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Health and Care Partnership

NHS West Yorkshire
Integrated Care Board

Kirklees Health and Adults Social Care Scrutiny Panel

6th August 2025

Winter Pressures 25/26

Kirklees
Health & Care
Partnership

Questions raised and addressed in relation to Winter Pressures

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Kirklees Adult Overview and Scrutiny Committee requested information to address and provide assurance on the following points:

1. • Joined up care between organisations
2. • Care packages available
3. • Services Locala provide
4. • Community care offered
5. • Is there a shortage of domiciliary providers?
6. • What has been learnt from previous years and how approaching 25/26 differently?

Winter Plans 2025/26

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- **The Kirklees Health & Care System is currently developing plans to support Winter 2025–26,**
- **Earlier System-Wide Winter Planning approach:** allowing time to embed protocols and review any potential mutual aid governance processes.
- **DRAFT submission due 31st July and FINAL plans by end August 25.**
- **The system demonstrates integrated partnership plans across:**
  - Kirklees ICB, Primary Care/PCNs
  - Calderdale and Huddersfield Foundation Trust
  - Mid Yorkshire Hospitals Teaching Trust
  - South West Yorkshire Partnership NHS Trust
  - Locala Community Partnerships CIC
  - Kirklees Council
  - Kirkwood Hospice
  - Voluntary & community sector organisations

Winter Plans 2025/26

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- **Plans give assurance of:**
  - Shifting Care from Hospital to Community
  - Vaccination readiness
  - Discharge and Flow improvements
  - Mental health A&E avoidance
  - SDEC/UTC coverage

- **The UEC Plan focuses on 7 key priorities for the system:**

1. Patients who are prioritised as category 2 (such as those with heart attack, stroke, sepsis or major trauma) receive an ambulance within 40mins.
2. Lengthy handover delays should be eradicated, and delays should be a maximum of 45minutes.
3. A minimum of 78% of patients who attend ED to be admitted, transferred or discharged within 4 hours.
4. Reducing the number of patients waiting over 12 hours for admission or discharge from an emergency department compared to 2024/25 so that this occurs less than 10% of the time.
5. Reducing the number of patients who remain in an ED for longer than 24 hours while awaiting a mental health admission.
6. Tackling the delays in patients waiting once they are ready to be discharged, starting with reducing the 30,000 patients staying 21 days over their discharge ready date.
7. Seeing more children within 4 hours resulting in thousands of children receiving more timely care than in 2024/25.

Joined up care between organisations

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Services/Schemes to prevent A&E Attendances and avoid Hospital Admission:

- Care Home Falls protocol
- YAS – Call before Convey
- Urgent Community Response (UCR)
- Same Day Emergency Care (SDEC)/ Urgent Treatment Centre (UTC)
- (ARI) Acute Respiratory Infection Hubs
- Additional GP capacity on Bank Holidays and Sunday's

Services/Schemes to improve discharge and flow :

- Home First Discharge Pathway
- Virtual Ward
- (EoL) End of Life ITOC pathway

Joined up care between organisations

Kirklees Home First Discharge pathway

Home without any new support **Pathway 0** 	The person is ready to be discharged home without any new support. **Community Transport** and **Age UK** can take people home from hospital and settle them back in. **Carer Support** can call carers to see how we are doing.
Home with new support **Pathway 1** 	The person is ready to be discharged home but needs some support at home to help them to be as independent as they can be. The **Home First Reablement Team** will help the person to be as independent as they can be by supporting them with things like meal preparation and self-care.
Intermediate Care **Pathway 2a** 	The person is ready to be discharged from hospital, but not ready to go home yet. They need extra support to regain their independence and will be cared for in an **Intermediate bed** setting until they are safe to go home. The **Intermediate Care Team** will support the person's needs in the Intermediate Care bed setting. Support will be available from nurses, therapists and carers. Together, a plan will be agreed with the person based on their abilities, needs and wishes to help them regain their independence.
Recovery Bed **Pathway 2b** 	The person is ready to be discharged from hospital, but not ready to go home yet. The person needs extra support and recovery time and will be cared for in a **Recovery bed** setting until they are safe to go home. The **Recovery Bed Team** will support the person's needs in the Recovery Bed setting. Support will be available from therapists and carers. Together, a plan will be agreed with the person based on their abilities, needs and wishes to help them regain their independence.
Long Term Care **Pathway 3** 	The person is no longer able to be looked after safely at home. It is in their best interest to move into a care home. The **Care Home** staff will support the person's needs. Together, a plan will be agreed based on the person's abilities, needs and wishes to keep at their best.

Kirklees Council Hospital Discharge

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- **Carers Count –** Informal Carers support service
- **Seamless Home from Hospital/Age UK -** Hospital to Home service
- **Reablement -** The Home First Service helps people to regain the skills and confidence needed to live independently at home, particularly after an illness or a stay in hospital.
- **Recovery Bed Hub -** at Moorlands Grange now fully staffed (40 beds). Admissions within 48 hours
- **Intermediate Care Beds -** The Intermediate care service provides support to people for up to 6 weeks in a community (40 beds at Ings Grove, Mirfield)
  or in the person's own home.
- **Night Sitting -** service fully established
- **Trusted Assessors – KirCCA** working with care homes in Kirklees
- **Movement & Handling team** – looking to reduce "double up" calls and promote single handed care
- **SCOTS (Social Care Occupational Therapists)** - Primarily an assessment team, identifying needs, agreeing goals and determining interventions
- **KICES –** Kirklees Integrated Community Equipment Services

