FORMAT FOR PAPERS FOR DISCUSSION AT THE HEALTH AND WELLBEING BOARD

KIRKLEES HEALTH & WELLBEING BOARD

MEETING DATE: 27th June 2024

TITLE OF PAPER: KHWS Update: Connected Care and Support Priority

1. Purpose of paper

To provide an update to the Health and Wellbeing Board (HWBB) on the Kirklees Health and Wellbeing Strategy (KHWS) priority of 'Connected Care and Support.' The Update will provide the Board with:

- Progress on the delivery of the Kirklees Health and Care Plan which has been identified as one of the mechanisms for delivery of the priority. This will include a focus on the delivery of the Kirklees Well Programmes.

2. Background

An agreement was reached at the HWBB on 24th November 2022 regarding an approach to implementing the KHWS. The Board has set an expectation that having set the strategic direction through the KHWS, partnerships and partners take responsibility for its delivery and the Board will receive regular updates on progress against of each of the KWHS priorities.

3. Progress Update

3.1 The Kirklees Health and Care Plan

A decision was taken to develop a Health and Care Plan which will outline how the Kirklees Place Based Partnership will deliver on the KHWS priorities, focussing primarily on Connected Care and Support but recognising the interdependency with Mental Wellbeing and Healthy Places. The Plan which was signed off by the ICB Committee in May 2023, was developed by a Strategy Group with representation from across the Health and Care Partnership including the Voluntary and Community Sector (VCSE) and Independent Care Sector.

The West Yorkshire Health and Care Partnership refreshed the West Yorkshire Integrated Care Strategy in 2022 developed a Joint Forward Plan in 2023 to outline how the strategy will be delivered. The Health and Care Plan outlines how Kirklees Place will support delivery of the West Yorkshire Integrated Care Strategy, alongside the Joint Forward Plan.

The priorities outlined within the Health and Care Plan are below in figure 1.

System Wide Strategic Themes/Programmes
Mental Wellbeing
Tackling Inequalities
Starting Well
Living Well
Ageing Well
Personalisation
Dying Well

Priority Actions
1. Improving Access to Health and Care
2. Holistic Approach to Out of Hospital Care
3. Crisis Response
4. Workforce

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

- Improving quality, safety experience and effectiveness and safeguarding for example embedding learning from safeguarding reviews
- Working with people through co-production
- Reducing the inequalities gap 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
- Promoting productivity, efficiency through transformation.
- Digital, recognising the importance of digital exclusion
- Estates including the output of the West Yorkshire Strategy for Estates and Facilities once it is completed.
- Responding to climate emergency
- Opportunities to do things at scale, working across the West Yorkshire ICB Programmes

Figure 1: Priorities for the Kirklees Health and Care Plan

Our Strategic Well Programmes cover the whole 'life course approach' and are the place where we come together to work on focussed initiatives, join up services and plan together for the best outcomes for people. The intention is that each Well Programme will be overseen by a board with a wide representation of stakeholders and partners from across the system. The purpose of the Board is to provide strategic direction and oversight to facilitate the delivery and implementation of the workstreams within the programme.

It is also recognised, that given the challenges we face, there are some immediate priorities we will need to focus on alongside the Well Programmes. These are:

- Improving access to health and care services
- Holistic approach to out of hospital care
- Crisis response
- Addressing our local workforce challenges

The Kirklees Health and Care Plan was signed off as a 'live plan' therefore has recently been through a refresh process. The updated Plan for 2024/25 was signed off by the ICB Committee in May 2024 and is provided as an appendix to this paper.

3.2 How is this relevant to the KHWS

The approach to developing the Health and Care Plan was to ensure the KHWS was one of the main drivers of the plan, some of the ways this was actioned are highlighted below.

- The vision for the Health and Care Plan is the same as the KHWS so not to distract from achieving the overall commitment made to improve health and wellbeing in Kirklees.
- The principles for transformation are a direct lift from the KHWS ways of working section to ensure they are embedded across the System.
- The plan responds directly to the I Statements included in the connected care and support priority and addresses the actions identified for Partners to do. The plan shows how we are supporting local people in taking ownership of the actions identified for them to undertake.
- The wider factors to improving health and wellbeing identified in the KHWS have been considered as a lens for each priority.
- The plan supports delivery of the outcomes identified within the KHWS, specifically those aligned with the connected care and support priority. The KHWS has an established outcomes framework to monitor success. The Kirklees Health and Care Plan measures have been developed to support delivery of the indicators within this, rather than developing something in addition.

