Public Document Pack

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Wednesday 24 November 2021

Notice of Meeting

Dear Member

Health and Wellbeing Board

The **Health and Wellbeing Board** will meet in the **Virtual Meeting - online** at **2.15 pm** on **Thursday 2 December 2021.**

This meeting will be live webcast. To access the webcast please go to the Council's website at the time of the meeting and follow the instructions on the page

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 Viv Kendrick (Chair)

Councillor Musarrat Khan
Councillor Carole Pattison
Councillor Mark Thompson
Councillor Kath Pinnock
Mel Meggs
Carol McKenna
Dr Khalid Naeem
Richard Parry
Rachel Spencer-Henshall
Helen Hunter
Karen Jackson
Beth Hewitt

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.

2: Minutes of previous meeting

1 - 8

To approve the minutes of the meeting of the Board held on 30 September 2021.

3: Interests

9 - 10

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: Public Question Time

The meeting will hear any questions from the general public. Questions should be emailed to jenny.bryce-chan@kirklees.gov.uk no later than 10.00am Tuesday 30th November 2021.

In accordance with Council Procedure Rule 51(10) each person may submit a maximum of 4 written questions.

In accordance with Council Procedure Rule 11(5), the period allowed for the asking and answering of public questions will not exceed 15 minutes

7: Covid-19 Update

The Board will receive an update on Covid-19 in Kirklees.

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

8: Showcasing Innovation : Kirklees Urgent Community Response

To receive an update on the innovative partnership-based approach to providing people who are experiencing a health or social care crisis an 'urgent community response'.

Contact: Julie Oldroyd, Senior Manager, Transformation, Community, Kirklees CCG

9: Kirklees Ageing Well Strategy 11 - 44

The purpose of the paper is to present the draft Kirklees Ageing Well Strategy to the Kirklees Health and Wellbeing Board for discussion and support/approval.

Contact: Nicola Cochrane, Programme Manager, Kirklees CCG and Julie Oldroyd, Senior Manager, Transformation, Community, Kirklees CCG

10: Health Check Pilot Update

45 - 78

The purpose of the paper is to update the Board on a key health and wellbeing initiative, the Health Checks Pilot, which went live on 8 November 2021.

Contact: Patrick Boosey, Wellness Service Lead

11: The Health and Care Bill: Update on preparations in West Yorkshire and Kirklees

To receive an update on the work underway in West Yorkshire and Kirklees to prepare for the changes set out in the Health and Care Bill.

Contact: Carol McKenna, Chief Officer NHS Kirklees CCG and Richard Parry, Strategic Director for Adults and Health

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12: Date of the next meeting

Board members are asked to note that the date of the next Health and Wellbeing Board meeting will be on the 20 January 2022.

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Contact Officer: Jenny Bryce-Chan

KIRKLEES COUNCIL

HEALTH AND WELLBEING BOARD

Thursday 30th September 2021

Present:	Councillor Viv Kendrick (Chair) Councillor Musarrat Khan Councillor Carole Pattison Councillor Mark Thompson Councillor Kath Pinnock Richard Parry Rachel Spencer-Henshall Carol McKenna Dr Khalid Naeem Helen Hunter Karen Jackson Beth Hewitt
In attendance:	Catherine Riley, Assistant Director of Strategic Planning Calderdale and Huddersfield NHS Foundation Trust Chris Lennox Diane McKerracher, Chair, Locala Alex Chaplin, Strategy and Policy Officer, Integration Councillor Habiban Zaman, Lead Member for Health and Adult Social Care Scrutiny Panel
Apologies:	Mel Meggs Jacqui Gedman

13 Membership of the Board/Apologies

Apologies were received from Mel Megg and Jacqui Gedman.

Dr Khalid Naeem, Deputy Chair of the Health and Wellbeing Board, chaired the meeting.

14 Minutes of previous meeting

That the minutes of the meeting held on the 15th July were approved as a correct record.

15 Interests

No interests were declared.

16 Admission of the Public

All agenda items were considered in public session.

17 Deputations/Petitions

No deputations or petitions were received.

18 Public Question Time

No questions were asked.

19 Covid-19 Update

Rachel Spencer-Henshall, Strategic Director, Corporate Strategy, Commissioning and Public Health provided an update on the current position regarding Covid-19 in Kirklees, highlighting some of the key points from the current data.

In summary, the Board was informed that in terms of the vaccination uptake, Kirklees, as a whole has an uptake of 82.9% in its over 18 population, for dose one and 76% for dose two. The data suggests that in terms of uptake there are some differences within the place-based community at a local level and there are a couple of district where uptake is not as good as in the rest of Kirklees.

The data also shows that the uptake of the vaccination in younger people is more gradual and anecdotal evidence suggests that it's more about people going for their vaccine when they find the time, or when it fits with their life, rather than actively booking it. The vaccine programme is going well however, there is still some work to do to increase uptake and the CCG, Council and partners have been working on trying to increase uptake up by working with schools, colleges, and universities. Work is currently being undertaken to roll out the vaccine to 12-15-year-olds in schools.

In response to the information presented, the Board raised a number of questions and comments as follows:

- Building on the discussion around young people are there any patterns or differences emerging between north and south Kirklees given that there is a university, bigger colleges, and more schools in south Kirklees?
- Will lateral flow tests no longer be free and if so, what will be the likely impact on testing arrangements?
- In terms of communicating to the public what are the key messages that residents of Kirklees should still be mindful of to keep themselves and others safe as far as is possible?

The Board was informed that it is important that people undertake their own personal risk assessment, for example wearing a face covering is a personal choice. As winter approaches there is less opportunity for people to be out and about in the fresh air, however, hand washing, keeping good ventilation, and giving people space are things that individuals can still do. In addition, get the vaccine and the booster program which will be starting shortly.

RESOLVED

That Rachel Spencer-Henshall be thanked for providing an update on the current position with regard to Covid-19 in Kirklees.

20 Showcasing Innovation : Kirklees Better Outcomes Partnership

Emma Hanley, Senior Contracting and Procurement Manager and Victoria Busby, Kirklees Better Outcomes Partnership provided the Board with an update on the work of Kirklees Better Outcomes Partnership (KBOP).

The Board was provided with background information which outlined the reason why the previous provision for housing related support services contracted with a number of different organisations to deliver different contracts to the most vulnerable in society, was remodelled. The service provides for people who have vulnerabilities, disabilities or lifestyle factors that may make them more at risk of becoming homeless or being able to live independently. For example, it might include people with mental health problems, drug and alcohol dependency, offenders, young people, and domestic abuse, people with a range of needs.

The previous contracts didn't always allow or encourage services to think differently or creatively, and as a result of significant budget reductions, interventions have become a lot shorter. While it may address the presenting need, it does not necessarily tackle the underlying root causes, thereby creating a revolving door.

The focus was on ensuring that people were accessing the correct benefits rather than truly maximising income by developing employability skills to enter work. The aim was to find a way to incentivise support services to address those underlying issues to help build on service users, resilience and encouraging sustainable skills, and behaviour. Developing more flexible interventions to improve outcomes instead of process focused service provision.

The new service model is now paid based on outcomes achieved. It uses additional top up funding from the Life Chances Fund utilising social investors through a social impact bond which brings new investment into the sector and creates new partnerships between social investors, commissioners, voluntary sector service providers and beneficiaries working co-productively. The services commenced in September 2019, and to date it has supported over 2500 new starts on the program.

The Board was informed that Kirklees Better Outcomes Partnership (KPOB) is a social enterprise with eight expert organisations collaborating to prevent homelessness. Each service has an individual specialism across mental health, support, substance misuse, domestic abuse, housing, and offending.
The social enterprise was formed as an alternative to traditional support services and a way to place outcomes at the forefront of delivery.

During the Covid period, delivery was expanded in a matter of weeks as part of a community led response implementing a seven-day emergency helpline, digital interventions, and home deliveries to frightened and isolated people.

The focus is on empowering individuals to achieve their ambitions and prevent homelessness. It was identified that traditionally contracts and services had been commissioned in a deficit focus way, with the effectiveness based on the number of

individuals using the program rather than the outcomes of the milestones achieved. The system and processes had prevented many from moving into independence fully from services.
The aim was to do something different, to use the flexibility of the outcomes-based contracts to reallocate power and decision making and handing it back to the person, using personalisation, advantage thinking, relationships and working on an equal person to person level.

The approach at KBOP is the belief that people can achieve anything they want when they are not trapped within a deficit system. This belief and the commitment to do things differently, gave the flexibility to innovate and change how services are delivered by moving away from traditional support towards person led models.

Processes have been changed to one that focuses on understanding what is important to people through conversation rather than through assessment. Paperwork and linear procedures have been removed enabling people to make their own decisions at the right time for them. Due to this approach and the hard work of partners and participants KBOP is now more than doubling the expected outcomes.

RESOLVED

That Emma Hanley and Victoria Busby be thanked for providing an update on Kirklees Better Outcomes Partnership.

21 Shaping the partnership response to Tobacco Control in Kirklees

Rebecca Gunn, Public Health Manager, presented a report which outlined the partnership response to shaping tobacco control in Kirklees.

The Board was informed that by way of background, the government set out its ambition that England will be smoke free by 2030, which is defined as rates of less than 5%. It is widely acknowledged that this will be a challenge particularly in areas of deprivation and among people living with mental health conditions for example. Therefore, bold action will be required both to discourage young people from taking up smoking and also support smokers to quit.

In the two years since this ambition was stated, it is estimated that around 200,000 children under the age of 16 will have started smoking and without action two thirds of those will go on to become regular smokers. It is really important within Kirklees that action is taken to drive down this prevalence through discouraging people from starting in the first place and supporting people to quit and normalising non-smoking within the communities.
Within Kirklees, there is a dispersed, model of smoking cessation across GP's, pharmacies and community providers for example, Auntie Pam's service and the Wellness service. They are doing some interesting work in terms of trying to encourage people to come to give up smoking in a range of different ways.

In order to achieve the government's ambition to be smoke free, there needs to be a district wide approach to tackling tobacco, and it was a good opportunity to strengthen the partnership approach. With the support of the Portfolio Holder for

Health and Social Care, work has begun to formalise a tobacco alliance (name to be to be to be confirmed for Kirklees).

There have been two virtual meetings held so far, with quite broad representation, including people from people from housing, licensing, the acute trusts, the mental health trust, Yorkshire Cancer Research and Public Health England. It is important to keep momentum going and work has started on drafting an action plan.

The partnerships aim is to reduce smoking prevalence for a healthier tobacco free future for the children and young people in Kirklees and looking to align to the ambition to make Kirklees smoke free by 2030.

The Board was informed that on the 9th June 2021, the All-Party Parliamentary Group (APPG) on Smoking and Health launched its report and recommendations for the forthcoming Tobacco Control Plan to secure the government's ambition of a smoke free country by 2030.

Within the report that there are there are twelve recommendations, and it is important to note the ones which relate to the funding of tobacco control programs through a tobacco control levy. It proposes that funding be secured through a 'polluter pays' amendment to the health and social care bill, which forces manufacturers to pay to deliver end of smoking. The levy on manufactures is expected to raise £700m in the first year.
Another key recommendation calls for targeted investment to provide additional support to help smokers quit in regions and communities where smoking does the most damage, for example, areas where people work in more routine and manual jobs, and people who are unemployed and people with mental health conditions.

The Board was informed that the next Tobacco Control Plan for England is due to be published in October 2021 and was asked to note the recommendations and to support the call for the tobacco levy.

The Board agreed it would be useful to have a further timely update once the report had been published to comment and understand how things are working and contribute to that discussion.

The Board commented that the information presented links into the conversations around the Joint Health and Wellbeing Strategy and the need to look at new and different ways to approach some of the challenges that have been around for a long time. The work of the alliance will do that and help to embed tackling inequalities which is a key priority for the Council and its partners.

The Board further commented on the connotations of the name 'tobacco alliance' and was advised that it has been introduced by that name in other areas and therefore Kirklees also went with that name, however this could be looked at.

The Board was asked to comment and make a formal decision regarding the reporting arrangements on the following recommendations:

- Tobacco Alliance is recognised as formally accountable to the Health and Wellbeing Board
- Health and Wellbeing Board receive updates regarding the work of the Tobacco Alliance on a regular basis as agreed by the Board
- Health and Wellbeing Board will shape the work of the Tobacco Alliance and influence the agenda at a strategic level

RESOLVED

- That the draft action plan once formulated would be shared with the Board for feedback
- That timely updates on the work of the Tobacco Alliance would be presented to the Board

22 The Health and Care Bill: Preparations in West Yorkshire and Kirklees for the proposed changes

Carol McKenna, Chief Officer and Richard Parry Strategic Director for Adults and Health updated the Board on the Health and Social Care Bill. In summary, the Board was informed that the legislation is focused on establishing Integrated Care Systems (ICS) as statutory bodies from the 1st of April 2022. This will mean that the functions that currently sits within Clinical Commissioning Group's (CCG) will transfer into ICS's and CCGs will be dissolved after the 31st March 2021.

There are a number of dimensions that it just be helpful for the Board to consider. The Health and Social Care Act will establish:

1) **Integrated Care Partnerships** (ICPs) - which is a broad alliance of organisations and representatives, and that is very, very similar to the Partnership Board that is now operating across West Yorkshire and Harrogate ICS

2) **Integrated Care Boards** (ICB) - which will bring together the NHS bodies to improve population health and care, and that is a statutory body that will be accountable for funding and performance

3) **Place-Based Partnership** (PBP) – will remain as the foundations of Integrated Care Systems building on existing local arrangements and relationships. This will be an important element of the new arrangement

ICS exist to achieve four aims:

- Improve outcomes for population health and healthcare
- Tackle inequalities in outcomes, experience, and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development

West Yorkshire and Harrogate have been operating as an informal ICS for several years now and it is fairly well developed. However, the changes required by the Act will see the current voluntary partnership move to statutory arrangements. The

intention remains that collaborating as an ICS will help health and care organisations tackle complex challenges that are beyond the scope of individual organisations.

The Board was informed that in the early drafts of the Health and Social Care Bill social care got very little mention, but there are two key changes:

- from 2023 the CQC will start to inspect local authorities social care functions, in addition to existing inspection of care providers
- the government being able to pass funding to directly fund social care providers, rather than money flowing into local authorities then to social care providers,

As the development of the Act moved through various stages there has been more focus on social care, for example, the Health and Social Care Act will establish a requirement to create a workforce plan for the effectiveness of the health and care workforce. There is also the potential complexity of some announcements around the future of social care funding and who pays for their own care, and the pricing structure for things like residential care, with further detail to follow on that. There is also talk of an integration white paper later this year.

