Kirklees Overview and Scrutiny Committee

Report on the development of the Kirklees Health and Wellbeing Plan

14 August 2018

1. Purpose

The purpose of this paper is to provide an update to the Kirklees Overview and Scrutiny Committee (OSC) on the development of the Kirklees Health and Wellbeing Plan. The report will also identify the relationship between the Kirklees Health and Wellbeing Plan and the West Yorkshire & Harrogate Integrated Care System (ICS) workstreams, and the development of the Care Closer to Home (CC2H) programme and impact on hospital activity.

2. Background

Kirklees developed a health and wellbeing plan in 2016, in part to support delivery of the Kirklees Joint Health and Wellbeing Strategy (2014-2020), and in part to provide a place-based plan / view to support the development of a Sustainability and Transformation Plan (STP) across the West Yorkshire and Harrogate footprint. Locally, there has been a greater desire to recognise Kirklees as a 'place' upon which to undertake joint planning to improve the health and wellbeing of the population, rather than planning solely on an organisational basis. In May 2018, the Chief Executives of the main health and care organisations in Kirklees established the Kirklees Health & Care Executive Group and agreed that it was an opportune time to refresh the Kirklees health and wellbeing plan. This group includes:

- Chief Executive, Calderdale and Huddersfield NHS Foundation Trust
- Chief Officer, Greater Huddersfield and North Kirklees CCGs
- Chief Executive, Kirklees Council
- Chief Executive, Locala Community Partnerships
- Chief Executive, Mid-Yorkshire Hospitals NHS Trust
- Chief Executive, South West Yorkshire Partnership NHS Foundation Trust
- Strategic Director for Adults and Health, Kirklees Council
- Regional Director, NHS England
- West Yorkshire & Harrogate Health and Care Partnership

It was agreed that the plan should clearly articulate the aspirations for the health and wellbeing of the population of Kirklees, involving wider partners and plan around the natural communities within Kirklees. This would serve to identify some system priorities for the organisations in Kirklees to work together to drive forward and provide a clear narrative to the ICS and wider national bodies in terms of the work being undertaken in Kirklees which in turn will support any opportunities for resource support in Kirklees and identify where other areas may be able to learn from some of the initiatives already delivered in Kirklees.

3. Scope

The Health and Wellbeing Board agreed the scope of the plan during June. The focus is to ensure that the plan provides an overview of all the activity to improve the health and wellbeing of the population in Kirklees, drawing upon existing plans and strategies from each of the organisations working in Kirklees. These will be appropriately referenced in the plan to ensure the source documents can be

quickly accessed for more detail. The plan will also identify the links with the West Yorkshire & Harrogate Integrated Care System (ICS) workstreams and how local work supports these priorities and how in turn, working at a West Yorkshire & Harrogate level will benefit the population of Kirklees.

The Health and Wellbeing Board agreed that the plan should identify some clear priorities which the system would focus on to deliver improved outcomes across Kirklees over a five-year period. These priorities were derived from an examination of the current needs of the population (Kirklees Joint Strategic Assessment, 2017) as well as some 'sense-checking' against system ambition, operational performance, current plans, gaps and momentum within the system. These priorities were tested and refined with the Health and Wellbeing Board during a development session on 26 July 2018.

4. Progress to date

The plan is currently in development, the following activities have been undertaken to develop the content:

- Stakeholder engagement across a wide range of local organisations and existing forums including the Kirklees Health & Wellbeing Board, Integrated Provider Delivery Board and the Integrated Commissioning Board
- Review of existing organisational strategies and plans
- Review of documentation in respect of the West Yorkshire & Harrogate ICS workstreams
- Testing and developing of priorities with key stakeholders, including a development session of the Health & Wellbeing Board

The plan is currently being drafted and is undergoing a cross-organisational review of the draft on 10 August 2018. The draft will then be shared with the Chief Executives represented on the Kirklees Health & Care Executive Group for final comments before being prepared as a final draft to be submitted for approval to the Kirklees Health & Wellbeing Board on 6 September 2018.

5. Key features of the Kirklees health and wellbeing plan

5.1. Population cohort planning

The health and wellbeing plan is focused on population health and wellbeing. On that basis, the population has been used as the starting point to understand the needs, impact of current plans and priorities required to deliver improvements in health and wellbeing.

Figure 1 below describes the four main population cohorts within Kirklees. Given the diverse communities, the proportion of each of these cohorts in local communities will differ, but the characteristics and support requirements will be largely similar. Taking this approach therefore allows local planning within natural communities and generation of a Kirklees-wide view.