3.3 Progress in Year 1 (full list available in the Health and Care Plan – see appendix 1)

3.3.1 Priority Actions

<u>Access Priority</u>

- Development of a cardiovascular disease (CVD) prevention strategy for Kirklees
- Insight gained by community champions, Healthwatch and VCSE has impacted on the diabetes support offer within Kirklees

- Cancer Educator employed to work with GP Practices to support them in the early identification of cancer
- Successfully embedded a Primary Care Network (PCN) approach to enhanced access, delivering more appointments in General Practice. Development of access improvement plans
- Development of the SEND Big Plan which sets out improvements to ensure children and families right support at the right time in line with statutory duties
- Redesign of neurodiversity referral pathways to support waiting list management

Holistic Approach to Hospital Care Priority

- Increased capacity for virtual wards within Kirklees. Admission alternative pathways included as part of the virtual ward offer alongside the discharge pathways
- Home first discharge model implementation with home first as the priority destination. Supported by recovery and intermediate care beds for people who require additional support before they can go home.
- Increased reablement and night support capacity to support discharge
- Access to a mental health hub for each PCN (made up of both clinical and non-clinical staff) designed to wrap care around the person with a seamless journey and improved access and focus on proactive care. This includes Mental Health Social Prescribers working outside of the primary care estate offering a range of services within local community settings
- Completion of the Kirklees Community Services review and development of underpinning service specifications. This will support a more sustainable community service model in the future
- Approved as an age friendly community. Worked with communities to understand what matters to them. Use of intelligence to define the programme of work.

Crisis Response Priority

- Urgent and Emergency Care Boards in place across both acute footprints as a forum for on-going discussion and to facilitate innovation and improvement
- Expansion of streaming and navigation pathways at the front door at Mid Yorkshire Teaching Trust (MYT). Focus on minor injuries, paediatrics and virtual wards to support discharge.
- Building of the urgent treatment centre (UTC) at Calderdale and Huddersfield Foundation Trust (CHFT) commenced.
- Successful implementation of the suicide prevention strategy has led to a reduction in the suicide rate in Kirklees.
- Mental health and learning disabilities have created alternatives to crisis as safe spaces.
- Creation of the mental health crisis (Well-bean) cafés
- Successful roll out of Recommended Summary Record for Emergency Care Treatment (ReSPECT) across Calderdale, Kirklees and Wakefield. Alongside the advanced care plans, this will ensure identification of the appropriate choice of care and support people to die in their preferred place.

Workforce Priority

- Kirklees and Calderdale Health and Care Careers Pathways Programme has continued throughout the year and has now delivered;

- Over 15,000 opportunities created for young people in Kirklees and Calderdale through live events, newsletters and digital resources
- Over 25 schools have had engaging and informative content on the careers available within the Health and Care sector.
- Over 100 unique volunteering opportunities for health and care staff to share their time and expertise through mentoring and volunteering.

Compassionate Cultures Programme

- Compassionate Cultures Conference
- Delivered two cohorts of the Compassionate Leadership Programme, showing attendees how to create a work environment where everyone feels valued and empowered to do their best. A Communities of Practice Group has been set up from the three cohorts of Compassionate Leadership Training carried out.
- Worked with Huddersfield University Health Academy Students to successfully integrate an ongoing compassionate leadership approach fostering a culture of empathy
- Delivered a two-day Train The Trainer programme for the Compassionate Leadership Programme and we are now supporting this in Wakefield and Calderdale. and care in their student led clinics.

Improved access to employment opportunities

- Worked with the Princes' Trust to run information events and build relationships with Health and Social Care Partners
- Outcomes to date; 176 young people registered, 49 offered permanent employment/apprenticeships of which 26 have sustained employment after 3 months.
- All targets set by Princes' Trust have been met fully.
- engaging partners through process and protocol to offer refugees work experience on a voluntary basis and where appropriate permanent employment opportunities.

Systems Leaders Programmes

- A bespoke Systems Leadership Development Programme in conjunction with NHS Leadership Academy for a cohort of 24 learners drawn from across our Partnership.
- Level 5 and Level 7 management and leadership apprenticeships in conjunction with the University of Huddersfield for 50 learners launched in September 2023. Recruitment now underway for second programme to run in September 2024.

