective health and social care system. However, most carers don't feel the y have enough control over their daily life , they are more likely to have poorer health but they are likely to have a job but many are restricted to part time work, and around 1 in 3 do not find it easy to find information about support, services or benefits	We want all carers to feel confident in their ability to deliver care and manage long term. To help achieve this we aim to have all health and social care organisations signed up to the carers charter through Investors in Carers and ensure that the caring community receive adequate support to improve their health and wellbeing and remain in employment.	Improve self-reported quality of life for carers Proportion of health and social care organisations signed up to the Carers Charter

Local Challenges – Finance and Efficiency Gap

Challenge	Ambition for the Future	How will we Measure Success?
The NHS England RightCare data packs have identified efficiency savings through reducing unwarranted variation across Kirklees.	Through the RightCare programme we plan to deliver efficiencies through our QIPP delivery program in 2017/18 e.g . MSK/pain pathway, respiratory pathway and delivering care closer to home through our Integrated Community Services Contract.	Working with our RightCare delivery partner we will monitor efficiencies using the RightCare methodology and principles. Robust QIPP monitoring processes.
The money available to us to spend is decreasing, demand for services is increasing and people are living longer. We also have a growing number of young people with complex needs in Kirklees who require intensive support	Our QIPP schemes aim to transform services in line with the changing needs of our population. For example changes to how we care for the frail elderly and the falls service are two of our QIPP schemes for 2017/18.	Reduction in avoidable admission for frail elderly population.

Finance and Efficiency Gap

The national finance and efficiency gap is forecast to be £22bn by 2020/21. The West Yorkshire gap is £1.070m and the Kirklees gap is £207m.



Finance and Efficiency Gap

The Kirklees finance and efficiency gap is forecast to be £207m by 2020/21. Schemes to close the gap are in varying stages of development. These figures are draft and still to be approved by every organisation. They are due to be updated.

Kirklees Patch Share of the WYSTP submission (based on population shares)	Challenge by 2020/21	Solutions by 2020/21	Residual Gap by 2020/21
	£'000	£'000	£'000
Greater Huddersfield CCG	- 28,213	- 31,799	3,586
North Kirklees CCG	- 35,764	- 39,472	3,708
Calderdale and Huddersfield Trust	- 48,987	- 27,848	- 21,139
Mid Yorkshire Trust	- 32,798	- 23,260	- 9,538
South West Yorkshire Partnership Trust	- 7,719	- 1,544	- 6,174
Kirklees Council	- 53,760	-	- 53,760
Total	**- 207,240**	**- 123,923**	**- 83,317**

From Vision to impact

The approach we are taking to deliver the Kirklees 2020 Vision is to progress and implement a number of transformational programmes. This will have a positive impact on the three gaps identified within the Five Year Forward View. The diagram below illustrates how the Kirklees 2020 Vision will be achieved, at both a local and regional level.

Local

Regional

Vision

- People in Kirklees are as well as possible for as long as possible both physically and psychologically
- People have a safe warm affordable home in an appropriate environment within a supported community
- People take up opportunities that have a positive impact on their health and wellbeing
- Affordable and sustainable
- Accessible, integrated services led by shared commissioning, workforce and community planning.
- **Acute services safe sized;**
- **Specialist care centres of excellence;**
- **New commissioning arrangements;**
- **Sharing of back office functions and estate;**
- **Innovation and best practice.**

Approach

Delivery of the transformational work streams and the supporting programmes of work across health and social care described within this plan and the supporting strategies/plans which underpin it. Implementation overseen by the Kirklees Health and Wellbeing Board.

Work planned at West Yorkshire and Harrogate level through the West Yorkshire and Harrogate STP. This work is connected to the six identified 'place based plans' for local delivery. Implementation overseen by the Health Futures Collaborative Leadership.

Impact on 3 gaps

- Greater focus on prevention, mental health, primary/community/social care and reducing unwarranted variation
- Empower local people to take more responsibility for their health and wellbeing
- Reduced demand on acute/specialist services, reduced costs and improvement in access standards

- **Greater Resilience of acute services;**
- **Improved quality, safety and reduced variation;**
- **Efficiencies through standardisation of good practice; lower cost of estate and back office.**

Delivering The Vision: Priorities for Change

The following areas of transformation and the supporting programmes overleaf were identified by members of the Kirklees Health and Wellbeing Board as priorities to work on collectively, through a systems approach to address the challenges described earlier in this document. These priorities have been tested with a number of stakeholders including patients and the public to ensure this plan is focussing on the right areas.

Areas of Transformation

- Early intervention & prevention

- Improving services for children

- Developing an adult wellness model

- Capacity & quality of primary care

- Sustainability of adult social care

- Change the configuration of acute services

- New model for continuing care

- Transforming care for people with learning disabilities

- Changing the commissioner landscape and new models of care

Delivering The Vision: Priorities for Change

Supporting Programmes

- Health & Social Care Workforce

- Digital Opportunities

- One Public Estate

- Kirklees Economic Strategy

Delivering The Vision: Changing Behaviours

Through developing the Kirklees Health & Wellbeing Plan a number of consistent themes emerged that we need to consider when making any changes to the services in Kirklees.

Planning for Kirklees

- Move away from separate organisational plans, developed in isolation, to a set of interlinked plans for Kirklees:
  - Our estate
  - Our digital future
  - Our intelligence needs
  - Our workforce

Kirklees People

- Grow our own workforce and retain them by making Kirklees a great place to work, live and learn.
- Work together to identify the future skills Kirklees needs to successfully deliver our ambitions for health and social care services and remove organisational barriers to training.
- Improve our shared understanding of the challenges within our local communities, e.g. the challenges faced by: Asian women; 'frequent flyers' and; isolated older people.
- Adopt a consistent way of recognising, valuing and supporting the critical role of carers.

Kirklees Pound

- Develop a system where money follows the patient/user around the system
- Develop our local supply chains to maximise the return on local public sector spend on the local economy
- Encourage local people to contribute to local causes
- Be bold in our approach to funding local voluntary services through innovative contracting processes
- Understand funding rules and funding flows
- Ensure our decisions make best use of the Kirklees pound rather than be based on individual organisational interest.

Appendices

The Kirklees Provider and Commissioner Landscape

Kirklees hosts two Clinical Commissioning Groups (CCG), **North Kirklees CCG** and **Greater Huddersfield CCG.** Both CCGs work jointly with **Kirklees Council.**

North Kirklees CCG is a membership organisation, comprising 29 member practices. Greater Huddersfield CCG is a membership organisation, comprising 37 member practices.

Over 430,000 people live in Kirklees rising to around 483,000 by 2030 if current trends continue in birth rate, increasing life expectancy and net international migration. Almost all of this increase is in the young and old age groups, with only a small increase for the working age population.

We have two acute trusts within Kirklees; **Mid Yorkshire Hospitals Trust (MYHT)** and **Calderdale and Huddersfield Foundation Trust (CHFT)**. MYHT has one of its three hospitals in Dewsbury, within **North Kirklees CCGs** boundaries. The commissioning of hospital services provided by MYHT is led by **Wakefield CCG**.

CHFT has two hospitals one in Huddersfield and the other in Halifax. **Greater Huddersfield CCG** is the lead commissioner for CHFT and works in collaboration with **Calderdale CCG** to commission hospital services.

South West Yorkshire Partnership Foundation Trust (SWYPFT) provides mental health services across Kirklees. The Lead Commissioner for this contract is Calderdale CCG.

Locala provide community based health services across Kirklees.

Social care is commissioned by **Kirklees Council** and delivered by a wide range of independent sector providers

This complex Kirklees planning unit is overseen by the **Kirklees Health and Wellbeing Board**. The Kirklees Health and Wellbeing Board holds responsibility for holding the system to account in the development and delivery of the changes outlined in the **Kirklees Health and Wellbeing Plan.**

The Kirklees Provider and Commissioner Landscape (continued)

Figure 1

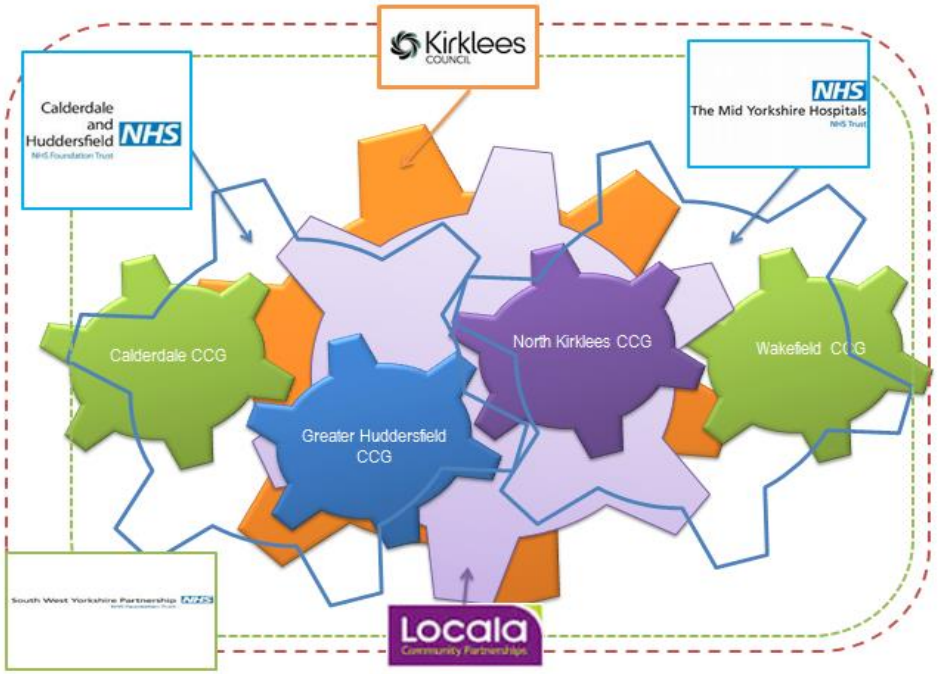
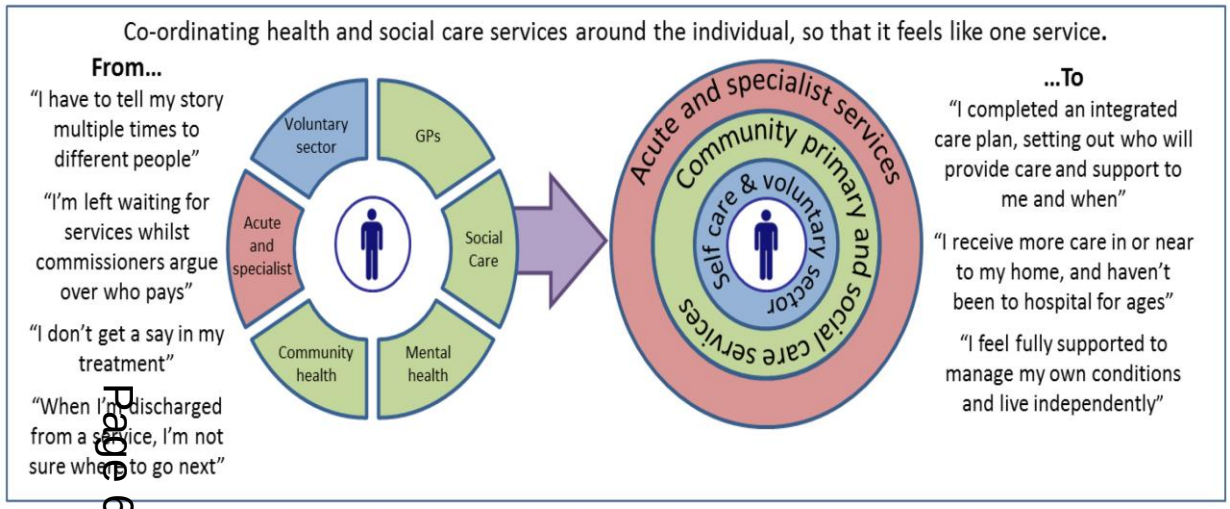


Figure 1 shows the different commissioning organisations described above and how they work together to ensure that high quality services are commissioned for the people of Kirklees.

