Public Document Pack

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Wednesday 29 August 2018

Notice of Meeting

Dear Member

Health and Wellbeing Board

The **Health and Wellbeing Board** will meet in the **Meeting Room 1 - Town Hall, Huddersfield** at **2.30 pm** on **Thursday 6 September 2018.**

The items which will be discussed are described in the agenda and there are reports attached which give more details.

Julie Muscroft
Service Director – Legal, Governance and Commissioning

Kirklees Council advocates openness and transparency as part of its democratic processes. Anyone wishing to record (film or audio) the public parts of the meeting should inform the Chair/Clerk of their intentions prior to the meeting.

The Health and Wellbeing Board members are:-

Member

Councillor Shabir Pandor (Chair)

Councillor Donna Bellamy
Councillor Viv Kendrick
Councillor Kath Pinnock
Councillor Cathy Scott
Dr David Kelly
Carol McKenna
Dr Steve Ollerton
Richard Parry
Rachel Spencer-Henshall
Fatima Khan-Shah
Steve Walker
Helen Wright

Agenda
Reports or Explanatory Notes Attached

Pages

1: Membership of the Board/Apologies

This is where members who are attending as substitutes will say for whom they are attending.

Contact: Jenny Bryce-Chan, Principal Governance Officer, Tel: 01484 221000

2: Minutes of previous meeting

1 - 6

To approve the minutes of the meeting of the Board held on 28 June 2018

Contact: Jenny Bryce-Chan, Principal Governance Officer, Tel: 01484 221000.

3: Interests

7 - 8

The Board Members will be asked to say if there are any items on the Agenda in which they have disclosable pecuniary interests, which would prevent them from participating in any discussion of the items or participating in any vote upon the items, or any other interest.

4: Admission of the Public

Most debates take place in public. This only changes when there is a need to consider certain issues, for instance, commercially sensitive information or details concerning an individual. You will be told at this point whether there are any items on the Agenda which are to be discussed in private.

5: Deputations/Petitions

The Board will receive any petitions and hear any deputations from members of the public. A deputation is where up to five people can attend the meeting and make a presentation on some particular issue of concern. A member of the public can also hand in a petition

at the meeting but that petition should relate to something on which the body has powers and responsibilities.

In accordance with Council Procedure Rule 10 (2), Members of the Public should provide at least 24 hours' notice of presenting a deputation.

6: Kirklees Health & Wellbeing Plan

9 - 58

To endorse the Kirklees Health and Wellbeing Plan (2018-2023).

Contact: Lucy Cole, Project Lead (Kirklees Health and Wellbeing Plan)

7: Update on Integration of Health and Social Care Commissioning and Service delivery

59 - 82

To receive a progress report on the work of the Integrated Commissioning Board and the Integrated Provider Board

Contact: Steve Brennan, Senior Responsible Officer, Working Together and Sue Richards, Service Director, Community Plus and Integration

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8: Integrated Care System Development

83 - 88

To discuss the West Yorkshire and Harrogate Partnership agreement

Contact: Rachael Loftus, Head of Regional Health Partnerships

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9: Director of Public Health Annual Report

89 - 100

To receive a presentation on the Director of Public Health's Annual Report

Contact: Rachel Spencer-Henshall, Strategic Director Corporate Strategy and Public Health, Tel: 01484 221000

10: Winter Review

101 - 106

To receive a briefing on the findings of the Winter review 2018 and endorse proposed actions

Contact: Phil Longworth, Health Policy Officer Tel: 01484 221000

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Contact Officer: Jenny Bryce-Chan

KIRKLEES COUNCIL

HEALTH AND WELLBEING BOARD

Thursday 28th June 2018

Present:	Dr Steve Ollerton (Chair) Councillor Donna Bellamy Councillor Kath Pinnock Councillor Cathy Scott Dr David Kelly Carol McKenna Richard Parry Fatima Khan-Shah Helen Wright
In attendance:	Rachael Loftus – Head of Regional Health Partnerships Ian Holmes – Director, West Yorkshire and Harrogate STP Phil Longworth, Health Policy Officer Jen Mulcahy, Programme Manager – Right Care, Right Time, Right Place Programme Jenny Bryce-Chan, Governance Officer
Invited Observers:	Councillor Elizabeth Smaje – Chair of Health and Adults Social Care Scrutiny Panel Catherine Riley, Calderdale and Huddersfield NHS Foundation Trust Diane McKerracher – Locala Matt England, Mid Yorkshire Hospitals NHS Trust John Keaveny, South West Yorkshire Partnership NHS Foundation Trust
Apologies:	Councillor Shabir Pandor (Chair) Councillor Viv Kendrick Rachel Spencer-Henshall Steve Walker Jacqui Gedman

1 Membership of the Board/Apologies

Apologies were received from the following Board members, Cllr Shabir Pandor, Cllr Viv Kendrick, Jacqui Gedman, Rachel Spencer-Henshall and Steve Walker.

Emily Parry-Harries substituted for Rachel Spencer-Henshall.

2 Minutes of previous meeting

RESOLVED – That the Minutes of the 22 March 2018, be approved subject to a correction to reflect that a question was asked in respect of the number of public responses to the Pharmaceutical Needs Assessment.

3 Interests

No Interests were declared.

4 Admission of the Public

That all agenda items be considered in public session.

5 Deputations/Petitions

The Board received a deputation from Christine Hyde, North Kirklees Support the NHS.

6 Public Question Time

No questions were asked.

7 Confirmation of Deputy Chair

That Dr Steve Ollerton be confirmed as the Deputy Chair of the Health and Wellbeing Board for the 2018/19 municipal year.

8 Plans to respond to Secretary of State letter

Jen Mulcahy, Programme Manager, Right Care, Right Time, Right Place (RCRTRP) Programme attended the meeting to provide an update on the RCRTRP Programme. The Board was informed that the proposals to reconfigure health services had been referred to the Secretary of State in September 2017 by the Joint Health Scrutiny Committee (JHSC).

The response from the Independent Reconfiguration Panel (IRP) was received by the Clinical Commissioning Groups (CCGs) in May 2018. In summary, the IRP concluded that maintaining the status quo was not an option and pursuing the proposal in more detail is reasonable in the interests of local health services. It recognised that the clinical case for concentrating all the relevant services for those with emergency needs in one location, and separating these from planned care had been reinforced, not contradicted. Additionally, the report identified that there is the prospect of needing to make service changes to protect their safety and quality.

The IRP report identified three areas which require further focus, those being; out of hospital (community) care, hospital capacity and the availability of capital financing. The Board was informed that the hospital had taken the lead in terms of the finances and hospital capacity and the CCG had taken the lead with out of hospital provision. The next steps will be a meeting with the Joint Health Scrutiny Committee in July and the deadline for responding to the Secretary of State is 10 August 2018.

RESOLVED - That the plans to respond to the Secretary of State letter be noted by the Board.

9 Integrated Care System (ICS) in Development

Rachael Loftus, Head of Regional Health Partnerships attended the meeting to update the Board on the Integrated Care System (ICS) in Development. The Board was advised that the Integrated Care System describes the partnership between health and care organisations across West Yorkshire and Harrogate.

In June 2017, eight partnerships were invited to be a part of the Integrated Care System Development Programme as part of the first wave. West Yorkshire and Harrogate is part of the second wave to receive this development support.

The Board was informed that across West Yorkshire and Harrogate there are approximately five hundred democratically elected councillors and it is important to make sure there are clearer routes for elected members to influence, challenge and inform the development of integrated care for the people of West Yorkshire and Harrogate.

The Board questioned how these routes were going to be developed and in response was advised that there will be an overarching Partnership Board being developed that will specifically include elected member representation. There will be more opportunities for local members to develop their collective input and also greater opportunities for members to hear about and ask questions regarding the West Yorkshire and Harrogate wide programmes. Over the summer elected members will be discussing the potential for a more formal partnership agreement as the system develops.

The Board was informed that there are members of the Health and Wellbeing Board who are involved in different strands of the work for example, Carol McKenna is leading on maternity, Drs Ollerton and Kelly are members of the Clinical Forum and Fatima Khan-Shah is championing carers. The Partnership Board proposals will also enable all partners to better participate in the governance of the partnership and develop more integrated approaches, both locally and at West Yorkshire and Harrogate level.

The Board asked in respect of the West Yorkshire and Harrogate Partnership where the decisions were being made, by whom and where will the money will come from. In response, the Board was advised that a design principle of the partnership is subsidiarity – in that all decisions, activity and investment will remain as locally as possible. This is except where critical mass is needed, where there is large variation in outcomes across the footprint or where there needs to be a radical change in order to achieve the ambitious outcomes that have been set.

The programmes that relate to this level of working have been agreed by the Partnership's "System Leadership Executive" which includes representatives from each of the organisations that make up the partnership. Funding for these West Yorkshire and Harrogate level programmes comes from a variety of sources, some of which is national funding (with mandated national programmes), some is funding that the Partnership has been successful in bidding for and a smaller proportion is where they are using existing resources in each place, but agreeing to share a single programme approach across all six places.

Work will continue on the governance structure over the summer but the main aims are to ensure greater transparency, mutual accountability and elected member engagement.

The Board felt that a substantive item on the Partnership Agreement/ Memorandum of Understanding should be brought back to the September meeting of the Health and Wellbeing Board for further discussion.

RESOLVED - That the Board notes the decision by NHS England and NHS Improvement to include West Yorkshire and Harrogate Health and Care Partnership in the next wave of Integrated Care Systems in Development

That the Board continues to shape the Kirklees engagement in the development of the partnership agreement

10 Developing the Kirklees Health and Wellbeing Plan

Richard Parry, Strategic Director for Adults and Health and Phil Longworth Health Policy Officer, updated the Board on developing the Kirklees Health and Wellbeing Plan. The Board was reminded that in 2016, Kirklees started the development of a Health and Wellbeing Plan to outline plans to implement the priorities in the Kirklees Joint Health and Wellbeing Strategy. This was partly in response to the NHS England mandate to create a Sustainability and Transformation Plan (STP) across the West Yorkshire and Harrogate footprint.

The STP Plan, led to the development of the West Yorkshire and Harrogate Health and Care Partnership with organisations working together across the region to improve health and care services.

The Board asked who the partners were and in response was advised that partners include the Council, Clinical Commissioning Groups, Acute Trusts, Locala, Healthwatch, South West Yorkshire Partnership NHS Foundation Trust and others.

The Board also raised questions regarding how the views of local people were being reflected in the plan. In response, the Board was advised that the plan was building on existing partnership and organisational plans which have all been developed in response to the views of local people.

The Board was informed that as the worked has developed, an independent organisation, Attain, has been commissioned to pull together the plans of each organisation to identify the gaps and opportunities and to take things forward. This will be summarised in a high level plan which sets out the key priorities for the coming years and will be presented to the Health and Wellbeing Board for approval in September.

RESOLVED -

That the Board:

a) Endorses the refresh and approach to development of the Kirklees Health and Wellbeing Plan

b) Engages in the refresh and development of the plan as outlined in the submitted report

11 Learning from winter 2017-18 across Kirklees

Richard Parry, Strategic Director for Adults and Health and Phil Longworth Health Policy Officer, updated the Board on developing the Kirklees Health and Wellbeing Plan. The Board was reminded that in 2016, Kirklees started the development of a Health and Wellbeing Plan to outline plans to implement the priorities in the Kirklees Joint Health and Wellbeing Strategy. This was partly in response to the NHS England mandate to create a Sustainability and Transformation Plan (STP) across the West Yorkshire and Harrogate footprint.

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RESOLVED -

That the Board:

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b) Engages in the refresh and development of the plan as outlined in the submitted report

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KIRKLEES COUNCIL

COUNCIL/CABINET/COMMITTEE MEETINGS ETC
DECLARATION OF INTERESTS
HEALTH AND WELL BEING BOARD

Name of Councillor

Item in which you have an interest	Type of interest (eg a disclosable pecuniary interest or an "Other Interest")	Does the nature of the interest require you to withdraw from the meeting while the item in which you have an interest is under consideration? [Y/N]	Brief description of your interest

Signed: …… **Dated:** ……

NOTES

Disclosable Pecuniary Interests

If you have any of the following pecuniary interests, they are your disclosable pecuniary interests under the new national rules. Any reference to spouse or civil partner includes any person with whom you are living as husband or wife, or as if they were your civil partner.

Any employment, office, trade, profession or vocation carried on for profit or gain, which you, or your spouse or civil partner, undertakes.

Any payment or provision of any other financial benefit (other than from your council or authority) made or provided within the relevant period in respect of any expenses incurred by you in carrying out duties as a member, or towards your election expenses.

Any contract which is made between you, or your spouse or your civil partner (or a body in which you, or your spouse or your civil partner, has a beneficial interest) and your council or authority -

- under which goods or services are to be provided or works are to be executed; and
- which has not been fully discharged.

Any beneficial interest in land which you, or your spouse or your civil partner, have and which is within the area of your council or authority.

Any licence (alone or jointly with others) which you, or your spouse or your civil partner, holds to occupy land in the area of your council or authority for a month or longer.

Any tenancy where (to your knowledge) - the landlord is your council or authority; and the tenant is a body in which you, or your spouse or your civil partner, has a beneficial interest.

Any beneficial interest which you, or your spouse or your civil partner has in securities of a body where -
(a) that body (to your knowledge) has a place of business or land in the area of your council or authority; and
(b) either -

the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or

if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you, or your spouse or your civil partner, has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

KIRKLEES HEALTH & WELLBEING BOARD

MEETING DATE: 6 September 2018

TITLE OF PAPER: Kirklees Health and Wellbeing Plan

1. Purpose of paper

The purpose of this paper is to present the draft Kirklees Health and Wellbeing Plan (2018 – 2023) to the Health and Wellbeing Board for endorsement. Subject to endorsement by the Health and Wellbeing Board, the plan will be submitted to each organisation's board / governing body for approval.

2. Background

The refresh and development of the Kirklees Health and Wellbeing Plan was initiated in June 2018 and an update on the scope and purpose of the document was provided to the Health and Wellbeing Board on 26 June 2018.

The document provides an overview of the planned work across Kirklees to deliver improvement in the health and wellbeing of the population, referencing and drawing upon the wide-range of existing strategies and plans at an organisational, place or system level supporting this delivery.

A range of stakeholders from across organisations in Kirklees representing health, social care, wider council services, the voluntary and community sector and Healthwatch were engaged in the development of the plan. A development session of the Health and Wellbeing Board on 26 July supported the shaping of the plan and the priorities contained within it.

The plan has also engaged the Integrated Commissioning Board (the draft Integrated Commissioning Strategy will underpin delivery of the Health and Wellbeing Plan), the Integrated Provider Board (which has aligned its priorities for delivery in 2018/19 to those within the Health and Wellbeing Plan) and the Kirklees Health and Care Executive, which will support the Health and Wellbeing Board with leadership for the implementation of the plan.

3. Proposal

The Kirklees Health and Wellbeing Plan provides a strategic plan for the delivery of improvements to health and wellbeing of the population between 2018 - 2023. 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):

- Living well
- Independent
- Complex
- Acute and urgent

<u>Priorities</u>

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

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

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

- 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
- 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
- Increase the proportion of people who feel in control of their own health and wellbeing
- Narrow the gap in healthy life expectancy between our most and least deprived communities.

Approach

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

- Working with nine 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
- A focus on prevention and early intervention and tackling the underlying cause of poor health and wellbeing
- Empowering people to stay independent and providing more support in the community or at home
- 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
- A Kirklees approach to commissioning services once across the Council and two Clinical Commissioning Groups (CCGs) through a single integrated commissioning board
- A single Kirklees integrated provider board to ensure services are delivered in a coordinated and integrated way with local communities and across Kirklees
- A commitment to openness, transparency and involvement of our communities and workforce in our conversations and decisions to deliver our ambition.

4. Financial Implications

None at this stage.

5. Sign off

Richard Parry, Strategic Director Adults and Health, Kirklees Council

6. Next Steps

Subject to endorsement from the Health and Wellbeing Board, the plan will be submitted to the boards and governing bodies of the partner organisations for approval. The plan will be a key document for the Health and Wellbeing Board, with the priorities informing the agenda of the Board going forward. Once finalised, the outcomes framework monitoring delivery of the plan will be regularly reported to the Board.

Whilst a number of the programmes described in the plan are already in progress, there is recognition that implementation activities must be joined-up and coordinated to effectively monitor delivery of the priorities across Kirklees.

The Kirklees Health and Care Executive is currently agreeing an approach to implementing the plan and how resources across Kirklees will be mobilised to support delivery.

7. Recommendations

The Kirklees Health and Wellbeing Board is asked to:

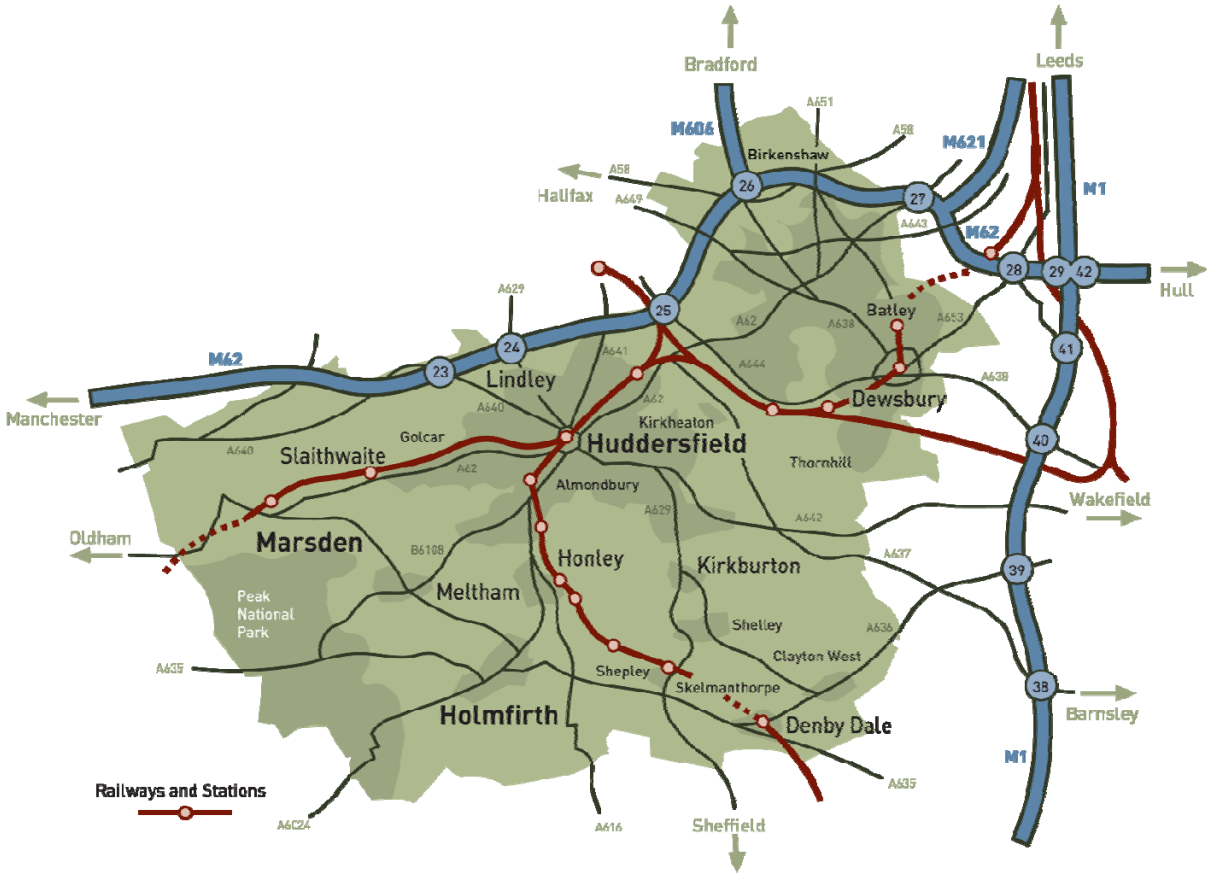
- Endorse the Kirklees Health and Wellbeing Plan
- Confirm its role in providing strategic leadership for delivering the plan
- Endorse moving the plan into implementation phase.

8. Contact Officer

Lucy Cole – Project Lead, Kirklees Health and Wellbeing Plan
07584 015524
Lucy.cole@attain.co.uk

Kirklees Health and Wellbeing Plan

2018 - 2023



Greater Huddersfield Clinical Commissioning Group

North Kirklees Clinical Commissioning Group

Kirklees Council

Locala Community Partnerships

The Mid Yorkshire Hospitals NHS Trust

Calderdale and Huddersfield NHS Foundation Trust

South West Yorkshire Partnership NHS Foundation Trust

Introduction

Around 431,000 people live in Kirklees with main population centres of Huddersfield, Dewsbury and Batley. The population has grown by 8.4% since 2002 and is expected to increase by a further 9.9% by 2031 with the largest growth in very young and older adult age groups.

'Kirklees' as an administrative boundary isn't what our residents identify with, rather the villages, towns and local communities that make up the Borough. The starting point for the development of this plan to improve the health and wellbeing of the *whole* population, is grounded within recognising the strength of our diverse communities and the people that live here.

Despite some significant improvements in some of the indicators of good health and wellbeing like life expectancy, we still have some significant challenges, and the inequalities across our borough are still a significant predicator of the health and wellbeing outcomes for people. Our vision is that:

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

Our health and wellbeing plan brings together partners to focus on the people who live in Kirklees (adults and children) and how, working collectively, we can improve the health and wellbeing of the whole population. This will be our starting point. We will overcome challenges of organisational and professional barriers to ensure people get access to the best quality support to start well, live well, and age well.

Building on our work to date, the foundation of our approach will be:

- Working with **nine** 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
- A focus on **prevention** and **early intervention** and tackling the underlying cause of poor health and wellbeing
- Empowering people to stay independent and providing **more support in the community or at home**
- 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
- A Kirklees approach to commissioning services once across the Council and two Clinical Commissioning Groups (CCGs) through a single **integrated commissioning board**
- A single Kirklees **integrated provider board** to ensure services are delivered in a coordinated and integrated way with local communities and across Kirklees
- A commitment to **openness, transparency and involvement** of our communities and workforce in our conversations and decisions to deliver our ambition

Our ambition for population health and wellbeing

Based on our priorities, we'll be focused on making impact in the following areas and use this as a barometer for improvement in population health and wellbeing. To make the biggest impact for our population and to deliver a system impact we will focus on prevention and early intervention with each of our population cohorts to:

- ✓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**
- 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
- ✓Increase the proportion of people who feel **in control of their own health and wellbeing**
- ✓Narrow the gap in **healthy life expectancy** between our **most and least deprived communities**

Striving to deliver these ambitions is a significant undertaking running beyond the duration of this plan.

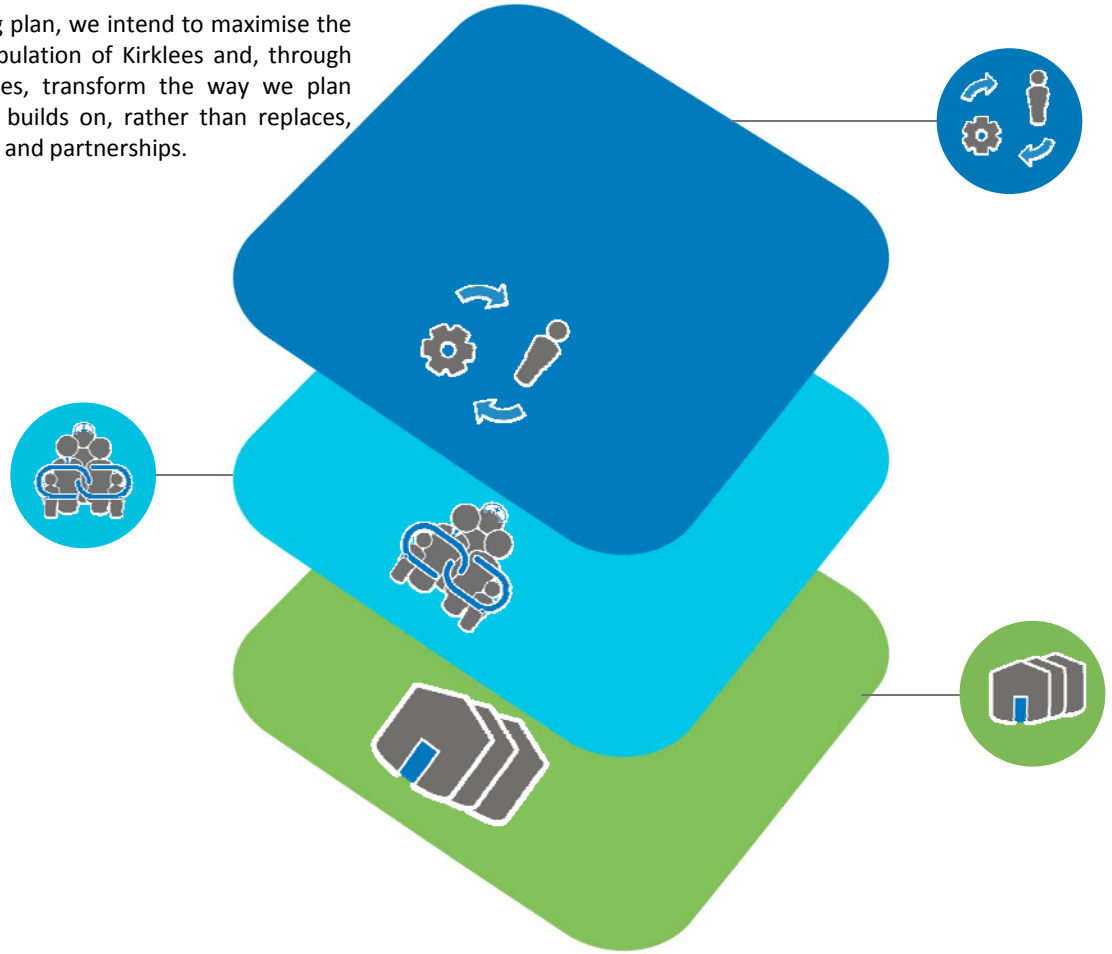
However, working together as a Kirklees system to deliver this plan, we will make a big impact for our population by 2023.

Setting this plan in context

In developing a joint health and wellbeing plan, we intend to maximise the value of our collective action for the population of Kirklees and, through collaborative working on shared priorities, transform the way we plan deliver services for our population. This builds on, rather than replaces, plans already in place led by organisations and partnerships.

Kirklees place plans

- Kirklees Joint Health & Wellbeing Strategy (2014-2020)
- Kirklees Economic Strategy (2014-2020)
- Tackling Poverty in Kirklees Strategy and Action Plan (2016-18)
- 'A Place to Live' - Joint commissioning strategy for accommodation for people who experience mental health problems in Kirklees
- Mental Health Crisis Care Concordat - Kirklees Action Plan
- Kirklees integrated commissioning strategy (draft)
- Kirklees Suicide Prevention Plan (2017-2020)
- Kirklees 'Whole Life Approach' for Mental Health & Wellbeing 2017-2021 (draft)



System and ICS plans

- West Yorkshire & Harrogate Health and Care Partnership, Next steps to better health and care for everyone (January 2018)
- West Yorkshire & Harrogate Suicide Prevention 5 Year Strategy (2017 - 2022)
- West Yorkshire & Harrogate Sustainability and Transformation Plan Draft Proposals (October 2016)
- Calderdale, Kirklees, Wakefield and Barnsley (CKWB) Transforming Care Partnership Plan

Organisational plans

- Kirklees Council Corporate Plan
- Greater Huddersfield and North Kirklees CCGs Joint Operational Plan (draft)
- 5 Year Strategic Plan for Calderdale & Huddersfield Foundation Trust
- Locala Strategy (draft)
- SWYFT Strategy (draft)
- Mid-Yorkshire Trust Strategy
- Greater Huddersfield Primary Care Strategy
- North Kirklees Primary Care Strategy

Case for change

Like health and care systems across the country, Kirklees faces some challenges which means we can't stand still. Continuing to provide support in the way we do now will not meet our ambition to improve the health and wellbeing of our population, tackle some of the underlying inequalities we face, nor maintain and improve the quality of care and support. Increasing demand and changing demographics alongside funding challenges means that trying to provide services in the same way is no longer sustainable. For some outcomes, we perform less well than other areas and need to improve, for others we are comparable or rank more favourably than other areas. However, these are still significant issues such as children living in poverty, obesity in children adults, which have become the 'norm'. We are ambitious for our population and will work with our diverse communities to change these norms and create places in which everyone can start, live and age well.