3.3.2 The Well Programmes

Starting Well Programme

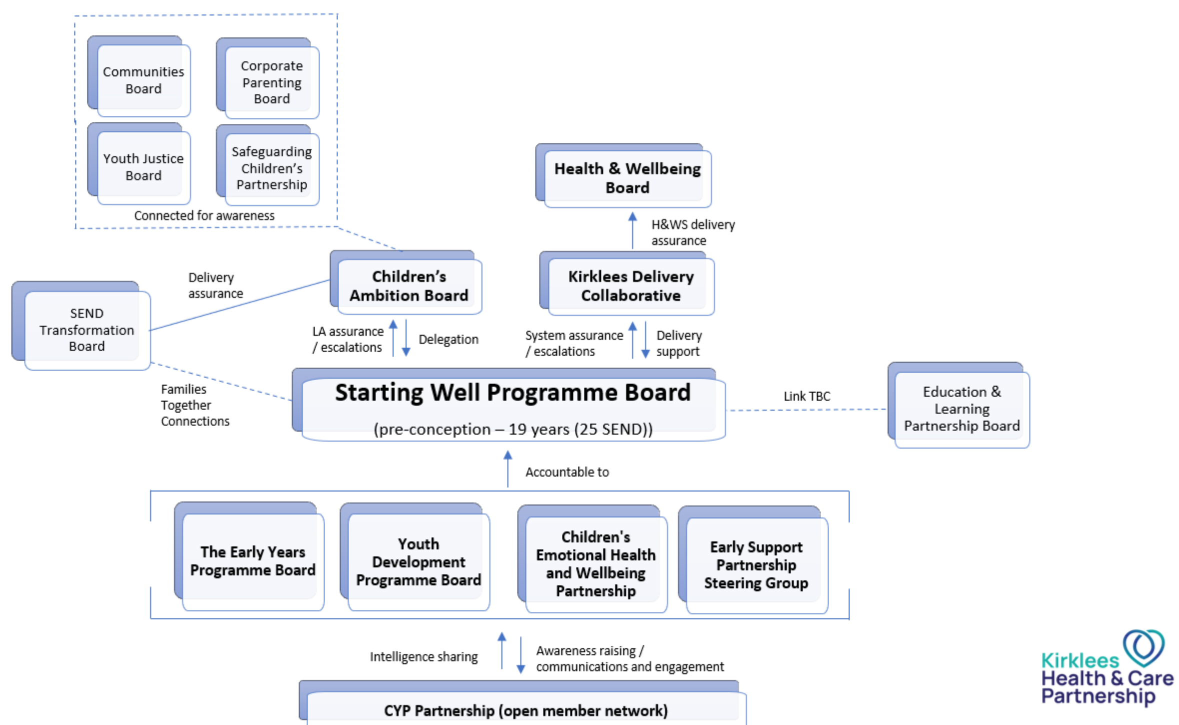
The Starting Well Programme (SW) offers Kirklees Health and Care Partnership:

- Alignment of children and young people priorities and subsequent resource to deliver on the priorities.
- A single place for all existing groups/boards to report to – enhancing partnership working; facilitating development of relationships; enabling of connected decision making and reducing duplication.
- A forum to discuss complicated system wide strategic issues/opportunities; to share learning and risk through partnership escalation and mitigation.
- A single assurance mechanism to support decision taking processes.
- Development of a system workplan – supporting groups such as the Ambitions Board.

- A point of contact for West Yorkshire level work, for example our Integrated Care System.
- Alignment of data and intelligence – as a partnership we can work with combined data sets to accurately measure if we are making a difference on agreed metrics. This will be seen to be both qualitive (children and young person and parent/carer voice) and quantitative (numerical).
- A partnership approach to delivering the Families Together work, in absence of additional central funding.
- Enabling better connection of services by ensuring links at an organisational level, but also with communities, for example linking Families Together with Area Hubs.

The governance structure for the Starting Well Programme is provided in figure 2.

Figure 2: Starting Well Programme Governance Structure



The current governance structure integrates the board into existing structures in Kirklees, whilst enabling support, challenge and accountability across the system on a range of key agendas.

