Kirklees Health and Care Partnership

Health and Care Plan

2023 - 2028

FINAL DRAFT

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Welcome to the Kirklees Health and Care Plan which outlines the changes we will make as a Health and Care Partnership over the next 5 years.

The landscape of health and care is changing. There is a shift away from purchasers and providers and a move towards collaboration and partnerships. We understand that to improve population health and address inequalities, partnership working with communities needs to be at the heart of everything we do.

The health and care system is also facing significant challenges. The COVID-19 pandemic resulted in significant backlogs in diagnosis and treatment and, despite significant progress reducing this during 2022, people in Kirklees are still waiting too long to be seen, whether this be for a physical heath condition or a mental health condition. The Winter of 2022 also saw unprecedented pressures across health and care, with demand on urgent and emergency care, primary, community and social care services at an all time high.

The Partnership has a responsibility to ensure the best use of resources and promote efficiency. Kirklees is facing significant financial challenges as a health and care system and this may result in some hard choices for the Partnership in the future.

There is a requirement to re-imagine the way services are delivered to ensure sustainability for the future. We recognise there is an immediate need to create the right environment to undertake effective and sustainable change and which enables resilience and flexibility to adapt to challenges as they arise. We will continue to recover the health and care system following the Pandemic, which will provide the capacity for system transformation. We will also focus on maturing relationships across the Partnership and gaining a better understanding of our communities, their capacity and how best to engage and work with them.

Our longer term transformation work will focus on bringing partners together and connecting care under a number of strategic themes, which span the life course, (starting well, living well and ageing well). Mental wellbeing and palliative and end of life care will be considered as a golden thread within each of the themes.

We will also focus on 4 priority actions, which have been considered through a number of lenses, where they are applicable:

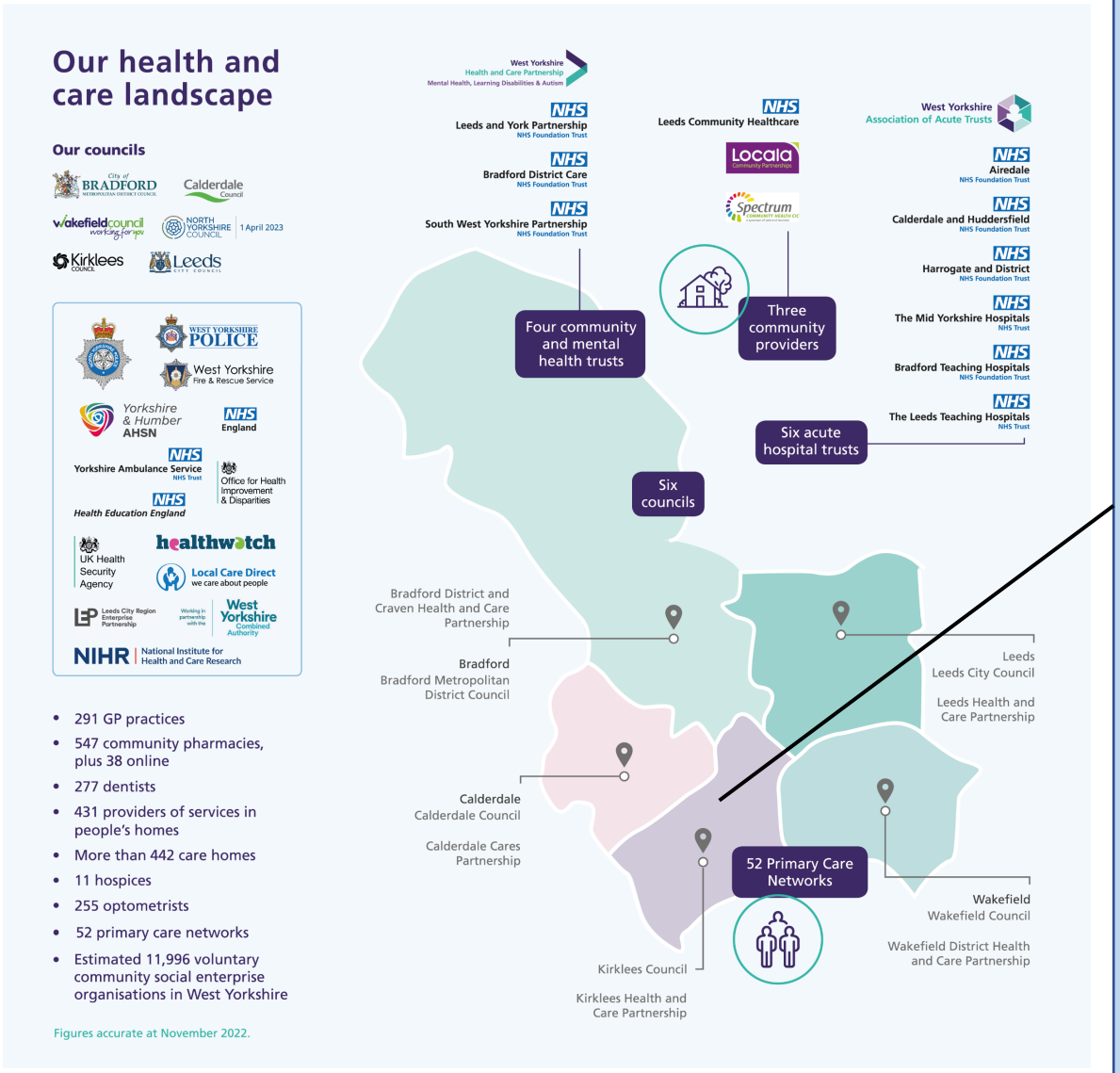
1. Improving access
2. Holistic approach to out of hospital care
3. Crisis response
4. Workforce

The Plan will contribute to delivering the Kirklees Health and Wellbeing Strategy and the West Yorkshire Joint Forward Plan alongside the Kirklees Economic and Environmental Strategies and the Inclusive Communities Framework.

The Health and Care Partnership has taken an inclusive approach to the development of this plan, ensuring that all partners have had the ability to influence its priorities and contribute to the narrative. The Healthwatch ‘I Statements’ have been a key driver in its development as a mechanism of ensuring we understand what is important to our local population and are able to respond to this. The intention is that this inclusive approach will continue once the plan is signed off, through on-going discussion and reflection which will feed an annual refresh process.

Throughout its development, we have ensured strong links to the West Yorkshire Integrated Care Strategy through the West Yorkshire Strategy Design Group and by actively contributing to the West Yorkshire Programmes. This joint work will continue as part of its delivery though the emerging communities of practice model.

The Kirklees Health and Care Partnership is part of the West Yorkshire Integrated Care System (known as the West Yorkshire Health and Care Partnership)



Further detail about the West Yorkshire Health and Care Partnership, including its mission and values can be found here

The Kirklees Health and Care Partnership

The Kirklees Population

- Population of 440,000 people centred around two major centres of Huddersfield and Dewsbury
- Relatively large area, mix of urban and rural areas
- The population is ethnically diverse and 22% are aged under 18
- Life expectancy is slightly below the England average and there are high levels of deprivation, especially in the north of Kirklees. Those living in areas of significant deprivation having a life expectancy of 6-7 years less than those living in more affluent areas, though there are pockets of deprivation in wealthier areas

The Partnership

Our Partnership brings together the local NHS, other health and care providers, Kirklees Council, Healthwatch, and community and voluntary sector organisations, to arrange and deliver services for people who live in Kirklees. Find a full list of organisations who are part of the partnership on the **Our partners page**.

Our vision for health and Care in Kirklees
People of all ages who live, work or study in Kirklees live their best lives with good health and wellbeing, free from inequality, stigma, discrimination and barriers, so they can do and enjoy the things that matter to them.

As a Partnership we are committed to delivering the following aims:

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

Our Partnership arrangements were formalised in June 2022 through the devolvement of Clinical Commissioning Groups into the West Yorkshire Health and Care Partnership and the establishment of the Kirklees place based partnership.

High proportion of people in Kirklees demonstrate health behaviours which have a negative impact on their health and wellbeing. For example, smoking or alcohol consumption. A high number of people are above a healthy weight, this is across the life course.

There is an increasing demand for emotional wellbeing services to support people with low mood and low level anxiety, particularly children and young people. Local services need to be flexible to respond to changes in demand for the type of support people require.

People from deprived areas are less likely to access services, especially preventative services such as screening. The inequalities gap will have been widened as a consequence of the cost of living crisis. There is an unmet need for health and care which usually presents as an emergency in our hospitals.

Infant mortality rate is increasing (rise from 4.9 in 2017 to 6.2 in 2019). Kirklees has higher rates of smoking at delivery than the national average and the maternal obesity is higher than the national average. The rate of babies born into poverty is also increasing.

There is an increasing demand for health and care services and our population is presenting to services with more complex conditions. Managing this alongside the targeted work to address the backlog from the Pandemic has resulted in significant system pressures.

The Kirklees health and care system is under significant financial pressure, which has been exacerbated by the current financial climate and cost of living pressures. There are significant risks to the sustainability of our independent care sector and the voluntary, community and social enterprise (VCSE) sector.

Poor housing and air quality has an impact on health and wellbeing. For example, Greenwood has a higher rate of asthma admissions. Better links to our economic and environmental strategies is required.

People who are being discharged back into the community have increasingly more complex needs which require more support from health and care services. Services in the community are not currently configured to respond to this in a sustainable way over the long term.

Lack of available estate and equipment to address increasing demand and the management of people in the community.

There is increasing demand for additional support to ensure children and young people with neurodiversity, social or emotional mental health needs or complex health needs have the opportunity to attend school and learn.

People are unable to access support from health and care services in a timely way, leading to inappropriate use of some services or people not seeking help at all.

Kirklees has long standing issues with recruitment and retention of its health and care workforce, particularly in the wider care sector where there is inequity in pay and conditions. The Pandemic has also had a negative impact on the wellbeing of our workforce.

Further detail on the specific population challenges for Kirklees can be found in the Kirklees Joint Strategic Assessment

Why partnerships

Since the introduction of the Health and Care Act 2022, all Integrated Care Boards across England have four key aims:

1. Improve outcomes in population health and health care
2. Tackle inequalities in outcomes, experience and access
3. Enhance productivity and value for money
4. Help the NHS to support broader social and economic development

These aims represent a marked shift from the decades focussed on organisational autonomy, competition and the separation of commissioners and providers, to a way of working that is instead based on collaboration, local partnerships and improving population health. This Health and Care Plan is the first time in this new era, that the Kirklees Health and Care Partnership has set out its joint plans, and the areas where strong partnerships will be fundamental to delivering our aims to improve outcomes and reduce inequalities.

