Name of Meeting: HEALTH AND ADULT SOCIAL CARE SCRUTINY PANEL

Date: TUESDAY 4 DECEMBER 2018

Title of report: INTEGRATION OF HEALTH AND ADULT SOCIAL CARE

Purpose of Report:

This report presents for information an updated position statement on the integration of Health and Adult Social Care in Kirklees.

Key Decision - Is it likely to result in spending or a saving of £250k or more, or to have a significant effect on two or more electoral wards?	N/A
Is it in the Council's Forward Plan (Key Decisions and Private Reports)?	N/A
The Decision - Is it eligible for "call in" by Scrutiny?	N/A
Date signed off by Director and name **Is it also signed off by the Assistant Director for Financial Management, IT, Risk and Performance?** **Is it also signed off by the Assistant Director, Legal, Governance and Monitoring?**	Richard Parry – 22 November 2018 N/A N/A
Cabinet member portfolio	Cllr Musarrat Khan, Adults and Public Health

Electoral wards affected: All

Ward councillors consulted: Consultation with Ward Councillors is not applicable to this report

Public or private: Public

1. Background and Information

A report updating on progress with the integration of health and adult social care was discussed at the February 2018 Health and Adult Social Care Scrutiny Panel. This paper provides a further update on progress and plans for 2019.

1.1 West Yorkshire and Harrogate Health and Care Partnership

1.1.1 Health and care service providers and commissioners have come together to form the West Yorkshire and Harrogate Health and Care Partnership.

1.1.2 The Partnership exists to improve outcomes for people locally therefore its success is built on local relationships in 'Places' to ensure change addresses local need and can happen as close to people as possible. By planning and working across a bigger footprint there is an opportunity to improve outcomes at a local level through sharing good practice and resources and learning from each other. The priorities within the Partnership (see Appendix 1) are driven by those identified within 'Places'. The Kirklees Health and Wellbeing Plan (see 1.3 below) was developed to identify the priorities within Kirklees which drive what we have agreed to work together on through the Partnership.

1.1.3 The document "Our next steps for better health and care for everyone" here describes the progress made since the publication of the initial plan in November 2016. It also sets out how the Partnership will further improve health and care for the 2.6 million people living across the area in 2018 and beyond.

1.2 **The West Yorkshire and Harrogate Joint Committee of Clinical Commissioning Groups**

1.2.1 The 9 CCGs in West Yorkshire and Harrogate are continuing to develop closer working arrangements within each of the six 'Places' that make up the West Yorkshire Health and Care Partnership.

1.2.2 The CCGs have established a Joint Committee, which has delegated authority to take decisions collectively. The Joint Committee is made up of representatives from each CCG. To make sure that decision making is open and transparent, the Committee has an independent lay chair and two lay members drawn from the CCGs, and meets in public every second month. The Joint Committee is underpinned by a memorandum of understanding and a work plan, which have been agreed by each CCG.

1.2.3 The Joint Committee is a sub-committee of the CCGs, and each CCG retains its statutory powers and accountability. The Joint Committee's work plan reflects those partnership priorities for which the CCGs believe collective decision making is essential. It only has decision-making responsibilities for the West Yorkshire and Harrogate programmes of work that have been expressly delegated to it by the CCGs (see https://wyh-jointcommitteeccgs.co.uk/ shared work plan).

1.3 **Health and Wellbeing Plan**

1.3.1 The Kirklees Health and Wellbeing Plan (here at Agenda Item 6) provides a strategic plan for the delivery of improvements to the health and wellbeing of the population between 2018/2023.

1.3.2 The Plan also serves as the Kirklees 'Place based plan' which provides the Kirklees health and care system view into the West Yorkshire and Harrogate Health and Care Partnership.

1.3 The Plan, which has been shaped and endorsed by Integrated Commissioning Board, the Integrated Provider Board, the Health and Wellbeing Board, Cabinet and partner governance bodies, builds on activity already being undertaken by individual organisations or across the system to deliver improvements to the health and wellbeing of the Kirklees population. The key aspects for the Plan are set out in Appendix 2. The rest of this report is structured around the 5 priorities in the Health and Wellbeing Plan:

1) Create communities where people can start well, live well and age well.
2) Create integrated person-centred support for the most complex individuals.
3) Develop our people to deliver the priorities and foster resilience.
4) Develop our estate to deliver high quality services which serve the needs of local communities.
5) Harness digital solutions to make the lives of people easier.

