Kirklees Health and Wellbeing Plan 2017

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7 November 2017

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

Kirklees Health and Wellbeing Plan 2017 - 2021

Foreword

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

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

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

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

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

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

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

Kirklees 2020 Vision for our health and social care system:

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

The principles underpinning the Kirklees 2020 vision are that:

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

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

Kirklees Joint Strategic Assessment

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

Key challenges

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

How do we tackle them?

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

Delivering the Vision Together

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

Our Part

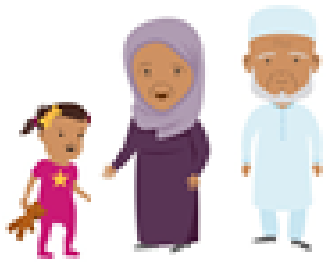
Local health and social care organisations will work together across Kirklees to:

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

Your Part

As a local resident you can play your part by:

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



Alignment with Other Plans and Strategies

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

West Yorkshire and Harrogate STP

Kirklees JHWS

Kirklees JSA

Kirklees Health and Wellbeing Plan

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

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

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

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

Involving local people

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

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

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

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

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

Get involved by visiting the following websites:

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

Local Challenges

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

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

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

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

Local Challenges – Health and Wellbeing Gap

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

Local Challenges – Health and Wellbeing Gap

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

Local Challenges – Health and Wellbeing Gap

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

Local Challenges – Care and Quality Gap

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

Local Challenges – Care and Quality Gap

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

Local Challenges – Care and Quality Gap

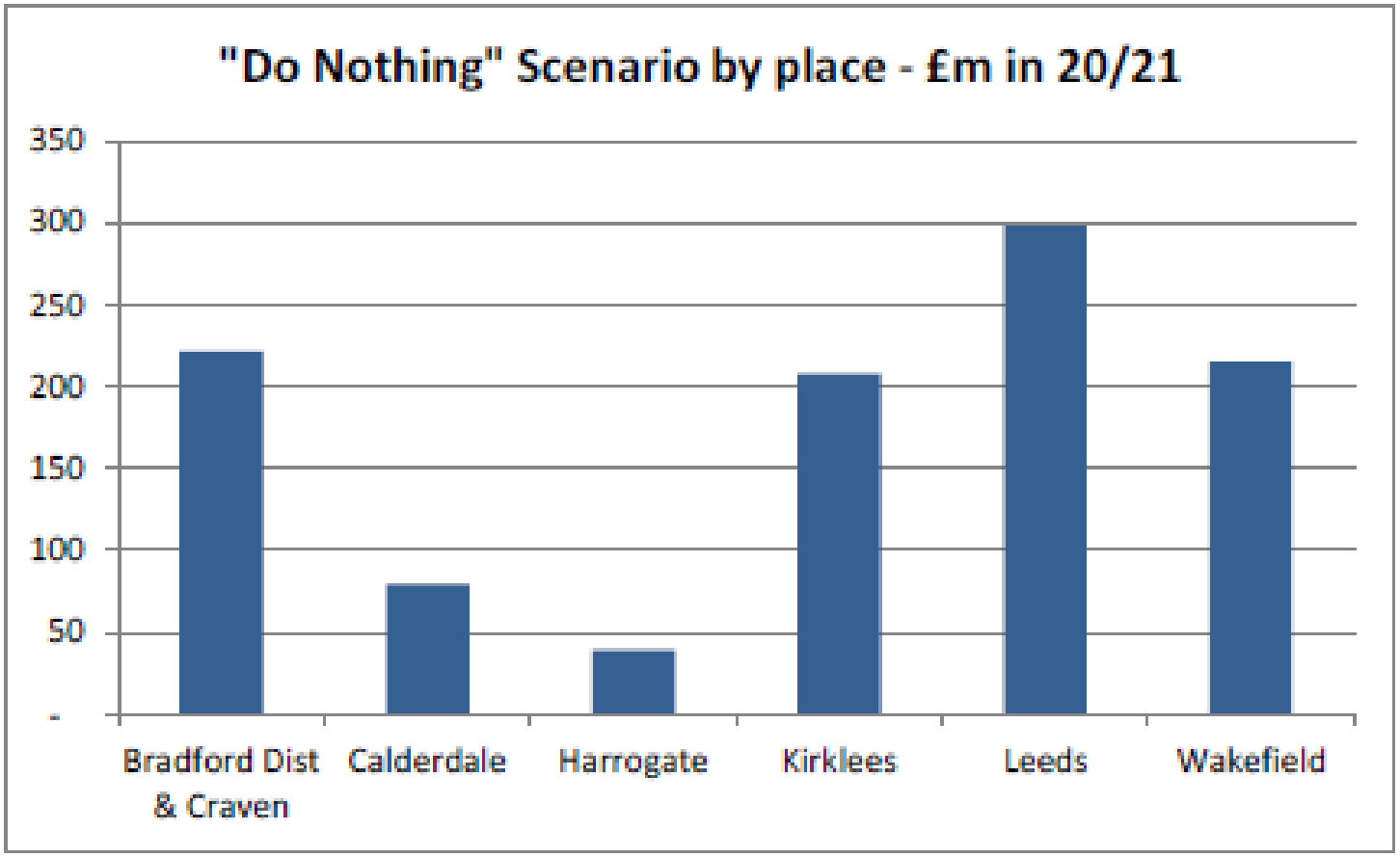
Challenge	Ambition for the Future	How will we Measure Success?
People with severe and enduring mental health needs die on average 15-20 years sooner than their neighbors in similar socio-economic circumstances.	Address this issue proactively through improved health screening in conjunction with primary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