Figure 1 – Kirklees population cohort planning

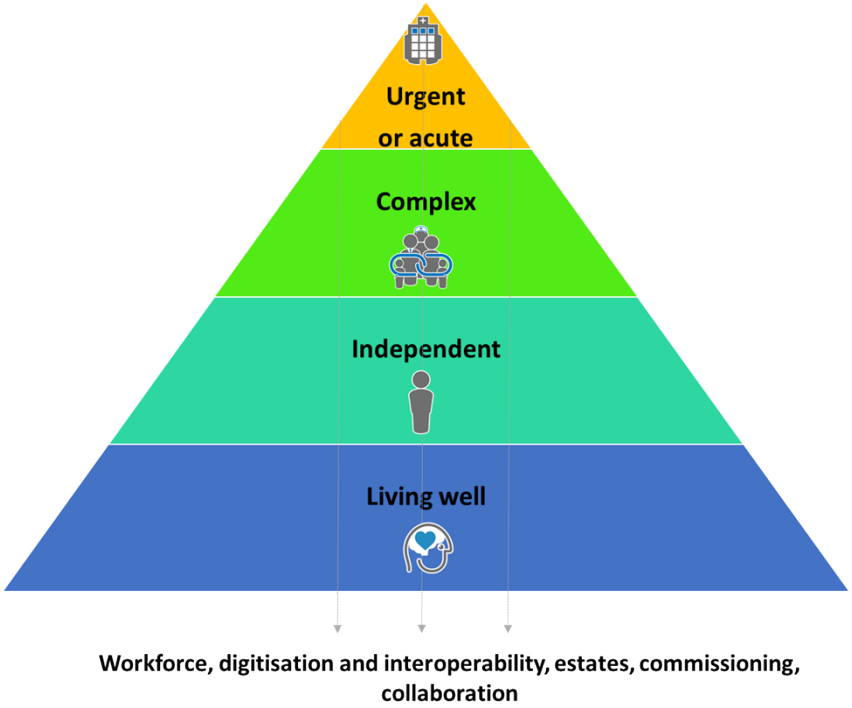


Table 1 below provides a descriptor of each population cohort:

Table 1

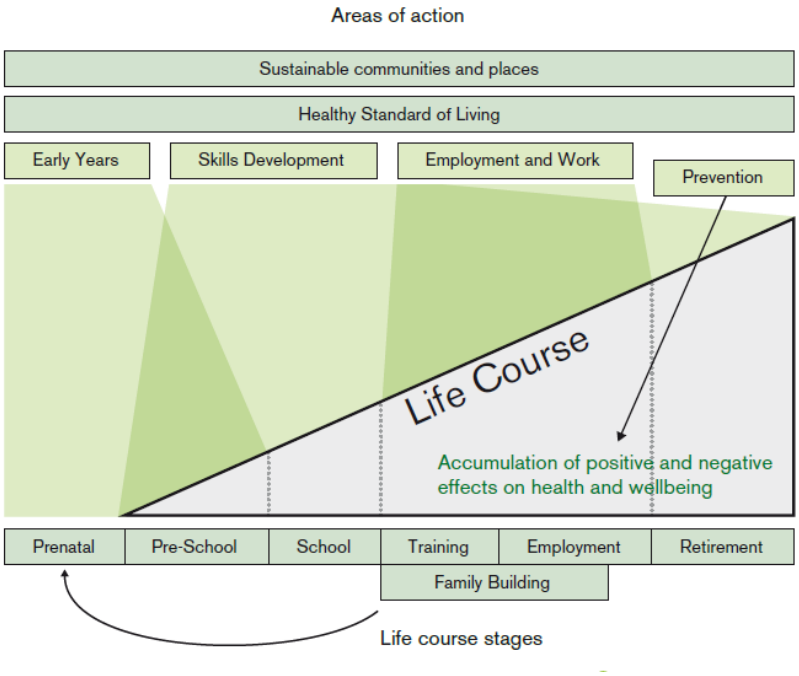
Planning for the population in Kirklees	
Urgent or acute needs	• At any time, some proportion of our whole population will have urgent or acute needs which need swift and/or specialist interventions
Complex	• A small proportion of our population are living with multiple long-term conditions, significant disabilities and complex needs, some may be at the end of their life • The needs of this group are often significant and debilitating, preventing work or regular opportunities for engagement with the wider community. Cost of provision of support to this group is very high.
Independent	• A smaller but significant proportion of our population are living with conditions or social factors impacting their health and wellbeing, who are largely managing independently or with informal support

Living well	• Majority of the population who are largely healthy (both mentally and physically), manage their own health and wellbeing and have little requirement for contact with formal or statutory services. • A proportion of this population are subject to risk factors related to behaviours (smoking, alcohol consumption, diet and exercise) or social factors (employment, housing, social isolation).