Health & Wellbeing

- Over half of adults are overweight, with one in five obese.
- 1 in 8 adults over 50 is a smoker, this increases to 1 in 6 under 50
- 1 in 3 adults has a mental health condition, up from 1 in 5 in 2012
- Kirklees has more full-term babies born with low birth weight than the national average
- 91,000 are in the segment most poorly motivated to look after their health
- There are an estimated 7,500 to 8,300 adults with a learning disability living in Kirklees. People with learning disabilities are far more likely to die early and to die of a preventable disease
- 60,000 households (1 in 3) are living in poverty
- 46% of respondents to Your Place Your Say (2011) said their home was not suitable for their needs
- Dementia in over 65s is expected to rise by nearly 60% by 2030

Care & Quality

- The most common causes of death in Kirklees are circulatory disease (31%), cancer (26%) and diseases of the respiratory system (14%)
- Services are fragmented and people don't get the best experience. We know this from engagement work we've done with our local communities, formal consultations and feedback gathered by our colleagues in Healthwatch Kirklees
- Demand for health and care services is increasing
- Whilst we have some high quality services, we also still have issues with the quality of some services across the spectrum including NHS services, care homes, domiciliary care and children's social care which we are working to address

Finance & Efficiency

- There are significant financial pressures across Kirklees.
- NHS organisations working in Kirklees are working to deliver planned efficiencies of over £70m in 2018/19 alone
- Kirklees Council also has a significant savings programme totalling £83m between 2017 - 2020, there is a savings target of £4m in 2018/19 for adult social care, alongside an expected volume growth totalling £3.6m
- Using our total health and care budget of over £700m* to best meet the outcomes of the Kirklees population

* Estimated Gross Value Added (balanced GVA). Analysis undertaken by Kirklees Council, March 2018.

Case for Change: Celebrating success and building on opportunities

Despite some of the challenges facing Kirklees linked to changing demographics, growing demand, inequalities, and financial sustainability, there is nonetheless much to celebrate and to build upon as we progress our plans to improve the health and wellbeing of the population of Kirklees.

Our strengths and opportunities include:

- A real commitment to prevention and creating communities in which people can start well, live well and age well.
- Huge assets contributing to positive health and wellbeing in our communities including a Premier League football club Huddersfield Town and Super League Rugby League team Huddersfield Giants, Gold rated University of Huddersfield and other high-performing educational establishments, world leading engineering and manufacturing companies, leisure facilities, parks and green space, galleries, theatres, festivals and Creative Kirklees.
- An asset base of people supporting people including 60,525 unpaid carers providing thousands of hours of support each day, 86,000 people regularly volunteering at least once a week, over 100 registered voluntary and community sector organisations in addition to over 1000 unregistered organisations.
- Strong relationships between the staff and organisations providing health and wellbeing support to our population – these operational relationships will be the bedrock for implementing our vision for the future.
- An energy to change things for the people we serve – many initiatives of varying sizes are taking place all over the district, led by the frontline workforce to improve the outcomes of people using services.
- Experience and a strong record of integrated working through commissioning, contracting and provision of services e.g. Care Closer to Home and Thriving Kirklees . Kirklees was one of the first areas to be peer reviewed in respect of integration, the review found identified some of our strengths upon which we continue to build.
- The emergence of forums to enable integration and closer working (Integrated Commissioning Board, Integrated Provider Delivery Board and Kirklees Health & Care Executive Group) which ensure we focus on the needs and outcomes of Kirklees people.

Preparation for Parenthood (PfP)

An example of our focus on prevention, early intervention and integration of support is our Preparation for Parenthood course.

Preparation for Parenthood (PfP) is a 6-week interactive education course for all first-time parents in Kirklees. It is delivered by the Nurturing Parents Partnership (Kirklees Council, Locala, Calderdale and Huddersfield NHS Foundation Trust, and Mid Yorkshire Hospitals NHS Trust). The course helps future parents understand the physical and emotional aspects of parenthood as well as what is best for their baby's wellbeing and social and emotional development. It also provides an opportunity for peer-support.

We have helped more than 1,000 parents since the course started in October 2015. Participants say they feel better prepared for becoming parents, understand how having a baby may change a relationship and how their baby's brain develops. A large proportion of people on the course also make friends with others on the course and stay in contact with them.

Our principles

Our focus for delivering our vision in Kirklees is through prevention and early intervention, working within the Strategic Framework of our Joint Health and Wellbeing Strategy.

Guiding principles

There are set of guiding principles that shape everything we do through our partnership in Kirklees and in representing Kirklees in the West Yorkshire & Harrogate Health and Care Partnership. This set of principles support us to work as a group of organisations and sectors across Kirklees to deliver the best outcomes to our population.

- We will be ambitious for the people we serve and the staff we employ
- The partnership belongs to its citizens and to commissioners and providers, council and NHS so we will build constructive relationships with communities, groups and organisations to tackle the wide range of issues which have an impact on people's health and wellbeing.
- We will do the work once – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict
- We will undertake shared analysis of problems and issues as the basis of taking action
- We will apply subsidiarity principles in all that we do – with work taking place at the appropriate level and as near to local as possible

Our shared values and behaviours

- We commit to behave consistently as leaders and colleagues in ways which model and promote our shared values:
- We are leaders of our organisation, our place – Kirklees, and of West Yorkshire and Harrogate;
- We support each other and work collaboratively;
- We act with honestly and integrity, and trust each other to do the same;
- We challenge constructively when we need to;
- We assume good intentions; and
- We will implement our shared priorities and decisions, holding each other mutually accountable for delivery.

Population planning

Kirklees is a collection of diverse communities, people who live here identify and find the most meaning in their local communities. This is why we are committed to working closely with these communities to understand their needs, plan and deliver services *with* them, and make these communities places in which health and wellbeing can flourish.

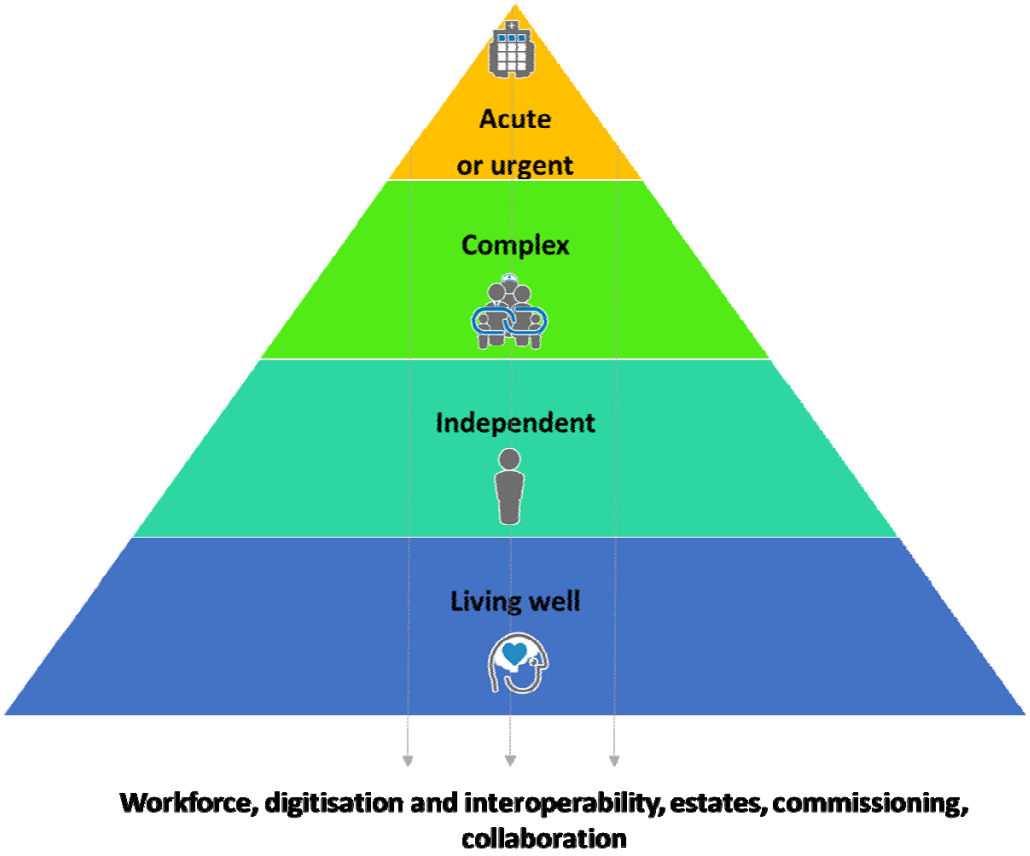
Amongst partners who commission and deliver health and wellbeing services in Kirklees, there is a real commitment to making improvements for our population, working with local communities collectively. This will mean building on some of our successes to collaborate further – integrating commissioning and how we buy services, integrating service provision to deliver seamless services to people in local communities and most importantly working with our local areas to create a community of coproduction in which people have a role in their own health and wellbeing, that of the community and in shaping local services.

We have some strengths upon which to build, already we know that 1 in 4 adults in Kirklees volunteer on at least a monthly basis with the 65-74 age group the most active in volunteering. We know that volunteering is strongly associated with social connectivity, wellbeing and resilience.

Within these communities, our population will be characterised by four main groups of people who will have different needs in relation to their health and wellbeing. These populations are:

- Living well
- Independent
- Complex
- Acute or urgent needs

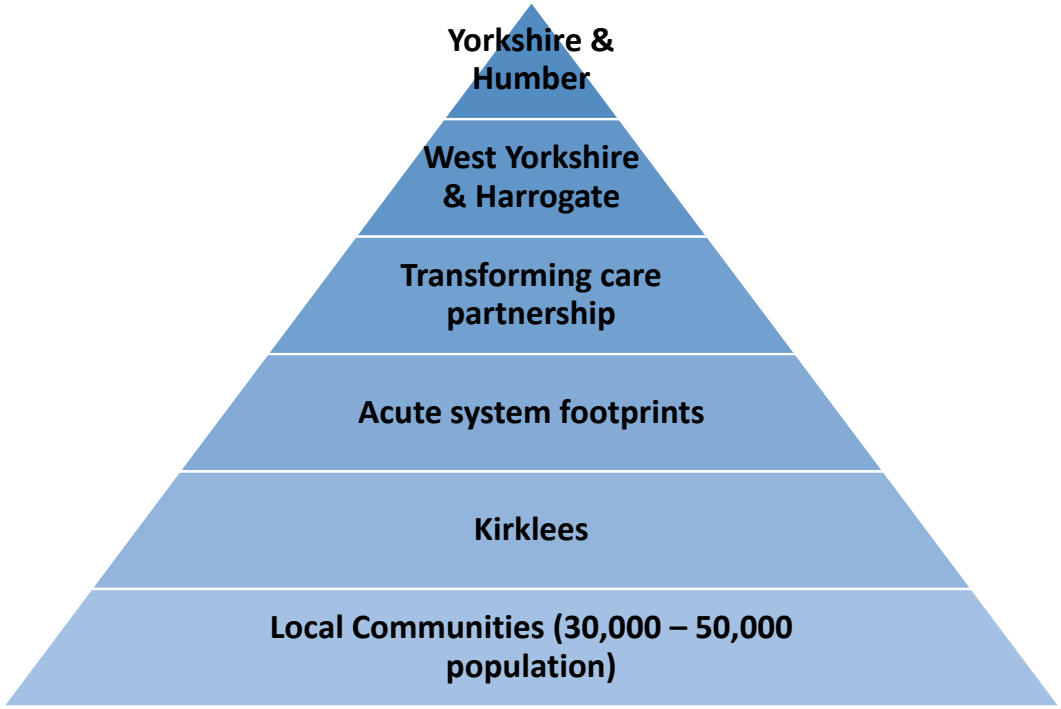
We are committed to using a **population health management** approach in Kirklees in which we can use our data and intelligence sources to better deploy our resources to meet the needs of our communities. This includes segmentation, stratification and impact modelling to identify local 'at risk' cohorts of the population – and, in turn, designing and targeting interventions to prevent ill-health and to improve care and support for people with ongoing health conditions, and reducing unwarranted variations on outcomes.



Starting with our populations and communities

Population characteristics		Our focus	What we know about this group
Living well	• Majority of the population who are largely healthy (both mentally and physically), manage their own health and wellbeing and have little requirement for contact with formal or statutory services. • A proportion of this population are subject to risk factors related to behaviours (smoking, alcohol consumption, diet and exercise) or social factors (employment, housing, social isolation).	• Keeping people well, physically and emotionally through the creation of healthy places which promote healthy behaviours and of resilient, connected and vibrant communities • Reducing risk factors associated to healthy behaviours or social factors, often linked to inequalities	• There are 91,000 adults living in Kirklees who are in the segment most poorly motivated to look after their health
Independent	• A significant proportion of our population are living with conditions or social factors impacting their health and wellbeing, who are largely managing independently or with informal support • Within this cohort, people will be accessing GP support or outpatient appointments specific to their needs	• Enable this population group to manage their own health and wellbeing through access to information, advice, support and digital opportunities • Ensure holistic support for physical and mental health and wellbeing needs	• 84% people over 50 has a long-term condition (67% people under 50). Half of these people are managing alone
Complex	• A small proportion of our population are living with multiple long-term conditions, significant disabilities and complex needs, some may be at the end of their life • The needs of this group are often significant and debilitating, preventing work or regular opportunities for engagement with the wider community. Cost of provision of support to this group is very high.	Create a new offer for people with complex needs which will: • Focus on strengths and assets in planning support • Reduce duplication between services and number of times a person has to tell their story • Focused on planned and preventative interventions rather than a reactive need for unplanned acute and urgent services	• Approximately 30,000 people over 65 are living with three or more long-term conditions
Acute or urgent	• At any time, some proportion of our whole population will have acute or urgent needs which need swift and/or specialist interventions	• Ensure that where people require urgent, acute or specialist care, this will be the right intervention provided in the right setting in a timely way	• On an average day (taken on 03/10/17) there are 437 A&E attendances and 8,744 routine and urgent GP appointments across Kirklees

Planning on different footprints



We can largely meet the needs of our communities and particularly for our living well, independent and complex populations by planning and delivering services on a local community or Kirklees-wide basis. Some of the most acute or specialist interventions need to be planned and delivered on a larger geographical footprint.

A fundamental part of being able to deliver improved outcomes for the population is planning and working with partners on different footprints.

As a principle, we will work as close to our population as possible. Change needs to happen as close to people as possible. Kirklees has a number of diverse communities which people recognise as the place they live. Whilst we need to work on different footprints to plan and deliver the best quality services and outcomes, and some services may need to be planned and accessed outside of our local communities or Borough, the needs of our population in Kirklees will always be the starting point for considering any changes to this. Where this is wider than Kirklees, we will work with wider partners to ensure the needs of Kirklees residents are met to best effect.

Planning and delivery

- Local communities – for many health and care services, evidence nationally and internationally points to planning and delivery being best focused around populations of 30,000 -50,000 people.
- Kirklees-wide
- Transforming Care Partnership footprint
- Acute footprints (Calderdale and Huddersfield and Wakefield and North Kirklees)
- Integrated Care System formerly Sustainability and Transformation Partnership (West Yorkshire & Harrogate)
- Yorkshire & Humber (e.g. Yorkshire Ambulance Services)
- Individual organisations – focused on the delivery of key priorities to ensure that the organisation is serving its population most effectively (for many of our organisations, this is wider than Kirklees) and ensuring that the organisation is functioning in the most efficient and effective way.

Kirklees priorities

Whilst there is significant work taking place to improve the health and wellbeing for the population in Kirklees, we believe by putting our energy into some key priorities, we will make the greatest impact for the whole population, and tackle the health inequalities experienced in some of our communities.

Tackling the underlying causes

1. Create communities where people can start well, live well and age well

- Create resilient, connected and vibrant communities using all available assets
- Promote connectedness and reduce social isolation and loneliness
- Increase proportion of the population moving of poverty and increase opportunities outside of the low wage economy
- Early intervention to start well – pre-natal support and the first 1000 days
- Increase proportion of the population at a healthy weight and the ability to make healthy choices the easy choice
- Increase proportion of non-smokers in Kirklees and increase numbers of people supported to quit smoking

Improving outcomes and experience

2. Create integrated person centred support for the most complex individuals

- Drive forward the development and implementation of the primary care networks model (*to do this, must first ensure the resilience and engagement of primary care),* the integrated model for intermediate care, end of life, and the model for care homes support

Using our assets to best effect

3. Develop our people to deliver the priorities and foster resilience

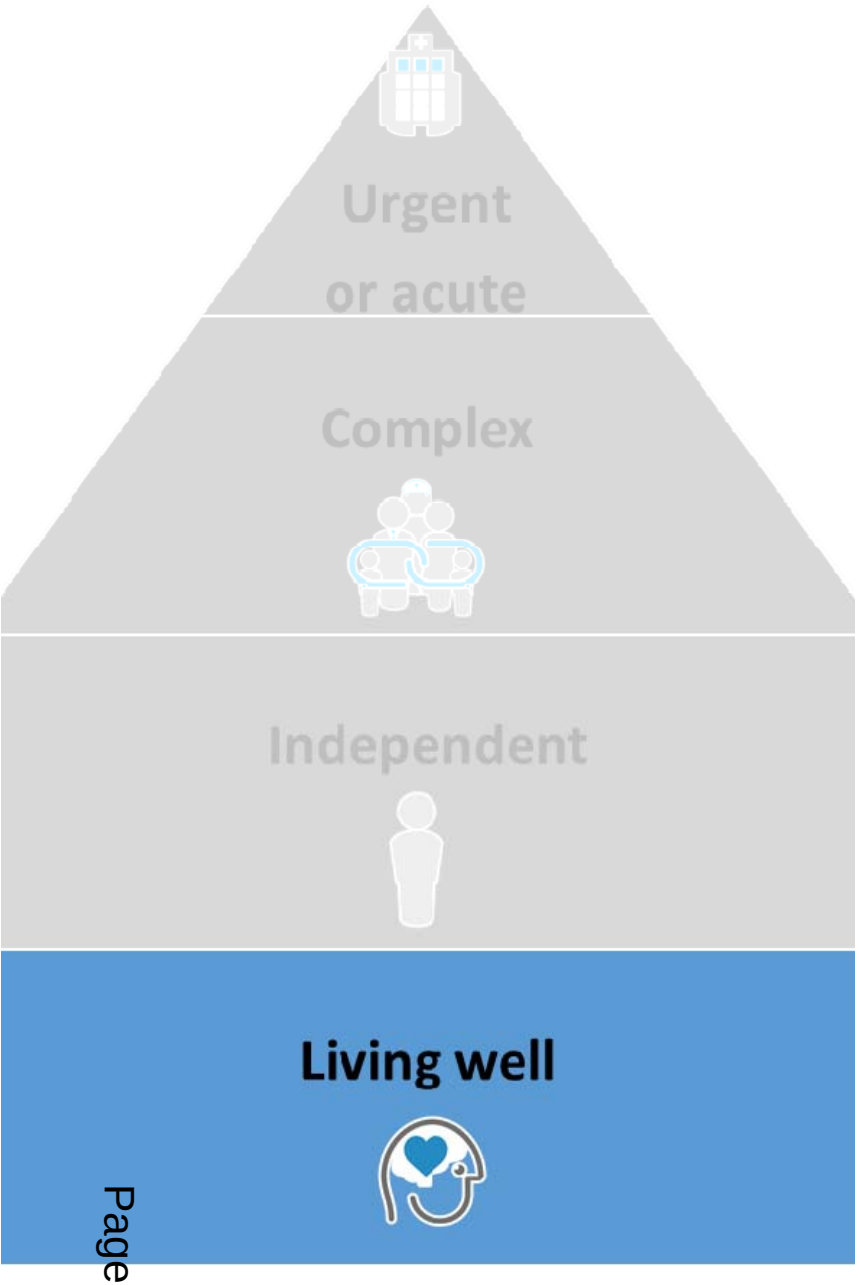
- Equip people the resources to stay independent and live well
- Change the conversation – focus on strengths, assets and responsibilities (Making every contact count)
- People who use and provide services work together to shape support
- Develop and nurture relationships and support people to change existing behaviours to deliver better outcomes

4. Develop estate to deliver high quality services which serve the needs of the local communities

- Using estate and facilities to generate social value and support the future model of provision
- Rationalising, sharing space to support collaborative and integrated working

5. Harness digital solutions to make the lives of people easier

- Raise the digital literacy of the population
- Focus on the solutions which will make people's lives easier, maintain independence, and support efficiency



Living Well

Our objectives:

- Increase the numbers of people in Kirklees moving out of poverty and increase numbers employed outside of the low-wage sector
- Increase access to safe, affordable housing
- Support communities to be resilient and make the best of our local assets, supporting our thriving VCS
- Increase the proportion of healthy pregnancies, reducing the numbers of babies born at a low birth weight
- Increase opportunities to live well – access to green space and opportunities to exercise
- Increase numbers of people who feel connected to their communities, with a focus on those most vulnerable: younger people, older people, people with mental health conditions, and carers who may be socially isolated
- Champion better public mental health and tackle stigma
- Increase proportion of the population who are non-smokers
- Increase the number of adults and children undertaking the recommended amount of physical exercise and eating a healthy diet
- Increase health literacy amongst the population with a focus on those living in the most deprived communities
- Increase in engagement and uptake of screening and immunisation programmes, with a focus on more disadvantaged populations

Living well: tackling the underlying causes of poor health & wellbeing

The Kirklees Joint Health and Wellbeing Strategy and the Kirklees Economic Strategy are recognised as fundamentally interlinked and supportive of one another. In order for people to start, live and age well in Kirklees, the underlying factors impacting health and wellbeing must be addressed.

Housing

Access to safe, affordable housing is a key determinant of health and wellbeing in the population. There are several strands of work to deliver this:

- Housing Commissioning policy is focused on delivery of three outcomes:
  - An appropriate supply of homes and jobs to meet the needs of a growing and aging population
  - Improved places to live by reducing inequalities and worklessness
  - Improved life chances for people by supporting them to find and keep an affordable, good quality home
- A series of accommodation strategies to support vulnerable groups including:
  - People with mental health conditions
  - People with learning disabilities
  - Older people

Poverty and low wage economy

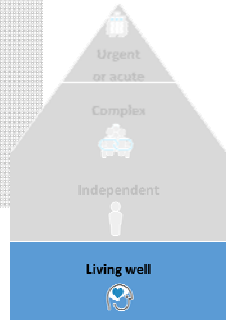
A successful economy that offers good jobs and incomes for all of our communities makes a huge contribution to prosperity, health and wellbeing of all age groups. Likewise, confident, healthy, resilient people are better able to secure a job and are more productive in the workplace. In the long term these goals will help prevent poverty. The Council is leading a strategy and action plan Tackling Poverty in Kirklees which is focused on the four Ps:

- Pockets: Policies to boost household resources now
- Prospects: Policies to improve long term life chances of individuals and their families
- 'Prevention: Policies to prevent people sliding into poverty
- 'Places': Policies that provide the backdrop of services that allow people to enhance their job prospects
- Kirklees Council will continue to lead by example and act as a champion for the local living wage both in its own area and the wider region beyond.

Healthy places

The Kirklees Local Plan and Kirklees Economic Strategy proposes a strong focus on creating 'Quality Places' as part of which, people have the opportunity of a healthy lifestyle, this includes:

- Avoiding allocating land for development in areas with the worst air quality
- Allocating and protecting employment opportunities in the areas of greatest deprivation
- Considering green infrastructure
- Recognition that the planning process can influence choices over food, diet and lifestyles choices when considering new proposals for such uses and can influence the range of services provided within a particular centre



Living Well: Creating connected, resilient and vibrant communities

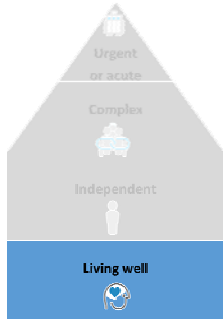
In order to have the most impact in communities, we are integrating and growing our community capacity resources offered through Community Plus, Local Area Coordinators, Schools as Community Hubs, Thriving Kirklees (0-19 services) and creating an Integrated Wellness Model. The next step is to align this to the creation of local neighbourhoods of communities of 30,000 – 50,000 people with health and care services wrapped around networks of general practices. This will enable greater connection between our statutory heath and care services with the wider community support and ensuring that people have their needs met with the right solutions rather than an unnecessary statutory response. This will support us to tackle issues such as social isolation and loneliness in our communities.

Our focus is on helping and supporting people and families who might be struggling to lead a better life by connecting them with local resources, groups and individuals. We believe this approach will serve to make our communities stronger and happier in the long term, preventing and reducing the demand on health and social care, and encouraging them to do more for themselves and empowering them to make their own choices.

- Support people to stay stronger - by identifying their vision for a good life and their plans how to get there
- Build local partnerships - explore what peer and neighbourhood support and community networking groups there are, and connect individuals to them
- Focus on building relationships - focus our work in the places that need it the most, and encourage people to become more self-sufficient.
- Build a supportive community - establish what local resources are already in existence, including groups and volunteers, and look at ways we can support them and connect them with local people
- Promote local opportunities - establish where there are gaps in the community and support the development of new community provisions.

Through this approach we will

- Improve the links between GPs and other health and care services to ensure that people are getting support from the right place for non-medical needs e.g. loneliness and isolation
- Strengthen the links between schools and wider services
- Provide impact and community intelligence to ensure services to better meet needs of people in communities
- Support people to stay safe, well and connected finding non-service solutions to problems wherever possible
- Support early intervention and prevention through community capacity building, identifying and responding to the health and wellbeing needs before they become complex or long-term needs
- Prevent, reduce and delay ill health and complex conditions
- Co-ordinate care and collaborate across services so people stay more in control of their own lives
- Improve quality of local services
- Improving individual outcomes to ensure people feel more in control, feel safer and able to make informed decisions, feel more connected to and able to contribute to their communities



Living well: promoting healthy living

Healthy behaviours including not smoking, moderate alcohol consumption, good nutrition, physical activity and safe sex have a positive effect on health. While the health of younger people tends to be less immediately affected by their behaviour, occupation or wealth, unhealthy behaviours in youth and early adulthood significantly determine a person's health in later life so prevention and early intervention throughout the life course is vital.

Smoking prevention

Smoking remains the highest risk factor for death in our region. As part of our work with the West Yorkshire Cancer Alliance we are committed to reducing smoking across the region from 18.6% to 13% by 2021.

A crucial part of this is taking a system-wide approach to creating a smoke-free Kirklees and creating an environment in which smoking

We will continue and expand smoking cessation support across the health and care system to ensure a Kirklees-wide focus on helping people to quit smoking in every intervention with our services.

Taking an early intervention approach is key to our success – tackling smoking in pregnant women and preventing children and young people from taking up smoking.

Promoting healthy diet and physical exercise

Poor diet and lack of exercise has become a norm amongst our population, prevalent in both children and adults. Being overweight or obese continues to be the most significant contributing factor to the burden of disease. We are committed to tackling this as early as possible and supporting people to live well. Our focus is to:

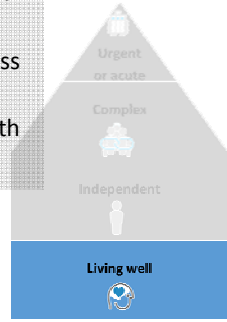
- Promote Healthy Weight via Building Healthy Public Policy
- Promote Infant Feeding and Early Nutrition
- Improve Food and Nutrition for Older People
- Co-produce a Supplementary Planning Document for Hot Food Take-Aways
- Improve Insight and Intelligence, in particular in relation to Food Poverty
- Build on the 'place-based' approach in Ravensthorpe and share the learning to facilitate the implementation of this approach in other schools and communities

Drug and alcohol usage

Kirklees has higher than average alcohol consumption and liver disease mortality rates in males. Those who are middle aged and have higher incomes are more likely to consume alcohol more frequently, but problematic drinking patterns are more prevalent in those with low household incomes. Drug misuse among adults and young people has fallen steadily in Kirklees, reflecting the national picture, although use of legal highs has risen.

