# Kirklees Health and Wellbeing Plan 2017–2021

**Draft: v 0.9**
**20th February 2017**

Calderdale and Huddersfield NHS Foundation Trust | Kirklees Council | Locala Community Partnerships | NHS Greater Huddersfield Clinical Commissioning Group | NHS North Kirklees Clinical Commissioning Group | South West Yorkshire Partnership NHS Foundation Trust | healthwatch Kirklees | NHS The Mid Yorkshire Hospitals NHS Trust

# Kirklees Health and Wellbeing Plan 2017 - 2021

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| **Draft V0.9** | 10.02.17, 20.02.17 | R Millson | Additional narrative added |

# Kirklees Health and Wellbeing Plan 2017 - 2021

**Contents:**

# Foreword

**TO BE COMPLETED**

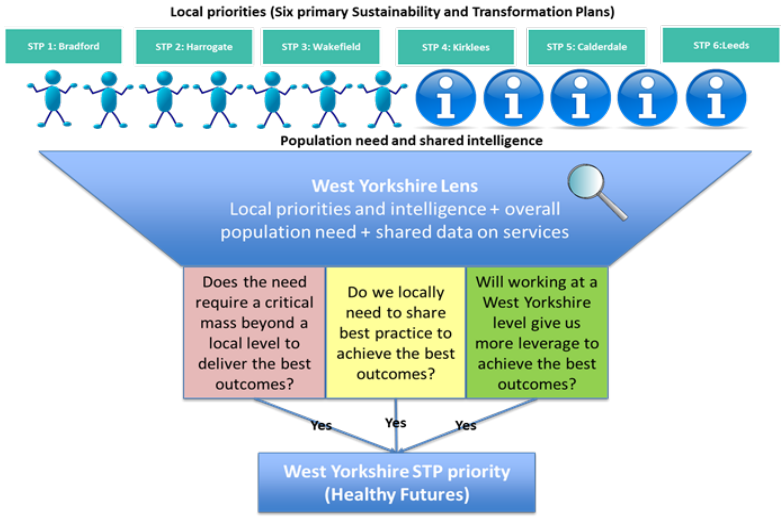
# Where does this plan fit?

West Yorkshire and Harrogate STP

Kirklees Health and Wellbeing Plan

| North Kirklees Clinical Commissioning Group | Greater Huddersfield Clinical Commissioning Group | Kirklees Council |
|---|---|---|
| • NKCCG 2 Year Operational Plan<br>• GPFV Transformation Plan<br>• Financial Recovery and Service Sustainability Plan | • NKCCG 2 Year Operational Plan<br>• GPFV Transformation Plan<br>• Financial Recovery Plan | **TO BE COMPLETED** |

# Where does this plan fit: Alignment with the West Yorkshire and Harrogate STP




- Cancer services
- Urgent and emergency care
- Specialist services
- Stroke (hyper-acute and acute rehab)

We work together because of the need for critical mass

- Standardisation of commissioning policies
- Acute collaboration
- Primary and community services

We work together to reduce variation and share best practice

- Mental health
- Prevention at scale

We work together to achieve greater benefits

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

Our local Acute Trusts are also using these principles to collaborate as providers across West Yorkshire through the West Yorkshire Association of Acute Trusts (WYAAT).

To support delivery of the West Yorkshire and Harrogate STP a joint committee for West Yorkshire is currently in development. It is intended that this committee will have delegated functions to make decisions. The role and function of this committee is currently being discussed by partners across the STP footprint and a decision is expected in Spring 2017. An operating model to implement the programmes within the STP is also currently in development. This model proposes that each programme has representation from each local plan to ensure alignment and that local priorities are reflected.

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

# About Us: The Kirklees Provider and Commissioner Landscape

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

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

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

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

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

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

**Locala** provide community based health services across Kirklees.

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


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

# About Us: Our Local Challenges – Health and Wellbeing Gap

| Challenge | Current Position | Ambition for the Future |
|---|---|---|
| **Prevent and Intervene Early** | • If we are to transform our approach to health and social care we need to prevent and better manage conditions at all ages by encouraging self care and brief, early and targeted interventions. Starting before birth, an approach based on nurturing and empathy should drive our approach to pregnancy and parenthood.<br>• Kirklees has the highest infant mortality rate in West Yorkshire, although a lot of progress has been made in previous years, more needs to be done.<br>• We are higher than the England average for cancers diagnosed as emergency presentations. These cancers are on average more advanced (stages 3 and 4) than those detected earlier and the outcome for the patient is poor.<br>• Uptake of cancer screening programmes in Kirklees is amongst the worst in West Yorkshire. This is a particular issue in North Kirklees in bowel and cervical screening. This issue is compounded by local population challenges.<br>• **Children's Data what do we know?– population of the future – will our plans for future provision be robust enough?** | • Starting before birth, an approach based on nurturing and empathy should drive our approach to pregnancy and parenthood. Our Healthy Child Programme will promote system-wide change that supports emotional and physical health and wellbeing to enable future generations to adopt healthy behavior and our community services need to identify and intervene early enough to divert people from intensive interventions later in life.<br>• Reduce infant mortality rate to the England average<br>• Reduction of people at high risk of developing diabetes by 2020 and increase in the number of people referred to Healthy Living Services.<br>• Improvements in cancer screening targets across Kirklees to support early identification of cancers. Aiming to improve to bring in line with the England average. Increase of 4% of cancers diagnosed at stages 1 and 2.<br>• Reduce the number of cancers detected as emergency presentation to bring in line with the England average. |
| **Start, Live and Age Well** | • At all points in the life stage there are too many people with mental and physical health needs that inhibit their personal, social, physical and economic development. A third (33%) of children age 10/11 and two thirds (66%) of adults are overweight and obese. Physical activity and emotional health and wellbeing are connected to this, and are a toxic trio leading to poorer outcomes and increasing risk of costly long term conditions.<br>• Our high obesity levels locally result in a higher than average prevalence of health conditions like diabetes.<br>• Across Kirklees smoking rates are falling in line with national trends. There are still a number of vulnerable population groups however where smoking rates are high.<br>• **Too many people smoking at delivery XXXX need numbers** | • Our services must make every contact count and support positive changes that promote health at all stages of the life course.<br>• **Perinatal mental health**<br>• **Reduce number of women smoking at delivery to xxx by xxx** |

# About Us: Our Local Challenges – Health and Wellbeing Gap

| Challenge | Current Position | Ambition for the Future |
|---|---|---|
| **Narrowing inequalities** | • People who live in poorer areas and/or have lower educational attainment/lower skills have, in general, worsened health behaviors and outcomes at all points in the life course. More affluent groups are increasingly heeding messages about healthy eating, exercise and smoking and so the gradient of inequality worsens. Almost twice as many children in the lowest socio-economic decile are obese compared to the highest decile. Social mobility is increasingly determined by lifelong learning and the ability to adapt to a changing environment. | |
| **Achieving healthy communities, housing and work** | • Good housing, work with prospects, green infrastructure and social mobility all influence the social capital of an area. In turn this generates a more confident, independent self sustaining culture that promotes further social and economic development and personal wellbeing. | • Reshaping our environment to promote health, volunteering, active travel and physical activity and use of our green spaces and cultural facilities helps shape how we feel about ourselves and communities. Confident cohesive communities are healthy communities. |
| **Improving resilience and enabling healthy behavior** | • Being resilient is about having a sense of purpose, self esteem, confidence and adaptability. Being emotionally aware and taking responsibility for their own physical and emotional needs and being supportive compassionate and connected to others.<br>• **Access to IAPT – Prevalence data indicates an unmet need**<br>• **MH – Emotional health and wellbeing** | • Enhancing self-care and people being increasingly independent, self-sufficient and resourceful so they are better able to confidently manage their needs and adapt their health and social behaviour in the face of the things life throws in our way.<br>• **MH – Emotional health and wellbeing** |