Our partnership aspirations

At its inception, and at many times in the recent past, the NHS has been focussed on treating patients with single conditions or illnesses. Since these times, the world has changed dramatically – people are living longer with multiple conditions, advances in medical technology mean more patients are living with long term conditions that require support from multiple professionals and we understand more about the impact mental health has on outcomes. Too often, this need for the input of several professions and organisations into a person's care results in fragmented services, non joined up decision making and a complex system for people and their families/carers to navigate.

We also understand that the drivers of poor health outcomes and inequalities sit outside of the direct control of the NHS. The quality of houses, whether someone is living in poverty, whether someone is in good employment, their educational attainment, the physical environment around people and their ethnic background are also things that evidence has shown have a strong association with health outcomes. Addressing health inequalities and outcomes is complex, but progress can be made through strong partnerships, concerted focussed effort and a joined up approach on the wider determinants of poor outcomes. Our relations with the our partners in the VCSE sector are particularly important to allow us to do this. In Kirklees this is what we are determined to do.

How are we strengthening our partnerships

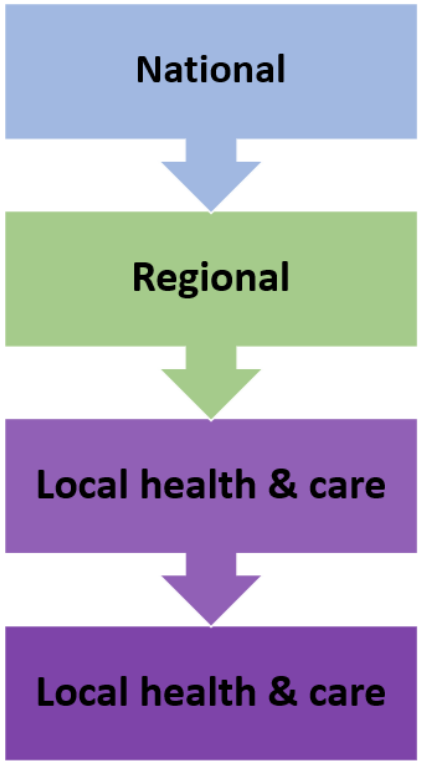
We recognise that changing the nature of relationships that have existed for many years will not happen immediately, but we have already made a start:

- We have established a Delivery Collaborative and Partnership Forum which involves partners from across Kirklees including the VCSE sector, and will provide forums for problem solving and innovation
- We are starting to appoint people to roles that span several organisations across Kirklees
- We have established a Joint Financial Recovery Group across Calderdale and Kirklees place involving all partner organisations
- We will continue to collaborate across the complex geography of our acute trusts, through mechanisms such as the Urgent and Emergency Care Boards. We will build on examples like the virtual ward model for Kirklees which has been developed jointly with partners in Calderdale and Wakefield
- We have already established formal alliances between organisations in mental health and end of life care. We will continue to develop these and look for opportunities to do more
- We will continue to work across the West Yorkshire Integrated Care Board (ICB) programmes and collaboratives. learning from other areas and working together where we can
- We will explore opportunities for cross working between organisations through sharing resource and development of single plans. For example, there are plans in place to increase joint working between Public Health and the Primary Care Transformation Teams to deliver a single plan for primary and secondary prevention
- We have an established Third Sector Leaders (TSL) which have been set up by local charities to support the sector and enable organisations to link strategically
- We have developed a Kirklees Workforce Development Strategy, which is being delivered by a Workforce Steering Group jointly with Calderdale place
- We have a Kirklees Digital Health and Care Board which is currently reviewing and re-defining its priorities

The Kirklees Health and Wellbeing Strategy (KHWS) outlines our shared commitment to improving the health and wellbeing of people who live, work and/or study in Kirklees. The Health and Care Partnership has a key role in shaping the health and care services which will deliver the strategy. The KHWS identifies three priorities:

1. Healthy Places
2. Mental Wellbeing
3. Connected Care and Support

The Health and Care Plan will contribute to delivering these priorities, by outlining how we intend to work together to ensure people are able to access the right care/support for their needs, when they need it, making the best use of all available resources. Its contribution to delivering upon the KHWS priorities should be considered alongside the Kirklees Economic and Environmental Strategies and the Kirklees Inclusive Communities Framework. The KHWS Approach and the 'I Statements' developed by Healthwatch Kirklees have been used to inform how we have developed and will deliver upon the Plan. Further detail on this and other drivers of the Plan are provided below.



The detail provided in the Plan is a summary and builds upon work we are already progressing. Supporting place/organisational plans and strategies will provide further detail on the implementation of the changes we intend to make and will be subject to the relevant assessment of impact as per our usual processes. It should be considered alongside the Kirklees Financial Strategy and Recovery Plans.

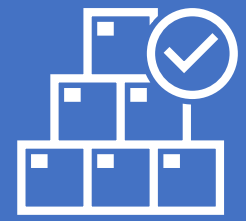
Links to the supporting plans and strategies is provided in appendix 2.

The Health and Care Plan covers a 5 year period. The first two years of the plan are provided in detail, with the remaining three years highlighted as aspirations and outcomes we hope to achieve. The content of the plan will be refreshed on an annual basis to reflect any changes, and to respond to publication of updated national strategy/guidance.

Our principles for transformation apply to all changes we make in relation to health and care within Kirklees. The principles are embedded within the Kirklees ICB's programme management office (PMO) documentation to ensure that they are applied to all of the work we undertake.

Kirklees Health and Care Partnership Principles for Transformation

- We will recognise that individuals are expert in their own health and care because you live it every day, and work with you rather than do things to you
- We will support you to take ownership and control of your own care and the management of long-term conditions
- We will support you in connecting with local resources, groups and individuals
- We recognise carers as a local asset and will create an environment where carers feel confident and supported to identify themselves
- We will work together to improve and deliver services which are more accessible, joined up using integrated care pathways and, where appropriate, in community settings
- We will improve the way we communicate with each other to prevent you needing to tell your story over and over again
- We will take a neighbourhood approach where possible and involve wider partners, for example education services
- We will reduce unintended and unnecessary duplication in services
- We will develop a 'one workforce' approach for health and social care with partners locally and across West Yorkshire
- We will maximise use of digital technology, when it is right for the individual, to access care and support
- We will share data to enable a joined-up approach to planning and delivering care and support
- We will work with partners to ensure quality planning, design, construction and management of spaces, places and homes
- We will take an integrated approach to monitoring and improving the quality of health and care services
- We will work together across the West Yorkshire Health and Care Partnership to identify areas for improvement and sharing of learning on a larger scale, where it adds value
- We will use the resources available to us responsibly taking into account the impact on the wider system
- We will minimise the impact of the services we provide on the environment and adapt to changes in the climate
- We will embed the inclusive approaches within the Inclusive Communities Framework to promote inclusivity
- We will promote compassionate cultures which lead to increased patient compassion and health outcomes



Health inequalities are the avoidable differences in health outcomes between groups or populations. Appendix 1 shows the wide-ranging factors that contribute to our health and wellbeing over our life-course and health inequalities. There is a social gradient to health inequalities with those who are the worst off, the most disadvantaged, experiencing the greatest inequalities. While good quality health and social care that is accessible, affordable, suitable, of high quality and effective positively impacts on our health, most factors that impact on our health and wellbeing, the social determinants, are beyond our health and care system. Social determinants are the social and environmental conditions that effect how we are born, live, grow and age and impact on our access to money, power and resources and health outcomes. Health inequalities are caused by the unfair distribution of these resources.

Why is this a priority?

- Increases in expectancy in England slowed between 2010 and 2020, with the greatest slowdown in more deprived areas. There is a social gradient to health with the worst off developing disabilities and dying earlier. The COVID-19 pandemic exacerbated and highlighted health and socio-economic inequalities, disparities in outcomes and experiences of healthcare, particularly for many ethnic minority groups and people with lower incomes
- Poverty has a cumulative negative impact on health throughout and is linked to poor mental and physical health, increased all-age mortality and lower life expectancy. The stress of poverty causes mental health issues and reduces the mental capacity to manage problems and live a health life
- While the pandemic has had a substantial impact on the wellbeing of children and young people, children living in persistent poverty are 3 times higher risk of mental ill health, 1.5 times greater risk of obesity and nearly double the risk of long-term ill health compared to those who have not been poor, as well as worse social and behavioural development
- Poverty and the cost of living crisis impacts on access to decent housing, employment, care and other services, the ability to have a healthy diet, heat the home, and increases the likelihood of debt and the associated stresses. The stigma of poverty means people often delay seeking help and as such the impacts will be under reported
- Poor quality and overcrowded housing harms health and widens inequalities. Cold homes affect physical and mental health, contribute to increases in circulatory and respiratory disease, colds and flu, chronic conditions (e.g. rheumatism) and excess winter deaths
- Physical inactivity is associated with factors linked to more deprived areas: higher levels of ill health and disability, unaffordability of activities, fewer green spaces and poorer travel infrastructure

Inequalities in Kirklees

28.2% of children under 16 live in relatively low income families. This is worse than the national average of **18.5%** and the regional average for Yorkshire and Humber at **25.2%**.

Overall, Kirklees has a similar rate of school readiness in children age 5 compared to England and Yorkshire and Humber. However, this is lower in more deprived areas.

Overall emotional wellbeing in 14 year old children has decreased since 2019, and also decreased from the beginning of the COVID-19 pandemic.

62% of adults with 3+ long term health conditions said they are confident managing their health. This has decreased from **71%** in 2016.

Most adults say their housing is suitable for their needs **(83%)** although this has reduced from **89%** in 2016. People in the most deprived areas and people with a disability are most likely to say their housing **is not** suitable for their needs.

Healthy life expectancy is lower for females **(61.2 years)** compared to males **(62.8 years)** and is also significantly lower than the national average for female healthy life expectancy. These inequalities are greater in the most deprived areas.

The Kirklees Health Inclusion Network

To improve the health of local people and reduce health inequalities we need to collaborate with system partners - including our communities, business and economic sectors - to address the social determinants, as well as focusing on improving health and care provision. By using a proportionate universalism approach and investing resources and interventions in line with need (i.e. more where need is higher) in conjunction with a life course approach we can improve health for all and flatten the gradient, improving health faster where need is greater. The Marmot principles are a guide in terms of where to focus intervention.

A Health Inclusion Network has been established across the Health and Care Partnership. This Network will be a platform to share good practice and undertake peer support and challenge. Over the next 12 months the group will identify some joint priority actions which we will take collectively to reduce the inequalities gap, building on the positive work in progress in relation to cancer screening, learning disabilities, health literacy, the VCSE sector and through the use of the Core20Plus5 funding.

The Kirklees Quality Framework describes how Quality Teams and leaders with responsibility for the quality and safety of service delivery will progress an increasingly collaborative and integrated approach to quality oversight, management of quality priorities plus enact a shared commitment to quality improvement. This will include routine and enhanced surveillance mechanisms, identifying roles, responsibilities, accountability, including governance structures.

