APPENDIX B

Kirklees Integrated Wellness Model
Model development update

1.0 Introduction

Since September, work has been underway, with the support of The Big Life Group as development partners, to design the future delivery and implementation approach for the Integrated Wellness Model (IWM).

The development work which is now ongoing is the translation of the IWM specification into a deliverable integrated service offer which offers the opportunity to deliver better outcomes for those that participate, support staff to develop into their new roles and offers a phased and feasible implementation journey, contributing to the delivery of better outcomes for the population of Kirklees. The model is intended to be implemented in a learning environment so it can evolve over time.

Analysis has been undertaken to support a clear understanding of current service provision and the system in which it operates in order to develop a vision, outline model and future change journey which are aligned to the commissioning transformation vision and offer a feasible and implementable operational plan.

The implementation of the model will be designed around a 1, 2 and 5-year programme, to develop more clarity for staff, IWM partners and wider system who are all key to the successful and sustainable wellness system.

The vision for the IWM is to offer a transformed approach to lifestyle behaviour change. The journey to achieving this will rely on effective partnership working within the IWM and system in which it operates. An essential element of taking this model forward is bringing partners with us, developing and integrating the wider IWM offer.

2.0 The transformation journey

The vision set out for the Wellness Model in Kirklees reflects key concepts that align with Kirklees Council's Corporate Plan 2018-20, particularly the three underpinning principles:

- Working with people not doing to them
- Working with partners
- Place-based working

Several other important concepts underpin the model:

- Personalisation, person-centredness and strengths-based. Demonstrated through individual behaviour change underpinned by a goal-based approach and an operational model that connects with communities and community assets
- Co-production. Demonstrated through a strengthening of the core communication and behaviour change skills of staff and developing more activities and support alongside and through partners, particularly clients and communities

- From a medical model to what makes us well. Shifting from a focus on people who are ill and a disease model of public health to a stronger emphasis on what makes us well.

These principles and the specification can be used to describe a 'theory of change' for Wellness in the Borough. This is set out below:

Theory of change for Wellness

If we move to an approach that focuses more on the idea of working with people to support them to identify what matters to them for their health and wellbeing, help them find their inner resources to make changes and remove some of the real-life barriers that get in their way, they will feel better. When people feel better, this also reduces the health behaviours that lead to longer term ill health.

We will achieve greater value by pooling and joining up resources, which will reduce duplication for individuals by supporting them to do more for themselves and helping them get what they need in fewer steps, for services by creating an offer that flexes around the person rather than focusing on a theme, and for the system by generating a focus for the wider resources that people can use to improve their lives.

We will know we have achieved this because we will see changes in people's confidence to do things for themselves, health behaviours, connectivity of people and resources at a local level, and improvements for specific groups of people that stand to gain the most from what we offer.

Change over time

It is recognised that this change will not happen overnight so we can also think about how the change might look if we work out where we want to get to and what changes are needed over time:

Longer term (5 years plus)	Medium term (2-5 years)	Short term (1-2 years)
Reaching more people who have opportunity to benefit most Staff and volunteers confident and spreading expertise Integrated with other wellness resources, in places that make sense to people locally, making more of assets Building capacity and wellness in individuals and reducing health behaviour risks for future ill health and strengthened ability of people and groups to do more for themselves Wider range of opportunities for people to participate in developing and delivering the service activities Changes sustained in key outcomes for individuals (efficacy and health behaviours) and continuous improvement of service-level goals Contributing to wider system change e.g. new ways of working (with individuals and as a service), integration of resources and impact on health and care outcomes	People and groups more connected, especially targeted communities and contributing to the development of local resources Staff working confidently, supporting each other to learn and embed expertise within the service and with immediate partners. Active wellness partnership connecting local people and especially marginalised groups with opportunities and resources Staff connect people to opportunities and local resources (formal and informal), through their knowledge of what works for people and place Volunteering and other opportunities to participate in the service Improvements in results of interventions Evidence of contribution to wider system outcomes	Activities to make connections and extend reach to priority groups and communities Activities to connect partners strategically and in communities who have similar goals and aspirations to us, especially for target groups Integrated team within the Wellness service Staff trained, building skills, effective support in place to help them learn from experience and improve Person-centred interventions e.g. 1:1 and groups, co-produced, connecting people to their own resources and wider assets, addressing barriers related to social circumstances, and building confidence and wellbeing Volunteers actively shaping activities and offers Baseline data being collected on interventions, and assessment against predictions (volume of outcomes, capacity and demand) Wellness model supporting wider system change especially supporting longer-term management of demand, development of place-based working and workforce development for person-centred care and support.