# About Us: Our Local Challenges – Care and Quality Gap

| Challenge | Current Position | Ambition for the Future |
|---|---|---|
| **Some people in Kirklees wait too long for to be seen/ for diagnosis/treatment** | • MYHT are not currently meeting the national access standards relating to 18 weeks RTT, A&E and some cancer targets.<br>• Our GP Patient Survey tells us that patients struggle to get appointments in GP Practices.<br>• Currently none of our GP Practices offer extended access outside of what is funded by the national enhanced scheme.<br>• **? CAMHS access**<br>• **? Performance against other MH access standards**<br>• **? MH Liaison Teams** | • Sustainable achievement of all NHS Constitution measures by 2018/19.<br>• 100% of GP practices offering extended access at evenings and weekends by 2018/19.<br>• **? MH** |
| **We do not have a sustainable workforce locally to support delivery of services in their current form.** | • Workforce crisis amongst both acute hospital consultants and trainees. **Info from CHFT and MYHT**<br>• North Kirklees is cited as being the 5th most under doctored area in the country.<br>• Recruitment and retention has been a long standing problem within Primary Care services in North Kirklees. It has resulted in the workforce becoming proportionately older with 22% of GPs over 55 years old compared to 16% across West Yorkshire and 19% of GPs aged 45-54. This pattern is repeated within the Nursing roles with 30% of Nurses over 55 years old and 32% aged 45-54 which is worse than West Yorkshire as a whole. 50% of GPs and 80% of Nurses are recorded as reaching or approaching retirement age within the next 5-10 years.<br>• Recruitment & retention of doctors , acute hospital consultants and trainees), nurses (especially in nursing homes), care workers, and social workers **NEED SOME EVIDENCE/BASELINE**<br>• Agency spend on medical, nursing and social work roles **NEED SOME EVIDENCE/BASELINE** | • Development of critical new roles including care worker plus/nurse associate, personal assistants, 'early help' workers<br>• Development of a range of key skills & behaviours; community asset building, strengths based approaches, motivational interviewing; commissioning skills; System leadership skills<br>• Increase the number of training practices in primary care **(NUMBERS)**<br>• Participate in overseas workers programme **(NUMBERS)**<br>• Development of a 'grow your own programme across North Kirklees'<br>• Work with local GP federation and practices to implement a plan to reduced the turnover of staff and the number of vacant positions within primary care by 2018/19.<br>• Championing new roles in general practice to be implemented in 2017/18. **NUMBERS** |

# About Us: Our Local Challenges – Care and Quality Gap

| Challenge | Current Position | Ambition for the Future |
|---|---|---|
| **We send too many people to specialist care services, including hospital, and they stay in contact with the services longer than they need to** | • Higher than average emergency admission rates for respiratory conditions and CVD conditions<br>• Higher than average admission rates for all cancers<br>**? DTOC figures**<br>**? AEC reports**<br>**? RightCare information** | • We will develop clinical resource centres to manage patients in primary care which will enable us to offer a wider range of services to meet the needs of local people and better access to services whilst using the workforce available to us more effectively. There is a strategic shift of activity planned from hospitals to the community, preventing the need for hospital admission wherever possible. With enhanced integration of services for vulnerable patients, the aim is to ensure that people do not spend any longer in hospital than they need to. Proactive management of activity shifts out of secondary care to primary care need to be properly planned and resourced. |
| **We need to improve the quality of care and the quality of life of children and adults who are in contact with social care services** | **TO BE COMPLETED** | **TO BE COMPLETED** |

# About Us: Our Local Challenges – Care and Quality Gap

| Challenge | Current Position | Ambition for the Future |
|---|---|---|
| **Too many people are not able to die in their preferred place of death**. | • In Kirklees, approximately 3,800 people die each year. Based on national projections the number is expected to rise by 17% from 2012 to 2030. The percentage of deaths occurring in the group of people aged 85 years or more is expected to rise from 32% in 2003 to 44% in 2030.<br>• Approximately three quarters of deaths are expected, which for Kirklees is 2,850 people, there is potential to improve the experience of care in the last year and months of life for these people, and those close to them, each year.<br>• We are aware that palliative and end of life care is still disjointed and that there is more which could be done to coordinate different services to ensure patients and their families receive the highest quality of care at the end of life. | • Increase in the numbers of people achieving their preferred place of death through earlier identification, proactive management, development of Advanced Care Plans and recording of preferences on the EPaCCS register. |

# About Us: Our Local Challenges – Care and Quality Gap

| Challenge | Current Position | Ambition for the Future |
|---|---|---|
| **Carers do not all get the recognition and support they need** | • 30.9% of carers in Kirklees did not find it easy to find information about support, services or benefits<br>• 10.5% of carers in Kirklees feel they are neglecting themselves and a further 29.4% sometimes cannot look after themselves well enough<br>• 69.2% of carers don't have enough control over their daily life and 12.1% have little social contact with people and feel socially isolated<br>• Carers more likely to have poorer health; especially pain and depression then non-carers<br>• They were as likely to have a job but many were restricted to part time work which restricts income and pension rights, and benefit take up is low.<br>• Having a caring responsibility is recognised nationally as one of the main characteristics of young people aged between 14 and 16 being bullied. | • All organisations to be signed up to the carers charter through Investors in Carers and ensure that the caring community receive adequate support to improve their health and wellbeing and remain in employment.<br>• All of Investors in Carers Partners will identify a baseline of Carers either as service users or just as importantly employees who have disclosed that they are carers to support appropriate signposting.<br>• Development of peer support networks for our carers community.<br>• Carers to feel confident in their ability to deliver care and manage long term conditions taking pressure off healthcare services. Aiming to reduce A&E attendances and avoidable admissions for exacerbation of conditions.<br>• Promotion of the health/care sector as a career thus contributing to the management of the local workforce crisis. |
| **The outcomes of care people receive in Kirklees is too variable** | • There is variation in the management of long term conditions in particular diabetes across Kirklees<br>• **RightCare Data**<br>• **Disparity in health outcomes for people with long term mental health needs** | • All practices have undergone a CQC inspection under the new model. We will be working to identify cross cutting themes of improvement for the whole GP economy in North Kirklees to drive system-wide improvement and reduce variation. A model of targeted support is being developed that will enable those practices who require specific interventions to improve the level of service delivered to patients in North Kirklees. |

# About Us: Our Local Challenges – Finance and Efficiency Gap

| Challenge | Current Position | Ambition for the Future |
|---|---|---|
| **There is too much unwarranted variation in Kirklees which creates inefficiencies** | • The NHS England RightCare data packs have identified a total of **£X** million in efficiency savings through reducing unwarranted variation across Kirklees | • Through the RightCare programme we plan to deliver **£X** million of savings across **X (endocrinology, MSK, trauma and orthopaedics and respiratory for NK ? GHCCG) BY WHEN** |
| **The money available to us to spend is decreasing, demand for services is increasing and people are living longer. We also have a growing number of young people with complex needs in Kirklees who require intensive support.** | • Our birth rate is the highest in West Yorkshire<br>• We have an high BME population<br>• We have an increasing elderly population in line with national trends.<br>• **NUMBERS TO SUPPORT THIS** | • **QIPP Schemes**<br>• **BCF targeted at proactive and preventative services to prevent crisis** |
| **All sectors in Kirklees are financially challenged** | • Do nothing gap across Kirklees is £208m<br>• Do something gap is £40m | **QIPP Schemes**<br>**New ways of working** |
| **We need to ensure local people are engaged in changes we make given the pace and scale of the work required and recognising that more needs to be done to engage hard to reach groups.** | **TO BE COMPLETED** | **TO BE COMPLETED** |

# About Us: Our Future Vision for People in Kirklees

At the Kirklees Health and Wellbeing Board in February 2016 it was agreed that by all partners that the Kirklees 2020 Vision describes our overall direction of travel as organisations. Each organisational vision contributes to the delivery of this.

***Kirklees 2020 Vision for a joined up health and social care system:***

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

The principles of this vision are;

People in Kirklees are as well as possible for as long as possible, both physically and psychologically;
Local people can control and manage life challenges through building resilience;
People have a safe, warm, affordable home in a decent physical environment within a supportive community;
People take up opportunities that have a positive impact on their health and wellbeing e.g. - People experience seamless health and social care appropriate to their needs; Taking up opportunities for wider learning.
That it is affordable and sustainable, and where investment is rebalanced across the system towards activity in community settings;
Based around integrated service delivery across primary, community and social care that is available 24 hours a day and 7 days a week where relevant; and
That is led by fully integrated commissioning, workforce and community planning.

# About Us: What Does this Vision Look Like for People in Kirklees?

**Patient Story to be added to illustrate service provision in the future**

**Patient Story to be added to illustrate service provision in the future**

# About Us: Our Approach to Engagement

Our Communications and Engagement strategy states that we aim to go above our legal duties to engage. We are committed where possible, to undertaking some form of engagement, even in cases where it is determined that it is not a statutory requirement. We aim to involve people at two key points when we are considering making changes to services.

1. **As proposals are being developed** *to ensure that patients/stakeholders have the opportunity to shape them*
2. **When we are making the final decision** *which may be as part of a formal consultation process*

We have established a Patient Engagement and Experience Group who are responsible for challenging our engagement activities to ensure they are considered and robust.

All the changes outlined within the Kirklees Health and Wellbeing Plan will be subject to the usual engagement processes which are described above.

Some examples of how we engage are detailed below:

We have well-established links with GP Practice Patient Groups and a CCG Patient Reference Group.

We work closely with Healthwatch Kirklees and the Kirklees Overview and Scrutiny Committee.

Our Your Health, Your Say programme provides the public with information about commissioning plans and opportunities to get involved.

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


We use a range of tactics to involve local people in specific service change programmes including surveys and patient representation on panels.

