working together

Kirklees Ageing Well Strategy 2022 - 2027

CONTENTS

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

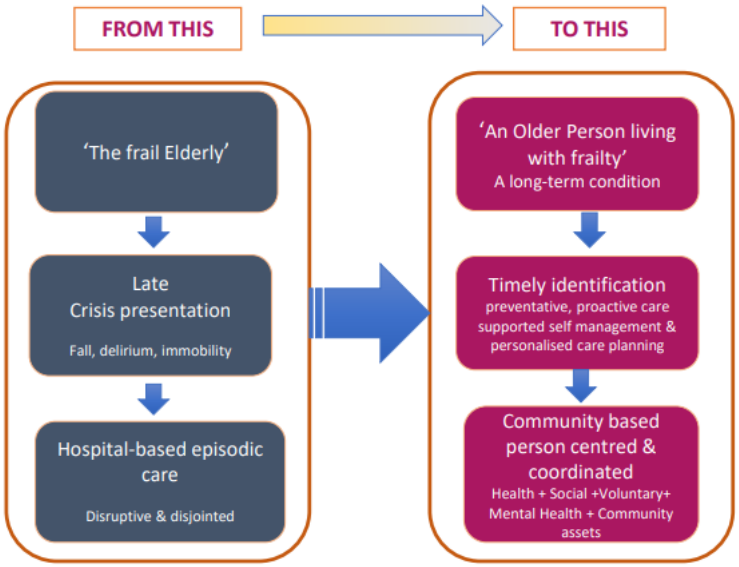
3. **Develop our people to deliver the priorities and foster resilience**
   - Equip people the resources to stay independent and live well
   - Change the conversation – focus on strengths, assets and responsibilities (Making every contact count)
   - People who use and provide services work together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

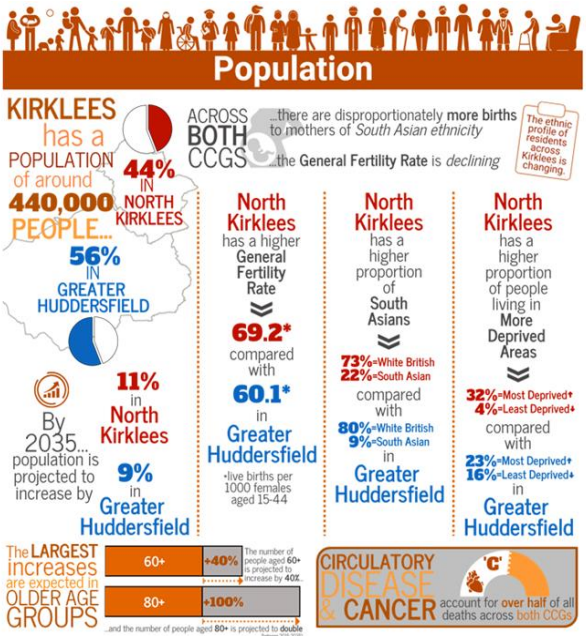
Health Education England and NHS England commissioned the development of a Frailty Core Capabilities Framework[10] to improve the effectiveness and capability of services for people living with frailty. One of the aims of this framework is to empower people living with frailty, as well as their family, 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