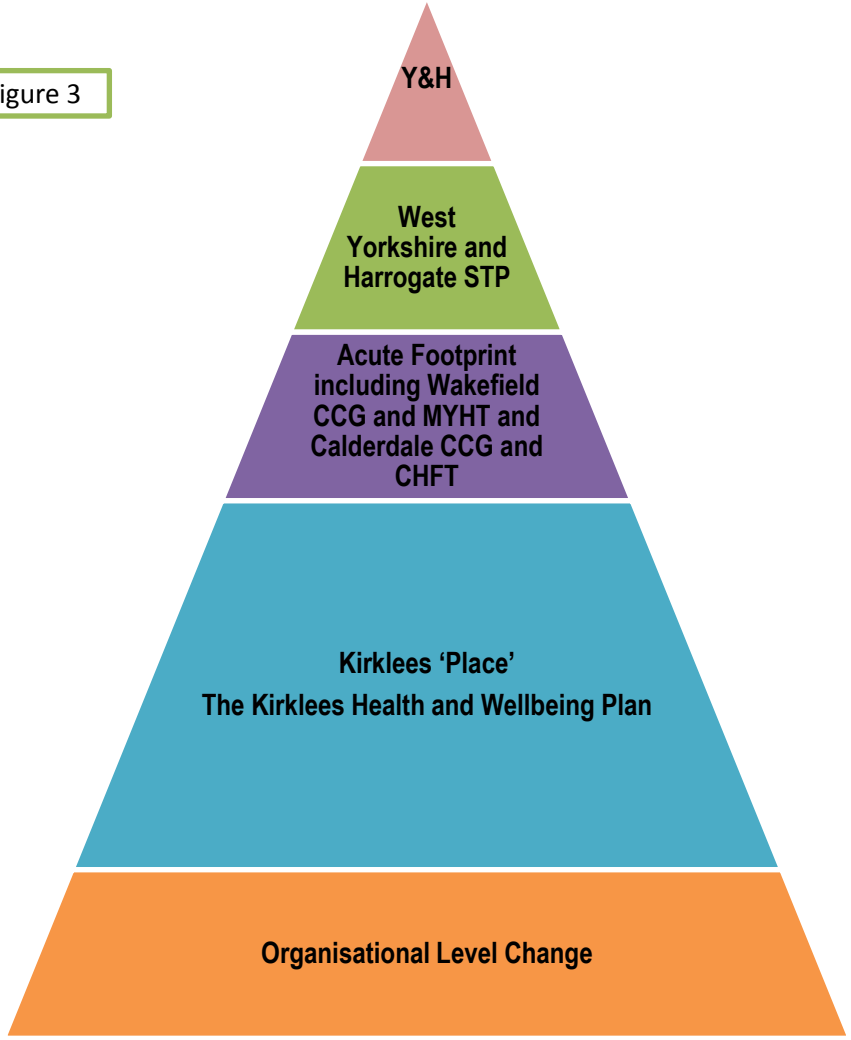
Figure 2 demonstrates our ambition for the future to improve health and wellbeing and reduce health inequalities for our local population by moving towards population based commissioning where the focus is on service user centred co-ordinated care.

Figure 2



Collaboration and Transformation

Figure 3



The commissioner/provider geography in Kirklees is unusual in that it crosses a number of organisational boundaries. This provides us with the opportunity to collaborate with a number of organisations over a number of footprints to deliver change. Figure 3 illustrates the different levels of commissioning arrangements we are currently engaged in as a system.

We are actively involved in the West Yorkshire and Harrogate STP and engaged in the identified work streams which will be delivered at this level. The Kirklees Health and Wellbeing Plan localises the delivery of these work streams and feeds local priorities and population need into the regional discussions.

To ensure services are reflective of local need our primary focus will be on sustainability and transformation within the 'Kirklees Place', recognising that where is adds value to patient outcomes we will need to work collaboratively across all levels of joint working in figure 3 and acknowledging the interdependencies with our acute footprints.

Within the Kirklees Place a number of priorities for system wide intervention have been identified to address our local challenges described earlier in this document and support us in our ambition to close the three gaps described in the Five Year Forward View.

Our identified priorities for delivery across Kirklees are described in appendix 3 of this document.

Governance and Decision Making

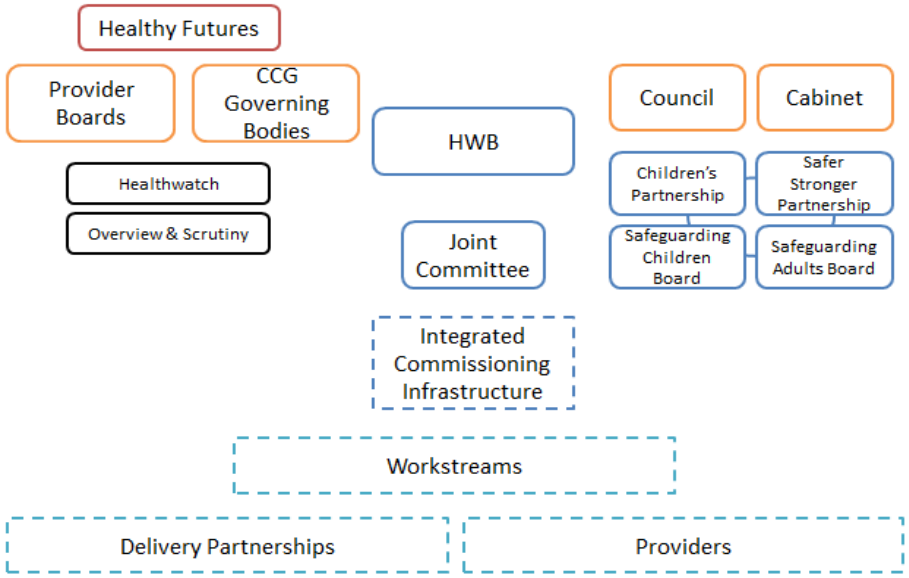
The Kirklees Health and Wellbeing Board will take the lead in the development and delivery of the Kirklees Health and Wellbeing Plan. The Plan recognises that all partners will need to take responsibility for embedding the Plan in their own organisational plans. The current governance arrangements will be updated to reflect the growing need for an integrated approach to decision making. Proposals are being developed and trialled for a new 'joint committee' with representatives from the Council and both CCGs. The joint committee will provide a mechanism for dealing with issues that require both CCGs and the Council to make a decision in a co-ordinated way and which are beyond the delegated powers of individual officers or would benefit from being made in a wider forum. Initial areas to be included in the work programme for the Joint Committee are the Healthy Child Programme and CAMHS Transformation Plan, Transforming Care Programme and Better Care Fund.

The Board also recognises that it needs to work more closely with the Safeguarding Boards, Safer Stronger Partnership and Children's Partnership as each of these bodies leads on critical aspects of health and wellbeing in Kirklees.

The Overview and Scrutiny function in the Council have been actively engaged in the development of the Plan from the outset. Kirklees Council is also collaborating with the other West Yorkshire Authorities on a joint-scrutiny for the West Yorkshire and Harrogate STP.

As we move to implementation of this plan, we will strengthen our integrated performance monitoring processes to support its delivery of the work streams within it.

Figure 4



Approach to Quality

Aims of the quality teams:

Quality is what matters most to people who use services and what motivates and unites everyone working in health and care. But quality challenges remain, alongside new pressures on staff, performance and finances. Therefore the quality teams will always be the voice to scrutinise and challenge all decisions made to reduce the quality impact on patient care.

The Quality teams across North Kirklees and Greater Huddersfield CCG's are working in a streamlined collaborative integrated way to deliver the overarching aims of the STP at local level. We will strengthen, triangulate and support robust assurance processes to ensure our patients are consistently receiving a high quality standard of care which is patient centred, effective and equitable across Kirklees. Furthermore where required we will respond, effectively and timely to safeguard our patients.

The Quality teams will work in partnership with the council and our providers and organisations to facilitate, support and develop quality improvement initiatives. We aim to identify where variation exists in our health provision and use quality improvement methodology and innovative practice in collaboration with the Improvement Academy and our partners to support and work collaboratively to reduce the gap and address variance whilst enhancing quality of care to benefit our population.

How this will be delivered:

The Quality teams will use the 'Seven Steps' set out in 'Shared commitment to quality' (National Quality Board 2016) as our framework for quality assurance and improvement work. This outlines what we need to do together to maintain and improve the quality of care that people experience.

Shared Portfolios and working together in a more integrated way across CCGs and with the council will support and assist in delivery of these aims.

Figure 5

1. **Setting clear direction and priorities** based on evidence.
2. **Bringing clarity to quality,** setting standards for what high-quality care looks like across all health and care settings.
3. **Measuring and publishing quality,** harnessing information to improve care quality through performance and quality reporting systems.
4. **Recognising and rewarding quality.**
5. **Maintaining and safeguarding quality.**
6. **Building capability,** by improving leadership, management, professional and institutional culture, skills and behaviours to assure quality and sustain improvement.
7. **Staying ahead,** by developing research, innovation and planning to provide progressive, high-quality care.

Approach to Quality

Our approach to Quality in Kirklees ensures that patients and quality care is at the heart of commissioning and provision of care now and in the future. The diagram below demonstrates how the work we are undertaking as part of the system wide quality agenda supports us in closing the three gaps described in the Five Year Forward View.

Patient Safety

Care and Quality Gap:

- Further development of assurance mechanisms: monitoring and triangulation of data to ensure that robust processes are embedded to enable equality across all providers and potential to extend across our AQP providers.
- Supporting and developing new models for workforce to transform our career pathways in providers to create a sustainable and effective workforce.

Finance and Efficiency Gap:

- Supporting providers to deliver safe effective care, e.g. transfers of care from acute to community and transformation of services.

Patient Experience

Care and Quality Gap:

- Review and triangulation of patient experience intelligence alongside quality dashboards and performance data. This will be embedded into our assurance frameworks and governance structures to ensure this intelligence is acted upon effectively and efficiently.

Finance and Efficiency gap:

- Supporting pathway development to meet our patients and carers needs and expectations whilst ensuring this is cost effective and clinically effective.

Clinical Effectiveness

Care and Quality Gap:

- Leading the developing our non medical primary care workforce to have the right skills at the right time to see the right patients to ensure quality of care is optimised with an enhanced patient experience.
- Reviewing of best practice guidance supporting our providers to ensure they are providing a high standard of quality care for all.
- Supporting the cultural development of robust incident reporting and learning systems from incidents to effectively and efficiently learn across Kirklees to benefit our patients.

Finance and Efficiency Gap:

- QIA & QIPP support (to safeguard and scrutinise quality of services)

Health and Wellbeing Gap

- Supporting new quality initiatives e.g. discharge letters
- Falls, Frailty models, Fragility work to improve the health of our population.
- Support in delivering new service models for primary care to transform our ways of working.
- Strengthening mortality review processes and the emerging safeguarding priorities 'Prevent', modern slavery and trafficking and support to Children's Social Care on their improvement journey.

Alignment with the West Yorkshire and Harrogate STP

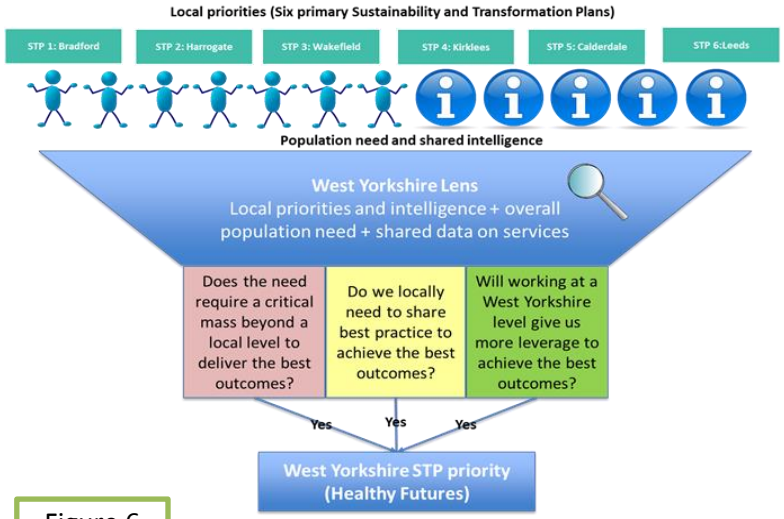


Figure 6

The mandate to develop Sustainability and Transformation Plans (STPs) was announced by NHS England as part of the *2016/17 National Joint Planning Guidelines*. Organisations (Provider, Commissioner and Local Authorities) were tasked through this mandate to collaborate over an agreed geography (footprint) and develop plans which would address local challenges across the three gaps in the NHS England, *Five Year Forward View*. A total of 44 STP footprints were agreed nationally, our local footprint being West Yorkshire and Harrogate. The Healthy Futures Programme was established to develop the STP and progress the underpinning work streams which will be developed to deliver the plan. The agreed work streams across the West Yorkshire and Harrogate STP and the rationale for taking a regional view on these areas are described in figure 6.