1.1. A life course approach

In order to best achieve the Kirklees outcomes, we have committed to taking a life course approach to planning, which in turn will ensure a focus on prevention and early intervention in everything we do and ensure with all our planning and interventions we are supporting the three stages of life:

- Starting well
- Living well
- Ageing well



1.1. Place based systems of care

Place based systems of care are vitally important as they will allow us to deliver different solutions to meet the needs of communities in Kirklees and are therefore a key feature of the health and wellbeing plan. These will be the foundations on which we deliver the other key components - working with local communities and leaders to do so. They will act as the framework on which we can build the other elements around.

In implementing place-based systems of care it is important to recognise that:

- Services and support in Kirklees operate on different footprints. For example, primary care, community hubs, community services and acute trusts.
- Communities are different with a wide variety of assets and needs.
- Different solutions will need to be found for different local areas

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

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

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

Figure 2 illustrates how we think this approach will look based on a population of 30-50,000. It is expected that there will be around 9 of these in Kirklees covering the whole population.

Figure 2 - Community Based Support and Delivery System

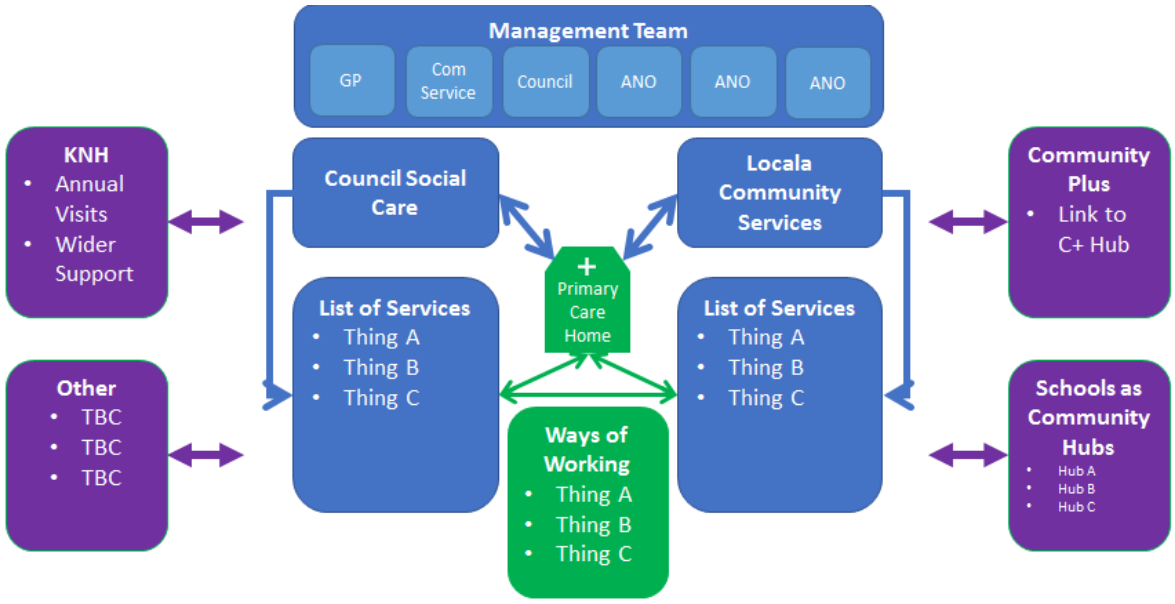


Figure 2 shows that whilst the core of the new approach is primary care, social care, and community services, some of the detail of which services will be included and how these will work together are still to be developed.

Over the coming months, commissioners and providers will work to refine the model further. This will include clarifying which elements of social care and community services are relevant to this approach and beginning to establish new ways of working so that these will be increasingly delivered in an integrated way. It is anticipated that the list will have some services that are common across each of the community delivery systems but that it allows for local flexibility in so that each area can include things which are of particular importance to their population.