3.0 Where are we now?

This section provides an analysis of the system now. In order to move towards the vision and a new model, it is important to take into account what is currently happening. The implementation journey starts practically from what is currently in place.

The scope of the IWM includes the following current range of services and activities:

- PALS
- Active for Life and Steps for Life
- Health Trainers
- Expert Patient Programme and Looking After Me
- NHS Health Checks Programme
- Smoking Cessation Services
- Tier 2 Weight Management

Analysis at both a qualitative and quantitative level to provide a detailed understanding of current service provision. The aim of the approach was not to provide an assessment of performance of current services but to understand the overall effectiveness and impact of provision based on intended outcomes as described in service specification (the gap between the goals of the Wellness Model and the current state), strengthen the narrative for change, assess the feasibility of change and inform the phasing of the transformation approach.

Insights from this work have been:

- The need to undertake detailed analysis of the financial envelope for Wellness to confirm the baseline from 1st April 2019, operating costs of the core service (those elements directly provided by Kirklees Council). This work is complete.
- The resources within the Health Checks and Smoking Cessation contracts provide an opportunity to deliver better value to Kirklees, and there may be an opportunities to redesign and release resources from these contracts to support development of the Wellness Model. More work is needed to articulate the Borough's strategic goals around smoking outcomes and quit targets and health check population outcomes and targets in partnership with the CCG, primary care and other stakeholders, and to determine the feasibility of new models of operational delivery aligned to the strategic goals.
- The purchasing of WeightWatchers vouchers for weight management is not a good fit with the ethos of the new model (issuing vouchers for participation) and does not meet NICE-specified requirements of a Tier 2 weight management offer.
- The PALS programme has been assessed against national guidelines for exercise referral schemes and needs changing to reflect good practice. It is not possible using data currently collected to assess its cost-effectiveness however it is unlikely to be cost-effective based on the guidelines. This includes two separately commissioned elements, Steps for Life and Active for Life. PALS is currently integrated with Kirklees Active Leisure (in terms of co-location and provision of a subsidised KAL membership). The requirements in the specification to support people both at risk of and with long term conditions to get more active do not dictate delivery of an exercise on prescription-type intervention, however it is recommended that a revised scheme in line with national guidance is delivered by the core service with wider development of a supported physical activity offer within leisure provision and communities.

- The Expert Patient Programme and Looking After Me Courses are also unlikely to be cost-effective and deliver best outcomes as they are currently delivered (based on NICE guidelines), represent an opportunity cost and can be replaced by a wider range of co-produced activities to support self-care.
- The staff and service's skills in lifestyle behaviour change and community approaches can be significantly strengthened and aligned with the design of interventions.
- Partnership working at service-level can be strengthened, particularly in relation to improving outcomes for target groups. Strategic partnership working is critical to the new model and needs to be a priority in the continued development of the model.

3.0 Why are we changing?

The vision for the IWM is to deliver:

- Person centred support with the solution being defined by the individual and not the service
- A holistic offer which is focussed on goal-based delivery and reducing health inequalities
- Sustainable service delivery which recognises multiple needs
- Empowerment through individual and community coproduction
- De-escalation and early intervention delivering support at the lowest point of need and with the least restriction
- Enhanced outcomes through joined up approaches
- System-wide cost savings achieved through reduced waste and prevention of cost at the higher end of the system
- Enhanced population health outcomes through innovative approaches and best use of resources

4. 0 How will we deliver this vision?

There will be a core service delivered in Kirklees Council that will be integrated with delivery partners that sit in scope of the model. These are:

- Primary care – General Practice, Pharmacies
- Kirklees Council departments
- Non-statutory Wellness delivery partners e.g. KAL, housing bodies, Community and Voluntary sector organisations
- People and groups in local communities

The wider integrated delivery model will collectively provide access to the wider support for people to improve wellness, whether that be in terms of secondary prevention (e.g. health checks and other screening, treatment, psychological therapies), primary prevention interventions and activities (e.g. access to range of opportunities to get more active or connect with other people, access learning opportunities, support to stop smoking, tackle financial or other issues relating to social circumstances).