The framework explains how a collaborative approach will be used which includes how feedback from users of services plus their families will contribute to quality improvement and oversight. The Quality Framework also sets out the mechanisms and processes for how assurance will be gained plus identification and processes for management of services requiring in depth reviews. Intrinsic consideration of the benefits of quality improvement will contribute to all aspects of the place based quality collaboration to allow proactive progression from routine assurance to progressive, proactive improvements which are clearly evident.

Our shared system vision for quality and the priorities which underpin it are aligned with the National Quality Board's Shared Commitment to Quality, which has been recently refreshed.

Our Priorities for Quality Improvement

1. To ensure the fundamental standards of quality are delivered – including managing quality risks, including safety risks, and addressing inequalities and variation
2. To continually improve the quality of services, in a way that makes a real difference to the people using them

The principles identified to support collective delivery of the priorities are:

- Quality is a shared commitment
- Population focused vision
- Coproduction with people using services, the public and staff
- Clear and transparent decision-making
- Timely and transparent information-sharing
- Subsidiarity

The 'Seven Steps' identified in the 'Shared Commitment to Quality' provides a framework for quality oversight and improvement work and outlines what needs to occur collaboratively to maintain and improve the quality of care people experience.

These form the basis of how we will achieve our vision for quality.

Further detail on the specific action which will be taken is provided in the Kirklees Quality Framework.

There is a collective ambition across Kirklees for Health and Care Organisations to further build on the power of communities which had been so evident during the Pandemic. There is a recognition that communities know themselves best and could bring about the best solutions to the challenges they face. We are committed to ensuring local people have an equal voice in developing the future health and care landscape and are able to influence how our plans are delivered through co-production. The Kirklees Communities Partnership Board has been established to achieve our vision for inclusive communities.

Inclusive Communities Framework (ICF)

We have followed a partnership-based approach to develop our Inclusive Communities Framework (ICF). This has been produced in collaboration with the public, VCSE sector organisations from across the district. The ICF articulates a set of core principles and approaches that organisations can use as a guide to improve inclusivity. The ICF has been endorsed as one of the top tier strategies within Kirklees alongside the Kirklees Health and Wellbeing Strategy.

As Health and Care Organisations we have signed up to the ICF and will embed it in our system change processes and how we work with Providers:

- ✓ We will create more **connections** in and between communities
- ✓ We will **communicate** more and better with communities
- ✓ We will create opportunities to work alongside local people sharing knowledge and resources, **'equalising'**
- ✓ We will **trust** communities more
- ✓ We will **celebrate** with communities

Community Anchors

We will support the work of the Community Anchor Network and TSL. Community Anchors are established locally rooted organisations who will:

- Help others by making connections and building trust
- Sustain and develop community activity
- Share information, resources and skills
- Provide practical help such as space, funds and help with policies and plans
- Help build organised, resilient, inclusive communities which support health
- Build, networks and relationships by supporting co-operation and partnerships

Community Champions

Kirklees Community Champions are trusted and trained individuals with a desire and commitment to make a difference within their local community. As individuals recruited from within their local community, they have an ability to reach, engage and communicate with Kirklees residents disproportionately impacted by health inequalities.

The model of work adopted by Community Champions is flexible and based on trust. It empowers communities to deliver change in a way which is tailored to the needs of their communities and values local knowledge. The work undertaken by the Champions demonstrates how, when partners and VCSE organisations 'work alongside' each other, real impacts can be made in local places.

Harnessing the Power of Communities

We have plans to work with two communities within Kirklees to strengthen the community infrastructure and empower them to take more control and ownership of the assets within their communities. We are developing two pilots in the north and south of Kirklees, which will be evaluated to determine the next steps.

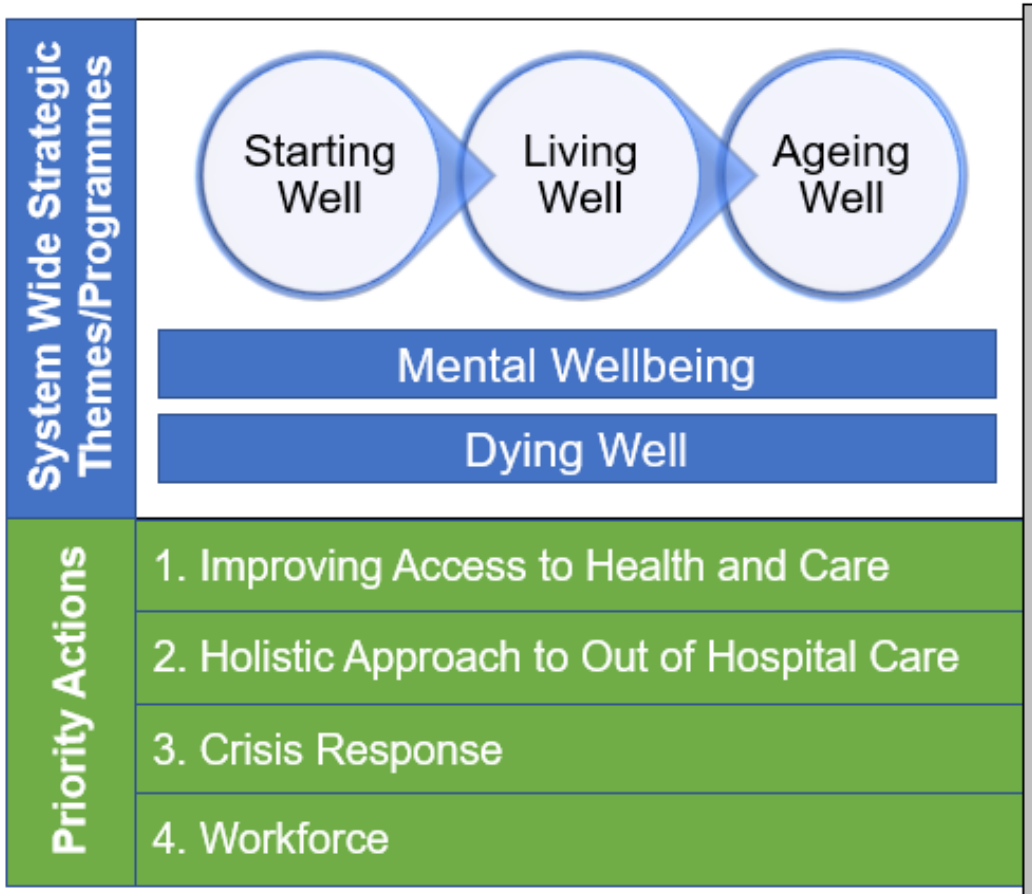
Community Voices

Community Voices is one of the mechanisms we use to engage with communities. They are individuals working in the VCSE sector who engage with the local population on our behalf. By working with volunteers in this way, the response to our conversations is strengthened and increased, particularly from seldom heard groups. We have worked closely the VCSE sector and community sector to continue to recruit and train Community Voices. We currently have 66 Community Voices, representing 53 organisations in Kirklees.

The priorities for the Kirklees Health and Care Partnership are outlined below. They build upon work which is already in progress, whilst responding to the JSA, KHWS, the West Yorkshire Joint Forward Plan and national mandates.

Our system improvement work will be undertaken across the life course, focussing on a number developing strategic themes/programmes. Improvements in mental wellbeing and ensuring choice and dignity at the end of life are an integral focus for all areas.

We will undertake targeted improvement work across 4 priority actions over the next 5 years. Further detail of the specific changes we will make in the short, medium and longer term for each of these can be found in the proceeding pages of this document.



Each priority will be developed using the following lenses where they are applicable.

- Improving quality, safety experience and effectiveness and safeguarding
- Working with people through co-production
- Reducing inequalities including the impact of poverty on health and wellbeing
- Supporting people to make informed choices and empowering them to take charge of their own health and care
- Early intervention and prevention
- Trauma informed approach
- Parity of esteem
- Supporting carers
- Use of population health data to drive change
- Digital, recognising the importance of digital exclusion
- Estates
- Responding to the climate emergency
- Opportunities to do things once at scale, working across the West Yorkshire ICB programmes using the 3 tests.
- Making the best use of available resources

The Health and Care Plan is a intended to be 'live' document. Some areas of the plan are still evolving and the detail will be updated in future revisions as it is developed. For year one of the plan, this applies to the following areas:

- Starting Well
- Living Well
- Discharge/home first
- Neighbourhood approach
- Adversity, trauma and resilience
- A collective approach to health inclusion/reducing health inequalities
- A collective approach to digital transformation

Year 1 of the Health and Care Plan will deliver upon the NHS operational planning requirements for 2023/24. For the system recovery targets which will be achieved through delivery of each of the priority actions see appendix 3

Scope

Develop a delivery model to deliver our Children and Young Peoples' (CYP) ambitions, as outlined in our Health and Wellbeing Strategy and Health and Care Plan, ensuring every child has the best start in life, irrespective of the circumstances they are born into, to enable them to maximise their potential, flourish and take control of their lives throughout the life course.

Current Position

A shared outcome in Kirklees is that *children will have the best start in life*. In order to achieve this we will adopt a partnership approach to the delivery of CYP ambitions, ensuring health, care, wider determinants and associated inequalities are seen as system priorities.

Recent system engagement has suggested there is room for improvement in CYP collaboration, with a lack of a system attended group that can be delegated accountability of ambitions and, as such, coordinate an ecosystem of services in Kirklees.

The development of our partnership **Starting Well Programme** aims to primarily better integrate CYP work, in Kirklees, whilst delivering on key outcomes, as identified by our Public Health Team, Joint Strategic Assessment data, by providers delivering services and by our citizens, receiving care.

Aims and Objectives:

1. Reduce infant mortality
2. Reduce maternal and childhood obesity rates
3. Improve maternal, infant, early years and adolescent mental wellbeing
4. Address maternal, infant, early years and adolescent inequalities, including leading the maternity Core 20+5 work
5. Support a partnership response to the SEND 'Written Statement of Action' work
6. Support Kirklees Family Outcomes Framework delivery

Governance:

- The current CYP infrastructure needs to be mapped and better understood
- A single group should be formed to assume leadership for CYP ambitions
- The broader CYP system should link with this group, to enable effective delivery
- Relationship with other Well Programmes and Kirklees Delivery Collaborative should be considered
- The Kirklees Health and Care Partnership could consider if this group has the maturity to be delegated budgets and accountability
- This enables a power shift empowers the CYP system to be delivered in a 'Provider Collaborative' approach, with distributed leadership

Next Steps

1. Facilitate a workshop with key stakeholders to review existing structures, with intention of initiating the following recommendations
2. Evolve an existing group(s) to become a Kirklees Starting Well Programme Board (SWB)
3. Ensure SWB has system representation and leadership, with a clear Senior Responsible Officer (SRO)
4. Agree a system SWB remit and terms of reference

Outcomes may change following broader system engagement

Scope

Develop delivery model to address long term condition prevention, diagnosis and management, ensuring alignment with wider determinants, with a focus on inequalities to lead on delivery of the Kirklees Health and Wellbeing Strategy 'Well' outcome - *people in Kirklees are as well as possible for as long as possible*, whilst supporting delivery of the 'Independent' outcome - *people in Kirklees live independently and have control over their lives*. N.B. there is potential for this scope to be extended.

