MEETING:	**KIRKLEES HEALTH AND WELLBEING BOARD**
DATE:	**THURSDAY 25 AUGUST 2016**
TITLE OF PAPER:	**KIRKLEES BETTER CARE PLAN 2016/17**

1. Purpose of paper

Further to the report agreed by the Board on 31 March 2016, attached for information is the final Kirklees Better Care Plan approved by NHS England.

2. Background and Key Points

2.1 On 31 March 2016 the Board received a report here setting out the national requirements for the content, assurance and approval of updated, for 2016/17, Better Care Fund Plans. The Board noted that the guidance setting out these requirements was not published until 23 February here. The requirements included the submission, by 25 April, of high level narrative BCF Plans signed-off by Health and Wellbeing Boards that build on 2015/16 plans and demonstrate that local partners have collectively agreed the following:

- The local vision for health and social care services – showing how services will be transformed to implement the vision of the NHS Five Year Forward View here and moving towards integrated health and social care services by 2020, and the role the BCF plan in 2016/17 plays in that context;
- An evidence base supporting the case for change;
- A co-ordinated and integrated plan of action for delivering that change;
- A clear articulation of how they plan to meet each national condition; and
- An agreed approach to financial risk sharing and contingency.

The guidance also included two new national conditions added to the six existing conditions here.

2.2 The Board noted that the work taking place, led by the CCG and Local Authority members on the Integrated Commissioning Executive who developed the 2015/16 BCF Plan, to update the Plan and prepare the high level narrative submission to meet all the NHS England requirements was proving to be complex and time consuming and that it would not be possible to submit it to the Board for approval prior to submission to NHS England. The Board therefore delegated authority to the Director for Commissioning, Public Health and Adult Social Care in consultation with the Chair of the Board and nominated CCG members to agree the final version of the updated Kirklees Better Care Plan.

2.3 The updated Kirklees Better Care Fund Plan was submitted to NHS England as required by their revised date of 3 May. The outcome of the regional and national moderation process is that the rating for the Kirklees Plan is “fully approved”.

2.4 Although the Kirklees BCF Plan and others received full approval, in mid-July NHS England issued a revised template which local areas were asked to check and amend if necessary for return by 19 August. The attached Kirklees Better Care Plan 2016/17 incorporates the revised NHS England template which was submitted on 17 August.

2.5 The Better Care Fund Implementation Plan, which sets out the actions taking place to deliver the aims and objectives set out in the Plan, forms Appendix 1 to the attached Plan.

3.	**Proposals** That the Board receives the Kirklees Better Care Fund Plan 2016/17 and notes that work will continue on the actions set out in the Better Care Fund Implementation Plan.
4.	**Financial or Policy Implications** There are no financial or policy implications arising from the agreement of the proposals set out in this report.
5.	**Sign off** Richard Parry, Director for Public Health, Commissioning and Adult Social Care.
6.	**Next Steps** Work will continue on the actions set out in the Better Care Fund Implementation Plan.
7.	**Recommendations** That the Board: 7.1 Receives the Kirklees Better Care Fund Plan 2016/17. 7.2 Notes that work will continue on the actions set out in the Better Care Fund Implementation Plan.
8.	**Contact Officer** Keith Smith, Assistant Director for Commissioning and Health Partnerships, 01484 221000.

Appendix 1 BCF Narrative Plan – see separate document

Appendix 2 BCF Planning Template – see embedded document

Better Care Fund
2016-17 Planning Ter

Kirklees Better Care Fund Plan 2016/17

Kirklees Council
Greater Huddersfield CCG
North Kirklees CCG

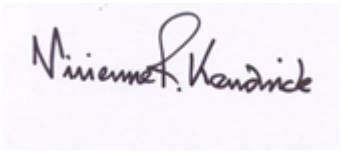
1. Authorisation and sign off

At the Kirklees Health and Wellbeing Board meeting on 31st March 2016 the Board agreed that delegated authority be given to the Director for Commissioning, Public Health and Adult Social Care in consultation with the Chair of the Board and nominated representatives from the CCGs to agree the final version of the updated Kirklees Better Care Plan.

Signed on behalf of the Council

Richard Parry, Director of Commissioning & Health Partnerships
3/5/2016

Signed on behalf of the Health and Wellbeing Board



Cllr Viv Kendrick, Chair
3/5/2016

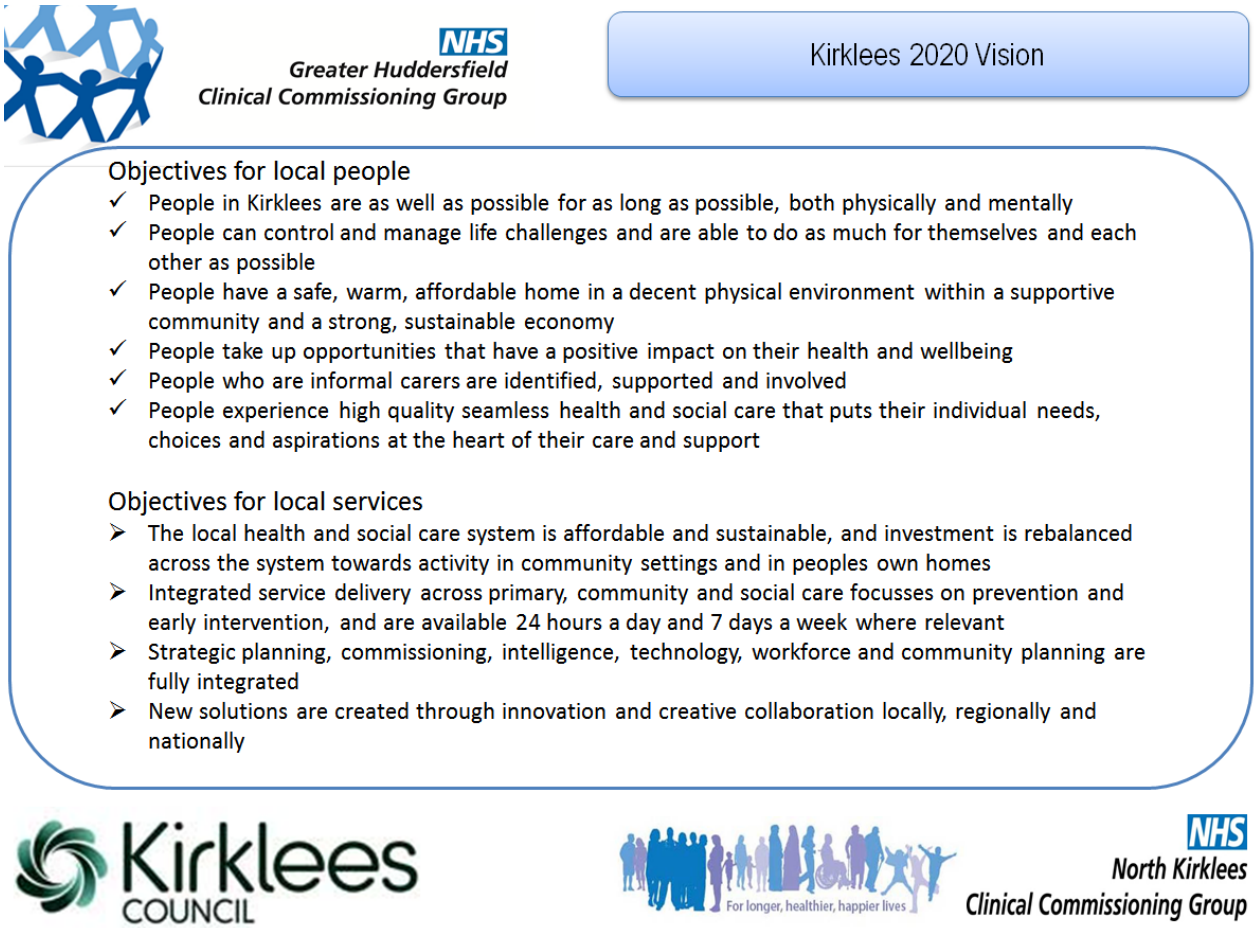
2. Key local documents

Kirklees JHWS	link
Kirklees STP	To add
NKCCG Operational Plan	link
GHCCG Operational Plan	link
Vision for Adult Social Care & Support in Kirklees	link

3. Vision for Health and Care Services

Our overall vision as set out in the Joint Health and Wellbeing Strategy (link) is that for everyone who lives in Kirklees – "By 2020, no matter where they live, people in Kirklees live their lives confidently, in better health, for longer and experience less inequality."

The JHWS recognises that whilst there have been overall improvements in local health and wellbeing there are still significant health and care challenges set out in the JSNA (link). The most recent refresh of the JHWS has sharpened the focus on creating an integrated health and social care system that is capable to responding to these challenges. The Health and Wellbeing Board is leading the development of the Kirklees Sustainability and Transformation Plan. The draft objectives are shown in Fig 1, and these draw on the objectives we set out for our first BCF Plan in 15/16 and the NHS 5 Year Forward View.



The overall population outcome we are aiming to achieve through the BCF plan 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 we will use to measure our progress are:

1. Non-elective admissions
2. Permanent admissions of older people (65 and over) to residential and nursing care homes
3. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
4. Delayed transfers of care from hospital
5. Dementia diagnosis (locally agreed measure – quality premium measure for GHCCG and NKCCG)
6. Patient / service user experience Everyone Involved in my Care knows my Story:
   (i) Improvement in response Rate on completion of care episode,
   (ii) Increase in % of patients/carers reporting satisfaction about the level of information services have about them on transfer NB as this is a new measure there is currently no baseline data.

Each of the specific schemes within the Better Care Fund has been selected on the basis of their contribution to delivering these outcomes, their strategic fit and their impact on our key performance measures.

Over the next 5 years primary, community and social care teams will be commissioned to work together in an increasingly integrated way, with co-ordinated, holistic assessments and rapid and effective joint responses to identified needs, provided in and around the person's home and community. By improving the way we work with people to manage their conditions, we will reduce the demand not just on acute hospital services but also on nursing and residential care.

In 2016/17 the BCF will be used to build on the joint work already taking place. Specifically the BCF pooled budget will be used to fund the following 8 schemes that form part of our overall strategy to deliver these changes:

1. Preventative Services
   - continuing to invest in community based prevention and early intervention activities delivered by voluntary and community organisations that support people with their health and social care needs
   - building on Kirklees' track record as a leader in self-care, including the development of an innovative web based 'hub' which will transform the way self-care information, support and resources are accessible to a wide range of people
   - continuing to support specialist alcohol nurses working in hospitals to reduce alcohol related admissions and repeat presentations for health and care services.
   - providing people with long-term conditions who are at risk of hospital admission or needing additional care services with short term support to build their confidence to manage their needs at home

2. Intermediate care (including Reablement Services, Bed Based Intermediate Care Services, Mobile Response Services)
    - enhancing investing in and redesigning community based domiciliary services to support admission avoidance and hospital discharge arrangements and integrated crisis and rapid response services to avoid unplanned admission to secondary care services.
    - investing in and redesigning where necessary our community bed base to facilitate early supported discharge and/or reduce need for admission to hospital if care can be provided closer to home. This includes additional investment in palliative and end of life care services.
3. Aids to daily living
    - our new Integrated Community Equipment Service went live in April 2014, and will work alongside activity on undertaking minor adaptations to property to ensure people are able to stay in their own homes as long as possible
4. Carers Support Services
    - investing in carer related support including respite care/short break activity and specified schemes for dementia related care etc.
5. Additional Community Health Services
    - Additional investments into Care Closer to Home services enabling patients to remain within their own homes for as long as possible and facilitate their return to their own home as soon as possible should they be admitted to hospital.
6. End of Life
    - increasing access to specialist high quality, responsive and holistic service palliative and end of life care for individuals, their carers and families to support personal preferences
7. Psychiatric Liaison Services
    - ensuring adults experiencing mental health problems who attend the acute hospitals are sign-posted to the most appropriate care; receive parity of care for physical and mental health needs; are not admitted into hospital just to avoid breaching the emergency care target; and receive on-going psychiatric assessment so that they are ready to be discharged once medically fit.
8. Protecting Social Care
    - Ensuring that those people with social care eligible needs can receive the care and support they need to maintain or regain their independence and reduce the risk of hospital admission, recognising that as more people have receive care out-of-hospital they will need additional social care support
    - Implementing the Care Act, including the predicted increased volumes of assessments, carers assessment and associated packages of care

(the financial allocations for each scheme are set out in Section 6)

By offering integrated high quality services at times required to meet the needs of the community Kirklees wishes to reduce reactive, unplanned care and do more planned care earlier. The benefits that patients and their carers will see as a result of the changes and how these will impact on emergency attendances and hospital admissions. People will receive care which is more timely and organised to meet their specific needs. The services they need will be co-ordinated across providers where necessary; ensuring care is co-ordinated and seamless as one coherent package with a focus on helping recovery and promoting independence.