There will be multiple routes to access the service e.g. direct through for example, a website, telephone number, email and also via other delivery partners through formal and informal referrals.

When someone gets in touch, there will be an initial assessment, underpinned by core person-centred communication skills, to explore what support the person to explore their

needs and choices. At this point, people may be signposted elsewhere e.g. social prescribing, practical support e.g. benefits or agree what support they will receive from the service based on the choices available. People engaging with the service offer will be assigned to a member of the team who will take them through a more detailed exploration of their situation and their needs and goals.

5.0 Who will the service be for?

The service will have a focus on supporting people to improve wellness, particularly by addressing health behaviours (such as smoking and healthy eating), their emotional wellbeing and the barriers to addressing these issues (often related to their social circumstances). It will be universally available to all adults, with a targeted approach for identified key population groups amongst whom we know there are a higher risk of health inequalities and multiple needs including those with protected characteristics such as age or disability, and priority groups set out in the specification such as people with those both at risk of and with Long Term Conditions and Carers including mental health issues.

The service delivery model will include population targeting which is linked initially to deprivation (poverty). Health Inequalities are described as differences in health between people or groups of people that may be considered unfair. Evidence tells us that deprivation is strongly linked to health inequalities, healthy life expectancy and indeed life expectancy itself. The starting point is to aim for good reach into the 10-20% most deprived within the population based on the theory that those with multiple risk factors will also have multiple barriers to change and therefore would most benefit from the IWM approach and also have the greatest need for improvement in the health and wellbeing outcomes. This is underpinned by a recognition of the impact of austerity and increasing levels of poverty that will increase the likelihood of people needs escalating.

In targeting these populations, it is understood that the service is likely to reach more people that fall into other priority groups and these characteristics will be monitored to assess the effectiveness of the strategy and for improvement. Over time the localities of focus may change, however the focus of the target approach will remain the same.

6.0 Direction of travel

The success implementation of the service and wider IWM will be contingent on the effective implementation of a culture shift which supports staff to delivered person-centred, client-led support. The journey may also require further changes to be realised amongst aligned and partner services, who play a key role in the delivery of wellness services in Kirklees.

The change journey will:

- Equip staff with the skills and knowledge they need to deliver the ethos and approach of the model
- Engage with system partners to ensure any shift in delivery approach is undertaken in partnership, minimising risk of service gaps and ensuring sustainable delivery in the long term
- Coproduce development approaches, in line with agreed engagement approaches both prior to and following successful implementation of the core service offer from 1st April 2019.

7.0 Principles of how we will get there

The change journey will align to the ethos of the IWM and offer a 'done with, and not to', approach to change. Staff will transition into the new wellness service from 1st April 2019. Between 1st April and the end of August, there will be a transition period where the current service offers will end and all client episodes closed effectively. The new service model will go live on Monday 2nd September 2019. During the transition period, there will be a programme to work with staff, service users, communities and partners to co-produce the service offer within the framework that has been developed so far.

The service will start out with a set of co-produced goals aligned with the theory of change, supporting its development over time. These may include goals to improve reach to specific communities and groups, to build relationships with partners, to develop additional client-led interventions.

8.0 Service model

The service model has been signed off by the commissioners at the end of December 2018. The transformation journey will continue beyond implementation of the core service offer on 2nd September 2019, to shift towards the longer term transformed delivery model which is described in Figure 1.

The core service offer is based on a coordinated client journey**,** 1:1 and group interventions (including a structured exercise on prescription scheme). The model is intended to be implemented in a learning environment so it can evolve over time.

Staff will be equipped to:

- Deliver person-centred and asset-based approaches including motivational interviewing
- Deploy a range of evidence-based assessments and interventions strengthening health, wellbeing, and wider determinants.

The service will coordinate all referrals centrally, allocating for referral review and triage. Referrals will be managed by staff who have the skills and knowledge to deliver the IWM ethos.

Clients will be able to access support from either a Wellness Worker or a Coach. These interventions will be linked to the level of client need, which will be determined with the client when they access the service.