Current Position

An ageing population and increments in the number of people living with Long Term Conditions (LTC) and the current cost of living crisis are developing a heightened need to focus on prevention and health inequalities.

In Kirklees a focus and a resource shift, to community based prevention and management of LTC are recognised as priorities. As such, integration of LTC and prevention workstreams, recognising their interdependencies, is critical.

Recent system engagement has indicated that these areas are not as joined up as they could be and that there is a lack of a Kirklees strategic vehicle to champion and lead collaboration.

The development of our partnership **Living Well Programme** aims to primarily better integrate LTC work, in Kirklees, whilst delivering on key outcomes, as identified by our Public Health Team, Joint Strategic Assessment data, by providers delivering services and by our citizens, receiving care.

Aims and Objectives:

1. Increase emphasis, and resource, on LTC prevention
2. Embed poverty informed practice in LTC work
3. Support embedment and delivery of neighbourhood holistic teams, offering personalised care
4. Assume responsibility for delivery of NHS Long Term Plan, Long Term Conditions Outcomes for: Cardiovascular Disease (including Stroke), Diabetes and Respiratory and of associated Core 20 plus 5 work
5. Support delivery of mental health and cancer outcomes

Governance:

- There are inconsistencies in current Kirklees LTC structures
- A single group should be formed to assume leadership for LTC ambitions
- The broader LTC system should link with this group, to enable effective delivery
- This group will link to WY LTC groups
- Relationship with other Well Programmes and Kirklees Delivery Collaborative should be considered
- The Kirklees Health and Care Partnership could consider if this group has the maturity to be delegated budgets and accountability
- This enables a power shift empowers the CYP system to be delivered in a 'Provider Collaborative' approach, with distributed leadership

Next Steps

1. Ensure system representation and leadership (management and clinical) – including SRO arrangements
2. Develop a Kirklees Living Well Programme Board (LWB)
3. Agree a system LWB remit, that the group is delegated LTC associated outcomes from the KHWS and the Health and Care Plan
4. Consider relationship with up-coming WY Fuller Board workplan

Outcomes may change following broader system engagement

A key ambition across the Kirklees Health and Care Partnership 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 we will support people in Kirklees to age well, an Ageing Well Strategy has been developed and is delivered by an Ageing Well Programme. The Ageing Well Strategy supports the key deliverables within the NHS Long Term Plan and the national NHS England Ageing Well Programme.

The Kirklees Ageing Well Programme is broader than the national definition and includes wider areas of work including age friendly, care sector, palliative and end of Life care and discharge/home first. Initially set up as a health focussed model, now that the programme is established it is looking to expand the scope to incorporate the wider factors which have an impact on health and wellbeing and ensure stronger links with mental wellbeing. This will include reducing stigma around older people's mental health and increasing opportunities for mental health support for our ageing population. Public Health prevention themes will be embedded within the programme areas to move towards a more sustainable, longer term support offer for the ageing population within Kirklees.

The delivery of the Ageing Well Programme is supported by the Kirklees Better Care Fund.

An Overview of the Ageing Well Programme

Programme	Descriptor
Proactive Care (formally 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
Age Friendly	➢ Kirklees becoming an age-friendly place to live. Creating places where age is not a barrier to living well and where the environment, activities and services support and enable older people to lead and enjoy life, feel well, be active/keep moving, be able to fully participate and contribute to society ➢ Use advances in technology ➢ System wide approach to frailty identification and response to frailty syndromes including workforce training and education
Palliative and End of Life	➢ Supporting people with life limiting illnesses to experience great personalised care so that they can live a good quality of life until they die, and those important to them can be supported through bereavement to 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
Care Sector Programme	➢ Developing a market that is financially sustainable ➢ Work in partnership with care sector to support the ongoing development and retention of staff, to co-designing the pathway for future staff development ➢ Delivery of high quality care, including end of life, dementia care and reablement and rehabilitation services promoting independence ➢ Deliver specialised care and support in the community that will be able to respond to individuals with complex health and social care needs
Discharge/Home First	➢ Embed and mature the discharge to assess and home first approach ➢ Improve patient flow out of hospital ➢ Build the evidence base on discharge practices, use of pathways, outcomes and the impact of intermediate care ➢ Evidence demand to support commissioning and sufficiency of supply
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. Aiming to avoid unnecessary hospital admission and support early discharge for medically optimised older people to leave hospital on time
Virtual Ward	➢ Virtual wards allow patients to get the care they need at home safely and conveniently, rather than being in hospital

Why Focus on Palliative and End of Life Care

- The population in Kirklees is getting older. If recent mortality trends continue, in 2040 there will be at least 1,200 more people who will need palliative care every year
- Approximately 30% of people in the last year of life use some form of Local Authority funded social care
- Over 20% of the entire NHS budget is spent on care provided to someone in the last year of their life. A study in 2014 found that care in the final three months of life averaged over £4,500 for every person who died. In Kirklees this would be over £17 million. The bulk of this cost is due to emergency hospital admissions where hospital costs can increase rapidly in the last few weeks of life
- More than half of the complaints referred to the Parliamentary and Health Service Ombudsman in the UK concern end of life care, and over half of these are upheld
- The Pandemic has brought into sharper focus the importance of proactive planning for people who may be in the last year of life, including the experience of people who are bereaved and the impact of death on their health and wellbeing

The Kirklees Palliative and End of Life Care Partnership/Dying Well Board

Since 2018, The Kirkwood have been instrumental in leading the development of a system-wide partnership across health and social care, which is evolving to become a Dying Well Board.

The vision for this partnership is to ensure more people in Kirklees can access great care at the end of their lives. This has been underpinned by the aims of reducing health inequalities, promoting personalised care, and improving the experience of carers.

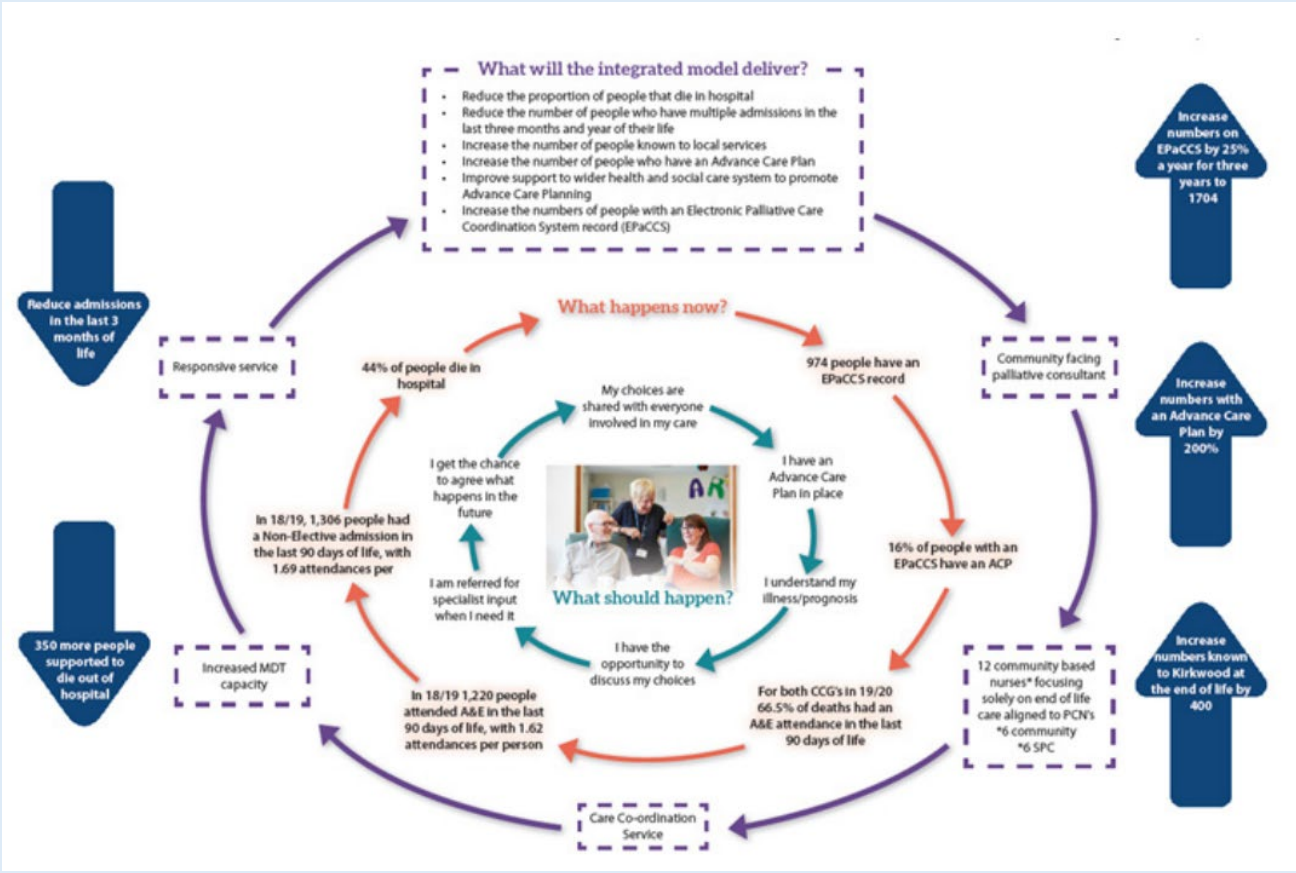
The Partnership have developed a future service development model for integrated palliative and end of life care in Kirklees which has been approved in principle and which is intended to be embedded across the life course through the starting well, living well and ageing well programmes.

Our ambition is to deliver this model in order to:

- Reduce health inequalities
- Improve support for carers
- Personalised care for more people to experience great quality of care

What is next for the Dying Well Board

- Developing a 'Quality of Dying' report, in conjunction with Public Health
- Producing a Health Needs Assessment for Palliative and End of Life Care
- Working with Healthwatch Kirklees to create a process to measure the experiences of bereaved people
- A review of advance care planning processes across organisations



Why is this important to the Partnership?