The Board was informed that there are five place-based partnerships within the West Yorkshire ICS. The potential activities and approaches of place-based partnerships include:

- Health and Care Strategy and planning at place
- Service planning
- Service delivery and transformation
- Population health management
- Connection support in the community
- Promote health and wellbeing
- Align management support

Provider Collaboratives – partnership arrangements involving at least two trusts working at scale across multiple places, with a shared purpose and effective decision-making arrangements to:

- Reduce unwanted variation and inequality in health outcomes, access to services and experience
- Improve resilience for example by providing mutual aid
- Ensure that specialism and consolidation occur where this will provide better outcomes and value

It is very much expected that the ethos of provider collaboratives will be the spirit of collaboration and cooperation rather than competition. The way the partnership has worked over the past 18 months in Kirklees to respond to the pandemic and deliver the vaccine program has been about collective teams and communities working together to address specific need.

The place-based partnership will take on delegated authority for some elements, from the ICB, in terms of funding and performance. The expectation at the moment is that the level of resource delegated back into place will be quite significant to continue to make decisions locally on matters that are relevant to each place under that delegated authority.

The expectation is that the Health and Wellbeing Board will continue into the new arrangement and will still be responsible for setting the overall strategy within which the rest of the system will operate.
With CCG's no longer being in place, there will no longer be governing bodies made up predominantly of GPs. The aim will be to create a multi-professional multi-disciplinary, clinical, and professional reference group who can provide advice and leadership and guidance into the system and ensure that the decisions that are made are clinically sound.

Timeline and next steps

September 21	ICS Chair and Chief Executive appointment (currently underway)
Oct/Nov 21	ICS shadow form
November 21	PBP Shadow form
December 21	Place lead appointed
March 22	CCG transition complete
April 22	ICS and PBP live

- The Integrated Health and Care Leadership Board and Design Team will continue to develop Kirklees PBP model and structures
- Continue to test back with NHSE and West Yorkshire (WY) ICS
- Develop plan to be shared with WY team in November
- West Yorkshire refining functions using once or five times model and developing structures

RESOLVED
That Carol McKenna and Richard Parry be thanked for providing an update on the Health and Social Care Bill

23 Date of the next meeting
The date of the next meeting be noted by the Board.

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: 2nd December 2021

TITLE OF PAPER: Kirklees Ageing Well Strategy

1. Purpose of paper

1.1. The purpose of the paper is to present the draft Kirklees Ageing Well Strategy to the Kirklees Health and Wellbeing Board for discussion and support/approval.
1.2. The strategy has been developed and shaped with system partners.
1.3. The strategy was presented to the Ageing Well Board on the 5th July 2021 and the Kirklees Integrated Health and Care Leadership Board on the 5th August and supported to take forward for approval at this board.

2. Background

2.1. A key ambition across Kirklees is to support the population to age well. To outline how the Kirklees system will support people to age well, a system-wide ageing well strategy has been developed.
2.2. This strategy supports the key deliverables within the NHS Long Term Plan and the national NHS England Ageing Well Programme. Local places are asked to mobilise key deliverables around Anticipatory Care, Enhanced Health in Care Homes and Urgent Community Response. The Kirklees ageing well programme is broader than the national definition due to the interdependences and includes wider programmes of work including Frailty, Care Homes, End of Life and Discharge to Assess.
2.3. The purpose of the Ageing Well strategy is to outline how quality of life and outcomes for the Kirklees population will be improved by supporting people to age well and remain independent for longer.
2.4. For the purpose of the strategy, the principles and outcomes have been split into 4 key domains as shown below.

KIRKLEES AGEING WELL VISION:

Our ageing population will be enabled to self-care in order to optimise their health and wellbeing, identify their own needs and be supported to live as safely and independently, for as long as possible, through an integrated proactive approach across the health and social care system.

Domain 1: Prevention	Domain 2: Healthy and safe Environment	Domain 3: Seamless, integrated system and support networks	Domain 4: High Quality, Person Centred and Personalised Care
Effectively communicate messages about healthy living according to the abilities and needs of individuals.	No matter where they live, people in Kirklees live their lives confidently, in better health, for longer and experience less inequality.	People experience seamless health and social care appropriate to their needs that it is affordable and sustainable.	Sustainable and future ready workforce that has the correct capability and competencies to deliver quality services.
Facilitate access to sources of health promotion information and support.	Access to a safe, warm, affordable home in a decent physical environment within a supportive community with timely access to appropriate services.	Kirklees residents are able to navigate around an integrated service delivery across the voluntary, primary, community, and social care sectors.	Embed NHS England Personalised Care Operating Model
The needs of carers will be identified and supported.	Holistic assessments will aim to identify a person's physical and mental health status and function as well as social and environmental issues.	Care is planned with people who work together to understand the service user and their carer(s), puts them in control and coordinates and delivers services to achieve the best outcomes.	People are able to agree the health and wellbeing outcomes they want to achieve
Encourage changes in behaviour that will have a positive impact on the health and wellbeing of individuals, communities and populations, i.e. Making Every Contact Count	Utilisation of appropriate technology, equipment and adaptations to support people to develop skills that enables them to remain independent for longer.	Joined-up approach to assessment, care and support planning and review, resulting in a joined-up personalised care and support plan which takes account of all their needs.	Shared Decision Making to hear the voice of the patient, carers and their families to ensure they are actively involved and engaged in their care.
People in Kirklees, their family, friends and carers are able to make the most of the support on offer and can plan effectively for their own current and future care			Co-produced and evidence based service transformation and design
			Population Health Management approach

NARROWING INEQUALITIES

3. Proposal

3.1. The proposal is for the Kirklees Health and Wellbeing Board to review the strategy and approve/sign off as a mechanism to support delivery of the identified outcomes.

4. Financial Implications

4.1. No stand-alone/direct financial implications have been identified around sign off of the strategy

4.2. Any financial implication with regards the individual workstreams within the Ageing Well Programme will be manged through the correct governance routes.

4.3. The Long-Term Plan provided an outline of system development funding available to support Ageing Well priorities to be available between April 2019 and March 2024.

4.4. Further targeted system development funding has been made available to pilot sites for Urgent Community Response. Kirklees is one of 7 pilots to receive additional non recurrent funding in 2020/21 and 2021/22.

4.5. In 2021/22 Kirklees Ageing Well system development funding of £1.975m is available to support delivery of Ageing Well priorities. The funding available in future years has not been confirmed, however recurrent ageing well commitments have been made (which include the urgent community response). The financial implications and risks of ageing well will form part of the Kirklees Place from 1/4/22.

4.6. One of the financial tools available to us is pooling of budgets through Section 75 Agreements. This is not an end in itself, but a tool to enable the integration and transformation of service delivery and achieving outcomes. The CCG and Council Joint Senior Management Team (JSMT) have responsibility for overseeing the Better Care Fund which brings together elements of the core budgets of the CCG and Council. The JSMT has agreed that the flexibilities available through pooling of budgets would provide opportunities to support the delivery of the Ageing Well Strategy. Consequently, the Better Care Fund is being realigned to support the delivery of our Ageing Well Strategy. There are no services that have lost funding as a result of the changes we have made. Our use of the Better Care Fund is subject to a national assurance process. A plan has been submitted based on the Ageing Well Strategy and our other actions to enable people to live as independently as possible.

5. Sign off

5.1. Karen Jackson is the SRO for the Ageing Well Programme and has approved this paper on 15/11/2021 to be submitted to the Health and Wellbeing Board.

6. Next Steps

6.1. The final strategy will be shared with system partners at the next Ageing Well Board meeting where colleagues will be asked to support delivery of the identified outcomes within their organisations.

7. Recommendations

The Kirklees Health and Wellbeing Board

7.1. Support and sign off the Ageing Well strategy

7.2. Note that the implementation of the Ageing Well Strategy will be enabled by the use of pooled budget arrangements where these can support integration and transformation of services to improve outcomes.

8. Contact Officer

Nicola Cochrane, Programme Manager, Kirklees CCG, Nicola.cochrane1@nhs.net
Julie Oldroyd, Senior Manager – Transformation – Community, Kirklees CCG, Julie.oldroyd@nhs.net

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Kirklees Ageing Well Strategy 2022 - 2027

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INTRODUCTION

A key ambition across Kirklees is to support the population to age well. Empowering people to stay independent and providing more support in the community or at home enables people to have greater control over their care. To outline how the Kirklees system will support people to age well, an ageing well programme has been developed. This strategy provides a high-level overview of the programme, detailed delivery plans and milestones for each individual programme will sit underneath this strategy.

In order to deliver effectively against the Ageing Well Strategy it is our intention that the ageing population of Kirklees are at the heart of informing what the key problems and issues are that they face. Our aim is to ensure we engage with our communities to understand what is working well for them and what may need to change using various networks and means to allow joint decision making together.

This strategy also supports the key deliverables within the NHS Long Term Plan and the national NHS England Ageing Well Programme. Local places are asked to mobilise key deliverables around Anticipatory Care, Enhanced Health in Care Homes and Urgent Community Response. The Kirklees ageing well programme is broader than the national definition and includes wider programmes of work including Frailty, Care Homes, End of Life and Discharge to Assess.

This Kirklees Ageing Well Strategy builds on the previous (2019-2022) Frailty strategy and outlines how the delivery of the national, regional, and local commitments around Ageing Well will be achieved. This document is not intended to be public facing, instead it demonstrates the strategic direction of travel around achieving the outcomes for our Kirklees population. The public facing elements will be embedded within the Kirklees Health and Wellbeing Plan.

PURPOSE

The purpose of this strategy is to outline how quality of life and outcomes for the Kirklees population will be improved by supporting people to age well and remain independent for longer. This will be achieved through taking a life course approach and focusing on effective prevention (primary and secondary) and management of long-term conditions, alongside maximising independence. A collaborative and systemic approach will be taken, working across all health, social care, and voluntary and 3rd sector partners. To support our population, their families and carers, a standardised approach to reduce variation, whilst providing personalised, person centred care will be developed. The key domains and principles describe the support available to help people develop the skills in order to promote their own wellbeing that enables people to self-care effectively. The system will focus on prevention, promoting support and maintaining independence for the Kirklees ageing population through early identification, developing high quality, personalised services that are flexible, proactive and responsive and enable the ageing population choice and control over how their health and care needs and support are provided.

WHY FOCUS ON AGEING WELL?

As the UK's population continues to grow there has been a shift in the age structure towards older ages meaning we have an ageing population. By 2050, it is projected that one in four people in the UK will be aged 65 years and over, an increase from approximately one in five in 2019[1]. The Health and Care sector is faced with challenges in supporting an ageing population as the likelihood of losing functional ability and living with complex health conditions increases as we age with many people developing conditions that reduce their independence and quality of life. This also impacts on the social care system as supporting people who are not ageing well is substantial and will increase, creating significant economic pressure.[2]

[1] https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/articles/overviewoftheukpopulation/january2021

[2] https://www.england.nhs.uk/blog/the-journey-to-age-equality/

The leading cause of death in the UK in 2018 was dementia and Alzheimer disease[3], accounting for 12.7% of all deaths registered. There are several reasons why the number of deaths from dementia and Alzheimer disease has increased in recent years. Dementia and Alzheimer disease are more likely to occur among older age groups, and more people are living longer and surviving other illnesses. In addition, a better understanding of dementia and improved diagnosis is likely to have caused increased reporting of dementia on death certificates. This may be a consequence of initiatives put in place in 2013 to 2014, such as the Prime Minister's challenge on dementia and the government's mandate to NHS England, which included an ambition that two-thirds of the estimated number of people with dementia in England should have a diagnosis.

As well as focusing on Ageing Well, it is equally important to focus on dying well. Over 20% of the entire NHS and social care budget is spent in the last year of someone's life. Over half of complaints to the Health ombudsman relate to care at the end of life and over half of these are upheld. The Kirklees Care Charter (see appendix 1) has therefore been developed and explains what you can expect, as a pledge to improving end of life care in Kirklees.

HOW CAN WE SUPPORT PEOPLE TO AGE WELL?

Extending independence as we age requires a targeted and personalised approach. With a move to Population Health Management and utilising tools to enable early identification of need allows the system to adopt a predictive prevention approach. This allows Health and Care services to be more pro-active. With the right support, people of all ages can take more control of how they manage their physical and mental wellbeing allowing them to have the skills to be as independent as possible for as long as possible.

Locally, work is underway to support Primary Care and the wider system to identify Frailty (mild, moderate and severe) for all age groups. Frailty is now nationally recognised as a long term condition which affects people's ability to recover when challenged by sudden, unexpected life changes. It can lead to a rapid decline in health and well-being leading to crisis situations. For people at risk of developing long term conditions there are potentially preventable or modifiable risk factors or conditions. These include alcohol excess; cognitive impairment, dementia, mental ill health, reduced mobility, delirium , falls, functional impairment, hearing problems, mood problems, nutritional compromise, physical inactivity, polypharmacy, smoking, vision problems, social isolation and loneliness. Promoting healthy ageing supports people to maintain their independence for as long as possible. Through early identification of need and management, health, social care and third sector/voluntary professionals are able to effectively support people to maintain independence, self-care and achieve better holistic outcomes (as described through the seven Kirklees Outcomes detailed in the Health and Well Being Plan – see Appendix 2.)

We will build on our previous achievements and take forward learning from Covid-19[4] including recognising protective characteristics to advance the equality in the design of future work to embed fairness and equity from the outset. We recognise the importance of mental health and wellbeing[5] and continue to strengthen work associated with Kirklees "Whole Life Approach" for Mental Health & Wellbeing 2017-2021 in conjunction of other key Kirklees strategies such as Kirklees Joint Health and Wellbeing Strategy 2014-2020, Living life to the Full with Dementia,

[3] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/articles/leadingcausesofdeathuk/2001to2018#uk-leading-causes-of-death-by-age-group

[4] https://www.england.nhs.uk/wp-content/uploads/2020/09/C0747_Dementia-wellbeing-in-the-COVID-19-pandemic.pdf

[5] https://www.kirklees.gov.uk/beta/adult-social-care-providers/pdf/mental-health-strategy.pdf

Better Mental Health for all: A Public Health Approach to Mental Health Improvement (2016), Prevention Concordat for Mental Health and the Kirklees Mental Health Alliance.

Developing an integrated model for end of life care is one of the priorities of the Kirklees Health and Wellbeing Plan 2018 – 2023. Through the integrated health and social care model we aim to work as a system supporting people at end of life of all ages to continue to have the best quality life, and when the time comes, death, as possible. End of life has its own workstream within the Ageing Well Programme however it also engages and threads through all the other workstreams and programmes to achieve this aim.

HEALTH INEQUALITIES

As described in the Kirklees Health and Wellbeing Plan[6] 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****."* 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. The below priorities will be embedded into the ageing well programmes with the aim of narrowing inequalities across Kirklees. The Domains within this strategy explain how this will be done.