1.4 **Creating communities where people can start well, live well and age well**

1.4.1 Community Plus and the Integrated Wellness Model (once mobilised) have core principles:

- Building community assets
- Enabling neighbourliness
- Strengthening individual resilience
- Supporting reciprocity
- Social investment

1.4.2 The focus on these principles, rather than discreet universal service development, ensures that community assets are mobilised in line with what residents and 'Places' decide are integration priorities for them.

1.4.3 Currently Community Plus has moved from an Early Intervention and Prevention Hub focused delivery model to adopting a stronger place based outreach approach, allocating identified staff to wards and where required more defined neighbourhoods. They are already utilising community touch down and drop in venues to ensure individuals can access support in non-stigmatising venues. A thorough knowledge of local assets; community groups, buildings, community activists, and the place based challenges that enables effective connecting and social prescribing activity across the age range. This also includes capacity building such as supporting individuals with lived experience to undertake volunteering to deliver self-help stay and play sessions that will enable health professionals to deliver more personalised and accessible health and care interventions where people are at. This community infrastructure development work will provide a firm foundation for when the Integrated Wellness Model goes live, offering more holistic targeted wellness interventions.

1.4.4 Community Plus delivery will align to the Primary Care Networks (see 1.5.1 below) in order to ensure their activity can focus on supporting individuals, communities and services to build on existing assets so as to design the PCNs around expressed needs relating to where people live. Co-location with cluster one is already in progress. Community Plus will be ideally placed to support this integration model and will create a blueprint for roll out across the development of all clusters, identifying system challenges arising for individuals and communities.

1.5 **Creating integrated person centred support for the most complex individuals**

1.5.1 **Primary Care Networks (PCNs)**

a) Work is taking place to create PCNs in 9 local communities, focusing on populations of 30,000 to 50,000, to explore the benefits that could bring for patients, practices and the wider health and care economy. A combined patient population of at least 30,000-50,000 allows practices to share community nursing, mental health, and clinical pharmacy teams, expand diagnostic facilities, and pool responsibility for urgent care and extended access. The NHS England Maturity Matrix will be used as a guide for both CCGs to establish networks which can be guided on a development journey towards integrated care which meets the needs of local populations.

b) PCNs are being asked to review the NHS England Maturity Matrix and consider the ambition, pace and scale of integration. They are also considering models for leadership of the network. Resources are being made available in 2018/19 to release time for Clinicians, Practice Managers and Practice Nurses to plan the development of their networks and to accelerate the journey towards integration.

c) There will be 5 PCNs in the Greater Huddersfield CCG area. The GP Federation 'My Health Huddersfield' will play a key role in facilitating change and transformation during 2018/19. The Federation is already taking a pivotal role in delivering extended access during the evening and weekends in partnership with Local Care Direct. Local initiatives are based on a strong focus on delivering the ten High Impact Actions to release time for care. We have introduced active signposting into every practice along with expanding the workforce and bringing new expertise by having clinical pharmacist staff across the whole of Greater Huddersfield. Work is taking place on implementing document management to free up GP time. The introduction in pilot practices of online consultations provides an opportunity to try out different ways of working that have been shown to be successful and of benefit to patients in other areas.

d) There will be 4 PCNs in North Kirklees. The CCG is working closely with the GP Federation Curo Health Ltd, to help bring about transformation. The Federation represents the whole general practice community as a collective and will provide leadership for change and will facilitate general practice to deliver new models of care. The investment of primary care transformation funding via Curo Health Ltd will enable the following to be designed and implemented at pace:

- Curo will develop as an organisation to deliver primary care at scale
- Enable patients to better self-care and have direct access to other services
- Better use of the talents of the wider workforce
- Provide leadership to redesign care pathways
- Development of new models of care

e) PCNs will work together, alongside Community Plus and (school) community hubs, to support the health needs of their populations. The networks will respond to population health data and support work to reduce health inequalities both across Kirklees as a whole and within their identified geographies. The use of population health data will support the PCNs to respond to the specific health needs of their populations – meaning that while each of the 9 will work to the principles of proportionate universalism, the particular issues they respond to will be different.