Local Challenges – Finance and Efficiency Gap

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

Finance and Efficiency Gap

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



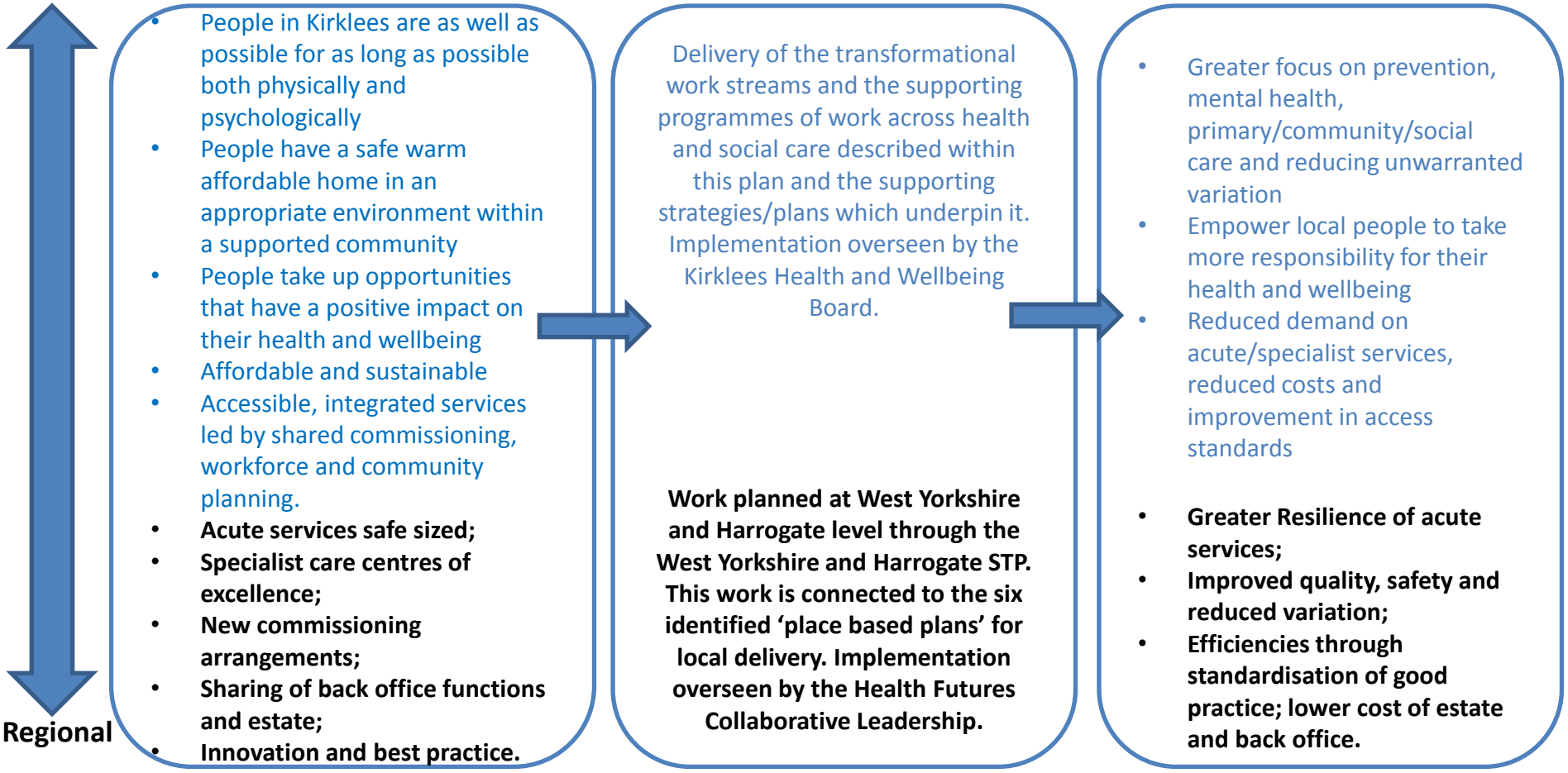
Finance and Efficiency Gap

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

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

From Vision to impact

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



Delivering The Vision: Priorities for Change

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

Areas of Transformation

- Early intervention & prevention

- Improving services for children

- Developing an adult wellness model

- Capacity & quality of primary care

- Sustainability of adult social care

- Change the configuration of acute services

- New model for continuing care

- Transforming care for people with learning disabilities

- Changing the commissioner landscape and new models of care

Delivering The Vision: Priorities for Change

Supporting Programmes

- Health & Social Care Workforce

- Digital Opportunities