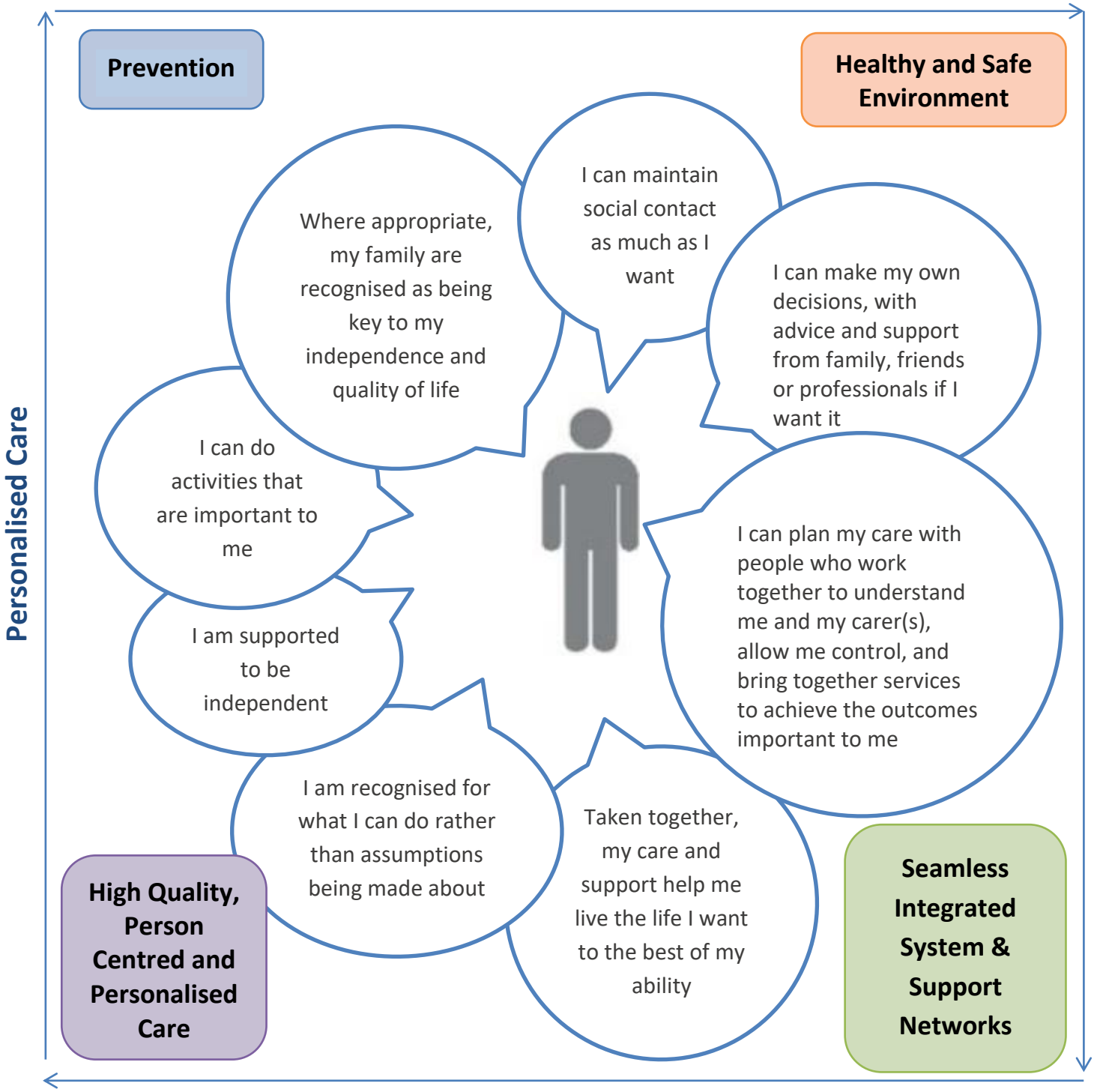
For the purpose of the strategy, the principles and outcomes have been split into 4 key domains. These are:

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

working together

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

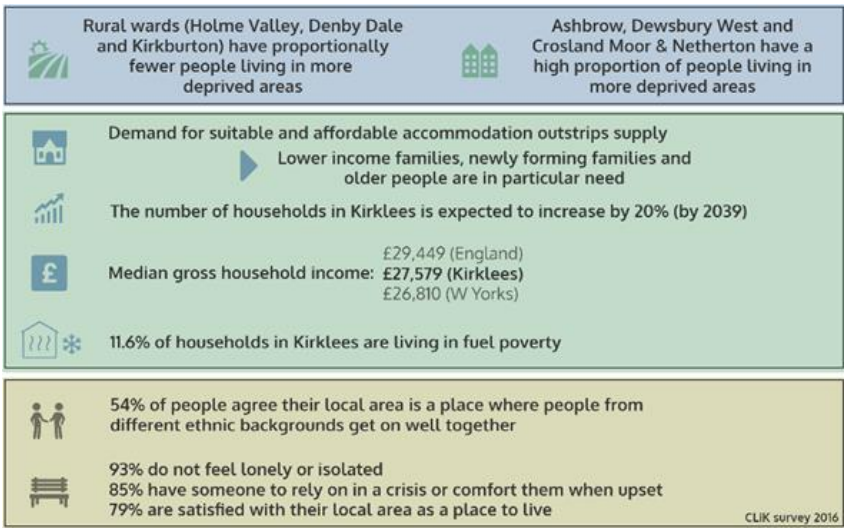
[16] https://www.england.nhs.uk/publication/learning-from-lives-and-deaths-people-with-a-learning-disability-and-autistic-people-leder-policy-2021/