Next steps for the programme include:

- Integration of the special educational needs (SEN) agenda into “Families Together” to greater improve reach, inclusivity, access and future SEN inspections.
- Site visits to regional authorities to share “best practice” and shared learning ie: Hull, Barnsley, Sheffield, Calderdale.
- Development of an online platform to improve families and young peoples access to information, help, advice and support. This will also support our compliance with our statutory duties ie: Education Act: Youth Offer, Childrens & Families Act: Local Offer
- Further development of our “Families Together” in Kirklees.
- Recruitment of a clinical lead to support with specialised health related topics, Autumn 2024 onwards.

- Creating mechanisms to support our priorities within the Health and Care Plan, including consistent used and measured metrics and a shared understanding and ownership across the partnership.

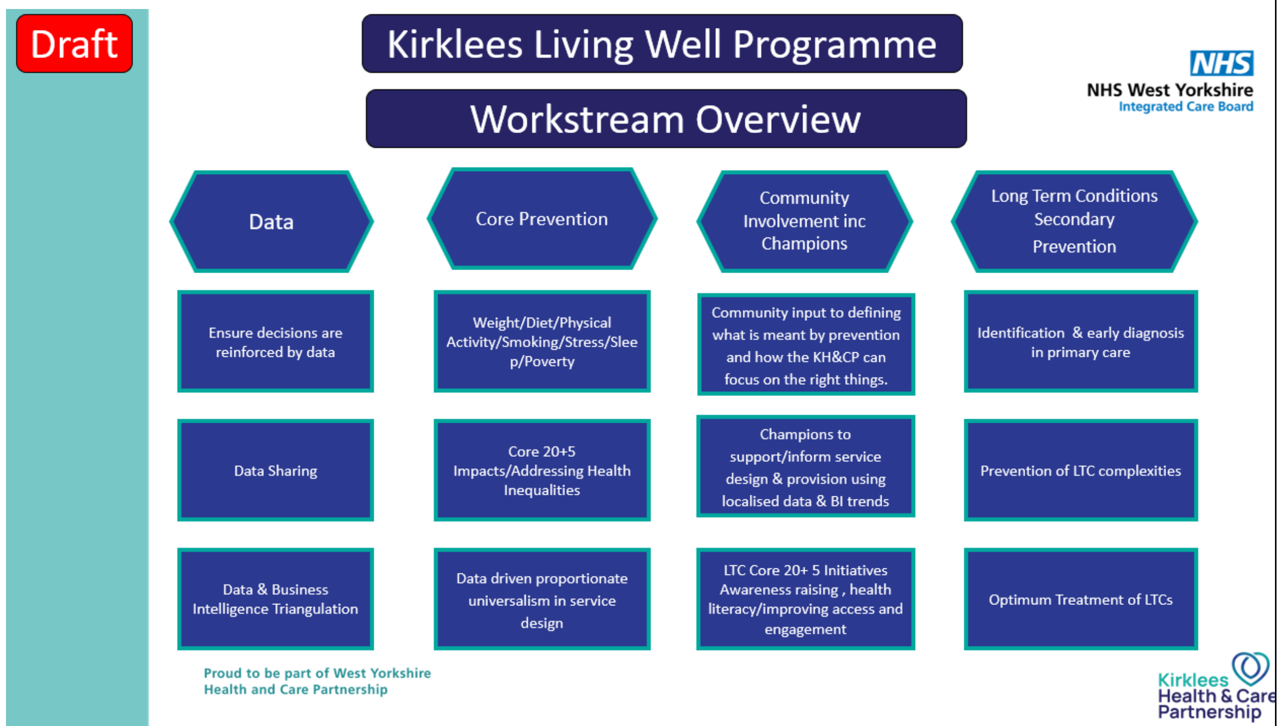
Living Well Programme

The Living Well programme is currently in a planning phase and does not currently operate in a formal board structure. An initial workshop explored priorities for the Programme to focus and given the commitments and ongoing national and regional programmes it was agreed that the initial scope of the programme would focus on Primary prevention, early identification and diagnosis and secondary prevention of long-term conditions (Diabetes, Cardiovascular Disease including stroke and Respiratory).