- People are waiting too long for diagnosis and treatment causing unnecessary harm. The longer people wait, the more their condition deteriorates. They can become deconditioned, impacting on their recovery, independence and mental wellbeing
- Accessing appointments in General Practice is difficult, resulting in people either accessing other services which are not appropriate for their needs or not accessing support at all
- People are waiting too long for a mental health diagnosis resulting in delays to accessing support and a potential deterioration in their condition. The waiting times to access support following diagnosis are also too long. There are specific challenges in terms of access to CYP mental health services, neurodiversity services, talking therapies and older peoples mental health services
- Accessing routine and emergency NHS dentistry appointments is difficult, resulting in people either accessing other services which are not appropriate for their needs or not accessing support at all. Increasing poverty poses further challenges to access and increases health inequalities as many people are unable to afford private care
- Demand for health and care is increasing, putting further pressure on access to services
- Not enough people are accessing preventative services which will keep them well for longer and reduce the need to access more acute health and care services
- There is a direct link between health inequalities and access to care, particularly access to preventative services such as health checks and health screening. People who are experiencing poverty, people with a mental health condition and certain ethnic groups are less likely to access care before they are in crisis
- Kirklees does not have a cohesive approach to management of the impact of trauma on health and wellbeing. Provision of early support, particularly for children and young people, will reduce the need to access services, and support young people to remain in education.

Our ambition for the future

- Increased focus and awareness of proactive and preventative support measures. Use of behavioural science approaches to gather insights for specific populations, and tailor approaches, communications and offers to increase engagement and uptake to preventative services, reducing the need to access health and care services
- Trauma informed approach embedded across all organisations and services reducing the need to access health and care services
- Children and young people receive the support they need to access learning
- Work in partnership with the VCSE sector and the Community Champions to ensure that people understand how to access services in a way that is relatable to them
- When people do require support they are able to access the right services for their needs in a timely way
- Care is personalised and focussed around what matters to people, reducing the need to access services on an on-going basis
- More people in Kirklees access great care at the end of life
- Improved data oversight and on-going demand and capacity modelling to support operational teams to identify opportunities for transformation and new ways of working
- Working in conjunction with the Kirklees Environmental Strategy to address the impact of poor air quality on health and the need to access services
- Working in conjunction with the Kirklees Economic Strategy to address the impact of poverty on health and wellbeing and the need to access services.

Achievements to Date:

- Kirklees Gypsy and Traveller health needs assessment recently completed
- Implementation of the LD/Dementia pathway including resources to support dementia diagnosis for people from ethnic minority communities
- Continued work to facilitate annual health checks through work with GP practices to align the register of learning disability (LD) patients, GP Practice LD awareness training and Strategic Health Facilitator posts
- Development of a referral pathway and service specification for perinatal and maternal mental health
- Development of complex care and rehabilitation pathways
- Review of neurodiversity referral pathways
- Reduced the backlog of elective care appointments in line with national requirements
- Successfully recovered the cancer waiting time standards
- Successfully embedded a Primary Care Network (PCN) approach to enhanced access, delivering more appointments in General Practice
- Improvements to cancer screening uptake, taking a system approach and working specifically with hard to reach communities
- Development of the Kirklees (End of Life) Care Charter.

Key Changes we will Make to Improve Access:

2023/24	
General Practice	• Better understanding and consistency in the recording and reporting of data to support demand and capacity analysis. Delivery of access improvement plans. • Deliver more appointments in General Practice in line with national targets through schemes such as embedding enhanced access and increasing uptake to the Community Pharmacy Access Scheme • Improving and increasing access to a variety of appointments and maximising opportunities for a digital approach, taking into account digital exclusion: ➢ Review of telephony infrastructure in General Practice ➢ Increased ability for online booking and direct booking via NHS 111 ➢ Review of cloud based telephony • Implementation of care navigation and signposting, supporting staff to undertake training available. • Review and embed learning and recommendations from the Gypsy and Traveller health needs assessment across the system • Increasing uptake of health checks and long term condition management reviews. • Improved interface between primary and secondary care, mental health services and community pharmacy.
Elective Care	• Monitoring of demand and capacity across the system including more active management and proactive support for those on waiting lists • Secure additional capacity and offering choice at the point of referral • Increase uptake of shared referral pathway and advice and guidance as a mechanism for GPs to seek advice from acute clinicians prior to/instead of referral. Increase personalised care and patient initiated follow up (PIFU). Embedding the culture change required to make PIFU successful, increasing access to first appointments • Theatre improvement programme • Digital alternatives and new ways of working to be tested. Digital exclusion and its impact on increasing health inequalities to be considered • Changes to estate to accommodate more activity at both Acute Trusts. Patients will be seen in the location closest to their home where possible • Development of the elective care market, putting more flexibility and resilience into the system. Inclusive of a framework to enable working at scale across the West Yorkshire ICB and West Yorkshire Association of Acute Trusts (WYAAT) • Kirklees residents will be able to access diagnostics in the community through the community diagnostic centres which will be operational within Wakefield.
Cancer Services	• Monitoring of demand and capacity across the system, including more active management of waiting lists and implementation of best practice timed pathways. • Increase uptake of shared referral pathway and advice and guidance • Undertake work to improve the flow of people into tertiary centres and back into acute care • Delivery of transformational schemes which support people to be treated in a more effective and timely way such as, Tele-Dermatology, Cytosponge, Colon Capsule Endoscopy, improved care model for non-surgical oncology, targeted Lund Health Checks, Prostate Shared Care pathways. Lung health checks and pin point blood testing evaluated and embedded • Promotion of FIT testing. Working with the West Yorkshire Cancer Alliance on a negative FIT test pathway • Provision of pre-habilitation and psychological support will be provided to help patients engage in diagnostics and treatment at an early stage. • Maintain delivery of an educational programme to support all GPs to refer into all pathways appropriately including the non symptom specific pathway. CHFT to pilot embedding an Advanced Care Practitioner in PCNs with high levels of deprivation to promote the pathway and encourage self referral, (pending successful innovation bid) • Understand the barriers to screening uptake • Improved access to diagnostics through the implementation of the community diagnostic centres, which will prioritise patients with suspected cancer • Work collaboratively with system partners, the West Yorkshire Cancer Alliance and tertiary centres to refresh local Cancer Strategies.

Key Changes we will Make to Improve Access:

2023/24	
Mental Health Services	• Availability of a 24/7 mental health support line, develop stronger links to NHS 111 to promote referral • Improved access to those people seeking support at times of crisis through development of crisis helplines, early response and drop-in opportunities and accommodation solutions • Perinatal Network meetings to be held. Training to be delivered to ensure services are aware of the local referral pathway and service specification • Review of community based mental health provision for children and young people (CHEWS) • Expansion of the school/college based Mental Health Support Teams (MHST) to provide full coverage across Kirklees • Development of a trauma informed strategy for children and young people • Improve access to mental health services in primary care through community transformation • Older people's mental health to be embedded across all of the adult mental health ambitions • Implement transformation of older people's Inpatient services, following consultation • Continue to improve access to IAPT/Talking Therapies services for adults and older adults with common mental health problems with a focus on those with long term conditions • Improved access to Individual Placement and Support (IPS) enabling people with severe mental illnesses to find and retain employment • Fully implementing health checks for people with SMI.
End of Life Care	• Benchmark current progress within a Quality of Dying report, supported by a health needs assessment for palliative and end of life care • Establish a process to measure the experiences of bereaved people • Working with Healthwatch Kirklees to create a process to measure the experiences of bereaved people • Review key outcome measures across the Partnership in order to understand which groups or demographics may be under-served • Undertake a training needs analysis for health and social care staff • Complete a review of advance care planning processes across organisations.
NHS Dentistry	• Work collectively across the West Yorkshire ICB and NHS Dentistry to understand the challenges to access and develop plans to address these.
Prevention	• Develop clarity on the range of preventative and wellbeing offers commissioned and delivered across the system • Working with the Community and VCSE sector to ensure they/communities are aware of what services are available and how to access them • Continue to improve uptake to cancer screening programmes and vaccination and immunisation programmes • Strategies for supporting people to make healthy lifestyle choices • Use innovative methods to work effectively to create a preventative approach to CVD which supports the people of Kirklees to lead healthier lives in informed communities and avoid the early onset of cardiovascular conditions • Core20PLUS5 to fund smoking prevention provision in Secondary Schools • Develop and embed poverty informed practice.
2024/25	
General Practice	• Monitoring of demand and capacity including appointment measurement • On-going development of online consultation and use of new technologies • Continue increasing uptake of health checks and long term condition management reviews targeted work with population groups who do not routinely engage with these services.

Key Changes we will Make to Improve Access:

2024/25	
Elective Care	• System wide pathway redesign to ensure a more sustainable solution in areas identified as 'pressured specialties'. Working at scale across West Yorkshire • Community diagnostic centres to be operational within Huddersfield • Development of a remote/virtual consultation strategy • Supporting patients to take more control of their own care through mechanisms like patient portals • Standardization of pathways and harmonization of policies • Productivity projects, for example theatre efficiencies combined with GIRFT, that could eventually lead to cost savings in certain specialties. CHFT is part of a pilot scheme to secure GIRFT Surgical Hub Accreditation status.
Cancer Services	• Increase awareness of cancer signs and symptoms awareness to increase early diagnosis and treatment. Use of behavioural science approaches and insight • Delivery of local cancer strategies.
Mental Health Services	• On-going implementation and transformation of older people's inpatient services • Care programme approach developments • Continue to build upon the improvements to access including a better understanding of inequalities. Development of plans to reduce inequalities • Development of a strategy for digital mental health • Availability of specialist community care from pre-conception to 24 months after birth with availability of evidence-based psychological therapies • On-going monitoring of the newly implemented CHEWS model, including mechanisms for step up/down to enable targeted support into schools.
End of Life Care	• Repeat the Quality of Dying report in order to measure progress • Implement the identified priorities from the training needs analysis • Targeted work within organisations to increase EPaCCS and advanced care planning numbers.
NHS Dentistry	• Implementation of improvement plans

Medium to Long Term Aspirations for improving access up to 2028 (detail to be added in future revisions of this plan)

- Reduction in smoking prevalence and healthy weight. Better uptake of screening and immunisations through use of behavioural science
- Effective long term condition management, keeping people well for longer
- Patients take more control of their own health and care and have the ability to upload their own healthcare data using online forms
- Digital first offer, where clinically appropriate, being mindful of digital exclusion
- Flexible and responsive elective care market which has the ability to adapt to changes in demand
- Improved coordination of support with in the community post procedure to improve discharge efficiency
- Increase the percentage of cancers diagnosed at stages 1 and 2 and reduce the numbers diagnosed at stages 4 and 5
- Increased cancer survival rate through early diagnosis and treatment and survivorship support
- No inappropriate out of area admissions for people with mental health or learning disabilities
- Robust and challenging process in place to ensure that locked rehabilitation is a last resort for complex mental health care pathways
- Improved neonatal cot capacity in line with the ambitions within the three year delivery plan for maternity and neonatal services
- Ability to support more children and young people in mainstream education where appropriate, to include upskilling teaching staff to support children in the classroom more effectively.