The core roles in the service reflect the segmentation of clients into two groups – described practically as those with <3 barriers to change and those with >3. Wellness Workers will support people using a motivational interviewing-informed approach and using goal setting to address a change the client wants to make, typically during up to 6 sessions. Coaches will work with people with more barriers to change, supporting them using motivational interviewing to explore ambivalence and to help them address multiple barriers for up to 12 sessions. Coaches will have deeper expertise in one or more specialist areas e.g. physical activity, drugs and alcohol, mental health and will develop a deeper understanding of using motivational interviewing and the process of coaching. Both groups will support people to

identify what changes they want to focus on and to set goals, and will capture data on specific measures related to service and individual outcomes e.g. weight loss,

As well as working 1:1 with clients, staff will co-develop and co-deliver group-based activities with clients working as volunteers. These activities will also capture measures of success that will feed into the service's performance framework.

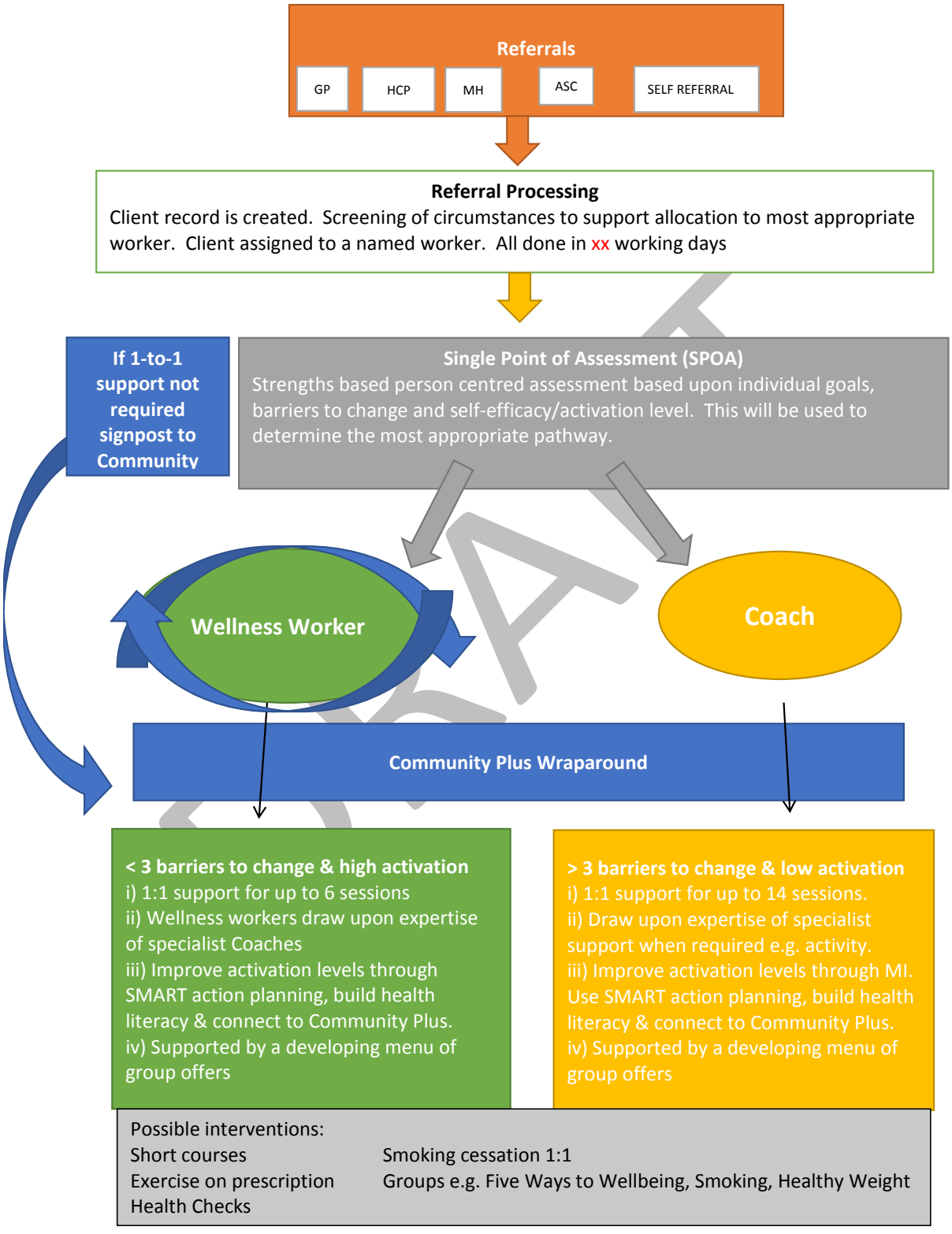
The service will also offer an Exercise Referral Scheme which will strengthen the design of the current PALS offer in line with NICE guidance and an evaluation framework to provide a better understanding of value and impact. This evaluation will be delivered as a component of the performance framework and support future decisions regarding service delivery and configuration.