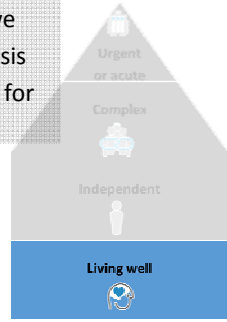
We will continue to ensure a Kirklees-wide focus on helping people with support and advice to manage alcohol and substance misuse including:

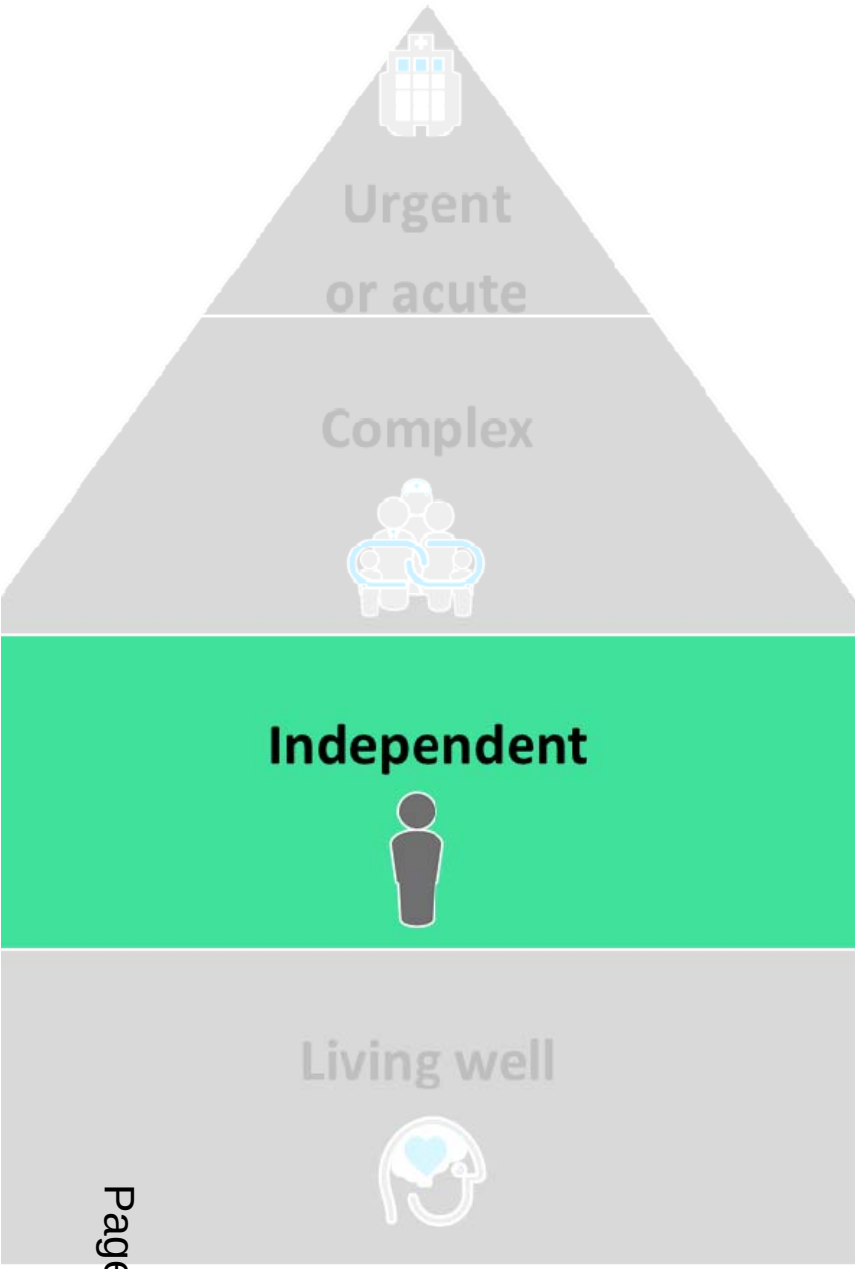
- Increasing access to advice, support and mutual aid for all
- Support to vulnerable people such as homeless people or those with mental health issues
- Provision of support to families of people with alcohol or substance misuse problems



Living well: promoting healthy living

Early intervention	Social isolation	Suicide prevention	Screening programmes
In taking a life course approach, our focus is working with expectant mothers and families to ensure children get the best start in life. We will focus on ante-natal support and the first 1000 days of a child's life. Implementation of the Better Births aspirations through the Local Maternity System will support this and we'll be trialling models to increase continuity of person caring for women during pregnancy. We will focus on healthy pregnancy and support expectant mothers to make healthy choices during pregnancy . This will continue to build on the advice and support locally through Auntie Pam's and the tailored support offered through our Thriving Kirklees service, offering intensive support to vulnerable parents.	Explore the impact of intergenerational work on reducing loneliness amongst older people in residential settings, for example, bringing services such as nurseries, youth clubs, and care homes under the same roof. Our community capacity building work and integrated wellness model will be refocused on social isolation an loneliness in communities, identifying the signs and connecting people into local groups, assets and resources. Proactively engaging with people who are about to retire from paid employment will continue to strengthen our volunteer network and prevent isolation and loneliness in this group. We have access to additional funding through the West Yorkshire & Harrogate ICS to support our work on social isolation.	In line with national aspirations, we aim to prevent suicides in Kirklees and reduce the numbers of people taking their own life by 10% by 2020/21. In Kirklees, the main risk factors for suicide include living alone, being male, being unemployed, misusing drugs and/or alcohol and living with mental illness. Building a partnership approach to tackle suicide is crucial to ensure a population based approach is taken. We have a suicide prevention action plan in place which details our actions across a wide-range of partners to prevent suicide and self-harm locally, underpinning our work collectively as part of the West Yorkshire & Harrogate Suicide Prevention Strategy.	Inequalities across Kirklees mean that there is often a low take-up of screening programmes in our more disadvantaged communities and as a result, poorer outcomes. An increase in engagement and uptake of screening and immunisation programmes particularly in more disadvantaged populations with a focus to diagnose more cancers earlier (Stage 1 and 2) and reduce the number of acute emergency presentations of cancer is a focus for the two local cancer networks, working as part of the West Yorkshire & Harrogate Cancer Alliance. This will include the FIT for bowel cancer screening. Working alongside partners in the West Yorkshire Cancer Alliance, we aim to deliver a new 28 day to diagnosis standard for 95% people investigated for cancer symptoms.





Independent

Our objectives:

- Increase proportion of people with long-term health conditions who feel confident in managing their health and wellbeing
- Increase digital and technological options to support self-care and maintain independence
- Recognise carers as an enormous local asset and create an environment where carers feel confident to identify themselves
- Increase numbers of people accessing secondary prevention programmes
- Provide access to regular care as needed by individuals – including health checks and health management plans where required
- Take a holistic approach to people and support the person rather than treat the condition
- Increase numbers of people with a mental health condition who are supported to live well
- Increase ability of people to access primary care to support their long-term health needs
- Access to planned care support will be user-led and available in a range of different ways

Independent: maintaining independence

A key focus is to maintain the independence of people and ensure, as far as possible, people have the resources to manage their own health and wellbeing needs. This includes the ability to self-manage their own health conditions, access community based support to maintain resilience and independence and specific actions to ensure the health and wellbeing needs of carers are met.

Self-care

A crucial part of our strategy is to enable people to manage their own health and wellbeing. To do this we will:

- Ensure that people have access to a range of information and advice to support resources to better understand their health and wellbeing needs
- Continue to develop our established expert patient programmes to support people with a long-term health condition to control and manage their health
- Utilise new digital developments such as apps (My Health Tools and others) and expand our capacity and capabilities in relation to telehealth, telecare and assistive technology to enable people to take control of their health and wellbeing and maintain their independence

Social prescribing

Better in Kirklees provides a social prescribing service to adults with one or more long-term health conditions and to unpaid carers, helping to support people to meet their outcomes and connect them to their local community and local services.

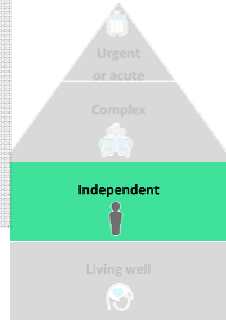
This service can connect people to a range of activities in their communities and improve their physical and emotional wellbeing through opportunities such as art classes, peer support groups, gardening, exercise clubs and social groups.

We will continue to develop initiatives such as Creative Minds which uses creative approaches and activities in healthcare; increasing self-esteem, providing a sense of purpose, developing social skills, helping community integration and improving quality of life. These projects are led by our Mental Health Trust through community partnerships to co-fund and co-deliver projects for local people.

Supporting Carers

Carers are a fundamental and significant part of our population, with over 60,000 adult carers, and 1 in 12 children with some caring responsibility, the support we offer to carers is vital to ensure that this often unseen support network has its own health and wellbeing needs met, both as an individual and as a carer. We will:

- Embed the Carer's Charter across organisations
- Make Kirklees a dementia friendly place
- Recognise that carers are an enormous local asset
- Support carers to recognise when they are actually carers
- Work with local businesses to help them recognise and support carers
- Support more carers' break schemes
- Enable 'hidden carers' (those not in touch with formal support services) to find support and advice
- Work collaboratively and creatively with carers to address the health and employment outcomes
- Utilise local assets to signpost carers to emotional support



Independent: improving health and wellbeing

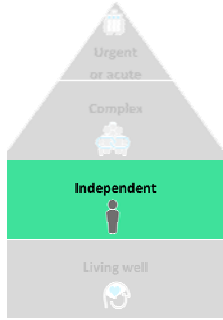
Our focus in supporting our independent population is not only to maintain independence but to prevent further issues developing and people developing more complex needs. This is essential for both physical and mental health and whilst our focus is holistic in supporting people's mental and physical needs, we are continuing to develop specific support in these areas, particularly as we know that people with mental health conditions and learning disabilities are much more likely to experience poor physical health.

Support for physical health

- To continue and expand smoking cessation support across the health and care system to ensure a Kirklees-wide focus on helping people to quit smoking in every intervention with our services
- Physical activity and healthy diet support / weight management
- In addition to national screening programmes for cancer, we are focused on the early detection of ill-health and support to prevent the development of more serious conditions including:
    - Atrial Fibrillation detection and management to reduce the chances of suffering a stroke
    - Swift cancer / non-cancer diagnosis and support
    - Implementing the national diabetes prevention programme to prevent new cases of Type 2 diabetes
    - Roll-out of Healthy Hearts campaign to prevent Cardiovascular Disease, learning from the success of our colleagues in Bradford
- For people identified has having low to moderate frailty, we are rolling out a programme (starting with a pilot in North Kirklees) to provide 'Companions to Care', supporting people to navigate through the health and care system and prevent social isolation and loneliness
- Continue to raise awareness of health checks and ensuring accessibility of health checks for those communities where we know take-up is low
- Access to primary care has increased and extended GP access provision will expand to 100% of the Kirklees population by October 2018, making appointments at the GP surgery easier to obtain in a timely way

Support for mental health and emotional wellbeing

- We have expanded the Improving Access to Psychological Therapies (IAPT) service to improve access for people with low level mental health issues, to ensure more people can get the support they need in line with the national standard waiting time and will continue to develop the service to ensure that this is meeting the needs of the local population, particularly those people with long-term physical health conditions.
- Increased funding and therefore access to assessments for Autistic Spectrum Conditions (ASC) to ensure people get the support they need
- We are launching a one-stop shop phone service for children and young people with emotional and mental health needs
- Piloted a scheme to provide support to school pupils with autism and mental health needs
- There are a range of statutory, voluntary and third sector early intervention and prevention as well as recovery-based services for service users and their carers in Kirklees. The Kirklees Recovery College is a key part of this work. We will continue to develop these services to meet the needs of service users and carers across the borough. By focusing on these services, we aim to reduce crisis episodes and development of more complex mental health and wellbeing issues.



Independent: Outpatient Transformation

While more and more care for long-term conditions is done in primary care, there are still large numbers of outpatient 'follow-up' appointments every year where people return to hospital to have their progress reviewed, or undergo regular tests and obtain results. Working locally and as part of the West Yorkshire and Harrogate Health and Care Partnership, we are focused on how a large proportion of this work could be done differently with care provided closer to home either through an appointment with the GP or at a community service, telephone calls and online consultations. This should free up time for the treatment of new people, and would save people time and money by not having to travel to hospital when they don't need to.

In Kirklees, we work on outpatient transformation across our two hospital footprints with partners in Calderdale and Wakefield respectively. Both Trusts are reviewing and redesigning the outpatient offer, working with clinicians across primary and secondary care and working with patients and service users. Key aspects of both programmes is the use of **e-consultation and virtual care solutions**, **managing capacity and demand**, and **referral support**. Given the significant number of specialities and large volume of activity, some specialities have been prioritised initially for review and redesign:

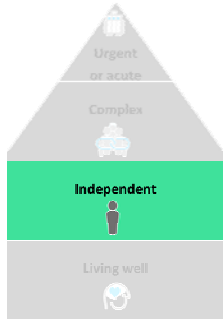
- Cardiology
- Gastroenterology
- General surgery
- Musculoskeletal service
- Ophthalmology
- Orthopaedics
- Pain services
- Respiratory
- Urology

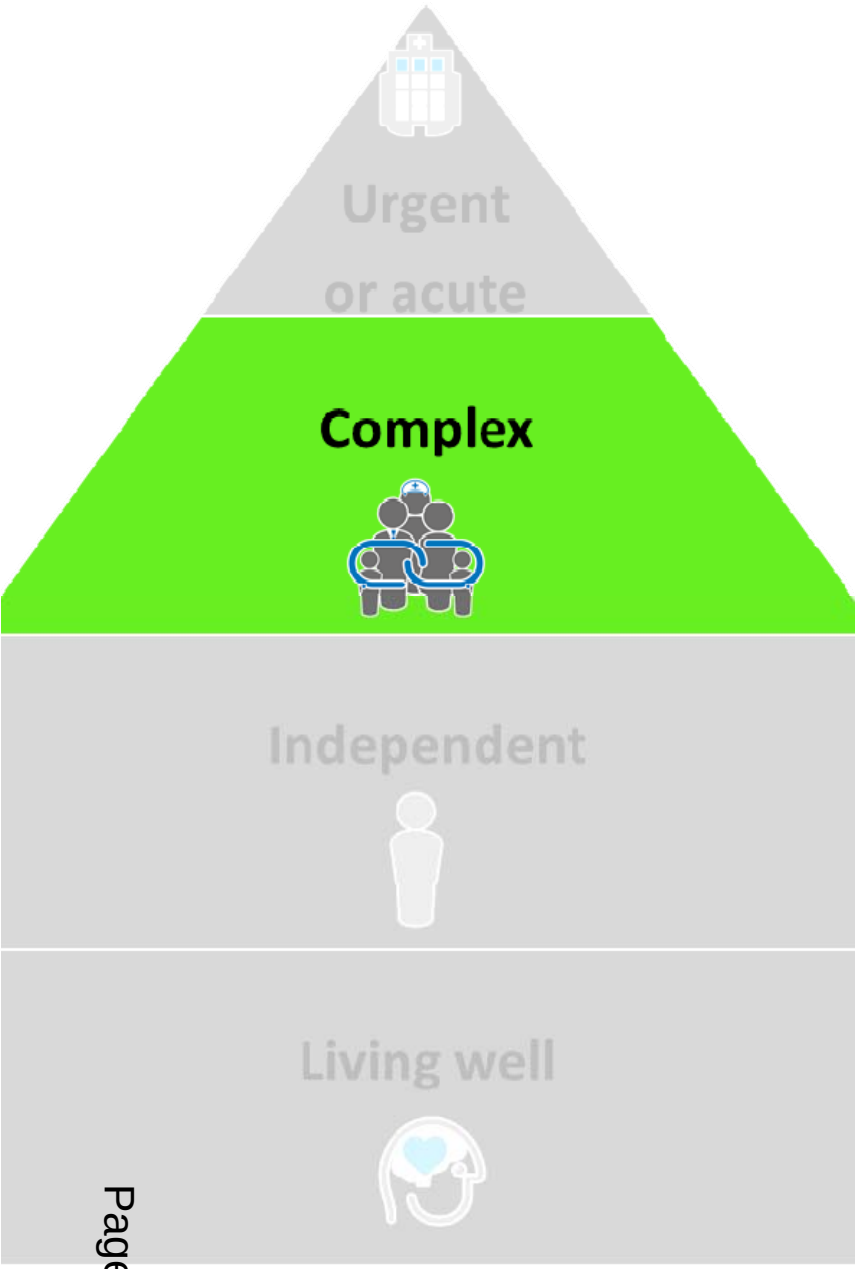
Cardiology: Rapid Access Arrhythmia Clinic

The one stop rapid access arrhythmia clinic enables patients to be seen quickly by a highly skilled multi-professional team, having their consultation, investigations and diagnosis in one visit to the hospital. This reduces the need for multiple unnecessary appointments.

Key aspects of this service are:

- It provides quick access - patients are seen within two weeks
- Investigations are done the same day
- There is prompt diagnosis and treatment
- Consultations include lifestyle advice & guidance and signposting to other services
- Patients leave with an individualised long-term management plan



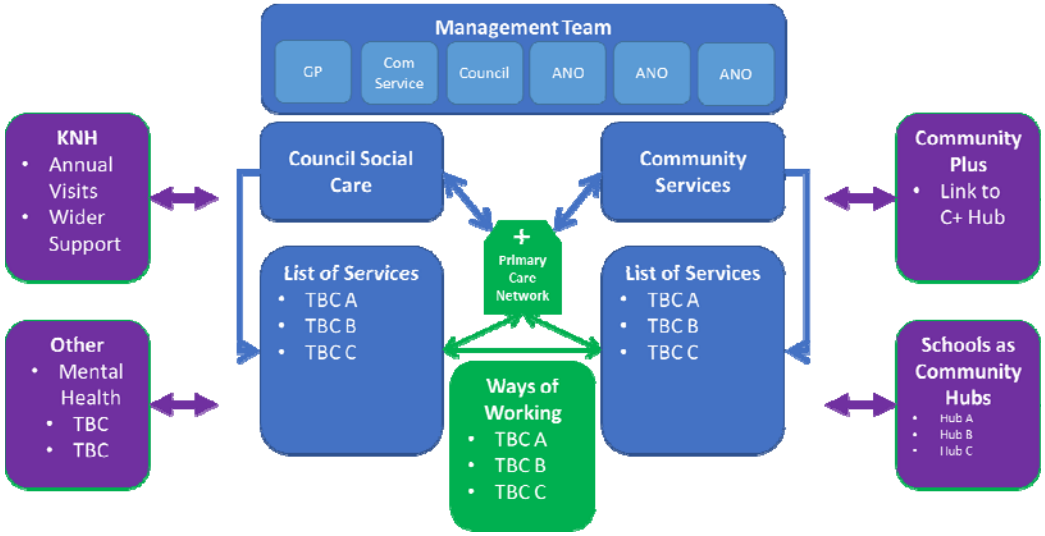


Complex

Our objectives:

- Integrate health, social care and wider community based services to provide seamless support to complex individuals in the community
- Improve the outcomes of people with complex needs through better coordination of services and continuity of care
- Increase numbers of people supported in the community rather than a hospital setting, where appropriate
- Get people home sooner with the right support, following a stay in hospital, acute mental health wards, or intermediate care services
- Increase numbers of people receiving rehabilitation support alongside reablement to prevent hospital admission, or following hospital admission
- Increase numbers of people supported in care homes where this is their place of residence, rather than admitted to hospitals and acute mental health inpatient facilities unnecessarily
- Improvement in the quality of care pathways for patients at end of life and their families, ensuring best value for money, and reducing duplication across services
- Increase proportion of people who are able to be supported at home, rather than admitted to care homes and nursing homes
- Increase numbers of people in control of their support through personal health and care budgets
- Increase numbers of people with a learning disability and/or autism living in the community

Community based support and delivery system: Primary care networks



Delivery of place based systems of care is one of our five Kirklees priorities. These will bring together different support and services in ways that relate to communities. Although there are no hard and fast rules, we expect these to cover populations of 30-50,000 and to be based around groups of GP practices working together with other providers and services.

Our initial vision is that we will integrate primary care, social care, and community services. This will provide us with the core of a community-based support and delivery model that can then be used as the focus around which we can integrate other existing place-based approaches around building community capacity. These include Community Plus, Local Area Co-ordinators, and Schools as Community Hubs. They will also allow us to develop new ways of working that build on these existing approaches.

In addition, these structures will provide a way in which other wider services such as the voluntary sector, housing, police, and fire can begin to interact and support the delivery of support and services to local communities.

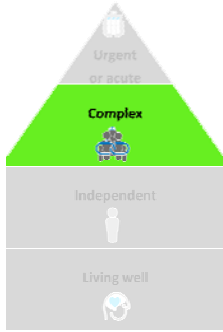
It is expected that there will be nine of these in Kirklees covering the whole population.

We will work with our staff and communities to identify which elements of social care and community services are relevant to this approach and beginning to establish new ways of working so that these will be increasingly delivered in an integrated way. It is anticipated that the list will have some services that are common across each of the community delivery systems but that it allows for local flexibility in so that each area can include things which are of particular importance to their population.

The importance of building new working relationships is key to making this a success. We recognise that we will need to invest time and effort in helping to support the development of these new working relationships. This work has commenced and will be an ongoing requirement during development and implementation.

The diagram shows how we think other important services and approaches will be linked into this model. For example, the existing Community Plus and Schools as Community Hubs will be able to link with the newly established model and over time begin to build mutually supportive ways of working. In addition, it provides a way in which wider determinants of health, such as housing, can be part of this new way of working.

Each of the new community-based support and delivery systems will need to be supported with managerial capacity to help with implementation and ongoing running.



Strengthening primary care

In order to create a primary care networks model in nine local communities, we need to ensure that we have resilient primary care services to work with, and wrap services around. General Practice in particular is under significant demand pressure, coupled with some challenges to the workforce. The business model across wider primary care services has often made engagement at a Kirklees level difficult. A focus on populations of 30,000 – 50,000 will mean that these partners are better able to engage in service development in their local communities

Creating resilience in General Practice: work to date

- Developed GP Federations (a single federation in each of NK and GH)
- Invested in the infrastructure of the federations using the £3 per head funding available to CCGs
- Created GP networks which support our plan for geographically based primary care networks (led by the GP Federations). These have been agreed with GPs in Greater Huddersfield
- Implemented extended access to planned and urgent GP appointments (covering 50%+ of the population)
- Commenced support for implementing the 10 High Impact Actions in General Practice
- Implemented new roles e.g. clinical pharmacist time for all 37 practices in Greater Huddersfield

Creating resilience in General Practice: future work

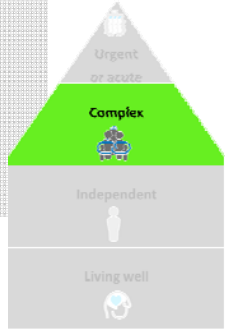
- Finalise the GP networks in North Kirklees around which to build the primary care networks
- Implement extended access to planned and urgent GP appointments (covering 100% of the population by October 2018)
- Roll-out of programme of hands on support to practices to implement the 10 High Impact Actions in General Practice (led by the federations)
- Full roll-out of the Referral Support System (OSCAR and TRISH) across practices in North Kirklees
- Using transformation funding, enable GPs and new primary care networks to engage and co-produce the primary care network model with wider partners and communities

Engaging wider primary care services

In addition to the significant role general practice has to play in the development of integrated care models, there is a significant opportunity to ensure closer working with wider primary care services in building resilient, connected and vibrant communities, shaped around local populations and networks of 30,0000 – 50,000 population including:

- Community pharmacy
- Community optometry
- Community dental services

There are 99 pharmacies across Kirklees (plus a further nine distance selling). The Kirklees Pharmaceutical Needs Assessment 2018 -2021 found that there is a reasonable and adequate choice in all areas, when examined by Council wards. Pharmacies are valuable assets in the local community with skilled staff able to offer advice and support as part of the wider health and care economy.



Integrated care models for the whole of Kirklees

Alongside developing primary care home within local communities of populations of 30,000 – 50,000 people, we are committed to integrating care for our population with complex needs on a Kirklees-wide basis. There are a three key areas in which we're working on delivering integrated services for people with complex needs:

An integrated model for end of life care

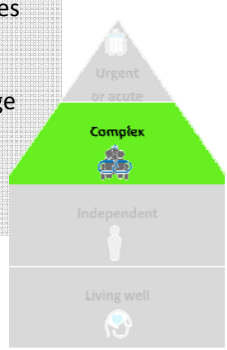
- Led by Kirkwood Hospice, an End of Life Provider Alliance will be established to support the delivery of an integrated package of community end of life services across Kirklees, to meet the needs of people requiring end of life care and their families and carers.
- The expectation is that this will support further improvement in the quality of care pathways for patients and families and ensure best value for money and reduced duplication across services.
- Whilst some services will be delivered across a Kirklees footprint, there will also be a focus on delivering services through local neighbourhoods of 30,000 – 50,000 to support the needs of those communities
- Through this model, we will ensure that as many people as possible have the best chance of dying in their preferred location
- By working in an integrated away, we will reduce the number of gaps in service provision and increase clarity of services for people using services and wider stakeholders.

An integrated model for intermediate care and reablement

- A joint intermediate care and reablement draft model has been developed with commissioners and providers
- This will incorporate Multidisciplinary Teams (MDT) consisting of Nursing staff, Therapists, Social Workers, and GPwsi, who would provide clinical leadership to the MDT, develop appropriate care plans and link with local geriatricians when required.
- There is an expectation that the MDT would support a reduction in length of stay (from 4 weeks to 3 weeks) and that patients would be discussed at MDT within 24-48 hours of arrival, mid-stay and post discharge ensuring they are receiving the right care.
- Recovery at home will be an expansion of existing community reablement services, with investment into reablement services to provide rehab support workers for daily rehab.
- There will be a dual role for reablement support workers (rehab and home care support) with additional therapy support to care for a further 20 patients at home. The service will provide a step down from hospital and step up from primary care

An integrated model for care homes support

- We are commissioning a new proactive and reactive service to individuals within care homes through a multi-disciplinary care home support team.
- This will also include physical health, social care with the addition of specialist mental health support, through expert psychiatric leadership, which will undertake reviews for high acuity patients
- In addition, the service will provide specialist advice, support and consultation into the wider primary care teams, including GPs and care home senior staff.
- The impact of the service for people living in care homes will be the ability to be supported in the place they live and achieve their outcomes
- The impact of the service for the system includes reductions in non-elective admissions and readmissions to both acute and mental health inpatient beds, and will support timely discharge from inpatient services.



Supporting people with complex needs

Children with complex needs

- Implement a model to ensure that children and young people who have an Education, Health and Care Plan receive integrated, seamless support covering the whole spectrum of services, e.g. educational support, therapy services such as physio and speech and language, mental health services, personal budgets, ensuring a continuum of support to improve outcomes
- Delivery of an all age disability service model and outcomes outlined in our Children with a Disability Health and Social Care Commissioning Strategy
- Further develop community care for children and young people to ensure early identification of need resulting in the delivery of early interventions which will support families to manage their own health and wellbeing
- Deliver our priorities for children and young people's mental health and wellbeing through our Kirklees Future in Mind Transformation Plan

Transitioning from children's to adult services

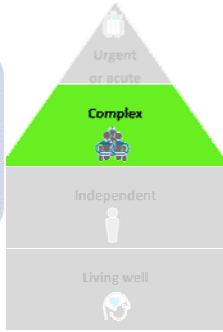
- Around 150 children with a disability or special educational needs (SEN) turn 18 and enter adulthood each year
- Ensure that services provision allows for seamless transition from CAMHS to adult mental health services. This applies in particular to areas of self-harm, eating disorders, ADHD and substance misuse
- Ensure that pathways for Young people transitioning into Adult service in both hospital and primary care are seamless and young person and family focused
- One integrated team approach across all agencies to minimise fragmented care improving pathways for children, young people and families
- Ensuring young people's voices are heard when transitioning from children's to adult services

Adults with learning disabilities

- Working with out colleagues in Calderdale, Wakefield and Barnsley, our Transforming Care Partnership plan is focused on:
- Providing support and accommodation in the community, reducing inpatient beds, delivering an almost 60% reduction across the partnership
- Developing a 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

Frail people

- We are developing a Frailty Services across Kirklees, which aims to support frail older people to live in appropriate homes; be as well as possible for as long as possible and experience seamless health and social care appropriate to their needs available 24/7 where required, and supporting needs of carers. This will ensure:
  - Frail older people in Kirklees are as well as possible for as long as possible, both physically and psychologically.
  - Local frail older people can control and manage life challenges by engaging with a supportive network of health, social care and voluntary services.
  - Frail older people have access to opportunities that have a positive impact on their health and wellbeing



Managing the social care market

Providers of social care support to people in their own homes or in care homes are a vital part of our health and care economy. Our Kirklees Market Position Statement recognises some of the demographic and financial chances faced by the social care market for current and new providers. Changing demographics which will present both challenges and opportunities for the care market. The value of the care market in Kirklees is estimated to be around £240m with 40% spent by Kirklees Council, 15% by the NHS on continuing healthcare support, and the remaining 45% purchased by individuals funding their own support of varying levels of complexity 'self-funders'. Approximately 10% of Council spending is used for personal budgets and direct payments, allowing people to take control of this funding to purchase their own support to meet their outcomes.