# About Us: Engagement Activities to Date

The Kirklees Health and Wellbeing Plan builds and expands upon work which was already been undertaken locally, ensuring a more collaborative approach with partners, where possible. As a consequence of this, there are a number of engagement activities already undertaken from which the insight and feedback contributes to the development of the vision and underpinning work streams detailed within this plan. An outline of engagement activities undertaken to date and any planned engagement for the future is provided in the table below.

**? Capture engagement activities with GPs**

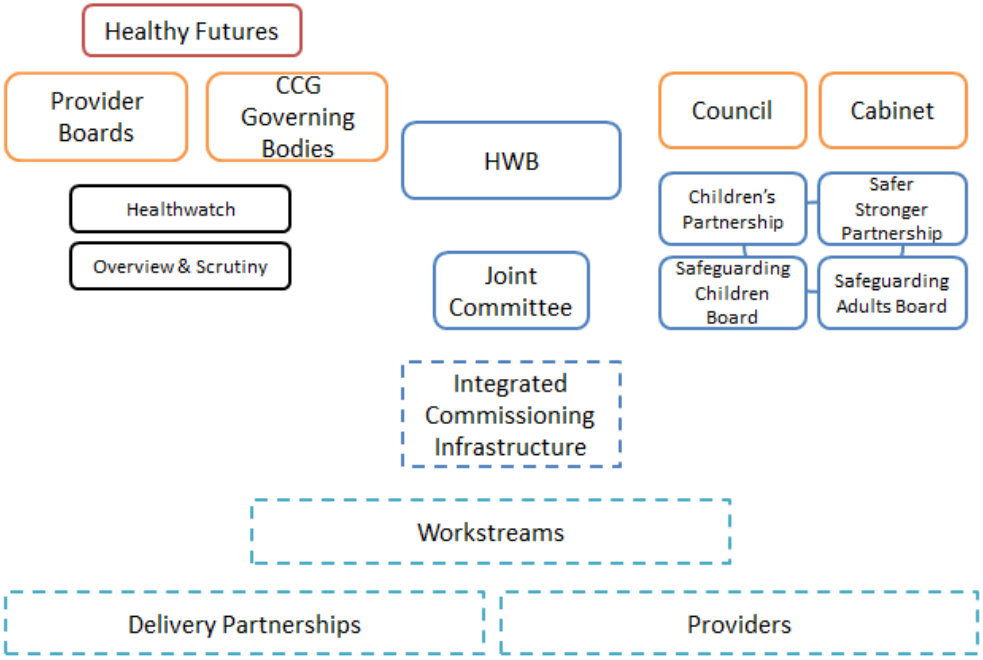
| Area of Transformation | Engagement To Date | Planned Engagement |
|---|---|---|
| **Early Interventions and Prevention** | • Call to Action Engagement September 2013<br>• Council Led engagement regarding EIP Programme 2016 | **TO BE COMPLETED** |
| **Healthy Child Programme** | • Spring 2016 | **TO BE COMPLETED** |
| **Wellness model** | | 2017/18 |
| **Primary, social and community services** | • Care Closer to Home 2014/15<br>• GHCCG Co-Commissioning 2015<br>• Primary Care Strategies 2015/16 | • NKCCG Co-Commissioning 2017 |
| **Acute Transformation** | • Meeting the Challenge Public Consultation 2013/14. On-going discussion with the public as changes are implemented,<br>• Consultation on Right Care, Right Time, Right Place from March 2016 to June 2016 . Some engagement in 2015. | **TO BE COMPLETED** |
| **Mental Health** | • SWYPFT re Crisis intervention.<br>• CAMHS<br>• SWYPFT re Transforming Care June 2013, October 2014 and July 2015. | **TO BE COMPLETED** |
| **Standardisation of Commissioning Policies** | • Engagement conversations September- 2016<br>• Talk Health Campaign – October 2016 | **TO BE COMPLETED** |
| **New Models of Care** | • Engagement with CCG Governing Bodies regarding the form and function of CCGs in the future throughout 2016/17.<br>• Development of the End of Life Care Strategy 2016/17 | • Development of a model for frailty, from January 2017.<br>• Development of the End of Life Care Offer 2017/18 |

# About Us: Governance and Decision Making

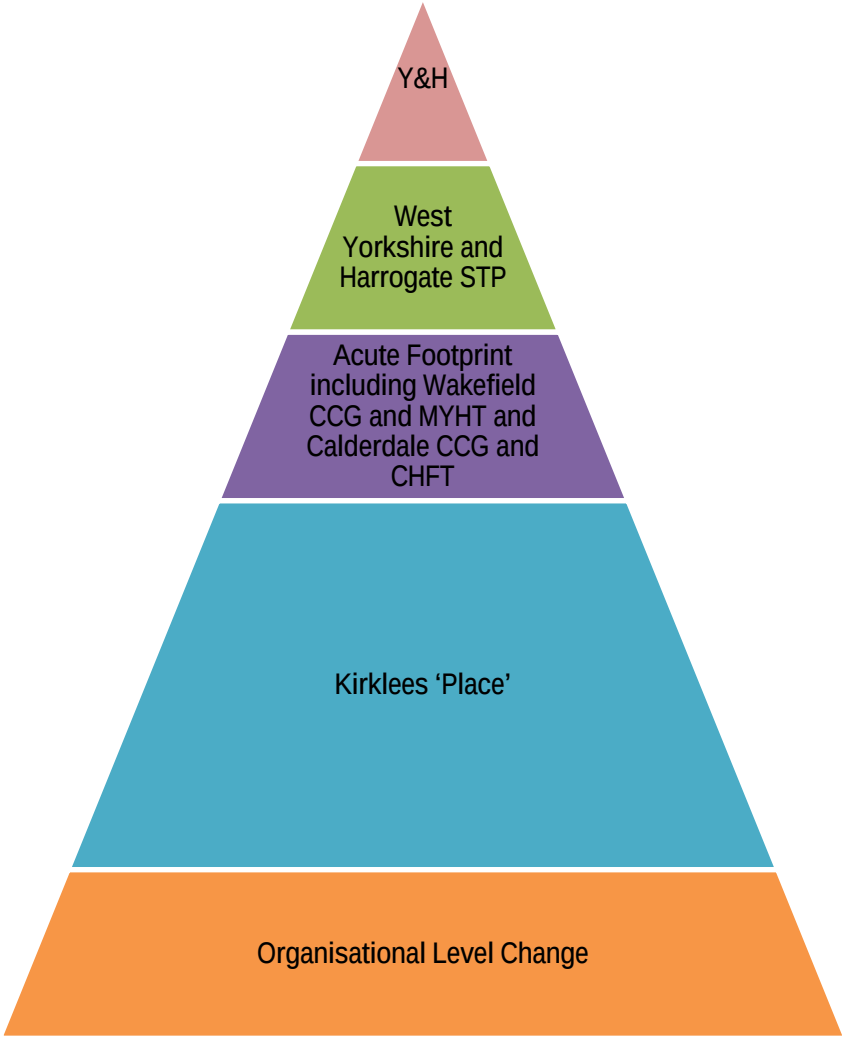
The Kirklees Health and Wellbeing Board will take the lead in the development and delivery of the Kirklees Health and Wellbeing Plan. The Plan recognises that all partners will need to take responsibility for embedding the Plan in their own organisational plans. The current governance arrangements need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

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

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



# About Us: Collaboration and Transformation




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

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

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

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

Our identified priorities for delivery across Kirklees are described in the next section of this document.

# Delivering Our Vision: Our Priorities for Change

## Areas of transformation

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

## Supporting programmes

| | | | |
|---|---|---|---|
| Health & social care workforce | Digital opportunities | One Public Estate | Kirklees Economic Strategy |

# Delivering Our Vision: Our Priorities for Change

## Cross Cutting Themes

All elements of the plan need to reflect these common themes

### Kirklees Plan

- We need to move from single organisation plans developed in isolation to a set of interlinked plans for the Kirklees place covering
  - our workforce
  - our estate
  - our digital future
  - our intelligence

### Kirklees People

- We need a common commitment to growing our own and keeping them by making Kirklees a great place to work and learn
- We need to link our approaches to organisational development and learning, investing time in learning how each others worlds work, breaking down barriers between organisations and going on the change journey together
- We need to develop a much better shared understanding of our local communities together eg the challenges faced by Asian women, our 'frequent flyers', isolated older people

### Kirklees Pound

- We need to ensure money follows the patient/user around the system
- We need to develop our local supply chains to maximise the return on local public sector spend on the local economy
- We need to encourage local residents and staff to contribute to local causes
- We need to find ways to support the local voluntary sector through contracting processes

# Delivering Our Vision: Our Priorities for Change

## Cross Cutting Themes

Our approach to  delivering the high level interventions and supporting programmes must always consider these common threads

### BUILDING PEOPLES STRENGTHS & RESILIENCE


How are we:

- Helping build stronger communities?
- Identifying and supporting carers?
- Developing stronger families?
- Enabling people to self-care?
- Building individuals resilience?