The offer will be supported by an insight-led menu of activities which will be designed on the basis of user needs. This might include different group activities in different areas and communities covering issues like healthy weight, stopping smoking or groups for carers to manage their wellbeing. The design approach will be further developed as part of the operational plan delivery. We will work with staff, volunteers and communities to coproduce the offer based on their understanding of their customer needs.

Current service provision is supported by the work of volunteers such as those who deliver the Expert Patient Programme and the PAMS within the PALS service. We will work with existing volunteers to design with them how they feel they can best support the future pathway. Coproducing the future role in this way is intended to promote a maintenance and expansion of the current volunteer engagement. This approach will commence by first working separately with the EPP and PAMS volunteers to understand their views and then bringing both groups together to deliver a shared vision and understanding of the future role of volunteers within the IWM.

A key element of the development journey for the staff and service will be the determination of the future approach to NHS Health Checks, healthy weight and Smoking Cessation delivery. It is linked to the development of new models of delivery in the wider IWM and will be determined in line with the constraints and opportunities described at section 13.0 of this document. In particular, the development of roles within the service to support these activities will need to be considered in line with the preferred overall delivery model. This may be for example, existing staff providing opportunistic smoking cessation support, delivering the service for the Borough, or investment in new roles to support the service working in a mixed delivery model with other providers. The agreed scale of the service's goals around delivery of these aspects will support the development of staff and other requirements such as training, equipment.

Figure 1: **Core service offer for implementation from 1st April 2019**



8.0 Description of service pathway functions

Referrals: Referral may be based on email, letter and telephone. A lightweight and rapid process will capture the minimum information required to support triage. Feedback and an assessment appointment will be provided immediately for telephone referrals, and within one working day for all other methods. Referral forms will be designed and developed with input from healthcare professionals to minimise inappropriate referrals.

Triage and assessment: Assessments will be undertaken within five working days of referral, and form an individual asset map of the client, including:

- Measure of self-efficacy/activation level (to be agreed)
- Health risk assessment capturing information around their holistic health, risk taking behaviour, information on wider determinants of health, and any prior methods of staying healthy
- Evidence-based assessments drawn from the multi-modality toolkit

Assessments use the following principles of conducting a good asset-based assessment:

- Have an understanding of the person's starting point
- Summarise facts back to the individual to ensure accuracy
- Ensure questions about the whole community are asked to ensure a community-based approach
- Focus on outcomes, only taking data on areas which will be monitored
- Build trust and be honest
- Conduct the assessment as a conversation, not an interview
- Perform the assessment as an intervention.

Allocation is informed by:

	Under three barriers to change	**More than three barriers to change (specialist support required)**
A high self-efficacy score	Support to build health literacy, promote self-care, increase knowledge of the assets in the community and provide short-term support.	Promotion of self-care, and increasing health literacy, knowledge of assets in the local community and the person's confidence and skills. Increased complexity means longer-term support is given.
A low self-efficacy score	Support to increase the individual's knowledge and skills and achieve behaviour change through SMART goal setting.	Longer-term support to individuals, drawing on motivational interviewing expertise to build individual capacity, support behaviour change in a number of areas.

As a rule of thumb, Wellness Workers will work with people who have fewer barriers to change and find it easier to identify what they want to change. Appointments are likely to be around 30 minutes. Coaches will work with people who need more support to get started, having more barriers. Appointments are likely to be around 45 minutes to an hour, especially early on in their support. Coaches will also have additional levels of expertise in an area that is important to the service.

There are options on how to approach triage and assessment. As staff develop their skills, they will be supported to determine what approach to assessment they think is most appropriate.

8.1 Service Configuration

The IWM will be a universal offer and promote equity of access for the population of Kirklees reflective of need. Configuration will be developed in line with identified targeting.