- One Public Estate

- Kirklees Economic Strategy

Delivering The Vision: Changing Behaviours

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

Planning for Kirklees

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

Kirklees People

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

Kirklees Pound

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

Appendices

The Kirklees Provider and Commissioner Landscape

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

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

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

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

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

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

Locala provide community based health services across Kirklees.

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

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

The Kirklees Provider and Commissioner Landscape (continued)

Figure 1

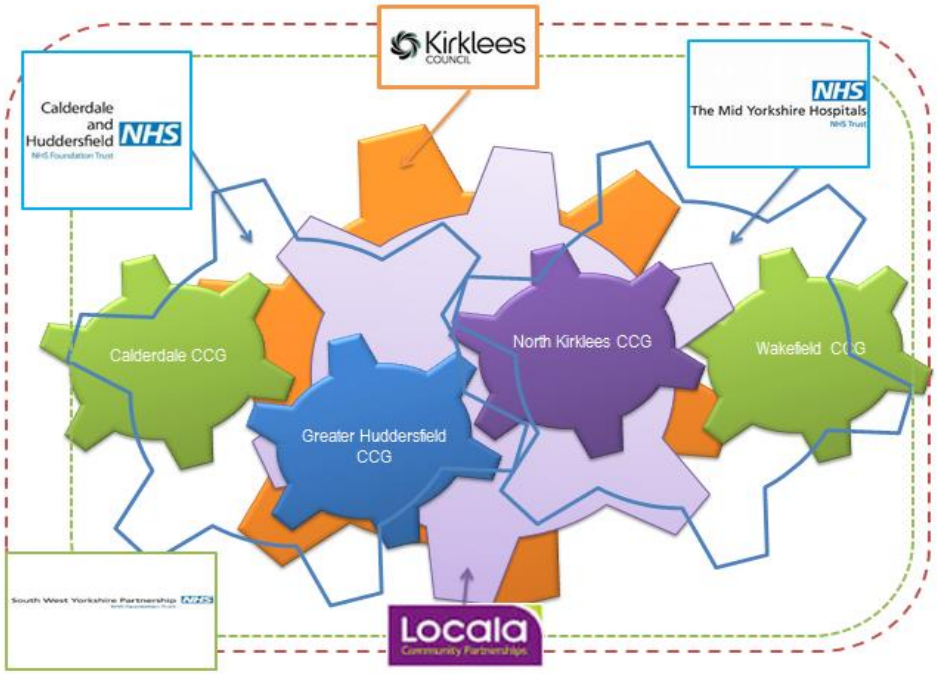
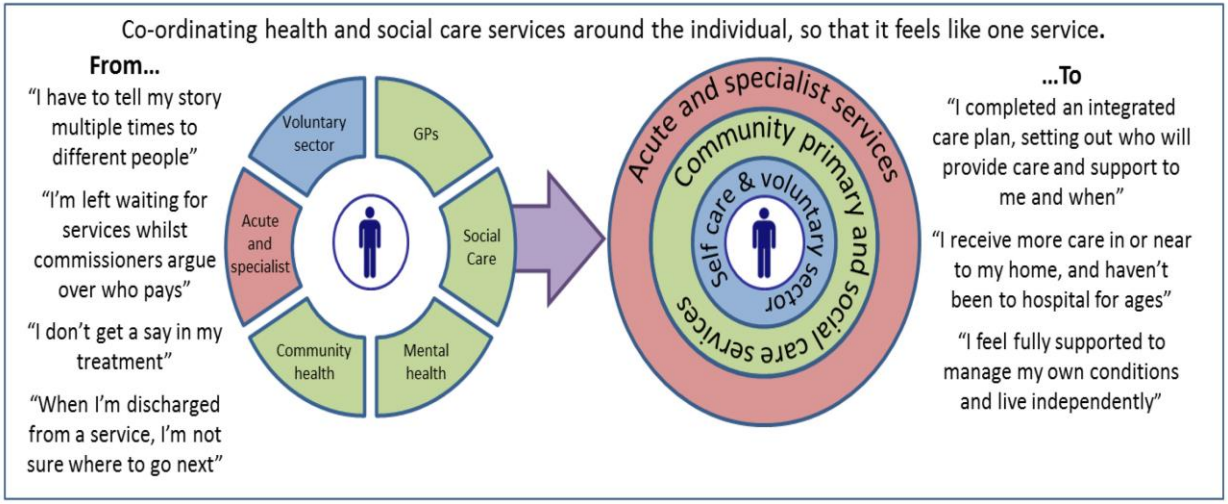