In addition, the ways of working will have some commonality across Kirklees but will be able to be flexible to meet the needs of individual areas and communities. The importance of building new working relationships is key to making this a success. We recognise that we will need to invest time and effort in helping to support the development of these new working relationships. This work has commenced and will be an ongoing requirement during development and implementation.

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

Figure 2 also shows that we anticipate that each of the new community-based support and delivery systems will need to be supported with managerial capacity to help with implementation and ongoing running.

Supporting elements

Having place-based systems of care in place will allow us to implement some key supporting elements in a more helpful way. It is the intention that these will be in place across Kirklees, but that there will be flexibility in how each of the primary care home areas can use them to deliver support and care that is best suited for their populations.

In this way we are aiming to achieve a consistent but locally tailored approach to the following:

- ***Focus on Population Health***
    - Improve outcomes and reduce variations in these
    - Includes services, support, lifestyle, and the conditions in which people are born, live and work
- ***Population Segmentation and Risk Stratification***
    - Separate populations into high, low and rising risk
    - Key to personalised care and support planning
- ***Public Engagement and Involvement***
    - Involve People and public in governance
    - Support patient decision making
    - Reinforced constantly
- ***Care Co-ordination and Management***
    - Person centred, assessment based, inter-disciplinary approach
    - Individual's needs assessed, and comprehensive care plan developed and monitored
- ***Maximising Digital Opportunities***
    - Clinicians have access to information to provide appropriate care

- Use of technology to support care and people

1.1. Priorities for delivery

A prioritisation exercise was undertaken with the Health and Wellbeing Board to identify the key priorities for place delivery over the course of the plan.

From analysis of the Joint Strategic Assessment in Kirklees (2017), taking the principles of using the population cohort analysis and a life course approach, there were several priorities identified. Alongside this, an analysis through the alternative lenses of system performance, system principles and ambition, addressing the gaps and following the momentum, three main categories of priority were identified:

- Tackling the underlying causes of health and wellbeing issues
- Improving outcomes and experience for the most complex population
- Using our assets to best effect

Table 2 below outlines these headlines priorities:

Table 2: Priorities for Kirklees

Tackling the underlying causes
1. Create communities where people can start well and live well • Early intervention to start well – pre-natal support and the first 1000 days • Reduce smoking rates and air pollution • Tackling the obesogenic environment • Create connections in communities – tackle social isolation and loneliness • Tackle poverty and the low wage economy
Improving outcomes and experience
2. Create person centred support for the most complex individuals • Drive forward the development and implementation of the primary care home model (*to do this, must first ensure the resilience and engagement of primary care)*, the integrated model for intermediate care, end of life, and the model for care homes support
Using our assets to best effect
3. Develop our people to deliver the priorities and foster resilience • Give people the resources to stay independent and live well • Change the conversation – focus on strengths, assets and responsibilities • People who use and provide services work together to shape support • Develop and nurture relationships and support people to change existing behaviours to deliver better outcomes **4. Develop estate to deliver high quality services which serve the needs of the local communities** • Using estate and facilities to generate social value and support the future model of provision • Rationalising, sharing space to support collaborative and integrated working **5. Harness digital solutions to make the lives of people easier** • Raise the digital literacy of the population • Focus on the solutions which will make people's lives easier, maintain independence, and support efficiency

The newly constituted Kirklees Integrated Provider Board has identified five key initiatives to progress during 2018/19 to support delivery of these priorities. These are:

1. Pilot the primary care home model (described in Section 5.3) around three practices in Holmfirth
2. Pilot the primary care home model (described in Section 5.3) around the Spen & Cleckheaton GP cluster
3. Deliver an integrated model for end of life care
4. Develop a vision for integrated community capacity / resource

5. Develop and deliver an integrated model for intermediate care and reablement

These are complementary to the priorities featuring in the draft Integrated Commissioning Strategy developed by the Integrated Commissioning Board (composed of Kirklees Council and Greater Huddersfield and North Kirklees CCGs). The commissioning strategy and the provider delivery plan will support the delivery of the Kirklees Health and Wellbeing Plan.

2. Relationship with the West Yorkshire & Harrogate Integrated Care System (ICS)

Kirklees is one of six geographical 'places' within the West Yorkshire & Harrogate Health and Care Partnership (HCP). The Partnership is built on the principles of subsidiarity and primacy of local place; this continues to be a cornerstone of the Health & Care Partnership now it is part of the Integrated Care System (ICS) development programme.