### IMPROVING SERVICES


How are we:

- Improving the health and wellbeing outcomes that are important to individuals?
- Reducing avoidable differences in outcomes?
- Dealing with issues at the earliest possible point in the person journey?
- Making services more productive?
- Improving the quality of services?

# Delivering Our Vision: Our Priorities for Change

## Roadmap for Delivery and Progress to Date

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# Delivering Our Vision: Our Implementation Model

**TO BE COMPLETED**

# Delivering Our Vision: Identified Work Streams to Deliver Change

## Work Steam 1: Early Intervention and Prevention including the Development of a Thriving Voluntary and Community Sector

**Aim of Work Stream:**

Early intervention and prevention is all about working with individuals and communities across the health and social care system inclusive of wider partners such as education, housing, police, fire etc. so that people have the lives they want with support from the formal services only when they need it to keep them well. It's all about giving people information and skills to prevent ill health whilst tackling the wider determinants of health, ensuring our communities are able to reside and work in the best environment possible. This includes ensuring the right support is available at the right time whilst making the best use of money and preventing people escalating to need unnecessary expensive care and support in the future. It is also about how we work together differently across the system to improve people's quality of life and reduce inequalities within our population.

The Council has been leading the development of the Early Intervention & Prevention Programme since 2015 as part of its shift to 'New Council'. The approach is based on recognising that some groups may need more support than others from those with complex needs, to those who need targeted support and a more universal community plus level (add diagram?). Supporting the voluntary and community sector to thrive is critical for all 3 levels. Progress has been made on, remodelling early help support for children, young people and their families, building a network of 'schools as community hubs', creating a new All Age Disability Service, reviewing the adult social care pathway and piloting our new locality based approach.

**How will this be Delivered:**

- Review of local alcohol prevention strategy to ensure alignment with West Yorkshire and Harrogate STP planning assumptions.
- Work with commissioned alcohol nurses to maximise potential to reduce alcohol related hospital admissions. The development of the Wellness Model will also support delivery of this.
- Implementation of national diabetes prevention programme across Kirklees .
- Facilitate the coming together of all partners to build on the progress made by the Council and ensure this initial work is a building block for next steps for any future development work.
- Proposal to mandate x% of spend on contracts (e.g. new models of care contracts) to voluntary sector providers
- Develop a strategic approach to improving mental health and wellbeing, preventing mental ill health and embedding a community based recovery model.
- Develop better understanding of impact of early intervention and prevention spend on other parts of the system using tools such as Care Trak
- Supporting carers to understand the condition of the person they are caring for and recognise signs of exacerbation. Proactive approach to managing long term conditions.
- Implement planned changes to early help offer for children, young people and families taking account of the consultation findings
- Supporting carers in the own health and wellbeing through the Carers Charter**.**
- Our Mental Health Provider will undertake a targeted piece of work to improve access to IAPT services for BME population groups.
- Integrating dementia risk reduction prevention programmes for example cardiovascular disease, type 2 diabetes, stroke and chronic obstructive pulmonary disease.
- Services and support groups accessible for people living with physical and mental health conditions and their carer/s and family.

**NEED INFO ON VOLUNTARY AND COMMUNITY SECTOR**

# Delivering Our Vision: Identified Work Streams to Deliver Change

## Work Steam 1: Early Intervention and Prevention including the Development of a Thriving Voluntary and Community Sector

**Impact of this Work Stream**

### Health and Wellbeing Gap

- Many people get invaluable support from family, friends or neighbours to find their own solutions to meet their needs. Where this is the case we don't want to get in the way of these arrangements. However, when additional information, advice, or guidance is needed, we do need to put people in touch with other organisations who can help, or in some cases offer support, so that they can remain safe and independent in their own home for as long as possible.
- Improved access to IAPT services for BME Communities. Reducing inequalities across different population groups.
- Reducing social isolation for both carers and people living with dementia and other physical and mental health conditions.

### Care and Quality Gap

- Shifting our focus and resources to address the causes rather than the symptoms – aimed at each part of the child, adult, family journey
- Reduction of people at high risk of developing diabetes by 2020 and increase in the number of people referred to Healthy Living Services.
- Improvements in cancer screening targets across Kirklees to support early identification of cancers. Increase of 4% of cancers diagnosed at stages 1 and 2.
- Reducing risk factors which contribute to vascular dementia

### Finance and Efficiency Gap

- We will make service savings, but will reinvest in early intervention and prevention to reduce or delay the need for costly crisis support or health and social care services. This is part of the longer term sustainability plan for Kirklees.
- Reduce x% of spend on contracts (e.g. new models of care contracts) to voluntary sector providers
- Better understanding of impact of early intervention and prevention spend on other parts of the system using tools such as Care Trak. **ANY RESULTING COST SAVINGS**

# Delivering Our Vision: Identified Work Streams to Deliver Change

## Work Steam 2: Improving Services for Children

**Aims of this Work Stream:**
The Kirklees Integrated Healthy Child Programme (KIHCP) covers the whole spectrum of services and programmes for children and young people's health and wellbeing, from health improvement and prevention work, to support and interventions for children and young people who have existing or emerging health problems. There will be a particular emphasis on improving mental and emotional health and wellbeing and the transitions between stages of development. (KIHCP) is best described as a 'way of doing things'. From 2017, workers in KIHCP will have a 'can do' attitude. The KIHCP workforce will first and foremost:

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

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

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

# Delivering Our Vision: Identified Work Streams to Deliver Change

## Work Steam 2: Improving Services for Children

**How will this be Delivered:**

- Coordinated approach to the commissioning of CAMHS aiming towards a tierless service in Kirklees which focusses on investment in low level preventative services to provide support earlier in the pathway and reduce the number of children requiring a more specialist intervention. Includes extension of psychiatric liaison services to all ages. Links to work across West Yorkshire and Harrogate relating to Tier 4 services and reducing out of area placements.
- Development of a sustainability plan for looked after children. Aiming to reduce out of area placements.
- Current Improvement Plan being reviewed and will be refreshed in light of OFSTED findings and recommendations in December 2016
- The Kirklees Healthy Child Programme will go live on 1.4.2017.
- Development and implementation of an action plan at a local level to ensure compliance with the recommendations of 'Better Births'. This work will build on the work already undertaken in advance of the 'Better Births' recommendations being published. Through Meeting the Challenge, MYHT have already developed a Midwife led Unit at Dewsbury District Hospital, which offers greater choice for women.
- Discussions regarding the geography over which regional elements of the 'Better Births' recommendations will be implemented to conclude by April 2017. Leadership and governance to be confirmed. Regional vision and implementation plan to be developed by the end of October 2017.
- Review of children's pathways focussing on respiratory conditions and IV administration initially in 2017/18. Whole systems approach to this working with a number of providers to deliver better quality outcomes for children and their families.
- Development of a local plan to support the transfer of funding for diabetes insulin pumps and continuous glucose monitoring from NHS England to CCG responsibility.

- **Perinatal MH – bid SWYPFT**
- **Further information to be added regarding preconceptial care. Focus on reducing smoking at delivery**
- **Autism (and other behavioural conditions) area to develop over the next couple of years including strategy and diagnostic services, education and support**

# Delivering Our Vision: Identified Work Streams to Deliver Change

## Work Steam 2: Improving Services for Children

**Impact of this Work Stream**

### Health and Wellbeing Gap

- Healthier and more resilient children have greater lifetime potential and exert a positive influence on inequalities as they are more skilled, more active and have the skills to flourish in communities and the economy.

### Care and Quality Gap

- Integration is increasingly evidenced as being an effective way to shift long standing behaviour patterns for children and parents, and to break into the cyclical nature of problems in some families.

- Reduction in the number of stillbirths, neonatal or maternal deaths during or soon after birth
- Reduction in childhood obesity
- Women smoking at delivery and other targets related to preconceptual care.
- CAMHS

### Finance and Efficiency Gap

- We will make service savings and generate an integration dividend. Healthy children become healthy adults and exert less pressure on health and social care systems. They are also more economically productive.