Figure 1 shows the different commissioning organisations described above and how they work together to ensure that high quality services are commissioned for the people of Kirklees.

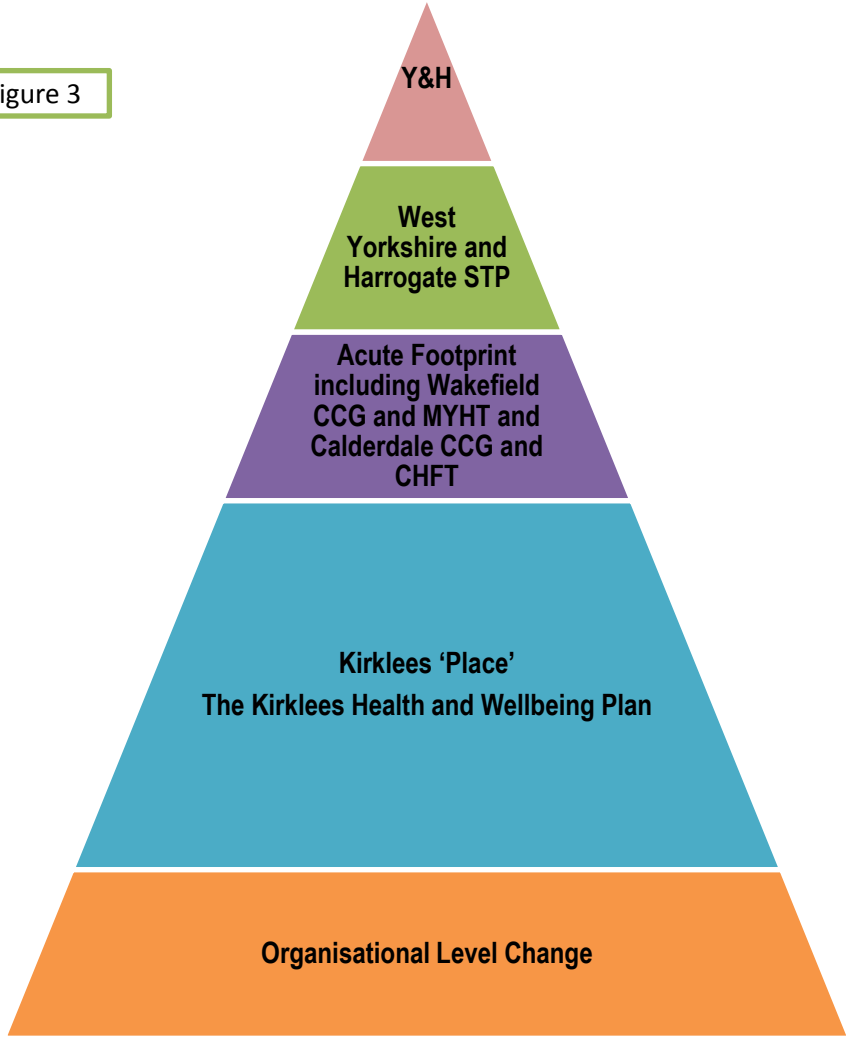
Figure 2 demonstrates our ambition for the future to improve health and wellbeing and reduce health inequalities for our local population by moving towards population based commissioning where the focus is on service user centred co-ordinated care.