Given the diverse communities within Kirklees and complexity of the organisational footprints, the refresh of the health and wellbeing plan has provided the opportunity to clearly articulate an overarching picture of the work to improve the health and wellbeing of the population, locally and through regional working within the ICS. The plan also serves to identify the local priorities for delivery which where Kirklees may require support from the ICS infrastructure.

By working as part of the ICS development programme, this will mean that Kirklees (and the other five local places) will have access to more resources to support the improvement of health and wellbeing locally and implementation of local priorities. These resources include:

- Transformation funding
- Capital
- Capacity, support and expertise from national bodies, using international best practice.

The governance structures established as part of the ICS support joint collaborative working, reinforcing that work is only done at an ICS level where all partners are in agreement that this is necessary and that it will bring greater benefits for the region and local populations. In addition, working within the ICS development programme will also give clearer routes for democratically elected members to influence, challenge and inform the work at West Yorkshire & Harrogate level and ensure that the ICS is supporting the delivery of local place-based plans and priorities, such as that described by the Kirklees health and wellbeing plan.

The ICS focus on place and delivery of integrated community support around the 30,000 – 50,000 population is entirely in line with the Kirklees strategy and plan described in Section 5.3 of this report, and a key priority to move forward in Kirklees. This will be a major transformation in the way care and support is provided to communities within Kirklees. As this is also an ICS priority, Kirklees is able to access funding equating to approximately £1 per head of registered population during 2018/19 to support the rapid piloting and roll-out of this work. A major risk in the ability to deliver a fundamental change such as this, is the engagement and resilience of primary care, specifically in General Practice. Through this additional resource, we will be able to secure the continued engagement of GPs, to drive the development and implementation of this work.

Whilst this model will offer a more integrated, wraparound support for the population with more complex needs, it will also serve to as a model to focus on prevention, build resilient communities and

tackle the underlying causes of poor health and wellbeing. Through the embedding of Community Plus, the Adult Wellness model and linking with the thriving network of voluntary and community sector organisations in local communities, the focus will be on changing the conversation with residents about their own strengths, assets and responsibilities in relation to their communities and creating places in which we can live well. This model of coproduction will change the way in which support is delivered from the workforce and will require new and different roles to fulfil this. The ICS will give Kirklees access to an additional £164,000 during 2018/19 to support this work under its priority workstream 'harnessing the power of communities'.

Our pilot sites in Holmfirth and Spen and Cleckheaton are built from willing partners wanting to drive forward this agenda. Using these sites as early adopters, we will test our aspirations around our priorities, including how use of technology can make people's lives easier, how we can better use our intelligence to identify and meet the needs of the local community, and how better our assets and infrastructure can be used in support of this. We will learn from these early adopters and use this learning to support roll-out across Kirklees.

Through focusing on all population cohorts with a preventative approach at all levels, locally we can make a major impact in terms of the delivery of some of the priorities agreed locally and as part of the West Yorkshire & Harrogate Health and Care Partnership.

Below (Figure 3) is an illustrative example of how our work at place level in Kirklees and in partnership at West Yorkshire & Harrogate level fit together to deliver the overarching objectives and achieve the benefits for Kirklees and for the region as a whole.