# Delivering Our Vision: Identified Work Streams to Deliver Change

## Work Steam 3: Development of an Adult Wellness Model in Kirklees

**Aims of this Work Stream:**

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

**How will this be Delivered:**

- Insight and design work is being scoped, specification designed and tendering processes clarified.
- Adult Wellness Model to be in place by Spring 2018.
- As the model develops it is expected that other services such as the Diabetes Prevention Programme, employment and skills support, IAPT, housing support and community engagement will work closely with and virtually integrate with the model. This will enable is to reduce the risk of people developing diabetes in North Kirklees in line with the WY&H STP ambitions.
- Integrated wellness model will bring together health improvement services across the life course enabling us to better target interventions on those at risk of long term conditions and in greatest need
- Development of an integrated system wide self-care strategy to transform our approach to self-care and promote independence and personal responsibility
- Plans to reduce smoking rates by 2020/21 through more effective commissioning of smoking cessation services to include health optimisation and health coaching through the wellness model. Our CIIK Survey indicates we are on track to reduce smoking rates across Kirklees in line with the WY&H STP ambition.
- Review of smoking cessation services in Kirklees.
- Reduce obesity levels and increase physical activity levels in Kirklees through more effective commissioning of weight management services and promotion of physical activity, exercise and healthy eating through PALS and Health Trainers, both of which will be central to the new model. Links to West Yorkshire and Harrogate STP prevention at Scale work.
- **ADD IN EMIOTIONAL HEALTH AND WELLBEING? EVIDENCE BASED SOCIAL PRESCRIBING**

# Delivering Our Vision: Identified Work Streams to Deliver Change

## Work Steam 3: Development of an Adult Wellness Model in Kirklees

**Impact of this Work Stream**

### Health and Wellbeing Gap

- People will live longer and in better health. Conditions like type II diabetes will be averted as more people are physically active and better at managing their own health.
- Health inequalities are minimised by promoting better mental health and physical activity.
- Reduce obesity levels and increase physical activity levels in Kirklees through more effective commissioning of weight management and supporting services Links to West Yorkshire and Harrogate Prevention at Scale work.
- Maintain current trajectories relating to smoking rates which are in line with the WY&H ambitions according to the recent ClIK Survey. Focus on vulnerable populations where smoking rates remain high, thus reducing inequalities.

### Care and Quality Gap

- Integration is increasingly evidenced as being an effective way to shift long standing behaviour patterns and will shift our focus and resources to address the causes rather than the symptoms of poor health. It will also enable us to move resources more rapidly around the system to deal with emergent issues more rapidly.
- **Reduce risk of diabetes diabetes prevention**

### Finance and Efficiency Gap

- We will make service savings via an integration dividend and will build the wellness model to a scale that can impact by April 2018. Further services can be integrated at a later date. Better targeting will also reduce or delay the need for costly crisis support or health and social care services, for example around type II diabetes, mental health, obesity and dementia.
- **Self care**

# Delivering Our Vision: Identified Work Streams to Deliver Change

## Work Steam 4: Improving the capacity and quality of primary care (including the GP Forward View)

**Aims of Work Stream:**

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

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

Our Strategies aim to:

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

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

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

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

# Delivering Our Vision: Identified Work Streams to Deliver Change

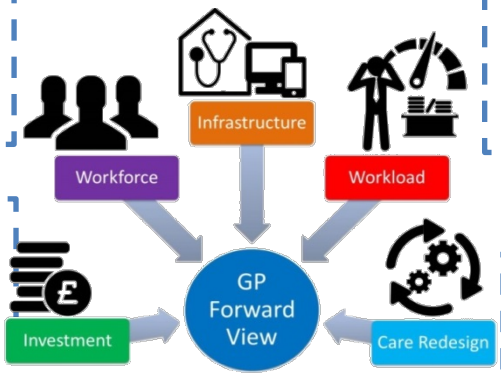
## Work Steam 4: Improving the capacity and quality of primary care (including the GP Forward View)

**How will this be Delivered:**

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

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

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




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

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

# Delivering Our Vision: Identified Work Streams to Deliver Change

## Work Steam 4: Improving the capacity and quality of primary care (including the GP Forward View)

**Impact of this Work Stream:**

### Health and Wellbeing Gap

- Reduce variability in long term condition management to promote better prevention and exacerbation of conditions

### Finance and Efficiency Gap

- Anticipate that improvements in access will release efficiencies elsewhere in the system. We are developing our model of improving access and this will be considered as part of this work.

### Care and Quality Gap

- Reduce unnecessary hospital admissions from GP Practices
- More support in primary care to navigate patients to the most appropriate clinician for their needs, first time.
- Reduce variability in long term condition management through peer support and challenge and the introduction of protocol driven referral management systems. Improve standards of quality of care received across Kirklees. Reduce number of referrals into Secondary Care Services.
- Support practices in improving performance in Dementia Diagnostic Rates and the number of Dementia Annual Care Plan Reviews that are carried out. Currently at the national average of 68.3%, however by March 2017 we are aiming to reach 71%.
- By 2020, 100% of North Kirklees patients will have access to weekend /evening routine GP appointments
- **Review skill mix of primary care workforce and introduction of new roles to manage demand differently to mitigate against the recruitment and retention risks locally.**

# Delivering Our Vision: Identified Work Streams to Deliver Change

## Work Stream 5: Making social care provision more sustainable and more effective, including the development of vibrant and diverse independent sector

**Aims of Work Stream:**

We all want to look forward to healthy and independent older age – and working to keep ourselves fit, to connect with other people and we will work together to help to make this possible. However, as the age profile of our population changes we will also see more and more people needing help to live at home. We expect to see demand for social care for people aged over 65 grow by 30% in the next 10 to 15 years. The Council has recently adopted a new Vision for Adult Social Care and Support in Kirklees. The Vision focusses on promoting independence and delaying the need for care, recognising and supporting carers as the bedrock of social care and support, promoting quality, choice and control, and developing partnerships and collaboration. This Vision will deliver a shift from formally assessed services towards targeted non-assessed services, community based services and informal support.

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

We want to make sure that:

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

# Delivering Our Vision: Identified Work Streams to Deliver Change

## Work Stream 5: Making social care provision more sustainable and more effective, including the development of vibrant and diverse independent sector.

**How will this be Delivered:**

- Review of pathways to make them more integrated and streamlined
- Procurement of new domiciliary care providers
- Development of tailored advice and guidance and a wider range of care and support options including extra care housing
- Develop a 'wellness model' for older people to enable them to retain their independence, including a step change in the use of technology
- Procurement of new domiciliary care contract providers
- **DEMENTIA**
- **Links to housing strategy**

**Impact of this Work Stream:**

| Health and Wellbeing Gap | Care and Quality Gap | Finance and Efficiency Gap |
|---|---|---|
| • Improved independence and quality of life for vulnerable adult and their carers, and an increased sense of control independence | • Improved choice of good quality support options that reflect individual needs | • Reduce demand on specialist and acute services<br>• Services have the right capacity to meet demand in an effective way |

# Delivering Our Vision: Identified Work Streams to Deliver Change

## Work Stream 6: Change the configuration of acute services to improve quality and create efficiencies through the implementation of Right Care, Right Time, Right Place, Meeting the Challenge and Healthy Futures plans

**Aims of this Work Stream:**

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

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

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

As these programmes develop and evolve, further work will be undertaken to assess the interdependencies and potential impact on the Kirklees population. The impact of the West Yorkshire Urgent and Emergency Care Vanguard which is being delivered as part of the Healthy Futures Programme will also be taken into consideration.

**MORE DIRECT RE THE IMPACT ON PATIENTS**
**Alignment to council principles for change**
**MH Liaison teams in local hospitals**

# Delivering Our Vision: Identified Work Streams to Deliver Change

## Work Stream 6: Change the configuration of acute services to improve quality and create efficiencies through the implementation of Right Care, Right Place, Right Time, Meeting the Challenge and Healthy Futures plans

**Meeting the Challenge**

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

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

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

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

# Delivering Our Vision: Identified Work Streams to Deliver Change

## Work Stream 6: Change the configuration of acute services to improve quality and create efficiencies through the implementation of Right Care, Right Place, Right Time, Meeting the Challenge and Healthy Futures plans

**Right Care, Right Place, Right Time**

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

*We have consulted on:*

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

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

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

# Delivering Our Vision: Identified Work Streams to Deliver Change

## Work Stream 6: Change the configuration of acute services to improve quality and create efficiencies through the implementation of Right Care, Right Place, Right Time, Meeting the Challenge and Healthy Futures plans

**Impact of this Work Stream:**

### Health and Wellbeing Gap

- **Every contact counts**
- **Self care and using other avenues**
- **Input and links with other Public Health Programmes e.g. alcohol**

### Care and Quality Gap

- Ensure people get the right advice and support to enable self-care, to provide highly responsive primary and community services to reduce reliance on A&E departments and to ensure a safe and effective integrated network of hospital urgent care services so that people with the most acute and complex conditions have the best chance of recovery
- Achievement of the national constitution measures for A&E, RTT and Cancer at MYHT.
- Reduction in avoidable admissions at both acute trusts
- Reduction in excess bed days
- Reduction in elective activity
- Reduction in unnecessary follow up appointments at MYHT
- Roll out of 7 day services in hospital to 100% of the population across the 4 initial priority clinical standards.
- **Reduction in avoidable deaths in hospital - ? Current position and target**
- **One year survival rates for cancer**
- **Definitive diagnosis of cancer within 28 days**

### Finance and Efficiency Gap

**TO BE COMPLETED**

# Delivering Our Vision: Identified Work Streams to Deliver Change

## Work Stream 7: New approach/model for how to support people with continuing healthcare needs

**Aims of this Work Stream:**
To ensure that we have commissioned locally available placements and care package to meet needs to reduce the risk of out of area placements, and associated risks and cost.