Why is this important to the Partnership?

- People are living longer with more complex health care needs
- The number of avoidable admissions to hospital is high, people can be better managed for their needs within the community
- People who are admitted to hospital are staying longer than they need to, leaving them susceptible to harm and leading to deconditioning, which will impact on their recovery and result in on-going care needs
- Ineffective discharge leads to bed blocking and increased pressure on Emergency Departments and Ambulance Services who are unable to admit patients to hospital
- People are being discharged into the community with higher levels of need, requiring more support from community nursing teams, home care and equipment and adaptations
- Patients' care pathways often feel disjointed. Professionals are constrained by their organisational boundaries and need to work together better to ensure the best outcomes. Improvements can also be made in the way health and care organisations share information which will prevent people having to tell their story over and over again
- On-going cost of living pressures are impacting on the ability to self care and engage in community healthcare.

Our ambition for the future

- Reimagine our out of hospital care offer to ensure that individuals access the right support for their needs when they need it and that care is personalised around what matters to the individual. This may require the movement of resource and clinical risk around the system as we manage more people out of hospital
- Development of an integrated neighbourhood approach which is proactive and has a focus on prevention
- Building on the work we have already undertaken, we will develop a home first model for discharge
- Improved prehabilitation pathways so people are able to able to leave hospital sooner
- Develop a Community and VCSE sector development and investment strategy which empowers organisations to create new community support offers and will reduce demand on other parts of the system
- Work in partnership with the VCSE sector to maximise the capacity available locally within communities
- Kirklees to be recognised as an Age Friendly place. We will work with older people to understand their needs and develop a more proactive and preventative approach. We will link to the Kirklees Economic Strategy in understanding what support/leisure services are important to them
- Emotional wellbeing support will be accessible for people with multiple long term conditions
- Therapeutic children's home offer within Kirklees
- More home based support for children and young people with an eating disorder.

Achievements to Date:

- Virtual wards are now established in Kirklees for respiratory and frailty conditions. Admission alternative pathways have been included as part of the virtual ward offer alongside the discharge pathways
- Local model for proactive care developed and piloted across 4 PCN sites. This is ahead of the national framework
- Commitment to develop age friendly communities including a focus on falls prevention
- Greater integration between discharge services is coordinated via the Integrated Transfer of Care Team and identifies the best discharge pathway for individuals
- Support to those in discharge to assess beds with nursing/therapy care as needed, with an aim to improve independence and avoid deconditioning
- Provision of night support on discharge to avoid the need for a discharge to assess bed where possible
- People can access support from Age UK for timely transport home and a setting in service
- Carers can access post discharge support via a follow-up service
- Development of the Kirklees (end of life care) Charter
- Community mental health programme, embedding new roles within communities and PCNs
- Implementation of an intensive support team for children and young people with autism.

Key Changes we will Make:

2023/24	
Virtual Wards	• Increase the number of beds for respiratory and frailty across Calderdale, Kirklees and Wakefield to support admission avoidance. Increase referral rates • Enhance virtual ward pathways to include self referrers from urgent care response (UCR) and the addition of further specialities • Staffing allocations will be reviewed to ensure that skill-mix for senior clinical decision makers reflects the labour market • Development a system admission avoidance capacity plan.
Care Sector Programme	• Development of a new fees model, taking account of impact of fair cost of care exercise • Identify opportunities to reduce care home urgent care activity • Share good practice and learning across including development of a quality improvement plan. Scope, develop and implement a Professional Nursing Forum • Improve digital infrastructure through DPST completion and NHS.mail set up. Develop robust data sharing processes • Endorsement for the end of life care charter and implementation within the system. Embedding the charter within care homes across Kirklees • Ensure home care providers and provision is built into our new integrated community neighbourhood models, and home care providers are part of newly formed neighbourhood teams and feel part of the multi-disciplinary team working • Explore and roll out new ways of working including: ➢ Creative care planning ➢ Development of new roles including the Enhanced Carer Role and supporting University student placements ➢ Digital solutions for example, electronic record system, falls detection tools virtual reviews and Tyto Care
Discharge / Home First **System wide workshop in May 2023 will determine next steps**	• On-going monitoring and responding to system demand and capacity • Development of a home first model for discharge, aiming to reduce the number of discharge to assess beds required across the system. This will include a review of the intermediate care bed base • Workforce development through promotion of multi disciplinary working and flexible working patterns • Development of a trusted assessor model to support discharge back to care homes which avoids waiting for care home assessment visits to hospital • Review of processes for allocation of equipment on discharge. Occupational Therapist working with Acute Discharge Teams to ensure the right equipment is in place • Hospital social care review to be undertaken • Evaluation of proactive care pilot to support further developments identifying what may prevent admissions for over 65 years with pathway 0 discharge • A review of palliative and end of life advance care planning processes across organisations • Maximise volunteering offers to support those at risk at neighbourhood level - expanded local volunteering offer (and NHSRP) to support those at risk and enable discharge • Discharge hubs to be established on both hospital sites.
Community Services Model	• Sustainable community service model – completion of the Kirklees Community Services review and development of underpinning service specifications • Development of a LTC Review and Management service specification for Community Services which will become a blueprint for the management of LTC • Embedding emotional wellbeing support into care plans for people with multiple long term conditions • System wide review and redesign of diabetes pathways to improve diagnosis and management • Maximise community minor ailment and injury services, including expanded offers for minor ailments and injuries to reduce demand for other services and provide care in neighbourhoods wherever possible • Development a system admission avoidance capacity plan.

Key Changes we will Make:

2023/24	
Age Friendly Kirklees	• Development of age friendly Kirklees Programme. Undertake baseline assessment to inform future action plan • Continue to improve identification of frailty and support mechanisms.
Community Based Neighbourhoods	• Promoting the use of neighbourhoods • Ensure home care providers and provision is built into integrated community neighbourhood models, and that home care providers are part of newly formed neighbourhood teams and feel part of the multi-disciplinary team working.
Mental Health and Learning Disabilities	• Reduced reliance on inpatient care and improved quality of inpatient care for adults and children with a learning disability. Transforming Care Programme supporting care delivered in homes not hospitals • Continued work with GP practices to align the register of learning disability (LD) patients including GP Practice LD awareness training • Continued facilitation of annual health checks. Learning from behavioural science could improve uptake with the LD and mental health check • Building capacity in Primary Care Networks to support the early prevention of mental health illness • Each PCN within Kirklees will have a mini mental health hub (made up of both clinical and non-clinical staff) designed to wrap care around the patient with a seamless journey and improved access. To include advanced care practitioner roles for mental health specialists, additional roles reimbursement scheme (ARRS) roles, specialist mental health pharmacists and support for children and young people • Mental Health Social Prescribers working outside of the primary care estate offering a range of services within local community settings • Social prescribing offer specifically targeted at children and young people • Improving annual dementia reviews and increasing diagnostic rates • System review of specialist accommodation LD supported living. Aiming to roll out to mental health and autism • Investment in rehabilitation and recovery for mental health.
End of Life Care	• Adoption of the Charter across the wider health and social care system.
Maternity Services	• All women will be offered personalised care and support plans • Improved oversight of services to ensure concerns are identified early and addressed.
2024/25	
Virtual Wards	• Remote monitoring element of the service to be in place • On-going evaluation of the respiratory and frailty pathways • Launch of an admissions avoidance model.
Care Sector Programme	• Share care plans across the system • Build volunteering capacity within the sector • Roll out of training passports.
Discharge / Home First	• Implementation and evaluation of the home first model for discharge • Review of local proactive care model alongside the national framework when published. Full roll out of model.
Community Services Model	• Agree a provider collaborative approach to service delivery beyond April 2024 • Monitor services and provide implementation support. Develop ongoing process for service monitoring, evaluation and improvement.

Key Changes we will Make:

2024/25	
Community Based Neighbourhoods	• On-going developments to promote the use of neighbourhoods working alongside the VCSE sector • Consider the wider factors which have an impact on health and care in the on-going developments.
Age Friendly Kirklees	• Development of a 3 year district wide plan of action, based on assessment findings • Frailty prevention incorporated including exercise on referral and strengthening and balance provision.
Mental Health and Learning Disabilities	• Roll out of the learning from the specialist accommodation review to mental health and autism • Implement legal developments including Mental Health Act, Mental Capacity Act and Use of Force • Development of an emotional wellbeing strategy for children and young people • Increased focus on early identification and prevention.

Medium to Long Term Aspirations up to 2028 (detail to be added in future revisions of this plan)

- Effective long term condition management, keeping people well for longer
- Patients take more control of their own health and care and have the ability to upload their own healthcare data using online forms
- Digital first offer, where clinically appropriate, taking into account the impact of digital exclusion on health inequalities
- Proactive care in the community for frail individuals, reducing the need for hospital admission
- Improved identification across the life course of individuals at greater risk of frailty and increased uptake of prevention measures
- Make Kirklees a desirable place for workforce to gain employment and further develop skills and experience
- Have in place a robust collaborative community service model which can flex capacity to meet varying demands without detriment to overall service delivery
- Improvements in patients with complex long term conditions
- Ensure VCSE, Wellness Service and Leisure Sector are empowered to help the prevention agenda, to keep people active and healthy throughout life
- Development of pre-habilitation pathways
- Development of a 3 year district wide plan to become an Age Friendly place based upon the assessment findings. Progress actions as part of district wide plan
- Linking the specialist accommodation review to the Specialist Accommodation Strategy. Provision of specialist accommodation to be needs driven
- To continue to implement/evaluate the Care Sector Programme.

Why is this important to the Partnership?

- People are attending Emergency Departments who could be managed better with an urgent visit from a health and care professional in the community or in their own homes. This puts unnecessary pressure on Hospitals and the Ambulance Service
- People are waiting too long to be seen in Emergency Departments, and ambulance handover times are too long
- System pressures and rising demand for services encourage us to be very reactive. There needs to be a shift in focus to encourage prevention and proactive care, which will reduce the number of people who require a crisis response
- Understanding what matters to an individual and ensuring care is personalised will support people to get the support they require, therefore reducing the risk of crisis
- Health inequalities can result in individuals not accessing early help, therefore increasing the risk of crisis
- Poor housing and air quality has a direct impact on development and exacerbation of long term conditions. We need to make better links to the Environmental and Economic Strategies to ensure more sustainable coordinated approach in the long term.