Our local Acute Trusts are also using these principles to collaborate as providers across West Yorkshire through the West Yorkshire Association of Acute Trusts (WYAAT) and are in the process of developing a Joint Committee in Common.

To support the delivery of the West Yorkshire and Harrogate STP a joint committee has been formed . It is intended that this committee will have delegated functions to make decisions. An operating model to implement the programmes within the STP is also currently in development. This model proposes that each programme has representation from each local plan to ensure alignment and that local priorities are reflected.

The West Yorkshire and Harrogate STP is unique in that a large proportion of the transformation which will achieve the set ambitions will be delivered at a local level. Local organisations have come together across Health and Wellbeing Board footprints to develop plans which outline the transformation priorities for doing this. The Kirklees Health and Wellbeing Plan fulfils this role.

Progress to Date and Building on this in the Future

The Kirklees Health and Wellbeing Plan builds and expands upon work existing work undertaken across the Kirklees health and social care economy, taking a more collaborative systems approach with partners going forward to ensure we are maximising opportunities to improve patient outcomes and deliver economies of scale. The diagram below illustrates the work we have already undertaken and how we will build on this through implementation of this plan and its supporting plans/strategies to achieve our vision for people in Kirklees.

Exploring/identifying opportunities across the health and care system for collaborative working between providers and commissioners. Using pooled budget principles to facilitate change. Test new ways of working in a number of areas and new models of care will emerge from this.

Review of the function and role of the CCG in response to the above to ensure we support new models of care and maximise the benefits for local people. Achieving the best outcomes for patients and their carers will be at the heart of this work.

Development of a future model for urgent care services focused at Dewsbury District Hospital, supported by the frailty model and delivery of extended access in GP Practices

Through the implementation of the Kirklees End of Life Care Strategy delivery of a joined up approach to palliative and end of life care services. Supported by a collaborative and coordinated commissioning model.

Integrated approach to delivery of community services across Kirklees through full implementation of the Care Closer to Home contract. Integrated Health and Social Care Teams.

Development of a new model of care for primary care which promotes collaboration and working at scale

Development of an integrated approach/model for frail elderly people delivered though provider collaboration

New approach to promotion of health and wellbeing, early intervention and prevention (EIP Model) and development of an adult wellness model for Kirklees

Kirklees Vision for Social Care agreed. Commitment to single approach to supporting the independent care sector.

Public consultation around changes to acute services at CHFT undertaken. Decision regarding next steps taken in 2017/18.

Commissioning of an integrated model for children's services (0-19 years) through the Healthy Child Programme

Development of CCG Primary Care Strategies and GP Forward View Transformation Plans.

Commissioning of an integrated model for community services (adults and children) through Care Closer to Home

CCG resources are being targeted at supporting practices to collaborate and be stronger together through federations

Joint Chief Officer post piloted across NKCCG and Kirklees Council. A similar arrangement piloted across the acute interface in North Kirklees.

Partners across the MYHT health economy mobilising the final year of the planned changes to acute services. Demand management initiatives identified.

How we have already involved local people?

We have already involved local people through a range of engagement and consultation activities. The insight and intelligence from all the activities listed below is already contributing to the development of the local vision and underpinning work streams detailed within this plan. An outline of engagement and consultation activities undertaken and any planned activity is provided in the table below.

Programme	Engagement and Consultation To date	Planned Engagement and Consultation
Early Intervention and Prevention	• Call to Action Engagement September 2013 • 4 week Council led engagement regarding EIP Programme July to August 2016 all stakeholders both internal and external stakeholders • 8 week council led statutory consultation on EIP Programme including Children Centres September to November 2016 both internal and external stakeholders	• Stakeholder engagement regarding the implementation of communities plus and targeted element of the agreed early help model planned in for 2017. • Regular updates/newsletters to be produced giving updates to the public on changes to services as they start to happen.
Healthy Child Programme	• ASC services , 2014 • Kirklees CAMHS Transformation Plan, 2016 • Consultation undertaken with providers workforce , parents, children and young people, schools, GP's and across a number of stakeholder and governance groups - 2016	• July/ August 2016 Consultation undertaken with providers workforce , parents, children and young people, schools, GP's and across a number of stakeholder and governance groups
Wellness model	• Stakeholder event - 10th February 2017 • Commissioned research company currently undergoing insight work with public.	• Future engagement activity throughout 2017still being planned
Primary, social and community services	• Care Closer to Home 2014/15 • GHCCG Co-Commissioning 2015 • Primary Care Strategies 2015/16 • Healthwatch Kirklees engagement regarding access to GP appointments, 2014.	• NKCCG Co-Commissioning 2017 • GHCCG 'Extended Access'
Acute Transformation	• Meeting the Challenge Public Consultation 2013/14. • Right Care, Right Time, Right Place Public Consultation from March 2016 to June 2016 and Pre Consultation in 2014/15. • Calderdale and Huddersfield Health and Social Care Strategic Review, 2012/13 • NKCCG School House Practice Walk-in-Centre 2013/14	• On-going discussion with the public as changes agreed through Meeting the Challenge are implemented. • Travel and transport group – Right Care, Right Time, Right Place

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We have already involved local people through a range of engagement and consultation activities. The insight and intelligence from all the activities listed below is already contributing to the development of the local vision and underpinning work streams detailed within this plan. An outline of engagement and consultation activities undertaken and any planned activity is provided in the table below.

Programme	Engagement and Consultation To date	Planned Engagement and Consultation
Mental Health	• SWYPFT re Crisis intervention. • CAMHS • SWYPFT re Transforming Care 2013, 2014 and 2015. • Learning Disability services as part of LDTCP	• Rehabilitation and Recovery services • Older people services • Kirklees Mental Health Strategy
Standardisation of Commissioning Policies	• Engagement conversations September- 2016 • NK/GHCCG and Healthwatch Smoking and BMI Engagement, 2016 • Talk Health Campaign – prescribing, IFR, prescription ordering 2016	Future engagement will be undertaken where necessary.
New Models of Care	• Engagement with CCG Governing Bodies regarding the form and function of CCGs in the future throughout 2016/17. • Development of the End of Life Care Strategy 2016/17	• Development of a model for frailty • Development of the End of Life Care offer

Early Intervention and Prevention including the Development of a Thriving Voluntary and Community Sector

Aim of Work Stream:

We will work with individuals and communities across the health and social care system so that people have the lives they want with support from formal services only when they need it to keep them well.

Our aim is to enable people with information and skills to prevent ill health whilst tackling the wider determinants of health, ensuring our communities are able to reside and work in the best environment possible. This includes ensuring the right support is available at the right time whilst making the best use of resources and preventing people deteriorating to need unnecessary more intensive care and support in the future. Delivery of this work stream will be supported by joint working across the system to improve people's quality of life and reduce inequalities within our population.

This work will build on the work undertaken through the Early Intervention & Prevention Programme. The programme is based on a tiered approach to support which is driven by need. Supporting the voluntary and community sector to thrive is also integral to the success of this work.

How will this be Delivered:

- Develop better understanding of impact of early intervention and prevention spend on other parts of the system using tools such as Care Trak
- Review of local the alcohol prevention strategy to ensure alignment with West Yorkshire and Harrogate STP planning assumptions.
- Implementation of national diabetes prevention programme across Kirklees .
- Review of contracting and procurement processes to ensure opportunities to work with the voluntary sector are maximised.
- Develop a strategic approach to improving mental health and wellbeing, preventing mental ill health and embedding a community based recovery model.
- Additional investment in IAPT services pending approval of application to NHS England. Undertake a targeted piece of work to improve access to IAPT services for BME population groups.
- Implement health screening for people with severe and enduring mental health needs to improve mortality.
- Suicide prevention work programme, and work to reduce inequalities in men's access to health care and health outcomes
- Implement planned changes to early help offer for children, young people and families
- Supporting carers to understand the condition of the person they are caring for and recognise signs of deterioration. Proactive approach to managing long term conditions.
- Supporting carers in the own health and wellbeing through the Carers Charter**.**
- Integrating dementia risk reduction prevention programmes for example cardiovascular disease, type 2 diabetes, stroke and chronic obstructive pulmonary disease.
- Development of a specialist perinatal community mental health service across the mental health provider footprint.
- Work to improve prevention and early detection of cancer including initiatives to improve cancer screening uptake. Includes links to regional initiatives through the West Yorkshire and Harrogate STP to increase diagnostic capacity across West Yorkshire.

Early Intervention and Prevention including the Development of a Thriving Voluntary and Community Sector

How will we know this work stream has been successful?

- Shift in our focus and resources to address the causes rather than the symptoms – aimed at each part of the child, adult, family journey
- We will make service savings, but will reinvest in early intervention and prevention to reduce or delay the need for costly crisis support or health and social care services. This is part of the longer term sustainability plan for Kirklees.
- Significant increase in the number of people with common mental health conditions who have access to early help.
- Improved access to IAPT services for BME Communities. Reducing inequalities across different population groups.
- Improved mortality rates for people with severe and enduring mental health needs
- Reducing social isolation for both carers and people living with dementia and other physical and mental health conditions.
- Reduction of people at high risk of developing diabetes by 2020 and increase in the number of people referred to Healthy Living Services.
- Improvements in cancer screening uptake across Kirklees to support early detection of cancer. Increase in the number of cancers diagnosed at stages 1 and 2. Reduction in cancers diagnoses as a consequence of an emergency admission.
- Delivery of the new cancer standard to give patients a definitive diagnosis within 28 days by 2020.
- Reduction in risk factors which contribute to vascular dementia

Improving Services for Children

Aims of this Work Stream:

Number of strands to this work stream:

Improvements to Maternity Services 'Better Births'
'Better Births' is a national initiative which aims to improve safety and quality of maternity care over the next 5 years. Work has already begun to implement the aims within the national initiative at a local level. It has already been identified that to ensure economies of scale some elements will require work at a regional level. Implementation will require input from providers, commissioners and NHS England.

Kirklees Integrated Healthy Child Programme (KIHCP)
This programme covers the whole spectrum of services and programmes for children and young people's health and wellbeing, from health improvement and prevention work, to support and interventions for children and young people who have existing or emerging health problems. There will be a particular emphasis on improving mental and emotional health and wellbeing and the transitions between stages of development.

The KIHCP will:
- Improve health and wellbeing of children, young people and families
- Mediate between families and different services, sectors and systems
- Facilitate and enable access to a supportive environment, information, life skills and opportunities for making healthy choices
- Deliver child and family-centred, integrated interventions appropriate to the needs of children, young people and their families
- Share skills and expertise between and across the whole workforce.

Children's Services Improvement Plan
Aims to transform the way we improve the lives of our most vulnerable children including children in need of help and protection, looked after children and care leavers, and children with Special Educational Needs and Disability. The Plan focusses on four areas:
- Workforce - Recruitment and retention of a stable workforce to sustain and accelerate improvement;
- Sufficiency and quality of placements for Looked after Children;
- Review of the Multi Agency Safeguarding Hub and Front Door to facilitate a swifter and earlier response to need;
- embedding a performance culture across the service to demonstrate and articulate impact.