The partnership has continued to work on successful delivery of the commitment published national strategy's such the Long-Term Plan[1], and subsequent annual operational planning guidance. There are currently draft workstreams that have been suggested for the programme via engagement with partners across the system, particularly Public Health colleagues as it is imperative core prevention and other associated portfolios are formally included in the programme.

Detail on each of the draft priority workstreams for the programme are provided in figure 3.

Figure 3: Draft Priority Workstreams for the Living Well Programme



The next steps will include identifying a Senior Responsible Officer (SRO), holding a workshop to amend and finalise the workstreams and continue to develop the draft data dashboards to ensure progress towards the national and regional commitments.

High-level progress of the programme can be found in Appendix 2.

[1] https://www.longtermplan.nhs.uk/

Ageing Well Programme

The Ageing Well programme consists of 7 workstreams which have been developed based on national and regional guidance and recommendations such as the Long-Term Plan[2], NHS England Ageing Well Programme[3], Yorkshire and Humber State of Ageing Report[4], Chief Medical Officers Annual Report[5] and the World Health Organisation 8 Domains of Healthy Ageing[6]. There are also strong links with key interdependent and enabling programmes such as the other well programmes, Mental Health, Housing, Carers and Civic Participation and Employment.

Detail on each of the workstreams within Ageing Well is provided in figure 4.

Figure 4: Ageing Well Programme Workstreams

Proactive Care	Age Friendly	Falls Prevention	Care Sector	Home First Discharge	Virtual Ward	Urgent Community Response (UCR)
Purpose: Providing personalised, co-ordinated, multi-professional support and interventions for people living at home with Frailty	**Purpose:** Addressing the 8 Domains of The Age-Friendly Communities Framework to better adapt structures and services to meet people's needs as they age.	**Purpose:** Identifying people who are most at risk of falls and developing a knowledgeable well-trained workforce alongside increasing access to health promotion information to support improved lifestyle choices.	**Purpose:** Support the development of a robust and resilient care sector delivering outstanding quality and tailoring care to the needs of individuals.	**Purpose:** Embed and mature the home first discharge approach to improve patient outcomes and improve patient flow out of hospital.	**Purpose:** Enable patients who would otherwise be in hospital to receive acute care and treatment in their own home.	Purpose: To provide urgent care to people in their own home within 0-2 hours
Outcomes: ➢ Delay the onset of health deterioration where possible ➢ Maintain independent living ➢ Reducing avoidable exacerbations of ill health	**Outcomes:** ➢ Baseline Assessment across 8 domains completed ➢ Engagement programme with older people	**Outcomes:** ➢ People, at risk of falls, receive falls risk assessments and know where to access falls prevention training ➢ Raised public awareness re falls risk prevention	**Outcomes:** ➢ Integrated working with the care sector to support market sustainability; quality; workforce, training, development and support; digital technology.	**Outcomes:** ➢ 14 additional people a week will be discharged from hospital directly home ➢ More people will go home following recovery bed stays	**Outcomes:** 2024-25: ➢ Frailty beds = 22 ➢ Respiratory Beds = 20	**Outcomes:** To avoid unnecessary hospital admissions and enable people to live longer independently

To track progress made within the programme, a set of high-level metrics have been developed for the purpose of the Ageing Well Board. These metrics are a standing agenda item at each board meeting. The development of the metrics is based on those that cut across the programme and aim to show the difference we are making to support the population to age well. Additionally, each workstream has a more detailed set of metrics which are reviewed regularly within the individual workstream meetings.

Current high-level progress within each workstream is included in Appendix 3.

Dying Well Programme

The Kirklees and Calderdale Dying Well Programme Board (KDWPB) builds on the work of the previous Kirklees Palliative Care Partnership, which was a system-wide partnership across health and social care. The overall vision for the Dying Well Board is to ensure more people of all ages

[2] https://www.longtermplan.nhs.uk/
[3] https://www.england.nhs.uk/ourwork/clinical-policy/older-people/
[4] https://www.yhphnetwork.co.uk/media/189407/state-of-healthy-ageing-in-yh-2023-apr-2023.pdf
[5] https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2023-health-in-an-ageing-society
[6] https://ageing-better.org.uk/age-friendly-communities/eight-domains

in Kirklees experience great care at the end of their life, and bereaved people are well supported. The four priority areas which report to the Board (Stigma and Comms, Identification and Care Planning, Bereavement and Care at Home) bring together all partners and stakeholders across the Kirklees and Calderdale systems who are involved in supporting those of all ages who are the end of their life, and people important to them.