Achievements to Date:

- Establishment of an urgent care response (UCR). The UCR service is provided by an Alliance of Providers to all patients who have a GP in the Kirklees area and operates 8am to 8pm daily (including Bank Holidays). In line with the national requirements, the service provides a holistic urgent 0-2 hour response to service users in their usual place of residence, aiming to support them to remain at home with after care provided by community services and adult social care. The service offer includes rapid response for reablement on the same day or within 48 hours of referral with after care provided for up to 7 days
- Building of the urgent treatment centre (UTC) at CHFT has commenced
- Urgent and Emergency Care Boards in place across both acute footprints as a forum for on-going discussion and to facilitate innovation and improvement
- Successful implementation of the suicide prevention strategy has led to a reduction in the suicide rate in Kirklees
- Mental health and learning disabilities creating alternatives to crisis as safe spaces
- Creation of the mental health crisis (Well-bean) cafés operated by Touchstone
- Development of and continued funding for the 24/7 mental health support line
- Emotional and wellbeing/mental health support offer for looked after children.

Our ambition for the future

- Improvements in proactive, personalised and preventative care will mean less people require a crisis response
- Work closely with the VCSE sector and leisure sector to increase the attraction of being active and moving more to support the prevention agenda
- If an individual does require crisis care, they receive the right level of care for their needs, first time and in the right place
- Where people do not meet the threshold for crisis care, there is an alternative service available to support them. A more joined up and coordinated offer with the VCSE sector.

Key Changes we will Make:

2023/24	
Urgent Community Response	• Promotion of the UCR service within YAS/111 and care homes and virtual ward to increase referrals and re-direct from the Emergency Department where appropriate • UCR to access the YAS call stacking system to pull out appropriate category C and D patients and provide an alternative community response • Better understanding and alignment of unplanned community care, aspiring for a single point of contact • Improving data quality and reporting of UCR through use of the community services data set.
Urgent and Emergency Care	• Develop a system plan for full implementation of population health management and segmentation enabling the system to respond collectively to rising risk • Develop data sets which provide clarity on the current state and future modelling, including equality and health inequalities data which enable targeted interventions • Care Hubs at CHFT as an alternative for lower acuity patients presenting at the Emergency Department, Monday to Friday, 8am - 6pm (after which the commissioned LCD GP Streaming Service starts) • Development/expansion of same day emergency care (SDEC) at both Acute Trusts mandated by the Urgent and Emergency Care Recovery Strategy • Expansion of streaming and navigation pathways at the front door at MYHT. Focus on minor injuries, paediatrics and virtual wards to support discharge • Development of new access pathways as the UTC estate is completed at CHFT • Consistent 7-day Emergency Department Hub offer as part of delivery of new model at CHFT • CHFT Emergency Department offer to include BLOSM (currently up to age 25 Trauma Navigator Pilot), to be a trauma informed service, make reasonable adjustments for people with a LD, provide Independent Domestic Violence advisors within the Emergency Department, and to be compliant with duties to the homeless • Contribute to reducing ambulance response times by reducing handover delays in our Local Hospitals • Optimise hospital-based opportunities for admission avoidance and ensure patients are referred or admitted in a timely way • Review of the walk in centre provision at Dewsbury Hospital • Development of a future model for urgent care at MYHT.
Admission Avoidance	• Development a system admission avoidance capacity plan • Maximise out of hospital pathways to avoid ambulance conveyance • Recruitment of social care responders to support admission avoidance • Strengthened support for high intensity users of urgent and emergency care services, including those in general practice (physical and mental health).
End of Life Care	• Identification of end of life and appropriate choice of care (ACP) to ensure people are supported to die if their preferred place. Prevent avoidable admissions and conveyances, with ambulance crew training in EOL identification and use of ReSPECT and ACP • Development of a local approach/strategy for paediatric end of life care, working with the children's hospices.
Mental Health and Learning Disabilities	• Consistent and timely offers for people of all age with a mental health condition attending the Emergency Department • Provision of the Intensive Support Team out of hours service for learning disabilities • Provision of alternative services in the community to support those in mental health crisis through the wellbeing cafes and the crisis house, early response and drop-in opportunities and accommodation solutions. Similar support to be available for people with learning disabilities through the crisis respite-safe space • Working in partnership with YAS to implement mental health response vehicles across West Yorkshire • 24/7 Crisis Resolution Home Treatment functions (CRHT) for adults operating in line with best practice • Continue to build upon the success of the implementation of the suicide prevention strategy.

Key Changes we will Make:

2024/25
• Establish a more joined up unplanned community care model, aspiring for a single point of contact 24/7 • Further develop partnership working within the UCR with the ambition to mobilise an alliance contract, utilising The Provider Selection Regime • Recommissioning of West Yorkshire Urgent Care Provision • Consistent YAS development and Transformation across ICF (3 ICBs) • Full roll out of mental health response vehicles led by the Yorkshire Ambulance Service • 24/7 community based mental health crisis response for adults and older adults available • Urgent Care reconfiguration at MYHT • UEC reconfiguration at CHFT • Development of a local step down facility for children and young people who do not meet the criteria for tier 4 mental health support.
Medium to Long Term Aspirations up to 2028 (detail to be added in future revisions of this plan)
• Completion of estate changes at CHFT and the provision of a UTC • Proactive care in the community for frail individuals reducing exacerbation of conditions and the need for crisis response. Frailty prevention for those identified at risk of frailty • Better management of long term conditions to prevent exacerbation and the need for a crisis response • Market engagement with children's homes to ensure they access crisis support locally • Development of alternative mental health crisis provision for children and young people

Why is this important to the Partnership? Our workforce is our BIGGEST ASSET

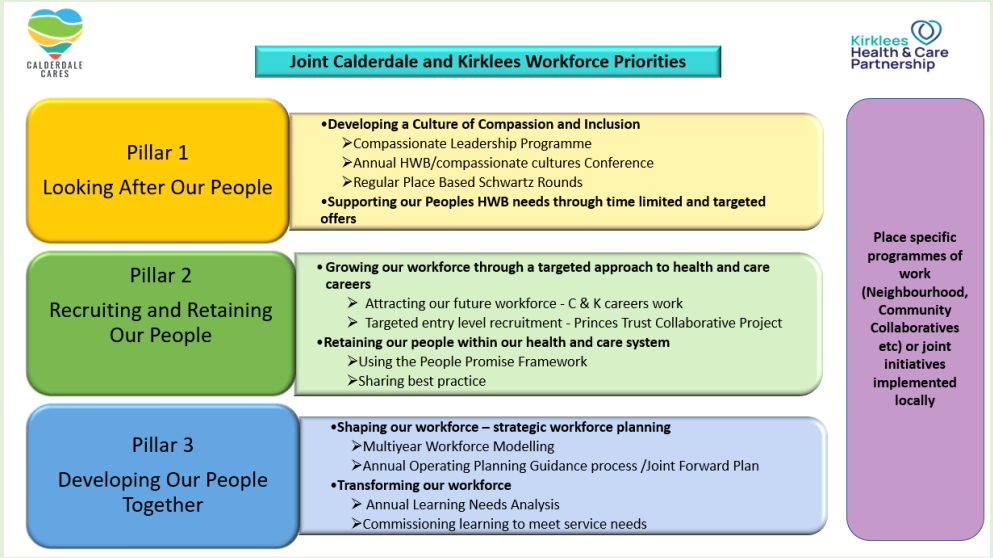
- The health and wellbeing of our staff is vitally important and we need to continue to work to improve this at organisational and system levels
- Although our health and care workforce is increasing, it is not keeping pace with demand. There are specific areas where these shortages are more severely felt leading to pressures on service delivery. We need to continue to work to attract people to work in health and care, to start doing so whilst they are still in education, and consider the broad range of roles available
- Retention of staff is an ongoing issue, and people do leave the health and care sector. A large proportion of staff are nearing retirement age
- We need to work with Health Education England and education providers to ensure the appropriate provision of training places going forward and to support these with appropriate placement provision both in terms of numbers and ensuring that placement locations better reflect the make up of our health and care system
- There is a disparity in pay and conditions between health and care sectors and, whilst much of this is outside our direct control, we need to be cognisant of this and work to mitigate the implications
- Whilst new ways of working are positive, the development of new roles can have unintended consequences and adversely impact other sectors and organisations. We need to get better at managing these
- We need to continue to work on improving the diversity in our workforce, particularly at senior levels
- Promotion of physical activity, helping staff look after themselves. We will be role models to patients and help themselves stay well for longer.

The Kirklees Workforce Development Strategy and Joint Workforce Steering Group

Our Strategic Priorities are set out in our Kirklees Workforce Development Strategy. The strategy covers all aspects of the health and care system, including the VCSE and independent care sectors. The focus of our partnership work is to work together on things which can only reasonably be done at the Kirklees level, or whereby doing so we can add value to the work of individual organisations. We have governance arrangements in place to help us deliver on our strategy. To support the delivery of our strategy we have recently moved to a joint Workforce Steering Group with Calderdale place. In addition to this we have 3 joint supporting working groups:

- Health and Wellbeing Group
- Recruitment and Retention Group
- Workforce Development Group.

These arrangements seek to maximise the impact of initiative and schemes across Calderdale and Kirklees by minimising duplication where possible and maximising benefits from working at scale. Locally, we use these arrangements to ensure workforce planning is undertaken in an integrated way, for example we focus on work including the multi-year workforce modelling, learning needs assessment and annual planning rounds.



Key Changes we will Make:

2023/24

- Calderdale and Kirklees Careers and the Ahead Partnership. Working with secondary schools across Kirklees and Calderdale to increase awareness of careers in health and care, support future educational choices, and employment choices
- Expansion of In2Care Scheme supporting the recruitment of staff for care homes and domiciliary care, including personal assistants and volunteers
- Compassionate cultures programme. Managers and leaders incorporate the knowledge and skills into their everyday practice to build compassionate cultures which lead to increased patient compassion and health outcomes
- Continuation of the Calderdale and Kirklees Integrated Schwartz Rounds and Halsa Wellbeing Sessions, with a focus on moving more
- Working with staff to manage the cost of living challenges
- Kirklees Integrated Systems Leadership and Development Programme
- Stronger relationships with the Care Association and Third Sector Leaders
- Introduction of new roles in Primary Care through the ARRS scheme
- Development of GP Flexible Pool arrangements in partnership with PCNs and practices
- Collective review of PCN recruitment plans in the context of health inequalities and 'hard to recruit to' areas
- Development of aspirations and potential within our local communities across our populations and geography amongst families, children and young people - linking in with place-based approaches
- Training needs analysis for health and care staff aimed specifically at supporting people at the end of life
- Development of the Calderdale and Kirklees Care Worker Role
- Raise system awareness of risk factors for suicide as part of our ambition to make this everyone's business
- Implementation of the local Kirklees action plan to address the concerns raised in the national NHS staff survey
- Working with Huddersfield University to identify opportunities for student placements in the speech and language therapy, physiotherapy and occupational therapists
- Continue the MHST workforce training programme to support the children and young peoples mental health workforce.