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:

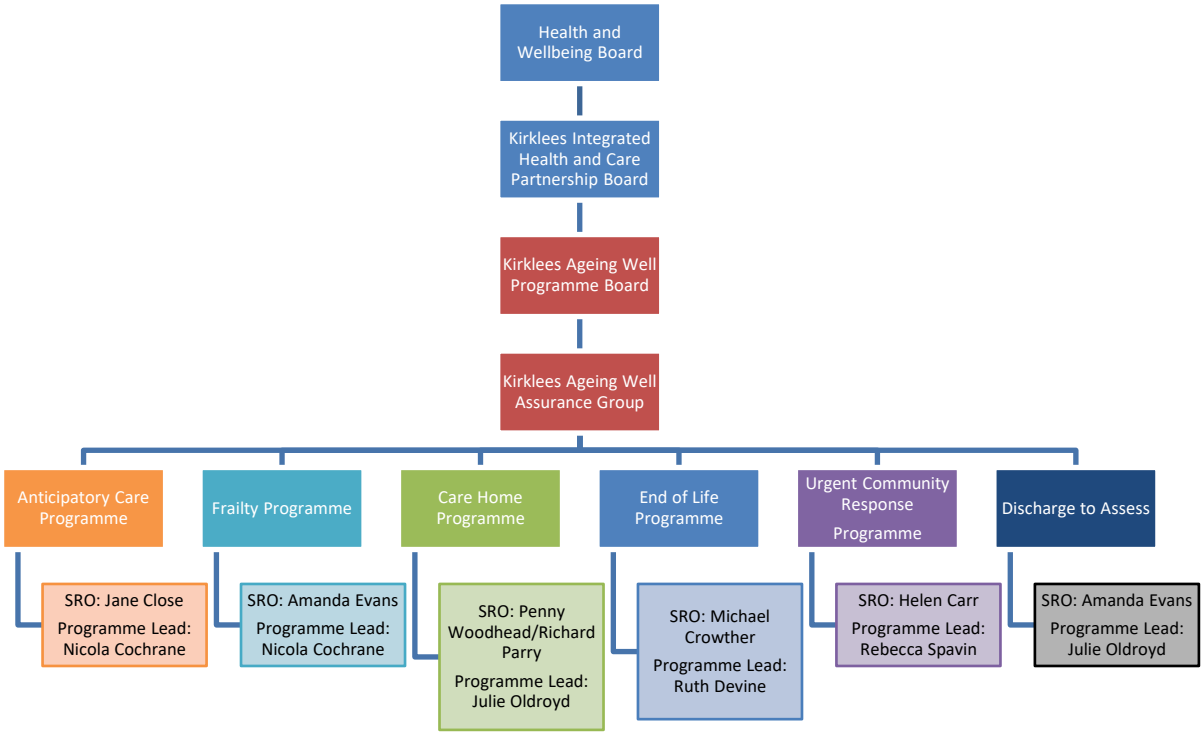
People in Kirklees will have improved health and wellbeing through:

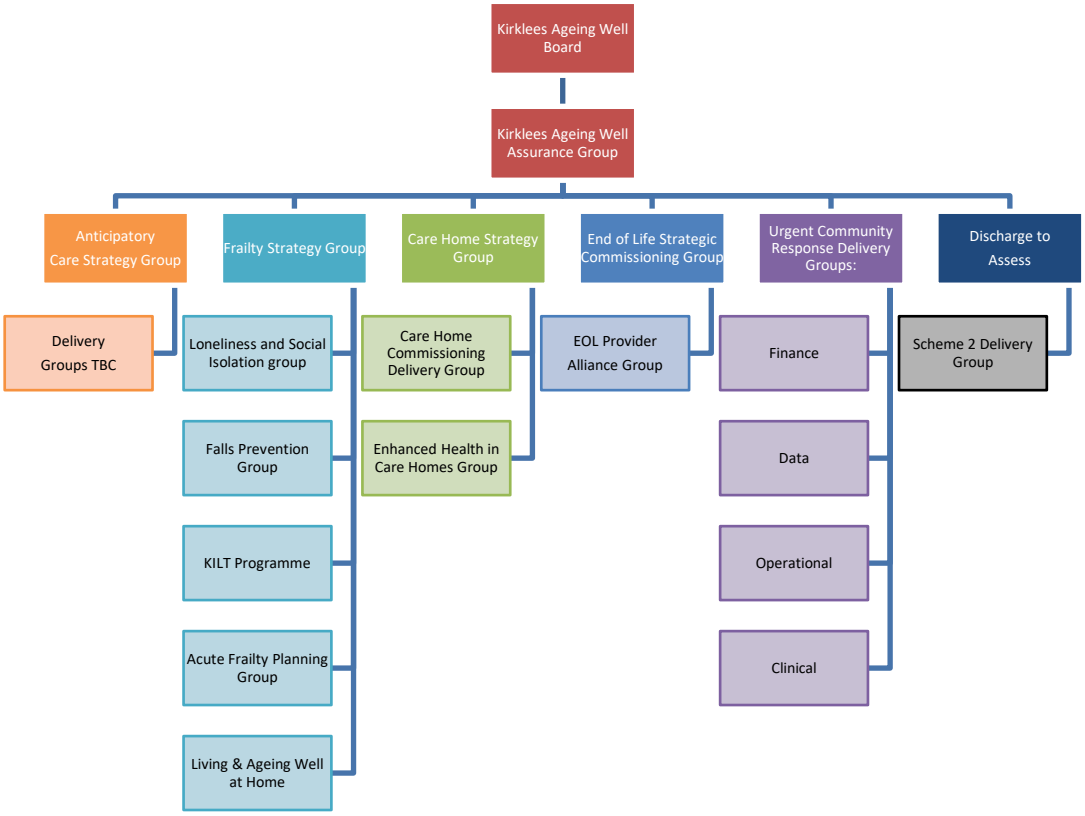
- Personal choice and control over the decisions that affect them
- Early identification, risk stratification, management, and support
- Increased shared decision making and patient understanding around long term conditions and keeping well through self-care
- Access to personalised care and selection 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





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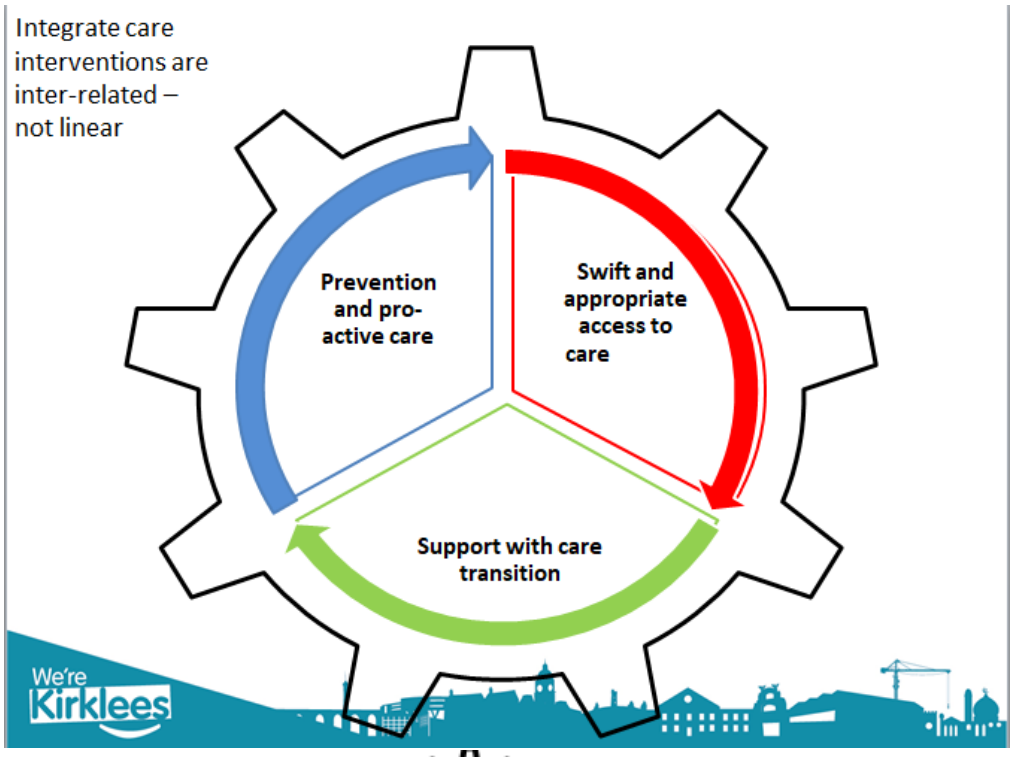
Taken from: https://www.kirklees.gov.uk/beta/delivering-services/pdf/public-health-report.pdf