Figure 3 – Delivering improvements to mental health services and outcomes

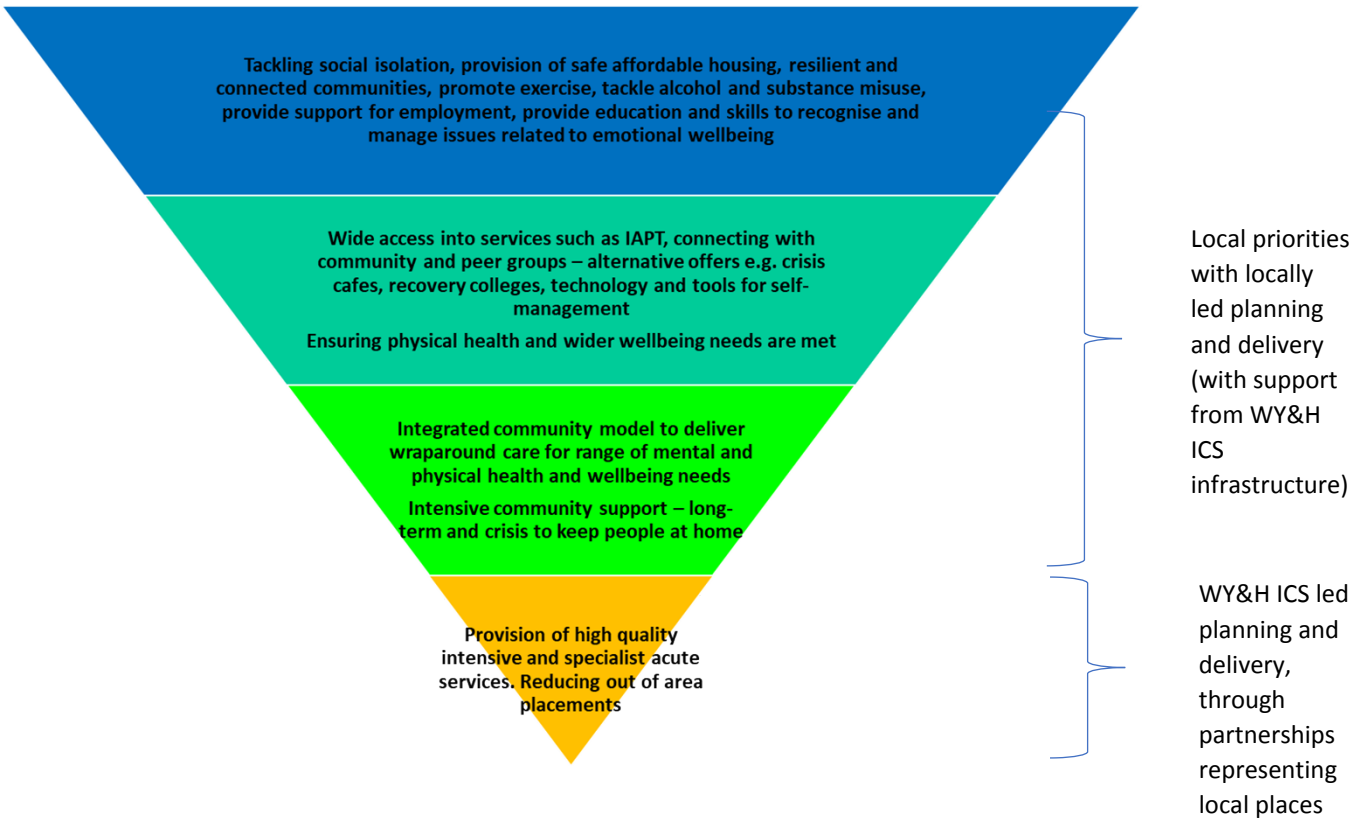


Figure 3 shows the relationship in respect of the local and regional priorities for improvement in mental health outcomes through interventions at each population cohort level. Planning and delivery of local priorities is led locally for the interventions targeted at supporting those populations who are living well, independent and have complex needs. In doing this, Kirklees has support from the ICS infrastructure in resource support, and access to best practice and learning from the other places within the ICS, and more widely through the input of national bodies.

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

3. Delivering care closer to home

As outlined in Section 5.3 of this report, the Kirklees health and wellbeing plan has a strong focus on delivering joined-up, integrated support for people in the community. The Health and Wellbeing Plan will be supported by a Kirklees Outcomes Framework which will provide indicators linked to the seven Kirklees outcomes, in order to monitor progress in delivery of the plan. This Outcomes Framework is currently in development, led by the Integrated Commissioning Board, and will be finalised by Autumn 2018.

In respect of the proposed hospital reconfiguration across the Calderdale and Greater Huddersfield footprint, a significant impact on the proposed bed reduction has been made through the work of partners (currently at 32.4 beds across Calderdale and Huddersfield sites, with a projection that this will reach 44.4 beds by the end of 2018/19). The work of the Calderdale and Greater Huddersfield CCGs to deliver the proposed 18% reduction in non-elective admissions has been supported and assured by the NHS Transformation Unit, which was commissioned in 2017 to undertake an independent review of the CCGs' plans. The final report was received in July 2017. The key findings from the report are:

- The CCGs' proposed schemes are aligned to the approaches being pursued in many other health communities and international evidence.
- To achieve 18% over 5 years is a challenging target. Taking on board demographic changes across the CCG, this target rises to a 23% reduction given the natural 1% growth pa. This equates to 3.5% to 4.5% per annum.
- This is a realistic assumption and is potentially achievable. It would require the CCGs to achieve the best in Class Upper Quartile position.

Section 6.1 of this report describes some of the schemes and changes already implemented across Kirklees or across the acute footprints of Calderdale and Greater Huddersfield (CHFT) and Wakefield and North Kirklees (MYHT) where appropriate, while section 6.2 outlines further planned changes.