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

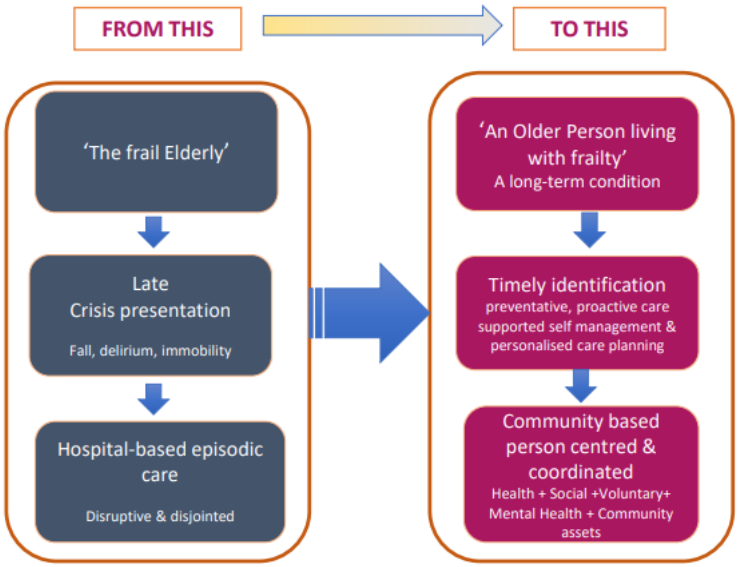
3. **Develop our people to deliver the priorities and foster resilience**
   - Equip people the resources to stay independent and live well
   - Change the conversation – focus on strengths, assets and responsibilities (Making every contact count)
   - People who use and provide services work together 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

The Public Health Kirklees Annual Report 2020-21[7] also takes a focus on Health and Inequalities. It explores the nature and scale of health inequalities experienced by our communities in Kirklees, using a life course approach. The report highlights that health inequalities, and the conditions which lead to them, are not inevitable. They can be addresses and reduced. Addressing inequalities is a priority across Kirklees and builds on the vision to work with people and partners, using a place-based approach to improve outcomes for our local population, particularly those who are currently most disadvantaged and at risk of poor health. There are a number of recommendations (see appendix 3) within the report demonstrating a commitment to tackle inequalities. These recommendations will be embedded into the Ageing Well programme and across everything we do in Kirklees.

[6] https://www.kirklees.gov.uk/beta/working-with-children/pdf/future-in-mind/2018-19/appendix-j-kirklees-health-wellbing-plan.pdf

[7] https://www.kirklees.gov.uk/beta/delivering-services/pdf/public-health-report.pdf

THE NATIONAL AND REGIONAL AGENDA



Ageing well is part of the national agenda, with NHS England producing a range of resources[8] for commissioners and professionals around ageing well and supporting people living with frailty. The resources describe how population-level frailty identification and stratification can help plan for future health and social care demand, manage and best structure resources to optimise equity and outcomes whilst also targeting ways to help people age well. The NHS Long Term Plan[9] sets out some changes required to support the population to age well. The plan articulates that extending independence as we age requires a targeted and personalised approach, enabled by digital health records, population health management and shared health management tools. Promoting the prevention, early identification and self-care agendas enables people to look after their health and wellbeing, prevent, delay and minimise the severity and impact of frailty, and maximise outcomes. Hospitals were also required to reduce avoidable admissions through the establishment of acute frailty services, so that such patients can be assessed, treated and supported by skilled multidisciplinary teams delivering comprehensive geriatric assessments in A&E and acute receiving units. These have already been established locally in the two Acute Trusts.

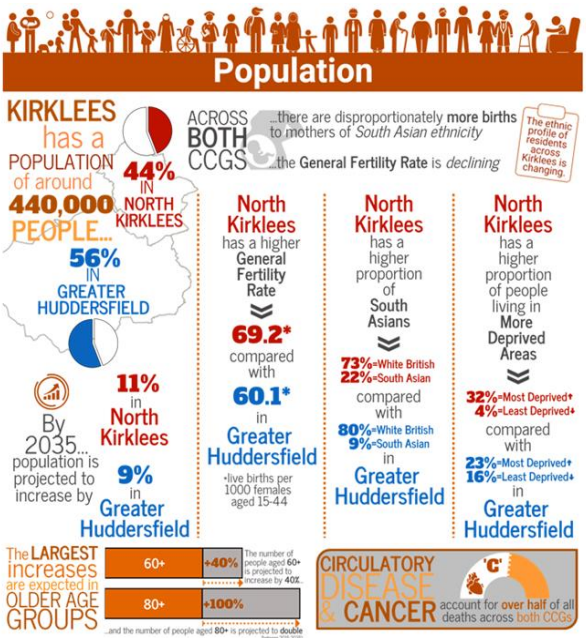
Health Education England and NHS England commissioned the development of a Frailty Core Capabilities Framework[10] to improve the effectiveness and capability of services for people living with frailty. One of the aims of this framework is to empower people living with frailty, as well as their family, friends and carers, to understand the condition, make the most of available support and to plan effectively for their own current and future care needs.

NHS RightCare has also developed a Frailty Toolkit [11]which provides expert practical advice and guidance on how to commission and provide the best system wide care for people living with frailty and supporting people to age well.

[8] https://www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/
[9] https://www.longtermplan.nhs.uk/
[10] https://skillsforhealth.org.uk/wp-content/uploads/2021/01/Frailty-framework.pdf
[11] https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2019/07/frailty-toolkit-june-2019-v1.pdf

THE LOCAL POPULATION

Around 440,000 people live in Kirklees (GP registrations January 2015) with roughly equal numbers of males and females. Kirklees has a varied population, many ethnicities are represented, speaking a range of languages and bringing a cultural diversity to the region. The population has increased by 8.4% since 2002, and is predicted to rise by a further 9.9% by 2030. Kirklees contains areas of high and low deprivation, with regions of highest deprivation found in some of the more densely populated urban areas to the north and east (including parts of Huddersfield, Dewsbury and Batley), and lower levels of deprivation found in the more sparsely populated rural areas to the south and west (including the Colne and Holme Valleys, Denby Dale and Kirkburton).



Population projections to 2030 from the Office for National Statistics (ONS) predict greater increases in the numbers of very young children and older adults (particularly those aged over 64), leading to a relatively smaller working age population supporting a larger dependent population. As the number of people with multiple long-term health conditions increases with age, a projected ageing population is likely to lead to a greater demand on resources. Research has shown that on average, people with a learning disability die earlier than the general public, and do not receive the same quality of care as people without a learning disability.

In 2019, the Index of Multiple Deprivation (IMD) [12] ranked Kirklees as 83 out of 317 local authorities in England (where 317 is the least deprived, 1 is the most deprived.) For the income and employment domains, Kirklees is ranked as one of the most deprived local authorities in England. Using local IMD rankings we can measure the extent of health inequalities within our communities by comparing health indicators. How well and how long people live is mainly linked to the wider determinants of health. As little as 10% of a populations health and wellbeing is linked to access to health care. The wider determinants influence health and wellbeing outcomes and inequalities throughout life. The key principles for improving opportunities for health for everyone and tackling inequatlities align with our council plan approach of working with people and partners using a place-based approach.

West Yorkshire and Harrogate Health and Care Partnership publication-Initiatives to help reduce unnecessary admissions and length of stay in acute hospitals for people with dementia-The Alzheimer's Society reports that over 40% of older people in hospital have dementia. Their length of stay will be twice that of people without the condition and a third of these patients do not even need to be there. People with dementia represent a quarter of delayed discharges and 10% of readmissions within 30 days.

Information above taken from https://observatory.kirklees.gov.uk/jsna

[12] https://www.kirklees.gov.uk/beta/delivering-services/pdf/public-health-report.pdf

WHAT DOES THIS MEAN IN RELATION TO AGEING WELL?

Understanding the changes in our local population allows the system to plan better for the future needs. Population projections highlight that the largest increases expected are in the young and older age groups. By 2030, 21% of the Kirklees population will be aged 65+ (compared to 16% in 2015.) This therefore highlights the need to ensure the Kirklees population are supported to age well, in the place of their choice, and that services are designed in such way.

Although changes have already started to take place locally in the way that the population is supported through earlier prevention methods, holistic approaches and the self-care agenda there are still improvements to be made. The Kirklees Health and Wellbeing plan (2018 – 2023) brings together partners to focus on the people who live in Kirklees and how, working collectively, we can improve the health and wellbeing of the whole population. The aim is to 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 and die well. The diagram in Appendix 4 (taken from the Health and Wellbeing Plan) describes the population characteristics of each of these groups and the focus in terms of supporting the population of Kirklees.

THE AGEING WELL PROGRAMME

NATIONAL AGEING WELL PROGRAMME

The national ageing well programme consists of delivery of 3 main elements:

KIRKLEES AGEING WELL PROGRAMME

The Kirklees Ageing Well Programme aims to broaden out the National definition. The table below provides a high-level description of the local Kirklees Ageing Well programme.

Programme	Descriptor
Anticipatory Care	Proactive health and care interventions targeted at people living with frailty, multi-morbidity and/or complex needs to help them stay independent and healthy for as long as possible. Focussing on what is important to the individual.
Frailty	➢ System wide approach to Frailty identification and response to frailty syndromes ➢ Training and education - Having a system wide skilled workforce to identify and care for our frail population ➢ Utilising advances in technology
Care Homes	➢ Roll out principles outlined in the Framework for Enhanced Health in Care Homes ➢ Strengthen support for the people who live or work in care homes ➢ Develop a market that is financially sustainable
End of Life	➢ Supporting people with life limiting illnesses to experience great personalised care, so they can live, live on and live well ➢ Deliver an integrated end of life care model across Kirklees which provides quality and coordinated end of life care when people need it. ➢ Delivery is underpinned by the Kirklees End of Life Care Charter.
Urgent Community Response	Increase the capacity and responsiveness of intermediate care services to provide crisis response within 2 hours of need and reablement within 2 days to both avoid unnecessary hospital admission and support early discharge for medically optimised older people to leave hospital on time
Discharge to Assess	Embed and mature the discharge to assess approach Improve patient flow out of hospital Build the evidence base on discharge practices, use of pathways, outcomes and the impact of intermediate care

There are also key interdependencies and enablers to the above programmes that are threaded through the individual delivery workstreams and are key to successful delivery of the desired outcomes for the Kirklees ageing population. These include:

Anticipatory Care	Frailty	Care Home	EOL	Urgent Community Response – pilot	Discharge to Assess
Mental health and learning disability programmes (https://leder.nhs.uk/) Including: Care homes Training and Support to enhance quality of life in care homes for people with dementia via pilot. West Yorkshire and Harrogate CLEAR Dementia work					
Public Health Ageing Well Agenda					
Carers: Support and Strategy					
Care Co-ordination and Multi-Disciplinary Teams					
Personalisation					
Digital and Assistive Technology					
Workforce					
Training and Education – for the Kirklees population and workforce					
Housing/Community Accommodation					
Indicators – e.g. Advance Care Planning					
Kirklees Research Group					
Kirklees End of Life Charter					

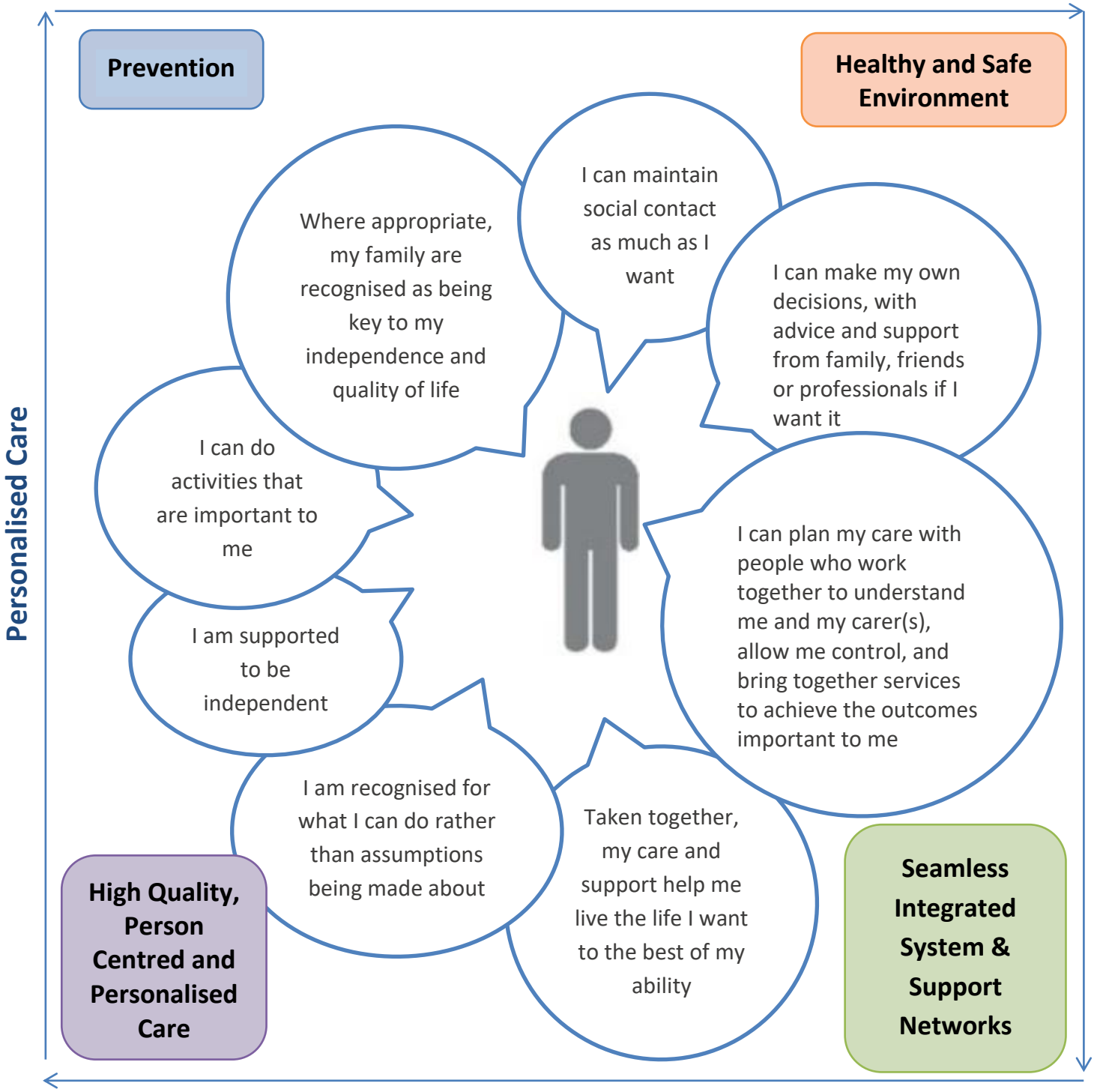
DELIVERING THE STRATEGY

For the purpose of the strategy, the principles and outcomes have been split into 4 key domains. These are:

1. Prevention
2. Healthy and Safe Environment
3. Seamless Integrated System and Support Networks
4. High Quality, Person Centred and Personalised Care

STRATEGIC AIMS, OBJECTIVES AND OUTCOMES

The key aim is that the population of Kirklees receives a more personalised approach tailored to support their needs. The focus will be on prevention and early identification. This approach will embed shared decision making in our working practice which is fundamental to changing the relationship with patients and ensuring they feel more empowered to take control of their care. This will also include outcome-focused care planning with a strengths-based approach. This will ensure that the ageing population of Kirklees are supported to live as independently as possible for as long as possible in their chosen place of residence. This will be underpinned by the ethos of providing the right care in the right place at the right time, first time; with a focus on quality, patient outcomes and effective use of financial resources. Care and support will be designed in a co-ordinated way that will support people to be successful in achieving the outcomes that matter most to them.