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

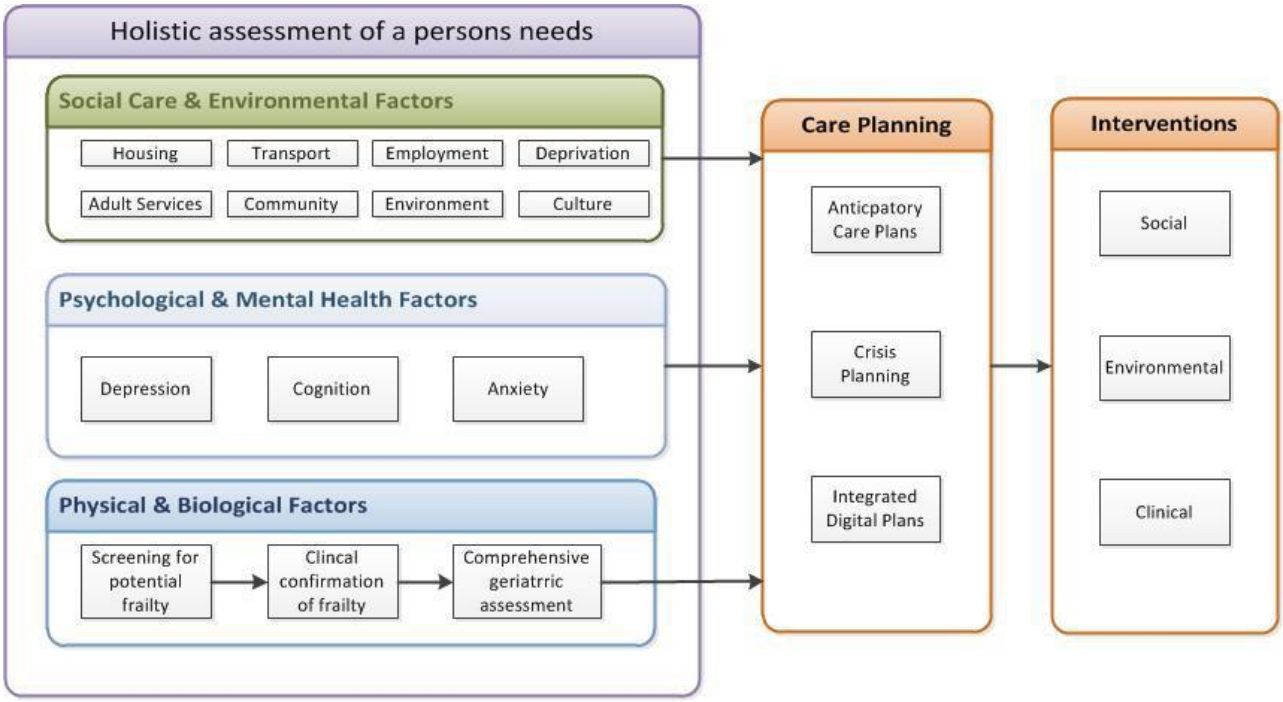
Community, General Practice and social care in-reach to support early assessment and discharge of people from different care settings

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



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APPENDIX 7: PERSONALISED CARE OPERATING MODEL