Our focus in shaping the care market

We will support shaping a care market in Kirklees where:

- Personal choice is not compromised in order to fit a service model
- People are easily able to purchase additional support
- There is a recognition of the importance of preventative support
- Investing in new or existing care organisations is encouraged
- There is a positive and person-centred approach to risk that keeps people safe whilst enabling choice and control
- Constant creativity and innovation is seen as the best way to deliver the range of outcomes desired by consumers
- Quality of the interaction takes precedent over completion of a care task
- Breadth of career opportunities in the care sector are known about and aspired to

We're committed to working with our existing and new providers of social care across Kirklees in order to meet some of the collective challenges we face. As well as shaping the market as commissioners, this includes:

- The integrated provider board will establish links with Kirklees care provider forums across care homes and domiciliary care support in order to better coordinate and integrate with these services to improve outcomes for service users and carers
- In addition to specific initiatives such as the new integrated model for care homes which is currently being commissioned, we will continue to work in partnership with care providers, seeking opportunities to upskill the social care workforce and provide appropriate support to enable the best outcomes for our service users
- Working together to ensure the best technology, digital solutions and equipment is available to reduce reliance on visits to people in their own homes
- Developing the capacity in care homes and home care services with a focus on prevention and enablement
- Promoting the personalisation agenda – increasing the number of people in control of their own needs and outcomes through personal budgets and direct payments for social care and health needs

On a typical day, people are in receipt of a range of social care support (analysis from 03/10/17 undertaken by Kirklees Council)

2,197 Care Home

46 Respite

225 Supported Living

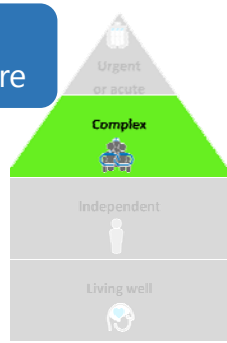
1,015 Nursing Home

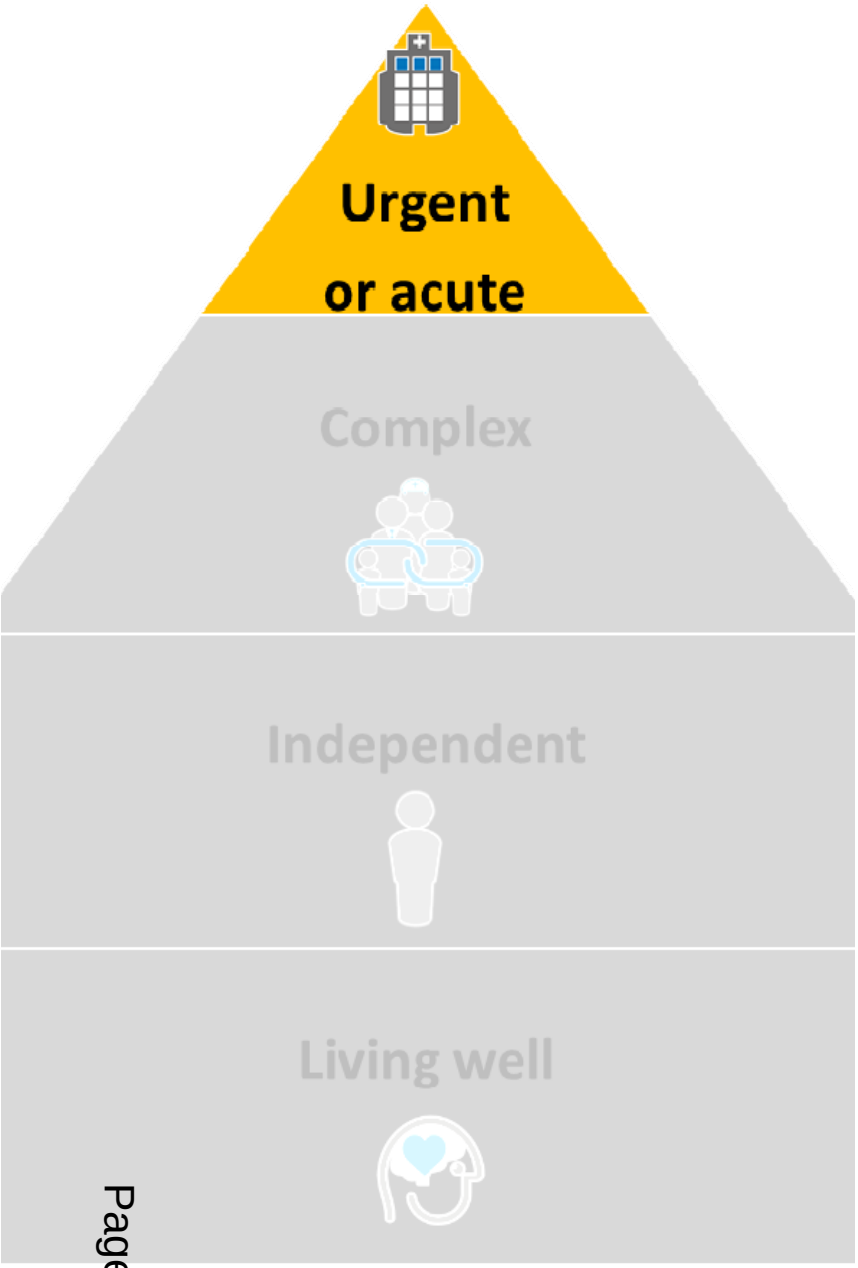
136 Extra Care

3, 142 Home care visits

54 Reablement interventions

194,038 Hours of unpaid care





Acute and urgent support

Our objectives:

- Where people require urgent, acute or specialist care, this will be the right intervention provided in the right setting in a timely way
- Ensure people can get access to primary care services in a timely way for urgent needs
- People can access urgent hospital treatment when they need it in a timely way
- Ensuring people can be treated closer to home and eliminate out of area placements for non-specialist acute mental health care
- Deliver sustainable urgent and acute services for the population of Kirklees
- Continue to ensure people can return home from hospital with the right support, as soon as possible
- Increase numbers of healthy births, reducing stillbirths, neonatal deaths, maternal death and brain injuries
- Increase alternative safe options for people to access when experiencing a mental health crisis, reducing use of police detention
- Get the best outcomes and reduce variation in outcomes for people who have suffered a serious acute episode e.g. hyper-acute stroke

Accessing acute and urgent in the community

We are committed to ensuring that as much provision as possible is made available as close to home as possible. For urgent and acute services, this includes:

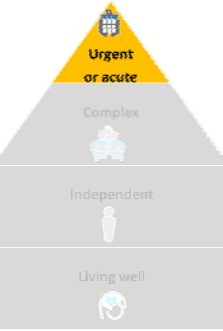
- Increasing extended access primary care – providing more access to GP appointments during core hours, extended hours (6.30 – 8.30 pm) for urgent and planned appointments, as well as provision for out of hours. We will ensure this provision covers the whole population in Kirklees by October 2018.
- 111 online has now been rolled out in Kirklees and we're testing the approach of allowing 111 to directly book people into GP appointments following a contact for an urgent need, this will be rolled out across our practices
- We're working with our partners across Yorkshire and Humber and leading on the recommissioning of the 111 service to provide an integrated urgent care service across the whole Yorkshire and Humber region which will meet our local requirements in Kirklees
- Provision of a rapid same day response in the community available to people with complex needs for physical health needs, mental health crisis and social care needs
- Delivering early intervention in psychosis services for people experiencing first episode psychosis in line with national standards
- For people experiencing a mental health crisis, our focus is on prevention, and during crisis to support people at home wherever possible including:
    - Maintain and develop a range of crisis care services, including accommodation-based provision, which meets the needs and demands of people living in Kirklees
    - Ensure that there are good and effective crisis care planning processes in place which includes reference to patterns, triggers and capacity
    - Support people to find their own solutions to managing their crises through the use coping mechanisms e.g. Wellness Recovery Action Plans (WRAP)
    - Implement and develop the actions of the Kirklees Crisis Care Concordat declaration statement
    - Further develop police liaison work across Kirklees (core 24 service standards)

Managing demand for hospital services

A large part of our ambition is to continue to develop support in the community or at home, where this is appropriate. A significant proportion of our plans are focused around strengthening primary care and community services in order to offer people the best planned and unplanned care closer to home.

We know that demand for hospital services has and will continue to grow and that this is not sustainable. We also know that there are opportunities to further reduce demand on hospital services through some of our service developments outlined in this plan (including through focusing on prevention and taking an integrated primary care network approach around communities of 30,000 – 50,000 people).

To understand the impact of these interventions, we are undertaking a detailed piece of modelling and analysis during 2018 and are committed to ensuring that hospital capacity is maintained until there is evidence of robust alternative provision in the community.



Acute and urgent: Local hospital services

Where our population needs access to hospital services, we are committed to ensuring that these are high-quality and achieve the best outcomes for our population, whilst ensuring that these services are sustainable for the future.

Ensuring quality and safety in hospital care

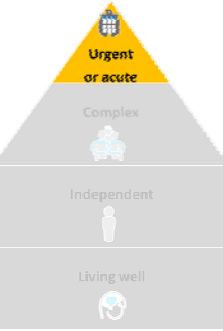
- Ensuring people stay in hospital only as long as they need to by improving our processes in hospital and working with the rest of the system including:
    - Implementing the nationally recognised SAFER bundle on hospital wards which improve outcomes for patients and support reductions in length of stay, ensuring people are not waiting in hospital beds unnecessarily.
    - Continuing to make improvements in relation to delayed transfers of care, including implementing the eight high impact actions and focus on operational and strategic system working through our A&E Delivery Boards
- We are focusing on delivering improvements in maternity care in safety towards the 2020 ambition to reduce stillbirths, neonatal deaths, maternal death and brain injuries. This includes full implementation of the Saving Babies Lives Care Bundle working through our Local Maternity System across West Yorkshire and Harrogate.
- Delivering support for people in our acute hospitals experiencing a mental health crisis through implementation of mental health liaison services and CORE 24 standards

Sustainable hospital services

There are some real challenges facing our local hospital services in terms of sustainability, particularly given the availability of workforce with the right specialist skills.

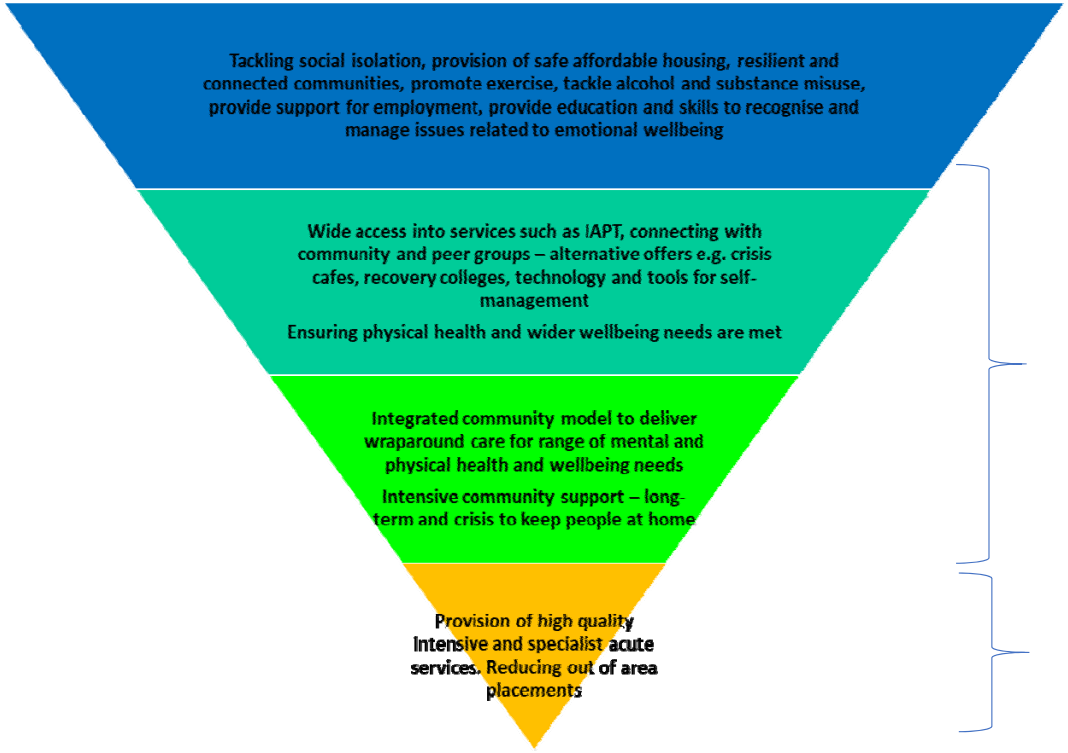
This means that some services need to be consolidated in order to ensure that services are safe, of high quality and sustainable for the future. Alongside the need to work within the tight financial envelope, the condition of some of our hospital estate, and the opportunities open to us through advances in healthcare, means that the current way we provide hospital services to our local population needs to change. We are continuing to develop our proposals in this area.

Given some of the workforce challenges facing us, we are working with partners across West Yorkshire & Harrogate through the West Yorkshire Association of Acute Trusts (WYAAT) and the West Yorkshire Mental Health Services Collaborative, in order to ensure sustainability of high quality acute clinical services for the population in Kirklees and across the region through clinical networks, eradicating any existing unwarranted variation in outcomes. This includes some of the ICS priority workstreams – mental health, stroke and cancer (through the West Yorkshire & Harrogate Cancer Alliance). We've recently taken this collaborative approach in order to ensure the sustainability of vascular services across the region.



Acute and urgent: working regionally to achieve the best outcomes

We know that for many of our acute services, we need to plan on a wider footprint than in Kirklees. This is a key area of focus in our involvement with the Integrated Care System, to bring the best outcomes for Kirklees and West Yorkshire and Harrogate as a whole. All our energies will be focused on prevention at primary, secondary and tertiary level, however there are times when our population in Kirklees will need access to specialist acute support on an urgent or planned basis. Our objectives for acute services is to ensure that people get the best possible treatment, achieve the best outcomes and that support after an acute intervention is provided as close to home as possible.

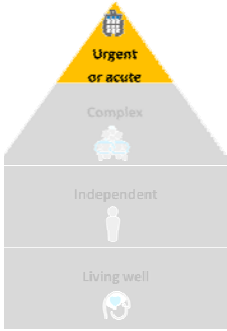


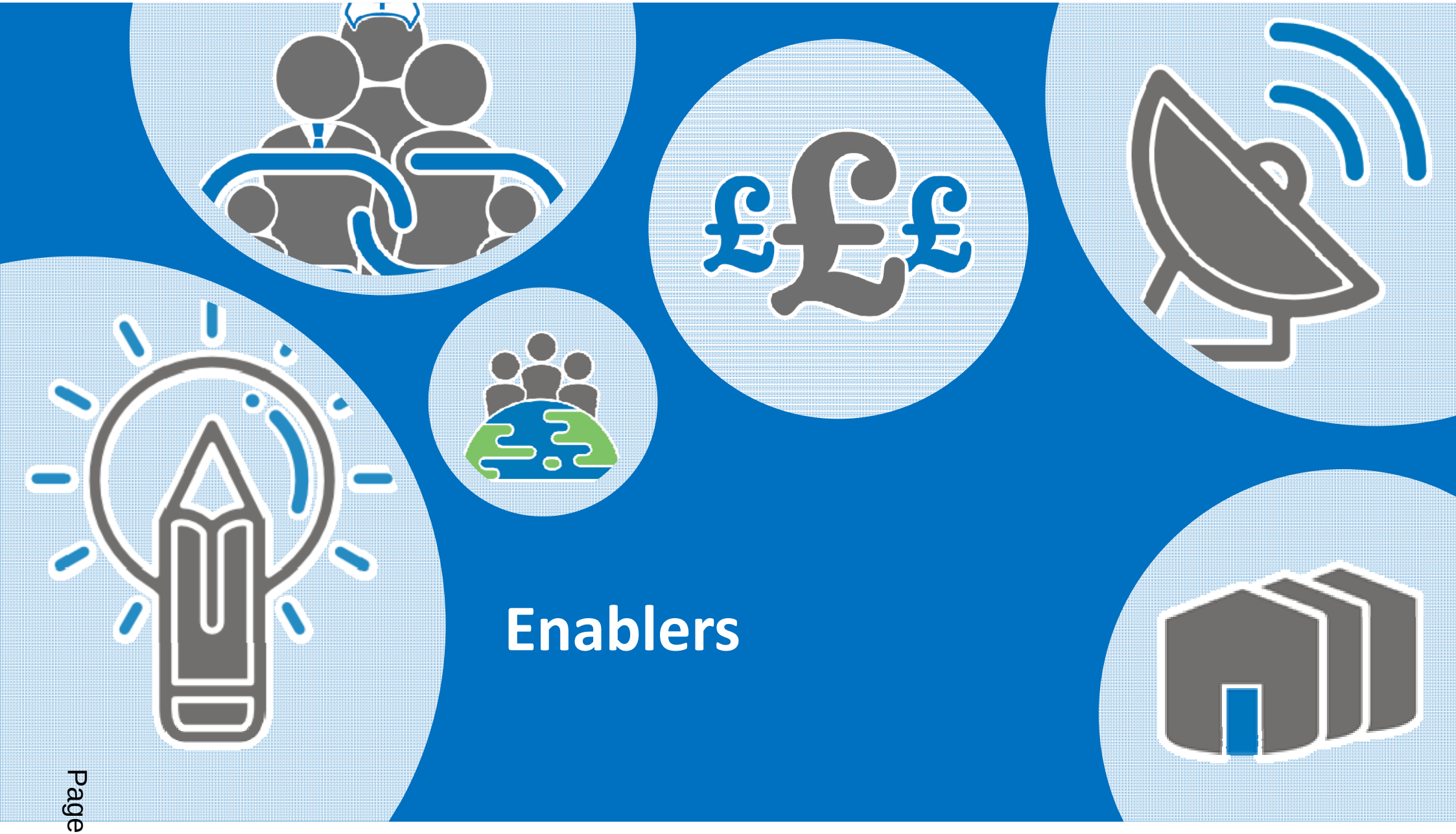
Local priorities with locally led planning and delivery (with support from WY&H ICS infrastructure)

WY&H ICS led planning and delivery, through partnerships representing local places

The diagram shows the relationship in respect of the local and regional priorities for improvement in mental health outcomes through interventions at each population cohort level. Planning and delivery of local priorities is led locally for the interventions targeted at supporting those populations who are living well, independent and have complex needs. In doing this, Kirklees has support from the ICS infrastructure in resource support, access to best practice and learning from the other places within the ICS, and more widely through the input of national bodies.

When people require intensive or specialist care in an acute setting for their mental health needs, this will be planned at a West Yorkshire and Harrogate level to achieve the best outcomes for the Kirklees population and the West Yorkshire & Harrogate population as a whole. This planning and delivery is a partnership between local places – for providers through the Committee in Common of the mental health trusts operating across the ICS, and through Joint Commissioning arrangements of the CCGs and in conjunction with NHS England as responsible for specialised commissioning for services of this nature are devolved to the ICS. This allows the system to tackle some important issues such as reducing out of area placements and ensuring that people receive support as close to home as possible.




Enablers

Our People: Communities

Fundamental to the delivery of our ambition is working with our biggest asset, our people, to best effect. Supporting development of connected, resilient and vibrant communities is crucial to this.

Changing the conversation: assets, strengths and responsibilities

To support us to start, live and age well, we need to have different conversations with our communities about how they can manage their own health and wellbeing, building on their own strengths and assets.

In order to support this, we need to ensure people have the resources to manage their own health and recognise their strengths and assets. This will mean different conversations with communities (through resources like Community Plus and the Integrated Wellness model) and with individuals, ensuring that all our services are taking a strengths-based approach to assessment and support and maximising self-management and independence.

As well as raising the profile of our priorities around those factors which determine our health and wellbeing, we need to focus on raising the health literacy of our communities experiencing the poorest health and wellbeing. By improving people's access to health information and their capacity to use it effectively, health literacy is critical to empowerment.

Co-production

Fundamental to our plan is to put people and our communities at the centre of all we do, starting from planning and design of services. We know that where we involve the people who use services in the design of these services, we get the right outcomes. We are experienced in engaging and consulting our population about the services they use and our ambition is to enable our local communities to co-produce any changes and influence design and development of new models of care.

We want to work in a way that is open and transparent, ensuring that we have meaningful conversations with people on the right issues at the right time.

We're committed to:

- Involving our communities in the design of services
- Using information we've already obtained locally through extensive engagement and consultation exercises
- Working with our partners in the voluntary sector and Healthwatch Kirklees to get this approach right
- Undertake formal consultation and engagement where appropriate on any major service change.

Our People: Workforce

People	Number
Volunteers	86,000 (1 in 4 adults)
Voluntary organisations (registered)	100+
Voluntary organisations (unregistered)	1000+
Unpaid carers	60,525
Paid health and social care workforce	20,573*

Addressing our workforce shortages

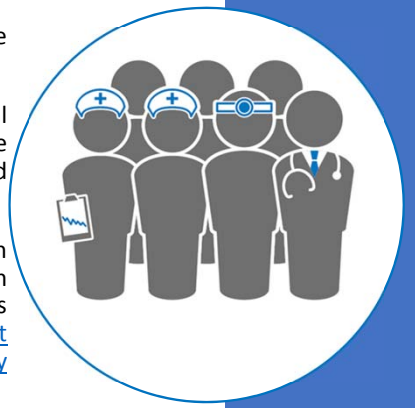
We know from our organisational and sector based analysis that there are significant issues in terms of training new workforce, retaining our existing workforce and an ageing profile in many areas.

In order to think differently about how support can be provided we have trialled new roles including nurse associates (in Mid-Yorkshire Hospitals NHS Trust), physicians associates (in Calderdale and Huddersfield NHS Foundation Trust) and Allied Health Professionals in primary care. We will continue to develop and expand these approaches.

We want to ensure our staff have the ability to work together across organisational and professional boundaries.

Our focus will be on shared vision, values and behaviours across Kirklees. We will work together to identify what this looks like and shape this into a coherent programme of workforce induction and training. Integrated models of care will fundamentally require people to work differently from their prescribed roles, to make this a success requires:

- Co-production of these models with staff who deliver support to people in Kirklees, empowering staff to act to deliver the best outcomes
- A programme of development to support staff and operational managers to work within the new integrated framework, challenge barriers to integrated working, and adopt an asset and strength-based approach to support planning
- A workforce strategy for Kirklees which identifies our vision, common values and behaviours that those supporting people with their health and care should exhibit, including delivery methods for doing this. This will build on our local vision for Kirklees developed as part of our West Yorkshire & Harrogate Health and Care Partnership Workforce Strategy (2018) and local initiatives we are already implementing
- Establishment of a Kirklees workforce group to oversee workforce developments in Kirklees and to take a single approach to, for example, engaging with Huddersfield University with regards to future training and workforce requirements. This will have strong links to the Kirklees Skills Strategy and action plan.
- Build on testing of new roles in Kirklees like nurse associate, physicians associates and use of allied health professionals such as physiotherapists, pharmacists and OTs in primary care, working with our Local Workforce Action Board (LWAB) to support us to manage our workforce challenges.



*Estimated direct FTE employed in health and social care activities in Kirklees (analysis undertaken by Kirklees Council, March 2018)

Digital: Enabling people to be independent

Using digital technology to make people's lives easier is one of our five priorities in Kirklees. We know that technology has revolutionised our lives and ability to managing our affairs independently and remotely. The same principles apply to our health and care. Significant developments are taking place nationally and internationally to use technology in health and care.

We believe that technology can support people to manage independently, allowing people to take control of their own needs and lead their own support.

We have been piloting an app library run by the mental health trust (SWYFT) in partnership with ORCHA, an organisation which runs the library and quality assures all the apps available for use so clinicians and people using the site know these are all approved. ORCHA has been awarded NHS innovation accelerator status.

The site has been piloted in Children and Adolescent Mental Health services (CAMHS) to support children and young people to self-care and understand and manage their own conditions. The site can be accessed by people using the service (self-access) or via a referral from a professional in the service. Take up and feedback from professionals during the first three months has been good.

The pilot has been extended to further test the impact and outcomes for service users and to expand the library to provide resources for early intervention in psychosis, smoking cessation and the Recovery College.

Through our involvement in the ICS, we have access to support from the Yorkshire and Humber Academic Health Science Network which has a number of nationally recognised evidence-based programmes to support improvement in care. A number of these offer opportunities for self-care including *My Diabetes, My Way, My COPD, Me and medications.* We also have a range of digital offers through My Health Tools.

We are committed to implementing digital products, such as apps, that have been proven to work and will enable people to manage their own support and conditions independently whilst offering alternative ways to access professional support when required. Increasing availability and normalising these applications as support options, will mean more people are able to manage their health and wellbeing in this way.

Teleheath, telecare and assistive technology is an area which can bring huge benefits to service users, for example in allowing people with dementia to remain independent and supported at home, or for people to monitor their conditions independently. It can often also increase efficiency, reducing costs for direct care and providing the system with greater capacity.

Through our outpatient transformation programme, we are exploring how virtual consultations and telephone consultations can be used so that people do not need to travel to hospital for an appointment unnecessarily. This will free up time for clinicians to see new people, whilst giving greater flexibility to the person in their follow-up care.

In order to deliver this transformation, we will also focus on the digital literacy of all our communities to ensure there is equal ability to access these solutions.

Digital: Improving service delivery

Alongside using technology to enable people to stay independent, we know that the right digital solutions can make service delivery more efficient, improve the quality of professional decision-making, and improve service user experience. We're already making progress on our digital infrastructure to support this, including:

- Acute clinicians can view patients' acute clinical records.
- Primary care clinicians can view clinical records across different practices which use the same system.
- Access to view clinical records for all patients across all practices is due to be complete in August 2018.
- Primary care clinicians can view patients' acute medical records
- Following a successful pilot, implementation of technology to allow Acute clinicians to view patients' primary care medical records is underway and due to complete in 2018 and will support the roll out of electronic advice and guidance (GPs seeking secondary care advice electronically).
- GP Practices can allow patients to undertake task related functions such as booking/amending/cancelling appointments and requesting repeat prescriptions online.
- A number of GP Practices allow Patients to directly book GP appointments through 111. This is planned to be extended.
- A number of GP practices support patient/clinician online consultation and this is planned to increase.
- Remote and flexible working for GP staff is supported through provision of laptops and access for patients and wider workforce through GP Wi-Fi.
- The mental health trust is now moving to SystmOne which will provide greater opportunities for sharing records across services

Interoperability and shared care records

West Yorkshire & Harrogate ICS, working as part of the wider Yorkshire & Humber footprint, has been successful in attracting £7.5m to support the joining up of health and care records as part of the Local Health & Care Records Exemplar (LHCRE) programme. A shared care record is a key enabler to support the delivery of integrated care, this will:

- Increase efficiency
- Improve decision-making and safety
- Improve service user experience (telling your story once)

The roll-out of the EPR system in parts of Kirklees will be a key learning and building block for our LICRE programme.

Working more efficiently through digital technology

We are reviewing a range of digital solutions to support us in the deployment of staff e.g. in delivery of extended access GP appointments and home visits which will support us to create capacity in the system to see more service users.

We will review our current multiple contact point arrangements and identify how these can be rationalised or more integrated through different technological platforms, to improve people's outcomes and experience when contacting services. Alongside this, in order to support integrated and neighbourhood based working, we will need to develop a comprehensive directory of services (DOS) available to the public and to professionals in order to ensure the full range of services and assets in communities are available for people to view and access.

Estates and assets

We hold a wide range of estates and assets across key partners in Kirklees. We know not all of this estate is bringing good value and some of this estate is not fit for purpose to deliver our vision for integrated community care in the future, as well as high quality acute services.

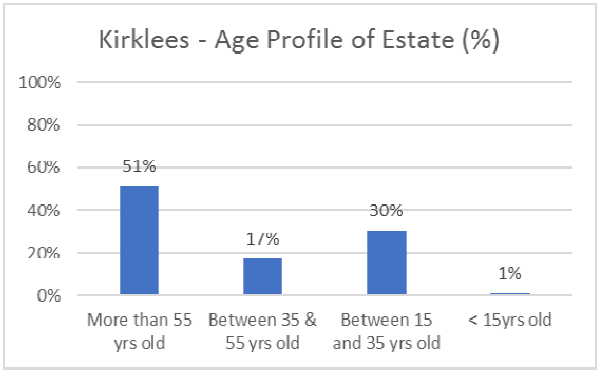
We have already commenced a process to review all of our estates across partners to understand our available resources in each of our communities. As well as developing a Kirklees Estates strategy for the future, we will identify how better we can use our assets through some of our priority initiatives like the early adopter sites for primary care home and the new integrated intermediate care services. In these cases, our estate will be used to support integrated working across organisations and teams and consider how our assets can generate social value in building strong, resilient communities e.g. sharing space with voluntary and community sector organisations.

Our neighbourhood approach (and the primary care network model) provides us with an opportunity to test some of our key principles in relation to our estate, including:

- How we can share estate to support integrated working across staff teams
- How we can use our estates in neighbourhoods of 30,000 – 50,000 to meet the needs of the local population
- How we can use our estate to generate social value and stimulate the growth and embedding of resilient, connected and vibrant communities.

Our current estate and assets

An analysis of NHS Trust (acute and mental health facilities has been undertaken). Over 68% of this estate is over 35 years old. Similarly, we know much of our community and general practice estate is not fit for the future. We are currently undertaking a detailed piece of work, led by Kirklees Council to map the full range of our public sector estate across Kirklees which will provide us with a valuable baseline.