*'**I statements**' developed by National Voices, UCL Partners & Age UK (2014)*

KIRKLEES AGEING WELL VISION:

Our ageing population will be enabled to self-care in order to optimise their health and wellbeing, identify their own needs and be supported to live as safely and independently, for as long as possible, through an integrated proactive approach across the health and social care system.

Domain 1: Prevention	Domain 2: Healthy and safe Environment	Domain 3: Seamless, integrated system and support networks	Domain 4: High Quality, Person Centred and Personalised Care
Effectively communicate messages about healthy living according to the abilities and needs of individuals.	No matter where they live, people in Kirklees live their lives confidently, in better health, for longer and experience less inequality.	People experience seamless health and social care appropriate to their needs that it is affordable and sustainable.	Sustainable and future ready workforce that has the correct capability and competencies to deliver quality services.
Facilitate access to sources of health promotion information and support.	Access to a safe, warm, affordable home in a decent physical environment within a supportive community with timely access to appropriate services.	Kirklees residents are able to navigate around an integrated service delivery across the voluntary, primary, community, and social care sectors.	Embed NHS England Personalised Care Operating Model
The needs of carers will be identified and supported.	Holistic assessments will aim to identify a person's physical and mental health status and function as well as social and environmental issues.	Care is planned with people who work together to understand the service user and their carer(s), puts them in control and coordinates and delivers services to achieve the best outcomes.	People are able to agree the health and wellbeing outcomes they want to achieve
Encourage changes in behaviour that will have a positive impact on the health and wellbeing of individuals, communities and populations, i.e. Making Every Contact Count	Utilisation of appropriate technology, equipment and adaptations to support people to develop skills that enables them to remain independent for longer.	Joined-up approach to assessment, care and support planning and review, resulting in a joined-up personalised care and support plan which takes account of all their needs.	Shared Decision Making to hear the voice of the patient, carers and their families to ensure they are actively involved and engaged in their care.
People in Kirklees, their family, friends and carers are able to make the most of the support on offer and can plan effectively for their own current and future care			Co-produced and evidence based service transformation and design
			Population Health Management approach

NARROWING INEQUALITIES

DOMAIN 1: PREVENTION

The number of people with diseases will double over the next 20 years and the number of people with more than one long-term condition is growing rapidly. The number of people with health and social care needs will also continue to increase unless we enable them to live and age well. Healthy behaviours, including not smoking, avoiding harmful alcohol consumption, good nutrition and physical activity have a positive effect on people's health and promoting that of future generations, contributing to them having the best start in life. Health inequalities have a significant impact on people's long-term health and wellbeing. Deprivation (including financial, food, housing, and fuel poverty) amplifies the effects of unhealthy behaviours and negatively impacts on people's life chances (including their likelihood of smoking, quality of education and employment) and their health and wellbeing. 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. [13]

There is a need to address all types of prevention: primary prevention by promoting health and wellbeing and preventing ill health; secondary prevention through early detection and intervention of ill health thereby reducing its severity and impact, halting or slowing its progress, and where possible promoting recovery and preventing/delaying relapse; and tertiary prevention where the impacts of ill health are minimised and quality of life and wellbeing are promoted.

An integrated holistic approach rather than a disease centred approach is needed to support the ageing well agenda and promote prevention properly and effectively. A comprehensive prevention approach should encompass

- Starting well - giving children the best start in life and promote intergenerational health and wellbeing;
- Healthy ageing - including integrated health and wellbeing approaches that support health promoting lifestyles and behaviours, for example, personal resilience, health weight, physical activity, nutrition, smoking cessation, risk factors of developing dementia and mental health conditions, substance misuse recovery and sexual health;
- Reducing health inequalities - including those associated with protected characteristics, LGBT, BAME, Learning Disabilities, poverty, housing, education and employment.
- Living and ageing well approaches with embedded education and enabling ethos - including accessible and up to date public information around how to remain independent and at home for longer, healthy, safe and enabling environments, self-care, falls prevention, medication reviews, vaccinations programmes, promoting nutrition and hydration, home exercise programmes, support to regain skills such as cooking or dressing, and approaches that build social networks and reduce isolation, depression and anxiety (Hendry A et al, 2018.);
- A personalised, holistic approach that includes the identification of people's unique personal preferences, their core economies, health and well-being, individual circumstances and priorities and values, resilience, capacity and assets. Support and resources should be tailored (as appropriate) to promote health, wellbeing, personal capacity, choice, resilience and individual and community assets.

By strengthening and better coordinating the local prevention approaches at all levels it will deliver improved outcomes for the local population. This has highlighted a need for greater focus locally around primary prevention through promoting physical activity, nutrition, social participation ensuring people have adequate, warm, and safe accommodation and reducing health inequalities. Early identification within secondary prevention will reduce the need for more intensive health and social care, and tertiary prevention will be enabled by comprehensive geriatric assessments, routine annual health check-ups, and supporting patients to have the ability to self-care. To further support people to achieve their goals, an outcome-based approach should be utilised. Using this approach, we are clear that the starting point of any planning process should be a clear statement of what conditions of wellbeing are desired (the outcome). 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 seven outcomes for Kirklees (see appendix 2) we will know that people are ageing well.[14]

[13] https://www.kirklees.gov.uk/beta/delivering-services/pdf/public-health-report-2018.pdf
[14] https://www.kirklees.gov.uk/beta/delivering-services/pdf/public-health-report-2018.pdf

Domain 1: Prevention

Principles:

- Positively promoting prevention and the benefits of ageing well
- Reducing the severity/acuity and impacts of Long-Term Conditions
- Promoting independence and community skills
- Physical and mental health and wellbeing
- Early identification

How will the Domain be embedded locally?

Delivery of the strategy – Identification

- Continue early identification of needs through a population health management approach, utilising tools such as the Electronic Frailty Index (EFI) and Rockwood to ensure Frailty is identified and patients' needs are assessed and where required patients are signposted to appropriate services.
- Continue to understand the importance of early recognition and timely management of conditions

Anticipatory Care Model Delivery

- Support patients to be able to identify their own health and care needs
- Once diagnosed as having Mild, Moderate or Severe Frailty, ensure key interventions are undertaken through an Anticipatory Care approach.
- Ensure patients are known to the social prescribers/link workers/local area co-ordinators to offer support where needed
- Medicines optimisation

Prevention and Awareness Workstreams

- Promote the use of the Kirklees Age Smart app
- Embed the Prevention and Pro-active Care Integrated Care Interventions (See Appendix 5)
- Integrated Wellness Model and associated resources including Integrated Wellness Service, Community Plus, Social Prescribing
- Falls service and falls prevention work-stream including strength and balance programmes
- Promoting physical activity, good nutrition and hydration, and social participation
- Self-care initiatives and resources
- Effectively communicate messages about healthy living according to the abilities and needs of individuals
- Link to MyHealthTools Kirklees Public Health promotion toolkit
- Anti-stigma Project
- The Public Health Minority Mental Health
- Better health and wellbeing for everyone: Our five-year plan[15]
- Facilitate access to sources of health promotion information and support
- West Yorkshire and Harrogate review report to tackle health inequalities for Black, Asian and minority ethnic communities and colleagues: Understanding impact, reducing inequalities, supporting recovery
- Understand approaches to prevent or reduce the risk of frailty syndromes
- Improving the use and quality of Advance Care Plans for people living with dementia and/ or frailty
- Raising Awareness and Training of Delirium – how to prevent it, spot it and manage it
- CLEAR dementia care tool – piloting use of tools within care home settings which help staff to understand and manage behaviours that can challenge
- Raising awareness and reducing health inequalities for people with learning disabilities to live longer happier lives[16]

Digital and Assistive Technology

- Assistive technology - opportunities to use digital tools and telehealth devices for physiological and behavioural monitoring which can support the need for early intervention of solutions to prevent potential deterioration.

Training and Education – workforce and the Kirklees Population

- Education and awareness locally to ensure the population of Kirklees:
  - Understand the importance of exercise, physical activity, diet and hydration for preventing and reducing the risk of long-term conditions
  - Are aware that factors such as smoking, obesity and inactivity increase the risk of frailty
  - be aware of and be able to access services such as health checks, free eye and hearing tests and home safety checks
- Developing capabilities in prevention, risk reduction, and a range of specific actions to support ageing well and maintaining independence to enable people and practitioners to deliver timely, high quality interventions that will in turn improve the outcomes and quality of life for people.
- Reducing stigma and especially in regard to people living with mental health disorders.
- Promoting early identification of symptoms that may suggest mental health diagnosis and early intervention.

Community

- Act on day-to-day interactions with people to encourage changes in behaviour that will have a positive impact on the health and wellbeing of individuals, communities and populations, i.e. Making Every Contact Count
- Raise public awareness of Delirium and how the condition can be managed to prevent un-necessary admissions that are not in the best interest of the patient
- Raise awareness of Dementia to DFC

Urgent Community Response and Admission Avoidance Schemes

- Admission avoidance schemes/services (e.g. UCR) delivered to ensure urgent help and support is available for people when they need it to enable them to remain as healthy and independent for as long as possible

Outcomes:

- Population of Kirklees will age well
- People in Kirklees live independently and have control over their lives
- People in Kirklees are more active, healthy population
- Fewer people in Kirklees will become frail or experience the acuity of Frailty worsening

[15] https://www.wyhpartnership.co.uk/download_file/view/1710/964

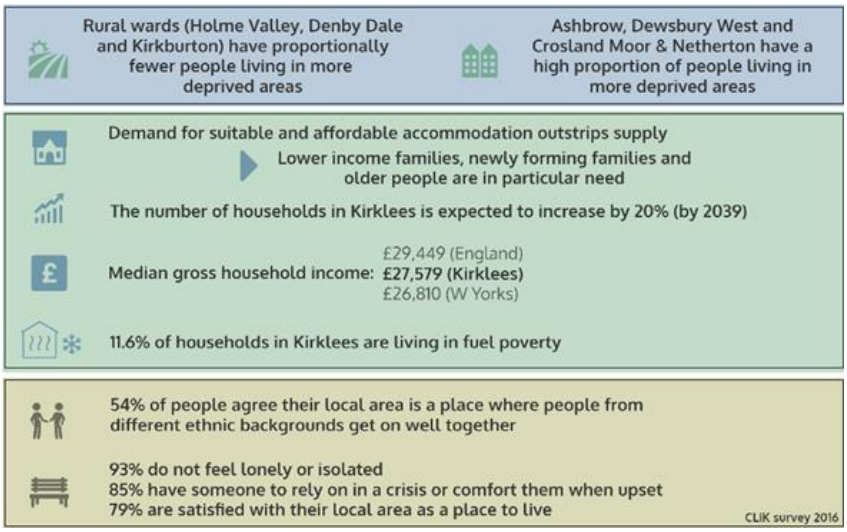
[16] https://www.england.nhs.uk/publication/learning-from-lives-and-deaths-people-with-a-learning-disability-and-autistic-people-leder-policy-2021/

DOMAIN 2: HEALTHY AND SAFE ENVIRONMENT

Creating a physical environment in which people can live healthier lives with a greater sense of wellbeing is hugely important in reducing health inequalities. Living close to areas of green space including parks, woodland and other open spaces can improve health, regardless of social class. The more deprived the neighbourhood, the more likely it is to have social and environmental characteristics presenting risks to health.

Decent, affordable and appropriate housing is increasingly needed to meet the current and longer-term needs of the population. In Kirklees 1 in 6 (16%) homes were in poor condition and often occupied by people who were most vulnerable (elderly, economically inactive, socially isolated) and who were unable to bring their homes up to a decent standard and maintain that standard. Overall, 1 in 6 (16%) householders felt their house was not suitable for their needs; older people were more likely to feel it was too large and families with children were more likely to feel it was too small.

In areas of Kirklees where high deprivation levels existed there were corresponding high levels of non-decent, poor quality housing, especially in the private rented and owner-occupied sector within central Huddersfield and Dewsbury.[17]



There are however a range of local assets in Kirklees that make a huge contribution to families and communities by supporting people to improve their outcomes, their wellbeing, and their health. It is vital to build on the assets of individuals and communities, including those in later life. These contributions can only be ensured if we foster people's health and participation as they age, through environments which promote accessibility, equity, safety, security and support age friendly and dementia friendly environments. The Ageing Well in Kirklees [18]report further defines these assets and provides detail and guidance on actions that can be taken.

[17] https://observatory.kirklees.gov.uk/jsna/housing

[18] https://www.kirklees.gov.uk/beta/delivering-services/pdf/public-health-report-2018.pdf

Domain 2: Healthy and Safe Environment

Principles:

- Promoting independence and community skills
- Voluntary, community, social enterprise and housing sectors as key partners and enablers

How will the Domain be embedded locally?

Community

- Community services will support people (and those who look after them) to stay at home safe and well, including supporting them to develop the skills to self-care where appropriate and live as independent as possible for as long as possible
- Build on the success of the Kirklees Independent Living Team (KILT) with further developments rolled out and learning adapted to other services.
- Embed and roll out the Kirklees Dementia Design Guidance to ensure public spaces/places meet the needs of people living with Dementia, mild cognitive impairment, sensory impairments, and those living with the general impairments of older age. This will include an 'at home' summarised guidance to support people to continue to live at home for longer.
- Provide rapid access to equipment, support services and a flexible bed base
- Outcomes focussed Domiciliary Care provision

Digital and Assistive Technology

- Utilisation of appropriate technology, equipment, and adaptations to support people to develop skills that enables them to remain independent for longer and ensuring necessary support to people in their own homes who may not have digital skills.
- Development of technology suite to demonstrate gold standards and awareness of what is available to support people to live as independently as possible.
- Maximise potential of Mobile Response through increased use of Care Phones

Housing Support

- Regularly re-assess needs within the living environment to ensure people remain as independent and safe as possible and the chance of re-admission to hospital is kept to a minimum
- Reduce the impact of environmental barriers/factors on people's physical and mental health and their ability to undertake activities of daily living in their own home
- Collaborate across service areas to develop and test new innovative models of provision of housing with care, coproduced with other stakeholders and at a local level to support innovation, service development and effective use of resources

Enhanced Health in Care Homes

- Continue to deliver the Enhanced Health in Care Homes offer

Discharge to Assess

- Promote a 'home first' philosophy to support as many people to stay in their own home environment
- Discharge to assess as soon as the acute episode is complete in order to plan post-acute care in the person's normal place of residence
- Recovery programmes should seek to address deconditioning in its widest sense, to frame it in positive terms so older adults feel like an active participant rather than a burden.