**How will this be Delivered: (Timescales)**

- Working with Kirklees Council we will scope and develop provision of a dementia service with nursing elements.
- With other partners we will develop a local physical disability service including long term care and respite.
- Develop the provision of a Fast Track domically service for care packages and care management.
- Work with Kirklees Council to ensure clarity on projected needs of the Learning Disability population in regard to day care and respite to support commissioning arrangements.
- Review the delivery of residential care with Kirklees Council for Learning Disabilities
- Delivery on commissioning of local services to meet local need for specialised physical disability, older peoples mental health residential and supported living.
- Complex care Strategic Panel to plan for future needs through transition 14 – 25

**Impact of this Work Stream:**

| Health and Wellbeing Gap | Care and Quality Gap | Finance and Efficiency Gap |
|---|---|---|
| TO BE COMPLETED | Reduction in out of area placements<br>TO BE COMPLETED | Reduction in out of area placements<br>TO BE COMPLETED |

# Delivering Our Vision: Identified Work Streams to Deliver Change

## Work Stream 8: Implementation of the Transforming Care Programme for people with learning disabilities

**TO BE COMPLETED**

**Aims of Work Stream**:

**How will this be Delivered: (Timescales)**

**Impact of this Work Stream**:

| Health and Wellbeing Gap | Care and Quality Gap | Finance and Efficiency Gap |
|---|---|---|
| | • **Number of people in IP beds for MH who have LD or ASD**<br>• Improving the physical health of people with learning disabilities and reduce early mortality | |

# Delivering Our Vision: Identified Work Streams to Deliver Change

## Work Stream 9: Changes to the commissioner/provider landscape, including more collaborative and more integrated approaches to new models of care

**Aims of Work Stream:**

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

The NHS Operational Planning and Contracting Guidance reinforces the national direction of travel towards increased integration of both commissioning and provision, in line with the Five Year Forward View.

Within Kirklees, we have already demonstrated our commitment to commissioning on an integrated basis via our care closer to home programme and a similar approach is reflected in our means of delivering many of our key interventions, for example, the Healthy Child Programme, Transforming Care and Early Intervention and Prevention.

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

The geography of Kirklees and our interdependencies with our neighbours means that each of our two CCGs will continue to work closely with its neighbours in Calderdale and Wakefield on matters where the acute footprint takes precedence. Our approach in Kirklees will focus primarily on the wider health and well-being agendas, and the commissioning and provision of 'out of hospital ' services where health and social key integration is a key component to success.

We are totally committed to keeping local people are the centre of our focus – not organisations. We will judge our success on outcomes for people and improvement in their experience of integrated services.

# Delivering Our Vision: Identified Work Streams to Deliver Change

## Work Stream 9: Changes to the commissioner/provider landscape, including more collaborative and more integrated approaches to new models of care

**How will this be Delivered:**

The new models of care and subsequent changes to the commissioning landscape set out in the latest planning guidance reflect local aspiration for a strengthened cross organisation approach to commissioning and provision of health and social care services in Kirklees.

Care Closer to Home, commissioned by the 2 CCGs but with significant Council input, encouraged a diverse range of providers to work together and established a strong foundation for increased integration of health and social care services. The Healthy Child Programme lead by the Council on behalf of the three organisations, supported by a pooled fund, again stresses a provider partnership approach.

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

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

We are embarking on conversations to determine which approach best suits our local circumstances and is more likely to be based on an alliance approach than the creation of a new organisation.

Across the Council and two CCGs, we now have monthly joint Senior Management Team meetings and are looking to create a joint commissioning committee. Changes such as IFR, prescribing and procedures of limited clinical value are being managed once across the 2 CCGs.

There are a significant number of shared posts/teams across the two CCGs (and with the Council) around place based services and with neighbouring CCGs in relation to acute provision. North Kirklees has piloted a shared Chief Officer role with the Council and a shared Chief Operating Officer role with Wakefield CCG. These arrangements have evaluated positively and as a consequence have been extended to explore further opportunities for collaborative working.

**Add links to sharing practice across WY**

# Delivering Our Vision: Identified Work Streams to Deliver Change

## Work Stream 9: Changes to the commissioner/provider landscape, including more collaborative and more integrated approaches to new models of care

**How will this be Delivered:**

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

- Grow the Better Care Fund and to focus it on a few high impact areas of activity including intermediate care
- Build on the success of the Kirklees Integrated Community Equipment Service and extend the arrangements to include assistive technology, home adaptations and other equipment
- Implementation of the Healthy Child Programme and the CAMHS Transformation Plan
- Implementation of our integrated approach to improving quality in care homes & the Care Home Strategy
- Further development of our integrated approach to intelligence and shared care record
- Development of our single point of contact arrangements

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

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

These developments will be underpinned by a robust set of principles around integration.

# Delivering Our Vision: Identified Work Streams to Deliver Change

## Work Stream 9: Changes to the commissioner/provider landscape, including more collaborative and more integrated approaches to new models of care

**Impact of this Work Stream:**

Health and Wellbeing Gap

**TO BE COMPLETED**

Care and Quality Gap

**TO BE COMPLETED**

Finance and Efficiency Gap

- **Reducing duplication**
- **Ability to share resource**

# Delivering Our Vision: Identified Work Streams to Deliver Change

## Work Stream 9: Changes to the commissioner/provider landscape, including more collaborative and more integrated approaches to new models of care

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

**TO BE COMPLETED**

# Delivering Our Vision: Identified Work Streams to Deliver Change

## Work Stream 9: Changes to the commissioner/provider landscape, including more collaborative and more integrated approaches to new models of care

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

**TO BE COMPLETED**

# Delivering Our Vision: Identified Work Streams to Deliver Change

## Work Stream 9: Changes to the commissioner/provider landscape, including more collaborative and more integrated approaches to new models of care

***TO BE UPDATED***

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

**The case for change to develop a North Kirklees Frailty model has been recognised due to:**

- The health status of care home residents becoming increasingly complex and there is not a coordinated approach to care
- Increasing numbers of patients with frailty/multiple long term conditions in housebound/care homes
- Increasing number of older people in care homes (20% of over the local population aged over 85 years)
- Despite the best efforts of partners hospital admissions are increasing (25% of admissions are classified as being avoidable and 40% are the result of exacerbations of long term conditions).
- The average length of stay in a care home is 18 months i.e. palliative phase
- The opportunities through the Mid Yorkshire Hospitals 'Meeting the Challenge' programme
- Improvements identified within the Kirklees Care Home Strategy

**We are exploring the option of developing a collaborative delivery model which will incorporate the following elements**:

- Medical cover for care homes
- Screening and identification
- Training and Education
- An Integrated Frailty team
- Out of Hours advice and support

Work is ongoing to ensure that the Frailty model is integrated with all our health, social care and self care programmes.

# Delivering Our Vision: Identified Work Streams to Deliver Change

## Work Stream 9: Changes to the commissioner/provider landscape, including more collaborative and more integrated approaches to new models of care

**Case Study Example: New Model for End Of Life Care**

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

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

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

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

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

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

Future work includes the development of:

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

# Delivering Our Vision: Identified Work Streams to Deliver Change

## Work Stream 10: Building a sustainable health and social care workforce to implement the high level interventions

**Aims of Work Stream:**

There are around 24,000 people employed in health and social care in Kirklees – around 90% of the workforce we will have in 5 years' time already work for us . The implementation of the STP depends on having the sufficient people with the right skills working in the sector. However we know there are significant challenges that cannot be tackled by working inside traditional organisational and professional boundaries. Whilst some issues will need a West Yorkshire or national led response, such as ensuring a supply of medical undergraduates, there are specific areas that we need to tackle as a local health and social care system and others we will need to tackle in collaboration with the Kirklees Economic Strategy. Our initial focus will be on

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

# Delivering Our Vision: Identified Work Streams to Deliver Change

## Work Stream 10: Building a sustainable health and social care workforce to implement the high level interventions

**How will this be Delivered:**

- Ensure workforce planning processes are in place to support implementation of our local plans, working closely to provide a quality workforce with the right skills in the right place.
- Explore new roles in primary care and review skill mix
- Explore opportunities to work collaboratively with Locala to recruit overseas GP's
- Implement Nurse Associates Programme across Kirklees
- Expand now roles providing mental health support in primary care.
- Map and understand current workforce roles working within Primary Care, work up proposals for extending and broadening the workforce to include Clinical Pharmacists, Mental Health Workers, Paramedics, Physio First
- Development of a local plan for making every contact count
- Elements of this programme will be delivered by the West Yorkshire STP Workforce Action plan e.g. development of an internal agency for NHS staff and nurse recruitment, others will be delivered as locally in collaboration with WY partners e.g. Health Promoting Trusts.
- Work has begun on developing a shared view about the local challenges and how these can be tackled. But this is at the early stages. The aim is to have an outline plan in place by Spring 2017.
- Explore the development of a Health and Care Academy in Kirklees.
- Encourage organisations to become accredited in delivering the carers charter. In doing this we will support more carers to remain in employment thus making Kirklees a more attractive place to work.
- Explore the development of a pathway so that somebody can develop transferrable skills through caring role which will support them in future employment. Particular focus on young carers