Figure 2



Collaboration and Transformation

Figure 3



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

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

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

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

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

Governance and Decision Making

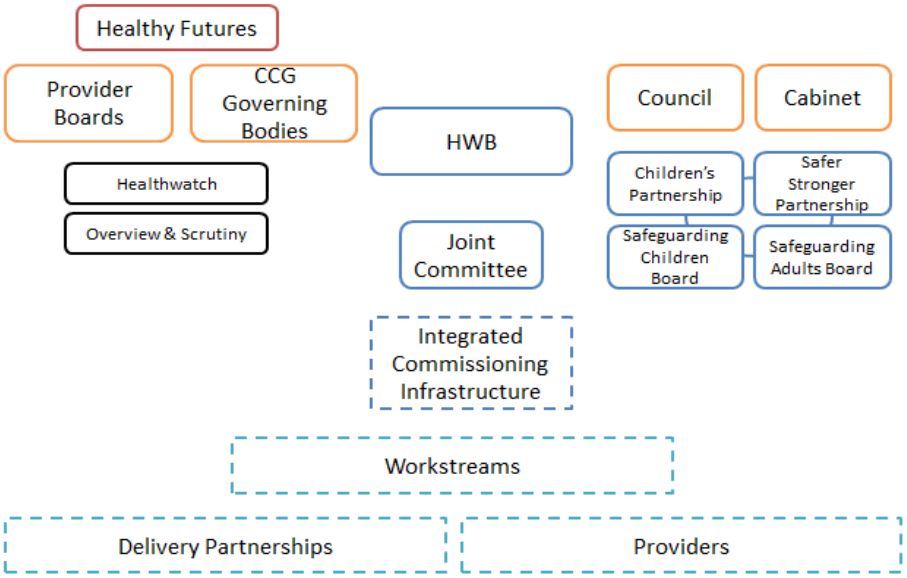
The Kirklees Health and Wellbeing Board will take the lead in the development and delivery of the Kirklees Health and Wellbeing Plan. The Plan recognises that all partners will need to take responsibility for embedding the Plan in their own organisational plans. The current governance arrangements will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

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

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

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

Figure 4



Approach to Quality

Aims of the quality teams:

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

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

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

How this will be delivered:

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

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

Figure 5

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

Approach to Quality

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

Patient Safety

Care and Quality Gap:

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

Finance and Efficiency Gap:

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

Patient Experience

Care and Quality Gap:

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

Finance and Efficiency gap:

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

Clinical Effectiveness

Care and Quality Gap:

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

Finance and Efficiency Gap:

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

Health and Wellbeing Gap

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

Alignment with the West Yorkshire and Harrogate STP

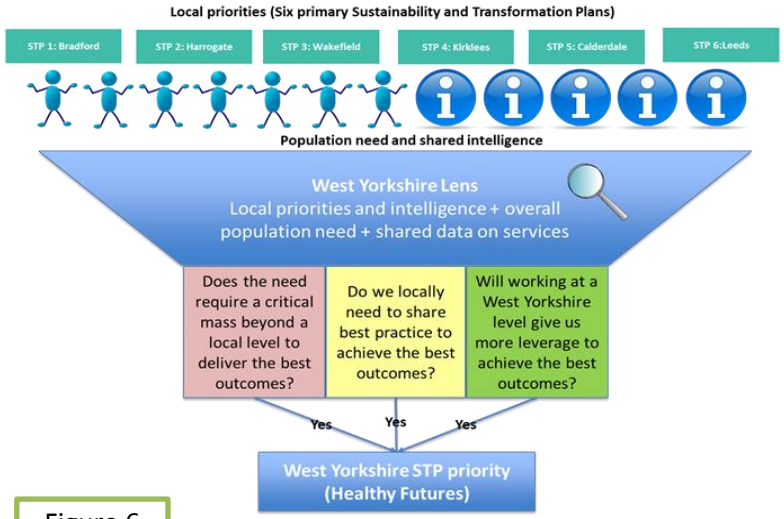


Figure 6

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

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

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

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

Progress to Date and Building on this in the Future

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

How we have already involved local people?

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

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

How we have already involved local people?

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

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

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

Aim of Work Stream:

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

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

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

How will this be Delivered:

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

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

How will we know this work stream has been successful?