Future integrated community assets

Our vision for the future is that our community resources will be built to 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.

Population health management

Population health management is seen as a key tool deployed in an Integrated Care System (ICS), which has most value when used to plan and deliver services within a place base. Kirklees sees this as a valuable tool in developing the planning and delivery of health and care services in the future. Our commitment to starting our planning process from population needs provides us with a solid base from which to use population health management tools.

What is population health management?

Population Health Management improves population health by data driven planning and delivery of care to achieve maximum impact. It includes segmentation, stratification and impactability modelling to identify local 'at risk' cohorts – and, in turn, designing and targeting interventions to prevent ill-health and to improve care and support for people with ongoing health conditions, and reducing unwarranted variations on outcomes.

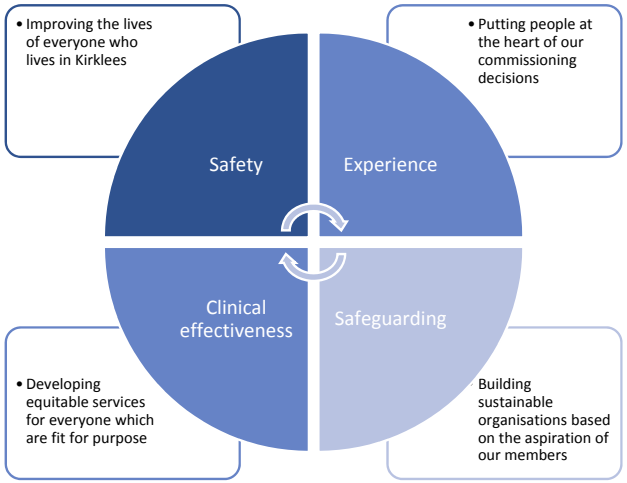
Through our involvement in the ICS development programme as part of the West Yorkshire & Harrogate Health and Care Partnership, we are part of a Communities of Practice in this developing area, working with national bodies including NHS England and Public Health England (PHE).

We will initially complete a self-assessment of our system maturity to deploy population health management during 2018/19 including infrastructure (leadership, population definitions, information governance, digital maturity, digital infrastructure), intelligence (supporting capabilities, analysis, reporting and decision management support), and care design (change support, workforce and leadership development, scaling innovation, patient empowerment and activation, care integration incentives, behavioural insight.)

Through the ICS, Kirklees can share learning and access support and best practice locally and from national bodies to deliver the approach in Kirklees.

Integrated commissioning

- There is a longstanding commitment in Kirklees to work collaboratively across the two CCGs and the Local Authority. This has taken the format of formal joint posts across health and social care, integrated governance to support development and delivery of the Better Care Fund and informal collaborative working to commission services in a number of areas, for example, children and young people inclusive of education and learning, mental health, care closer to home and hospital avoidance. Together we have created an Integrated Commissioning Strategy to underpin delivery of integrated commissioning in Kirklees, to support this plan
- The two CCGs which commission health services for the population of Kirklees (Greater Huddersfield CCG in the South of the Borough and North Kirklees CCG in the North) are now working together much more closely. The two CCGs are now operating with a joint management structure.
- We recognise that often commissioning is as fragmented as service delivery and in order to deliver our priorities, services will need to be commissioned differently to support us to achieve the Kirklees outcomes. The testing of new models of support such as primary care home, will support Commissioners in identifying where commissioning does not enable integrated provision and inform how new models of integrated care can be commissioned in future to achieve the best outcomes for the population of Kirklees.
- For those services which are provided on a wider-footprint than that of Kirklees, we work with neighbouring commissioners through formal joint structures to commission services in the best interest of Kirklees (for example the West Yorkshire and Harrogate Joint Committee of Clinical Commissioning Groups)



Improving **quality of care** is central to our approach and taking a unified approach to quality is central to our integrated commissioning strategy. This will link closely with providers of health and social care, including independent sector partners like care homes.

As part of the West Yorkshire and Harrogate Health and Care Partnership, we are a national demonstrator site acceleration of implementation of the **personalisation and choice** agenda. We have assessed our current position and are now focused on increasing personalisation and choice and extending access to personal health budgets across a range of provision including continuing healthcare, and for children and young people with complex needs.

Funding flows and sustainability

System recovery and financial sustainability

- The Kirklees health and care economy is financially challenged. Whilst this presents a significant task to address, the partners across the system are committed to tackling the underlying financial deficits in order to reach financial balance and ultimately sustainability. This is part of the core business of each of the organisations, and the service improvement agenda to drive changes which improve quality, cost efficiency and productivity.
- As with our operational and strategic planning, we work together where it makes sense to do so, on the most appropriate footprints. Given that the majority of health care expenditure is currently spent on hospital care, we have been working together across the acute hospitals and with our neighbouring CCGs, in Calderdale and Wakefield respectively, on system-based recovery.
- We have negotiated aligned incentive contracts for 2018/19 with both hospital trusts operating across Kirklees to ensure that financial risk is shared and owned by the system. This is a new approach.
- We have system and organisational recovery plans in place to support return to financial balance, agreed with NHS regulators.
- The new funding deal for the NHS will see funding rise by between 3.1% and 3.6% for five consecutive years from 2019/20 onwards, however there has been no funding deal agreed for social care and there is no planned increase to Council budgets.

Funding transformational change

Our development as a West Yorkshire & Harrogate Health and Care Partnership has been recognised nationally and the Partnership is now part of the ICS development programme. This brings a number of opportunities, including access to transformation funding.

The ICS has secured £8.9m of transformation funding during 2018/19 which has been agreed by the partnership to be distributed to key priorities in the system around primary care network development, UEC and engaging communities.

Whilst the financial position of the health and care economy in Kirklees is challenging, access to transformational funding will allow us to move ahead with our priorities at a greater pace, with the capacity required to ensure that these priorities are progressed without undermining service delivery and quality during this transformational process.

Governance and decision-making in Kirklees

In order to deliver our ambition and priorities for Kirklees, we recognise the need for strong governance and decision-making structures to support this. The Kirklees Health and Wellbeing Board will provide the strategic leadership as the statutory body with responsibility for health and wellbeing in Kirklees. To strengthen the place-based governance arrangements, we have established the Kirklees Health and Care Executive Group with representation from the Chief Executives of the main health and care commissioning and provider organisations in Kirklees. Integrated commissioning across the Council and CCGs is led by the Integrated Commissioning Board and providers have come together to drive forward Kirklees priorities as an Integrated Provider Board, representing health, social care and third sector organisations. This is based on a partnership approach and does not replace or supersede statutory responsibilities of the partner organisations.

We are committed to involving our communities and our workforce in the design of services and delivery of our ambition for the health and wellbeing of the population of Kirklees. As part of this, we will ensure openness and transparency in all of our discussions.

Governance and decision-making: working as an ICS

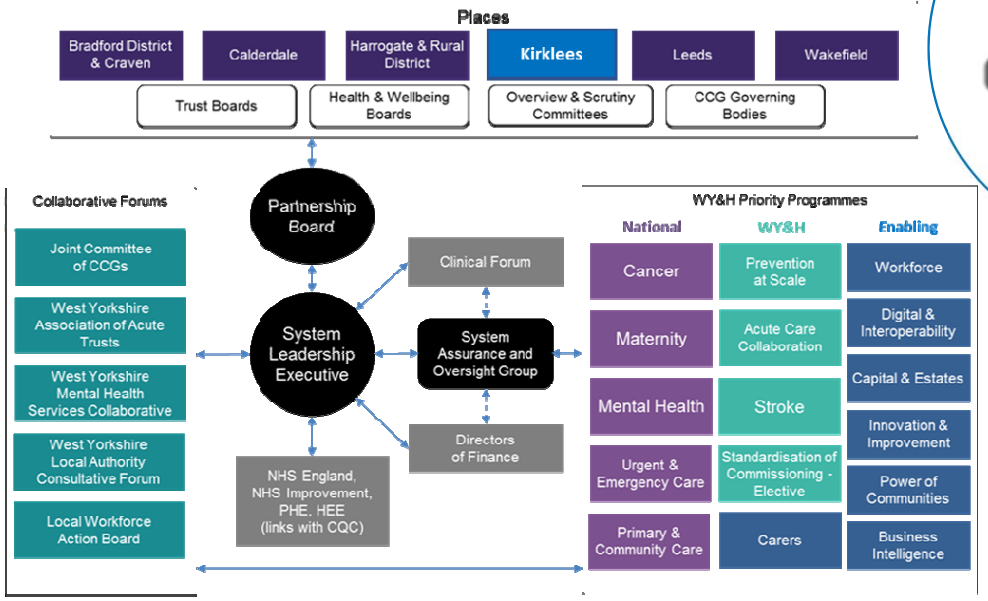
A key part of delivering this plan and our ambition for the population of Kirklees, is working as part of the West Yorkshire & Harrogate Health and Care Partnership to deliver our priority programmes. The developing Integrated Care System is built on partnership governance arrangements and the principle of subsidiarity, in that the Partnership serves local places and supports local improvements. We apply three tests to identify where we need to work together on an ICS rather than at Kirklees only level, these are:

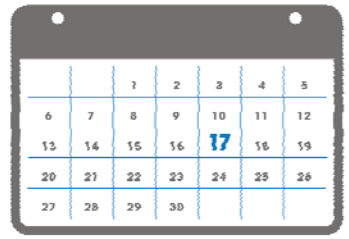
- Do we need a critical mass beyond the local level to achieve the best outcomes? – for example cancer or stroke services
- Will sharing and learning from best practice and reduce the variation in some outcomes for people across different areas? – for example the Wakefield Health and Housing partnership; the Kirklees model of identifying and supporting carers
- Can we achieve better outcomes for people overall by applying critical thinking and innovation to challenging issues? – for example establishment of 'primary care networks', or workforce issues.

The diagram outlines the ICS governance and accountability relationships. Kirklees, like the other places in the Partnership, is represented in all of the collaborative forums, partnership forums and within the priority programmes.

Kirklees and the other places within the Partnership are looking at strengthening the relationships through a Memorandum of Understanding. The ICS governance arrangements do not replace or override the authority of the partners' boards and governing bodies. Each of them remains sovereign and our Council remains directly accountable to our electorate in Kirklees.

In time our expectation is that regulatory functions of the national bodies will increasingly be enacted through collaboration with our leadership within the ICS. It will work by building agreement with leaders across partner organisations to drive action around a shared direction of travel.





Benefits, outcomes and milestones

Benefits and Outcomes

Starting with outcomes enables us to step back from the things we are already doing or commissioning and explore what needs to be done, by whom and with whom to achieve improved outcomes for the citizens and places of Kirklees and the people who use our services. If we achieve the outcomes in Kirklees we will know that people are starting well, living well, and ageing well.

Improving population health and wellbeing through monitoring the delivery of these outcomes will be our focus. Alongside this, all the initiatives and changes across Kirklees to improve population health and wellbeing will be impact assessed for impact and improvements to:

- **Quality of services** (included achievement of local and national standards)
- **Cost and service efficiency**
- **Equality and equity** – ensuring service change does not discriminate or disadvantage people
- **Sustainability**

There are seven Kirklees Outcomes:

Children

Children have the **best start in life**

Healthy

People in Kirklees are **as well as possible** for as long as possible

Achievement

People in Kirklees have aspiration and **achieve their ambitions** through education, training, employment and lifelong learning

Safe & Cohesive

People in Kirklees live in **cohesive communities, feel safe and** are **protected** from harm

Economic

Kirklees has **sustainable economic growth** and provides good employment for and with communities and businesses

Clean & Green

People in Kirklees experience a high quality, clean, and **green environment**

Independent

People in Kirklees **live independently** and have control over their lives

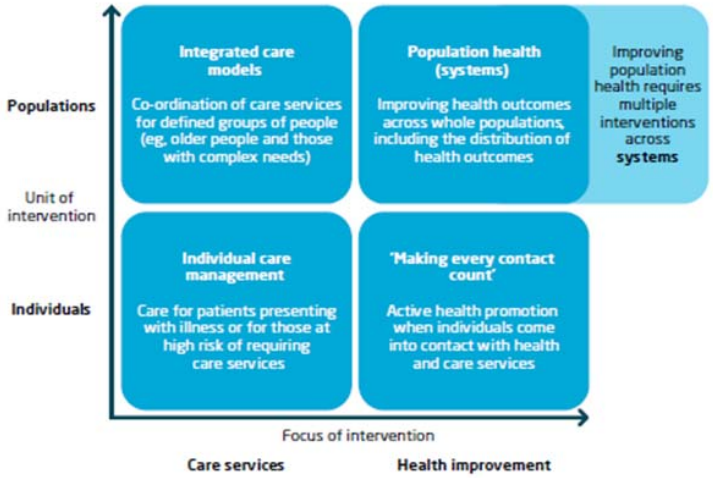
Measuring system impact

We believe that the health and social care system can have the most potential impact on the following outcomes:

- Children have the best start in life
- People in Kirklees are as well as possible for as long as possible
- People in Kirklees live independently and have control over their lives
- People in Kirklees live in cohesive communities, feel safe and are safe/protected from harm

However, achieving these outcomes is significantly influenced by progress on the other outcomes, and that the system also has a role in contributing to these e.g. as a major employment sector contributing to sustainable economic growth and good employment and therefore all outcomes are relevant to the improvement of health and wellbeing of the population in Kirklees.

In order to focus on quality and outcomes for people, we need to shift the focus from measuring activity in the system to a more outcomes based approach. These draw on some existing performance measures (national and local) and build in new elements in order to shift the focus.

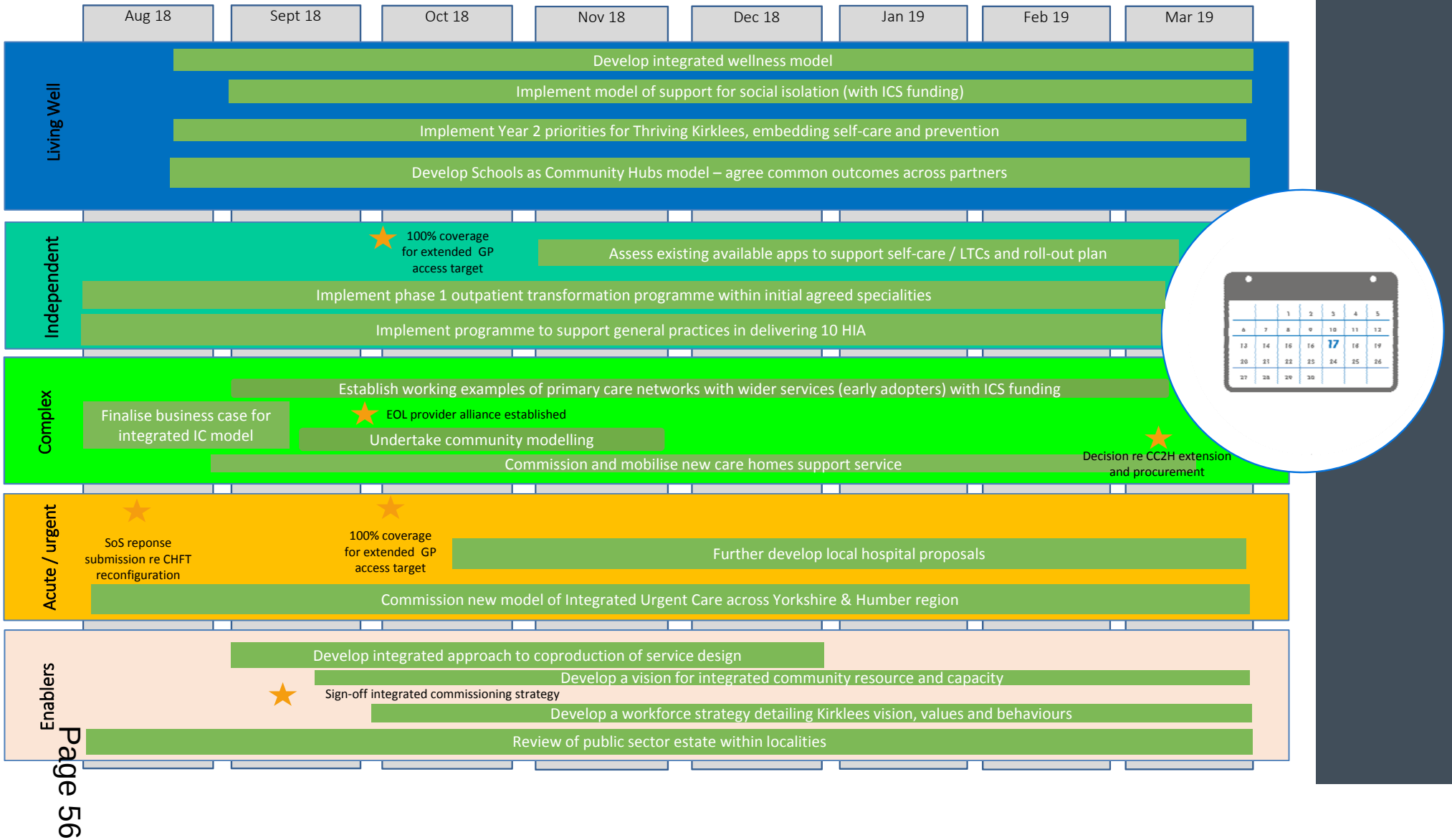


We are developing an outcomes framework which builds from the seven Kirklees Outcomes:

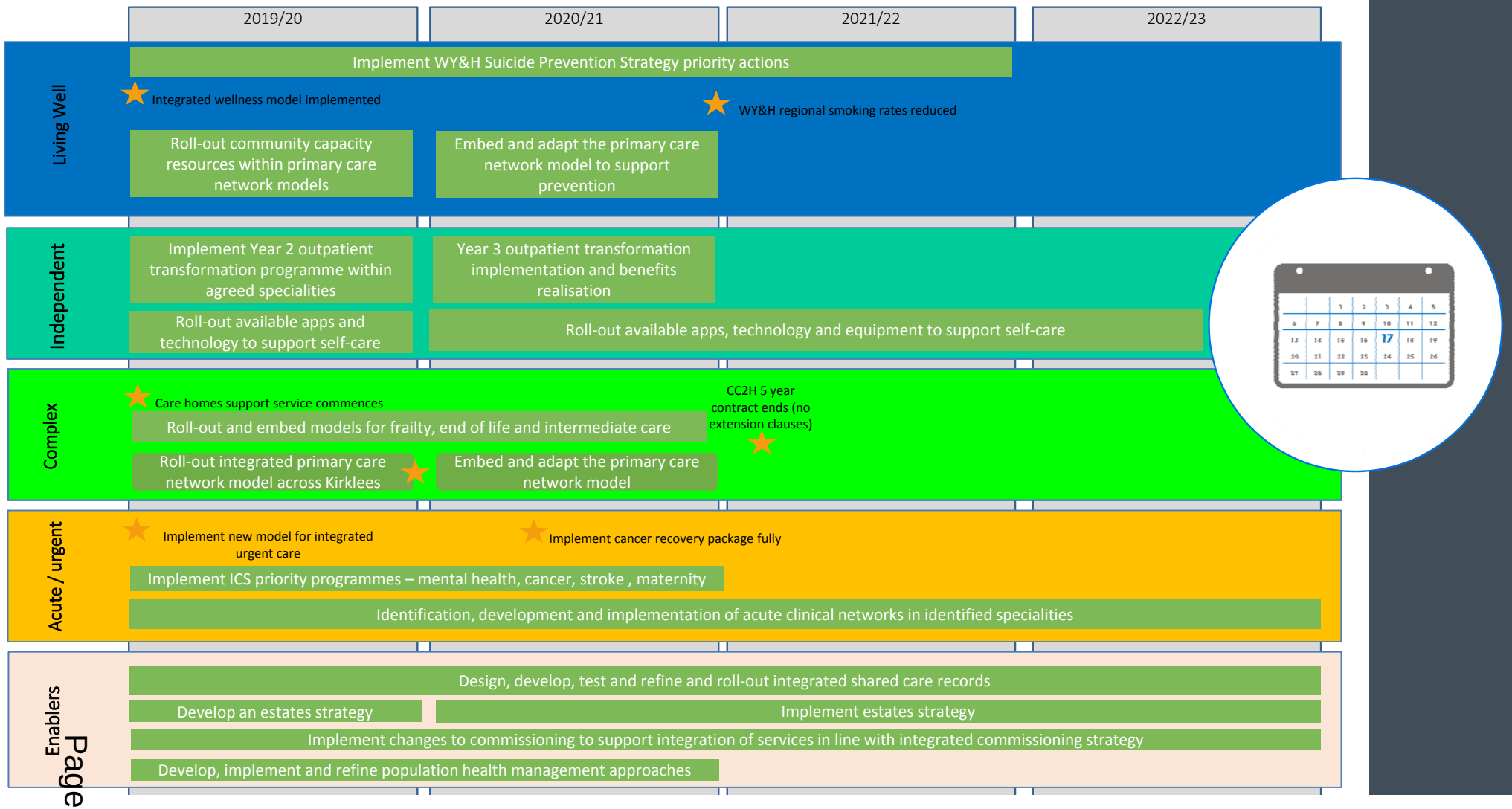
- Population indicators
- Supplementary indicators
- Local performance measures / individual outcomes

This has been developed by the Integrated Commissioning Board and will form the basis of how we will measure improvements in health and wellbeing in Kirklees. This will be a tool that commissioners, providers and the Health and Wellbeing Board can use to monitor our progress and will be completed by Autumn 2018.

Short-term delivery: 2018/19



Medium-term delivery: 2019 – 2023



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KIRKLEES HEALTH & WELLBEING BOARD	
MEETING DATE:	**6th September 2018**
TITLE OF PAPER:	**Update on Integration of Health and Social Care Commissioning and Service Delivery**

1. Purpose of paper

1.1 This report provides an update on the progress made in integrating health and social care commissioning and service delivery.

2. Background

2.1 The Board has previously received several updates on the ongoing work to integrate health and social care commissioning and integration. This report provides a further update on recent progress.

3. Proposal

3.1 The main arrangements we have put in place to oversee integrated commissioning and service delivery are the Integrated Commissioning Board and the Kirklees Integrated Provider Board. These are supported by the Kirklees Health and Care Executive Group. In addition, there are the existing Kirklees Health and Wellbeing Board arrangements.

3.2 Integrated Commissioning Board (ICB)

3.2.1 The ICB has met 5 times since it was established in April 2018. To date it has focused on the priority areas set out in its terms of reference:

- A unified approach to Quality
- Communications, Engagement, and Equality
- A unified approach to Outcomes
- Integrated Commissioning Strategy
- Integrated Provision and Early Initiatives
- A unified approach to Intelligence

3.2.2 Lead officers have been identified for each area and project teams established. Regular monthly updates are provided to the ICB and work is progressing in all areas. A summary of the work being done in each area is included as Appendix A.

3.2.3 The work around the Integrated Commissioning Strategy is progressing well. Drafts of the document have been discussed with the Integrated Commissioning Board. The final draft version is attached as Appendix C. This is being presented to the ICB for endorsement immediately prior to this Health and Wellbeing Board. The strategy has been developed alongside the refresh of the Kirklees Health and Wellbeing Plan, an update on which is included on the agenda for this meeting. Once both documents have been approved they will be formatted to reinforce the close inter-relationship between them.

3.2.4 In addition the ICB continues the work required to oversee and drive the areas within the Better Care Fund.

3.3 Kirklees Integrated Provider Board (KIPB)

3.3.1 One of the ways in which we want to drive integration is through working with existing providers to encourage and support them to work together in more integrated ways to join up services and care around the needs of patients. The KIPB has been set up to help take this forward. The establishment and ongoing operation of the KIPB is being led by Sue Richards (Service Director for Integration) and the meeting is chaired by Karen Jackson (Chief Executive of Locala). It consists of senior representatives of both GP Federations, both acute trusts, SWPFT, Locala, Kirklees Neighbourhood Housing, and the voluntary sector including Kirkwood Hospice. In addition commissioners attend the meeting to help to ensure it is working in co-ordination with the ICB.

3.3.2 The KIPB began meeting in July 2018 and has had 3 meetings to date. In this sense it is still in its formative stages and is working up formal 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 30-50 thousand. A graphical representation of how this will look is included in Appendix B.
- An integrated Community Service Capacity Model for those services that are best delivered once across Kirklees.
- Integrated Intermediate Care and Reablement services.

3.3.3 In addition the KIPB will 'keep in view' a number of other ongoing areas of work to help support their development and implementation including Integrated End of Life Care.

3.3.4 The focus over the coming months will be on taking these areas forward and these are in line with priorities identified in the draft Integrated Commissioning Strategy.

3.4 Kirklees Health and Care Executive Group

3.4.1 This is a relatively new forum which met for the first time in June 2018 and meets on a monthly basis. It consists of the Chief Executives of Kirklees Council, SWYPFT, CHFT, MYHT, Locala, the CCGs Chief Officer and representatives of NHS England Yorkshire and Humber including the Director of Commissioning Operations.

3.4.2 The group is still in its formative stages and is working through terms of reference. However, one of its key aims is to establish a forum where leaders of organisations come together on a regular basis to talk about Kirklees as a place rather than focusing on different organisational footprints. This will also to help to continue to build working relationships with the Yorkshire and Harrogate Health and Care Partnership so that Kirklees is fully involved in this work.

3.5 Kirklees Health and Wellbeing Board (KH&WB)

3.5.1 We are currently refreshing and updating the Kirklees Health and Wellbeing Plan to ensure that it is relevant in the context of greater integration between the CCGs and Council,

the emphasis on integrated provision within Kirklees, and the progress made in establishing the West Yorkshire and Harrogate Health and Social Care Partnership.

3.5.2 This work is being overseen by the Kirklees Health and Wellbeing Board and an update was provided to the July 2018 meeting of the Board. The focus of the Kirklees Health and Wellbeing Plan will be on:

- Planning on the basis of population cohorts
- Focus on prevention and taking a life course approach
- Tackling the underlying causes of ill health and poor wellbeing
- Improving outcomes and experiences for those with ill health or other issues impacting their wellbeing
- Using our assets to best improve health and wellbeing in Kirklees.

3.5.3 More detail on this are included on the agenda for this meeting.

3.6 Other Work and Areas of Focus

3.6.1 The following paragraphs provide a brief summary of other ongoing work to support integration to help the Health and Wellbeing Board understand the range of work that is being undertaken.

3.6.2 **Primary Care Networks:** The establishment of Primary Care Networks is a key part of how we will integrate care and support around the needs of local populations and communities and the individuals within them. It will help to deliver the aims of both CCGs existing Primary Care Strategies. Both GP Federations have a role to play in establishing Primary Care Networks and we are working alongside them and partners in social care and community services to take this work forward. It is a key focus of the IPB and will feature heavily in both the Integrated Commissioning Strategy and Health and Wellbeing Plan. There is a growing consensus about what needs to be done and the key now is to ensure that we turn this into action across Kirklees.

3.6.3 **Organisational Development:** Many of the changes that we want to make will require new ways of working and new relationships to be formed. We are working with organisations in Kirklees, the West Yorkshire and Harrogate Health and Social Care Partnership, and the NHS Leadership Academy to develop a programme of organisational development to support this. We are hopeful that in the next few weeks we will have identified the resources to do this and can begin to turn this into a programme that will be delivered over the last half of 2018/19.

3.6.4 **Workforce:** Workforce challenges are one of the key issues facing health and social care and will continue to be so in the future. Working in integrated and collaborative ways can both help to address some of these issues whilst at the same time creating new challenges in how we recruit, train, and retain staff who can work in these ways. We are working with NHS England and the West Yorkshire and Harrogate Health and Social Care Partnership to establish a Kirklees steering group to focus on primary and community care workforce planning. This will include representatives from primary care, community care and social care and is planned to be established by September 2018. It will then feed into a West Yorkshire and Harrogate Primary and Community Care Workforce Steering Group.

3.6.5 **Population Health Management** is an approach that improves population health by data driven planning and delivery of care to achieve maximum impact. It includes segmentation, stratification and impact modelling to identify local 'at risk' cohorts – and, in turn, designing and targeting interventions to prevent ill-health and to improve care and support for people with ongoing health conditions and reducing unwarranted variations on outcomes.

Population health management is a key tool deployed in an Integrated Care System, which has most value when used to plan and deliver services within a place base. Our commitment to starting our planning process from population needs provides us with a solid base from which to use population health management tools.

Through our involvement in the West Yorkshire & Harrogate Health and Care Partnership, we are part of a Communities of Practice in this developing area, working with national bodies including NHS England and Public Health England (PHE). The first stage is to complete a self-assessment of our system maturity to deploy population health management during 2018/19.

3.6.6 **Other CCG and Council:** We are increasingly working in more integrated ways with the Council. These include:

- Helen Severns working as the Service Director – Integrated Commissioning across the CCGs and Council. This will help to ensure that the commissioning resources are more closely aligned and begin to work as a unified team.
- Monthly Joint CCG and Council Senior Management Team meetings. This helps to discuss operational matters and gain a greater understanding of the ongoing work of each organisation.
- Fortnightly meetings of the core team of staff working on integration which we are now extending to include others as the scope and depth of what we are doing increases.