Kirklees Adult Services

Locala Community Services

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Kirklees Community Services (KCS) Contract

As part of the Kirklees Community Services (KCS) contract awarded April 2024, Locala Health and Wellbeing deliver a range of holistic and integrated community-based services within the new specifications developed as part of a system approach led by the ICB. **The Adult services include**:

- Community Nursing including Self Care
- Ageing Well Team
- Long Term Conditions Review Service
- Care Home Support Team
- Cardiac Rehabilitation
- Heart Failure
- Community Rehabilitation Service
  - Community Stroke Service
  - Neuro & Complex Disabilities
  - Frailty & Orthopaedics
  - Speech & Language Therapy
  - Dietetics
- Treatment room service
- Dermatology (South Kirklees)
- Tissue Viability Nurses
- Tuberculosis Service
- Respiratory including Virtual Ward (South Kirklees)
- Continence, Colorectal & Stoma Service
- Specialist Diabetes Service
- Podiatry General
- Podiatric Surgery (South Kirklees)
- Integrated Transfer of Care Team
- Intermediate Care Service
- Outpatient Parenteral Antimicrobial Therapy (OPAT)

Locala Health & Wellbeing

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Kirklees Health & Care Partnership

Kirklees Adult Services

Locala Community Services

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Kirklees Services – Wider Contracts

In addition to the overarching KCS contract, Locala are commissioned to deliver other adult community services including;

- The Whitehouse GP Practice
- Special Allocation Service (SAS)
- Reablement
- Kirklees Sexual Health Services
- Hand Surgery
- Treatment Room Service

Service delivered as part of an alliance and/or integrated service

- Virtual Ward (Frailty) – Delivered in partnership with Mid-Yorkshire Teaching Hospital and Calderdale & Huddersfield Foundation Trust)
- Urgent Community Response – Delivered as an alliance with Kirklees Council, Local Care Direct and Curo GP Federation
- Community Dental Service (Adults / Children's) – Delivered as part of a West Yorkshire Partnership

Locala Health & Wellbeing

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Kirklees Health & Care Partnership

Locala Community Services

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Kirklees Children's Services

Locala are also commissioned to provide a range of children's services across Kirklees as part of the KCS overarching contract and other commissioned contract. These are:

Kirklees Community Services Contract

- Children's Community Nursing (including specialist services)
- Children's Therapies Service
- Youth Justice Service
- Children Looked After Service

Other Contracts

- Kirklees 0-19 service (inc; MDT support into Families Together Gateway)
- Child Health Service (North Kirklees)
- WYVIC – School Age Immunisation Service

Kirklees Domiciliary Providers

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Is there a Shortage Of Domiciliary Providers?

The current domiciliary care market includes too many providers competing for a limited volume of commissioned hours, this feedback has been shared by the market with Commissioners.

This has made it difficult to sustain a stable market, especially as the majority of home support is commissioned rather than privately purchased.

Providers are covering large areas across Kirklees, resulting in high travel times, and the fragmented nature of the market has made it challenging to build strong, consistent partnerships.

We're currently developing a new contract model focused on locality-based provision. The aim is to allocate work in a more managed and strategic way, supporting a more sustainable and collaborative market. The new contract is scheduled to go live in June 2026.

Learning and informing 25/26

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- Developing a Kirklees Discharge Process across both trusts – introduction of the Discharge Dashboard
- Proportionate Care Act Assessment
- In the process of planning mitigations should MG or IMC close to infections. Closer links now between ASC and the Stroke Pathway.
- MAST MDT pilot as part of the Integrated Neighbourhood Health.
- Streamlining Transfer of Care (TOC) meetings with the introduction of OPTICA
- Left Shift Hospital Avoidance – Integrated Front Door / Single Point of Access
- Hospice involvement will be built into winter planning to support palliative discharge flow
- Colocation in acute trusts ITOC Hubs
- Work is underway to define clear governance for Tactical+, Silver, and Strategic escalation, ensuring a smoother system response in peak periods.
- Commitment to explore direct referral into virtual wards for the bariatric cohort, as an alternative to hospital conveyance and to ease discharge delays. Also to explore bariatric issues.
- Exploration of a rapid discharge team within SWYPFT to review and expediate flow out of mental health wards.
- Mental Health Service within Better Care Funding Arrangements

Learning and informing 25/26

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- Provision of Primary Care Enhanced Access sessions on weekday evenings / Saturday and additional sessions provided on a Sunday and Bank Holiday's.
- Provision of ARI Hubs (Two ARI Hubs, one in Greater Huddersfield and other in North Kirklees), running Mon-Fri excluding bank holidays in 25/26 from 1st Oct 25 – 31st Mar 26 with provision for referrals from primary care, A&E and 111. Point of Care Testing also to be introduced.
- Flu and COVID-19 vaccination activity, all Practices encouraged to delivery flu and covid vaccinations and targeted activity carried out with the aim of increasing population uptake of the vaccinations.
- Patients referred to pharmacy first - the consultation service enables patients to be referred into community pharmacy for a minor illness or an urgent repeat medicine supply.
- Weekly Opel scoring and reporting by practices, practices will flag pressures and reasons for these pressures to the system and ICB via RAIDR.
- Practices encouraged and supported to utilise initiatives that aim to improve patient access and demand, including utilisation of online consultation tools.
- Work through PCN's, including work carried out by social prescribers and links to care homes to provide regular contact and care.