2024/25

- Calderdale and Kirklees Academy
- On-going development of the Health Innovation Campus in Huddersfield
- Continuing to work with Health Education England to shape future workforce training provision, placements, and deployment to support emerging new models of care
- Working with Huddersfield University to develop a robust and sustainable offer for the Senior Leader apprenticeships scheme
- Learning needs assessment.

Medium to Long Term Aspirations up to 2028 (detail to be added in future revisions of this plan)

- Establishment of the Health Innovation Campus in Huddersfield. The University is working with local health and care organisations to offer a range of enhanced training opportunities, co-location of services building on the existing podiatry service and developing further innovative opportunities over the next 5 years
- Work with our local acute trusts to deliver upon the workforce targets within the three year delivery plan for maternity and neonatal services
- Embed the adversity and trauma informed programme across the workforce
- Upskilling staff within schools to support children and young people with their health and wellbeing.

The changes we make through the Health and Care Plan will support the delivery of the West Yorkshire Integrated Care Strategies '10 Big Ambitions' and the shared outcomes in the KHWS. An outcomes framework is in development to support the delivery of the KHWS shared outcomes and embed the KHWS approach within Organisations.

The NHS Operational Planning metrics for 2023/24, which will be some of the underpinning delivery measures for this plan have been aligned to the priority actions and are available in appendix 4.

As we implement the changes outlined within the Plan, we will ensure the impact in terms of qualitative and quantative measures is defined. We will ensure that the planned impact for future years of this plan is included when it is refreshed for 2024/25.

Our ambition will be to map the measures to support delivery of the Health and Care Plan to the KHWS outcomes and West Yorkshire '10 Big Ambitions' to illustrate a clear line of delivery.

All projects to deliver upon the priorities will be overseen by the ICB PMO.

Assurance on progress against the milestones for delivery will be reported on a quarterly basis to the ICB Transformation Sub Committee and Delivery Collaborative.

Regular updates will be presented to the Kirklees Health and Wellbeing Board for information and assurance upon delivery of the KHWS.

KHWS Shared Outcomes

Children have the best start in life	• Healthy birth weight • Healthy weight at age 5 • Children in poverty • Emotional wellbeing of 13/14 year olds
People in Kirklees are as well as possible for as long as possible	• Healthy life expectancy • Confidence managing health • Adults' emotional wellbeing
People in Kirklees live independently and have control over their lives	• Overall life satisfaction • Loneliness/isolation • Suitable housing • Proportion of people who live with social care support
Shaped by people: We make our places what they are	• People get involved in their community and something positive comes out of it • Local area is a place where people trust each other • People pull together to improve their local area • People can personally influence decisions affecting their local area
People in Kirklees live in cohesive communities, feel safe and are protected from harm	• Adults who say people get on well together • Adults who say they feel safe in their local area • Crime rate • Proportion of people who say that Anti-Social Behaviour is a problem in their area
People in Kirklees have aspiration and achieve their ambitions through education, training, employment and lifelong learning	• School readiness at age 5 • Educational achievement at age 11 • People qualified to Level 2 • People qualified to Level 4
Kirklees has sustainable economic growth and provides good employment for and with communities and businesses	• Economic growth (productivity/GVA per head) • Gross disposable income per household • Average minimum travel time to nearest employment centre
People in Kirklees experience a high quality, clean and green environment	• Overall satisfaction with local area • CO2 emissions • Amount of household waste produced • Air quality/pollution • % Premises with access to superfast broadband

West Yorkshire 10 Big Ambitions

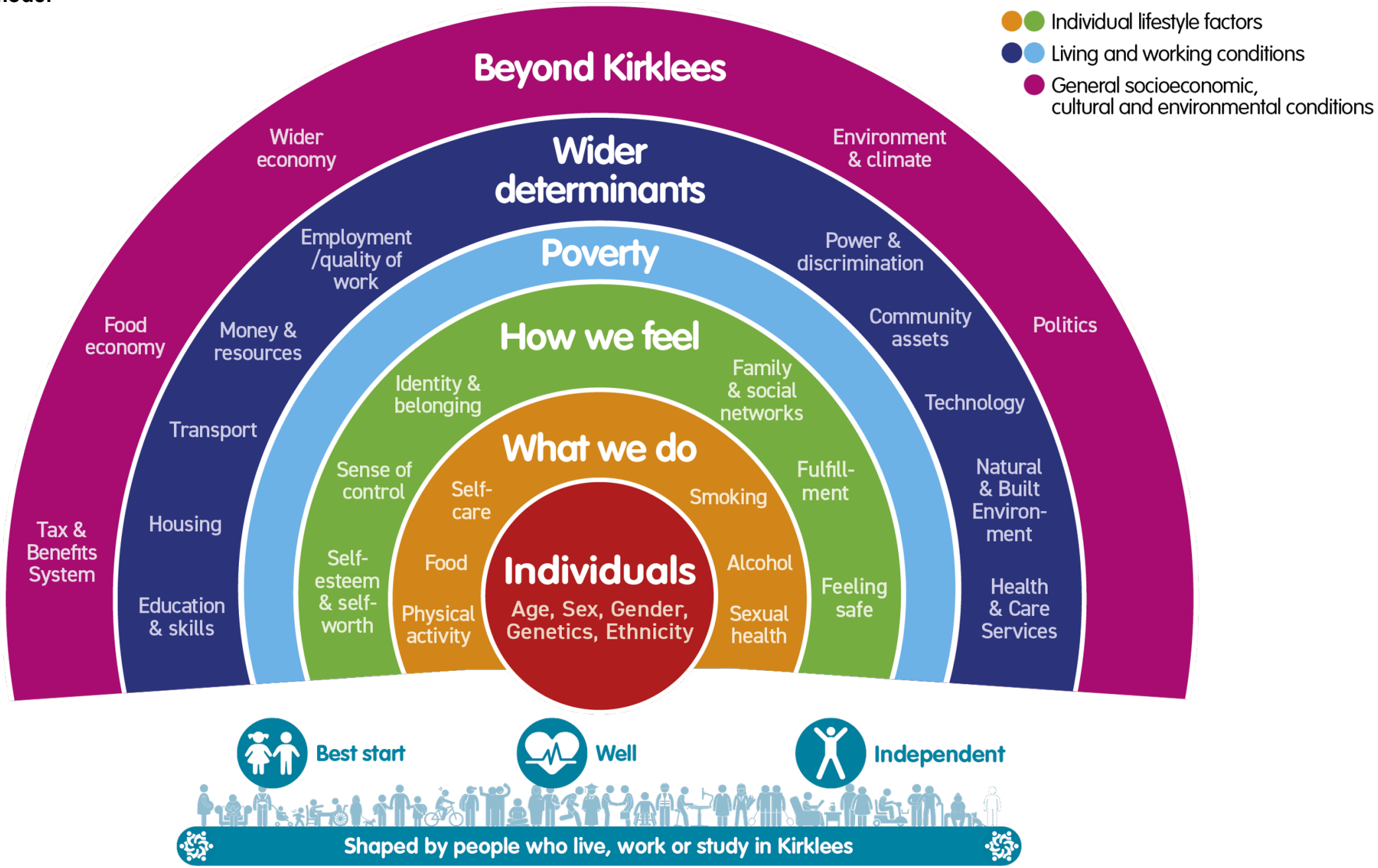
West Yorkshire Health and Care Partnership '10 Big Ambitions' *:

1) We will increase they years of life that people live in good health
2) We will reduce the gap in life expectancy between people with mental health, learning disability and autism and the rest of the population
3) We will address the health inequality gap for children living in households with the lowest incomes
4) We will increase our early diagnosis rate for cancer
5) We will reduce suicide
6) We will reduce anti-microbial resistance infections
7) We will reduce stillbirths, neonatal deaths, brain injuries and maternal morbidity and mortality
8) We will have a more diverse leadership that better reflects the broad range of talent in West Yorkshire
9) We aspire to become a global leader in responding to the climate emergency
10) We will strengthen local economic growth by reducing health inequalities and improving skills, increasing productivity and the earning power of people and our region as a whole.

* Ambitions as at September 2022

What makes a difference to our health and wellbeing?

The 'rainbow model'



Kirklees Finance Strategy and Recovery Plan

Kirklees Sensory Strategy

Kirklees Workforce Development Strategy

Kirklees Quality Framework

Kirklees Ageing Well Strategy

Voluntary Sector Investment Strategy

Kirklees Mental Health Strategy

Kirklees Suicide Prevention Strategy

Further strategies and links to be added as identified

Priority Action	Ambition for 2023/24
1: Improving Access to Health and Care	1. Eliminate waits for elective care of over 65 weeks at both Acute Trusts 2. Increase the percentage of patients that receive a diagnostic test within six weeks of referral aiming for 95% by March 2025 by increasing diagnostic capacity 3. Continue to reduce the number of patients waiting for cancer treatment for longer than 62 days 4. Maintain performance of 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days 5. Increase the number of adults and older adults accessing IAPT treatment 6. Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need 7. Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels 8. Recover the dementia diagnosis rate to 66.7% 9. Improve access to perinatal mental health services 10. Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024 11. Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019) 12. Increase percentage of patients with hypertension treated to NICE guidance to 77% 13. Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60.
2: Holistic Approach to Out of Hospital Care	1. Reduce adult general and acute (G&A) bed occupancy 2. Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services 3. Work towards eliminating inappropriate adult acute out of area placements for people with a mental health condition 4. Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit 5. Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals.
3: Crisis Response	1. Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25 2. Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25 3. Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard.
4: Workforce	1. Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise 2. Continue to recruit 26,000 ARRS roles by the end of March 2024 3. Increase fill rates against funded establishment for maternity staff.

VCSE - Voluntary, Community and Social Enterprise Sector	
ICB – Integrated Care Board	
TSL – Third Sector Leaders	
KHWS - Kirklees Health and Wellbeing Strategy	
PMO – Programme Management Office	
ICF – Inclusive Communities Framework	
JSA – Joint Strategic Assessment	
CYP – Children and young people	
SWB – Starting Well Board	
SRO – Senior Responsible Officer	
SEND – Special educational needs and disability	
LTC – Long term condition	
WY – West Yorkshire	
LWB - Living Well Programme Board	
PIFU - Patient initiated follow up	
WYAAT - West Yorkshire Association of Acute Trusts	
CHFT – Calderdale and Huddersfield Foundation Trust	
MYHT – Mid Yorkshire Hosptial Trust	
MHST - Mental Health Support Teams	
GIRFT – Getting it right first time	
PCN – Primary Care Network	
YAS – Yorkshire Ambulance Service	
LCD – Local Care Direct	
UTC – Urgent Treatment Centre	