Each of the four workstreams for the KDWPB are aligned to the Kirklees Care Charter, which embodies the partnership approach. This was jointly created and adopted by partner organisations and is aligned to the national 'Ambitions for Palliative and End of Life Care'. The Charter is for people with a life limiting illness living in Kirklees and explains what care people can expect, and for the partner organisations it is a pledge to improve end of life care in Kirklees

The workstreams were identified following a whole system workshop in October 2023, which had over 90 representatives across health and social care (including GP's, social workers, care home staff, community nurses, acute colleagues, specialist nurses, YAS, hospice staff, and the voluntary and third sector). At the workshop, Healthwatch launched their Dying in Kirklees- What Matters? Report.

The workstreams and outputs are detailed in table 1.

Table 1: Summary of Dying Well Programme Workstreams

Overall vision: More people of all ages in Kirklees experience great care at the end of their life, and bereaved people are well supported			
Stigma and Comms	**Identification and Care Planning**	**Bereavement**	**Care at Home**
Purpose: Develop the Kirklees Campaign/ Call to Action to raise awareness of death and dying, addressing stigma, underpinned by a range of stories.	Increase numbers of people of all ages being identified and supported with good quality conversations for care planning.	Improve how bereaved people are identified and supported across all parts of the system.	Define the pathways for care provided at home at all ages of EOL, identify issues and challenges, review data and make recommendations to DWB.
Outputs: • Campaign covering 3 years of activity. • Comms plan developed with input across the system. • Stigma busting resources created and shared. • Resources identified in different formats, tailored to different ages, groups and audiences, focusing	• Develop targeted training and resources, with a focus on earlier and more comprehensive conversations. • Influencing multi disciplinary teams (MDT's) to provide a Kirklees best practice example • Embedding the supportive and palliative care	• Mapping current processes including those for bereaved parents- pulling together what we already know. • Identifying local support and resources available. • Develop joint signposting information and central process to disseminate/refer.	• Pathway mapping/ data review/ identifying 'cohort in common'. • Identifying best practice and quality review of people's journeys. • Improved understanding of challenges as outlined in the Healthwatch report • Recommendations for change.

on inequalities and deprivation. • Opportunities identified to bring open discussions about death and dying into a range of audiences.	indicators tool (SPICT). • Ensuring we consider the needs of children and young people, and their loved ones. • Creating resources and training to improve the quality of Advance Care Planning, for people of all ages.		• Review of activity against the Charter.

3.4 Key areas of change identified for year 2 (full list available in the Kirklees Health and Care Plan – see appendix 1)

3.4.1 Priority Actions

<u>Access Priority</u>

- Deliver more appointments in Primary Care in line with national targets through schemes such as embedding enhanced access and increasing uptake to Pharmacy First.
- Working with elective care specialties to optimise how tools such as the shared referral pathway, Patient initiated follow up (PIFU) and referral triage can enhance the pathway. Tailoring the approach to complement the pathway and improve outcomes.
- Elective Care Groups/Elective Transformation Boards in place for MYT and CHFT which will provide a system wide focus on:
- Monitoring demand and capacity including wider discussions re the PIDMAS tool, which allows people to apply to move to another provider if they have been waiting over 18 weeks for treatment, for ensuring effective use of capacity. Delivering choice at the point of referral
- Active management and proactive support for those on waiting lists.
- Resource targeting and investment priorities
- Improved access to diagnostics through the implementation of the community diagnostic centres (CDCs)
- Continued delivery of transformational schemes which support people to be treated in a more effective and timely way, through promotion the use of tele dermatology with GP Practices, expansion of Lung Health Checks to the South of Kirklees. Consider adoption of new technologies, for example artificial intelligence dermatology
- Implementation of Caja project as a way of using behavioural science to promote screening uptake, across outstanding practices in Kirklees and future monitoring of cervical screening uptake in practices who have implemented Caja
- Continue to improve access to mental health services in primary care through community transformation. Continuation of the PCN hub models offering access to mental health services in a primary care
- Implement transformation of older people's inpatient services following consultation
- Continue to improve access to Talking Therapies services for adults and older adults with common mental health problems with a focus on those with long term conditions