1.5.2 **Intermediate Care and Reablement**

a) There are four types of intermediate care and reablement delivered in partnership by Kirklees Council and Locala: crisis response, home-based intermediate care, bed-based intermediate care and reablement

b) The improvement of Intermediate care and reablement services is currently a BCF Scheme (see 1.9 below and Appendix 3). The key aim is to develop an integrated offer that ensures the delivery of a cycle of care that is seamless and effective and delivers improved outcomes for patients and carers.

c) Currently there are between 7 and 10 referral routes into support. These routes have grown over time as new teams and initiatives have developed on an ad-hoc basis. The route has long been seen as the right route out of hospital or from the community. However, there is a growing number of people coming into the service that are not appropriate for the support offered, in particular reablement support. This includes cases where an end of life need or residential care setting is the most proportionate service.

d) Central to the proposed redesigned services is the establishment of an integrated Kirklees Independent Living Team (KILT), a co-located multi-disciplinary team which will provide a single central point of access to requests for intermediate care services. The team will always consider the 'Home First

Principal' when triaging cases and will consist of; OT's, Physiotherapists, START Nurses, Social Workers, Senior Community Assessment and Support Workers, Reablement specialists, Assistive Technology specialists and Pharmacist. Referrals from acute trusts, GP's and community hubs/services will all go through one single access point, the KILT, where an initial assessment will be made to ensure that only people who would benefit from intermediate care would be triaged through to the appropriate pathway:

- **Bed Based Service**

  Bed-based intermediate care – offers support mainly from health professionals in a community hospital or care home with beds being used flexibly to support the system.

- **Home based intermediate care / reablement**

  - Home-based intermediate care – provides services at home, or in a care home delivered by a multidisciplinary team but most commonly by health professionals, such as nurses and therapists.
  - Reablement – offers services at home from specially trained social care staff. Rather than undertaking tasks, staff work to enable people do things themselves and re-learn skills that may have been lost while unwell, and so recover the ability to live safely at home.
  - Contingency provision – to support hospital avoidance.

- **Long term ongoing care**

e) The proposals for the redesign have been endorsed by the CCG Governing Bodies, the Integrated Commissioning Board, SCLT and Member Briefing. The final business case will be considered by the Integrated Commissioning Board in spring 2019.

1.5.3 **Care Homes**

a) Proving support to care homes is an iBCF Scheme (see 1.9 below and Appendix 3). The funding is being used to employ Trusted Assessors in North and South Kirklees to improve the admissions process to care homes from hospitals and to provide enhanced clinical support to avoid unnecessary admissions from care homes to hospital.

b) Procurement of the new Care Home Support Service is in progress. Care home staff will be able to call on specialist advice and support from primary care teams, including GPs. Care home residents will receive a new proactive and reactive service which will include physical health, social care with the addition of specialist mental health support.

c) To ensure quality in care homes the CCGs and the Council are working in partnership to develop and implement an early support and prevention framework.

1.5.4 **End of Life Care**

a) The implementation of the joint commissioning of End of Life Services has focused on the establishment of the Strategic End of Life Commissioning Group, the End of Life Provider Alliance and the supporting End of Life Strategy Group.

b) The short term priorities identified in October include:

- The use of primary care networks to 'test out' some of the areas identified. The PCN in the Valleys has already identified end of life as a key focus for their Network.

- Establishing a group to focus on operational activity.
- Development of a charter to reaffirm the evident commitment of the Commissioning Group.

1.6 **Develop our people to deliver the priorities and foster resilience**

1.6.1 We recognise that organisations within Kirklees are already working to develop their staff. We are looking to build on this work both within organisations, across Kirklees and the West Yorkshire and Harrogate ICS by understanding, supporting, and managing interdependencies, duplication and gaps in existing workforce and organisational development projects across. In particular we are working to support the development of Primary Care Networks (see 1.5.1) and the wider integration of health, social care, the voluntary sector around communities of 30,000 - 50,000 to promote improvements in the health and wellbeing of our population.

1.6.2 To do this we are currently working on a programme of organisational development supported by the NHS leadership Academy and the West Yorkshire and Harrogate Health and Social Care Partnership (see 1.1). This is planned to take place over 3 months early in 2019 and will be aimed at helping staff working in primary care and community settings to build new working relationship across organisational and professional boundaries to support the move to more integration of care.

1.6.3 We have also recently established a Kirklees Integrated Care Workforce Development Steering Group. The role of this group will be to contribute to developing a workforce that is fit for purpose to deliver integrated care based around the needs of our populations and individuals based on support for carers, building integrated teams, and building core skill sets.