# Delivering Our Vision: Identified Work Streams to Deliver Change

## Work Stream 10: Building a sustainable health and social care workforce to implement the high level interventions

**Impact of this Work Stream:**

**Health and Wellbeing Gap**

- Shift skills and attitudes of staff towards prevention, earlier intervention and promoting resilience and self care

**Care and Quality Gap**

- Making the sector a more attractive place to work will aid recruitment and retention of staff – especially in the 'hard to fill' groups

**Finance and Efficiency Gap**

- Shift to more resilience and self care focussed skills will reduce unnecessary demand on specialist services

# Delivering Our Vision: Identified Work Streams to Deliver Change

## Work Stream 11: Maximising the digital opportunities (building on the Digital Roadmap)

**Aims of Work Stream:**

"Establish a digital environment across the Kirklees health and care economy that adopts a philosophy of;

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

By;

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

**How will this be Delivered:**

- Full interoperability of healthcare records inclusive of mental health services
- Further expansion of e-prescribing across all services by 2019/20
- Increase use of e-consultation by 2018/19
- Increase sharing of GP clinical record
- Implement Acute Electronic Patent records
- Increase electronic transfers of care across all settings by 2019/20
- Shared Infrastructure utilising the opportunities through the Health and Social Care Network
- WIFI deployment in GP Practices by Q4 2017/18
- Professionals across care settings to access GP-held information on GP-prescribed medications, patient allergies and adverse reactions by 2019/20
- Professionals across care settings to be made aware of end-of-life preference information through further roll out of EPaCCS by 2019/20

# Delivering Our Vision: Identified Work Streams to Deliver Change

## Work Stream 11: Maximising the digital opportunities (building on the Digital Roadmap)

**Impact of this Work Stream:**

### Health and Wellbeing Gap

- Patients able to view their own records online

### Care and Quality Gap

- **Improvement in electronic health record sharing**
- **Paper free at the point of care**

### Finance and Efficiency Gap

- **E consultation as an alternative to face to face in primary care**
- Shared infrastructure
- Digital maturity in primary care

# Delivering Our Vision: Identified Work Streams to Deliver Change

## Work Stream 12: Moving towards a 'One Public Estate' approach

**Aims of Work Stream:**

The public sector across Kirklees has a huge array of buildings and land. The traditional approach of single organisations plans for the use of their estate is clearly not the way forward. Our aim is to develop an integrated plan for the development of the health and care estate – that is driven by the STP and the service strategies that flow from it. The impact of digital technology is one of the main drivers of change in the estate requirements – our approach to estates must be developed in close collaboration with our approach to digital technology. The approach needs to be based on what we need to deliver excellent customer focussed services, not just how to use what we've already got.

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

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

This is a new area of work and will need to build links not just across health and social care organisations but also with the Kirklees Economic Strategy and the Local Plan. There is an emerging forum to discuss these opportunities, led by the Council.

**How will this be Delivered:**

- Map utilisation of current estates usage and their occupancy, aim to increase usage to support out of hospital care.
- We have recently been successful with a bid to the national One Public Estate programme to develop a pilot in Batley – the aim is to identify opportunities to bring together adult social care, Locala, CCG, Children's Centre, Police and local VCS. The pilot will provide a 'proof of concept' for delivering the value of the OPE – especially more integrated and customer focused services.
- Once the pilot is up and running to extend the approach across other hubs including Dewsbury
- Work with all health and care partners and those leading the Economic Strategy and the Local Plan to identify other opportunities, and to explore alternative approaches to funding developments
- Clearly articulating the benefits to organisations and local people of shifting the current estate towards a more integrated estate
- Bring together single organisations estates plans into a coherent plan for Kirklees

# Delivering Our Vision: Identified Work Streams to Deliver Change

## Work Stream 12: Moving towards a 'One Public Estate' approach

**Impact of this Work Stream:**

### Health and Wellbeing Gap

- Maximise the impact of the health and social care estate on economic growth, local employment and healthy environments

### Care and Quality Gap

- Co-location of services will facilitate integration of front line services

### Finance and Efficiency Gap

- Reducing the size and cost of the public estate and getting better value out of multi-use sites

# Delivering Our Vision: Identified Work Streams to Deliver Change

## Work Stream 13: Work with the Kirklees Economic Strategy to maximise the impact of the sector on the local economy and to maximise the health and wellbeing benefits of the Economic Strategy

**Aims of Work Stream:**

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

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

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

**How will this be Delivered:**

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

**Impact of this Work Stream:**

**Health and Wellbeing Gap**

- Creating (good) jobs; supporting higher incomes and reducing poverty:
- Promoting healthy, safe, diverse workforces and workplaces;
- Creating a green infrastructure that supports physical activity and emotional wellbeing;
- Ensuring quality housing with high energy efficiency supports affordable warmth, good health and reduces living costs

**Care and Quality Gap**

- Building skills that aid employability and enhancing the pool of confident people able and willing to work;

**Finance and Efficiency Gap**

The Economic Strategy can support health by:

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

# Delivering Our Vision: Risks to Delivery

| Theme | Risk Description | Mitigating Action |
|---|---|---|
| **Organisational Form and Integration** | Risks in terms of the different rules/mandates organisations are bound by. Recognise it will be challenging to overcome these to develop a systems approach to care in Kirklees. This applies to all work streams within this plan. | **TO BE COMPLETED** |
| | NHS configuration and reform has led to a high level of variability between organisations. Lots of work to do to agree a standardised approach. Scale of the task | **TO BE COMPLETED** |
| | All organisations are at different stages in terms of this development – can we move at a fast enough pace together | **TO BE COMPLETED** |
| | A joint governance structure to deliver this plan will be difficult to implement. Risks in terms of the willingness to delegate control. | **TO BE COMPLETED** |
| | Doing things in individual/smaller organisations or footprints which can be better achieved at a larger scale West Yorkshire level. Risk that the work progressed through the West Yorkshire and Harrogate STP will not move at the pace required locally. | **TO BE COMPLETED** |

# Delivering Our Vision: Risks to Delivery

| Theme | Risk Description | Mitigating Action |
|---|---|---|
| **Engagement and Stakeholders** | Health and social care sector not being actively engaged in wider economic development activity | **TO BE COMPLETED** |
| | Engagement with clinical staff across the system. Culture within organisations and an unwillingness to change. | **TO BE COMPLETED** |
| | Public perception – risk that local people feel decisions are being taken out of their hands as discussions become more diluted at a sub/regional level | **TO BE COMPLETED** |
| | Emotional attachment to some buildings/sites and transport options for both staff, managers and public makes driving change difficult. | **TO BE COMPLETED** |
| | Consultation and engagement required regarding any potential change to current provision | **TO BE COMPLETED** |
| | Political sensitivity around some decisions which may need to be made in the future. | **TO BE COMPLETED** |
| | Individuals are unwilling to take more responsibility for themselves of their communities, changing hearts and minds will take time. | **TO BE COMPLETED** |

# Delivering Our Vision: Risks to Delivery

| Theme | Risk Description | Mitigating Action |
|---|---|---|
| **Transformation and Implementation** | Current financial pressures across all sectors of the system inhibit the ability to invest in early intervention and prevention measures for a sustainable future and the ability to invest in new models of care which will deliver transformation. | **TO BE COMPLETED** |
| | Pace of change required to deliver the work streams within this plan | **TO BE COMPLETED** |
| | Current operational pressures within the system hindering the ability to make transformational change | **TO BE COMPLETED** |
| | Challenging and ageing population within Kirklees means that care needs are increasing and becoming more complex. | **TO BE COMPLETED** |
| | Some of the changes described within this plan will require extensive mobilisation and a transformation agenda across all partners. This will take time and the benefits realisation timescales may fall outside of the lifespan of this plan. | **TO BE COMPLETED** |
| | Risk in making the care landscape more complicated for the wider system through re-configuration and centralisation of services. Need to consider the system wide impact of changes to ensure we do not destabilise services. | **TO BE COMPLETED** |
| | Organisations requirements and timelines to make changes to their estate do not fit with other partners needs/aspirations. | **TO BE COMPLETED** |
| | Learning from Serious Case Reviews we know that too many people involved with individuals/families with more complex needs can lead to confusion. When integrating services across the system we need to ensure that this is undertaken in a coordinated approach which keeps the patient as the focus point. | **TO BE COMPLETED** |