Prevention and Awareness Workstream

- Falls service and falls prevention work-stream
- Delivery of the loneliness strategy
- Good neighbour scheme
- Social Prescribing link workers
- Kirklees Joint Dementia Strategy

Outcomes:

People in Kirklees, will have improved health and wellbeing though:

- Being able to maintain their independence and enjoy the best possible quality of life wherever they live
- Professionals competently providing advice, guidance, and signposting on changing or adapting physical and social environments to ensure physical safety, comfort, and emotional security
- Professionals and people's awareness of how living with long term conditions affects and is affected by many different aspects of a person's life (including the person's physical health, immobility, mental health, loneliness, cognitive function and their social and home environment) and is actively supported to self-care and signposted to supports as appropriate
- Living in enabling and supportive environments where they feel valued and understood.

DOMAIN 3: SEAMLESS INTEGRATED SYSTEM AND SUPPORT NETWORKS

The future direction of travel for the NHS is around the development of Integrated Care Systems and Integrated Care Partnerships. Stronger partnerships in local places are key to providing joined-up care. The proposals are designed to serve four fundamental purposes:

- Improving population health and healthcare
- Tackling unequal outcomes and access
- Enhancing productivity and value for money; and
- Helping the NHS to support broader social and economic development

The aim is a progressively deepening relationship between the NHS and local authorities, including on health improvement and wellbeing. Building on the NHS Long Term Plan's vision of health and care joined up locally around people's needs, the main aims are to ensure:

- Decisions taken closer to the communities they affect are likely to lead to better outcomes
- Collaboration between partners in a place across health, care services, public health, and voluntary sector can overcome competing objectives and separate funding flows to help address health inequalities, improve outcomes, and deliver joined-up, efficient services for people
- Collaboration between providers (ambulance, hospital and mental health) across larger geographic footprints is likely to be more effective than competition in sustaining high quality care, tackling unequal access to services, and enhancing productivity.

The experience from the Covid-19 Pandemic has taught us that the continued integration of services is able to be implemented at pace across Primary, Community and Social care by investing and using new technology across systems. Much of this is supported by strong working relationships and adoption of technology by both patients and staff. The experience has demonstrated that in working together the system can train, support, induct and develop competencies quickly and safely.

Effective and sensitive communication that takes account of individual characteristics, needs and circumstances is required to develop supportive, caring relationships. It is also needed to build and support the networks of care that enable people living to maintain their independence and enjoy the best possible quality of life, whatever circumstances of their life. Families and carers provide the key foundation for this care for many people who have additional care needs. However, due to the complex and multidimensional nature of ageing well, people often benefit from the involvement of a wide range of other people and organisations. In order to achieve the best outcomes, these individuals and organisations must work in close partnership with individuals, their families, carers, and of course with each other. An individual's health, emotional wellbeing and quality of life are highly dependent upon wider social and economic circumstances. Factors such as isolation and housing may have pervasive effects that reduce an individual's ability to live their lives, manage their own health and respond to illness.

Domain 3: Seamless, Integrated System and Support Network

Principles:

- Collaborative and integrated working
- Leadership in transforming services
- Research and evidence-based practice
- Families and carers, or representative of the individual as partners in care
- Reduced duplication and variation across the system
- Effective use of resource
- Communication

How will the Domain be embedded locally?

Delivery of the Strategy:

- Implementation of the White Paper around the development of the Integrated Care Partnership
- A shared vision, aim and objectives will be owned by all key Stakeholders
- Providers will be supported and encouraged to work together in a holistic way putting the person at the heart of decision making
- System-wide, evidenced based and standardised recognition of the signs and assessment tools for conditions associated with ageing.
- Kirklees Joint Dementia Strategy and Detailed Action Plan developed and implemented
- Kirklees "Whole Life Approach" for Mental Health & Wellbeing 2017-2021"No Health, without Mental Health"
- Building on previous and recent strategies across the district

Anticipatory Care Model

- Embed the Integrated Care Interventions around swift and appropriate access to care and support with care transition (Appendix 5)

Prevention and Awareness Workstreams:

- Social isolation and loneliness strategy developed – continue with the delivery of the strategy and progression within the strategy group

Community

- Family, carers and social networks will be involved in planning and providing care
- Value and acknowledge the experience and expertise of people, their families, their carers and support networks, enabling choice and independence as far as is practical
- Patients, family and carers will be supported to access and use information and local support networks
- Ensure patients identified as being palliative or at the end of life, and their carers, feel supported both during end of life care and after the person has died

Communication and Engagement

- Regular communication channels with all key Stakeholders is required to remain up to date with progress of each project. This will include regular reports through formal governance structures
- Raise awareness of frailty and the risk factors associated across the Kirklees health and social care system
- Ensure appropriate training is available for all staff across all sectors. This includes frailty recognition, assessment tools, Delirium and Advance Care Planning

Training and Education – Workforce and the population of Kirklees:

- Embed the Frailty Core Capability Framework locally which will support the workforce to have the correct skills in supporting people
- Mechanism will be established to ensure professionals are aware of social networks or groups which provide leadership within the community to support people and how they can get involved

Outcomes:

People in Kirklees will have a better experience of care and improved health and wellbeing through:

- The integration of the ageing well programme across health and social care
- Engaged stakeholders working together towards a common goal with a single approach and joined up services.
- Highly skilled and educated workforce with the correct competencies to meet the needs of the population
- A single approach to frailty assessments and reduced duplication and variation
- Stakeholders aware of progress with local projects
- People in Kirklees will have improved health and wellbeing outcomes through system wide approach

DOMAIN 4: HIGH QUALITY, PERSON CENTRED AND PERSONALISED CARE

Some of the challenges identified locally include some of our services being reactive to patients presenting in a crisis, often with a specific physical problem that has become urgent. Also, many of our services are designed to treat one condition at a time missing out on the benefits of using a holistic approach.

Domain 4 will therefore involve a number of projects to ensure patients receive the best personalised services in accordance with their needs, in a timely manner, using a shared decision-making approach and embedding holistic assessments (see appendix 6). This will be underpinned with the ethos of providing the right care in the right place at the right time, first time; with a focus on quality, spend and patient defined outcomes.

The 3 elements of quality (clinical) are identified and measured through:

- Patient experience
- Clinical effectiveness
- Patient safety

The delivery of high-quality services therefore requires the above 3 elements to be measured throughout the patient journey to be able to identify what works well and which areas require improvement. This will contribute towards a seamless pathway and wrap around care for patients. Evidence based pathways are also key. There have been a number of national documents and guidance published around ageing well and the Kirklees system needs to review these and ensure they are implemented and embedded locally.

Other quality aspects and measures are required to address the environment, loneliness and isolation, physical conditioning, strength and balance and all that contribute to promoting health and wellbeing. These factors can impact the ability for people to age well.

Taking a person-centred approach to care, which recognises values and builds upon this individuality, is essential in helping to achieve the best outcomes for people. NHS England has a strong focus on person centred and personalised care with the role out of the personalised care operating model (see appendix 7). This model will be embedded across the system.

In order to provide a high quality, personalised approach, firstly patients need to be identified in order to be managed and supported appropriately. Frailty is relatively easy to recognise when severe but identifying it in people with less advanced frailty can be challenging. It's important that people who are defined by the electronic Frailty Index (eFI) as mild or moderately frail are supported to manage their health and wellbeing as they age, while those identified as living with severe frailty are properly supported according to their needs.[19]

[19] https://www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/

Domain 4: High Quality, Person Centred and Personalised Care

Principles:

- System wide understanding of ageing well
- Proactive support and prevention
- Physical and mental health and wellbeing
- Care and support planning
- Needs identification and assessment
- Person-centred approach
- Voice of the individual first

How will the Domain be embedded locally?

Person Centred:

- Understanding individual's ability to self-care and their protected factors
- Individuals are supported to engage fully, or a representative of the individual are supported through decision making in their best interests

Patients at the heart of decision making:

- NHS England Personalised Care Operating Model will be embedded (see appendix 7)
- Shared Decision Making
- Making Every Contact Count
- Promote self-management through long term condition reviews
- Ensure people are informed as early as possible about the approach to end of life to enable informed decision making about their preferences

Early frailty identification and assessment:

- Use the electronic frailty index tool to identify those at risk of frailty and understand our frail population
- Develop a process for stakeholders to inform general practice of those at risk of frailty
- Promote consistent use of frailty assessment tool (Rockwood) to confirm frailty across all sectors
- Offer a full comprehensive frailty assessment for those identified with moderate and severe frailty
- Support those assessed as severely frail or palliative to access end of life care that is timely and compassionate

Service Outcomes and KPIs

- Align service outcomes and robustly monitor for effectiveness, quality, and patient experience

Care Plans:

- Outcome-focused care planning undertaken with a strengths-based approach. Agree to use a range of care planning tools to support the varying needs of our population
- Use the approved NHSE audit tool as a framework to ensure care plans are personalised
- Where appropriate use the Patient Activation Measure as a marker of a person understands of their condition and how to manage it.
- People who are approaching the end of life should be offered the opportunity to agree an **End of Life Plan** which articulates their wishes and preferences around future care (EPaCCS)

Workforce:

- Services delivered by qualified and well-trained staff.

Outcomes:

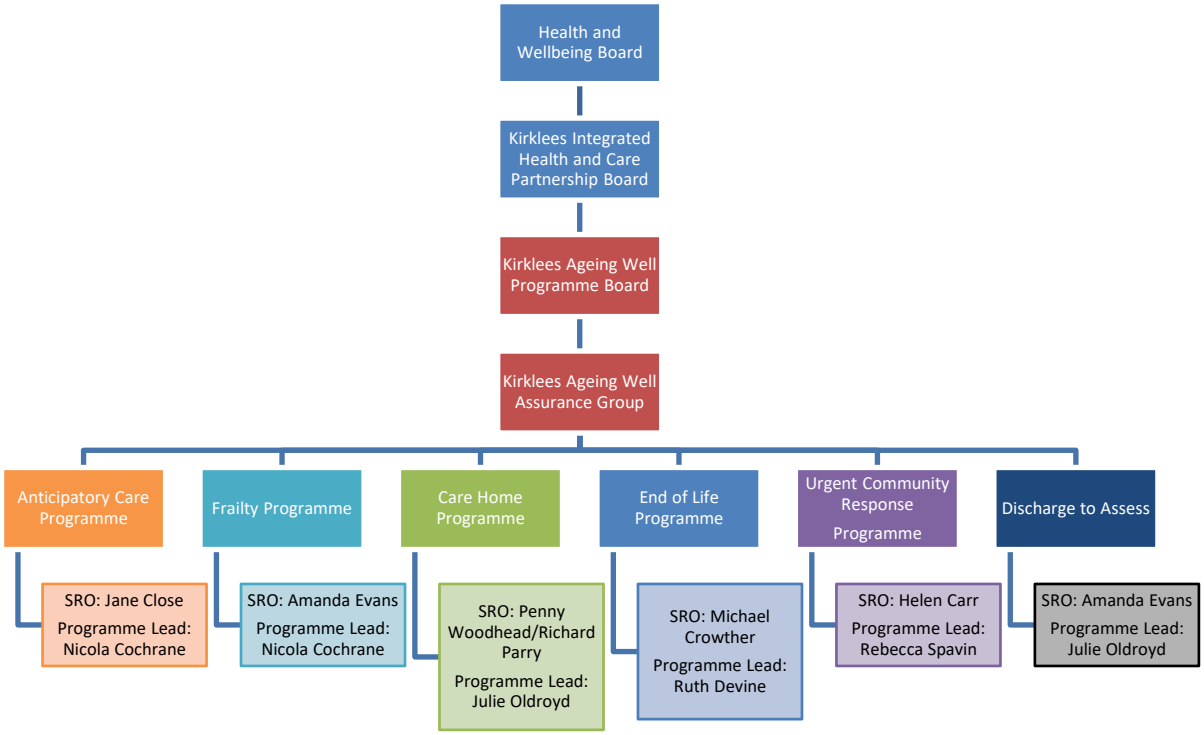
People in Kirklees will have improved health and wellbeing through:

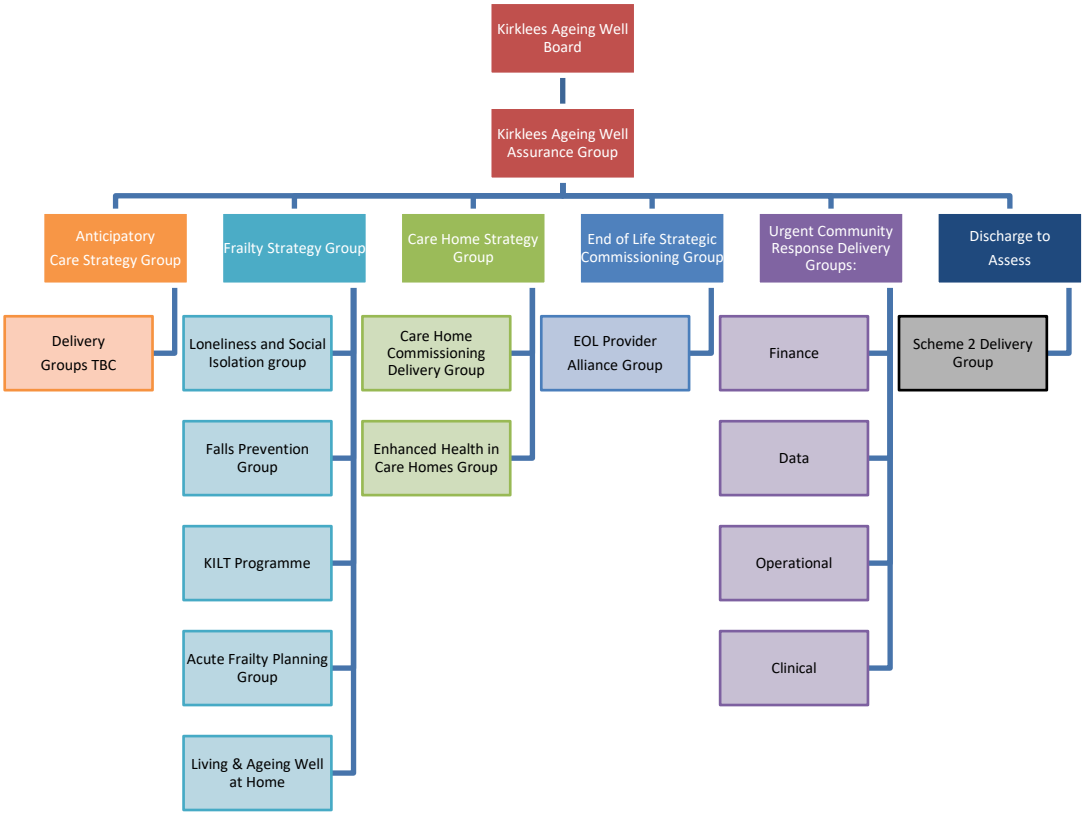
- Personal choice and control over the decisions that affect them
- Early identification, risk stratification, management, and support
- Increased shared decision making and patient understanding around long term conditions and keeping well through self-care
- Access to personalised care and selection of outcomes that matter to them the most (refer to I-Statements)
- Maximised independence

EVALUATING DELIVERY OF THE AGEING WELL STRATEGY

Evaluation of delivery against the strategy is an on-going process within all the individual ageing well workstreams. A number of local measures and key performance indicators have been identified within each workstream area and are monitored through the ageing well governance process. This is supported through the development of an ageing well monitoring approach and dashboard. Detailed programme plans are in existence for each workstream.