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

Improving Services for Children

Aims of this Work Stream:

Number of strands to this work stream:

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

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

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

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

Improving Services for Children

How will this be Delivered:

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

How will we know this work stream has been successful?

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

Development of an Adult Wellness Model in Kirklees

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

How will this be Delivered:

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

Development of an Adult Wellness Model in Kirklees

How will we know this work stream has been successful?

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

Improving the Capacity and Quality of Primary Care

Aims of Work Stream:

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

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

Our Strategies aim to:

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

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

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

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

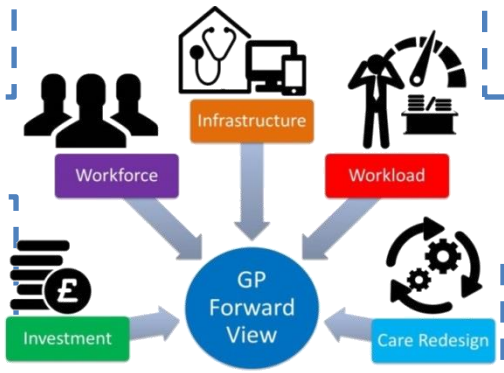
Improving the Capacity and Quality of Primary Care

How will this be Delivered:

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

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

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



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

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

Improving the Capacity and Quality of Primary Care

How will we know this work stream has been successful?

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

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

Aims of Work Stream:

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

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

We want to make sure that:

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

How will this be Delivered:

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

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

How will we know this work stream has been successful?

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

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

Aims of this Work Stream:

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

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

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

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

NHS Meeting the challenge

RIGHT CARE
RIGHT TIME
RIGHT PLACE

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

How will this be Delivered:

Meeting the Challenge

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

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

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

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

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

How will this be Delivered:

Right Care, Right Place, Right Time

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

We have consulted on:

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

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

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

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

How will we know this work stream has been successful?

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

New Approach/Model to support people with Continuing Healthcare Needs

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

How will this be Delivered:

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

How will we know this work stream has been successful?

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

Implementation of the Transforming Care Programme for people with Learning Disabilities

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

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

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

The key aims for our plan will be:

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

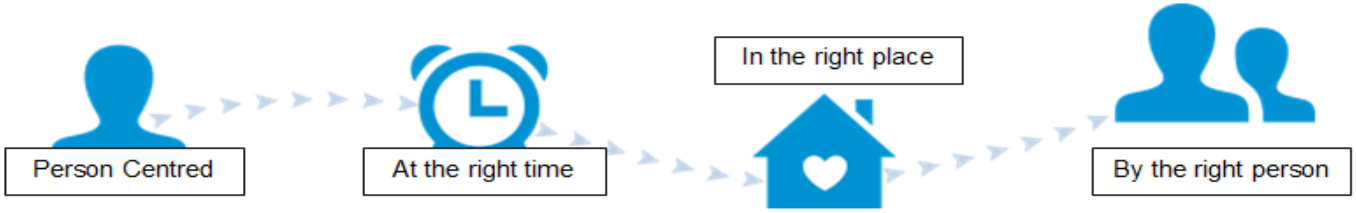
How will we know this Work Stream has been successful?

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

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

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

Figure 7



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

Aims of Work Stream:

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

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

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

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

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

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

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

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

How will this be Delivered:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Our emerging integrated approach to the frail elderly population will:

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

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

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

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

Case Study Example: New Model for End Of Life Care

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

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

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

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

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

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

Future work includes the development of:

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

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

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

Our initial focus will be on :

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

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

How will this be Delivered:

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

How will we know this work stream has been successful?

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

Maximising the digital opportunities (building on the Digital Roadmap)

Aims of Work Stream:

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

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

By;

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

How will this be Delivered:

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

Maximising the digital opportunities (building on the Digital Roadmap)

How will we know this work stream has been successful?

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

Moving towards a 'One Public Estate' approach

Aims of Work Stream:

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

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

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

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

How will this be Delivered:

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

How will we know this work stream has been successful?

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

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

Aims of Work Stream:

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

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

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

How will this be Delivered:

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

How will we know this work stream has been successful?

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

The Economic Strategy can support health by:

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

Risks/Issues/Key Concerns to Delivery

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

Risks/Issues/Key Concerns to Delivery

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

Risks/Issues/Key Concerns to Delivery

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

Endorsement of this Plan by Stakeholders

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

References

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

Get involved

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

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

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