Improving Services for Children

How will this be Delivered:

- Discussions regarding the geography over which regional elements of the 'Better Births' recommendations will be implemented to conclude by April 2017. Leadership and governance to be confirmed. Regional vision and implementation plan to be developed by the end of October 2017.
- Development and implementation of an action plan at a local level to ensure compliance with the recommendations of 'Better Births'. This work will build on the work already undertaken in advance of the 'Better Births' recommendations being published. Through Meeting the Challenge, MYHT have already developed a Midwife led Unit at Dewsbury District Hospital, which offers greater choice for women.
- Implementation of the KIHCP
- Coordinated approach to the commissioning of CAMHS aiming towards a tierless service in Kirklees which focusses on investment in low level preventative services to provide support earlier in the pathway and reduce the number of children requiring a more specialist intervention. Includes extension of psychiatric liaison services to all ages. Links to work across West Yorkshire and Harrogate relating to Tier 4 services.
- Development of a sustainability plan for looked after children.
- Review of the current Children's Improvement Plan being in light of OFSTED recommendations made in December 2016
- Whole systems review of children's pathways to deliver better quality outcomes for children and their families. Initial focus will be on respiratory conditions and IV administration.
- Development of a local plan to support the transfer of funding for diabetes insulin pumps and continuous glucose monitoring from NHS England to CCG responsibility.
- Work to improve pre-conceptual care in Kirklees with a specific focus on reducing the number of women smoking at delivery.
- Development of a strategy for Autism (and other behavioural conditions) including diagnostic services, education and support

How will we know this work stream has been successful?

- Healthier and more resilient children who have greater lifetime potential and exert a positive influence on inequalities as they are more skilled, more active and have the skills to flourish in communities and the economy.
- Healthy children become healthy adults and exert less pressure on health and social care systems. They are also more economically productive.
- Reduction in out of area placements for CAMHS services.
- Reduction in the number of children who require specialist intervention through more proactive and preventative services.
- Reduction in the number of women smoking at delivery
- Further improvements to infant mortality rate

Development of an Adult Wellness Model in Kirklees

Aims of this Work Stream:
Integration of Health Improvement services to enable a more focused approach to behaviour change across the health and social care system, including the third sector. The development of an integrated wellness model will offer referral from primary and social care alongside self-referral and an approach rooted in community empowerment. Partnership will be central and work on emotional health and wellbeing, smoking, healthy weight, physical activity, alcohol, diabetes will be delivered in a seamless, co-ordinated manner via health coaching and a focus on wider influences on health such as housing, income and social capital. Health checks will be used to identify people at risk of conditions such as type II diabetes and healthy ageing will be central to the model. Services such as Health Trainers, PALS, IAPT and the diabetes prevention programme will be more closely aligned and will target people at risk of long term conditions as well as enabling better management of those conditions. The model will also promote personal resilience and self-care and population segmentation using risk stratification tools will enable better targeting of limited resources.

How will this be Delivered:
- Adult Wellness Model to be in place by Spring 2018.
- Development of an integrated system wide self-care strategy to transform our approach to self-care and promote independence and personal responsibility
- More effective commissioning of smoking cessation services to include health optimisation and health coaching through the wellness model. Focus on vulnerable populations where smoking rates remain high.
- More effective commissioning of weight management services and promotion of physical activity, exercise and healthy eating through PALS and Health Trainers. Links to West Yorkshire and Harrogate STP prevention at Scale work.

Development of an Adult Wellness Model in Kirklees

How will we know this work stream has been successful?

- People will live longer and in better health. Conditions like type II diabetes will be averted as more people are physically active and better at managing their own health.
- Realisation of efficiency savings through integration.
- Reduction or delay the need for costly crisis support or health and social care services, for example around type II diabetes, mental health, obesity and dementia.
- Health inequalities will be minimised by promoting better mental health and physical activity.
- Reduce obesity levels and increase physical activity levels in Kirklees
- Reduction in smoking rates by 2020/21. Our CIIK Survey indicates we are on track to reduce smoking rates across Kirklees in line with the West Yorkshire and Harrogate STP ambition.
- Reduction in inequalities in smoking rates across Kirklees.

Improving the Capacity and Quality of Primary Care

Aims of Work Stream:

Both CCGs have developed strategies which outline plans for future proofing General Practice and ensuring sustainable provision of Primary Care Services for people in Kirklees. These strategies have been revised in response to the GP Forward View and transformation plans have been developed which outline how the objectives within the GP Forward View will be delivered through implementation of the respective strategies.

Whilst there are two documents which respond to the differing population challenges and organisational challenges in North and South Kirklees, the essence of the documents in terms of what they are trying to achieve is consistent.

Our Strategies aim to:

- Enable patients to be able to make appropriate choices and responsible decisions about their health and wellbeing
- Provide easily accessible primary care services for all patients
- Ensure consistent, high quality, effective, safe, resilient care delivered to all patients
- Develop a strong, innovative and resilient multidisciplinary workforce in primary care
- Improve use of modern technology
- Provide education and training opportunities that cultivate professional excellence and high motivation
- Improve premises and infrastructure which increases capacity for clinical services out of hospital and improve 7 day access to effective care
- Provide effective contracting models which are fairly and properly funded to deliver integration and positive health outcomes
- Develop a culture which promotes openness, transparency and the ability to make mistakes in a supportive and learning environment
- Ensure General Practice are at the heart of the health and social care system working collectively with partners and the wider community
- Encourage collaboration with partners

Our CCG primary care strategies can be accessed via the link below:

https://www.northkirkleesccg.nhs.uk/wp-content/uploads/2016/01/Primary-Care-Strategy-2016-2021-vFINAL-220116.pdf

https://www.greaterhuddersfieldccg.nhs.uk/wp-content/uploads/2016/08/GHCCG-Primary-Care-Strategy-final-v1.0.pdf

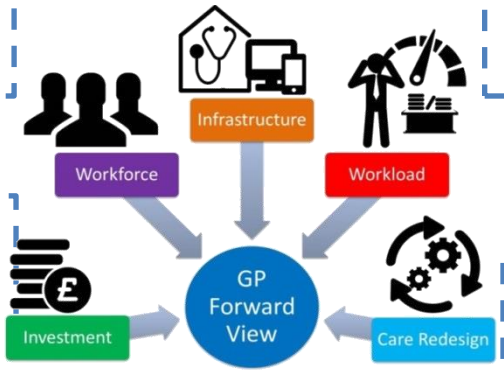
Improving the Capacity and Quality of Primary Care

How will this be Delivered:

- New models of care
- Review of skill mix and introduction of new roles (Care Navigators, Clinical Pharmacists, Mental Health Workers)
- Increase number of training practices
- Initiatives to encourage recruitment and retention including use of overseas workers.
- Look at more diverse working arrangements across different sectors to encourage recruitment and retention

- Better use of technology
- Estates strategy to support new ways of working

- Participate in the productive general practice programme
- Local implementation of 10 High Impact Changes within the GPFV
- New models of care
- Social Prescribing (All Together Better) and links to self-care interventions
- Streaming of patients to the right place – care navigators
- Education of the public on appropriate use of services
- Supporting GPs in recognising and meeting the needs of carers as an approach to indirectly reducing workload.



- Investment in strategies to deliver increased access through new models of care and more collaborative working
- Investment in technology and estates /infrastructure to support the above
- Investment in workforce initiatives to deliver future sustainability. Including introduction/piloting of new roles
- Equalisation of funding so everyone is on a level playing field.
- Move towards fully delegated status for co-commissioning by April 2017 (NKCCG).

- Work towards new models of care. (Collaboration of providers and hub and spoke approach/central resource centre)
- Different approach to streaming of patients.
- Development of federations
- Strategies to deliver increased access using the above
- Use of technology
- Development of leaders in primary care

Improving the Capacity and Quality of Primary Care

How will we know this work stream has been successful?

- Patients will have access to weekend/evening routine GP appointments. Improvements in access will release efficiencies elsewhere in the system. We are developing our model of improving access and this will be considered as part of this work.
- More support in primary care to navigate patients to the most appropriate clinician for their needs, first time.
- Improvements in GP Survey results relating to access
- More sustainable primary care workforce through a review in skill mix and introduction of new roles to manage demand differently
- Reduction in unnecessary hospital admissions from GP Practices
- Reduction in the variability of long term condition management through peer support and challenge and the introduction of protocol driven referral management systems. Improve standards of quality of care received across Kirklees. Reduce number of referrals into Secondary Care Services.
- Improvements in dementia diagnostic rates and the number of dementia annual care plan reviews that are carried out. Currently at the national average of 68.3%, however by March 2017 we are aiming to reach 71%.

Making social care provision more sustainable and more effective, including the development of vibrant and diverse independent sector

Aims of Work Stream:

The Council has recently adopted a new Vision for Adult Social Care and Support in Kirklees. This vision focusses on promoting independence and delaying the need for care, recognising and supporting carers as the bedrock of social care and support, promoting quality, choice and control, and developing partnerships and collaboration. This will deliver a shift from formally assessed services towards targeted non-assessed services, community based services and informal support.

The independent care sector provides the majority of social care in Kirklees, but the social care market locally and nationally face significant financial, quality and workforce challenges.

We want to make sure that:

- There is a wider range of different, affordable services on offer to meet everyone's needs – including more proactive and tailored advice and guidance at key decision points in people's lives;
- All services help people keep well and independent for as long as possible – and encourage people to take action to maintain their independence; services are of an excellent quality and offer value for money; services work in partnership with people who need support (co-productively), meeting people's needs and aspirations and treating people with dignity and respect; services can attract, recruit, develop and retain a high performing and high quality workforce;
- We encourage innovation and creativity – supporting the development of organisations that offer genuine alternatives to traditional social care;
- When we do contract for services, we look at the overall value they can offer including value for money, social value to local people and communities and environmental value.

How will this be Delivered:

- Review of pathways to make them more integrated and streamlined
- Procurement of new domiciliary care providers
- Development of tailored advice and guidance and a wider range of care and support options including extra care housing
- Develop a 'wellness model' for older people to enable them to retain their independence, including a step change in the use of technology
- Ensure appropriate links are made to work being undertaken across Kirklees relating to making improvements in dementia care.
- Ensure appropriate links are made with the Kirklees Council Housing Strategy

Making social care provision more sustainable and more effective, including the development of vibrant and diverse independent sector

How will we know this work stream has been successful?

- Improved independence and quality of life for vulnerable adult and their carers, and an increased sense of control independence
- Improved choice of good quality support options that reflect individual needs
- Reduce demand on specialist and acute services
- Services have the right capacity to meet demand in an effective way

Change the configuration of acute services to improve quality and create efficiencies through the implementation of Right Care, Right Time, Right Place, Meeting the Challenge and Healthy Futures plans

Aims of this Work Stream:

We are engaged in the reconfiguration of hospital services at both Acute Trusts within the Kirklees footprint which has been initiated due to the challenges which are described earlier in this document. The focus of these programmes is to:

- Ensure people are cared for in the most appropriate setting by the most appropriate clinical team for their need, first time.
- Make improvements for patients keep them safe and improve the quality of care they receive.
- Optimise the use of resources to ensure services can meet growing demands
- Respond to the workforce crisis within our hospitals
- Create efficiencies and ensure sustainability by reducing duplication

Achievement of the above is reliant on a whole system approach which engages community services, primary care and the voluntary and community sector. The commissioning and staged implementation of our integrated model for community services, 'Care Closer to Home', the strengthening of primary care services through implementation of the GP Forward view and the measures being taken to ensure sustainability of social care provision are key elements of our strategy to improve out of hospital care and support the ambitions within our hospital reconfigurations.

As these programmes develop and evolve, further work will be undertaken to assess the interdependencies and potential impact on the Kirklees population. The impact of the West Yorkshire Urgent and Emergency Care Vanguard which is being delivered as part of the Healthy Futures Programme, the wider work being progressed under the umbrella of the West Yorkshire and Harrogate STP relating to regional provision of services and the work delivered through the West Yorkshire Association of Acute Trusts (WYAAT) by will also be taken into consideration.