3.1. Implemented changes and service improvements

Musculoskeletal (MSK): In 2017/18 over 10,000 patients have been triaged in the Locala MSK Community Hub in Greater Huddersfield (Locala Community Partnerships is an independent Community Interest Company providing NHS community services to people in Kirklees) over 50% have been seen by the GPSI community service, with only 16% triaged out to hospital-based services. This is a significant reduction on previous years.

End of Life services: Through the delivery and implementation of an Electronic Palliative Care co-ordination system (EPaCCs) the key aim has been to improve quality of care pathways for patients and their families and carers. The impacts achieved for our population include improved care-coordination of patient pathways, resulting in more people dying in their preferred place of care, this has supported a reduction in non-elective admissions to hospital. The percentage of people dying in hospital with a completed EPaCCs has reduced from 15.4% to 8.69% (national average is 8%) The numbers of patients with a completed EPaCCs has increased from 409 to 852, a 108% improvement.

Local Incentive Scheme 2017/18: Targeting the 5 most common reasons for avoidable emergency admission for patients known to Locala across Kirklees, these were Falls, UTIs, Respiratory, CVD and cellulitis. Nationally, the number of avoidable emergency admissions significantly increased by up to 40%, locally we saw a reduction of 113 admissions on the previous year, although this is not huge amount, it also highlights that national growth was absorbed.

Delayed Transfers of Care (DTOC): Implementation of the 8 High Impact Changes across both acute hospital footprints supporting flow from the acute trusts into patient home or alternative community settings in a more-timely manner as soon as the patient is identified as medically optimised. Development of a more rigorous validation system which clearly identifies those patients which are DTOC and measures in place to move them onwards.

Referral Support Service: In 2017 a referral support system was commissioned and mobilised through TRISH and OSCAR across North Kirklees and Wakefield (MYHT footprint). GPs now send referrals to the TRISH service which screens and ensures they are sent to the most appropriate service (acute or community) first time. OSCAR is an online referral support tool which includes clinical pathways to aid decision making.

The introduction of a clinically integrated system to ensure referral standards are elevated to that of a 'good' referral across the CHFT footprint is planned for 2018/19.

OPAT: Introduction of an OPAT service to treat patients in the community, rather than being admitted to hospital for the duration of their treatment or attend hospital as a ward frequent attender.

OPAT Quarterly summary	Q1 Total	Q2 Total	Q3 Total	Q4 Total	TOTAL
Referrals	47	51	39	38	**175**
Bed Days saved	330	436	463	362	**1591**
Completed Treatments	48	51	38	39	**176**
IV Administrations	466	576	607	489	**2138**
Admissions avoided	33	31	22	26	**112**

3.2. Planned service improvements

Service improvement work is core to the business of the CCGs as well as to our community providers. We are focusing on the following:

Intermediate Care beds: A joint intermediate care and reablement draft model has been developed which will incorporate Multidisciplinary Teams (MDT) consisting of Nursing staff, Therapists, Social Workers, and GPwsi, who would provide clinical leadership to the MDT, develop appropriate care plans and link with local geriatricians when required. This would lead to an expectation that the MDT would support a reduction in length of stay (from 4 weeks to 3 weeks) and that patients would be discussed at MDT within 24-48 hours of arrival, mid-stay and post discharge ensuring they are receiving the right care.

Recovery at Home: This service will be an expansion of existing community reablement services, with investment (from the reduction in acute beds and IBCF funding) into existing reablement services to provide rehab support workers for daily rehab. There will be a dual role for reablement support workers (rehab as well as home care support) with additional therapy support to care for an additional 20 patients at home. The revised service will provide a step down from hospital and step up from primary care including:

- clinical input for patients with rehab needs in their own home following acute episode in hospital;
- therapist provision for assessment and care planning
- reablement support workers to provide up to 4x day calls, providing daily cares in accordance with care plans
- reablement support workers to carry out basic rehab at home, with supervision from Therapists
- specialist therapy support with skills around management of stroke into IMC+ and recovery at home
- potential for night sitters to be available if required
- pharmacy technician as part of Support and Independence Team would be additional support for service that would enhance the offer

Home Oxygen Assessment and review service: Service to ensure that when Home Oxygen is prescribed, it is appropriate to the needs of the patient as established by thorough assessment and regular review

Care Home Support Service: to provide a proactive and reactive service to individuals within care homes through a multi-disciplinary care home support team. This will also include specialist mental health support, through expert psychiatric leadership, which will undertake reviews for high acuity patients. In addition, the service will provide specialist advice, support and consultation into the wider Primary Care Teams, including GPs and care home senior staff. The impact of the Care Home Support Service includes reductions in non-elective admissions and readmissions to both acute and mental health inpatient beds and will support timely discharge from inpatient services.