# Delivering Our Vision: Risks to Delivery

| Theme | Risk Description | Mitigating Action |
|---|---|---|
| **Enablers** | Workforce pressures inhibit the ability to make change. Whilst plans are being out in place they will take time to implement. | **TO BE COMPLETED** |
| | Continued focus on individual organisation workforce issues and plans rather than a shared Kirklees view | **TO BE COMPLETED** |
| | IT not in place to support fully integrated working | **TO BE COMPLETED** |
| | Access to information to support decision making. | **TO BE COMPLETED** |
| | The care sector being an attractive enough employment sector to recruit and retain a sufficiently skilled workforce | **TO BE COMPLETED** |
| | The fee levels paid for publicly funded care enabling independent sector providers to thrive | **TO BE COMPLETED** |
| | Funding required to make both large scale Digital advances and smaller transformational changes | **TO BE COMPLETED** |
| | Organisations requirements and timelines to make changes to their estate do not fit with other partners needs/aspirations. | **TO BE COMPLETED** |
| | Lack of investment in developing capacity to meet the workforce needs of community based services across health and social care | **TO BE COMPLETED** |

# Closing the Care and Quality Gap

**TO BE COMPLETED**

# Closing the Finance and Efficiency Gap

**West Yorkshire and Harrogate STP**

Detail to be added

Total Do Nothing Surplus / (Deficit)

| TOTAL | 2016/17 £'000 | 2017/18 £'000 | 2018/19 £'000 | 2019/20 £'000 | 2020/21 £'000 |
|---|---|---|---|---|---|
| Bradford & Airedale | (8,021) | (78,538) | (126,793) | (171,975) | (221,137) |
| Calderdale | (572) | (27,265) | (49,309) | (63,286) | (79,442) |
| Harrogate | 6,412 | (10,264) | (19,067) | (29,493) | (38,909) |
| Kirklees | (30,419) | (119,731) | (153,802) | (176,349) | (207,836) |
| Leeds | (30,807) | (129,450) | (184,630) | (229,681) | (297,932) |
| Wakefield | (16,614) | (108,727) | (142,746) | (174,110) | (214,672) |
| YAS | 2,014 | (2,265) | (6,470) | (10,489) | (14,640) |
| **Total** | **(78,009)** | **(476,239)** | **(682,816)** | **(855,382)** | **(1,074,567)** |

Total Do Something Surplus / (Deficit)

| TOTAL | 2016/17 £'000 | 2017/18 £'000 | 2018/19 £'000 | 2019/20 £'000 | 2020/21 £'000 |
|---|---|---|---|---|---|
| Bradford & Airedale | (8,021) | 0 | 0 | (0) | (18,124) |
| Calderdale | (572) | (17,006) | (32,047) | (43,609) | (55,251) |
| Harrogate | 6,412 | (5,915) | (9,132) | (13,861) | (17,609) |
| Kirklees | (30,419) | (76,655) | (83,014) | (83,136) | (94,089) |
| Leeds | (30,807) | (61,534) | (51,857) | (38,423) | (46,169) |
| Wakefield | (16,614) | (28,370) | (26,822) | (26,149) | (27,737) |
| YAS | 2,014 | 612 | (567) | (1,412) | (2,213) |
| **Sub Total** | **(78,009)** | **(188,868)** | **(203,440)** | **(206,590)** | **(261,191)** |

# Closing the Finance and Efficiency Gap

## Financial Assumptions: West Yorkshire and Harrogate STP

- Both CCGs have assumed to get back to a surplus position but there are no defined solutions at this moment to deliver this.
- LA not assumed solutions at this stage.
- CCGs and providers have used national growth and tariff assumptions.
- The impact of the potential CHFT hospital reconfiguration has been included however the full savings are not shown here as the business case extends an additional year beyond the STP timeline to 2021/22. The loss on disposal of land and buildings has been excluded.
- An attempt to give a “Kirklees” financial position has been generated using patch population shares of the provider positions.

Further detail to be added

# Closing the Finance and Efficiency Gap

**Kirklees Position**

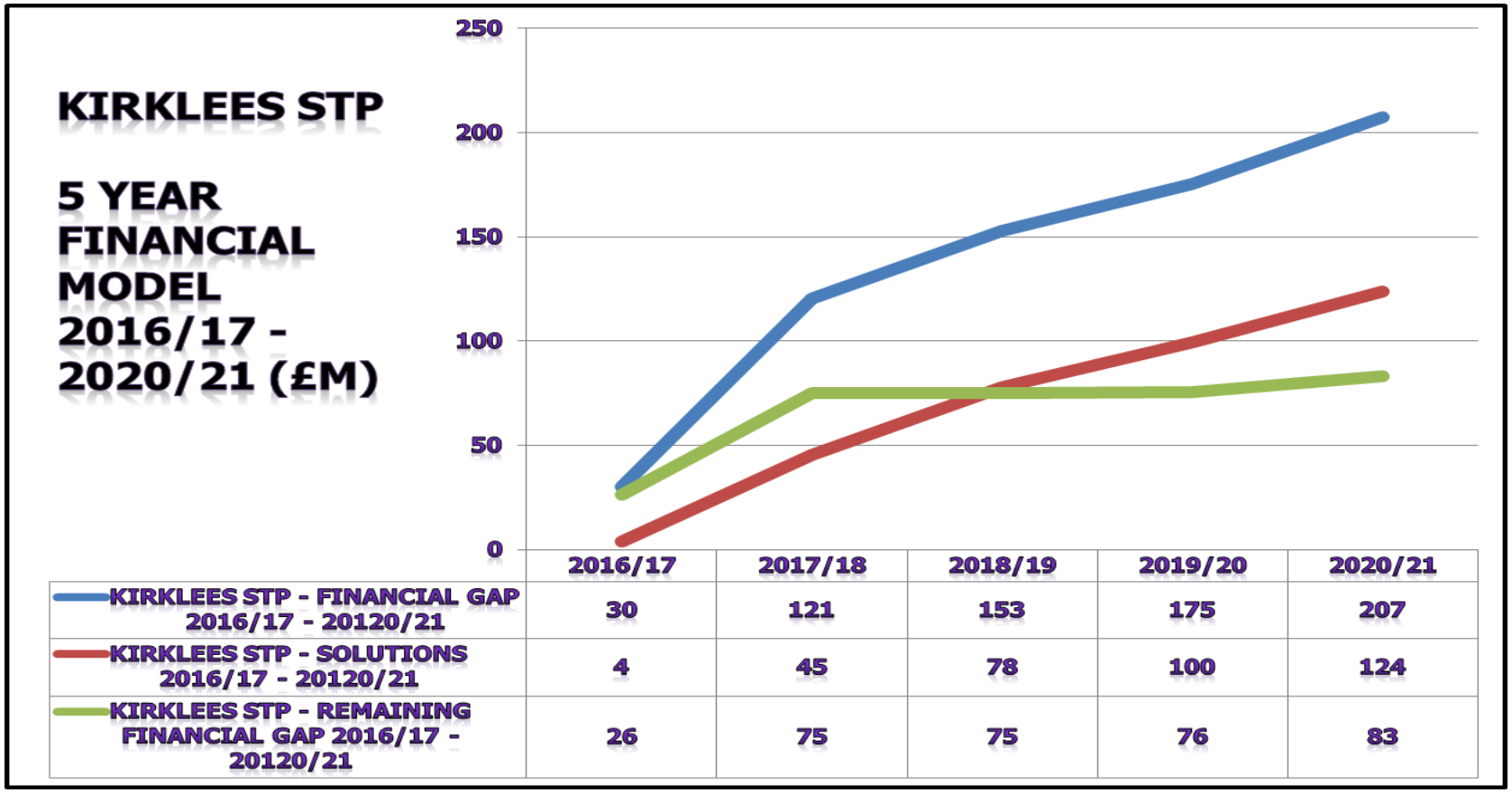
Detail to be added

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

# Closing the Finance and Efficiency Gap

**Kirklees Position: Future Projections**

Detail to be added




| | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 |
|---|---|---|---|---|---|
| KIRKLEES STP - FINANCIAL GAP 2016/17 - 20120/21 | 30 | 121 | 153 | 175 | 207 |
| KIRKLEES STP - SOLUTIONS 2016/17 - 20120/21 | 4 | 45 | 78 | 100 | 124 |
| KIRKLEES STP - REMAINING FINANCIAL GAP 2016/17 - 20120/21 | 26 | 75 | 75 | 76 | 83 |

# Appendix 1: Endorsement of this Plan by Stakeholders

| Organisation/Body | Endorsement Route | Date |
|---|---|---|
| TO BE COMPLETED | | |
| | | |
| | | |

# Appendix 2: References


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