NHS Meeting the challenge

RIGHT CARE
RIGHT TIME
RIGHT PLACE

Change the configuration of acute services to improve quality and create efficiencies through the implementation of Right Care, Right Place, Right Time, Meeting the Challenge and Healthy Futures plans

How will this be Delivered:

Meeting the Challenge

Mid Yorkshire Hospital Trust (MYHT), through the implementation of the 'Striving for Excellence' Strategy aims to provide high quality healthcare services. Working closely with the wider health and social care economy, the vision is to achieve excellent patient experience each and every time. MYHT is continuing to progress the Acute Hospital Reconfiguration as part of the Meeting the Challenge (MTC) programme. The Reconfiguration is rooted in the need to provide services differently across the Trust's three sites to ensure quality and safety are maintained. The programme entered a critical phase of implementation in 2016/17 which continues into 2017/18. The key system changes which underpin this are:

- The re-profiling of A&E services provided from the three hospital sites;
- An integrated approach between acute, primary care and community services which supports patient flow and early supported discharge;
- Delivering services 7 days per week;
- Centralising some services to improve quality and safety such as acute medicine to Pinderfields hospital; and
- Greater reliance on delivery of urgent services outside of hospital and providing elective services, outpatient, day case and inpatient surgery, at the closest hospital to where a patient lives.

We have an agreed framework for transformation of planned care built upon effective clinical threshold management and robust pathways of care as a key theme of the Five Year Forward View and an essential enabler of the Meeting the Challenge reconfiguration of hospitals. We will continue to accelerate the work and already underway with a clinical leader's forum of primary and secondary care clinicians to transform planned care across the Mid Yorkshire footprint working through the new Joint Planned Care Improvement Group. In partnership there will be a focus on:

- Managing growth for non-urgent, non-cancer referrals from primary care
- Understanding and tackling any unexplained variation in non-urgent, non-cancer referrals from primary care;
- Promoting the use of e-consultation to minimise the need for primary care referrals for face-to-face outpatient appointments;
- Supporting secondary care clinicians to initiate e-consultations with primary care, as an appropriate alternative to an outpatient referral;
- Re-looking at services which require provision in a hospital environment and those that do not;
- The potential to minimise hospital face-to-face outpatient follow-ups by primary and secondary care clinicians adopting shared-care protocols and revised care pathways.
- Utilisation of right care data to develop a collaborative approach to demand management
- Active participation in conversations relating to a regional approach to the delivery of services, where deemed clinically appropriate. Initial discussions are focusing on Stroke and Vascular pathways.

Change the configuration of acute services to improve quality and create efficiencies through the implementation of Right Care, Right Place, Right Time, Meeting the Challenge and Healthy Futures plans

How will this be Delivered:

Right Care, Right Place, Right Time

NHS Greater Huddersfield and NHS Calderdale Clinical Commissioning Groups (CCGs) have undertaken a consultation exercise about some far reaching proposed changes to hospital services and further proposed changes to community health services. Our proposed changes would help us to address some big challenges.

We have consulted on:

Emergency and acute care; Urgent care; Maternity; Paediatrics; Planned care; and Community Health Services.

The Governing Bodies met in parallel and in public to consider if the findings from the Right Care, Right Time, Right Place consultation and subsequent deliberation provided sufficient grounds to proceed to the next stage.

Each CCG agreed to proceed to explore implementation in the Full Business Case, in line with the proposals within the consultation. The Full Business Case will be considered by key stakeholders prior to implementation.

Change the configuration of acute services to improve quality and create efficiencies through the implementation of Right Care, Right Place, Right Time, Meeting the Challenge and Healthy Futures plans

How will we know this work stream has been successful?

- People receive the right advice and support to enable self-care, to provide highly responsive primary and community services to reduce reliance on A&E departments and to ensure a safe and effective integrated network of hospital urgent care services so that people with the most acute and complex conditions have the best chance of recovery
- Achievement of the national constitution measures for A&E, RTT and Cancer at MYHT.
- Reduction in avoidable admissions at both acute trusts
- Reduction in excess bed days
- Reduction in elective activity
- Reduction in unnecessary follow up appointments at MYHT
- Roll out of 7 day services in hospital to 100% of the population across the 4 initial priority clinical standards.
- Increase in diagnostic capacity working in collaboration with the West Yorkshire and Harrogate STP
- Increase in one year survival rates for bowel cancer
- Reduction in avoidable deaths in hospital

New Approach/Model to support people with Continuing Healthcare Needs

Aims of this Work Stream:
To ensure that we have commissioned sufficient placements and care packages to meet needs of our local population who meet the eligibility criteria for Continuing Healthcare. Our ambition is to provide care in local settings to reduce the number of out of area placements and associated risks and costs associated with this.

How will this be Delivered:

- Scoping and development of a dementia service with nursing elements.
- Development of a local physical disability service including long term care and respite.
- Development of the provision of Fast Track domically services for care packages and care management.
- Joint working with Kirklees Council to ensure clarity on projected needs of the Learning Disability population in regard to day care and respite to support commissioning arrangements.
- Review the delivery of residential care for Learning Disabilities
- Commissioning of services to meet local need for specialised physical disability, older peoples mental health residential and supported living.
- Complex care Strategic Panel will plan for future needs through transition from ages 14 to 25 years
- Continue to ensure that assessments for Continuing Healthcare funding take place in a community setting in line with the mandate set in the NHS England Five Year Forward View Next Steps.

How will we know this work stream has been successful?

- Reduction in out of area placements
- 85% of all assessments for Continuing Healthcare funding to take place in a community setting

Implementation of the Transforming Care Programme for people with Learning Disabilities

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

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

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

The key aims for our plan will be:

- ✓ Reduction of in-patient beds, delivering an almost 60% reduction across the partnership by 2019 taken from baseline data in December 2015
- ✓ Developing better/new/broader range of specialist community services that are flexible and responsive to manage crisis better and prevent admission
- ✓ Developing capable communities to enable people to live in their own homes
- ✓ Developing a better understanding of our local populations with complex needs and how best to support them in a crisis
- ✓ Ensure people with a learning disability and/or autism have the opportunity to live meaningful and fulfilled lives

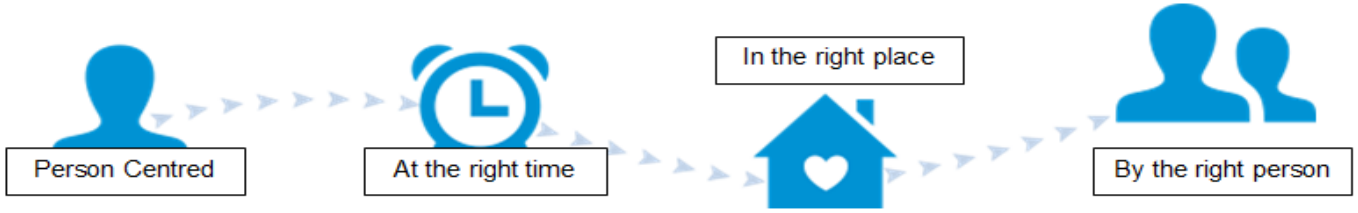
How will we know this Work Stream has been successful?

Our vision is to radically change the parts of the system that are not working well and become an area of best practice to meet the needs of the complex population.

We will invest in a model of care and support that meets the needs of the LD population now and in the future. We will work collaboratively and innovatively to look at the way we commission and deliver future care and services. We will ensure that the change is system wide and encompasses the cultural shift that is required to succeed.

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

Figure 7



Changes to the commissioner/provider landscape, including more collaborative and more integrated approaches to new models of care

Aims of Work Stream:

There is a long and strong history of joint working across the two CCGs in Kirklees and Kirklees Council, and between these organisations and others in the region. This joint working spans a wide range of activity and includes both formal and informal arrangements, including a range of shared senior posts.

The NHS Operational Planning and Contracting Guidance reinforces the national direction of travel towards increased integration of both commissioning and provision, in line with the Five Year Forward View. Our approach in Kirklees will focus primarily on the wider health and well-being agendas, and the commissioning and provision of 'out of hospital ' services where health and social key integration is a key component to success.

Within Kirklees, we have already demonstrated our commitment to commissioning on an integrated basis via our care closer to home programme and a similar approach is reflected in our means of delivering many of our key interventions, for example, the Healthy Child Programme, Transforming Care and Early Intervention and Prevention. These programmes are also giving rise to a change in the way our providers work together, with a shift towards partnership approaches and collaboration.

During this period, we have also seen an ongoing commitment to the development of GP Federations – one in North Kirklees and one in Greater Huddersfield.

The CCGs and the local authority are committed to developing this approach further. We already have a range of senior shared appointments and will look to increase these in the functions where they bring most benefit. We want these joint working arrangements to be supported by joint governance arrangements, possibly a Joint Committee, that will enable us to make the right decision once, reinforcing a commitment to a single Kirklees approach in identified functions. We are not planning wholesale re-organisation – we will ensure that form will follow function, and we will make best use of tools such as pooled budgets.

The geography of Kirklees and our interdependencies with our neighbours means that each of our two CCGs will continue to work closely with its neighbours in Calderdale and Wakefield on matters where the acute footprint takes precedence. In addition, each CCG will be a member of the West Yorkshire Joint Committee to ensure consistent decision making on the areas of work we have agreed to manage on a West Yorkshire basis.

We recognise that introducing new models of care is unlikely to be a 'one size fits all' approach across Kirklees, and therefore will explore new ways of working though initiatives such as the "Batley and Spen" pilot and specific schemes (e.g. frailty model) to learn what works in building these new models.

Changes to the commissioner/provider landscape, including more collaborative and more integrated approaches to new models of care

How will this be Delivered:

The two CCGs and the Council will develop an implementation plan for the areas of priority set out in this Health & Well Being Plan, with defined milestones and measures being established for each programme.

To ensure we do not lose sight of the needs of local people in our complex commissioner/provider environment, a set of principles to support system change will be developed. These principles will be used as a tool to support decision making and the development of new models of care.

There are a wide range of areas where we have made significant progress, and we want to develop further, for example:

- Maximising the potential of the Better Care Fund
- Build on the success of the Kirklees Integrated Community Equipment Service and extend the arrangements to include assistive technology, home adaptations and other equipment
- Implementation of the Healthy Child Programme and the CAMHS Transformation Plan
- Implementation of our integrated approach to improving quality in care homes & the Care Home Strategy
- Further development of our integrated approach to intelligence and shared care record

Over 2017 and 2018 we will establish fully integrated commissioning arrangements for:

- People with continuing care needs
- Frail older people
- Vulnerable children and families
- Adults with health limiting behaviours or at risk of developing health/independence issues
- Adults receiving specialist Learning Disability services or at risk
- People approaching end of life
- Older people with social care needs living in their own home or specialist accommodation
- Adults receiving specialist mental health services or at risk

Changes to the commissioner/provider landscape, including more collaborative and more integrated approaches to new models of care

Case Study Example: New Model of Care for Children and Vulnerable Families (Batley and Spen Pilot)

- We have recently been successful with a bid to the national One Public Estate programme to develop a pilot in Batley – the aim is to identify opportunities to bring together adult social care, Locala, CCG, Children's Centre, Police and local VCS. The pilot will provide a 'proof of concept' for delivering the value of the OPE – especially more integrated and customer focused services.
- Once the pilot is up and running to extend the approach across other hubs including Dewsbury

Changes to the commissioner/provider landscape, including more collaborative and more integrated approaches to new models of care

Case Study Example: Further Developments to Support Delivery of Integration of Health and Social Care within Community Services through the Care Closer to Home Contract

Care Closer to Home is the vision for the development of integrated community based health, social, primary care and mental health services across Kirklees for children and young people, the frail and older people specifically targeting those vulnerable groups who have identified health needs.

We commissioned an integrated community service model in October 2015. This work was supported by Kirklees Council. The implementation of the integrated service model is phased across the duration of the contract. Our ambition is to continue to expand the scope of services provided within the model and to further integrate health and social care services using the better care fund as a lever.