End of Life: As an ongoing priority, Kirklees has committed, to the development of a provider-led Integrated End of Life/Palliative Care Model. The expectation is that this will support further improvement in the quality of care pathways for patients and families as well as ensuring best value for money and reduced duplication across services.

Place-based systems of care (Primary Care Home): As outlined in section 5.3 of this report, based around populations of 30-50k, this place-based system of care will include social care, community services and Primary Care initially and develop to include mental health, voluntary and other services and support in the future. Within this overall approach we will ensure we maximise the benefits of:

- Focusing on Population Health
- Population Segmentation and Risk Stratification
- Public Engagement and Involvement
- Care Co-ordination and Management
- Maximising Digital Opportunities

Moving towards this approach will take time and is a long-term shift which will need to be worked on for some time to come. The high-level timescales are:

By March 2019:

- Primary Care Home clusters of GP practices in place
- Clarification on the social care and community services at the core of the new approach
- Clarification on the new ways of working at the core of the new approach
- Established working example of the new approach in both North Kirklees and Greater Huddersfield including establishing links with other services such as Community plus, Schools as Community Hubs
- Clarified the managerial support and capacity required to support the approach

During 2019/20:

- Roll out of the new approach across Kirklees to cover the whole population, recognising that some areas will need greater support to do this

2020 onwards:

- New approach is in place across Kirklees and is now the way in which we work but recognising that we will need to continue to work hard to embed the approach and further develop it to increasingly reflect the needs of the different nature of each community.

Outpatient Programme: Transformation of the Outpatient Programme across the CHFT footprint with pathways in all specialities to be reviewed with an initial focus in year 1 (2018/19) in General Surgery, Gastroenterology, Trauma and Orthopaedics, Ophthalmology and Cardiology. To Include:

- Redesigning the outpatient offer
- Leading change across WYAAT/ STP
- Rapid change at scale
- Leader in the use of virtual care
- Intensive clinical engagement to ensure a co-produced future taking the best from primary care, secondary care and patient views
- Changing the financial relationship (commissioner/ provider/ primary care split).

Across the MYHT footprint, the Elective Care Transformation programme has established six specialities to be the focus of transformation: respiratory, ophthalmology, gastroenterology, urology, MSK, and pain services. Two key workstreams are also in place:

- Managing and reducing demand
    - E-consultation
    - Referral Support
    - Commissioning Policy
    - Supporting Healthier Choices

- Capacity Management
    - Review use of Any Qualified Provider (AQP) /other demand allocation
    - Review of outpatients.

Frailty: The CCGs are developing a model to deliver Frailty Services across Kirklees, led by a fully integrated commissioning process, which aims to support frail older people to live in appropriate homes; be as well as possible for as long as possible and experience seamless health and social care appropriate to their needs available 24/7 where relevant. There are several outcomes which will be achieved through delivery of the frailty programme.

- Frail older people in Kirklees are as well as possible for as long as possible, both physically and psychologically.
- Local frail older people can control and manage life challenges by engaging with a supportive network of health, social care and voluntary services.
- The needs of carers will be identified and supported.
- Frail older people have access to a safe, warm, affordable home in a decent physical environment within a supportive community.

- Frail older people have access to opportunities that have a positive impact on their health and wellbeing e.g. people experience seamless health and social care appropriate to their needs that it is affordable and sustainable, and where investment is rebalanced across the system towards activity in community settings.
- Frail older people can navigate around an integrated service delivery across the voluntary, primary, community, and social care sectors that is available 24 hours a day and 7 days a week where relevant.

4. Next steps

The Kirklees Health and Wellbeing plan is currently in development and will be presented in draft to the Kirklees Health and Wellbeing Board for approval on 6 September 2018. Strategic oversight of the implementation of the plan will be led by the Kirklees Health and Wellbeing Board, with implementation leadership from the Kirklees Health & Care Executive Group.

5. Recommendations

Kirklees Overview and Scrutiny Committee is asked to:

- Note the contents of this report and comment on the developments set out in this paper.

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