4. Financial Implications

4.1 There are no financial implications arising directly from this paper.

5. Sign off

Richard Parry, Strategic Director for Adults and Health, Kirklees Council

6. Next Steps

6.1 Work will continue to progress the areas outlined in this report with further updates to be provided to the Board as and when requested.

7. Recommendations

7.1 The Board are asked to:

- note the contents of this report
- support the ongoing work outlined in the report
- approve the Kirklees Integrated Commissioning Strategy, subject to endorsement from the Integrated Commissioning Board
- request further updates on progress.

8. Contact Officers

Steve Brennan, SRO Integration and Working Together, 01924 504913

Sue Richards, Service Director Integration, 01484 221000

Appendix A Summary of Integrated Commissioning Board Key Project Areas

Project Name: **Unified Approach to Quality across Kirklees to Support Integration**	
Accountable Person: **Penny Woodhead**	Project Team: Saf Bhuta, Emma Bownas Stakeholders Consult: Rachel Spencer-Henshall Stakeholders Inform: TBC
Aim:	Reviewing arrangements for quality across Kirklees and agreeing an unified approach to support Integration. This includes processes and procedures for how we define, measure and improve quality as well as governance arrangements to support integrated commissioning and provision.
Rationale:	Although there are many similarities in how the CCGs and the Council approach the management of quality there are also some differences. The Kirklees HWB received a paper in 2017 which set this out and agreed to support a more integrated approach in development. Having consistent processes and procedures will make it easier for staff working across health and social care to work together. Having a single governance arrangement to support the Integrated Commissioning Board will re-inforce this and help the Board in its work. The work will draw on 2 national documents published in 2017: Adult Social Care – Quality Matters, and Shared Commitment to Quality – NHS National Quality Board. A Summary of the key aspects of these documents is attached.
Timescales:	Work will begin in April 2018 and is planned to be completed by July 2018.
How Progress Will be monitored:	Monthly Updates to the Integrated Commissioning Board.

Project Name: **Unified Approach to Outcomes across Kirklees to Support Integration**

Accountable Person:	**Emily Parry-Harries**
Project Team:	Saf Bhuta, Emma Bowness, Phil Longworth, Helen Bewsher, Carl Mackie, Jill Greenfield, Rebecca Spavin
Stakeholders Inform:	
Stakeholders Consult:	

Aim:	To agree a pan Kirklees set of outcomes that describe our broad vision and values for the health and wellbeing of the people of Kirklees . A set of indicators will also be developed and agreed to give assurance across the system that we are making progress towards the outcomes. We will work towards an agreement that KPIS written into contracts reflect the Kirklees outcomes. This will in turn inform commissioning decisions by focussing us on what we want to achieve across the system.
Rationale:	Developing a shared set of outcomes across Kirklees means that all agencies will be working together towards shared goals, with shared values and an agreed direction of travel. Focussing on outcomes will enable us to use data to plan rather that look retrospectively at services that have been delivered The joint outcomes, indicators and KPI framework can be shared regularly to provide a top level view of progress towards outcomes and support earlier 'diagnosis' of pressure points in the system The outcome framework will support a shift towards prevention and support performance management based on outcomes rather than outputs
Timescales:	Work will begin in April 2018 and a first draft on the Kirklees Outcomes Framework will be planned to be completed by May 2018 for presentation at the Integrated Commissioning Board in June 2018. Three task and finish group meetings are planned for March, April and May 2018.
How Progress Will be monitored:	Monthly Updates to the Integrated Commissioning Board.

Project Name: **Integrated Commissioning Strategy**

Accountable Person: **Helen Severns**

Project Team: Phil Longworth, Rachel Millson, Helen Pearson

Stakeholders Engage: Health and Wellbeing Board, Governing Body, Wider Integration and Commissioning Teams, Transformation Teams

Stakeholders Inform: TBC

Aim:

To develop a clear narrative which outlines our vision for how we will work together (formally and informally) across organisational boundaries, both NHS and Local Authority, to commission integrated services which improve outcomes. Our intention is to look wider than health and social care and outline how we will work together to commission services which take into account wider determinants, for example, housing.
This narrative will articulate our plans and associated timescales for delivering this vision.

Rationale:

There is a long and strong history of joint working across the two CCGs in Kirklees and Kirklees Council. Between these organisations and others in the region and we have already demonstrated our commitment to commissioning on an integrated basis through care closer to home, transforming care, Better Care Fund, continuing care and early intervention and prevention programmes. Our intention to build on this work was articulated in the Kirklees Health and Wellbeing Plan in 2017 which is our local vehicle to deliver the ambitions within the West Yorkshire and Harrogate Health and Care Partnership. The following work streams have been identified as initial areas of new and continued integrated working; frailty, care homes, intermediate care and reablement, continuing care, end of life care, equipment and adaptations, mental health and learning disabilities, carers, Children's and YP Commissioning incl healthy child/CAMHS and development of a wellness model. It will also cover the development of new integrated models of care building on the identified key elements of integrated care with an emphasis on place based approaches.
As of April 2018, governance arrangements and commissioning functions within the CCGs are integrated and joint ways of working agreed , with the establishment of the Integrated Commissioning Board . To support delivery of the work streams identified above, we will build on this work and develop integrated commissioning teams with a single commissioning approach across the CCGs and Council. This will also be supported by the project areas looking at Quality, Outcomes, Intelligence, Comms/Engagement/Equality.

Timescales:

Strategy agreed Sept 18
Implementation plan in place Oct 18
Quarterly update reporting from Nov 18

How Progress Will be monitored:

Monthly Updates to the Integrated Commissioning Board. Where necessary reports on specific issues from the areas in scope will be presented to the Board for discussion/approval.

Project Name: **Unified Approach to Intelligence across Kirklees to Support Integration**

Accountable Person:	**Mike Henry**
Project Team:	Fiona Henderson
Stakeholders Consult:	Emily Parry-Harries (link to Outcomes Work) Natalie Ackroyd (link to CCG Performance) Steph Potts (CCG Data Quality Manager
Stakeholders Inform:	TBC
Aim:	To agree a unified approach to Intelligence across Kirklees to support closer integration of commissioning and provision. To include clarifying what Intelligence means, approaches to joint working, Information Governance, greater cohesion and use of existing intelligence, potential to identify further intelligence sources, consideration of common/compatible systems, platforms and processes where helpful.
Rationale:	To build on ongoing work in the Council and CCGs and further develop a unified approach to facilitate greater sharing and use of intelligence to support integration. To include consideration of how to support the emerging approaches to place based community focused ways of integrating and delivering services. Initial areas of focus are: agreeing a definition for Intelligence and scope of existing intelligence resources (eg BI, consultation, service/contract performance, research, etc), opportunities for part time co-location of CCG and Council staff to support joint working, Information Governance to support intelligence sharing, opportunities to share/link platforms, opportunities for joint working with external partners (incl University, provider organisations, others), develop links with other integration work streams and pro-active approach to be able to influence and respond to emerging intelligence needs (eg place based, supporting delivery v monitoring performance)
Timescales:	Apr/May/June progression of existing Council/CCG work mindful of integration considerations including potential to share/link platforms and opportunities for joint working with external partners June/July/Aug agree definition of intelligence and scope of existing intelligence resources May/June/July part time co-location of CCG and council staff May/June/July /Aug develop links with other integration work streams and support/influence emerging intelligence needs including describing how intelligence will support integration
How Progress Will be monitored:	Monthly Updates to the Integrated Commissioning Board.

Project Name: **Integrated Provision and Early Initiatives**

Accountable Person:	**Sue Richards**
Project Team:	To be identified leads from organisations
Stakeholders Consult:	Chief executives, Third sector leaders, GP federations
Stakeholders Inform:	TBC

Aim:	**Organising the provider and wider system in a more organised / integrated system that delivers better outcomes for people. More detail is set out in the Summary Narrative Document**
Rationale:	Integrated commissioning is supported by delivery that is joined up and acts as a system rather than a set of individual components. This also ensures the most the most efficient use of resources that sit within the system. Integrated provision is more than the integration of service delivery. If we are to properly invest in early intervention and prevention it is important to build community capacity that supports better outcomes for people. It therefore makes sense that integration is across the whole system and includes wider aspects such as housing and voluntary and community services. This makes integrated provision very complex and consequently difficult to manage. There is general support across the system for the premise of a range of strands to integrating provision. This includes the broader range of stakeholders and support from the project team to drive forward.
Timescales:	**Work will begin in April 2018 and will continue for at least 3 years. There will need to be clearly defined milestones along this timeline.** **Early initiatives to be managed during 2018/19 with timescales dependent on the nature of each initiative.**
How Progress Will be monitored:	**Monthly Updates to the Integrated Commissioning Board.**

Project Name: **Communications, Engagement, Equality**

Accountable Person:	**Siobhan Jones, Penny Woodhead**
Project Team:	Siobhan Jones, Penny Woodhead, Rachel Spencer-Henshall
Stakeholders Consult:	TBC
Stakeholders Inform:	TBC

Aim: Explore opportunities for more collaborative/joint-working across Kirklees and in support of the Integrated Commissioning Board. This includes processes and procedures and opportunities to 'do things once' across the patch.

Rationale:

As key support functions for commissioning, there will be a need to come together in a co-ordinated way to ensure that the Integrated Commissioning Board and other integrated functions receive the appropriate advice, guidance and practical support it needs in line with LA and CCG statutory duties.

There may be opportunities to develop Kirklees-wide communications campaigns to support priority areas of work.

There may be opportunities to learn from different approaches and to share resources/assets in relation to engagement and equality.

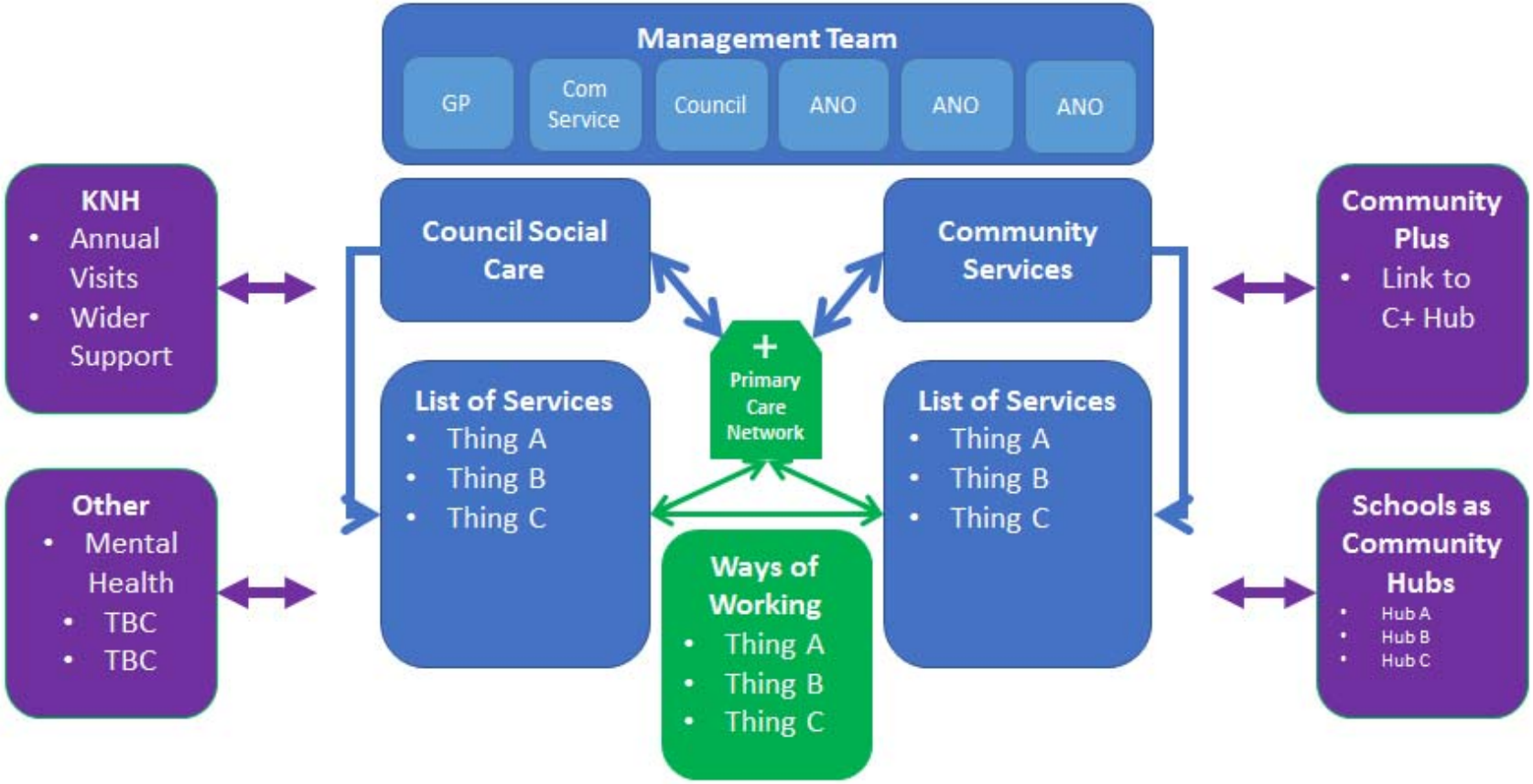
Timescales:

Exploratory discussions to take place in May 2018 . By October 2018 aim to have identified the scope of this work , project teams and timescales.

It is anticipated that there will be project teams identified for each of the three areas

How Progress Will be monitored: Update Board in October 2018

Appendix B Community Based Support and Delivery System



Appendix C Integrated Commissioning Strategy



Kirklees Integrated Commissioning Strategy

working together

NHS Greater Huddersfield Clinical Commissioning Group

NHS North Kirklees Clinical Commissioning Group

Kirklees COUNCIL

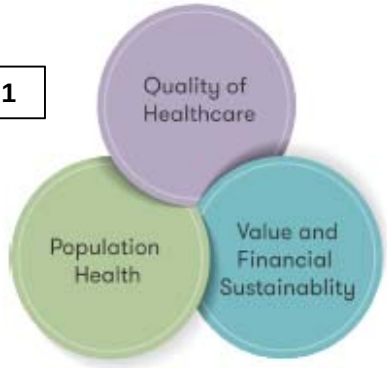
Version	**5.8**
Status	**Final Draft**
Author	**Rachel Millson, Senior Strategic Planning and Development Manager, NKCCG and GHCCG**

Background and Context

There is a long standing commitment in Kirklees to work collaboratively across the CCGs and Local Authority. This has taken the format of formal joint posts across health and social care, integrated governance to support development and delivery of the Better Care Fund and informal collaborative working to commission services in a number of areas, for example, children and young people (inclusive of education and learning), mental health, care closer to home and hospital avoidance. Building upon this work and expanding the integrated commissioning arrangements across health and care is a key enabler identified within the Kirklees Health and Wellbeing Plan.

The NHS and Local Authorities are operating in an increasingly challenging environment, striving to maintain the availability of high quality services which respond to increased demand from a growing, ageing population within the restraint of less resource. This is something we and a number of other organisations are experiencing locally. NHS England set out its expectations for addressing these challenges in the 'Triple Aim' and tasked organisations with ensuring services are high quality and financially sustainable in the future, (see figure 1). Integration of commissioning functions in conjunction with integrated provision focussing on populations of 30,000 to 50,000 people will support us in addressing the objectives described in the NHS Triple Aim.

Figure 1



This document describes how we will bring together commissioning partners to focus on people who live in Kirklees (adults and children) and how through working collectively, we deliver the objectives set in the Kirklees Health and Wellbeing Plan to improve the health and wellbeing of the whole population. The detail of how this strategy will be delivered is within its underpinning Delivery Plan.

The Kirklees Integrated Commissioning Strategy is interdependent with a number of other priorities identified as part of the Case for Change for Integration. These are:

- Joint approach to quality;
- Shared outcomes framework;
- Digital and shared business intelligence;
- Joint approach to communications, engagement and equality;
- Integrated provision.

Please note: This strategy will require review once the Green Paper for Social Care and NHS Plan are published.

Vision

To move towards population based commissioning across the health and social care system, built around the needs of local people and delivered by a collaboration of organisations covering populations of 30,000 to 50,000 people.

Our vision for the future is underpinned by a number of principles for change. Services which are commissioned in a more integrated way in the future will be built upon these principles.

Individuals and their carers will feel:

1. Supported to start well, live well and age well;
2. Enabled to draw upon their own personal resources, and those of their community;
3. Supported and in control of their health and wellbeing enjoying independence for longer through a strong focus on prevention and early intervention;
4. Enabled and empowered to access care in the most appropriate place with a focus on integrated and holistic care pathways;
5. The care they access is proactive, co-ordinated and seamless;
6. Supported to navigate the system effectively.

Services and solutions will:

1. Be created in a way which is open and transparent, ensuring we have meaningful conversations with people on the right issues, at the right time;
2. Maximise the assets within communities;
3. Be delivered through integrated models of care provided by a collaboration of organisations across general practice, primary, secondary and social care and education;
4. Promote a longer term vision of integrated personalised care, population based budgets and reducing health inequalities;
5. Break down silos in service delivery so the focus is on person centred care;
6. Remove barriers between organisations and consider the impact of change on the wider system;
7. Eradicate duplication of systems, processes and work;
8. Deliver high quality care which is sustainable, cost effective and within available budgets;
9. Use digital technology across organisations to improve outcomes for people and work more effectively;
10. Be delivered by a workforce that is trained to respond to health and social care needs and support a 24/7 service, where required;
11. Be commissioned by a range of agencies within the framework of this strategy;
12. Be delivered as close to our population as possible, recognising that some services may need to be accessed outside of our local communities. The needs of our population in Kirklees will always be our starting point for considering any changes to this.

Aligned with the Kirklees Health and Wellbeing Plan in supporting us to improve the health and wellbeing of the whole population.

Priorities for Change

To realise the vision for integrated commissioning we have identified a number of interventions which have been grouped together and themed into priorities for change. Further detail on how these priorities will be delivered is available within the Delivery Plan.

New Models of Care

Vehicles to deliver the vision include a number of existing and emerging care models. Development of primary care networks will be instrumental as the foundation to the success of this strategy.

The identified new models of care which will underpin delivery of this strategy are:

- GP Practice, Primary Care Networks;
- Schools as Community Hubs;
- Adult Wellness Model;
- Frailty;
- Intermediate Care and Re-ablement Services.

Build on what is working well

There are a number of existing programmes which already have collaborative working arrangements in place. It is our ambition that these will become fully integrated and supported by pooled budget arrangements.

These are:

- Thriving Kirklees;
- Integration of SEND Provision including personalisation;
- Carers Services;
- Adult Mental Health and Learning Disability Services;
- Joint commissioning of Continuing Care;
- Alignment of the elements that comprise the Aids to Daily Living Service;
- Implementation of the Care Homes Strategy and improving Quality In Care Homes;
- Joint commissioning of End of Life Services.

Changing how we work as commissioners

- Aligned Teams across the CCGs and Council which commission services within a single budget where appropriate.
- Move away from the traditional change management techniques to adopt an outcomes based approach to commissioning services which is supported by population health management.
- Transition will be supported by robust organisational development.
- Giving permission to 'get on and do' by trialling new ways of working and learning from this rather than ensuring all the infrastructure is in place at the start.

Supporting Providers to work differently

To deliver the vision we require providers to come together and work collaboratively rather than in competition. We recognise this is not how providers are used to working and will therefore provide support in the form of organisational development.

There are existing pockets of provider collaboration through identified provider initiatives.

Development of a Provider Board and development plan.

Priorities for Change

To realise the vision for integrated commissioning we have identified a number of interventions which have been grouped together and themed into priorities for change. Further detail on how these priorities will be delivered is available within the Delivery Plan.

Changing relationships between commissioners and providers

Whilst we retain our formal responsibilities as commissioners we will move towards more partnership working and joint planning in how we develop models of care, specify delivery and set/monitor performance indicators for the services we commission. Our aim is that this will ensure that providers have the flexibility to innovate and collaborate to respond to population needs across Kirklees. We recognise that this will present some challenges to existing contracting arrangements and we will work to ensure that we manage and mitigate the risks of this.

Development of Infrastructure to Support Integrated Commissioning

- Establishment of a committee structure with clear reporting lines and delegation to make decisions on behalf of the system.
- Development of tools and frameworks.
- Enabling co-location through flexible working and IT.
- Processes in place to ensure links are made to other areas of the CCGs and Council which are not in scope of this strategy. Key interdependencies include housing and economic development.

Quality, Equality and Engagement

- Development of a shared set of outcomes and underpinning measures across the integration agenda.
- Development of a joint approach to communications, engagement and equality.
- Development of a joint approach to quality.

This work is being delivered by separate work streams but is interdependent to this strategy, for further detail please see (**link to be added**).

Enablers

- Digital and business intelligence
- Single approach to estates and assets
- Single approach to workforce strategy and development
- Population health management
- Market development

This work is being delivered by separate work streams but is interdependent to this strategy, for further detail please see (**link to be added**).

New Models of Care 

For people in Kirklees, we want a joined up system of health and social care which is supported by community, voluntary sector and wider provision, that allows people to maximise their independence from formal services and to reach their goals and aspirations, whilst getting the right support when needed. This requires a reshaping of the way services are provided.

Community, primary and social care and general practice needs to be integrated in a way that achieves improved outcomes within existing budgets. Work has already begun in some areas and we need to build on this in the future.

The key components of integrated new models of care;

Recognise that services and support in Kirklees operate on different footprints. The scope of these services is clear and interdependencies identified.	Recognise communities are different with a wide variety of assets and needs.	Different solutions will need to be found for different local areas.	Bring together different support and services in ways that relate to communities.	Delivered by collaborations of organisations to populations of 30,000-50,000 as a minimum.
Build new ways of working incorporating the other key things that need to be in place.	Improve outcomes and reduce variations in these, includes services, support, lifestyle, and the conditions in which people are born, live and work.	Population segmented by risk and supported by personalised care and support planning.	Maximise digital opportunities ensuring clinicians have access to provide appropriate care and that technology is available to support people.	Public involvement is key in all elements of care delivery. This includes decision making and governance.

Community based support and delivery system

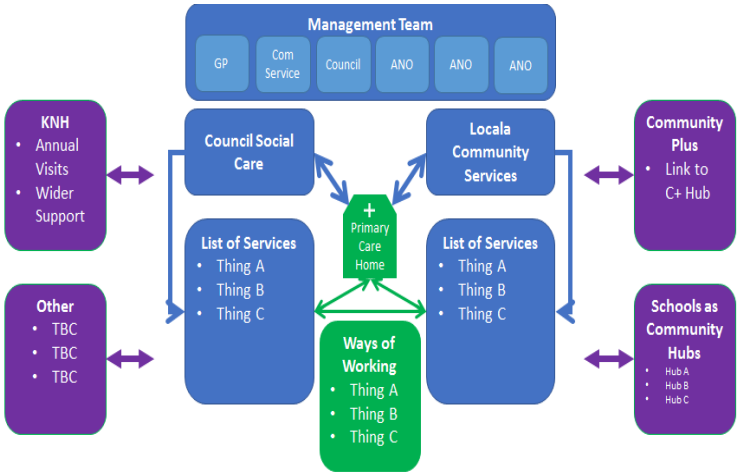
Delivery of place based systems of care is one of the five priorities within the Kirklees Health and Wellbeing Plan. These will bring together different support and services in ways that relate to communities. We expect these to cover populations of 30,000-50,000 and to be based around groups of GP practices working together with other providers and services.

Our initial vision is that we will integrate GP practices, primary care, social care, and community services. This will provide us with the core of a community-based support and delivery model that can then be used as the focus around which we can integrate other existing place-based approaches around building community capacity. These include Community Plus, Local Area Co-ordinators, and Schools as Community Hubs. They will also allow us to develop new ways of working that build on these existing approaches.

In addition, these structures will provide a way in which other wider services such as the voluntary sector, housing, police, and fire can begin to interact and support the delivery of support and services to local communities.

It is expected that there will be nine of these in Kirklees covering the whole population.

We will work with our staff and communities to identify which elements of social care and community services are relevant to this approach and begin to establish new ways of working so that these will be increasingly delivered in an integrated way. It is anticipated that the list will have some services that are common across each of the community delivery systems but that it allows for local flexibility in so that each area can include things which are of particular importance to their population.



The importance of building new working relationships is key to making this a success. We recognise that we will need to invest time and effort in helping to support the development of these new working relationships. This work has commenced and will be an ongoing requirement during development and implementation.

The purple boxes show how we think other important services and approaches will be linked into this model. For example, the existing Community Plus and Schools as Community Hubs will be able to link with the newly established model and over time begin to build mutually supportive ways of working. In addition, it provides a way in which wider determinants of health, such as housing, can be part of this new way of working.

Each of the new community-based support and delivery systems will need to be supported with managerial capacity to help with implementation and ongoing running.

Scope

The Kirklees Integrated Commissioning Strategy applies to health, social care, public health and some of the children's services which are commissioned within the Kirklees footprint. Our initial focus is on commissioned services which have been identified as within our immediate ability to influence. Whilst there is a recognition that individual peoples' outcomes are impacted by wider determinants, for example, the Kirklees economy, we will not be including these within scope at this stage. Strong links between this strategy and others will be maintained however.

Pooling budgets can support our ambition for integrated commissioning, but is not a requirement. We will be explicit when we have agreed that working towards pooling of specific budgets is required to achieve our ambitions.

The table below outlines the scope of services and budgets included within this strategy and the potential for future services to be included in the future. The scope will be reviewed as the wider integration agenda develops.

1. Services currently commissioned on an integrated basis or we expect to be by the end of 2019
(italics = some elements in existing Section 75 Agreements)

Healthy Child inc CAMHS
Carers support – children and adults
Intermediate Care & Reablement
Equipment, adaptations and assistive technology
Hospices & End of Life Care
Continuing Healthcare Packages & Team (Children's, Adults, FNC, Personal Health Budgets)
Community health service contracts
Some elements of learning disability and mental health non-Inpatient services
Some elements of Mental health voluntary sector contracts
Community Plus (including Wellness)
Primary care locally commissioned services
Substance Misuse
Sexual Health Services
Infection Control
Children's Services including: Occupational Therapy , Speech and Language Therapy, Physiotherapy, LAC Designated Nursing and CAMHS
Kirklees Youth Offending Team
Some element of SEND provision; Thriving Kirklees , Children's Therapies

2. Services that we intend to be commissioned on an integrated basis or we expect to be over the next 18 months to 3 years. This will require work on alignment over the next 18 months.

Locality based commissioning for populations of 30k – 50k
Adults Social Care (ASC)
- Advice and Information
- Early Intervention and Prevention
- Social Work, Assessment and Safeguarding
- Domiciliary Care, Day Care
- Residential and Nursing Care, Supported Accommodation, Extra Care
- Hospital Avoidance and Discharge

Adults Safeguarding
Prescribing & Medicines Management
SEND provision across health, education and social care
Safeguarding Children & Young People Services including Children Social Work and Looked After Children

3. Budgets that are managed across a different footprint and require an awareness and alignment

Innovation funding
Ambulance Services
NHS 111
Learning Disabilities & Mental Health Inpatient services
Primary Care IT (GMSS)
Acute NHS contracts
Acute independent sector contracts, CATs, NCAs & AQPs
Community non contracted activity
Some elements of Mental Health contracts

4. All other local revenue budgeted resource (that has a major impact on health and well being) that do not fall within the other the other 3 areas but requires an awareness and alignment

Core GP Delegated Contracts
Earmarked Reserves and QIPP
Dedicated Schools Grant Schools Block
Dedicated Schools Grant, Early Years and High Needs
Kirklees Active Leisure grant
Housing Strategy & Management

Measuring Success – Benefits and Outcomes

Starting with outcomes enables us to step back from the things we are already doing or commissioning and explore what needs to be done, by whom and with whom to achieve improved outcomes for the citizens and places of Kirklees and the people who use our services. If we achieve the outcomes in Kirklees we will know that people are starting well, living well, and ageing well.

Improving population health and wellbeing through monitoring the delivery of these outcomes will be our focus. Alongside this, all the initiatives and changes within the Integrated Commissioning Strategy to improve population health and wellbeing will monitored to ensure they are having the impact that is required.

There are 7 Kirklees outcomes:

The Kirklees Integrated Commissioning Strategy specifically supports us in improving these outcomes

An outcomes framework is in development which builds from the seven Kirklees Outcomes:

- Population indicators
- Supplementary indicators
- Local performance measures / individual outcomes

This has been developed by the Integrated Commissioning Board and will form the basis of how we will measure improvements in health and wellbeing in Kirklees. This will be a tool that commissioners, providers and the Health and Wellbeing Board can use to monitor our progress and will be completed by Autumn 2018.