As part of this 5 year transformation plan of transforming services closer to home we will be working jointly with Locala to reconfigure services to be delivered within the community. This will include:

- Review and improvements to respiratory services focussing on COPD and Asthma. The aim is to improve services to ensure provision is delivered within the patient home unless they clinical require more specialist intervention in another setting.
- Preventing people requiring hospital intervention through pro-active long term condition management supported by robust care planning and multi disciplinary team meetings with relevant healthcare professionals across the health and social care system.
- Increase the throughput of patients being administered antibiotic therapy in their own home working with the OPAT (Outpatient Parenteral Antibiotic Team)
- Continue to improve community in-reach services to ensure patients are supported back to their usual place of residence with the appropriate support as quickly as possible.

Changes to the commissioner/provider landscape, including more collaborative and more integrated approaches to new models of care

Case Study Example: Integrated Frailty Approach Focussing on the Frail Elderly Population

Our ambition is to create a collaborative approach between providers which supports true integration of frailty services in line with the Five Year Forward View, New Models of Care and Fit for Frailty (British Geriatrics Society, 2015).

Our emerging integrated approach to the frail elderly population will:

- Optimise referral to, access and use of prevention programmes
- Implement an early identification process using an electronic frailty index (eFI)
- Implement an evidence-based proactive holistic assessment process for those with an eFI score of > 0.25
- Embed a care planning approach
- Provide a rapid access to services in times of crisis
- Adequately support people assessed as severely frail or palliative
- Deliver an integrated system-wide frailty service

The integrated frailty service is intended to deliver the following functions:

- Work collaboratively with partners to recognise Frailty as a long term condition and ensure a consistent approach across the health and social care system.
- Collaborate with general practice to review and diagnose patients identified as potentially frail (eFI scores > 0.25).
- Provide a community based multi-disciplinary frailty team to carry out a comprehensive and holistic review of medical, functional, psychological and social needs based on comprehensive geriatric assessment principles in partnership with older people who have frailty and their carers.
- Provide a 24 hour reactive crisis response service (clinical and medical) for those patients diagnosed with moderate/severe frailty.
- Provide care home medical provision.
- Provide a Specialist Frailty Assessment Unit on the Dewsbury District Hospital site (part of the Mid Yorkshire NHS Hospital Trust [MYHT] estate) with multi-specialist assessment/short stay treatment.
- Provide a step-up and step-down facility for appropriate patients.
- Work with the ambulance service and secondary care colleagues to ensure assessment starts at the time of 999 call/front door and continues through to discharge to assess.

Changes to the commissioner/provider landscape, including more collaborative and more integrated approaches to new models of care

Case Study Example: New Model for End Of Life Care

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

- People are informed as early as possible about the approach of end of life to enable informed decision making about their preferences.
- End of life care is timely, compassionate and reflects needs and wishes with respect to physical, social, psychological, cultural and spiritual aspects.
- People during end of life phase remain in a place of their preference where possible
- Pain and other symptoms are managed as effectively as possible.
- All children and adults in Kirklees die with dignity and in a place of their preference.
- People and their carers feel supported both during end of life care and after the person has died.
- People and their carers are engaged in the co-production of services and service developments linked to end of life care.

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

- Kirklees integrated End of Life Care Strategy
- Review of choice in End of Life Care
- Service review to scope the possibility of a lead commissioner model
- Quality, innovation, productivity and prevention

The work to develop an Kirklees wide end of life offer has been on-going for some time and our key achievements to date include the development of:

- A central point of access for bereavement services
- An integrated commissioning plan for training and education which looks at specific needs of different professionals, especially in primary care.
- The roll out of an Electronic Palliative Care Co-ordination System (EPaCCS) across Kirklees.

Future work includes the development of:

- A Lead Provider model for end of life services across Kirklees
- A Frailty model which incorporates those who are severely frail and palliative.
- Continued work to reach more people with diseases other than cancer and to reach people from different parts of the community in Kirklees that have not traditionally accessed palliative care services.

Building a sustainable health and social care workforce to implement the high level interventions

Aims of Work Stream:
The implementation of this plan depends on having the sufficient people with the right skills working in the sector. However we know there are significant challenges that cannot be tackled by working inside traditional organisational and professional boundaries. Whilst some issues will need a West Yorkshire or national led response, such as ensuring a supply of medical undergraduates, there are specific areas that we need to tackle as a local health and social care system and others we will need to tackle in collaboration with the Kirklees Economic Strategy.

Our initial focus will be on :

- Developing Kirklees as a great place to work in health and social care , including making the most of our partnership approach to 'growing our own' and retaining people with the skills we value. The role of the University and Colleges will be crucial in this.
- Recruiting & retaining key staff groups, including nurses (especially into care homes), care workers (especially in rural areas), and the quality and retention of social workers.
- We need to make the workforce more representative of the local population and adopt a value based approach to recruitment.
- Developing the 'Kirklees core skills' and building key skills & behaviours including community asset building, strengths based approaches, motivational interviewing, and the capacity to enable people to develop these skills in the right settings e.g. placements outside hospital.
- Developing apprenticeships and critical new roles including care worker 'plus' and nurse associates, personal assistants and 'early help' workers, along with clarifying and simplifying employment pathways to enable people to work across the local health and social care sector (and being more consistent about what we call people to avoid confusion)
- Development of new roles and more innovative approaches to collaboratively managing local workforce challenges, including more of an multidisciplinary approach to care delivery.
- Developing a more co-ordinated approach to rewards for our staff – especially those on the lowest wages and those with key skills
- Reducing agency spend
- Improving the wellbeing of staff

Building a sustainable health and social care workforce to implement the high level interventions

How will this be Delivered:

- Development of a shared view about the local challenges and how these can be overcome.
- Ensure workforce planning processes are in place to support implementation of our local plans, working closely to provide a quality workforce with the right skills in the right place.
- Development of a local plan for making every contact count
- Explore opportunities to take part on national training initiatives led by NHS England.
- Elements of this programme will be delivered by the West Yorkshire STP Workforce Action plan e.g. development of an internal agency for NHS staff and nurse recruitment, others will be delivered as locally in collaboration with WY partners e.g. Health Promoting Trusts.
- Implement Nurse Associates Programme across Kirklees
- Map and understand current workforce roles working within Primary Care, work up proposals for extending and broadening the skill mix to include Clinical Pharmacists, Mental Health Workers, Paramedics, Physio First
- Explore opportunities to work collaboratively to recruit overseas GP's
- Encourage organisations to become accredited in delivering the carers charter. In doing this we will support more carers to remain in employment.
- Explore the development of a pathway so that somebody can develop transferrable skills through caring role which will support them in future employment. Particular focus on young carers

How will we know this work stream has been successful?

- Shift skills and attitudes of staff towards prevention, earlier intervention and promoting resilience and self care
- Making the sector a more attractive place to work will aid recruitment and retention of staff
- Shift to more resilience and self care focussed skills to reduce unnecessary demand on specialist services

Maximising the digital opportunities (building on the Digital Roadmap)

Aims of Work Stream:

To establish a digital environment across the Kirklees health and care economy that adopts a philosophy of;

- Effective digital collaboration
- information sharing
- Joint planning that enables the population to receive the highest possible quality of care.
- Clinicians to have access to technology and appropriate information required to provide appropriate care".
- Establish utilisation of technology which demonstrates improved health and well-being, across the priorities identified in the STP and future priorities.
- Provide digitalisation where appropriate to deliver the right care in the right place at the right time.

By;

- Investing in technology appropriately – ensuring alignment with clinical objectives across the CCG, its partners and service providers.
- Utilising technological to enable improvement in the quality of services, achieve better outcomes for patients by enhanced communications, information and collaboration for people and systems.

How will this be Delivered:

- Full interoperability of healthcare records inclusive of mental health services
- Further expansion of e-prescribing across all services by 2019/20
- Increase use of e-consultation by 2018/19
- Increase sharing of GP clinical record
- Implement Acute Electronic Patent records
- Increase electronic transfers of care across all settings by 2019/20
- Shared Infrastructure utilising the opportunities through the Health and Social Care Network
- WIFI deployment in GP Practices by during 2017/18
- Professionals across care settings to access GP-held information on GP-prescribed medications, patient allergies and adverse reactions by 2019/20
- Professionals across care settings to be made aware of end-of-life preference information through further roll out of EPaCCS by 2019/20
- Increase ability to electronically book appointments in GP Practices from other care settings

Maximising the digital opportunities (building on the Digital Roadmap)

How will we know this work stream has been successful?

- Patients able to view their own records online
- Improvement in electronic health record sharing
- Paper free at the point of care
- Increased usage of E consultation as an alternative to face to face in primary care
- Shared infrastructure
- Digital maturity in primary care

Moving towards a 'One Public Estate' approach

Aims of Work Stream:

Our aim is to develop an integrated plan for the development of the health and care estate – that is driven by the service strategies that flow from it. The impact of digital technology is one of the main drivers of change in the estate requirements – our approach to estates must be developed in close collaboration with our approach to digital technology. The approach will be based on what we need to deliver excellent customer focussed services, not just how to use what we've already got.

The national One Public Estate (OPE) programme has identified the potential benefits of a more integrated approach:

- More integrated and customer focused services
- Creating economic growth
- Reducing running costs
- Generating capital receipts through the release of land and property

This is a new area of work and will need to build links not just across health and social care organisations but also with the Kirklees Economic Strategy and the Local Plan.

How will this be Delivered:

- Bring together single organisations estates plans into a coherent plan for Kirklees
- Map utilisation of current estates usage and their occupancy, aim to increase usage to support out of hospital care.
- Implementation of the One Public Estate pilot in Batley. This will be evaluated and rolled out to other localities if successful.
- Work with all health and care partners and those leading the Economic Strategy and the Local Plan to identify opportunities, and to explore alternative approaches to funding developments
- Clearly articulating the benefits to organisations and local people of shifting the current estate towards a more integrated estate

How will we know this work stream has been successful?

- Maximise the impact of the health and social care estate on economic growth, local employment and healthy environments
- Co-location of services will facilitate integration of front line services
- Reducing the size and cost of the public estate and getting better value out of multi-use sites

Work with the Kirklees Economic Strategy to Maximise Benefits on the Local Economy

Aims of Work Stream:

The JHWS and KES have been developed as complimentary strategies that do different things and cover different ground but are fundamentally connected:

- Confident, healthy, resilient people are more productive, better able to contribute to communities and secure work.
- Good jobs and incomes for all of our communities make a huge contribution to health and wellbeing

Whilst some progress has been made over the last 2 years, as we move to a more 'place based' focus these connections will need to be strengthened

How will this be Delivered:

Council agreed its approach to 'Economic Resilience' as part of the New Council programme in October 2016. This sets out how the Council will work with partners to deliver the outcomes in the Kirklees Economic Strategy

How will we know this work stream has been successful?

- Creating (good) jobs; supporting higher incomes and reducing poverty:
- Promoting healthy, safe, diverse workforces and workplaces;
- Creating a green infrastructure that supports physical activity and emotional wellbeing;
- Ensuring quality housing with high energy efficiency supports affordable warmth, good health and reduces living costs
- Building skills that aid employability and enhancing the pool of confident people able and willing to work;

The Economic Strategy can support health by:

- resilient people powering business success; more productive employees and volunteers working for longer;
- positive perceptions of places and communities support investment
- economic opportunities from growth in the health and social care sectors

Risks/Issues/Key Concerns to Delivery

Theme	Risk/Issue/Concern Description	Mitigating Action
Organisational Form and Integration	Developing a systems approach to care in Kirklees is challenging due to the different rules/mandates organisations are bound by. This applies to all work streams within this plan.	Governance to support integration and development of principles to support system change.
	NHS configuration and reform has led to a high level of variability between organisations.	Agree a standardised approach and where appropriate commission services which are consistent across Kirklees.
	A joint governance structure to deliver this plan will be difficult to implement. Risks in terms of the willingness to delegate control.	All stakeholder organisations have committed through the Kirklees Health and Wellbeing Board to working collaboratively. Overall accountability sits with the Kirklees Health and Wellbeing Board which all stakeholders are represented. Relationships to build a joint governance structure have been in development for a number of years therefore we have a strong platform locally to build upon.
	Risk that the work progressed through the West Yorkshire and Harrogate STP will not move at the pace required locally.	Agreement by the West Yorkshire and Harrogate STP Leadership that local place based change will require implementation from different starting points and that change will be implemented at different paces. Commitment from local place based collaborations that change regardless of pace will be driven by achievement of the overall outcomes described in the West Yorkshire and Harrogate STP Plan.