4. Case for Change

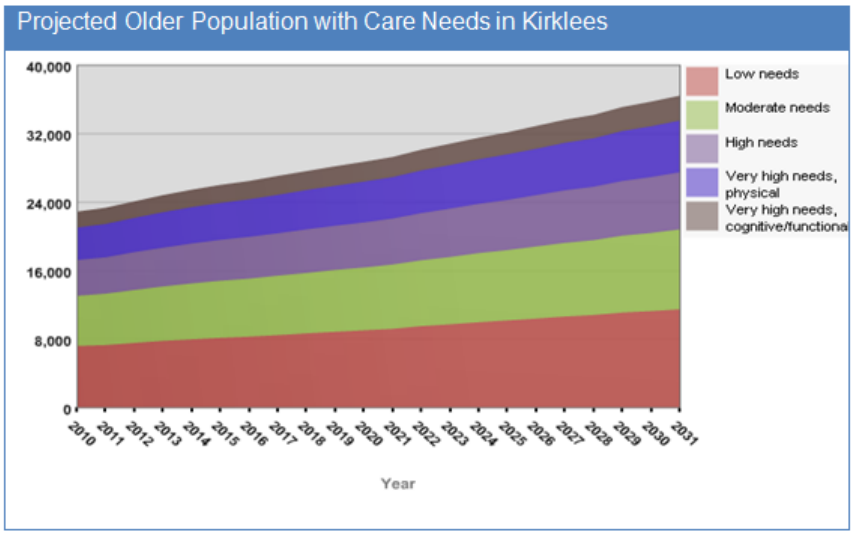
The growing demand for services at a time of diminishing financial resources creates unprecedented need for change. The case for change is built upon several well-known pressures:

- Diminishing financial resources across the whole system
- Current Service models not always delivering desired quality and performance outcomes
- prevalence of long term conditions and the rising burden of demography

Long term conditions are estimated to affect more than 126,000 people aged over 18 in Kirklees, with 30% of the population reported to have one long term condition, 13% reported to have two long term conditions and more than 10% reported to have 3 or more long term conditions.

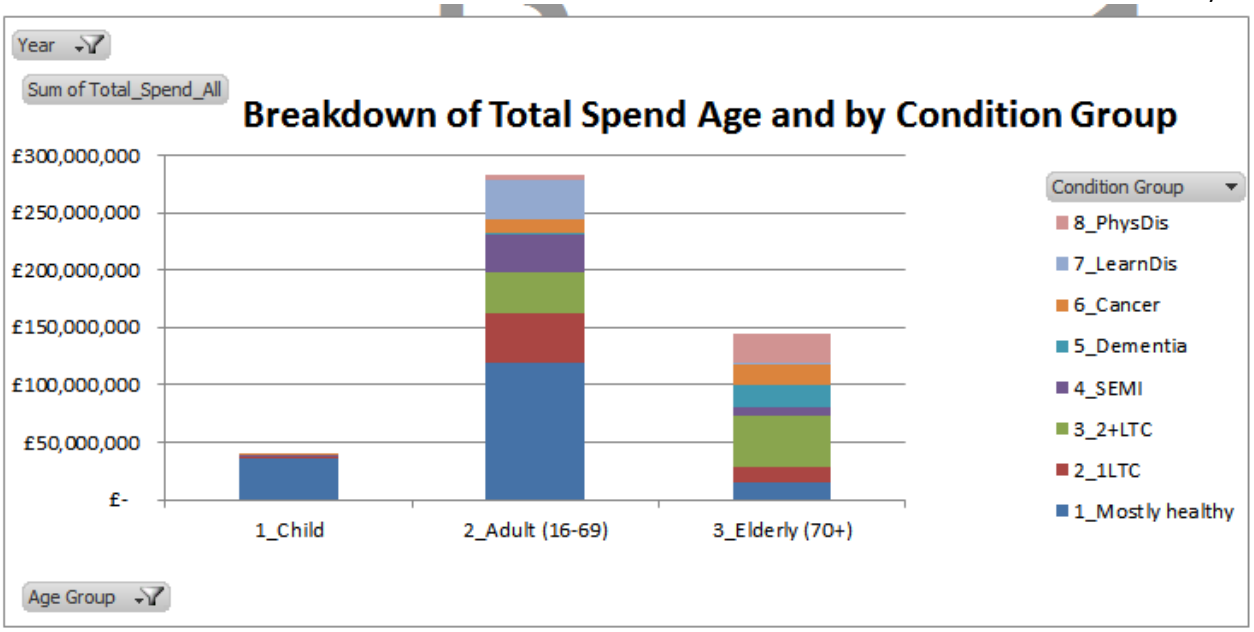
As the older population increases, the numbers of people with mental and physical health related problems is projected to increase. The graph below shows how the need for social care in Kirklees is expected to rise in line with this population growth.

Almost 50% of people aged 70 and above report having one or more long term conditions, this with the expected substantial increase in the number of older people in Kirklees (an increase of almost 54% by 2030) means one of the major challenges facing Kirklees in terms of population groups is tackling the frail and elderly and those people with long term conditions.



Population Segmentation

We have utilised the recently published Monitor Care Spend tool to provide us with an indicative segmentation of our population. The exhibit below is an example output from this tool, showing the breakdown of estimated total spend on health and social care in Kirklees by age and by condition group.



This highlights that although people aged 70 and above represent almost 15% of the total Kirklees population, a significant proportion of expenditure equating to almost £150m (30% of total spend) is allocated to this age group. Similarly, almost 30% of health and social care expenditure in Kirklees is for people with one or more long term conditions – with people aged 16 to 69 accounting for 58% of total spend on long term conditions. This further emphasises our case for change proposals.

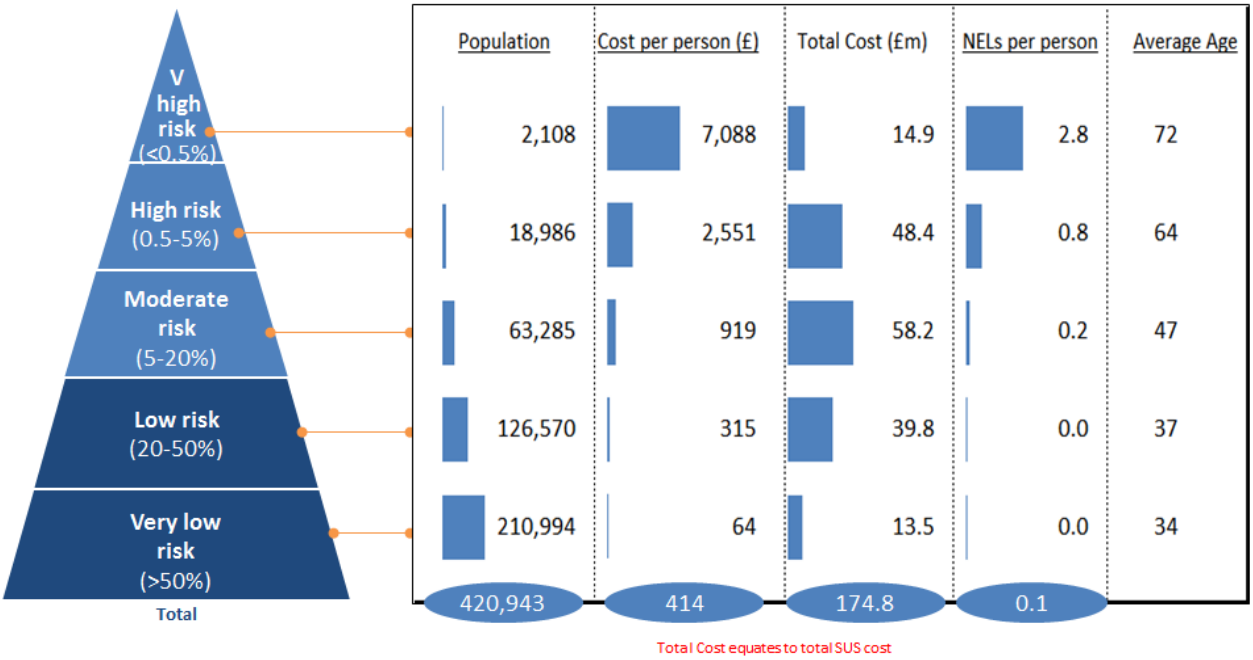
Emergency Admissions

Our analysis of emergency admissions during 2013/14 indicates that in total emergency admissions in Kirklees cost £76.7m. Data shows that £15.3m of spend (20%) on emergency admissions could be considered avoidable. Of this, £5.5m of spend (36%) related to the over 65s.

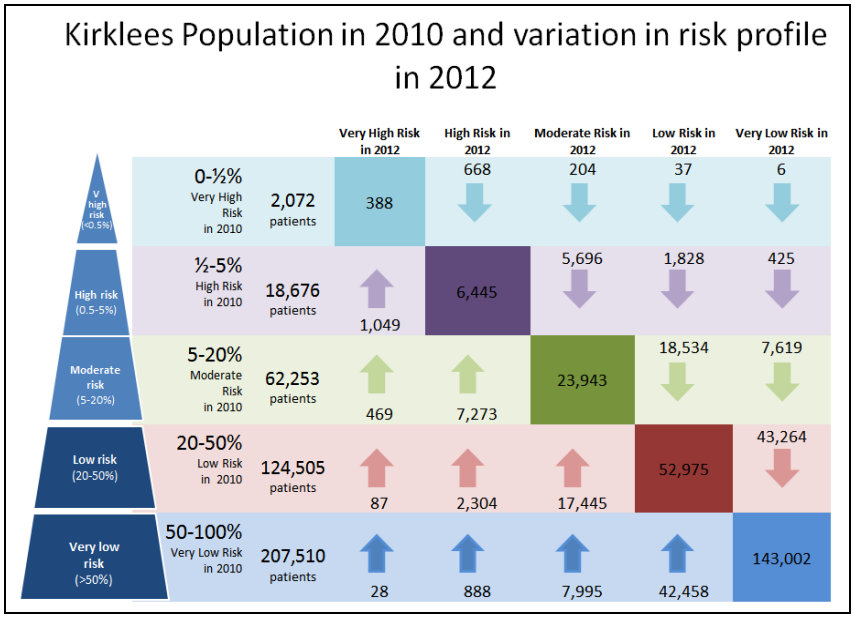
Risk Stratification

Risk stratification in Kirklees has been utilised since 2010, initially with a Combined Predictive Model and now with an Adjusted Clinical Grouper (ACG) model. Uptake has always been good with 98.8% of the population stratified, and we have recently reached 100% coverage in August 2014. This has primarily been used for case finding within GP practice and supporting multi-disciplinary team meetings (GP and community staff). It has also been key to specific incentives such as a vulnerable adult scheme run within one CCG, prompted medicine reviews, comparative analysis and benchmarking between practices, clusters and localities as well as supporting our inclusion within the Year of Care Funding Model pilot in years 1&2 (which evidence the existing good work in Kirklees on integration).