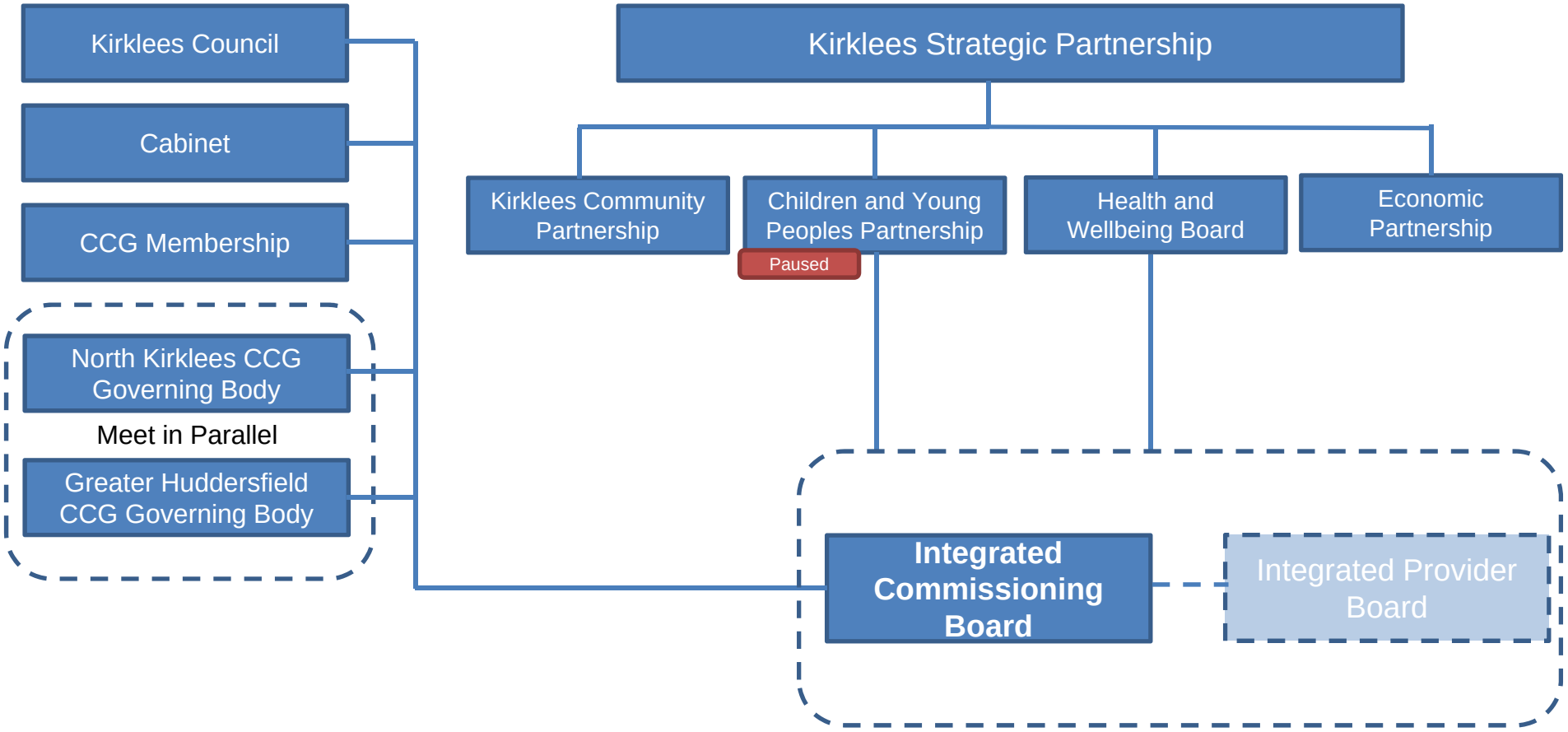
Governance

Partnership approach to delivering our shared outcomes

Kirklees Strategic Partnership

Kirklees Communities Partnership	Children and Young People's Partnership	Health and Wellbeing Board	Economic Partnership
People in Kirklees live in cohesive communities, feel safe and are safe/protected from harm People in Kirklees experience a high quality, clean, sustainable and green environment	Children have the best start in life People in Kirklees have aspiration and achieve their ambition through education, training, employment and lifelong learning	People in Kirklees are as well as possible for as long as possible People in Kirklees live independently and have control over their lives	People in Kirklees have aspiration and achieve their ambition through education, training, employment and lifelong learning Kirklees has sustainable economic growth and provides good employment for and with communities and businesses

Governance



Integrated governance arrangements continue to evolve, and are likely to change throughout the life of the Strategy. As such, this diagram presents a snapshot at the point of approval. The latest governance structures are available upon request.

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KIRKLEES HEALTH & WELLBEING BOARD	
MEETING DATE:	**6 September 2018**
TITLE OF PAPER:	West Yorkshire and Harrogate Health and Care Partnership Memorandum of Understanding

1. Purpose of paper

1.1 To seek the Health and Wellbeing Board's views and endorsement for partners in the Kirklees health and care system to sign the Memorandum of Understanding (MoU) for the West Yorkshire and Harrogate (WYH) Health and Care Partnership (HCP).

1.2 For the Kirklees Health and Wellbeing Board to commit to continue working with the WYH HCP.

2 Background

2.1 Kirklees has been part of the WYH HCP since its inception as a Sustainability and Transformation Plan in March 2016.

2.2 In May 2018, WYH HCP was one of four areas to be invited to part of the Integrated Care System (ICS) development programme. Being a Shadow ICS is about helping the partnership to develop the sophistication of process and relationships that means, in future, the partnership itself will be able to take on some powers and budgets from national bodies. This would mean that decisions about investment in health and care can be taken more locally by those with a closer relationship to the impact of the funds and decisions.

2.3 In practice, at this stage, this does not change the status of the partnership itself, or remove or revoke any responsibilities or sovereignty from the organisations that make up the Partnership. It does, however, provide the opportunity to develop a clear statement of intent from all partners about how we will work together to develop that greater level of sophistication for more effective local decision making.

2.4 All partners are clear that the next phase of partnership working is about the right systematic leadership for integration across health and care from across all the 30+ organisations that make up the Partnership as well as how the Partnership works with the hundreds of other organisation that have an impact on health and care, including third sector organisations, pharmacies, care homes, hospices and domiciliary care providers.

2.5 It includes continuing to negotiate for the kind of WYH HCP and partnership outcomes that we have agreed are important: investment in prevention, primary care and mental health, community-wellbeing, better join up between 'health' and 'care' and democratic accountability and transparency about where we direct our collective resources.

2.6 The Joint Kirklees Health and Wellbeing Strategy 2014-2020 continues to guide our efforts to improve the health and care system – it sets the ambition for Kirklees to be a district combining great quality of life and a strong and sustainable economy where there is high prosperity and low inequality and people enjoy better health throughout

their lives. These principles guide Kirklees involvement in the WYH Partnership and engagement with central government and NHS England.

2.7 The emerging Kirklees Health and Wellbeing Plan is our Kirklees 'place based plan' and sets in more detail our plans to implement the priorities set out in the Joint Health and Wellbeing Strategy.

3 Proposal

3.1 In October 2017 the West Yorkshire and Harrogate Partnership (WYH) Senior Leadership Executive Group (SLE) agreed that a Memorandum of Understanding (MoU) should be developed to formalise working arrangements and support for the next stage of the Partnership's development.

3.2 The MoU is a formal agreement between WYH health and care partners.

3.3 It also provides the basis for partners to collectively negotiate a refreshed relationship between local NHS organisations and national oversight bodies.

3.4 It does not introduce a new hierarchical model but aims to instil the principle of mutual accountability to underpin the collective ownership of the outcomes partners have agreed are essential.

3.5 It is not a legal contract, but is a formal agreement between all of the partners. It is based on an ethos that the Partnership is a servant of the people in West Yorkshire and Harrogate and of its member organisations.

3.6 It specifically does not replace or override the legal and regulatory frameworks that apply to statutory NHS organisations and Councils. Instead, it is designed to sit alongside and complement these frameworks, creating the foundations for closer and more formal collaboration.

3.7 The MoU is intended to be read in conjunction with the West Yorkshire and Harrogate Sustainability and Transformation Plan, published in November 2016, the West Yorkshire and Harrogate Next Steps document published in February 2018 and the emerging refreshed Kirklees Health and Wellbeing Plan. Together these documents set out the details of our commitment to work together in partnership to realise our shared ambitions to improve the health of the 2.6 million people who live in our area, and to improve the quality of their health and care services.

3.8 The MoU has been drafted by a working group of colleagues from across Local Government and the NHS.

3.9 The text of the MoU covers the context for the partnership, how partners are expected to work together across WYH, including principles, values and behaviours, mutual accountability and governance arrangements, including how the Partnership moves towards a new approach to assurance, regulation and accountability with the NHS national bodies.

3.10 Development of the MoU has aimed to provide a platform for:

3.10.1	a refresh of the governance arrangements including the relationship and interplay between the six Places and statutory bodies
3.10.2	exploring what mutual accountability means in the context of collective ownership for delivery, rather than a top-down approach
3.10.3	developing a new approach to commissioning, and maturing provider networks that collaborate to deliver services in place and at WYH level
3.10.4	improving clinical and managerial leadership of change in major transformation programmes
3.10.5	developing more transparent and inclusive approaches to citizen engagement in development, delivery and assurance
3.10.6	improving political ownership of, and engagement in the agenda, including regular opportunities for challenge and scrutiny
3.10.7	developing a new assurance and accountability relationship with the NHS regulatory and oversight bodies that provides new flexibilities for WYH to assert greater control over system performance and delivery and the use of transformation and capital funds
3.10.8	agreeing an effective system of risk management and reward for the NHS bodies in the system
3.11	The Memorandum:
3.12	The text of the MoU sets out details of:
3.12.9	The context for the Partnership
3.12.10	The partner organisations
3.12.11	How partners will work together in WYH, including our principles, values and behaviours
3.12.12	The objectives of the Partnership, and how our joint priority programmes and enabling workstreams will improve service delivery and outcomes across WYH
3.12.13	The mutual accountability and governance arrangements, including how we will move towards a new approach to assurance, regulation and accountability with the NHS national bodies
3.12.14	Our joint financial framework
3.12.15	The support that will be provided to the Partnership by the national and regional teams of NHS England and NHS Improvement
3.12.16	Which aspects of the agreement apply to particular types of organisation
3.13	In order for all signatory partners to have had a full opportunity to comment on the draft text – the final version of the Draft Memorandum of Understanding will not be publicly circulated until after the 31st August.

3.14 We will re-publish this paper with the Memorandum of Understanding included as an appendix as soon as possible and paper copies will be available at the Health and Wellbeing Board meeting.

3.15 Signatories:

3.16 All partners are being asked to take the process for sign-up through their own governance structures, including making any final decision at a meeting that takes place in public.

3.17 The process for all partners to go through their governance structures is anticipated to take place during September and October 2018.

4 Financial Implications

4.1 At this stage there resources and value for money implications for the Health and Wellbeing Board specifically relating to the MoU – as this responsibility is held with each of the organisational signatories.

4.2 As a key Kirklees multi-agency forum, with a democratic mandate from local communities through elected members, the Health and Wellbeing Board will remain fully engaged on any future funding arrangements and resource allocations decided through the WYH HCP to ensure that this represents value for public money and that the interests of the Kirklees population are fairly met.

5 Sign off

Richard Parry, Strategic Director for Adults and Health, Kirklees Council

6 Next Steps

6.1 All partners in the WYH Partnership are currently undertaking formal discussions about signing the Memorandum of Understanding and taking it through the relevant governance arrangements.

• Recommendations

The Health and Wellbeing Board is asked to:

- Note the Memorandum of Understanding that will be available after 1st September 2018.
- Recommend to Kirklees Health and Wellbeing Board members whether or not to sign up to the spirit and letter contained in the Memorandum of Understanding.

8. Contact Officer

Rachael Loftus, Head of Regional Health Partnerships, rachael.loftus@leeds.gov.uk , 07891 271054

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KIRKLEES HEALTH & WELLBEING BOARD

MEETING DATE: 6 September 2018

TITLE OF PAPER: Director of Public Health Report 2018 (Ageing Well in Kirklees)

1. Purpose of paper

This paper highlights to the board the newly published Director of Public Health (DPH) Annual Report 2018 on Ageing Well.

Directors of Public Health have a statutory requirement to write an annual report on the health of their population. The focus of the report is up to the DPH and its aim is to inform local people about the health of their community as well as inform decision makers on health gaps and priorities that need to be addressed.

The paper outlines the purpose and content of the DPH report which the board can use to support intelligence-led commissioning for healthy ageing in Kirklees.

2. Background

The focus of the latest DPH report is ageing well in Kirklees. The aim of the report is to describe effective ways to help us age as healthily as possible by highlighting some of the issues we experience as we age that can impact on our health and wellbeing and the kinds of things we can do to tackle these more effectively. It focuses on the range of local assets that make a huge contribution to families and communities by supporting people to improve their outcomes.

The report is presented in a visually engaging infographic format and is underpinned by an outcomes-based, asset-based and life course approach. It highlights inequalities whilst also celebrating and promoting inclusion and diversity and includes useful information about the local population focussing on people aged 50 and over. The report is sub-divided into four key sections: healthy people (health issues and behaviours); care and support (changing need and carers); good communities (housing, accessible places and social inclusion); and working longer (employment and volunteering). Each section provides an illustrative example of how an issue impacts across the life course; a 'Kirklees snapshot' using the latest local data and intelligence; information on local assets; and a series of 'next steps' for improving local understanding and taking action.

The report's foreword from the DPH and the sections on 'changing need' and 'accessible places' are included as Appendix 1 for illustrative purposes.

3. Proposal

The board is asked to endorse the findings and recommendations in the DPH Annual Report to support partnership working for healthy ageing across Kirklees.

4. Financial Implications

None

5. Sign off

Rachel Spencer-Henshall

6. Next Steps

The DPH report has recently been published on the Kirklees website and a link to the report will be embedded in the Kirklees Joint Strategic Assessment (KJSA) which provides a comprehensive picture of the health and wellbeing of the Kirklees population.

7. Recommendations

- Acknowledge the links between ageing well and the achievement of JHWS and Kirklees outcomes.
- Ensure that the intelligence and insights from the report are used to support a system-wide, evidence and asset-based approach to healthy ageing.
- Given the changing demographic profile of Kirklees, this report provides a timely contribution to local intelligence and evidence. The board is asked to endorse a more positive and affirming view of ageing rather than the 'burden' of old age that is often presented.

8. Contact Officer

Rachel Spencer-Henshall, Strategic Director Corporate Strategy and Public Health, rachel.spencer-henshall@kirklees.gov.uk

Helen Bewsher, Senior Manager Public Health Intelligence, helen.bewsher@kirklees.gov.uk

Ageing Well in Kirklees

Director of Public Health
Annual Report 2017/18

Kirklees COUNCIL

Foreword

The aim of this report is to describe effective ways to help us age as healthily as possible by highlighting some of the issues we experience as we age that can impact on our health and wellbeing and the kind of things we can do to tackle these more effectively.

It focusses on the range of local assets that make a huge contribution to families and communities by supporting people to improve their outcomes, their wellbeing and their health.

MENTAL WELLBEING

Although it's positive to see that a high number of Kirklees' older population feels socially included, 1 in 4 experience feelings of loneliness and isolation at least some of the time.

The impact of **intergenerational** work in residential settings in reducing feelings of loneliness amongst older people needs to be determined, to inform longer term planning decisions.

It is important to understand **which groups** are more likely to experience loneliness and isolation at different life stages or following different life events and how local assets can help to prevent this or reduce the impacts.

Spotting **early signs** and responding to distress is vital in preventing depression. Mental health first aid is an evidence-based way of helping people do this, so supporting the provision of training must be a priority.

INTELLIGENCE-LED COMMISSIONING

Older people are the largest users of health services, representing two thirds of NHS users. Four out of 10 adult admissions to hospital last year were people aged 65+.

Whilst many of these admissions and stays are entirely appropriate, better use of **data** and **intelligence** can help ensure people stay out of hospital when being admitted will not improve their outcome.

Longer GP appointments can help reduce avoidable hospital admissions of older people cost-effectively.

Designing social care provision in **equal partnership** with the people that use them (and their carers) will inform the design and delivery of more effective services.

WORKING WITH PEOPLE (NOT 'DOING TO' OR 'DOING FOR' PEOPLE)

People working together in their communities to solve their problems and make the most of opportunities is at the heart of the way in which health and wellbeing outcomes are improved.

People with long-term conditions that feel able to **manage** their condition generally do better, are more independent and use expensive acute services less.

Barriers, such as organisational bureaucracy and professional hierarchy, that prevent people from working together need to be **removed** so that communities and organisations can develop solutions together, engage people and build relationships based on trust to create long-term, positive change.

Person-centred services and interventions need to be supported and commissioned, enabling people to increase their confidence, achieve self-defined goals and maintain health improving behaviour change.

It is not just about people being equipped to manage their health. People need **opportunities** to learn and develop new skills throughout their lifetime, explore opportunities for wider development, not just related to their current work role (e.g. gaining financial and technological skills to generate retirement savings or improve work and health outcomes).

Working longer and **volunteering** throughout life meets a desire to help others, meets a need to feel useful and valued, can help people make friends, and promotes enjoyment of new activities.

EQUITY

The importance of being inclusive cannot be overestimated; ageist attitudes harm older people as they lead to age-based discrimination.

Sensory impairment has a large impact on quality of life, access to social networks and access to services, particularly for those facing additional language or communication barriers. It's important to ensure these impacts are **mitigated**.

Finally, all organisations should embed the '**Carers Charter**' and develop flexible working policies (e.g. flexible working hours and home–office solutions to enable paid work alongside unpaid care) to support people irrespective of their circumstances to work, and to work healthier for longer.

RSpencer-Henshall

Rachel Spencer-Henshall,
Director of Public Health

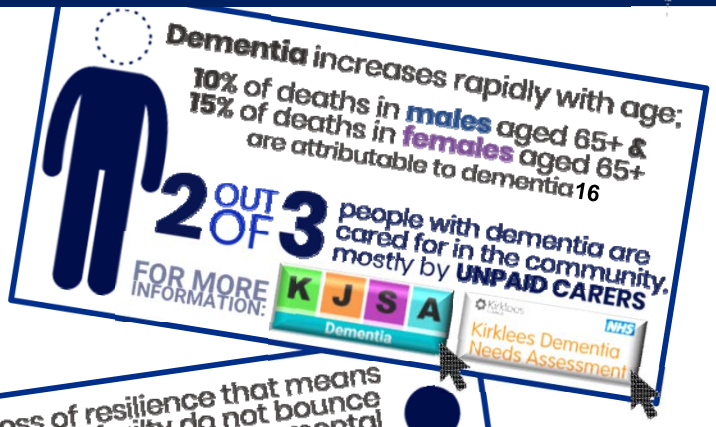
Care and Support

Changing Need

As well as an increase in the amount of ill health, population ageing will mean a greater prevalence of age-related conditions. The 'oldest old', who have a substantial risk of requiring long-term care, are the fastest growing age group in the UK.

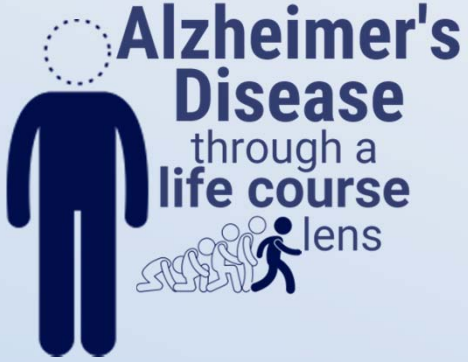
Carers

Over the last 20 years, the management of chronic disease has moved from secondary care to primary and community care, with older people receiving the majority of their personal care from family and other unpaid carers. The way in which people receive care is changing. Traditional hospital in-patient stays are reducing, and more management of long term conditions is possible in the community.



Alzheimer's disease is the most common cause of dementia and, with an ageing population, prevalence is increasing yearly. Alzheimer's is not determined in any single time period but results in the complex interplay between genetic and environmental exposures throughout the life course.

A healthy lifestyle can help reduce the risk of Alzheimer's disease and other dementias. It has been estimated that up to half the cases of Alzheimer's disease worldwide may be the result of seven key modifiable risk factors: diabetes, high blood pressure, obesity, smoking, depression, cognitive inactivity or low education, and physical inactivity.



Risk factors for developing Alzheimer's include intrauterine environment and birth weight.

Cognitive stimulation throughout the life course, especially during the sensitive period in early life, influences dementia risk.

Smokers have a 45% higher risk of developing dementia than non-smokers. Exposure to second-hand smoke (passive smoking) may also increase the risk of dementia.

Low socioeconomic status (SES) in parents may lead to a similarly low attained SES in their offspring, which in turn may lead to suboptimal adult SES – a risk factor for Alzheimer's.

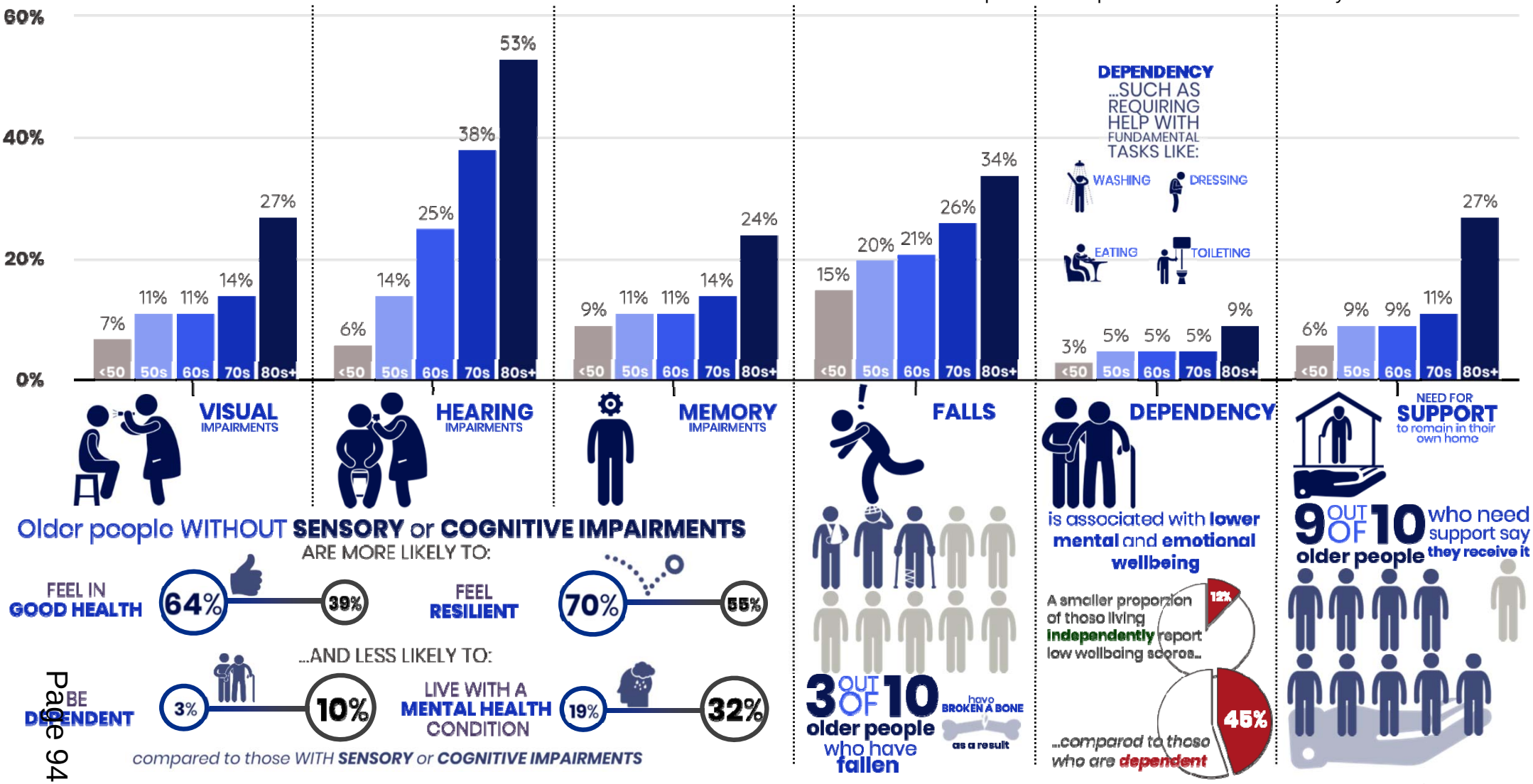
Being obese in mid-life doubles the risk of developing dementia at a later age, but the mechanisms behind the link between remain unknown.

Health literacy throughout the life course facilitates the recognition of symptoms in later life and timely diagnosis and care.[18,19]

Kirklees Snapshot : Living with **Additional Needs** & **Age-Related Impairments**

Dependency is associated with higher health and social care costs so it is important that people live as well as they can for as long as they can. Older people are the largest users of health services, representing two thirds of NHS users. 41% of all admissions to hospitals last year were people aged 65+.[15]

The risk of frailty increases with age and, in those aged 65 and over, lower socio-economic status is associated with more physical, psychological, cognitive and overall frailty. Between a quarter and a half of people over 85 are estimated to be frail, which is associated with disability and crisis admissions to hospital.[20] Dementia is also becoming a critically important issue in terms of both the high personal and social costs related to the disease and the wider impact on other parts of the health and care system.



Source: Current Living in Kirklees (CLiK) Survey, 2016

Local Assets

Kirkwood Hospice provides support to people living with illness or deteriorating functional status in order for them to achieve the best quality of life.

Making Space delivers the Kirklees Dementia Information Service, providing comprehensive information about services available within Kirklees and appropriate signposting support to People with Dementia, their Carers and Family Members.

The 'Museum in a Box' scheme is a range of historical resources which have been produced by Kirklees Museums and Galleries. The boxes are primarily used for reminiscence work and have proven to be an effective way of reaching people living with dementia.

The Kirklees Dementia Hub is a partnership between Community Links and Age UK Calderdale & Kirklees and offers community activity, awareness raising and information and advice sessions for adults of any age a diagnosis of dementia.

An active Dementia Action Alliance with almost 200 members. 'Dementia Friendly' training sessions can be provided by the alliance to businesses, schools and community groups.

There are many local groups and services for people with age-related conditions; befriending, dancing, lunch clubs, exercise classes and community groups such as Dementia Cafes. There are also various mental health services that provide support for older people.

Breathe Better – Feel good, do more

End of Life Care – End of Life Care Admiral Nurse

The Share + Care Group

St Anne's Community Services

S2R CREATE SPACE – Promoting Positive Mental Health

HOOT creative arts

community links – inspiring hope, inspiring change

Kirklees Advocacy Service

women's Centre

CASE STUDY

Museum in a Box

Supporting people through reminiscence

The 'Museum in a Box' project was developed nine years ago and now consists of 20 boxes (which are available for groups and organisations to borrow for free) on a variety of themes including school days, kitchen and washday, textile mills and rugby league.

Each box contains a range of 20 multi-sensory objects to help stimulate discussion, including tactile objects that can be handled, photographs, CDs and smells from bygone times. The themed objects and resources help to rekindle memories, encourage conversations, boost self-esteem and can offer support at a time of change. Over 90 box loans took place during January to June 2017, from 24 different organisations include care homes, hospitals, charities, agencies and community groups.

Kirklees Museums and Galleries have recently commissioned The Audience Agency to undertake an evaluation of the health and wellbeing impacts of the Museum in a Box scheme. Nine organisations that have used the boxes on a regular basis over the last year were surveyed. These organisations are using the boxes to supporting a range of service users including the elderly, people living with dementia and their families, people with long term health conditions, limited mobility and people with learning difficulties. Of those organisations surveyed:

- All strongly agreed that service users have enjoyed reminiscing/engaging with their personal history through using the boxes.
- All strongly agreed/agreed that Museum in a Box resources and sessions have enabled service users to improve their social interaction with others (e.g. care staff, family, other service users/participants).

Some of the benefits of using this scheme which were expressed in the survey included:

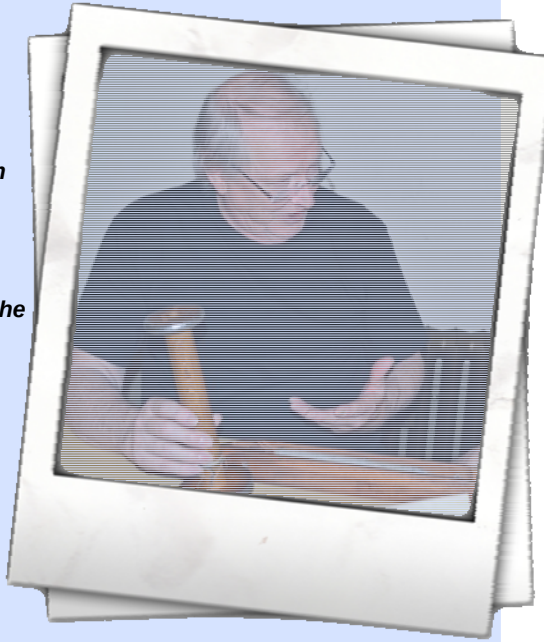
"Some residents really look forward to the sessions. Improves confidence and self-esteem as they realise how much they know. Creates laughter and positive feelings."