1.6.4 It will establish a coordinated, partnership approach to workforce development across primary and community care, recognising unpaid carers, volunteers and the interdependencies with acute care. It will set the strategic direction for integrated care workforce development and transformation across Kirklees and oversee the implementation of a prioritised programme of actions that will deliver on these strategic aims and objectives.

1.6.5 It has links into the West Yorkshire and Harrogate Health and Care Partnership and will report into the Kirklees Integrated Commissioning and Provider Boards (see 1.10 below). In recognition that this is a new group for the first few months, up until March 2019, it will focus on developing and agreeing an integrated care workforce development strategy. In doing this the Group will use data on existing staffing levels, needs analysis etc. to inform the work that is required going forward.

1.7 **Develop estates and community assets to deliver high quality services which serve the needs of the local communities**

1.7.1 Health and social care partners hold a wide range of estates and assets in Kirklees. We know that not all of this estate is bringing good value and some of it is not fit for purpose for our vision to deliver integrated care in the future. As a first step to developing a Kirklees Estates Strategy we have commenced a mapping exercise and review of all the estates across all partners. Our neighbourhood approach (and the Primary Care Network model- see 1.5.1 above) provides us with the opportunity to test some of our key principles in relation to our estate, including how we can:

a) Share estate to support integrated working across staff teams.
b) Use our estates in neighbourhoods of 30,000 to 50,000 to meet the needs of the local population.
c) Use our estates to generate social value and stimulate the growth and embedding of resilient, connected and vibrant communities.

1.7.2 Our vision for the future is that our community assets will provide communities with a wide-range of services and support, not just health and care interventions, but a wider range of community services to serve a much broader range of wellbeing and social connectedness needs. Taking inspiration from national models which have worked well, we will outline our vision for the future across partners and assess our ability to access capital to support this development. We will establish a Kirklees forum to review our collective assets, agree a future vision and a plan to deliver this.

1.8 Harness digital solutions to make the lives of people easier

1.8.1 We know that technology has revolutionised our lives and the ability to manage our affairs independently and remotely. The same principles apply to our health and care.

1.8.2 Initially we will be focussing on:

a) The integration of care records – using the support available through the regional Local Health and Care Record Exemplar programme.

b) How the public / patients can use digital methods to access services – including developing the Kirklees resident account.

c) Increasing the use of assistive technology – building on existing initiatives such as myhealthtools and learning from experience in other areas.

d) Mobile and agile working for our staff – ensuring staff delivering integrated services can work in the most appropriate locations.

e) Integrated communication - enabling staff to be more connected with each other and also with the public.

f) IT infrastructure – ensuring our networks have the right capabilities to support integrated working

1.9 Better Care Fund (BCF) and improved Better Care Fund (iBCF)

The BCF is being used to fund the 8 schemes that form part of our overall strategy to deliver integration. IBCF funding is being invested in 3 of the BCF schemes and into 2 additional schemes. Details of these schemes and the associated funding is set out in Appendix 3.

1.10 Establishment of the Integrated Commissioning Board and the Health and Care Executive Group

1.10.1 The Integrated Commissioning Board (ICB) was established in April 2018 and has met on a monthly basis since then. The ICB is now well established and to date it has concentrated on work to:

- Oversee the development of the new Integrated Commissioning Strategy which was endorsed by the Kirklees Health and Wellbeing Board. The ICB will monitor the progress made in implementing this strategy.
- Support the development of Kirklees wide approaches to quality, an outcomes framework, communications, engagement and equality, and intelligence.
- Oversee the development of integrated provision focusing on Primary Care Networks and the wider integration of health, social care, the voluntary sector around communities of 30,000-50,000 to promote improvements in the health and wellbeing of our population.

1.10.2 A Kirklees Health and Care Executive Group was established in the summer of 2018. This consists of the Chief Executive of Kirklees Council, the Chief Officer of the Kirklees CCGs, the Chief Executives of CHFT, MYHT, SWYPFT, and Locala, and representatives from the Yorkshire and Harrogate Health and Care Partnership and NHS England. The focus of the Group is to provide a senior leadership forum for Kirklees to support the work of other forums such as the Kirklees Health and Wellbeing Board, Integrated Commissioning Board, and Integrated Provider Board. Many of these officers also have roles within the West Yorkshire and Harrogate Health and Care Partnership and the Group provides a focal point for promoting the Kirklees 'Place' within this.