The exhibit below shows how the Kirklees population is grouped across the various risk strata, note the average age of those within the 'Very High' and 'High' risk strata in Kirklees is 72 and 64 respectively, with a significant 'cost per person' and a high rate of non-electives across these groups.



Further to the above, our historical analyses of risk stratification data enables us to map how patients over time have moved up or down in terms of their risk of unplanned emergency admission. This is shown in the exhibit below:



This along with our other evidence highlights that in Kirklees over the years we have already seen some success through our approach to integration. The evidence is clear that patients who are empowered, knowledgeable and supported, utilise services less and have better health outcomes. Kirklees is already seeing some benefits of integration and is following a tried and tested model which we can build on through the Better Care Fund. Our plans for the Better Care Fund have therefore been designed accordingly to build on our existing good work on integration.

5. Plan of Action

The 2015/16 BCF Implementation Plan and Risk Log have been updated to reflect the progress we have made in implementing the specific BCF schemes and the key developments that will deliver the national conditions and our local strategies for creating an integrated health and social care system.

See Appendix 1 Kirklees BCF Implementation Plan

See Appendix 2 Kirklees BCF Risk Log

6. BCF funding

A split of contributions and schemes is shown in the table below

Summary of Partner Contributions and Schemes

	Greater Huddersfield CCG £k	North Kirklees CCG £k	Total CCGs £k	Kirklees Council £k	Total Pool £k
Contributions					
Minimum Revenue	14,726	11,878	26,604		26,604
Additional Revenue				1,692	1,692
Total Revenue	14,726	11,878	26,604	1,692	28,296
Disabled Facilities (DFG capital)				2,483	2,483
Total Pool	**14,726**	**11,878**	**26,604**	**4,175**	**30,779**
Schemes					
Health	5,844	4,458	10,302		10,302
Social Care (revenue)				17,994	17,994
Social Care (DFG capital)				2,483	2,483
All Schemes	**5,844**	**4,458**	**10,302**	**20,447**	**30,779**

There is a very small increase in the minimum revenue contribution (derived from CCG allocations) of £49k, this increasing from £26,555k in 2015/16 to £26,604k in 2016/17. In addition, the capital allocation for disabled facilities (Disabled Facilities Grant – DFG) paid to Kirklees Council has increased significantly from £1,362k to £2,483k.

£1,036k was received by Kirklees Council in 2015/16 for social care capital. This allocation has been discontinued from 2016/17 onwards.

The partners have agreed in principle that it is important that the schemes contribute materially to the objectives of the Better Care Fund. Some adjustments have therefore been made to the schemes included in the 2016/17 plan whilst broadly maintaining the aggregate split between health and social care. Schemes will be reviewed in the first half of the year to determine whether any further adjustments should be made, though recognising that there will be continuing contract and funding commitments that will impact on the timing of any changes.

An aggregate amount equivalent to the 2013/14 NHS funding transfer to local authorities is subsumed within the schemes.

A maximum of £2.45m was available through the P4P arrangements in 2015/16 (though the projected amount as at quarter 3 was £2m which is to be retained by the CCGs to attribute to acute activity). £2.5m has been set aside in the 2016/17 plan for "local NHS risk share" targeted at acute service pressures.

The 2016/17 plan includes £8.2m for NHS commissioned out-of-hospital services which is in excess of the minimum amount for local share of ring fenced funding of £7.56m. £1.55m has been allocated to implementation of the Care Act which is in excess of the indicative amount from the £138m allocated nationally. £988k has been allocated in support of carers.

When compiling the 2016/17 plan, and taking into account the relative success of the schemes' contributions to the Better Care Fund's objectives, consideration has also been given to the impact of changes on continuing service provision.

Changes have been limited. Working together across the system we see the BCF as enabling system integration. As part of this we are reviewing services to ensure that they are meeting the needs of our most vulnerable patients, reducing the inequality gap, improving wellbeing and that the services are efficient and value for money. North Kirklees CCG has evaluated the 15/16 BCF Scheme - Over 75s Health Checks. The CCG and BCF Partnership Board agreed with the recommendation from the evaluation that the Over 75s Health Check is viewed as an additional preventative tool alongside the national NHS Health Check which is available for patients aged 40-74. The two services should form the basis of a practice's planned prevention activities and be tied to patient education programmes offering clear lifestyle advice, brief intervention and support for patients to access other health and wellbeing support services before they develop long term conditions. In addition, due to a delay in the start of the pilot the clinical care-co-ordinators which was funded through the BCF in 15/16 this will continue with support from North Kirklees CCG until final evaluation and recommendation in May 2016.

	Original BCF allocation £k		**Additional Partner contribution £K**	
Scheme 1 - Preventative Services				
(a) - Support to the Voluntary and Community Sector	400			
(b) - Generic Workers	571			
(c) - Self Care Hub	98			
(d) - Secondary Care Alcohol Nurses	168			
Total Preventative Services		**1,237**		
Scheme 2.1 - Intermediate Care	7,499			
Total Intermediate Care		**7,499**		
Scheme 3 - Aids to Daily Living				
(a) - Integrated Community Equipment Service	2,192		1,692	
(b) - Assistive Technology	250			
(c) - Adaptations Service	2,483			
Totals Aids to Daily Living		**4,925**		**1,692**
Scheme 4 - Carers Support Services		**988**		
Scheme 5 - Additional Community Health Services – GHCCG	2,963	**2,9643**		
Scheme 6 -End of Life	350	**350**		
Scheme 7 - Psychiatric Liaison Services	1,356	**1,356**		
Scheme 8 - Protecting Social Care		**7,267**		
Local NHS Risk Share	2,502	**2,502**		
Total BCF allocation		**29,087**		
Total additional partner contributions				**1,692**

The process for developing the schemes used a clear set of criteria, that schemes

1. reflect the broad aims and scope of the BCF
2. will impact on the BCF metrics within a timescale that reflects the need to deliver the agreed system changes e.g. acute service reconfiguration
3. are critical to meeting the national conditions and commissioning of the schemes can be directly influenced by Health and Wellbeing Board through the Integrated Commissioning Executive.

In developing these criteria and applying them to the BCF schemes we have assumed at least a 1:1 return on investment on each area of investment, unless we already have local data to show a different level of return.

7. Overarching governance arrangements for commissioning integrated care

The Health and Wellbeing Board has established a robust set of integrated commissioning arrangements in Kirklees. A 'Memorandum of Understanding' between the Council and the CCGs was agreed in summer 2013. At the heart of this was a commitment to use the 'Partnership Commissioning Cycle' and 'Joint Commissioning Principles' that we have developed locally.

The BCF programme is being managed by the Integrated Commissioning Executive (ICE) on behalf of the Health and Wellbeing Board.

The ICE brings together the senior officers responsible for commissioning health and social care and public health across the Council and CCGs. It is chaired by the Assistant Director for Commissioning and Health Partnerships. In view of the scale of the BCF it was agreed to set up a BCF Partnership Board as a part of the integrated commissioning arrangements to oversee the further development and implementation of the Kirklees BCF plan.

The ICE:

- provides strategic direction to the overall BCF programme
- ensures that the BCF continues to develop in a way that is integrated with the wider development of care closer to home, the implementation of the Care Act and changes in hospital services
- receives quarterly reports from all schemes highlighting progress, risks and outcomes
- escalates risks to appropriate decision making bodies in the CCG, Council and other partners including the Health and Wellbeing Board

The BCF Partnership Board:

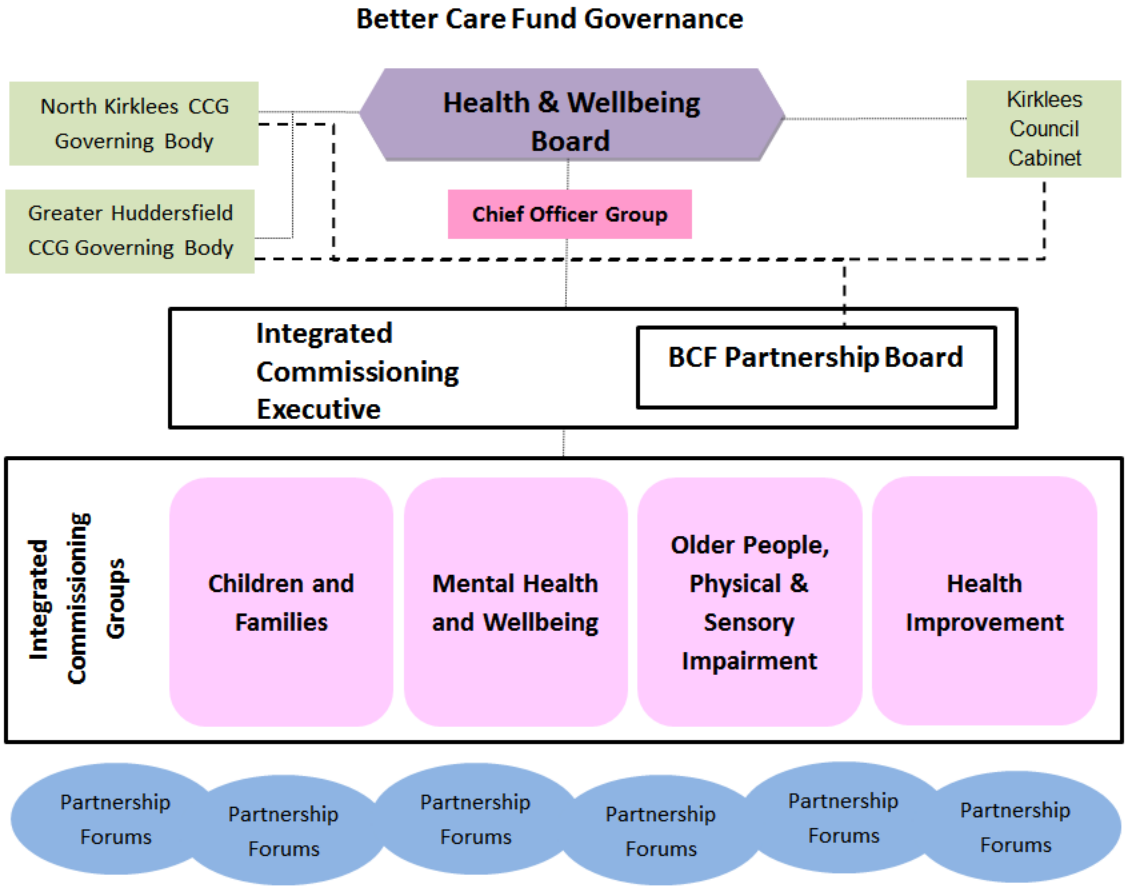
- provides strategic direction on the individual BCF schemes;
- receives the financial and activity information;
- reviews the operation of the Individual Schemes and make worthwhile recommendations to the Lead Commissioners;
- oversaw the national BCF Payment for Performance regime and any local performance payment arrangements during 2015/16;
- makes recommendations for use of any underspend or inclusion of additional schemes for endorsement by relevant decision-making bodies in the Council and CCGs;
- identifies new opportunities to meet the stated aims of the BCF.

The Partnership Board membership is drawn from the ICE membership and the meetings run consecutively. There are direct links through members of the Board into the programme structures for the JHWS, CCGs, social care, public health and the other key local programmes – especially CC2H Integration Board, Calderdale & Huddersfield Right Care, Right Time Right Place programme, Mid Yorkshire Meeting the Challenge programme and the two local System Resilience Groups.

See Appendix 3 - Terms of Reference for the Kirklees Better Care Partnership Board

All the BCF schemes have management and reporting arrangements in place. There are dedicated finance and performance officers responsible for ensuring the flow of information between the schemes, their existing management arrangements and the ICE.

The governance diagram below shows the relationship between the key bodies.