- Offer for Specialist Social Emotional Mental Health to understand what additional support children can access whilst in school. Alternative provision linking special and mainstream schools to increase support
- Transformation of children and young people's mental health services in Kirklees through the Keep in Mind Programme. Interim model in place until review is completed. To include a review of the entry points to consolidate and ensure MDT triage of all referrals.
- Develop the Kirklees campaign to raise awareness of death and dying, addressing stigma, underpinned by a range of stories

Holistic out of Hospital Care Priority

- Increase the number of virtual ward beds for respiratory and frailty across Calderdale, Kirklees and Wakefield to support admission avoidance. Increase referral rates
- Enhance virtual ward pathways to include referrals from UCR and the addition of further specialities.
- Explore and roll out new ways of working within the care home sector including:
- Development of Kirklees Delegated Task guidance
- Providing University student placements in care homes. Continue to offer volunteer opportunities through In2Care
- Deployment of the Kirklees Falls Assessment Response Tool
- Digital solutions for example, expanding use electronic record systems, falls detection tools and virtual review technology.
- On-going development of the home first model for discharge supported by an integrated transfer of care (ITOC) hub and reviewed intermediate care bed base.
- Development of a trusted assessor model to support discharge back to care homes, which avoids waiting for care home assessment within hospital
- Joint system work with Therapy Teams to reduce risk of deconditioning in hospital whilst awaiting discharge, alongside access to appropriate equipment
- Principles which promote neighbourhood working are being tested through the Kirklees Community Services review. Discussion has taken place regarding the Kirklees approach to neighbourhoods to re-prioritise the work. Agreement to prioritise as an area of focus for 2024/25. Further discussion is required to agree focus and approach.
- System review of specialist accommodation learning disability (LD) supported living. Aiming to roll out to mental health and autism.
- Investment in rehabilitation and recovery for mental health
- Progression of the mental health community transformation programme, with a focus on Children and Young People's Mental Health Practitioners and Peer support for Trauma Informed Personality Disorder via the Recovery College.
- Development of a digital guided self-help offer for Disordered Eating with an evaluation included to identify any gaps and to address health inequalities
- Review of parent support offer through the Keeping in Mind Programme. Promotion of early support in a more coordinated, partnership approach.
- Continue to implement maternal mental health support across West Yorkshire.
- A review of palliative and end of life advance care planning processes across organisations

Crisis Response Priority

- Work with the LD sector to raise awareness and use of UCR.

- Development of a future model for urgent care across the MYT footprint, including the walk-in centre provision
- Development of new access pathways as the Enhanced ED estate is completed at CHFT.
- Further widen out the proactive care programme through engagement with system partners to look at how this model can be mobilised wider than PCNs.
- Identification of end of life and appropriate choice of care to ensure people are supported to die in their preferred place. Prevent avoidable admissions and conveyances, with ambulance crew training in End of Life (EOL) identification and use of Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) and advanced care planning
- 24/7 Crisis Resolution Home Treatment functions (CRHT) for adults operating in line with best practice which includes Dementia.
- Continue to build upon the success of the implementation of the suicide prevention self-harm awareness action group

Workforce Priority

- 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.
- Running further cohorts of the Level 5 and Level 7 apprenticeship programmes with the University of Huddersfield
- Continuing to build stronger relationships with the Care Association and Third Sector Leaders
- Development of GP Flexible Pool arrangements in partnership with PCNs and practices
- Working across our Partnership and with colleagues across WY to expand placement capacity and the breadth and scope of placement opportunities
- Continued involvement in the on-going development of the Health Innovation Campus in Huddersfield including the implementation of the Health Innovation UKSPF bid.
- Working to support asylum seekers and refuges into employment or volunteering opportunities

3.4.2 The Well Programmes

Starting Well

- Continue with further development of the Starting Well Board, with a focus on strategic partnership outcomes.
- Development of the “Families Together” model with a focus on:
  - 4 main sites across Kirklees
  - Comprehensive fixed and rotating offer of services with face-to-face availability
  - Online digital offer
  - Universal branding and marketing materials produced and utilised by partners.
- Evolution of the 4 partnership boards which feed into the Starting Well Board: Youth Development Partnership, Emotional Health & Wellbeing Partnership, Early Support Partnership Steering Group, Early Years Development Board.
- Action plan to be produced to support the aims and ambitions highlighted in the Kirklees Health and Care Plan.
- Creation of a starting well strategy which will bring together the 4 partnership boards ambitions and integrate the: Early Help, Supporting Families and Families Together agendas.