GOVERNANCE ARRANGEMENTS





working together

APPENDICES

APPENDIX 1: KIRKLEES CARE CHARTER

Kirklees Care Charter

The Kirklees Care Charter has been jointly created and signed up by all of the organisations below. This has been developed for people with a life limiting illness living in Kirklees. It explains what you can expect, as a pledge to improving end of life care in Kirklees.

I am seen as me

I am informed as early as possible that I have a condition which is life limiting and will shorten my life, although I might continue to live an active life for some time. I, and the people important to me, get the opportunity to have honest, informed and timely conversations.

I have access to care

The people important to me are supported all the way through my journey. My care reflects my physical, social, psychological and spiritual needs.

I am supported by staff who are prepared to care

All the staff I come across, wherever I am, bring empathy, skills and expertise to give me care which is compassionate

I am confident that my wellbeing and comfort come fi

I can choose to stay where I prefer and avoid unnecessary visits to hospital. My care is regularly reviewed and my symptoms are managed as well as they can be.

I received co-ordinated care

My needs and plans are known by everyone involved in my care and I am helped to achieve them. I know how to reach someone who will listen and respond at any time of the day and night.

I live in a community that is prepared to help

My community recognises that we all have a role to play in supporting each other in times of crisis and loss.

Curo Health Limited

Local Care Direct
we care about people

Kirkwood
The Hospice for Kirklees

Care and support through terminal illness | Marie Curie

APPENDIX 2: SEVEN KIRKLEES OUTCOMES

APPENDIX 3: HEALTH INEQUALITIES – RECOMMENDATIONS

LOOKING FORWARDS…

A COMMITMENT TO TACKLING INEQUALITIES: to reduce health inequalities and improve health and its determinants for all of our communities, deliberate action must be taken.

Such action must be both:
Targeted and specific – in order to address the most urgent inequalities experienced by particular groups.
Embedded across everything we do – to create health-enabling places and services which will improve outcomes for all, and particularly those experiencing the greatest disadvantage and health risks, in a sustainable way.

RECOMMENDATIONS:

People

1. Incorporate actions to address health inequalities and the wider determinants into the Wellness Service.

2. Undertake a Health Needs Assessment for children and adults living in poverty.

3. Engage the public and service users in any proposals to tackle inequalities.

4. Support increased health literacy and self-management of health and wellbeing.

5. Support and enable communities to continue building resilience and their capacity to act on their local priorities, building on the coproduction approaches which have been successful in the COVID-19 response.

Partners

1. Fully engage partners across the Kirklees place in the commitment to tackle inequalities and the development of any proposals, including the health and social care system, other statutory services, and the voluntary, community, and social enterprise (VCSE) sector.

2. Work with local and regional networks to understand what actions may be taken at scale and share learning.

3. Establish shared priorities and actions on health inequalities with partners.

4. Use partnerships and commissioning to move towards equitable service provision, where services are delivered at a scale and intensity proportionate to the degree of need.

Place

1. Continue to use and expand on our use of place-based approaches and partnerships, including building on the success of the place-based community engagement undertaken during the pandemic.

2. All decision-making should be led by a population health management approach, utilising local data and risk stratification. Also consider place and impactability (where and who to target to achieve the greatest impact).

3. Review any gaps in data and intelligence on inequalities and explore possibilities to address these, including population surveys and bespoke research.

4. Work with partners to create integrated datasets to support population health management and address data gaps.

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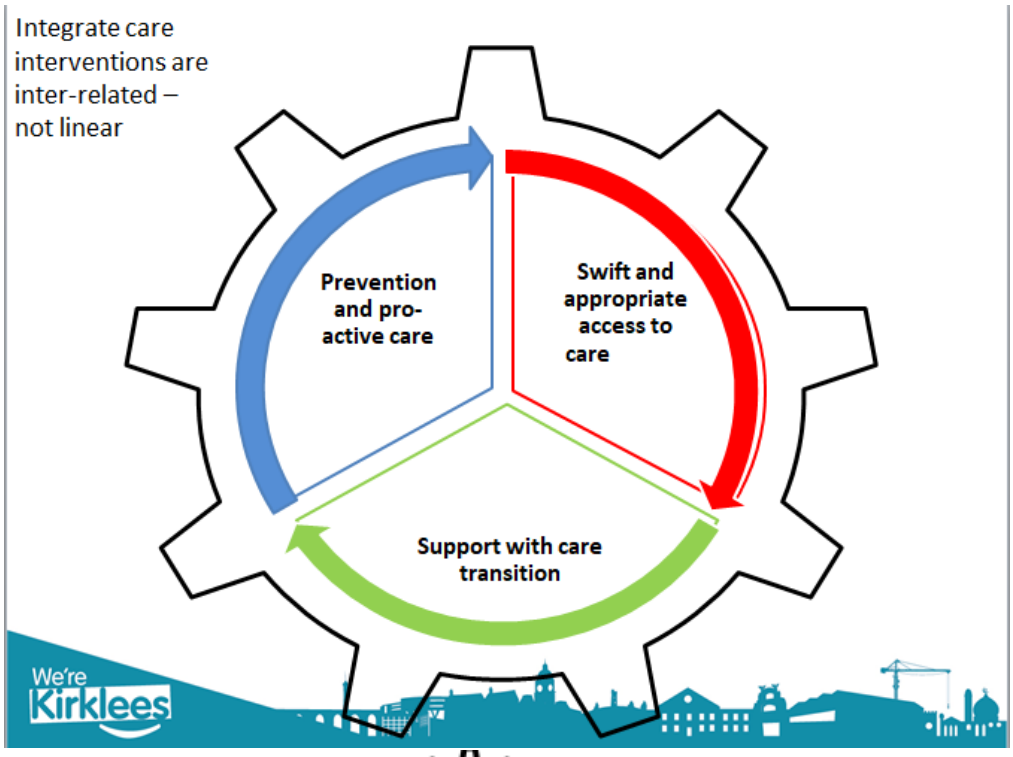
Taken from: https://www.kirklees.gov.uk/beta/delivering-services/pdf/public-health-report.pdf

APPENDIX 4: POPULATION CHARACTERISTICS AND OUR FOCUS

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

Taken from the Health and Wellbeing Plan

APPENDIX 5: INTEGRATED CARE INTERVENTIONS



Prevention and pro-active care

1 Self-empowerment and education

Education programmes and use of technology to support self-care, with the aim of promoting independence and resilience , and people taking responsibility for their own health and wellbeing

2 Regular planned follow-ups

Use of regular scheduled follow-ups to reduce the requirement for urgent care services

3 Frequent contact

Provide a single point of contact and help people and their supporters to navigate complex services. Can be a specialist care navigator/care co-ordinator, or the person themselves or their informal carer

4 Personalised care plan

Develop a person centred care plan based on a persons current and future needs, focusing on what is important to them, and taking a 'life course' approach

5 Care co-ordination

Provides a single point of contact and helps people and their supporters to navigate complex services. Often provided by a care navigator, or care co-ordinator, but this can also be the person themselves

6 Multidisciplinary teams

A regular MDT session with a core group of professionals to pro-actively discuss people who are at risk of requiring increased input. Additional professionals may participate on an ad hoc basis.

7 Case management

Pro-active case finding, assessment, care planning and care co-ordination for people with long term conditions, putting them, their families and carers at the centre of decision making

Swift and appropriate access to care

8 Rapid response

A multidisciplinary team that can be deployed to assess people and keep them in the community by providing health or social care support for those experiencing an episode of illness or injury

9 Rapid access to General Practice

Facilitating access to General Practice. Includes improved access from extended opening hours or other channels, e.g. eConsult and also in the hospital setting, after appropriate triage

10 Access to specialist care

Access to consultant and specialist health and social care support in the community, including diagnostics, equipment, adaptations etc

11 Appropriate referral and medication practices

Avoid unnecessary interventions by only referring patients as appropriate in line with evidence base or local guidelines/protocols

Support with care transition

12 Discharge/transition support

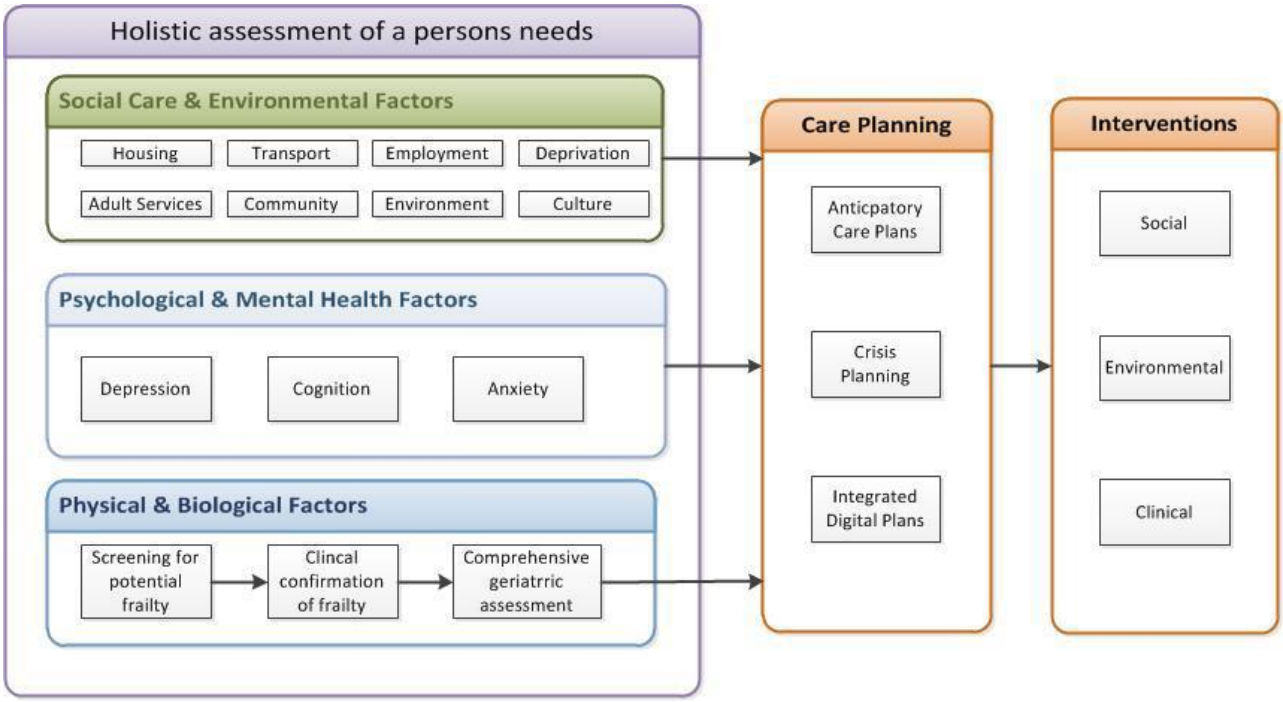
Community, General Practice and social care in-reach to support early assessment and discharge of people from different care settings

13 Intermediate care

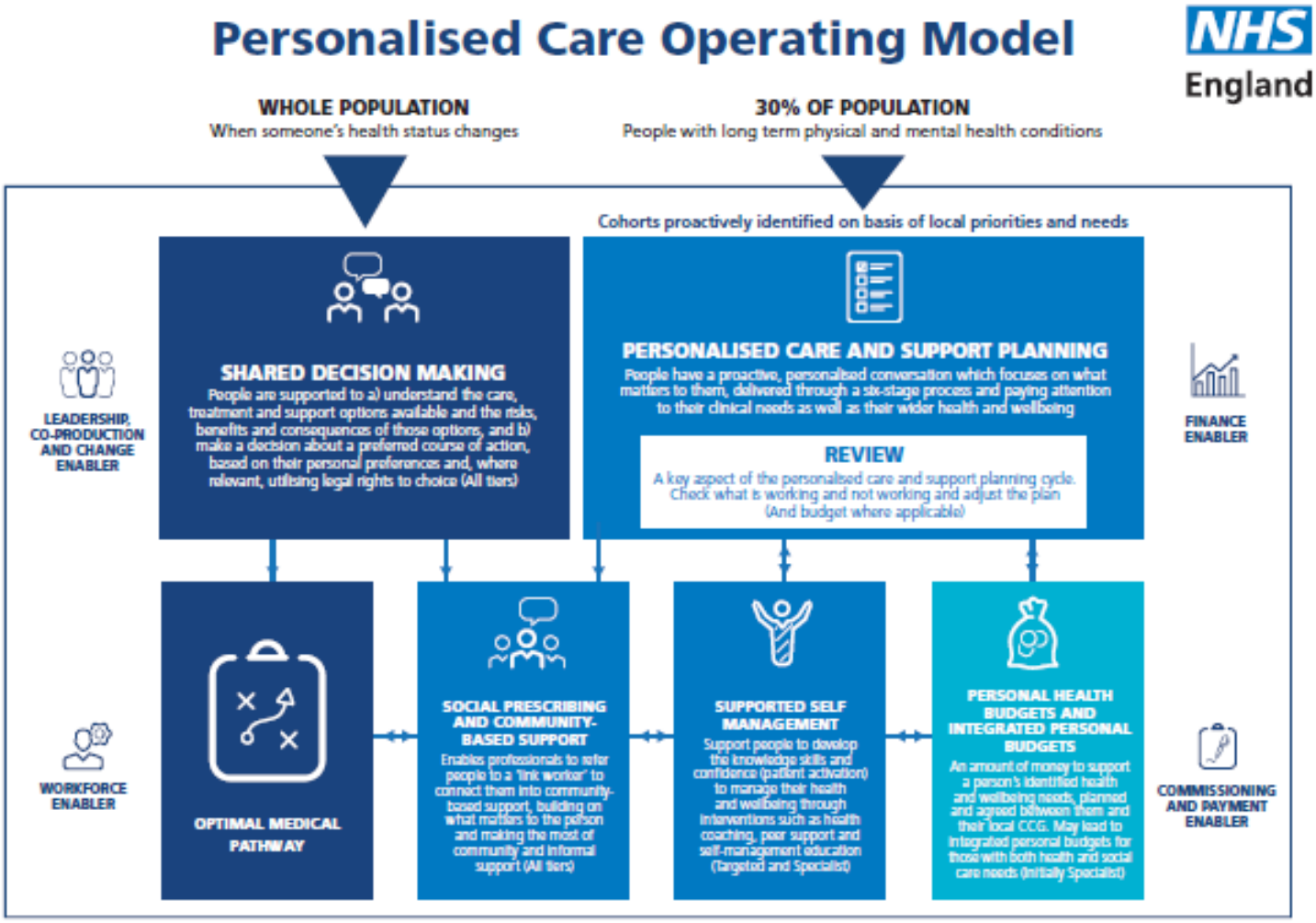
Provision of step-up or step-down care in a person's home or a community facility to prevent unnecessary admissions to, and to facilitate early discharge from, care setting

We're Kirklees

APPENDIX 6: HOLISTIC ASSESSMENTS OF A PERSON'S NEEDS



APPENDIX 7: PERSONALISED CARE OPERATING MODEL



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KIRKLEES HEALTH & WELLBEING BOARD	
MEETING DATE:	**2nd December 2021**
TITLE OF PAPER:	**Health Check Pilot Update**

1. Purpose of paper

The purpose of the paper is to update the board on a key health and wellbeing initiative, the Health Checks Pilot, which went live on 8 November 2021. We are also asking the Board to endorse and support proposals for the next phases of the pilot as it focuses in new and innovative ways to tackle health inequalities in Kirklees.