8. Risk and Contingency

Kirklees BCF have agreed to retain the former performance related funds in the scheme as part of a local risk sharing agreement to be held by CCGs. The reduction in emergency admissions and the associated costs were not fully achieved in 2015/16 and CCGs have had to include this activity in their baseline plans with acute providers in 2016/17. To fund this and also commission additional out of hospital services would not be financially sustainable for the CCGs and would cause additional pressures to the CCGs being able to maintain financial balance. As a consequence the former performance related funds will be utilised to fund acute hospital care in 2016/17. We believe this is consistent with the planning requirements to ensure financial balance of the health economy.

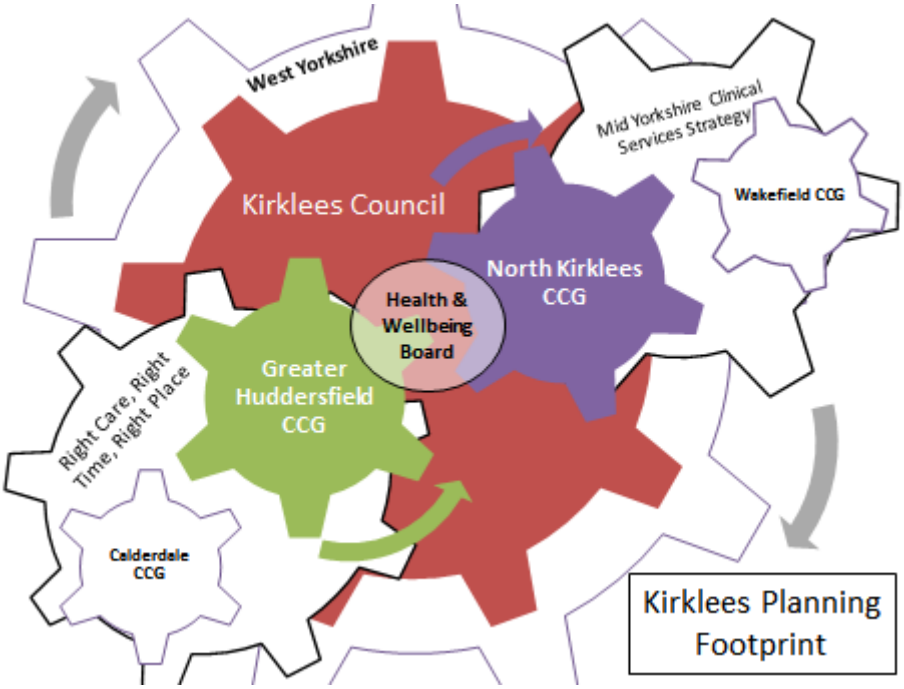
9. How BCF plans align with other initiatives related to care and support

The BCF provides a key opportunity to reinforce and accelerate the changes that the Council and CCG partners have identified in existing and emerging strategic plans and processes. There are several inter-locking strands to this work which are set out below. However it is important to note the complexity of the Kirklees planning footprint.

The Kirklees planning footprint

The Council and CCGs are co-terminous and the positive working relationships across the organisations have been developed over many years. Whilst the two CCGs each have distinctive identities and focus which reflects the needs of their populations they are in close dialogue. As key commissioning partners, with Calderdale and Huddersfield Foundation Trust and Mid Yorkshire Hospitals Trust as their main acute service providers and South West Yorkshire Partnerships Trust as the mental health service provider, they are also working closely with their neighbouring CCGs – Calderdale and Wakefield. The CCGs and Council are working together on the major transformation programmes focussing on acute reconfiguration at the two acute hospitals footprints – Right Care, Right Time, Right Place in Calderdale and Huddersfield, Meeting the Challenge in North Kirklees and Wakefield.

At the same time the Council is also undergoing a major change programme – to become a 'New Council'.



The diagram above illustrates the complexity of the Kirklees planning footprint, showing how the different planning and commissioning strands dovetail to ensure that high quality services are commissioned for the citizens of Kirklees. The timelines for these inter-related strands is a particular challenge for not only the Council and CCGs, but also for local service providers and service users and their carers.

In accordance with the 2016/17 NHS England Planning Guidance the Kirklees planning footprint will be developing a Sustainability and Transformation (STP) for Kirklees in the coming months. Integration across this footprint which is enabled through the pooled budget arrangements in the Better Care Fund will be a key feature within this plan.

The Kirklees primary STP will link into an umbrella secondary STP across West Yorkshire 'Healthy Futures'. This arrangement will link the work which is been undertaken at a Health and Wellbeing

Board level into work which is being progressed at a regional level to ensure wider system sustainability.

Kirklees Health and Wellbeing Board

A key role of the Health and Wellbeing Board is to bring this complex tapestry of strategies, geographies and timelines together to ensure that the whole health and social care economy is working together effectively to achieve our overall vision for the future. The Board is chaired by the Portfolio Holder for Health, Wellbeing and Communities and has been meeting since mid-2011. The first Joint Health and Wellbeing Strategy was agreed in Autumn 2012, and has recently been refreshed. The refreshed JHWS has a much stronger emphasis on delivering integrated community based health and social care.

All the major local providers of health services and the police are invited observers on the Board. This has enabled all the major partners to participate in the strategic discussions at the Board about the future direction of health and social care in Kirklees.

BCF plan alignment with existing CCG operating plans for 2016/17 and STP

In 2014/15 a 5 strategic plan was developed across Kirklees with both CCGs also developing operational plans to support implementation of the strategic vision. Better Care Fund was a key enabler which runs through each of the progammes of work both within the strategy and operational plans.

Systems are required to come together over a specific footprint in 2016/17 to develop an STP, this approach to planning is inclusive of providers, commissioners and Local Authorities. CCGs are also required to develop one year operational plans which set out the local deliverables within the first year of the STP. The Kirklees STP and operational plans will build on the vision outlined in the Kirklees 5 year strategic plan and progress the transformation programmes which were detailed as supporting deliver the strategic vision. Within the STP and operational plans there are a number of strategic priorities which will ensure that we maintain sustainable health and social care services in Kirklees. These are identified as;

- Care at or closer to home
- Acute services transformation
- Transformation of primary care
- Transformation of planned care pathways and use of clinical threshold management to support new ways of working
- Integration and collaboration

Better care fund will continue to be a key enable which runs through each of these transformation programmes.

BCF plans alignment with plans for primary care co-commissioning

North Kirklees and Greater Huddersfield CCGs have embraced the co-commissioning agenda as a means to improve outcomes for our local populations.

Our aspirations and aims are:

- A more holistic approach to commissioning services for local people
- supporting greater integration of health and care services, in particular more cohesive systems of out-of-hospital care that bring together general practice, community health services, mental health services and social care to provide more joined-up services and improve outcomes;
- raising standards of quality (clinical effectiveness, patient experience and patient safety) within general practice services, reducing unwarranted variations in quality, and where appropriate, providing targeted improvement support for practices;

- enhancing patient and public involvement in developing locally-tailored community based services; and
- providing 24/7 primary care

North Kirklees CCG remain at a status of greater involvement which enables some influence over GP contracting decisions with the responsibility and accountability remaining with NHS England as the contract holders. Locally North Kirklees CCG will work to progress the co-commissioning agenda.

Greater Huddersfield CCG have full delegated authority.

It is anticipated that co-commissioning will provide us with levers to implement our care at or closer to home plans more effectively in particular in relation to the role of primary care in the service model.

10. Protecting social care services

It is accepted by all partners on the Health and Wellbeing Board that all aspects of health and social care are interdependent and of equal value and importance – any change in one part of the system can have an impact on another. The partners on the Board are committed to not taking action as a single commissioner that will have a potentially detrimental impact on the whole health and social care system, without prior consultation and engagement with all partner organisations. The Board have signed up to a set of joint commissioning principles. Through adhering to these principles in all our joint planning work, we aim to ensure that social care, along with all other parts of the health and social care system are protected.

The BCF will seek to protect identified services that impact on the key BCF outcomes set out in our Vision. This will make a significant contribution to ensuring funding is in place for the local authority to sustain its commissioning and delivery of key social care services – and the future developments necessary to deliver the Care Act duties.

We will focus on improving outcomes for people, particularly through prevention and early intervention and reducing pressures on services later in the care pathway – for example focusing on reablement and active rehabilitation which should reduce the net impact on residential and nursing home placements and release resources. We will use the BCF in new and innovative ways to enable us to implement the Care Act. A working sum for implementation has been identified in line with national allocations. Our Better Care Plan acknowledges within the overall priorities, the design of specific schemes and overall financial allocations the need to sustain local services that will best impact upon our system and current demand pressures.

The BCF will contribute towards supporting social care across the three domains of the Care Act - 'prevent, reduce and delay'. The key areas of investment include:

- support to Voluntary and Community Sector Partners
- development of self-care support
- improving reablement, hospital avoidance and mobile response teams
- bed based intermediate care
- integrated equipment service, assistive technology, adaptations
- support for carers
- packages of support including 'self-directed support', residential placements, home care
- care management

11. 7 day services in health and social care

This commitment is clearly articulated in both CCGs operational plans, the Council's Vision for Adult Social Care and will be a key deliverable within the Kirklees STP. Continuing further the development of 7 day services in health and social care will be progressed through the further implementation of care closer to home, plans for acute services reconfiguration and implementation of the primary care strategies which have been developed by both CCGs.

A range of schemes have already been put in place, including;

- Implementation of an integrated model of care for community services through re-commissioning of the community services contract. This includes urgent and routine community nursing work streams, a single point of contact for both adults and children and a more holistic approach to care through better integration with mental health and GP practices.
- 24 hour mobile response for care phone users to reduce transfers to Emergency Department and hospital admissions
- Additional resource to support Hospital Avoidance including rotational working in the Emergency Department from community based staff
- 7 day assessment and discharge facilitation for social care in hospital and in intermediate care facilities
- Transformation of the Continuing Health Care Team to provide continuing care nurses in our acute hospitals to facilitate timely Decision Support Tools are completed and discharge is supported to prevent delays.
- Support to a number of additional primary care schemes to improve access to primary care services at weekends. These schemes aim to reduce unnecessary admission and pressure on the urgent care system.
- Over pressured times, such as winter, support to intermediate care through additional capacity in step up/step down provision and immediate and on-going support to vulnerable adults working with voluntary agencies, for example, Age UK.
- Additional specialist palliative care provision including the availability of 7 day access to beds and a 24 hour helpline

The Mid Yorkshire SRG have identified through their work with the ECIP 8 high impact changes which will be fully in place by 2017 when the final Meeting the Challenge changes are implemented, this includes

- Consultant led morning ward rounds should take place 7 days a week so that discharges at the weekend are at least 80% of the weekday rate and at least 35% of discharges are achieved by midday throughout the week. This will support patient flow throughout the week and prevent A&E performance deteriorating on Monday as a result of insufficient discharges over the weekend.

In addition to the schemes detailed above Greater Huddersfield CCG have implemented the following:

- 7 Day Therapy: enhancing the Physiotherapy and Occupational therapy ward staffing in order to provide a robust 7 day service across all critical care, Respiratory, AE, MAU, SSU, Medical and complex care ward areas at both CRH and HRI.
- Physician in A&E: a senior medical doctor between the hours of 10am and 6pm together with an MAU senior nurse at the front door of A&E. The senior medical doctor grade and experience of working on MAU will enable them to make decisions about discharging patients.

- Virtual Ward: The Virtual Ward team are a dedicated multi-disciplinary team designed to identify and support those patients who are at high risk of readmission following a discharge from hospital.

The national clinical standards for 7 day services are being progressed by the Systems Resilience Groups which are operational across each respective acute trust footprint. Action plans are in place to achieve three of the standards by March 2017. Mid Yorkshire Hospitals NHS Trust have been selected as an early implementer of this programme.

12. Data sharing

Kirklees has an established information governance and information sharing framework which covers both NHS and Local Government IG requirements (through the West Yorkshire Wide Information Sharing Protocol) and we are committed to ensuring all developments take place within established guidelines. The West Yorkshire wide Protocol provides the framework for sharing of data across health and social care partners in Kirklees and has supported our local work so far in integrating care in Kirklees.