Risks/Issues/Key Concerns to Delivery

Theme	Risk Description	Mitigating Action
Engagement and Stakeholders	Engagement with stakeholders across the system. Inclusive of patients and citizens Culture and an unwillingness to change may inhibit implementation of this plan. Some changes may be politically sensitive and require consideration through a consultation process, slowing the ability to realise any potential benefits identified.	In line with existing processes stakeholder analysis and communication and engagement plans are developed for all work we undertake. Assessments are made at this stage of the process of any potential barriers to change and plans built with this in mind.
	Unwillingness of individuals to take more responsibility for themselves and their communities, changing hearts and minds will take time.	As part of our benefits realisation process, any benefits identified through initiatives which are supported by individuals taking more responsibility of their own care are considered longer term deliverables. Tools available to support people in fulfilling this responsibility.
Transformation and Implementation	Current operational/financial pressures across all sectors of the system are impacting on our ability to run existing services. It also inhibits the ability to invest in early intervention and prevention measures for a sustainable future and the ability to invest in new models of care which will deliver transformation.	All organisations involved in development and delivery of this plan are committed to future investment in prevention and new models of care as part of short and longer term measures to promote sustainability. Organisational and system level schemes in place to create efficiencies which over time will release funding and capacity to do this.
	Some of the changes described within this plan will require extensive mobilisation and a transformation across all partners. This will take time and the benefits realisation timescales may fall outside of the lifespan of this plan.	This plan is a 'live' and evolving document which will change in scale and pace over time. The Health and Wellbeing Board and contributing organisations recognise the importance of this in creating a sustainable system in the long term.
	Risk in making the care landscape more complicated for the wider system through re-configuration and centralisation of services. Need to consider the system wide impact of changes to ensure we do not destabilise services.	A set of principles have been developed which will be used as a tool when considering system change or developing new models of care. We will consider the system wide impact of changes as part of these principles to ensure we do not destabilise services.

Risks/Issues/Key Concerns to Delivery

Theme	Risk Description	Mitigating Action
Enablers	Workforce pressures inhibit the ability to make change across all care sectors. Whilst plans are being put in place they will take time to implement. This is also compounded by the local recruitment and retention challenges we face regarding Kirklees as an 'attractive' place to work.	Organisational level plans are developed and take into account short term initiatives to manage the risk. Workforce work stream will bring all organisational level plans together and identify priorities at a systems level as part of linger terms sustainability plans. Regional/national workforce initiatives are also being put in place to mitigate the risk.
	IT is not in place to support fully integrated working. Funding is required to make both large scale Digital advances and smaller transformational changes.	Plans to improve information sharing across organisations through the implementation of the Local Digital Roadmap for Kirklees.
	The current levels of funding for publicly funded adult social care results in market instability.	Within the constraints of available budgets for statutorily funded care, we will work with local providers to build their resilience and support them to provide good quality affordable care .

Endorsement of this Plan by Stakeholders

Organisation/Body	Endorsement Route	Date
Health and Wellbeing Board	Committee Meeting	02.03.2017 27.04.2017
North Kirklees CCG	Governing Body Committee Meeting	09.08.2017
Greater Huddersfield CCG	Governing Body Committee Meeting	14.06.2017
Calderdale and Huddersfield Foundation Trust		
Mid Yorkshire Hospitals Trust		
Locala Community Partnerships CIC		
South West Yorkshire Partnership NHS Foundation Trust		

References

- CLiK Survey 2012 and 2016
- Royal College of GPs report into workforce 2015
- NKCCG Workforce Data, Health Education England, September 2016
- RightCare Data Packs
- The Kirklees Adult Carers Survey 2014/15
- Carer's Allowance - All Entitled Cases Caseload (Thousands): Local Authority of Claimant by Region; February 2012. Available from: http://83.244.183.180/100pc/ca_ent/ccla/ccgor/a_carate_r_ccla_c_ccgor_feb12.html)

Get involved

For more information on how you can get involved and have your say in the work CCG will be progressing as part of this plan, please see the web links below:

https://www.northkirkleesccg.nhs.uk/get-involved/

https://www.greaterhuddersfieldccg.nhs.uk/get-involved/have-your-say/

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Kirklees COUNCIL

Name of Meeting: **Health and Adult Social Care Scrutiny Panel**

Date: **12 December 2017**

Title of report: **Better Care Fund (BCF)**

Purpose of Report: This report presents information about the BCF 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**	**1 December 2017 - Richard Parry** **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

1. Summary

1.1 The Better Care Fund (BCF) is a national programme, announced in the 2013 Spending Review, which is intended to transform local health and social care services so that they work together (based on a plan agreed jointly between the local CCG(s) and the Local Authority) to provide improved and joined up care and support.

1.2 The BCF brings together existing resources from the NHS and Local Authorities into a single pooled budget. CCGs are required to contribute minimum amounts which are pooled with the Local Authority Disabled Facilities Grant (capital funding for adaptations to the homes of disabled people). Local Authorities and CCGs can, if they wish, contribute more to the pooled budget than the minimum BCF allocations. See here for more information about the BCF.

1.3 The full Kirklees BCF Plan 2017/2019 received formal approval through the national assurance process in October 2017, this included the Fund 'Plan on a Page' which is attached in Appendix 1.
The overall population outcome the Kirklees BCF Plan is aiming to achieve is:

"People with health and social care needs feel supported and in control of their condition and care, enjoying independence for longer."

This overall outcome is underpinned by four specific person centred outcomes:

- People who need support are in control of high quality, personalised support in their own home or community that enables them to stay safe, healthy and well for as long as is possible.
- People who need care that can only be provided in a specialist setting are admitted and receive good quality specialist care only for as long as is clinically necessary.
- People who have received care regain, as far as possible, their skills, abilities and independence through enhanced reablement and rehabilitation support.
- People with ongoing support needs manage their condition/needs as well as possible.

The key performance measures that are being used to measure progress are:

- Non-elective admissions.
- Permanent admissions of older people (65 and over) to residential and nursing care homes.
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services.
- Delayed transfers of care from hospital.

These measures are set nationally and subject to a quarterly assurance process.

1.4 The Kirklees BCF is being used to fund the following Schemes:

1. Aids to Daily Living

This scheme will facilitate the use of community equipment and aids to daily living, minor adaptations costing less than £1,000 (Kirklees Integrated Community Equipment Service, the Handy Persons' Scheme and assistive technology) and adaptations to property (Accessible Homes Team) provided through the Disabled Facilities Grant, to enable people with long-term conditions, disabilities, or requiring rehabilitation from acute conditions, or end of life patients to remain in their own homes. The outcomes will be:

- **Kirklees Integrated Community Equipment Service:** People with long-term conditions, disabilities, or requiring rehabilitation from acute conditions, or end of life patients are enabled to live as independently as possible in the home of their choice through the timely provision of relevant equipment and aids to daily living.
- **Handy Person Scheme**: People with long-term conditions or disabilities will receive assistance to maintain and repair their homes to a decent, safe and warm standard. This could include tasks such as changing lightbulbs, removing trip hazards, arranging for reputable tradesmen to repair a roof or to replace a boiler.
- **Assistive Technology**: People will feel more in control of their own care and support without having to depend upon, sometimes intrusive, people based services through maximising the use of assistive technology. Through the provision of technology, and possibly alongside other services, people are supported to remain independent in their own homes when otherwise they might be forced to move into other care settings.

- **Accessible Homes (Adaptations)**: Living in accessible homes will restore or enable independent living, privacy, confidence and dignity for individuals and their families through modifying disabling environments.

2. Intermediate Care and Reablement

This scheme includes intermediate care and reablement services that enable people who have received hospital care, or are at high risk of needing hospital care, to regain, as far as possible, their skills, abilities and independence through enhanced reablement and rehabilitation support. The overall aim of the scheme is to help to reduce avoidable hospital admissions, support timely discharges and prevent re-admissions. A key aim of the scheme is to develop an integrated offer that ensures the delivery of an effective cycle of care that is seamless and effective and delivers improved outcomes for patients and carers; with the following outcomes:

- Improved independence for patients and carers.
- Less dependency and the need for long term placements.
- A reduction in admissions for non-elective care.
- A reduction in excess bed days.

3. Carers Support Services

This scheme includes carers breaks (paid and volunteers), carers emotional support, self-help and enablement courses, carers assessments, carers information and advice, peer support, awareness raising, carers having a voice, carers advocacy, specialist support for carers of people with mental health concerns, support for carers of people at end of life, specialist support for carers of people with Dementia, workplace support for carers. The overall aim of the scheme is to support carers to continue caring in an informed, safe, and healthy manner; with the outcomes of:

- Reducing avoidable hospital and residential care admissions.
- Supporting timely hospital discharges and preventing readmissions.
- Preventing an escalation of future caring needs and preventing pressure on other care services.

4. Continuing Care

This scheme comprises jointly funded packages for older people and adults with a physical disability who are eligible for NHS continuing health care provision. The aims and outcomes of the scheme are to:

- Reduce duplication, making the best use of commissioning resources.
- Embed the joint commissioning strategy and commissioning intentions with the needs of the local community, based on the JSNA and comprehensive needs assessments as appropriate.
- Align investment and service development to make best use of public resources across health and social care, with increasingly integrated care pathways responding to patients and service users and their identified unmet needs.
- Ensure that strategic commissioning and service development responds to the expressed needs of the Kirklees population through a joint approach to the engagement of service users and citizens which seeks to identify gaps in service and provision, and offer suitable solutions.

5. Protecting Social Care

This scheme includes services that deliver social care packages for people who are in the high and very high risk categories, ie:

- Care management to ensure care is properly planned and co-ordinated.
- Self-directed support packages for people who are able to be supported in the community.
- Independent sector home care to enable people to continue to be supported in the community.
- Independent sector residential placements for older people and people with a learning disability who need 24 hour care.
- Required activity to support local implementation of the Care Act.

The aims and outcomes of the scheme are to:

- Reduce non-elective admissions to acute care.
- Reduce delayed transfers of care.
- Reduce permanent admissions to residential and nursing homes.
- Increase the number of people using social care services who receive self-directed support.

6. Eye Clinic Liaison Officers

The overall aim of this scheme is to achieve the best possible outcomes and quality of life for people of all ages with a visual impairment and/or at most risk of sight loss and wherever possible reduce avoidable sight loss across Kirklees. The outcomes will be that service users will:

- Have someone to talk to prior to, and at point of, diagnosis.
- Understand their eye condition and the registration process.
- Feel better able to adjust positively to their changed circumstances and cope with the changes they need to make to their lives as a result of sight loss.
- Have reduced anxiety and worry knowing that knowledgeable people are there to support and guide them.
- Have a better understanding of statutory benefits and services available to support them.
- Feel supported to manage their eye condition and make better-informed decisions about the future.
- Have increased confidence in making best use of the sight that they have and motivation to achieve goals.
- Feel healthier and happier and able to make the changes necessary to help prevent further deterioration of their eye condition.
- Feel less isolated, more able to get out and about and do things like volunteering.
- Feel less dependent on health and social care support.

7. Mental Health Contracts

This scheme brings together the Council and CCG contracts with the VCS for services for people experiencing mental health problems (18+), living within the boundaries of Kirklees including those with Dementia, learning disabilities (where criteria are met), autism, Asperger's and hidden disabilities.

The scheme will ensure improved outcomes for service users and best value for commissioners by facilitating the commissioning of services that provide a range of accessible opportunities and experiences across the communities of Kirklees, which will promote, protect and improve individuals' mental and physical health, as well as their emotional wellbeing and recovery and which will reduce the need and impact on health and social care services and treatment.