The next section (background) gives an indication of where we have come from since the initial discussions in February 2020. Section 3 give some 'hot off the press' data for the first couple of weeks of the pilot. This section also demonstrates how the 'wellness' approach is working within the pilot to provide access to a holistic, community-based health check in a non-clinical environment with follow on support appropriate to the individual.

2. Background

The NHS Health Check programme has been delivered in General Practices in Kirklees since March 2012, offering a CVD risk assessment and personalised advice to all individuals aged 40-74, who do not have pre-existing cardiovascular disease or related conditions. It is offered once every five years to all eligible individuals to increase awareness of healthy living and reduce cardiovascular morbidity and mortality rates. Data shows that there is a very low take up of the NHS Health Check in some localities and from those people experiencing health inequalities (e.g. BAME groups, people living with mental health conditions or those living in areas of greater deprivation). Research by Public Health and the Wellness Service confirmed this and led to further research into other areas in the country where different models have been adopted and trialed.

Kirklees Public Health has commissioned the Kirklees Wellness Service to research and develop and deliver a pilot project to look at ways of maximising the impact of the health checks programme, finding innovative ways to target and reach those most at risk and provide more person-centred support for health improvement, leading to better outcomes for people. A range of materials used in the pilot is in see Appendix 1.

An example of innovative evidence led approaches to tackling health inequalities is the Weight Neutral approach (see Appendix 2); a new approach to issues of weight and health that is driven primarily by compassion, takes blames away from individuals and fully acknowledges the mental and financial burden poverty and inequality places on people.

The Kirklees Wellness Service has responsibility for conducting and evaluating the pilot and making recommendations for the future delivery of this programme.

The pilot will run for a minimum of six months from 8th of November 2021, in the Primary Care Network areas of Viaduct, Greenwood, and Batley & Birstall. These three areas were chosen for the pilot due to populations with high levels of health inequalities. All clinical directors are fully on board with the pilot and providing support as required.

3. Proposal: Where we are now and what we are proposing for the coming months

In September/October 2021 the pilot entered a critical phase moving from planning and preparation to focused engagement and delivery. The pilot start was slightly delayed for additional quality assurance, clinical oversight and staff training.

The much-needed clinical lead is now in post as of 31 August and is working closely with the Wellness Service Health Coaches to ensure they are confident and competent health check deliverers.

Outcomes to date:

- All staff fully trained to a high clinical standard
- Point of care testing equipment and standard operating procedures have been fully stress tested by staff during training.
- Robust clinical supervision is in place to ensure coaches feel confident in delivering a quality experience for people presenting for a health check.
- All staff are fully vaccinated against Covid-19 and Hepatitis B.
- Fully tested IT systems are in place for data gathering and recording.
- A fully integrated promotions, communication and marketing plan in place and operational – social media campaigns, promotional photo shoots & videos, targeted campaigns and links to community teams operating in pilot areas.
- As part of the training Local Integrated Partnerships Service staff were invited to undergo a health check ahead of the public launch on 8 November, and asked to provide 'critical friend' feedback.
- The University of Huddersfield is providing a comprehensive evaluation of the pilot, utilising both qualitative and quantitative data to measure the success of this approach.

The 5 Health Coaches have enthusiastically embraced the start of the pilot on 8 November and are working with the Clinical Lead and pilot project team to deliver checks within an agile framework that allows for adaptation throughout the life of the pilot. Feedback from the first week and a half shows that we are already making a positive impact.

"I enjoyed getting my results there and then and being explained to what my levels meant"

"There was a lot to take in so the booklet was really good to take away and read it all. I like it's informative style without being preachy."

"I have just attended the Jubilee Centre for my Health Check. I found it useful and informative. Alison was extremely helpful and accommodating and took time to explain each aspect of the health check to me. The Health Check project is a valuable programme; especially at a time when access to healthcare services is at an all-time low for many people."

Here are some important numbers from the first couple of weeks delivery:

- 178 Health Check referral received since launch
- 72% of all referrals have come from the target 3 PCN areas
- 33 Health Checks completed in week 1 (8th – 12th Nov)
- 41 Health Checks booked/37 Completed for week 2 (15th – 18th Nov)
- 50 Health Checks completed as of 16th November
- 3 Health Coaches delivering Health Checks in 11 venues across 3 PCN areas
- 2 Health Coaches providing additional capacity, project support ie: Business (Foxes Biscuits), Schools (Paddock) & Mosque engagement
- Out of the 50 checks completed, 40 showed abnormal results and have received appropriate follow up support, or signposting
- 2-3 Week Follow Up check-ins offered to people as required/requested. This can include Wellness support, signposting or referrals.

Quality Assurance:
The Standard Operating Procedures (SOP) manual for the Health Checks Pilot has now been signed off through the Integrated Quality Group. The SOP details thresholds and pathways, with clear processes for staff to follow and is a live document, which is underpinned by close clinical supervision through the clinical lead role. All 5 Health Coaches now have non-NHS staff and NHS partner access to SystemOne for the recording and tracking of health check results.

Impact: Tackling Health Inequalities
The pilot is a chance to understand what works and what doesn't as we test new and innovative ways of working with minimal risk. For example, are the target cohorts of people more likely to take up health checks if that check is provided at workplaces, faith settings, sports venues or libraries; or at weekends and evenings.

The impact of the project is being evaluated by our partners, the University of Huddersfield and will be available in Autumn 2022. The evaluation will collect and measure qualitative and quantitative data such as:

- Uptake of health checks offered
- Delivery of health check
- Community engagement activity
- Health check process
- User experience
- Outcomes (incl. follow up care)
- The impact of clinical governance

Data gathered so far in the pilot indicates that we are basing the pilot in the heart of some of the most deprived communities which face the highest health inequalities such as Batley West, Paddock, Lockwood, Deighton etc. We are using KOMPASS mapping to prioritise and plan future delivery sites and inform resources that we need. Key resources are provided in the 5 most common community languages with interpreters being made available where requested.

Independence & resilience
The Wellness Service was chosen to lead this pilot because the whole ethos of the service is about working alongside people to increase the level of control they have over their health and wellbeing.

Involvement & Collaboration
Throughout the planning and preparation for the pilot the Wellness Service has had the much valued involvement of colleagues in Public Health, Kirklees Active Leisure, Huddersfield Town Foundation, Healthwatch, Community Plus, the Clinical Commissioning Groups and Locala. They have been instrumental in developing and shaping the pilot. As we have moved into the delivery phase of the project, our partnership with Locala has been especially valuable through the services of our Clinical Lead, Helen Arnold. As part of the pilot we are forming important partnerships with

- The Clinical Directors and GPs in the 3 pilot PCNs, sharing patient lists of those who have not attended for GP health checks, providing facilities for disposal of clinical waste, and playing and important part of shaping the project through attendance at project meetings.
- Venues such as the Al-Hikmah Centre and Chestnut Centre (to pick out just 2) where we have been able to reach and engage communities, provide safe and familiar

surroundings for health checks and be part of shaping the next phase of the project with links to businesses etc.

Future Pilot Developments

An initial planning meeting took place on 23 November to begin to scope out the next phase the pilot, which we have agreed to extend for a further 6 months, making it a 12 month pilot in all. Future developments include working with businesses, schools, places of worship, Covid vaccination centres, using targeted communication and engagement informed by the indicative data gathered in the first phase of the pilot.

4. Financial Implications

The pilot is funded through a combination of the Wellness Service budget (as commissioned through Public Health) and funding from the Tackling Inequalities Board for the appointment of the clinical lead role. Apart from that major expenditure it is anticipated that the main ongoing expenditure will be consumables for use in the point of care testing equipment. There is no specific financial ask of the Health and Wellbeing Board.

5. Sign off

Rachel Spencer-Henshall, Director of Public Health, Kirklees Council

6. Next Steps

The next steps for this project are the successful completion of what we are terming 'Phase One' of the pilot to January 2022. Planning is already taking place for Phase 2 which will look at the scope and reach of the pilot so far, and map this against areas and cohorts of health inequality to ensure the pilot continues to reach its intended audience.

Targeted promotional events and social media campaigns are planned to follow on from the promotion already done with key health and community leaders The Wellness Service has been very well supported by colleagues in the Council Comms Team.

At the end of November, the project steering group and partners will meet to plan the detail of the next phase starting in January 2021. Proposals for this next phase include taking the pilot to local employers, schools, sports venues, faith centres and to also trial evening and weekend delivery. A key focus will be specifically targeting communities and places of interest in the heart of areas which face the high health inequities and which barriers to access are present.

7. Recommendations

The Board support the project from a strategic standpoint, both locally and regionally. We would also like the boards suggestions on any innovative approaches to engaging specific communities, places of interest or ways we can adapt our approach to better tackle Health Inequalities across Kirklees.

8. Contact Officer

Patrick Boosey,
Wellness Service Lead,
Patrick.boosey@kirklees.gov.uk

01484 234095

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Kirklees **Wellness** Service

Health Checks

Aged 40 – 74?
You could be eligible for a Free Health Check!

It doesn't take long and can help you prevent:

- Heart disease
- Stroke
- Diabetes
- Kidney failure
- Dementia

Our nearest session is

To book your free health check visit **www.kirkleeswellnessservice.co.uk**

Wellness: it starts with you

Kirklees COUNCIL

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Kirklees **Wellness** Service

Health Checks

Aged 40 – 74?
Get your FREE Health Check

Kirklees COUNCIL

in partnership with

BATLEY BIRSTALL NETWORK

Delivering Partnered Healthcare

If you are aged between 40 – 74 and live in Kirklees, you could be eligible for a FREE health check from our Wellness team.

Unable to get to your GP? We're coming to your community and making it easier for you to get a health check.

Helping you prevent serious illness including:

- Heart disease
- Stroke
- Diabetes
- Kidney failure
- Dementia

For more information and venue details visit **www.kirkleeswellnessservice.co.uk**

Wellness: it starts with you

Kirklees **Wellness** Service

Egészség felmérés

40-74 éves?
Ön jogosult lehet az ingyenes egészség felmérésre!

A rövid vizsgálat segít a következők megelőzésében:

- Szívbetegség
- Sztrók
- Cukorbetegség
- Veseelégtelenség
- Demencia

Közelben lévő vizsgálatok:

Foglaljon időpontot a vizsgálatra itt: **www.kirkleeswellnessservice.co.uk**

Wellness: it starts with you

Kirklees COUNCIL

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Kirklees Wellness Service

My Health Check Report

Provided by the Kirklees Wellness Service

Your name .....

Your Health Coach's name .....

Date of Health Check .....

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What is a health check?

Getting a health check is an important part of looking after your health. Health checks provide the opportunity to learn about your health and understand your risks of developing certain conditions in the future.

Health checks are not intended to provide a diagnosis. A Wellness Service Health Check will focus on ways in which you can live a healthier, happier life, feel more able to look after yourself and reduce your risk of future ill health. Just like we have regular MOTs for our cars, it's equally important to look after our body and mind through regular checks.

Who are the Health Coaches?

Health Coaches are trained and qualified professionals who work alongside people to support them to gain knowledge, skills, tools and confidence to enable them to make lifestyle changes to help them reach their health goals.

What information do we collect?

The amount and type of information we ask for will depend on the content of your health check. It is likely this will include background information about you (such as your name, date of birth and postcode), your lifestyle and habits (such as smoking, alcohol consumption, exercise, your medical history (such as any current diagnosis) and the results of some medical tests (such as your blood pressure and cholesterol levels).

We will also ask which GP practice you attend and your contact information such as a phone number, email address or postal address.

How do we use your personal information?

We will only use your personal information in accordance with the Data Protection Act 2018 to provide you with a health check delivered by the Wellness Service. This will mean your personal information will be held digitally by the Wellness Service which is part of Kirklees Council, and may be shared for clear and specific purposes, with your GP and other health professionals involved in delivering or evaluating the health check service. The information will be part of your medical records.

If you are encouraged to have a health check by your employer your information will not be shared automatically with your employer, but this could be done at your request and with your consent.

We only ask for the specific information that we require to enable us to offer you a full and comprehensive health check. We will protect your information and ensure that only those people who have appropriate authorisation are given access to it. We will keep your personal information in accordance with our retention schedule requirements and when we no longer have a need to keep it, we will delete or destroy it securely.

Anonymised data may be used to provide statistical and demographic information, for example to report on and evaluate the health check service. This may involve your anonymised data being shared with individuals in external organisations who are supporting the evaluation of the service.

Wellness Service Contacts

Telephone: 01484 234095 (Mon to Fri 9.00 am to 5.00 pm)

Email: wellness.service@kirklees.gov.uk

Website: www.kirkleeswellnessservice.co.uk

Your Wellness Service Health Check

Blood pressure

- Blood pressure is made up of two numbers:
- The systolic pressure (the higher number) is the highest level your blood pressure reaches when your heart beats
- The diastolic pressure (the lower number) is the lowest level your blood pressure reaches as your heart relaxes between beats

It is important to know your blood pressure because most people with high blood pressure will not feel ill straight away.

If your blood pressure is too high it can put extra strain on your blood vessels. This can cause damage to your heart, brain, kidneys and eyes. Over time it can cause stroke, heart attacks, kidney disease and dementia.

If your blood pressure is too high at present, the good news is there are several ways you can reduce your blood pressure.

My blood pressure is currently ...../..... mmHg

My next steps.....