Within our Better Care Fund plan we will continue to ensure that IG does not act as a barrier to delivery of integrated health and social care. Our BCF plan, along with our existing governance arrangements for data/information, will support the culture change required to encourage the sharing of relevant personal confidential data among registered and regulated health and social care professionals where there is a legal basis, as highlighted within Caldicott 2.

We recognise the importance of information sharing to support the integration of services; as a result Commissioners and providers in Kirklees, including the Council, are using the NHS Number as the key identifier for correspondence across all health and care services. As part of our ambition to integrated commissioning intelligence across the pathway of care (through CareTrak) we are working closely with HSCIC DSCRO to ensure that data flows are in line with Caldicott 2 and have a number of data sharing and data processing agreements in place. However, there are acknowledged challenges around delivering IG for integrated working, especially shared data (and the specific legal basis for flows of data from HSCIC), shared systems and common care processes. Therefore, within our BCF plan we propose to establish a Kirklees wide Informatics Board to strengthen the locality wide approach to information governance and joint data flows.

NHS Number

Use of the NHS number is a key enabler that will support the local health and social care system in meeting the growing challenge of an increasing elderly population and a demand for health and social care that cannot be met by doing more of the same. In Kirklees, adopting the NHS number as the primary identifier for all social care records affects 150,000 social care service users, current and historic, from people receiving low level support through to those service users receiving intensive social care. In excess of 100,000 enquiries for social care support and 30,000 referrals for social care assessments are made each year, which adds to the affected population

Kirklees Council has proactively invested over the years in partnering with our CCGs to ensure all social care records are matched to an NHS number. Via several 'data matching' attempts we have successfully matched almost 150,000 social care service users to an NHS number which equates to around 80% of social care records. All matched NHS numbers are routinely uploaded to our core social care IT system to ensure the NHS number remains as the primary identifier for service users.

As more people live with long-term medical conditions, it will become increasingly important to find ways of taking earlier action to support people with preventive care aimed at promoting independent living. The ability to identify these people in both social and health domains, via the

use of the NHS number and the joining up of health and social care records, will enable targeted, effective support and preventive care aimed at promoting independent living. To this end our intention is to integrate social care records as part of our approach to the risk stratification of the Kirklees population enabling a more holistic view of the patient across the health and social care system.

Open APIs

Supporting the development of more open and connective systems through the use of open APIs is a key part of Kirklees' integrated offer. Open APIs is also integral to our preparations for the Care Act, we anticipate that interoperability will enable information to be easily accessed and shared between systems utilised by the Kirklees health and social care economy.

Universal adoption of the NHS number is crucial for interoperability to be effective. However, alongside this is the requirement for standardisation of health and social care information to enable data to remain portable across organisational systems. To this end we are engaged with the HSCIC in the national changes to social care data and returns with a view to ensuring national standardisation of key social care data.

Although Kirklees is committed to Open APIs this requires an assessment of cost and requires collaborative dialogue with system suppliers. In social care, system suppliers are actively engaged via the national ADASS Information Management Group on the tasks required within local authority adult social care informatics community to support implementation of the Care Act (and the Better Care Fund) – this includes local changes required to core social care IT systems to ensure APIs are both technically and commercially open to facilitate efficient integration of different systems.

The issue of legacy system publication of APIs remains a challenge in some areas. Older legacy systems are an area where obtaining APIs can be difficult. Some of these systems are based on non-current database technologies and/or non-current application/programming technologies. We have set up an Informatics workstream to support our preparations for the Care Act. An assessment of the systems across Kirklees has been carried out as part of this work and although Open APIs might not be available for all systems, it is felt that there are credible, safe, and secure mechanisms through which data can be accessed despite this.

Part of the work to support our approach to informatics is assessment of providers' internal systems to identify APIs. Where these are not available the alternate methods for data exchange are to be identified. It is recognised that some data items may not be available in real time, but rather a batched or cached version of the data would be held. Further assessment of these data items is part of our work on Informatics to support both the BCF and the Care Act

Information Governance (IG) Controls

Kirklees is working together as a health and social care community to develop and implement system-wide best practice information policies and protocols to support the sharing of patient/service confidential information. We have made some progress over the years on integrating health and social care systems and data. For instance, use of internal cross-organisational access to systems in key parts of care provision is providing a mechanism for access to shared information where systems aren't joined up. Matching and recording of NHS Number across social care systems is in place and ongoing via direct entry or batch tracing of NHS number. We have already used the national Demographic Batch Service to match almost 80% of current social care records to NHS numbers and uploaded these back to our core social care system CareFirst. This work is progressing, but there is still further work to be done, particularly on matching those records that do not return with a positive identification. Kirklees Council is also IGSOC compliant and utilises GCSX secure protocols when sharing data with Health partners.

Supporting our work is the use of contractual arrangements for employment and confidentiality, information sharing agreements and the overarching West Yorkshire wide Information Sharing Protocol which is used to facilitate and govern the effective sharing of data where relevant. The West Yorkshire wide protocol is supported with individual organisational policies across our partners.

In Kirklees there is a commitment to develop an IG framework for Integration and we are committed to maintaining data protection principles. Services will be enhancing current IG controls based on the recently published IG guidance by the HSCIC, this includes the 5 Confidentiality Rules and the Secure Email Specification (currently out for consultation). Local health and social care services will ensure that the requirements of the ISB0086 Information Governance Toolkit are complied with to provide the strategic assurance needed.

As part of our work in this area thus far a standardised consent form was developed jointly by the Council and the CCGs to be shared across all providers to support the process of gathering explicit and informed consent and enable sharing of person identifiable data across multiple providers. Supporting this was accompanying guidance and privacy notices to public and care professionals along with ICO recommended Privacy Impact Assessments. However, due to the national media profile of the care.data programme a board level decision was taken to postpone any further work in consent capture. We are hopeful however of using the BCF as a means of renewing our work to support the sharing of relevant information to realise our vision for the delivery of integrated care.

To ensure this work is driven forward in a co-ordinated way we are establishing an **Informatics** Group to oversee a range of key developments including:

- Information Governance arrangements
- NHS number as the universal unique identifier
- Integrated data flows and data sharing
- Risk stratification and demographic and behavioural segmentation
- A coherent set of dashboards
- Use of open APIs

13. Joint assessment and accountable lead professional for high risk populations

Kirklees has a well-established process for risk-stratification which enables us to risk stratify the whole population – all GP practices in Kirklees are engaged with this process and those at the highest risk are the subject of a Multi-Disciplinary Team (MDT) approach. From 1 April 2014 we will increase the threshold from the 1.5% most at risk to 2%, and the data is refreshed monthly.

This ensures that the system supports accountable lead professionals to work in a more proactive and preventative way, identifying patients before deterioration of health and ensuring they have a personalised care plan in place.

The risk tool currently utilised in Kirklees is the Adjusted Clinical Grouper model (algorithm from John Hopkins University), which is a positive progression from the Combined Predictive Model we have used over the last 3 years. The tool enables historical data to be presented in a patient centred manner, enabling a visual representation of all key primary, secondary and A&E related health activity against a patient timeline, we are working towards exploring the sharing of this directly with patients on a trial basis to further engage with patients as part of their care.

As one of eight early implementer sites for the National Year of Care funding model, we are working towards making our current joint working across health and social care more holistic and valuable to all the professionals involved, including trying to weight mental health and social care

users so that services are equitably balanced on the holistic needs of the patient (risk stratification is primarily focused on physical health indicators).

Kirklees have continued to ensure this work remains within an approach which is robust and compliant with data protection and information governance. We have recently taken Legal advice on the sharing of patient level data across the Kirklees health and social care system, with legal approval for the sharing of risk scores and risk segments (non-sensitive data) across health and social care. To support our work towards further integration and better targeted support, we are currently exploring ways in which Kirklees health and social care partners can obtain informed and explicit consent from patients and service users for the sharing of potentially sensitive care data.

Accountable lead professional

Locally we have agreed that a person's GP will be the default 'accountable lead professional'. The over 75 practice population across GHCCG and NKCCG is 30,400. However we also recognise that for some people in certain risk groups it will be more appropriate for another professional to be the accountable lead professional:

- community matrons for adults with severe long term illnesses or a complex range of conditions. (24 community matrons with a current caseload of 1,500, 217 over 75's are on Continuing Health Care and 323 on Funded Nursing Care)
- community psychiatric nurses for adult with ongoing, complex mental health and social care needs subject to Care Programme Approach. So far this year 2,600 people have received support through CPA.
- social workers for adults with complex on going social care needs, social workers also care manage people in receipt of Continuing Health Care (128 Social Workers and Senior Practitioners supporting around 6,000 people aged 65 and over and 3,000 18-64 year olds in the community and 2,000 adults/older people in residential and nursing care)

We have identified that embedding a coherent and consistent approach to assessment and care planning and co-ordination with a named lead is a major challenge that needs further work, and this has been highlighted in our BCF performance return as our only outlier against the national conditions.

We want our approach to embed the self-care principles that are at the heart of our BCF plans and it must therefore reflect the different needs and capabilities of individuals and their carers, and the skills and capacity of key health and social care staff.

Our successful bid to the regional Local Implementation Support Fund will enable u to bring in dedicated expertise to review the existing processes and support the community health service provider, Council, primary care and other partners to develop our local approach and ensure it reflects the principles set out in our BCF Plan.

The expertise will be provided by Attain under the CCG Lead Provider Framework. They provided support to the local system throughout the process of procuring the new community health services contract that went live in October 2015. As such they have detailed knowledge of the local system which makes them well placed to 'hit the ground running' and deliver this project.

As part of our BCF plan we are also piloting a suite of integrated commissioning intelligence via the CareTrak solution provided by PI Care and Health. This draws on both health and social care data and enables us for the first time to understand their journey across health and social care. The first tranche of analysis will be available in January 2016 and we want to use this to identify patient cohorts that would benefit from better care planning. The use of Caretrak data will also enable us to track the change in activity for the cohort that have used the new care planning, and compare this with historic data.

14. Local action plan to reduce delayed transfers of care (DTOC)

Many hospital beds are occupied by patients who could be safely cared for in other settings or could be discharged. Locally we have agreed that the two System Resilience Groups will lead on local plans to reduce delayed transfers of care, by ensuring that sufficient discharge management and alternative capacity such as discharge-to-assess models are in place to reduce the DTOC delayed days rate to 2.5%. This will form a stretch target beyond the 3.5% standard set in the planning guidance. Both SRGs have been working with the Emergency Care Improvement Programme (ECIP), and are committed to using the High Impact Change Model to inform the local action planning and implementation.

The following analysis has been developed in consultation with the NHS England DTOC Analytical Team to shows the local 2015/16 baseline and the 2016/17 full year rate to achieve the 2.5% provider targets.

Provider Targets	2015-16 YTD Delayed Days	2015-16 YTD Occupied Bed Days	2015-16 YTD Rate	2015-16 YTD Delayed Days KIRKLEES	% of Delayed Days in Kirklees	2016-17 Target Rate	Delayed Days Required to Achieve Target	Target days applied to Kirklees proportion
BARNSLEY HOSPITAL	824	114495	0.7%	69	8.4%	2.50%	2862	240
BRADFORD TEACHING HOSPITALS	2904	163184	1.8%	101	3.5%	2.50%	4080	142
CALDERDALE AND HUDDERSFIELD	12013	223911	5.4%	6095	50.7%	2.50%	5598	2840
CAMBRIDGE UNIVERSITY	15624	284898	5.5%	20	0.1%	2.50%	7122	9
HULL AND EAST YORKSHIRE	5134	318692	1.6%	3	0.1%	2.50%	7967	5
LEEDS TEACHING HOSPITALS	28339	522883	5.4%	28	0.1%	2.50%	13072	13
MID YORKSHIRE HOSPITALS	15036	312696	4.8%	2518	16.7%	2.50%	7817	1309
SOUTH WEST YORKSHIRE PARTNERSHIP	4342	157015	2.8%	1587	36.5%	2.50%	3925	1435
TOTAL	**84216**	**2097774**		**10421**			**52444**	**5992**

KIRKLEES RATES PER 100,000 Population	Numerator	Denominator	Annualised Rate
15/16 YTD Actual	10421	337499	3368.4
15/16 YTD To Achieve 2.5% Provider Targets	5992	337499	1936.9
16/17 FULL YEAR Rate to Achieve 2.5% Provider Targets	6581	339751	1936.9

Mid Yorkshire SRG High Impact Changes

Key outcomes within the DTOC action plan include;

- Staff understand the relevance of accurate DTOC reporting in relation to targets and returns
- A thorough process is in place to accurately identify all delays across MYHT
- The reporting process is in line with national reporting guidelines and a localised System Operating Plan (SOP) ensures partner organisations work collaboratively.