Living Well

- Establish formal board structure and meeting structure.
- Continue with scope and look to introduced new focus areas/workstreams.
- Focus on the Living Well dashboard monthly to monitor progress against the metrics and develop actions where improvements are required.
- Continue to support partners to deliver plans for successful deliver of projects which transform services based on the needs and wishes of the population.
- Continue to use the Core 20+5 approach in our all our work.
- Continue to ensure health inclusion groups needs is present throughout our work.
- Work collaboratively with the West Yorkshire Long Terms conditions and Personalised Care Team on system wide projects.

Ageing Well

- Continue to review the Ageing Well Dashboard on a monthly basis to monitor progress against the metric and develop actions where improvements are required.
- 6 weekly board meetings to continue.
- **Proactive Care**: Continue to engage with system partners around further embedding the local model.
- **Age Friendly**: Start action planning around the key emergent themes based on the outcome of the community engagement.
- **Care Sector**: continue to progress with the key focus areas within the 24-25 plan.
- **Home First Discharge**: continue to progress with the key focus areas within the 24-25 plan.
- **Virtual Ward**: continue to work with the acute trusts to develop trust footprint VW models. Mobilise plan agreed for 2024 around Remote. Further establish Task and Finish Group to work through a series of identified actions for 2024-25 delivery.
- **UCR**: Phased launch enabling 0-2 hour district nurse referrals to be received in the UCR Hub.

Dying Well

- Board meeting to continue, with further alignment across Kirklees and Calderdale
- Draft metrics to be finalised.
- Launch of the Director of Public Health report, with a planned launch event bringing together members of the Kirklees and Calderdale Dying Well Programme Board and other system partners and organisations
- **Stigma and Comms** workstream to engage with the Kirklees Comms and Engagement Network, to support the development of the underpinning 3-year plan.
- **Care at Home** workstream to continue to develop an integrated model of care.
- **Bereavement:** information on how to access support during bereavement is to be made available both in written form, to be given to people registering a death, and online via Kirklees Council's website bereavement page
- **Identification and Care Planning**: review of use of templates and information sharing throughout the system to identify good practice and opportunities for how we could do things in an agreed way across the system.

- Clinical leadership: The Dying Well Programme has been without a Clinical Lead for Kirklees since October 2022. Primary care expertise and clinical leadership is currently being identified on an interim basis to support the programme and permanent clinical lead role to be identified.
- Share learning with the West Yorkshire Palliative Care Programme

3.5 Role of the Kirklees Delivery Collaborative

The Kirklees Delivery Collaborative has responsibility for oversight of the delivery of the Kirklees Health and Care Plan and the Well Programmes. The role of this group is currently under review, and it is expected to evolve to be more focussed on delivery whilst maintaining its oversight function.

Monthly progress updates are submitted to the Delivery Collaborative for the Health and Care Plan and Well Programmes.

4. Financial Implications

None to note at this stage.

5. Sign off

This report has been signed off by:

Vicky Dutchburn, Director of Operational Delivery and Performance, Kirklees ICB

Ageing Well SRO: Karen Jackson

Dying Well SRO: Vicky Pickles

6. Next Steps

Following presentation of the update at the Kirklees Health and Wellbeing Board, work will continue to deliver the priorities outlined within the Kirklees Health and Care Plan.

The Delivery Collaborative will continue to have oversight of delivery, with further updates provided to the Health and Wellbeing Board as requested.

7. Recommendations

The Health and Wellbeing Board are asked to;

1. Receive the update and be assured on the work in progress to deliver the connected care and support priority of the KHWS.
2. Note that the Living Well Programme is yet to be formally established and as yet does not have an identified Senior Responsible Officer (SRO). If a particular Board Member is potentially interested in discussing further the SRO position, please contract Living Well Programme Lead.

8. Contact Officer

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Ageing Well Programme: Nicola Cochrane, Programme Manager, nicola.cochrane1@nhs.net

Dying Well Programme: Sadaf Adnan, Service and Partnership Development Manager, Sadaf.Adnan@thekirkwood.org.uk