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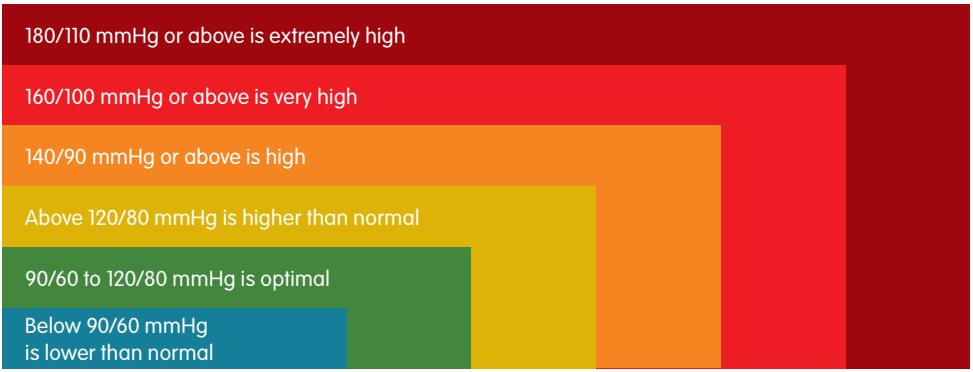

If your blood pressure is lower than normal and you have symptoms such as sickness, dizziness or fainting you will be encouraged to contact your GP.

If your blood pressure is higher than normal we will encourage home monitoring where this is possible or testing at Pharmacy/in GP practice and a follow up appointment with a Health Coach.

If your blood pressure is high we will repeat the test at least once to rule out any problems with the equipment or other factors. We will record and save these readings. We will also ask whether your blood pressure has been previously high and over how long. We may recommend home monitoring or weekly testing at Pharmacy/in GP practice, if available. You will be offered follow up appointments with a Health Coach to support you to manage your blood pressure through lifestyle changes etc. If no change after 3 months we recommend you book an appointment at your GP practice.

If your blood pressure is very high we will recommend you book an appointment regarding blood pressure at your GP practice. We will offer follow up appointments with a Health Coach to support you to manage your blood pressure through lifestyle changes etc.

The person's blood pressure is extremely high the Wellness Service will inform the GP practice and recommend that you book the next urgent appointment for a blood pressure check at your GP practice. We will offer follow up appointments with a Health Coach to support you to manage your results through lifestyle changes etc.

Body Mass Index (BMI)

BMI is a guide to understanding if you are carrying additional weight which can put you at risk of ill health. However, it may not be accurate if you are pregnant or have large amounts of muscle. Muscle is denser than fat, so very muscular people may still be a healthy weight with a higher BMI. Ethnicity can also be a factor. For example, adults of South Asian origin may have a higher risk of diabetes even if BMI is 23.

My weight is.....kg (……..st ……..lb)

My height is.....cm (……..ft ……in)

My BMI is currently.....

An ideal BMI is between 18.5 and 24.9. The good news is you can be supported to make lifestyle changes to improve your BMI, by the Wellness Service. We will discuss your options to access support for your weight including our healthy weight groups.

My next steps.....

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Diabetes

We use HbA1c to assess risk of diabetes because it gives a picture of how much glucose has been in your blood over the last 2-3 months. This is more useful than a 'glucose test' which will only measure how much glucose is in your blood at the time the sample is taken. Your HbA1c score is a good predictor of your risk of diabetes. It is important to know about your risk of diabetes because many people with diabetes do not feel ill straight away, making it difficult to spot. If it is not managed, diabetes can cause damage to your kidneys, increase your risk of heart attacks, stroke, vision problems and nerve damage to hands, legs and feet.

Your HbA1c score is currently .....

Diabetes risk (HbA1c)		
Healthy Below 42 mmol/mol	Elevated risk 42-47mmol/mol	High risk 48 mmol/mol or above

If your HbA1c score is at elevated risk we will recommend you make an appointment with a Practice Nurse at your GP practice to repeat this test because you are at an elevated risk of developing diabetes. We will offer follow up appointments with a Health Coach to work with you to manage these results through lifestyle changes etc. We will measure HbA1c if measurements within the health check indicate a possible risk.

Diabetes (continued)

If your HbA1c score is at high risk we will recommend you make an appointment with a Practice Nurse at your GP practice, as soon as possible, for follow up as you are at a high risk of developing diabetes. We will offer follow up appointments with a Health Coach to work with you to manage these results through lifestyle changes etc.

*Note: Your HbA1c should not be checked again for 3 months as glycated haemoglobin requires 3 months between tests to see a change.

My next steps.....

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Cholesterol

Cholesterol is a waxy substance made by the liver and some foods can raise our cholesterol levels. Your body needs some cholesterol to work properly, but too much can cause harm.

- HDL (High-Density Lipoprotein), or "good" cholesterol absorbs cholesterol and carries it back to the liver. The liver then flushes it from the body. High levels of HDL cholesterol can lower your risk for heart disease and stroke
- LDL (Low-Density Lipoprotein) or "bad" cholesterol, makes up most of your body's cholesterol. High levels of LDL cholesterol raise your risk for heart disease and stroke.
- Total cholesterol is the sum of your HDL and non-HDL and shows how much cholesterol is in your blood.
- Your cholesterol ratio is calculated by dividing your total cholesterol by your HDL. The lower the number, the higher proportion of good cholesterol in your blood.

Your Cholesterol levels	Healthy	At Risk
Total cholesterol	5 mmol/L or less	More than 5 mol/L
HDL.....	1 mmol/L or greater	Less than 1 mmol/L
*Cholesterol ratio	4 or less	More than 4

Cholesterol (continued)

The good news is for most people you can improve your cholesterol level and your health relatively quickly. *It is the ratio that is important in your results.

If your total cholesterol is over 5 mmol/L. we will offer a follow up appointment with a Health Coach to work with you to manage the results through lifestyle changes etc. You should also ensure you get a retest with a Pharmacy or with GP after 3 months. If there is no change after 3 months we recommend you make an appointment at your GP practice for follow up.

If your total cholesterol is above 7.5 mmol/L. we will recommend you make an appointment with a practice nurse at your GP surgery to discuss the risks of genetic high cholesterol. We will also offer a follow up with a Health Coach

My next steps.....

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Alcohol

It is important to be mindful of how much you are drinking. Sometimes it can be difficult to spot when you are drinking too much, especially if your friends and family seem to be drinking the same amount. Any amount of alcohol can be harmful, and there is no 'safe limit'.

Keeping your alcohol intake under 14 units per week and having 2 alcohol free days is beneficial to your health. This is about six pints of average strength beer or six medium glasses of average strength wine. Regularly drinking more than this can harm your health, and increase your risk of cancers, stroke, heart disease, liver disease and brain damage. Alcohol can also affect your mood and cause weight gain.

Your Health Coach can work with you to help you to reduce your drinking and can refer you to more specialist services if appropriate.

Your Alcohol levels

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Alcohol	Audit score
Your audit score	
Lower risk	0-7
Increasing risk	8-15
Higher risk	16-19
Possible dependence	20 or above

My next steps.....

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Physical activity

Being active benefits your body, mind and health – there are lots of easy ways you can get moving. Physical activity is anything that gets you moving. The Wellness Service can support and inspire you to move more for a fitter, healthier and happy life, and to think about the amount and type of activity you have in your life.

Whatever your physical condition or age you can benefit from moving more often. Even a little increase can make a real difference to your health and wellbeing.

Why move more?

- Improves cardiovascular health
- Improves sleep
- Maintains healthy weight
- Improves quality of life
- Manages Stress

And it reduces your risk of

- Cardiovascular disease
- Type 2 Diabetes
- High blood pressure and hypertension
- Depression
- Joint and back pain
- Some cancers

If you haven't been active for a while or you are just starting out, you may feel a little apprehensive. Moving more often doesn't mean you have to join the gym or run a marathon. Simply increasing your daily step count, doing some gardening or parking further away from the shops or work can greatly increase your activity levels and support a healthier lifestyle. A Wellness Service Coach can work with you to explore your reasons for wanting to move more and what would work for you.

Simple things you can start to do are

- Reduce time spent sitting or lying down
- Walk to the shops
- Do some gardening
- Stand up whilst on the phone
- Step on the spot whilst the kettle boils
- Find activities that you enjoy like walking, cycling or dancing

My GPPAQ* (General Practice Physical Activity Questionnaire) score is

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* GPPAQ is a screening tool used to assess adult physical activity levels

My next steps.....

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Smoking

Smoking is one of the biggest causes of death and illness in the UK and increases your risk of more than 50 serious health conditions.

90% of lung cancers are caused by smoking and smoking increases the risk of at least 10 other types of cancer.

Smoking also damages your heart and lungs; this increases your risk of heart disease, strokes, heart attacks, bronchitis, Chronic obstructive pulmonary disease (COPD) and pneumonia.

My current smoking status is

.....

Smoking				
Lower risk	Increased risk	High risk		
Non smoker	Ex-smoker	Light smoker (less than 10 a day)	Moderate smoker (10-19 a day)	Heavy smoker (more than 20 a day)

Most people who smoke know that this is damaging their health, but they find it difficult to stop smoking without support.

The good news is there are lots of opportunities in Kirklees to get support. This can make it easier for you to stop smoking and protect your health. We will offer a follow up appointment with a Health Coach for those that want to quit. Your health coach can explore with you the different options available to help you quit smoking.

My next steps.....

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Dementia

Dementia affects the way the brain normally works. This makes it difficult to do every-day activities. For example, people who have dementia often forget things or get confused.

There are different types of dementia. All of them interfere with daily life and all of them get worse over time. Alzheimer's disease is one type of dementia.

Most older people do not get dementia. But those people who are affected are usually over 65. It cannot be cured but you can reduce your chances of getting dementia. Even if someone has dementia, they can take action to lessen the symptoms.

The Health Check Pilot will provide useful information about Dementia if it is appropriate to your situation, or someone you care for.

If you have concerns about dementia you should contact your GP who will help you and provide support that you may need.

Risk factors that increase the chances of developing vascular disease e.g. heart disease, stroke, diabetes and kidney disease also increase the chance of developing dementia. Taking action to adopt a healthier lifestyle, such as increasing physical activity, can help to reduce your risk of developing dementia, as well as other vascular conditions such as heart disease, stroke, diabetes and kidney disease

QRISK

The QRISK algorithms have been developed by doctors and academics working in the NHS and is based on GPs data.

These scores calculate your risk of having a heart attack, a stroke, or developing type 2 diabetes within the next ten years.

	Your % QRISK score	% QRISK score for a healthy person similar to you
Your risk of having a heart attack or stroke within the next 10 years is:		

My next steps.....

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Do you support or look after someone?

Many people find themselves caring for a family member or friend suddenly, perhaps overnight and others may come into their caring journey more gradually as the health and wellbeing needs of the person they care for increase over time.

The Wellness Service can support you by acknowledging some of the challenges and difficult emotions you may be facing and explore different ways to manage your challenges, stress levels. We can share ideas and techniques you can use to improve and support your own physical and emotional wellbeing whilst caring for someone.

You can self refer for this support through:
www.kirkleeswellnessservice.co.uk/service/carers-support

Useful Links www.kirkleeswellnessservice.co.uk

Blood Pressure
www.bloodpressureuk.org - 'How to lower your blood pressure' page
www.bhf.org.uk - British Heart Foundation 'Preventing Heart Disease' page
www.nhs.uk/bloodpressure - NHS choices

Cholesterol
www.bda.uk.com/foodfacts - The association of UK dietitians
www.heartuk.org.uk - Heart UK, The Cholesterol Charity
www.nhs.uk/conditions/Cholesterol - NHS choices

Diabetes
www.diabetes.org.uk - The leading charity for people living with diabetes in the UK
www.bda.uk.com/foodfacts - The association of UK dietitians
www.hns.uk/diabetes - NHS choices

Healthy Weight/Healthy Eating
www.kirkleeswellnessservice.co.uk/service/healthy-weight
www.bda.uk.com/foodfacts - The association of UK dietitians
www.nhs.uk/healthyeating - NHS choices

Physical activity
www.kirkleeswellnessservice.co.uk/service/move-more
www.nhs.uk/Change4Life - 'Get Going' page
www.kal.org.uk - Kirklees Active Leisure

Alcohol
www.kirkleesinrecovery.com - Recovery from addiction - Help & Support
www.nhs.uk/alcohol - NHS drinking and alcohol

Smoking
www.kirkleeswellnessservice.co.uk/service/stop-smoking
www.nhs.uk/smokefree - NHS stop smoking advice

Dementia
www.commlinks.co.uk - Kirklees Dementia Hub Kirklees Dementia Hub | Community Links
www.nhs.uk/dementia - NHS dementia guide
www.dementiauk.org - Dementia advice and support

Mental Health
www.kirkleeswellnessservice.co.uk/service/mental-health
www.kirkleesiapt.co.uk - Improving Access to Psychological Therapies

Carers Support
www.carerscount.org.uk
www.kirkleeswellnessservice.co.uk/service/carers-support

Free Kirklees 24/7 helpline 0800 183 0558

Kirklees
Wellness
Service

Wellness Service Contacts

Telephone: 01484 234095 (Mon to Fri 9.00 am to 5.00 pm)

Email: wellness.service@kirklees.gov.uk

Website: www.kirkleeswellnessservice.co.uk

Wellness Service – Weight Neutral Approach

Weight-neutral approaches to health interventions are a relatively new therapeutic alternative to traditional weight-loss approaches. Evidence is emerging that many physical health improvements attributed to weight loss interventions relate to changed behaviours eg. Increased physical activity, reduced intake of salt and saturated fats, increased fruit and vegetable intake, rather than weight loss itself. National Health and Medical Research Council (NHMRC) of Australia weight management guidelines reports A level evidence for weight regain in weight managing services. "Regardless of the degree of initial weight loss, most weight is regained within a 2-year period and by 5 years the majority of people are at their pre-intervention body weight.". It therefore makes sense to focus on the health behaviours rather than the weight loss goals when supporting people to improve their health.

Weight-neutral approaches generally involve focusing on improving health behaviours such as patients' relationships with food, removing moral judgments around food, building awareness of hunger and fullness cues, emphasizing emotional and physical wellness over the pursuit of a lower weight or size.

The Kirklees Wellness Service has piloted 'Our Wellbeing' sessions which offer a weight neutral approach to health. There are modules on managing stress, sleep, increasing physical activity, improving relationships with food and exploring the relationship between food and mood. We will be offering a free "mini health check" pre and post the sessions to try to identify baseline markers and identify positive change to physical health because of the sessions. We currently have our first group running with attendees in the coming weeks and are excited to see the outcomes in the new year.

This approach will also underpin, where appropriate, our Wellness Serviced 1:1 support with people, especially if their primary focus isn't a weight loss target or traditional outcome measure (BMI reduction for example). This is a great fit with the Wellness service approach in general, support is person led, focused, upskilling individuals to improve their ability to take control of issues which are important to them. We will be working closely with Public Health Kirklees to evaluate this initial pilot and approach, we hope over time this is something we can offer in our "core" Healthy Weight programme in the future.

What a weight neutral intervention might look like:

- Size accepting - encourage/enable healthy behaviours regardless of current weight status or body shape, with an emphasis on body acceptance and self-worth
- Focus on health gains and longevity boosters that are independent of weight, size , or shape
- Regular activity/movement and improving diet quality/better nutrition
- An end to people feeling having embarrassing conversations about weight, and instead having positive conversations about health

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