"Some residents who do not communicate much seem to come alive when we start to do the reminiscence session."

"Increases feelings of happiness and creates a 'buzz'"

The multi-sensory nature of the boxes are key to their success. One survey user commented:

"The variety of items, including tactile items, smells, music etc. all work on the brain in different ways to invoke memories."



What next?

	Insight...	Action...
		Enable upstream, preventive interventions across the life course using evidence-based commissioning of 'age friendly' services.
		Utilise new technology to support people with sensory and cognitive impairments and their carers to continue to live independently. Enable older people to stay at home, feel safe and confident managing their daily routines. Develop activities and opportunities (including volunteering) specifically aimed at older people. Promote peer and mentor support.
	Improve data quality on frailty and falls in older people to identify vulnerable and at-risk groups.	Ensure older people have access to health services that do not discriminate and which are equipped to provide safe, high quality care. Co-production of social care provision, designing and delivering services in equal partnership to improve outcomes for older people. Promote and enable carer-friendly health and care services.
	Understand how referral and recovery rates and routes to Cognitive Behavioural Therapy and psychotherapy differ between age groups.	Access to stepped care approaches such as Cognitive Behavioural Therapy and Psychotherapy.
	Particular challenges for older carers from different Black and Minority Ethnic groups. Understand the impacts of sensory impairment on quality of life and social networks and access to services particularly for those facing additional language or communication barriers.	
		Embed the Carer's Charter across organisations. Develop more Dementia Friendly initiatives. Work with local businesses to help them recognise and support carers. Support more carer break schemes. Enable 'hidden carers' (those not in touch with formal support services) to find support and advice. Work collaboratively and creatively with carers to address their health and employment outcomes.

Good Communities

5

Housing

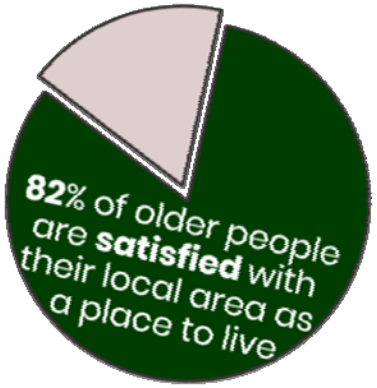
Good housing throughout the life course helps people to stay warm, safe and healthy, and enable them to do the things that are important to them. We know that people in later life spend more time in their homes and immediate neighbourhood than any other age group.

Accessible Places

People interact with outdoor spaces and the built environment in ways that reflect their lifestyles and physical capabilities. For some older people, their external environment has a major impact on mobility, access to resources and services, social participation, independence and quality of life. Places which are accessible and supportive facilitate social inclusion.

Social Inclusion

Staying connected (with family, friends, events, services, news and activities) is a key part of life. Social relationships are particularly important for older people, not only in facilitating access to support and leisure, but also in increasing resilience and promoting recovery from illness in socio-economic circumstances that otherwise would be detrimental to health.

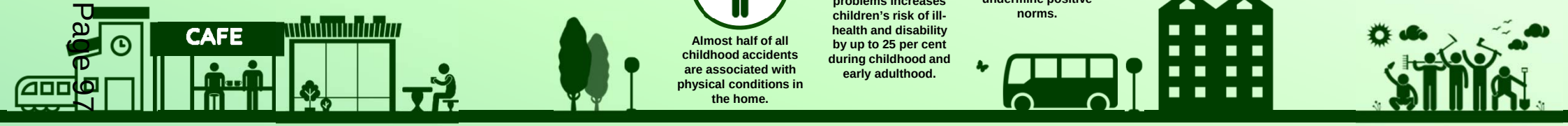


Source: Current Living in Kirklees (CLiK) Survey, 2016

The home and neighbourhood are seen as having a crucial role in the wellbeing of older people. The home and place in which people live are an essential element of their quality of life; the home cannot simply be viewed as a 'setting'.

The sense of belonging to a place is connected with identity; deterioration in a neighbourhood and fear of crime have a strong negative influence on wellbeing by limiting activity and engagement with the outside world.

Neighbourhoods through a life course lens



Almost half of all childhood accidents are associated with physical conditions in the home.

Experience of multiple housing problems increases children's risk of ill-health and disability by up to 25 per cent during childhood and early adulthood.

Having more affluent neighbours can help inspire more positive norms among residents, but not as much as "bad influences" can undermine positive norms.

The chronic stress of living in dangerous or rundown neighbourhood can affect parenting styles, which can in turn affect children.

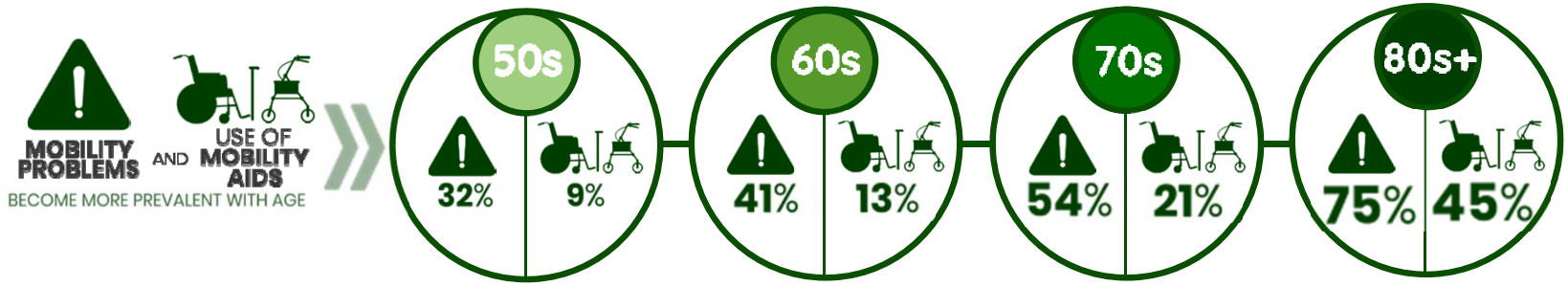
Unfit housing is linked to lower educational attainment and greater likelihood of unemployment.

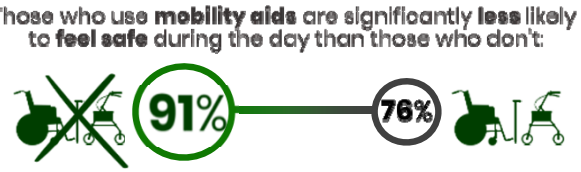
Overcrowded conditions have been linked to slow growth in childhood, which is associated with an increased risk of coronary heart disease in later life. [21,22]

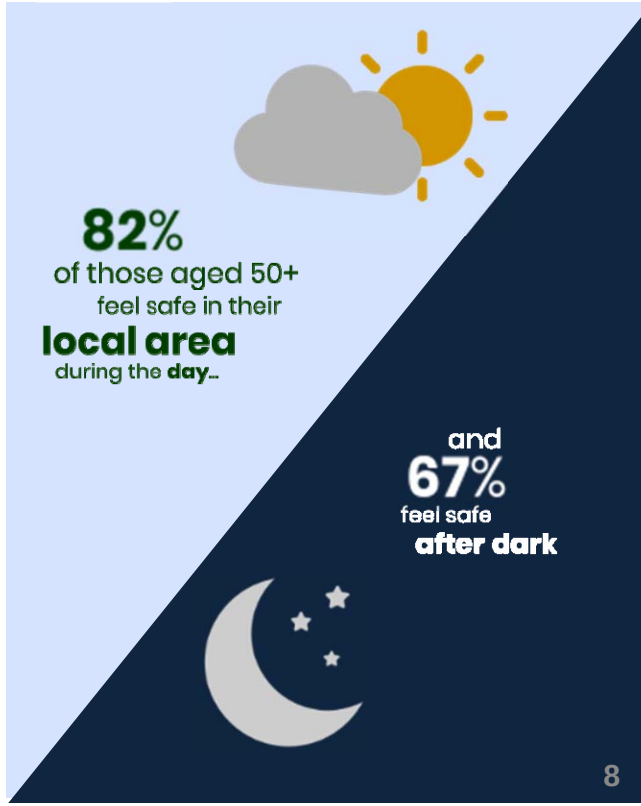
Kirklees Snapshot : Mobility, Facilities & Safety

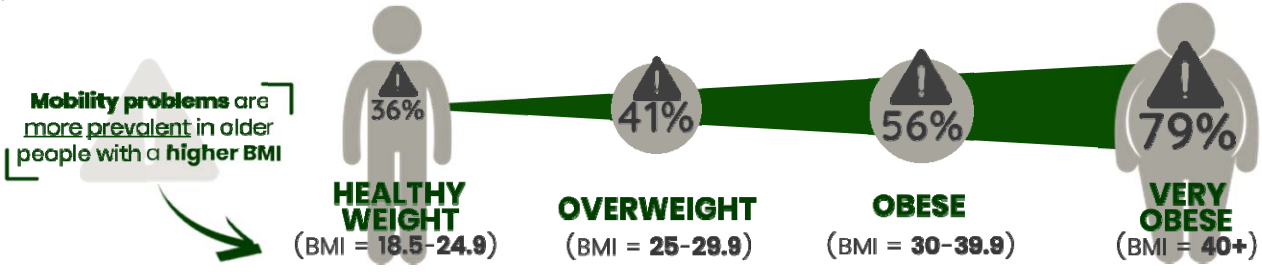
Well-designed and accessible environments have a positive effect on individual and community health and wellbeing and reduce isolation. For older people, these could include well maintained recreational areas, ample rest areas, safe pedestrian routes and accessible buildings as well as affordable and accessible transport.

Areas with more accessible green space are associated with better physical and mental health and the risk of mortality caused by cardiovascular disease is lower in residential areas that have high levels of "greenness". There is also evidence that exposure to nature could be used as part of the treatment for some conditions.[23] Illnesses related to sedentary urban lifestyles are creating an increasing economic and social cost. In order to maintain good health as we grow old, we need to be more physically active throughout our lives. Increasing the accessibility of the local environment can enable people to be more active, more often.









Source: Current Living in Kirklees (CLiK) Survey, 2016

Local Assets

AccessBus

A door-to-door service using specially equipped vehicles for people who have difficulty in using conventional public transport. A number of free of charge Access Bus routes are available to those eligible throughout West Yorkshire.

Steps are being taken to ensure accessibility is at the heart of the West Yorkshire Local Transport Plan; procedures are in place to help disabled people, older people and people with dementia feel safe; transport information is made available in Braille, large print and easy-read; bus drivers can attend awareness information sessions; Travel Assistance Cards are designed to help disabled and vulnerable people when using public transport to let drivers know about any requirements they may have.

Working to become Dementia Friendly

SCOOT

A number of road networks in Kirklees operate a SCOOT system (world leading adaptive signal control system). It responds automatically to fluctuations in traffic flow through the use of vehicle detectors reducing congestion and maximising efficiency. This brings benefits to vulnerable road users including older people via reducing emissions and improving air quality and by prioritising public transport.

CASE STUDY

Local Improvements

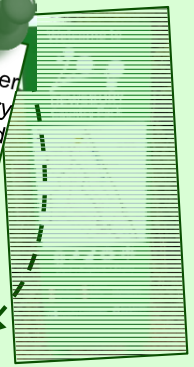
Over the past few years, the Landscape Team have been making improvements to local parks and green spaces across Kirklees to increase their accessibility.

September 2014
Tolson Museum Memorial Garden
Huddersfield

An area of the park was identified, tucked away behind the museum, where a secluded space could be used to create a memorial garden which would be a quiet, peaceful and uplifting environment to reflect on how wars and conflicts affected people. Working in an intergenerational context, the area was made safer and more accessible as well as being more informative and interesting.

July 2015
Dewsbury Country Park
Ravensthorpe

The 76 acre park, which is a former landfill site, is bordered by Dewsbury Moor, Mirfield and Heckmondwike and also includes the Spen Valley Nature Reserve. The rejuvenation of the site included a car-parking facility with an attractive and welcoming entrance point and a footpath network with trails for cycling and horse riding. These transformations have helped to make it welcoming and accessible and a vital resource for the health and wellbeing of the local people

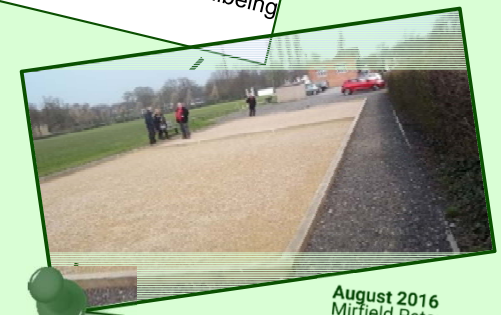


November 2012
Rectory Park
Thornhill Lees

The Landscape Team were commissioned to project manage the creation of new compacted gravel surfaced paths with timber board edges, designed to provide wide, even and regular surfaces to walk on and to allow wheelchair access where possible. The improvements also included the installation of benches and of ramps over uneven and sunken areas.

August 2016
Mirfield Petanque
Mirfield

The Landscape Team were asked to project manage the extension of the petanque court in the Mirfield Memorial Park. Petanque is a form of boules and the existing court is well used and appeals mostly to older users. It is anticipated that the extension will help to encourage greater use of this outdoor activity area, particularly amongst older people in the Mirfield area.



October 2011
Ings Grove Park
Mirfield

Ings Grove Park was hidden away from view behind a high retaining wall and was overgrown. A new entrance from Huddersfield Road was created and more accessible footpaths were designed throughout the site. Improvements were also made to the War Memorial in consultation with the British Legion, with the creation of an accessible ramp and lighting to the monolith.

What next?

	Insight...	Action...
LIFE COURSE	Preventable illnesses and injuries resulting from inadequate housing. How parks could be made more accessible and support their creation and maintenance amongst communities. Which groups are more likely to experience loneliness and isolation at different life stages or following different life events and how local assets can help to prevent this or reduce the impacts.	Encourage cycling and walking amongst all age groups. Raise awareness of accessibility issues and barriers to services. Promote active citizenship across the life course.
WORKING WITH PEOPLE (NOT 'DOING TO' OR 'DOING FOR' PEOPLE)	How people in residential/care homes could remain at home for longer. What helps to make older people feel safe so they can more easily and confidently access facilities and services in their communities. Spatial and social barriers to using public transport (e.g. location of bus stops, accessibility of vehicles). More about the barriers and facilitators to participation in local networks and lifelong learning opportunities.	Facilitate planned downsizing. Improve physical accessibility to aid social inclusion. Enable older drivers to recognise whether physical problems or medication are affecting their driving. Support older people to maintain existing relationships and develop new connections.
INTELLIGENCE-LED COMMISSIONING	Return on investment for provision of specialist accommodation. Evidence to support commissioning and future supply of housing stock.	Increase availability across all tenures to meet all needs and budgets. Gendered interventions to tackle inclusion barriers. Involve older people in design. Reach people at 'trigger points' for increased loneliness/ isolation and signpost to appropriate sources of support.
MENTAL WELLBEING		Improve access to green spaces to improve wellbeing. Utilise psychological approaches to loneliness, e.g. cognitive behavioural therapy and mindfulness.
EQUITY	Perceptions, expectations and experiences of housing of different black and minority ethnic (BME) groups and vulnerable groups.	Inclusive design of outdoor spaces (adequate seating, public toilets, etc.). Provide audible and visual road crossings and short crossing distances.
ASSOCIATED FACTORS		Familiar location to maintain community ties and stability. Promote intergenerational relationships. Utilise technology. Use the Local Plan to achieve accessible, safe, and people-centred communities for new infrastructure, and protect and enhance accessibility of existing facilities.

MEETING:	**KIRKLEES HEALTH AND WELLBEING BOARD**
DATE:	**THURSDAY 6th SEPTEMBER 2018**
TITLE OF PAPER:	**LEARNING FROM WINTER 2017-18 ACROSS KIRKLEES**

1. Purpose of Paper

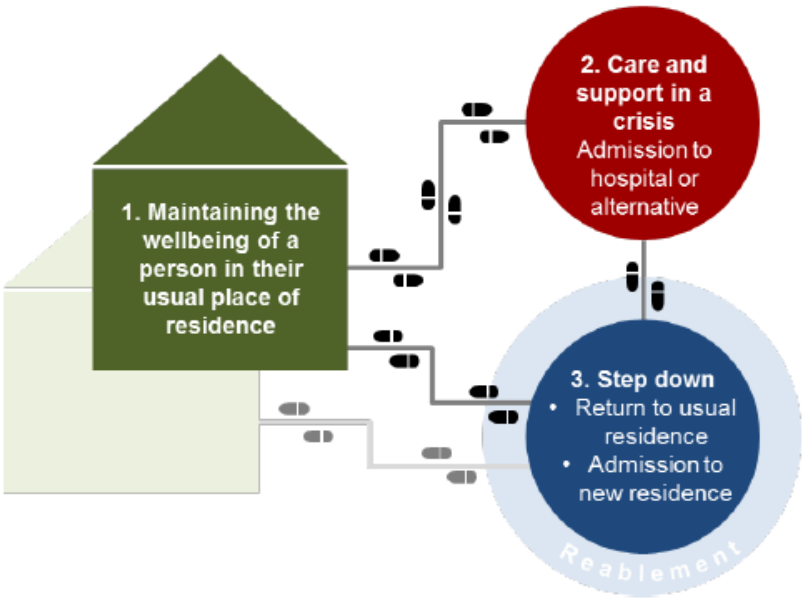
1.1 To present the findings of the review of Winter 2017-18 and proposed actions to take forward the lessons learnt.

2. Background and Key Points

2.1 In March 2018 the Board supported the proposal to undertake a Kirklees health and social care system wide review of local experiences over winter 2017/18 to identify the key learning points and propose actions to improve outcomes and system efficiency and effectiveness. And to receive a report setting out the lessons learnt and the proposed actions for the Kirklees health and social care system.

An interim progress report was presented to the Board on 28th June 2018.

The proposed approach was based on the model being used by CQC in their Local System Reviews[1]:



2.2 The focus for the operational response to the winter pressures in Kirklees is through the 2 local A&E Delivery Boards which are based on the acute Trust footprints – Calderdale & Huddersfield and Mid-Yorkshire (in Mid-Yorkshire this is called the A&E Improvement Group). Both A&E Delivery Boards have undertaken their own reviews, and these include the neighbouring areas of Calderdale and Wakefield. This Kirklees place based review drew on these but also took a wider Kirklees health and social care system view.

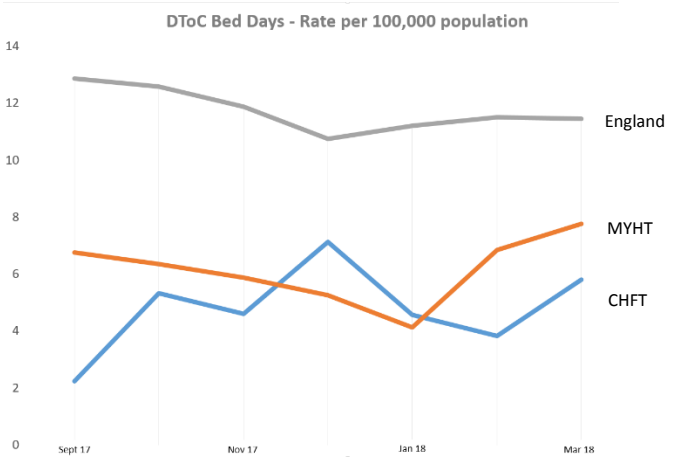
2.3 The review was based on in depth interviews with people from across the Kirklees health and social care system. The framework for the interviews drew on the key themes that have emerged from the CQC reviews, and the complimentary report 'Why not home? Why not today?'[2];

- How well led do you feel the 'system' was over winter? Where did that leadership come from? Were there any leadership issues?
- How did relationships between different partners affect the local response to winter?
- We all agree that putting the person, and their best possible outcome, at the forefront of everyone's thinking and focus is crucial. How well do you think we did this over the winter?
- See person journey diagram. How well do we share ownership of the person's entire journey through the system?
- Where have the pressure points been and missed opportunities?
- What should we be measuring to show that we are making a difference?

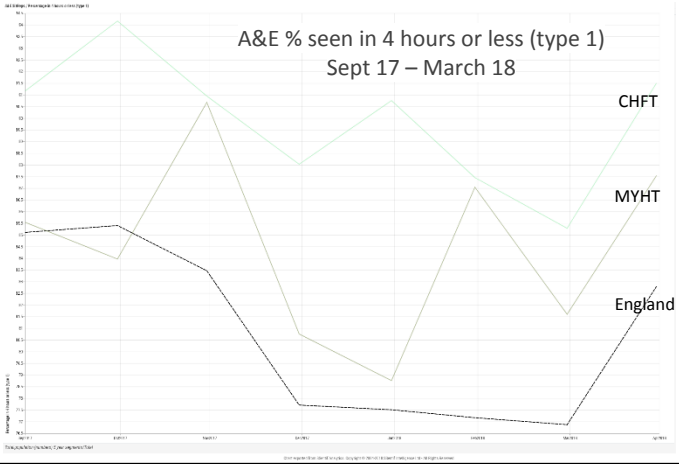
2.4 More than 40 people from across the system have been interviewed individually or in groups. The interviews were undertaken by Steve Brennan (SRO for Integration), Emily Parry Harries (Head of Public Health) and Phil Longworth (Health Policy Officer). The findings from the interviews were used as the basis for a facilitated workshop on the 13th July to which all interviewees were invited.

2.5 Interviewees included people from across the system, i.e. both acute Trusts, adult social care operations and commissioning, CCGs, Locala, domiciliary care, Healthwatch, Kirklees Equipment Service and Accessible Homes Team, Locala, primary care & GP out of hours, residential care, SWYFT and both A&E Delivery Board chairs.

2.6 Whilst the system both locally and nationally was under significant pressure performance against 2 key metrics, delayed transfers of care and A&E waiting times, showed that across both footprints the local system compared well with the national picture.



Lower is better



Higher is better

3. Lessons learnt and proposed actions

3.1 The key headlines across include:

a) Positive relationships at all levels, from operational front-line staff to senior and strategic leaders are essential, but these cannot be established only in the very pressurised environment of OPEL based winter planning. Therefore, all partners need to invest time in building these relationships across the year. There has been significant positive progress on developing these relationships in 2018 and this needs to continue.

b) The importance of a shared understanding across the system of levels of risk being carried by each part of the system and how these can be managed through formal partnership mechanisms e.g. OPEL and informal collaboration.

c) The value of consistency of involvement to enable the development of positive relationships and shared understanding, and all partners being proactive in sharing information about actions they are taking to improve outcomes especially actions that will reduce pressure across the system.

d) Several organisations, including the Council, Locala, SWYFT and Local Care Direct are playing into two silver command arrangements and A+E Board arrangements rather than one and this presents additional challenges in terms of the calls on staff time.

e) The whole system needs to speak with a single voice about how it is responding to periods of increased pressure and how staff, partners, users/patients and the wider community can play their part in enabling us to achieve the best outcomes for those in the greatest need.

f) Planning for winter should not be a separate process from planning for overall system improvement, and the scheduling of planning and governance activity should recognise the need to focus on service delivery when the system is under pressure because of increased levels of activity.

g) The continuing challenges around nursing home capacity, especially specialist elderly mentally ill homes, and the availability of domiciliary care. Understanding the implications of actions in other parts of the system on these very challenged services, for example, the impact of additional recruitment activity by NHS organisations on nurse capacity in nursing homes.

h) Taking a more concerted and consistent approach to population stratification and using the knowledge we have about who is most vulnerable to unplanned hospitalisation to focus on admission avoidance and to support organisational and system level capacity planning across hospital, primary, community and social care.

i) We need to develop Kirklees wide mechanisms for getting feedback and ideas about additional contributions from across the system. Whilst there are very robust mechanisms for getting feedback and planning action from the hospital-based parts of the system this is not complimented by feedback from the non-acute parts of the systems, especially primary care and social care.

j) We can lose the patients voice in the pressures of winter – despite the best efforts of staff we became very focused on transactional relationships. Nor is

there a routine mechanism for gathering user/patient views of the system response during winter.

k) During the most pressurised periods all parts of the system find it difficult to keep the focus that they would like to on being user/patient and carer centred. At times the focus seemed to be on freeing up beds and rather than improving outcomes for the person.

l) It can be difficult to keep the right focus on self-care and supporting people to maintain their health and independence to avoid/delay the need for hospital admission, or to avoid discharges not being well-planned.

3.2 These lessons were presented to the workshop with interviewees in July. That workshop reflected on these lessons and identified a range of actions that the system could take to improve outcomes. A key message that came out of that workshop was the positive steps that have already been taken over the last few months, the extensive range of new developments that were either already in place or in an advanced stage of planning. These actions are set out in Appendix 1.

4. Next Steps

4.1 Share the lessons learnt with both A&E Delivery Boards.

4.2 Continue to implement and plan that actions set out in Appendix 1 that have already been agreed by partners.

4.3 To develop in more detail proposals in response to the lessons learnt and the new ideas set out in Appendix 1 and seek approval from relevant partners, particularly:

- Reviewing progress and arrangements for achieving the 8 high impact changes for managing transfer of care
- Implementation of hospital 'Moving on' policies
- A coherent system wide approach to population stratification and capacity planning
- A system wide performance dashboard that reflects the range of partners contributions and challenges
- Communications planning for urgent care and periods of system pressure
- Kirklees Council and other partners who work across the district to be conduit of good/bad practice across the system
- Building on the progress already made in embedding positive relationships and mutual understanding across the system**.**

4. Financial or Policy Implications

The review highlighted the need to rebalance efforts across the health and social care system. In recent years the focus has been on the pressure experienced by hospitals over winter, and there has been a particular emphasis on finance and performance against specific hospital focussed metrics. Whilst all those involved in the review recognised the importance of efficient and effective acute care focussing almost exclusively on this part of the system has not resulted in the system wide improvements that are necessary. Improvement activity needs to tackle the 'triple aim' set out in the Five Year Forward

	View i.e. health and inequality; quality and care; finance and performance, and the contributions and challenges of partners across acute hospitals, primary and community care, mental health, social care and the third sector through the proposed system wide performance dashboard.
5.	**Sign off** Richard Parry, Strategic Director for Adults and Health.
6.	**Recommendations** That the Board: • Comment on the lessons learnt • Note the positive progress in responding to the lessons learnt • Endorse the next steps.
7.	**Contact Officer** Phil Longworth, Health Policy Officer, Kirklees Council phil.longworth@kirklees.gov.uk 01484 221000

[1] CQC Local System Reviews: Interim Report (December 2017) http://www.cqc.org.uk/publications/themes-care/our-reviews-local-health-social-care-systems

[2] Better Care Fund Support Programme/Newton Europe. December 2017 https://www.local.gov.uk/sites/default/files/documents/NEW0164_DTOC_Brochure_Online_Spreads_1.0.pdf

Appendix 1: Proposed actions

	In place	Planning	New idea
Domiciliary Care - work with providers - Quality - Recruitment - Admission avoidance - Timeliness – brokerage role	 ✓ ✓	 ✓ ✓	
Care Homes Early Support Programme (CHESP)	✓		
Trusted assessors	✓		
Bed state tool roll out	✓		
Red bag scheme	✓		
Admission avoidance		✓	
Links to Primary Care Home			✓
Carers - review of support arrangements		✓	
Admission avoidance - risk stratification including 3rd sector, Multi-disciplinary team and DTs, Primary Care Networks - Shared records and IT - Integrated Pathways for community services		 ✓ ✓ ✓	
Choice - implement moving on policy - use joint training to embed consistent approach - managing expectations in both the acute and community – whole system to manage		✓	 ✓ ✓
'Choice & recovery' beds		✓	
Capacity planning - at org level - season level - intermediate care - at system level via OPEL		 ✓ ✓ ✓	 ✓
Virtual community frailty ward (North Kirklees)		✓	
Myth Busting e.g. KICES			✓
Joint intermediate care/reablement pathway including pilot in south as enhanced reablement		✓	
Transport – review of arrangements		✓	
System level performance reports		✓	
Understanding temporary registration of residents			✓
Review progress and arrangements for achieving the 8 high impact changes			✓
Clarify who is taking forward actions that have already been identified (e.g. access to 4x4s)			✓
Kirklees Council and other partners who work across the district to be conduit of good/bad practice across MYHT & CHFT			✓
Communications plan for urgent care			✓
Start silver face to face now to build relationships (fortnightly)			✓
Pre book calls at key pressure points e.g. post bank holidays			✓