- A process is in place to demonstrate effective management of existing and new cases and this is accurately recorded and monitored.
- Complex cases are managed effectively from a multi-disciplinary and case management approach.
- Issues identified regarding potential inaccurate recording will be managed in a timely manner by ensuring staff are effectively trained in the coding and reporting process.
- Enablers to facilitate the moving on of delays, such as management of patient expectation, the moving on policy and the engagement with community partners on alternatives to acute beds, is in place.
- Staff are educated on how to effectively complete assessments.
- The principles of the Safer Care Bundle underpin timely discharge planning.
- A "Home First" approach is adopted across MYHT

Current Work:

- Commissioned new service model as part of CC2H which will put in place both admission avoidance services, services at the entry point at A/E, and support and pull for discharge. The Services are easily available through a single point of access and responsive within a period of 2 hours 24/7 where needed.
- Hospital discharges are supported to transfer as soon as the patient is medically optimised and assessed for further care within their own home by the most appropriate professionals.
- This is monitored as part of the contract for CC2H with KPIs.
- We are working with the CC2H provider and the LA to develop a new model of a flexible bed base, part of which is discharge to assess to ensure that people are supported and assessed in the most appropriate environment to meet their needs. This will include enhanced support at home, to services and beds in other locations.
- The new model also ensures best practice in all areas of delivery across mental and physical health and demonstration of person centred coordinated care.
- MYHT are part of the Delayed Transfers of Care Improvement Programme. The preparatory visit took place on 08/03/16 and the development of the PDSA cycles on specific areas will be put in place and monitored by the SRG

Calderdale & Huddersfield SRG High Impact Changes

The Calderdale and Greater Huddersfield SRG has developed an action plan – 'Implementing high impact changes – managing delays in the transfer of care from hospital beds'. The Action Plan provides an overview of the planned work for 2016/17. Whilst the SRG have developed action plans separately for Calderdale and Greater Huddersfield which reflect the operational differences that exist, one of the key principles is to ensure consistency of approach wherever possible, particularly at the interface with hospital care.

See Appendix 4 Calderdale and Greater Huddersfield SRG: Implementing high impact changes – managing delays in the transfer of care from hospital beds.

15. National Metrics

Non-elective admissions (General and Acute)

The NEA trajectory for 2016/17 is based on a capacity plan which has been agreed with providers through contract negotiations. This plan takes into account growth, other national conditions and is informed by the delivery of our local transformation plans and the impact of 2016/17 QIPP challenge.

Admissions to residential and care homes

Planned 2016/17 rate of admissions accounts for growth in older people population. Note also that there is a new ASCOF definition for this metric from 2016/17 onwards which now includes admissions of older people funded fully by Health. Planned trajectory does not yet account for this change in definition (i.e. plans are based on the current ASCOF definition) as the new requirements are currently being refined locally.

Effectiveness of reablement

Given the growth in NEA admissions during 2015/16, along with increasing complexity of need in older people at the point of discharge (data also indicates a growth in live discharges for older people in Kirklees) our forecast suggests performance against the indicator will be below plan. However, through BCF 2016/17 we anticipate increasing maturity of our BCF schemes, this along with improved flows of pathway data equates to a more confident forecast of 94.8% during 2016/17

Delayed transfers of care

See Section 14

Estimated diagnosis rate for people with dementia

Kirklees Dementia Strategy was agreed by the Health and Wellbeing Board in November 2015. Increasing the diagnosis rate is a key feature of the associated implementation plan.

Patient Experience

Everyone Involved in my Care knows my Story:
(i)Improvement in response Rate on completion of care episode
(ii) Increase in % of patients/carers reporting satisfaction about the level of information services have about them on transfer

This is a new measure and the baseline data is now being collected.

16. Engagement

All health and social care partners are committed to using statutory and local structures and processed for ensuring that the views of local people are effectively represented in our planning and decision making:

- The Health and Wellbeing Board have been actively engaged as we jointly develop our integrated community service models.
- The Overview and Scrutiny Panel for Well-Being and Communities have taken a very active role in helping shape and challenge local plans for health and social care (link), including a Joint Scrutiny Panel with Wakefield on the Mid Yorkshire Hospital proposals (link).
- Our local HealthWatch actively seeks the views of local people on a wide range of issues including those related to our BCF proposals.
- Patient and carer panels, eg as part of the CC2H process and to inform our implementation of the Care Act
- Targeted engagement activity with specific user groups in service areas where major change is possible.
- public events at which public, patients, carers and stakeholders will be asked for views and opinions about changes to community based services

The North Kirklees CCG and Greater Huddersfield CCG undertook consultations on their joint Care Closer to Home (CC2H) programme which focuses on the development of integrated, community-based healthcare services across Kirklees which support people to stay healthy and live independently for longer.

The Greater Huddersfield CCG together with Calderdale CCG are undertaking a major consultation on the future shape of the healthcare services at Huddersfield Royal Hospital and Calderdale Royal Hospital link.

The Mid Yorkshire Hospitals Clinical Services Strategy undertook a substantial 'Meeting the Challenge' consultation on their reconfiguration of services (link). A major plank the engagement activity throughout the implementation phase was 'Our Street' link . Our Street is a virtual street with typical houses and residents. The street's residents are used to explain and engage people in the service provision and changes through their health and social care issues

The Council's innovative "Time to Talk" engagement programme (link) enables members of the public to find out about and inform the Council's Budget process. The challenges facing health and social care have been and continue to be an integral part of this conversation.

The Council also has well established mechanisms to enable the voice of users, carers and the wider public to be incorporated into proposals for service development / redesign which include:

- Membership of the Partnership Boards referred to above and their sub-groups, the Carers' Strategy Group, and the new carers service, 'Carers Count'.
- Consultation on specific service developments/changes, e.g. the Kirklees Integrated Community Equipment Service
- On-line tools, including social media and Community Conversations (link)

NHS Foundation Trusts and NHS Trusts

Our on-going engagement with key stakeholders has included the acute trusts locally.

Acute trusts were identified as a key stakeholder in the commissioning of the care closer to home model and engagement activities were undertaken to ensure they had the opportunity to contribute to its development.

The Better Care Fund aligns directly to our Operational Plans which were developed with contribution and engagement from both acute trusts. Our plans are currently being developed and will be presented to Acute Trusts as part of the ongoing engagement process.

Acute Trusts have been identified as being key stakeholders in the development of the Kirklees STP and as a consequence will be involved in the development and implementation of this.

Implications for acute providers

Across both Greater Huddersfield CCG and North Kirklees CCG areas the volume of emergency and planned care activity in hospitals will reduce through alternative fully integrated community-based services. This will enable a reduction in acute beds.

As described above the timescales for the two strategic reviews will have a major influence on the implementation of the BCF.

North Kirklees are now in year 3 of the implementation phase of the Mid Yorkshire Clinical Services Strategy and the outline business case has identified a number of evidence based opportunities for reducing admissions and length of stay for people in the North Kirklees area. North Kirklees CCG has proposed schemes to manage the acute hospital demand down from the expected 3% to 1% and this has been assumed within the Mid Yorkshire full business case. The plans also include interim schemes that support the discharge process and aim to reduce the number and effect of delayed discharges within the hospital and support people to be cared for closer to home for example increased specialist nurses to support patients with COPD and heart failure and increased access to community nurse provision over 2016/7.

The schemes are described in a series of Business Cases that have been developed and approved by North Kirklees CCG. Each of the schemes were chosen to assess how the improvements in service quality and service access could achieve a reduction in 9,600 (20% stretch 11,520) emergency bed days (No. of Admissions X Length of Stay = Bed Days).

A number of these schemes have already been put in place and are part of the BCF, these include:

- Additional specialist community nurses and increased capacity to respond to crisis.
- Additional resource for the Hospital Avoidance Team including rotational working in the Emergency Department
- Provision of a Continuing Care Nurse in Mid Yorkshire Hospitals Trust to ensure Decision Support Tools are completed in a more timely way.
- Additional specialist palliative care provision including the availability of 7 day access to beds and a 24 hour helpline.
- 7 day assessment and discharge facilitation for social care in hospital and in intermediate care facilities.
- 24 hour mobile response for care phone users to reduce conveyance to Emergency Department and hospital admissions.

North Kirklees Schemes	Current schemes	20% stretch
Admission Avoidance Schemes		
HAT (hospital avoidance service)	1,301	1,561
Community capacity (additional hours of teams, Specialist nurses, technology, MDT)	3,456	4,147
Hospice schemes	495	593
Total for admission avoidance	5,251	6,301
Supported Discharge Schemes	4,349	5,219
Total by end of 2016/17	9,600	11,520

North Kirklees CCG are in the process of assessing the additional benefits of the implementation of the care closer to home model and the impact this will have in contributing to reducing non-elective admissions and improving early supported discharge.

In addition the urgent care transformation programme is being delivered alongside the clinical service strategy for Mid Yorkshire Hospitals Trust. North Kirklees CCG is committed to ensuring a vibrant urgent health care environment at Dewsbury and District Hospital, recognising the opportunity to strengthen the offer through the integration of 24/7 primary care provision. Plans are being developed to move towards a more integrated emergency department model with primary care support at the 'front end' in line with the Keogh recommendations.

The Calderdale & Greater Huddersfield Right Care, Right Time, Right Place is a key vehicle for driving forward significant and radical transformational change across the system and delivering £167m of efficiency savings over next five years. The work is aimed at integrating health and social care services through the collaboration between its seven partners - to shift the balance from unplanned hospital based care to planned community based services coordinated around General Practice where appropriate. The seven partners are formally committed to this collaboration and the approach to realising system efficiencies which are critical to system change.

Our CCG 5-Year Plan assumes, taking account of 1% demographic growth, a 3% reduction in acute activity per annum which is the basis on which we have set our improvement trajectories in our Better Care emergency admission metric.

The anticipated improvement trajectories we are working to are as detailed below:

Greater Huddersfield	Non Elective	Emergency
2014/15	24934	4790
2015/16	25183	4646
2016/17	25435	4507
2017/18	25690	4372
2018/19	25946	4241

We can confirm that CHFT would recognise the content of this section of template and would be comfortable with the approach outlined.

The Right Care, Right Time, Right Place is now at a key stage. Three providers – Calderdale and Huddersfield NHS Foundation Trust, Locala, and the South West Yorkshire Partnership Foundation NHS Trust – have produced a Strategic Outline Case which sets out their response to the shared vision of all the Strategic partners. The CCG is now undertaking a widespread engagement process which will enable us to confirm any options for a future public consultation.

At the same time, the providers are producing an outline business case which will set out in more detail the modelling assumptions used, including our shared understanding of the likely

implications of the Better Care Fund. The OBC will reflect work already done to identify scope for improvement in areas such as length of stay, discharge management and bed usage already highlighted through the Trust's Interserve programme of work.

While this work progresses, we are using existing mechanisms such as the Urgent Care Working Group and established contract management groups to maintain a dialogue with providers about the Better Care Fund, to ensure there are 'no surprises'.

Primary care providers

In addition to the activities outlined above we have undertaken specific engagement activities with our GP membership to involve them in the ongoing development and implementation of the care closer to home model and the acute service transformation proposals, which are key in achieving the desired outcomes of the better care fund. Our GP membership were also key in the development of the 2 primary care strategies and are signed up to the implementation plans which have been put in place to operationalise these.