Poverty is proposed as an initial focus for the targeting of the service offer (see section 12.0 for further details). It is suggested that this targeting approach is considered on a geographic basis alongside the promotion of access for identified target groups including carers, people with mental health problems and protected characteristic groups. The service model will be configured in to enable this approach. Service goals will be developed in year 1 to determine the target impact for these groups of people, and impact measurement undertaken against identified goals to evaluate reach and outcomes for target populations. The operational plan development for the model will need to consider in practice the approach to engagement with identified groups and areas.

Primary Care Networks are still under development and therefore whilst it is anticipated that future targeting and configuration will be linked to these, at this stage this is not a feasible option.

Configuration will be designed to make best use of the Community Plus and EIP locations (i.e. libraries, schools as community hubs) to support cohesive system delivery. A key consideration for locations will also be proximity and access to a leisure centre for the provision of Exercise Referral approaches.

9.0 Staff involvement

The underpinning ethos of the service will inform all approaches and delivery. Staff will be key to successful implementation of the service offer, as this will rely as much on the culture and approach of the service, as the specific interventions delivered.

Following conclusion of HR transition processes, staff will be supported to adopt new ways of working via a training package designed to equip them with the tools to deliver in the desired approach. This training and development approach will be ongoing and will not cease with the launch of the new offer in September 2019. Staff development is also recognised as a journey in the same way that transformation is recognised as needing a phased approach.

Prior to 31st March 2019, all staff involvement will be delivered in line with the requirements of HR transition processes. Following the December staff session, the next follow-up session will be planned for March (subject to HR confirmation).

During December, January and February we will be:

- Further developing the model and operational framework with IWM delivery partners and the wider system
- Designing the performance and outcome framework
- Scoping changes to operational processes, including standard operating procedures, recording systems, policies, customer information and branding

Where possible staff will be involved subject to constraints of HR policy and process. Following conclusion of HR processes, the change journey will support active staff involvement in the shaping and design of future developments, embedding a culture of continuous improvement based on user-led insights.

10.0 Transition

The successful implementation of the Integrated Wellness Model will need to ensure a seamless transition between pathways and prevent a gap in service provision for service users.

Detailed work is underway to define the transition process and understand how all current service users are supported. This will be clearly communicated as part of the Communications and Engagement plan and staff will be given guidance and support to enable them to manage customer expectations during the transition period.

Alongside this communications process existing managers will support team members with caseloads and be supported to advise on good practice for transition.

Existing staff are key to ensuring a professional transition through completion of current pathways where appropriate and transitioning clients to the new model and relevant pathway.

11.0 Next Steps

The following activities are underway to support the transition:

- Mapping of existing workloads / planned programmes to support identification of referral management process and transition dates during Quarter 4 18/19
- Active engagement with opportunities for staff, volunteers and partners.

Active and open communication will be key to supporting the successful implementation of the Integrated Wellness Model. A Communication and Engagement Plan describes:

- Communication approach to support awareness of transition to new service model for customers, staff, partners and broader system stakeholders
- Engagement plan for delivery from 1st April 2019 which supports active participation in the design of model developments. This will also be designed to support active engagement with partners regarding future developmental work to secure system buy-in and ownership and offer a managed approach to future expansion of the service offer.
- Branding and marketing plan to ensure a clear identity for the new model which supports awareness and understanding of the offer and buy-in to the model concept. The model branding will be developed with staff to ensure that it meets the needs of identified target groups based on staff insights of their needs, motivations and barriers to access.