1.10.3 **Integrated Provider Board**

The Kirklees Integrated Provider Board was established in July 2018 and is still in its formative stage and developing its terms of reference.

However it has identified areas where providers can work together to make a significant difference to integrating services over the next 6-9 months. These are actively supporting and driving the delivery of:

- Primary Care Networks and the integration of primary care, social care, community services and wider stakeholders around local populations of 30,000 to 50,000.
- An integrated Community Service Capacity Model for those services that are best delivered once across Kirklees
- Implementing the integrated intermediate care and reablement services model (see 1.5.2 above).

In addition the Board will keep 'in view' a number of other ongoing areas of work to help support their development and implementation including end of life care. The focus over the coming months will be on taking all these areas forward and these are in line with priorities set out in the Integrated Commissioning Strategy.

2. Information required to take a decision

This report is submitted for information only.

3. Implications for the Council

3.1 Early Intervention and Prevention

Work to progress the integration of health and social care is in line with Priority 3 "As part of new Council we will work in partnership with lots of organisations, communities and people."

3.2 Economic Resilience

There will be no impact arising from this report.

3.3 Improving Outcomes for Children

The current integrated commissioning arrangements for children are well established and included in the scope of the Integrated Commissioning Board.

3.4 Legal/Financial or Human Resources

There will be no impact arising from this report.

4. Consultees and their opinions

This report has been jointly prepared by the Council and CCG Partners in integration.

5. Next steps

Not applicable.

6. Officer recommendations and reasons

That this report be received.

7. Cabinet Portfolio holder recommendation

Not applicable.

8. Contact Officers

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9. Background papers and history of decisions

Not applicable.

10. Service Director responsible

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Appendix 1: West Yorkshire and Harrogate Health and Care Partnership Priorities

The Partnership has identified nine priorities:

1. Preventing ill health
2. Primary and community services, which covers a wide range of services including local GPs, pharmacies, social care services and local charities.
3. Mental health
4. Stroke
5. Cancer
6. Urgent and emergency care
7. Hospitals working together
8. Planned care and reducing variation
9. Maternity

And six enabling work streams:

1. Best practice and innovation
2. Workforce
3. Digital ways of working
4. Harnessing the power of communities
5. Capital and estates
6. Business and intelligence

Appendix 2: Kirklees Health and Wellbeing Plan

The plan outlines the planned objectives and key planned interventions and programmes of work for each of the four population cohorts (and for a series of enabling functions):

1. Living well
2. Independent
3. Complex
4. Acute and urgent

The headline shared priorities for the Kirklees population within the plan are:

a) Create communities where people can start well, live well and age well.
b) Create integrated person-centred support for the most complex individuals.
c) Develop our people to deliver the priorities and foster resilience.
d) Develop our estate to deliver high quality services which serve the needs of local communities.
e) Harness digital solutions to make the lives of people easier.

Through delivery of these priorities, we will work to make a real impact in the following areas:

a) Make healthy weight the norm for the population in Kirklees, increasing the proportion of the population of who are a healthy weight in childhood and adulthood, starting with increasing the proportion of babies born in Kirklees at a healthy weight.
b) Increase the proportion of people who feel connected to their communities, reducing the proportion of people who feel lonely or socially isolated and reducing the prevalence of mental health conditions amongst our population.
c) Increase the proportion of people who feel in control of their own health and wellbeing.
d) Narrow the gap in healthy life expectancy between our most and least deprived communities.

The plan builds on activity already being undertaken by individual organisations or across the system, delivering our vision through:

a) Working with 9 local communities of 30,000 – 50,000 populations across Kirklees, bringing together NHS, social care, wider council services, and voluntary and community sector organisations tailored to the needs of those diverse communities and building resilience and connectedness within those communities which with our residents identify.
b) A focus on prevention and early intervention and tackling the underlying cause of poor health and wellbeing.
c) Empowering people to stay independent and providing more support in the community or at home.
d) Delivering high quality acute and specialist services for our whole population working with a single group of hospitals, the West Yorkshire Associate of Acute Trusts and a single group of mental health providers, the West Yorkshire Mental Health Services Collaborative.
e) A Kirklees approach to commissioning services once across the Council and two Clinical Commissioning Groups through a single Integrated Commissioning Board.
f) A single Kirklees Integrated Provider Board to ensure services are delivered in a coordinated and integrated way with local communities and across Kirklees.
g) A commitment to openness, transparency and involvement of our communities and workforce in our conversations and decisions to deliver our ambition.