We recognise that primary care providers are key stakeholders in delivering and supporting the functions identified in our community models. On a regular basis we have presented proposals and requested feedback at GP forum meeting and GP cluster meetings and they have also participated in wider stakeholder engagement across Kirklees.

Both CCGs have developed strategies for transforming Primary Care. The principles for transforming primary care across Kirklees are;

- Improving access to a broader range of primary care services, including enhancing the range of diagnostics in primary care
- Reducing dependency on hospital services and shifting the balance of care from unplanned to planned. This will be particularly valuable for vulnerable patients with long term conditions and complex needs.
- Responding to the urgent care agenda with aspirations for 24/7 primary care provision through extended hours and demand and capacity analysis
- Reducing variation in services and improving quality
- Enhancing the services offered to patients by optimising the use of NHS resources, including the use of technology and referral management systems
- The central role of general practice and community based teams in the management of patients with long term conditions
- Services wrapped around the registered populations of our practices
- Practices working collaboratively to deliver services at scale
- Supporting patients and carers to manage their own health and care

We have placed particular focus on improving patient access to primary care services, providing primary care at scale, improving quality and reducing clinical variation and ensuring we have a sustainable workforce for the future. A central theme will also be working closely with primary care to ensure integration into the care at home models.

17. Appendix 1 Kirklees BCF Implementation Plan 2016/17

Action	Lead	Timescale
1. **Mobilisation of Care Closer to Home** Programme (CC2H), including piloting of Locality Teams	CC2H Integration Board	ongoing
2. Implement **plans for the individual BCF Schemes**	BCF Partnership Board	ongoing
3. **Review all BCF schemes** for impact against BCF outcomes and value for money (making use of CareTrak outputs). Programme of reviews to be agreed at BCF Partnership Board.	BCF Partnership Board	May 2016
4. Review and refine current approaches to **assessment and care planning** across health and social care (based on the outputs from the BCF Local Improvement Scheme funded project)	Integrated Commissioning Executive (ICE)	June 2016
5. Review current pattern of investment across **intermediate care, reablement and rehabilitation** and develop proposals to maximise impact and value for money. Proposed approach to be agreed at ICE	ICE	August 2016
6. Develop **an integrated Care and Nursing Home Support Team** to deliver the new Care Home Strategy, starting with a team development and action planning event.	ICE	May 2016
7. Develop and agree an **integrated approach to managing continuing care**	ICE	June 2016
8. Develop an **integrated strategy for 'Aids to Daily Living'** covering community equipment, assistive technology and adaptations	ICE KICES Board	December 2016

Action	Lead	Timescale
9. Continue development of **self-care approach and roll-out of MyHealthTools**	Health Improvement ICG Self Care Board	ongoing
10. Reprocure the **Drug & Alcohol service**	Health Improvement ICG	April 2016
11. Implementation of **Kirklees End of Life Strategy**	OPPSI ICG/CCGs	Ongoing
12. Incorporate **Mental Health Voluntary and Community Sector contracts** into the BCF Section 75 Agreement	Mental Health ICG	Sept 2016
13. Develop a whole system approach to **medications support for people receiving domiciliary care**	OPPSI ICG	Sept 2016
14. **Integrated workforce development plan** to support the new delivery models in place	ICE	Sept 2016
15. Develop **models of patient flows** along key health and social care pathways to inform pathway change/redesign using outputs from CareTrak	ICE/Informatics Working Group	June 2015
16. More coherent **arrangements for joint intelligence** across CCGs, Social Care and Public Health in line with the New Council Integrated Intelligence Hub and Spoke Model	Integrated Intelligence Group	March 2017

Action	Lead	Timescale
17. Establishment of a **Kirklees Wide Informatics Board**, supported by a Local **Informatics Working Group** to oversee development of:		
17.1. The Kirklees Local Digital Roadmap – in partnership with the CCGs and providers, move towards a paper free point of care by 2020 in line with the Governments Five Year Forward View	Digital Roadmap Group	Ongoing
17.2. In collaboration with NHSE and LGA, pilot the Social Care Digital Maturity Assessment to support national work on identifying the digital and informatics needs of the social care sector		June 2016
17.3. Develop integrated data flows and data sharing, starting with mapping of all key internal and external data flows	Integrated Intelligence Group	Sept 2016
17.4. Risk stratification model incorporating a comprehensive range of health and social care data		Sept 2016
17.5. Demographic and behavioural segmentation tools making best use of local data being used routinely by commissioners and service planners		Sept 2016
17.6. Information Governance arrangements – compliance with IGTK Level 2 standards as well as undertaking a cost/benefit analysis of achieving ASH status	Information Governance Board	Dec 2016
17.7. NHS number as the universal unique identifier and all necessary agreements are in place to share individual data for care planning and service planning		Jan 2017
17.8. Dashboard which links to other Dashboards, eg Urgent Care Board, System Resilience Groups	Integrated Intelligence Group	
17.9. NHS Open Standard Contract compliance – use of open APIs Potential use of APIs in Council contracts	BCF Performance Group	Jan 2017 March 2017
18. Agree the respective roles of the **Integrated Commissioning Executive (and BCF Partnership Board) and two System Resilience Groups**, especially in relation to DTOC.	ICE	May 2016
19. Ensure that the development of the **Sustainability & Transformation Plan**, the Councils **early intervention and prevention** approach and the BCF Plan are consistent	ICE	June 2016

18. Appendix 2 Kirklees BCF Risk Log

Risks	*Likelihood x impact =* Overall risk			Mitigating Actions	Responsibility	Timescale
1. Shifting of resources to fund joint interventions and schemes will destabilise current service providers, particularly in the acute sector – (across both the GHCCG / CHFT & the NKCCG / MYHT geographical patches)	3	5	15	1.1 Our current plans are based on the agreed strategies for Calderdale & Greater Huddersfield CCGs as agreed in the Right Care, Right Time, Right Place which includes all 7 health & social care agencies in the locality; and the North Kirklees & Wakefield CCGs as agreed in the Mid Yorkshire Hospitals Clinical Services Strategy which includes the 8 health & social care agencies in the locality. 1.2 The development of our plans will be conducted within the framework of both the Strategic transformation programmes, allowing for a holistic view of impact across the Kirklees landscape and putting co-design at the heart of this process.	CCGs Ongoing	Complete Ongoing
2. GH & NK CCG QIPP plans fail to realise the levels of savings required to establish the fund.	3	5	15	2.1 The CCGs QIPP Programmes have been carefully planned to meet the level of savings required to release funding flows. 2.2 Our savings programmes will take into account the target reduction in emergency admissions 2.3 We have established an integrated commissioning executive with escalation to our Health & Wellbeing Board which will drive through implementation of the Better Care Fund.	CCGs CCGs ICE	Complete April 2016 Ongoing
3. Improvements in the quality of care and in preventative services will fail to translate into the required reductions in acute and nursing / care home activity , impacting the overall funding available to support core services and future schemes.	3	5	15	3.1 We have modelled our assumptions using a range of available data, including metrics from other sources such as the West Yorkshire 10CCG collaborative and each of our Strategic Transformation programmes.	CCGs	Ongoing

Risks	*Likelihood x impact =* Overall risk			Mitigating Actions	Responsibility	Timescale
4. Community and social settings may be unable to pick up increased demand as care moves from acute settings.	4	3	12	4.1 All partners are committed to shifting resources where possible to increase capacity in community and social settings.	ICE	Ongoing
5. Workforce plans do not align with changes in skill set required to deliver our planned changes.	3	5	6	5.1 Partners are committed to making the capacity to support organisational and workforce development available. 5.2 Senior commissioners and workforce leads to develop an overarching workforce development plan	CCG/Council ICE	Ongoing Sept 2016
6. Work outlined may not adequately ensure the Protection of Adult Social Care services.	2	3	6	6.1 The Protection of Adult Social Care Services has been fundamental to the development of proposals and of Kirklees' wider ambition of a high quality and sustainable health and social care system. The focus has been on protecting existing spend whilst developing an investment pool to invest to reduce overall health and social care spend.	Council	Ongoing
7. Misalignment of commissioning plans for primary care services in Kirklees as these are dependent on NHS England Area Team Specialist Commissioning plans.	2	4	8	7.1 Develop more robust relationships with NHS England through co-commissioning	CCG NHS England	Ongoing
8. The number and complexity of providers and lack of alignment of organisational approaches, e.g. different approaches to procurement and contracting	2	3	6	8.1 Creation of a partnership vehicle to manage and deliver contracts and/or procurement	ICE	tbc

Risks	*Likelihood x impact =* Overall risk			Mitigating Actions	Responsibility	Timescale
9. Lack of information sharing and access to data between health, social care and wider stakeholders	3	3	9	9.1 We have made significant progress on this as part of the CareTrak project, and will be further developed through the Informatics Board	ICE/ Informatics Board	tbc
10. BCF schemes do not deliver the planned reduction in emergency admissions resulting in higher costs to the CCGs	3	5	15	10.1 We have aligned our BCF schemes with our CC2H commissioning intentions & have invested during 2015/16 in a number of business cases which are complementary to our BCF programme, identified within QIPP & Non recurrent programmes, which will contribute to the total reduction in emergency admissions on a wider system basis.	CCG	ongoing
11. Section 75 agreement not in place by June 2016	2	3	6	11.1 Critical path agreed by the BCF Partnership Board, recognising that this is a continuation of the 15/16 Section 75 Agreement.	BCF Partnership Board	June 2016

19. Appendix 3 Terms of Reference for the Kirklees Better Care Partnership Board

1. Membership

1.1 **GHCCG**

- Head of Strategic Planning & Service Transformation
- Chief Financial Officer

or a deputy to be notified to the other members in advance of any meeting

1.2 **NKCCG**

- Head of Strategic Planning & Service Transformation
- Chief Financial Officer

or a deputy to be notified to the other members in advance of any meeting

1.3 **The Council**

- Assistant Director, Commissioning & Health Partnership
- Head of Commissioning & Quality
- Consultant in Public Health

or a deputy to be notified in writing to Chair in advance of any meeting and the substitution will be recorded in the minutes.

1.4 The CCG Chief Officers and the Director for Commissioning, Public Health and Adult Social Care shall be able to attend any Board meeting.

2. Role

The Partnership Board shall:

a) Provide strategic direction on the Individual Schemes;

b) receive the financial and activity information;

c) review the operation of the Individual Schemes and make worthwhile recommendations to the Lead Commissioners (subject to Clause 30.2);

d) Oversee the national BCF Payment for Performance regime and any local performance payment arrangements;

e) Make recommendations for use of any underspend or inclusion of additional schemes for endorsement by relevant decision-making bodies in the Council and CCGs;

f) Identify new opportunities to meet the stated aims of the Better Care Fund;

3. Partnership Board Support

3.1 The Partnership Board will be supported by officers from the Partners from time to time.

3.2 Although not mandatory, it is anticipated that at least one finance officer and one performance officer will attend every Partnership Board meeting to provide relevant finance and performance input on the operation of the Pooled Fund and the Schemes.

3.2 The Council, as Host, will provide sufficient administrative support to ensure the effective operation of the Partnership Board.

4. Meetings

4.1 The Partnership Board will be chaired by the chair of ICE or his nominee. In the absence of such a person attending a meeting, a chair for the meeting will be nominated from those present.

4.2 The Partnership Board will meet at least quarterly at a time to be agreed following receipt of each Quarterly report of the Pooled Fund Manager. It may meet more often.

4.3 Agendas and supporting papers will be sent to members of the Board five working days before the meeting.

4.4 The quorum for meetings of the Partnership Board shall be a minimum of one representative from each of the Partner organisations.

4.5 The Partnership Board has no power to make decisions and is not an entity in its own right but for the avoidance of doubt any matters requiring resolution within the role of the Partnership Board shall be resolved unanimously.