12.0 Targeting model and deprivation

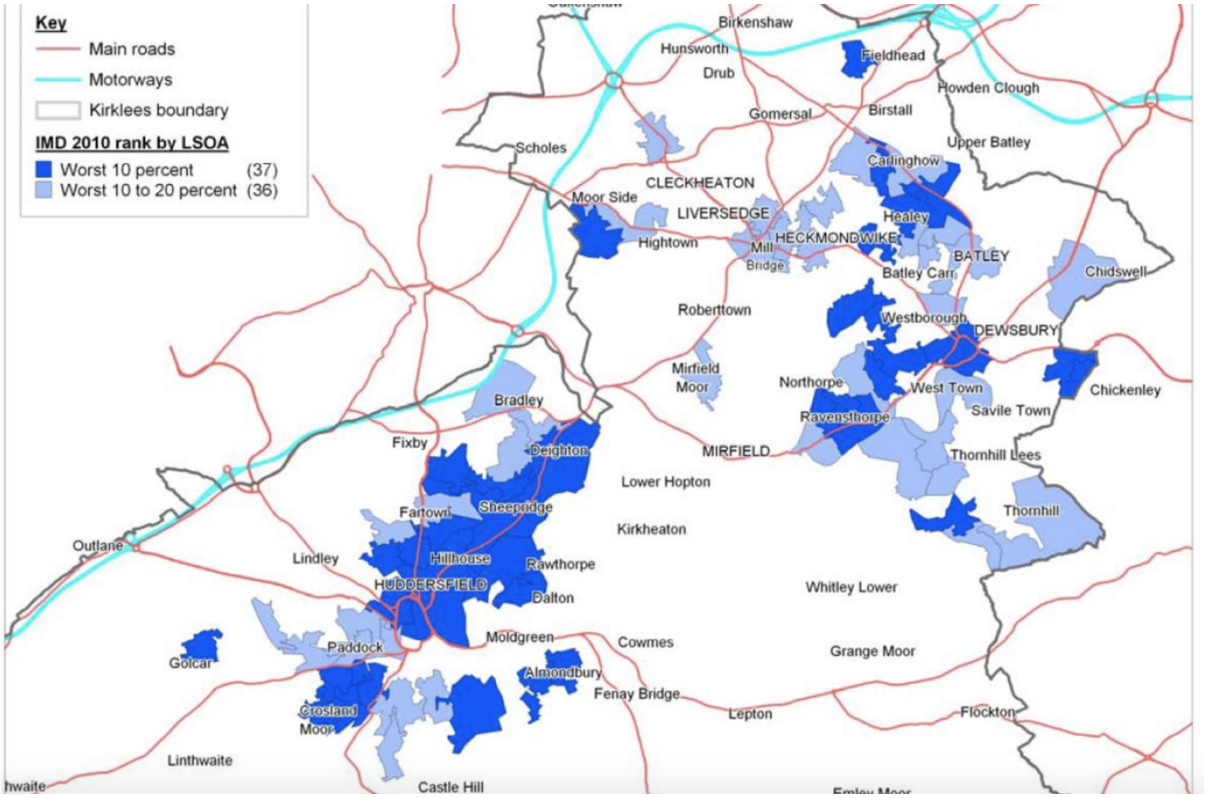
The initial focus for this model, in line with Public Health principles, is on reducing health inequalities and by targeting areas with greatest deprivation our hypothesis is that if we get it right for these people, we will get it right for all.

Analysis has shown that Kirklees has 17 of the 5% most deprived LSOA in the country (out of 1,624) with the most deprived LSOA being 390th, in the worst 1.2% nationally. Dalton has 3 of its 12 LSOA in the worst 2% nationally but then no more until the 23rd percentile, whereas Dewsbury West has 7 of its 11 LSOA in the worst 10% nationally. Crosland Moor & Netherton have 5 of their 11 LSOA in the worst 10% nationally and Ashbrow has 5 of its 11 nationally.

Therefore, there is a strong argument to have services focused in Dewsbury West, Crosland Moor and Ashbrow as the latter services could provide some in-reach to Dalton and the former to Batley West.

Figure 2 shows the geographical spread of these areas and supports visualisation of the potential configuration of provision.

Figure 2: Kirklees Map of Deprivation (IMD 2010)



13.0 Constraints

The development and implementation of the service model will need to be managed within the following constraints of the existing system:

- Continuity of service for current service users
- IWM delivery partner and wider system involvement
- Opportunity to redesign current systems for Health Checks and Smoking Cessation in context of current contractual relationships, investment envelope available, maintenance of positive partnership approaches with current service providers particularly Primary Care Networks and potential impact on them which will need to be based on clear journey of change, rationale and understanding of system impacts
- Weight Management – WeightWatchers contract currently extended until end of Q2
- Pace of cultural shift and change needed to support staff group to develop into new roles and expectations and in line with HR transition processes
- Pace of development of broader operating system including readiness for integration and the personalised care agenda
- Realisability of new investment for model is linked to pace at which resources can be released from current contractual arrangements
- HR transition timescales