8. Supporting the Voluntary Sector

This scheme comprises funding for:

- The social prescribing service "Better in Kirklees" which is delivered via a contract with a voluntary sector organisation. Anyone over the age of 18 with a long-term health condition / social care need living in Kirklees can be referred to the service which enables them to access community support / activities that will help them to avoid or delay the need for NHS interventions.
- Capacity building in the voluntary sector to increase the provision of voluntary sector support / activities to people who have long-term health conditions / social care needs that will also benefit health by avoiding or delaying the need for NHS interventions.

1.5 The **improved Better Care Fund (iBCF)** was first announced in the 2015 Spending Review. It is paid as a 3 year direct grant to local authorities, with a condition that it is pooled into the local BCF Plan/pooled budget. The iBCF has to be spent on three purposes:

- Meeting Social Care Needs.
- Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready.
- Ensuring that the local social care provider market is supported.

However there is no requirement to spend across all three purposes, or to spend a set proportion on each. See here for more information about the iBCF.

1.6 The Kirklees iBCF grant allocation is being invested via the following schemes:

1. Ensure adults currently receiving a care package and their carers have the right size packages that enable them to live as independently as possible

Outcome: Timely and comprehensive reviews will ensure that adults with long-term care needs, adults with learning disabilities and carers have care packages that are up-to-date, appropriate to their needs, maximise their independence and support their carers.

This funding/scheme is also contributing to the BCF Schemes Protecting Social Care and Carers Support Services.

2. Introduce electronic call monitoring system across independent sector home care providers

Outcome: Providers and commissioners will be able to monitor the length of home care calls which will ensure that service users / the Council only pay for the service received.

This funding/scheme is also contributing towards the BCF Scheme Protecting Social Care.

3. **Support the transition from the current model of older people's day care to a more sustainable community based model**

   Outcome: The Council's MTFP identifies savings against the current model of older people's day care. The move to a fully sustainable model of community based day care needs time and investment to ensure that the needs of service users and the Council can be effectively met.

4. **Additional support to the care home sector to deal with people with more complex needs and to improve the admissions process**

   Outcome: The care home sector will be able to more effectively meet the needs of people with increasingly complex health conditions/ needs – so avoiding unnecessary admissions to hospital. The introduction of 7 day independent assessors for people in hospital who need to move to residential/ nursing care will speed up hospital discharge, reduce lengths of stay, and under occupancy in care homes and the time wasted by care home staff visiting prospective residents whose needs the home cannot meet.

5. **Support to independent sector providers to recruit care staff, develop leadership and management skills and develop new roles such as personal assistants**

   Outcome: Independent sector providers will be able to recruit more care staff and be well led and managed. Providers will therefore be more sustainable and resilient and better able to provide consistent quality of care. The market will be in a better position to meet the increasing demand for personalised care delivered by personal assistants.

   This funding/scheme is also contributing towards the BCF Scheme Protecting Social Care.

6. **Improve the capacity, effectiveness and flow of people through reablement services**

   Outcome: Improved capacity, effectiveness and flow through of services. Service users will be able to be assessed at home so avoiding unnecessary waits in hospital; people with less complex needs will be able to return home sooner and people who have moved through the short-term reablement service will receive care packages that provide ongoing support to optimise their recovery over a longer period.

   This funding/scheme is contributing towards the BCF Scheme Intermediate Care and Reablement.

7. **Remodel the hospital avoidance and discharge service**

   Service users will experience a combined service that offers increased capacity and efficiency through the ability to provide a multi-disciplinary wrap around service which will be more effective at avoiding hospital attendance and admissions and reduce the risk of people moving into residential care unnecessarily.

   This funding/scheme is contributing towards the BCF Scheme Intermediate Care and Reablement.

8. **Additional investment in community capacity building**

   More people will be identified and support provided before they hit crisis and need statutory services. More inclusive and resilient communities will support vulnerable people and targeted community based prevention and early

intervention will help to prevent or delay their need for specialist health and social care support.

9. Transformation Capacity

The Council is implementing the most significant transformation programme in many years in order to delivery improved outcomes within its reducing budgets. It has recognised that the transformation of adult social care is one of the critical areas of change. This aspect of the Council wide programme is focussed on the overall adult social care offer, all age disability, the front door, reablement and integrated commissioning.

10. Resourcing local volume and price pressures

The Council has committed substantial additional funding to ensure that more people can receive adult social care, and those organisations providing the care receive a fair price for that care. The iBCF will contribute to supporting the Council to do this.

This funding/scheme is contributing towards the BCF Scheme Protecting Social Care.

1.7 BCF and iBCF funding comprises:

BCF pooled budget	2017/18	2018/19	2019/20
BCF	£35.8m	£36.6m	tbc
iBCF Autumn Statement 2015	£0.8m	£7.1m	£12.8m
iBCFSpring Budget 2017	£8.3m	£5.3m	£2.6m
Totals	£44.9m	£49.0m	tbc

At the time of developing proposals for the use of the iBCF the allocations for the main BCF (which are for only 2 years) were still subject to confirmation from NHS England through the BCF statutory guidance. It was considered that if recurrent financial commitments were made against the iBCF it could put the Council's budget strategy at risk. Consequently the Council agreed a financial strategy for the new allocations which included commitments in 2017/18 on what is necessary to pump prime key initiatives developed in conjunction with Clinical Commissioning Group partners to respond to service and market pressures and support enabling activity to drive transformation and savings set out in the Medium Term Financial Plan for 2017/21, and to release £5.7m of base budget revenue resources in-year to support local volume and price pressures (see iBCF Scheme 10 above).

1.8 The Panel received a report in November which summarised the local plans for integration of health and social care commissioning and delivery of out-of-hospital care, available here. These plans were also included in the Better Care Fund Plan 2017-2019. The BCF narrative plan and the associated financial and performance plans are drawn wherever possible from existing plans. The intention has always been to avoid another plan with potentially competing or contradictory actions and expectations.

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

The BCF Schemes all have the aim of reducing or delaying the need for costly crisis support or care services and will therefore assist the Council in achieving EIP Priority 2, ie; “We will make service savings, but will reinvest in EIP to reduce or delay the need for costly crisis support or care services.” Also Priority 4 “We will help more people in the most appropriate way with the money we have available.”

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 prepared in consultation with CCG partners in the BCF.

5. Next steps

Not applicable.

6. Officer recommendations and reasons

That this report be received.

7. Cabinet Portfolio holder recommendation

Not applicable.

8. Contact Officer

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

9. Background papers and history of decisions

Not applicable.

10. Service Director responsible

Amanda Evans, Service Director for Adult Social Care Operations, 01484 221000

Appendix 1: Kirklees Better Care Fund 2017/2019 'Plan on a Page'

Kirklees Outcomes

- People in Kirklees live independently and have control over their lives
- People in Kirklees are as well as possible for as long as possible

Kirklees 2020 Vision for our health and social care system:

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

The principles underpinning the Kirklees 2020 vision are that:

- ❑ 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
- ❑ To support the achievement of this Vision we will need to work with a wide range of partners who can influence the wider determinants of health and wellbeing, including housing, learning, income and employment.

Kirklees Better Care Fund Plan

Kirklees BCF Person centred outcomes

- People who need support are in control of high quality, personalised support in their own home or community that enables them to stay safe, healthy and well for as long as is possible
- People who need care that can only be provided in a specialist setting are admitted and receive good quality specialist care only for as long as is clinically necessary
- People who have received care regain, as far as possible, their skills, abilities and independence through enhanced reablement and rehabilitation support
- People with ongoing support needs manage their condition/needs as well as possible

Key performance measures to measure our progress

- ✓ Non-elective admissions
- ✓ Permanent admissions of older people (65 and over) to residential and nursing care homes
- ✓ Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
- ✓ Delayed transfers of care from hospital

Kirklees Health & Wellbeing Plan: Priorities for Change

Areas of Transformation

- Early intervention & prevention
- Sustainability of adult social care
- Capacity & quality of primary care
- Change the configuration of acute services
- New model for continuing care
- Transforming care for people with learning disabilities
- Changing the commissioner landscape and new models of care
- Developing an adult wellness model
- Improving services for children

Enablers

- Health & Social Care Workforce
- Digital Opportunities
- One Public Estate
- Kirklees Economic Strategy

Kirklees Better Care Fund Schemes & other commissioning integration activity

2017/18

- Intermediate care and reablement
- Aids to daily living
- Carers support
- Sustainability of adult social care
- Continuing care
- Community based mental health support
- Supporting the voluntary sector

2018/19

- New frailty model
- Care home support
- Transforming care for people with learning disabilities
- Mental Health

Integration activity outside BCF

- End of Life
- Adult Wellness
- Healthy Child Programme & CAHMS Transformation
- Children and Young People – SEN, sick /looked after/vulnerable children
- Schools as Community Hubs
- New models of care in localities

Integrating out of hospital care delivery

- Local area/hub working
- Single point of access/contact
- Single trusted assessment
- Accountable lead professional/person
- Common Pathways
- Digital: telehealth/AT, mobile/agile, interoperability
- One Public Estate

NB - BCF Plan covers highlighted boxes

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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. <u>Panel meeting 14 November 2017</u> The Panel received an update on the progress of the integration of health and adult social care. The panel requested further information to include : • A high level timeline to include details of engagement work • An update on work taking place in North Kirklees to provide similar provision to that delivered by the Whitehouse Centre, Huddersfield • Details on how progress is being made to provide a

FULL PANEL DISCUSSION		
ISSUE	**APPROACH**	**AREAS OF FOCUS/OUTCOMES**
		single point of access across the sector. A further update is to be scheduled for early 2018.
5. CQC Inspections	To maintain an overview of the progress of the Action Plans developed by a number of local providers following a CQC inspection either through written updates/ Feedback from Lead Member /presentations at panel meetings.	Review progress from the following provider action plans : • Calderdale and Huddersfield NHS Foundation Trust • Locala Community Partnerships • South West Yorkshire Partnership NHS Foundation Trust • Mid Yorkshire Hospitals NHS Trust
6. All Age Disability and Adult Pathways	The Panel to receive updates on the work that is being done on developing the All Age Disability and Adult Pathway workstreams.	<u>Panel meeting 4 July 2017</u>. The Panel received an update on the work that is being developed on Adult Services Pathways that included an overview of the key areas of transformation The Panel has requested further information that provides: • An overview of the timescales and key milestones for the various transformational work streams and redesign of the Adult Services pathways • The headline financial figures that outline where the projected savings will be achieved.
7. The Healthy Child Programme (0-19 services) The Kirklees Integrated Healthy Child Programme (KIHCP) is seen as a catalyst for transforming work with children and young people across a range of systems, interventions, sectors and services over the next 5 -10 years.	In March 2017 the Panel was presented with an update on the KIHCP procurement process; the approach being taken to implementing the programme; and progress of implementation. Further updates will be presented at panel meetings during 2017/18. This item has been scheduled for discussion at the meeting 12 September 2017.	At the March meeting the Panel agreed to: • Maintain an overview of the development of the service to include progress on implementation • Receive an update on how the key risks/issues have been managed as outlined in the March meeting. <u>Panel meeting 12 September 2017.</u> The Panel received an update covering the areas identified

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

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		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 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.

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		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.
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	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

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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.		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.
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. <u>Panel meeting 14 November 2017</u> The Panel considered the outcomes of the consultation and a findings report. The Panel issued a number of recommendations that included requesting Locala to consider how the issues highlighted by the consultation will be addressed. In addition the Panel requested that it is provided an opportunity to see the final report that outlines the proposed changes before a final decision is made. The final report has been scheduled for presentation at the meeting 13 February 2018.
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	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.

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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.		
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.
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.

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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. <u>Panel meeting 14 November 2017</u> The Panel was presented with details of the proposal for interim Acute Inpatient Elderly Medicine, Cardiology and Respiratory Service provision at CHFT. The Panel made a number of recommendations that included a request for written assurance that the proposed interim change was a discrete piece of work. The Panel agreed to retain the issues on its work programme in order maintain an overview of the impact of these changes in Kirklees.

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 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.	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. A discussion on the issue has been scheduled to take place at the meeting 16 January 2018. Initial questions and key lines of enquiry have been sent to CCGs. The approach for the meeting has still to be finalised but will include a focus on user experience and input from Healthwatch Kirklees.

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.