4.6 No Partner shall be subject to any commitments above those which are set out in this Agreement at 1 April 2015 unless that Partner expressly agrees to them in writing.

4.7 Minutes of all meetings and declarations of conflict of interest shall be kept and copied to the Authorised Officers within seven (7) days of every meeting.

5. Delegated Authority

The Partnership Board is not a decision-making body and has no delegated authority. Any recommendations will be taken through the appropriate governance mechanisms of the Partner organisations.

6. Information and Reports

The Pooled Fund Manager shall supply to the Partnership Board on a Quarterly basis the financial and activity information as required under the Agreement.

7. Further Reporting Arrangements

7.1 The minutes of the Partnership Board will be presented to the Chief Officers Group (which consists of the chief officers of each of the CCGs, the Chief Executive of the Council, the Director of Commissioning, Public Health and Adult Social Care, the Director of Childrens Services, and the Director of Public Health).

7.2 A Quarterly report will be presented to:

- Kirklees Council's Cabinet as part of the corporate performance report
- GHCCG's Finance & Performance Committee
- NKCCG's Quality, Performance & Finance Committee
- Chief Officer Group

7.3 The CCGs' Chief Financial Officers and the Council's Director of Finance will be invited to attend the Chief Officer Group meetings which receive the Quarterly Reports to ensure an appropriate level of 'financial stewardship'.

7.4 Reports on specific issues will be prepared for consideration by the Council's Cabinet, the CCGs' Governing Bodies, and the Health & Wellbeing Board, as appropriate.

20. Appendix 4 Calderdale and Greater Huddersfield SRG: Implementing high impact changes – managing delays in the transfer of care from hospital beds

Change 1: Early Discharge Planning.

Greater Huddersfield/Kirklees footprint	
Current Rating and rationale	Level 2: whilst we have plans as a system to improve discharge planning we do not currently have joint pre-admission discharge planning in place. Not all emergency admissions have a discharge date set within 48 hours of admission. We have primary care discharge nurses working with several practices in Greater Huddersfield. The whole hospital is not currently focused on discharge dates for those admitted non-electively. The delivery of integrated health and social care teams is being developed as part of Vanguard/CC2H but as yet is not provided at scale.
Actions to be taken	a) Complete development of an integrated discharge model business case and agree with all partners including strengthening the role of primary care b) SRG to agree case and funding (Q1) c) Implementation Plan for new model agreed by DTOCB (Q1) d) Begin implementation of relevant recommendations from the January 2016 ECIP report (Q1) e) Implementation of operational SAFER bundle activity in CHFT and with partners as necessary (Q1) a) Ensure all partners are sighted on plans to integrated health and social care teams to support discharge (Q1)
Leadership	TOC Board
Measurement	• Provisional discharge dates set upon admission (non-elective care) - % to be locally agreed. • 100% of discharge dates are set prior to admission for (elective care) • Patient experience KPIs to be confirmed • Delivery of KPIs in business case for integrated model • Delivery of KPIs/ECIP recommendations

Change 2: Systems to Monitor Patient Flow

Both footprints	
Current Rating and rationale	Level 1: this level describes well the current issues in our system. We have started work to understand capacity and demand issues, but this is at a very early stage and does not currently include; calculations of capacity needed to meet demand on different pathways or analysis of bottlenecks and the changes in practice needed to make the changes sustainable. We need improvements in real-time data capture as well as a more robust system-wide approach to planning capacity to meet demand.

Actions to be taken	a) Continuation of work to strengthen flow information in advance of an agreed system (Q1) b) Further development of proposals to new system to manage flow – as discussed at SRG (Q1) c) Agreement on system BI and informatics support needed for current and future system (Q2) d) Being implementation of relevant recommendations from the January 2016 ECIP report (Q1)
Leadership	TOC Board
Measurement	• Performance data available for DTOCB and SRG • New system in place and supporting improvement

Change 3: Multi-Disciplinary/Multi-Agency Discharge Teams, including the voluntary and community sector

Greater Huddersfield/Kirklees footprint	
Current Rating and rationale	Level 2: Multi-agency MDTs Monday to Friday during periods of surge but not standard practice daily at other times with ASC attendance in HRI. Development of model of 'roving MDT' being developed. Discharge to assess models only used where patient meets re-ablement criteria, not standard practice and do not fully utilise community-based opportunities including third sector. Work to do on 'trusted' discharge plans. However, we do deliver some elements of Level 4 - in Continuing Care, most DST's generated are now completed following discharge from hospital especially where transfer to a care home is required. To facilitate discharge to the appropriate placement prior to DST completion, a pragmatic decision is made as to whether the individual requires a nursing placement; the CCG agree to fund the Funded Nursing Care element until the DST is completed. Plans are in place to provide further training between health and social services to support the CHC assessment process, this will improve efficiency in both the acute and community settings. The Continuing Care Team has a designated Lead Nurse at HRI and DDH and this continuity enables a good working relationship between health and Social Services. There is also a buddy system to share good practice.
Actions to be taken	a) Build on current processes are in place for tracking and action planning the number of outstanding assessments; the list should reflect new cases daily and how many days existing cases have been waiting and how many cases were completed and taken off list previous day (Q1) b) Ensure process in place to tackle long waits an integrated health and social care focus group and action plan for each case with clear discharge dates as a matter of priority (Q1) c) Complete development of an integrated discharge model business case and agree with all partners (Q1) d) SRG to agree case and funding (Q1)

	e) Implementation Plan business case agreed by DTOCB (focus on initiation of MDTs and Discharge to Assess) (Q2) f) Commence delivery of relevant recommendations from the January 2016 ECIP report (Q1) a) Implementation of operational SAFER bundle activity in CHFT and with partners as necessary (Q1)
Leadership	TOC Board
Measurement	• Number of joint MDTs taking place • % patients covered by joint MDT working • % MDTs with community/third sector involvement • No/% of patients discharged to assess

Change 4: Home First/Discharge to Assess

Greater Huddersfield/Kirklees footprint	
Current Rating and rationale	Level 3 – Joint reablement services in place, improvements in number of people admitted permanently to care homes. The only caveat for this assessment is the fact that we are not currently meeting the target for care home assessment in 48 hours. Currently the majority of people do not return home prior to their assessment and we do not deliver care home assessments within 24 hours (see caveat for this element of the assessment above)
Actions to be taken	a) Continue work to strengthen current joint reablement services, including strengthening KPIs, response times and capacity and demand analysis (Q2) a) Confirm SRG views on involvement in the national programme "Shared Lives" (Q1) b) Further work to be done with care homes who are unresponsive to requests to speed up assessments in hospital – linked to contractual levers where possible (Q1) a) Pilot discharge to assess with care homes in Calderdale (Q2)
Leadership	TOC Board Care Homes work-stream in Kirklees
Measurement	% people discharged into joint reablement services and no. of days taken for discharge to take place % people in receipt of joint reablement still at home 91 days after discharge %care home assessments undertaken in hospital within 48 and 24 hours of agreement to discharged % assessments undertaken at home/care homes rather than hospital % people discharged home % people admitted into permanent residential/nursing care

Change 5: Seven-Day Service

Greater Huddersfield/Kirklees footprint	
Current Rating and rationale	Level 1: Plans for 7DS being developed with NHSE, some hospital departments are available at evenings at weekends and plans are being developed to expand this further. However it is recognised that the current configuration of acute care does not facilitate this happening at scale currently. We do not have new 7 day working patterns across health and social care, and hospital departments are not widely available 24/7. We do not have contracts currently for assessment and restarts over 7 days, and staff contracts enable choice of working over 7 days rather than more formal commitments.
Actions to be taken	a) Confirm current 7DS offer locally through local stakeholder event delivered by NHSE Improvement Team (Q2) b) Confirm progress with negotiation of staff contracts for health and social care (Q2) c) Confirm progress on provider negotiation on homecare assessment and re-starts at weekends (Q2) d) Full action plan to be agreed to delivery on 7DS national expectations, with recognition of current acute site constraints (Q2) a) Take learning from public consultation on acute configuration (CHFT footprint) and agree the future care model (Q3)
Leadership	SRG agreement on governance and leadership required
Measurement	• Contractual monitoring of 7DS delivered across a range of providers • Response time for 7DS already in place • KPIs and timelines developed within system plan • KPIs and timelines developed for hospital change programme in line with consultation

Change 6: Trusted Assessors

Greater Huddersfield/Kirklees footprint	
Current Rating and rationale	Level 1: Hospital avoidance team to undergo training on the Calderdale framework tool. ASC developing online assessment This is confirmed by the recent ECIP report recommendations in that wards are reporting that there were regular delays to patient discharge due to waits for staff attending the ward to carry out assessment of patients. A number of Trusts across England are now developing alternative arrangements for assessment which involves nursing or therapy staff in the Trust becoming accepted as 'trusted assessors' for a number of agreed Nursing Homes in the area. This is a model which the Trust may wish to explore. Further details, in the form of a case study will be available on the ECIP website shortly.

Actions to be taken	(a) Agreement to develop to "trusted assessor" arrangements based on good practice elsewhere (Q1) (b) Implementation timelines agreed and shared with SRG (Q2)
Leadership	TOC Board
Measurement	To be agreed with the TOC Board as part of implementation plan

Change 7: Focus on Choice

Greater Huddersfield/Kirklees footprint	
Current Rating and rationale	Level 3: New Discharge Policy developed, agreed and being embedded to ensure a fully integrated approach. Jointly agreed information shared with patients and their families, local choice policy agreed across the SRG and included in the policy document. Infrastructure contracts in place with voluntary sector and strengthening the links with acute care, voluntary sector providing some support to patients prior/on discharge, however they are not currently integrated within discharge teams and this approach needs to be scaled up. New Seamless Home from Hospital (SHFH) Service funded recurrently across Calderdale and Greater Huddersfield.
Actions to be taken	(a) DTOC Board to keep a watching brief on Policy implementation and issues and escalate to SRG as needed (Q1) (b) Develop SOP confirming expectations around the pace of delivery interventions for those whose discharge is delayed – this will be updated regularly with latest guidance codes and will reflect changes in daily weekly and monthly reporting recommendations (Q2) (c) Strengthen links between CHFT and voluntary sector who can support post/on discharge and ensure staff are fully aware of offers – via CC2H plans (Q2) (d) Update on SHFT to SRG as part of evaluation of winter schemes (Q1) (e) Feedback to SRG on implementation of new Discharge Policy, including impact on LOS (Q2) (f) Ensure third sector play a key role in the development of emerging new care models (Q2)
Leadership	TOC Board CC2H Contract Board
Measurement	• LOS for medical patients • Reductions in long lengths of stay • No of third sector organisations involved in integrated discharge planning/% patients covered • KPIs for patient and family satisfaction with discharge • Reductions is SIs related to poor discharge planning

Change 8: Enhancing Health in Care Homes

Greater Huddersfield/Kirklees footprint	
Current Rating and rationale	Level 3: Care Home Pilot in place Stimulating the market and creating resilience is currently a challenge for Local Authorities and CCGs and we have capacity issues in step-up/step down/intermediate care beds and nursing and EMI beds. Agreed focus locally includes the need to also strengthen the home care market in order to support flow. *Caveat on level 3 is the need to test quality and safeguarding plans are in place within care homes*
Actions to be taken	(a) Ensure shared learning across the two different care home models (Q1) (b) CCG and CHFT working to establish any joint opportunities to develop a new approach to community beds (Q1) (c) SRG work-stream is established but there is a need to strengthen planning, reporting and challenge (Q1) (d) CCG working with CMBC working at a place-based level to develop a short, medium and long-term plan to strengthen the care home and home care markets. Implementation Plan to be agreed SRG (to include other elements of this plan including discharge to assess and improving speed of assessments (Q2)
Leadership	SRG through Care Home Work-stream CC2H Board for place-based work
Measurement	• Care Home Pilot dashboard • Variation in admissions by individual care homes • Patient experience improved • Reductions in care home SIs