Appendix 3: Better Care Fund (BCF) and improved Better Care Fund (iBCF)

1) Aids to Daily Living

This scheme facilitates the use of community equipment and aids to daily living, minor adaptations costing less than £1,000 (delivered by the Kirklees Integrated Community Equipment Service, the Handy Persons' Scheme and via assistive technology) and adaptations to property (managed by the Accessible Homes Team) provided through the Disabled Facilities Grant which has been incorporated into the BCF. The aim of the scheme is to enable people with long-term conditions, disabilities, or requiring rehabilitation from acute conditions, or end of life patients to remain living in their own homes.

2) Intermediate Care and Reablement

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

(iBCF) is being invested in this scheme to improve the effectiveness and flow of people through the reablement service and enable the remodelling of the hospital avoidance and discharge service.

3) Carers Support Services

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

4) Continuing Care

This scheme comprises the integration of jointly funded packages for older people and adults with a physical disability who are eligible for NHS continuing health care provision. The aim of the scheme is to improve service user and carer experience, reduce duplication and make the best use of commissioning resources.

5) Protecting Social Care

This scheme includes services that deliver social care packages for people who are in the high and very high risk categories, eg self-directed support packages and independent sector home care to enable people to continue to be supported in the community, independent sector residential placements for older people and people with a learning disability who need 24 hour care. The aim of the scheme is to reduce non-elective admissions to acute care and permanent admissions to residential and nursing care and to increase the number of people using social care services who receive self-directed support.

iBCF funding is being invested in this scheme across non-residential support services to assist with resourcing local volume and price pressures, improving adult social care packages, support the implementation of new domiciliary care contracts and on supporting the social care workforce.

6) **Eye Clinic Liaison Officers**

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

7) **Mental Health Contracts**

This scheme brings together the Council and CCG contracts with the VCS for services for people experiencing mental health problems (18+), living in Kirklees including those with dementia, learning disabilities (where criteria are met), autism, Asperger's and hidden disabilities. The contracted services provide a range of accessible opportunities and experiences that promote, protect and improve individuals' mental and physical health as well as their emotional wellbeing and recovery.

8) **Support to the Voluntary Sector**

This scheme comprises funding for:

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

iBCF funding is being invested in the capacity building element of this scheme with the aim of further increasing capacity.

i. iBCF Scheme – Investment Care Home Support

iBCF funding is being used to employ Trusted Assessors in North and South Kirklees to improve the admissions process from hospitals and to provide enhanced clinical support to care homes to avoid unnecessary admissions from care homes to hospital.

ii. iBCF Scheme – Investment in Transformation Capacity

1. Care Offer - changing the way the service reviews and assesses its customers to encourage independence and utilise community support.
2. All Age Disability - to provide a consistent service from nought to end of life which promotes independence.
3. Front Door – to manage demand through increased self-service and greater resolution at the first point of contact.
4. Sufficiency - undertaking more reablement and transfer in-house residential care to the provider market.
5. Commissioning - establishing an overarching, long-term view of commissioning requirements.

BCF AND iBCF ALLOCATIONS

	2018/19 £K	
Scheme 1 – Aids to Daily Living		
(a) – KICES (including Handyman Scheme)	3,728	
(b) - Accessible Homes (inc Disabled Facilities Grant)	3,467	
(c) – Assistive Technology	277	
Total Aids to Daily Living		**7,472**
Scheme 2 - Intermediate Care and Reablement	9,829	
*iBCF investment	917	
Total Intermediate Care and Reablement		**10,746**
Scheme 3 – Carers Support		**2,377**
Scheme 4 – Continuing Care		**6,996**
Scheme 5 – Protecting Social Care	7,550	
*iBCF investment	10,263	
Total Protecting Social Care		**17,813**
Scheme 6 – Eye Clinic Liaison Officers		**75**
Scheme 7- Mental Health Contracts		**2,028**
Scheme 8 – Supporting the Voluntary Sector	246	
*iBCF investment	530	
Total Supporting the Voluntary Sector		**776**
*iBCF Scheme – Investment into Care Home Support		**250**
*iBCF Scheme - Investment into Transformation Capacity		**442**
Total		**48,975**

FUNDING SOURCES

	£K
BCF Budget (contributions from the 2 CCGs and the Council)	36,573
*iBCF Grant (grant funding paid directly to the Council)	12,402
Total	**48, 975**