

<b>KIRKLEES HEALTH &amp; WELLBEING BOARD</b>
<b>MEETING DATE: 6 September 2018</b>
<b>TITLE OF PAPER: Kirklees Health and Wellbeing Plan</b>
<p><b>1. Purpose of paper</b></p> <p>The purpose of this paper is to present the draft Kirklees Health and Wellbeing Plan (2018 – 2023) to the Health and Wellbeing Board for endorsement. Subject to endorsement by the Health and Wellbeing Board, the plan will be submitted to each organisation’s board / governing body for approval.</p>
<p><b>2. Background</b></p> <p>The refresh and development of the Kirklees Health and Wellbeing Plan was initiated in June 2018 and an update on the scope and purpose of the document was provided to the Health and Wellbeing Board on 26 June 2018.</p> <p>The document provides an overview of the planned work across Kirklees to deliver improvement in the health and wellbeing of the population, referencing and drawing upon the wide-range of existing strategies and plans at an organisational, place or system level supporting this delivery.</p> <p>A range of stakeholders from across organisations in Kirklees representing health, social care, wider council services, the voluntary and community sector and Healthwatch were engaged in the development of the plan. A development session of the Health and Wellbeing Board on 26 July supported the shaping of the plan and the priorities contained within it.</p> <p>The plan has also engaged the Integrated Commissioning Board (the draft Integrated Commissioning Strategy will underpin delivery of the Health and Wellbeing Plan), the Integrated Provider Board (which has aligned its priorities for delivery in 2018/19 to those within the Health and Wellbeing Plan) and the Kirklees Health and Care Executive, which will support the Health and Wellbeing Board with leadership for the implementation of the plan.</p>
<p><b>3. Proposal</b></p> <p>The Kirklees Health and Wellbeing Plan provides a strategic plan for the delivery of improvements to health and wellbeing of the population between 2018 - 2023. The plan outlines the planned objectives and key planned interventions and programmes of work for each of the four population cohorts (and for a series of enabling functions):</p> <ul style="list-style-type: none"> <li>• Living well</li> <li>• Independent</li> <li>• Complex</li> <li>• Acute and urgent</li> </ul> <p><u>Priorities</u></p> <p>The headline shared priorities for the Kirklees population within the plan are:</p>

1. Create communities where people can start well, live well and age well
2. Create integrated person-centred support for the most complex individuals
3. Develop our people to deliver the priorities and foster resilience
4. Develop our estate to deliver high quality services which serve the needs of local communities
5. Harness digital solutions to make the lives of people easier

Through delivery of these priorities, we will work to make a real impact in the following areas:

- Make healthy weight the norm for the population in Kirklees, increasing the proportion of the population of who are a healthy weight in childhood and adulthood, starting with increasing the proportion of babies born in Kirklees at a healthy weight
- Increase the proportion of people who feel connected to their communities, reducing the proportion of people who feel lonely or socially isolated and reducing the prevalence of mental health conditions amongst our population
- Increase the proportion of people who feel in control of their own health and wellbeing
- Narrow the gap in healthy life expectancy between our most and least deprived communities.

#### Approach

The plan builds on activity already being undertaken by individual organisations or across the system delivering our vision through:

- Working with nine local communities of 30,000 – 50,000 populations across Kirklees, bringing together NHS, social care, wider council services, and voluntary and community sector organisations tailored to the needs of those diverse communities and building resilience and connectedness within those communities which with our residents identify
- A focus on prevention and early intervention and tackling the underlying cause of poor health and wellbeing
- Empowering people to stay independent and providing more support in the community or at home
- Delivering high quality acute and specialist services for our whole population working with a single group of hospitals, the West Yorkshire Associate of Acute Trusts and a single group of mental health providers, the West Yorkshire Mental Health Services Collaborative
- A Kirklees approach to commissioning services once across the Council and two Clinical Commissioning Groups (CCGs) through a single integrated commissioning board
- A single Kirklees integrated provider board to ensure services are delivered in a coordinated and integrated way with local communities and across Kirklees
- A commitment to openness, transparency and involvement of our communities and workforce in our conversations and decisions to deliver our ambition.

#### **4. Financial Implications**

None at this stage.

#### **5. Sign off**

Richard Parry, Strategic Director Adults and Health, Kirklees Council

## **6. Next Steps**

Subject to endorsement from the Health and Wellbeing Board, the plan will be submitted to the boards and governing bodies of the partner organisations for approval. The plan will be a key document for the Health and Wellbeing Board, with the priorities informing the agenda of the Board going forward. Once finalised, the outcomes framework monitoring delivery of the plan will be regularly reported to the Board.

Whilst a number of the programmes described in the plan are already in progress, there is recognition that implementation activities must be joined-up and coordinated to effectively monitor delivery of the priorities across Kirklees.

The Kirklees Health and Care Executive is currently agreeing an approach to implementing the plan and how resources across Kirklees will be mobilised to support delivery.

## **7. Recommendations**

The Kirklees Health and Wellbeing Board is asked to:

- Endorse the Kirklees Health and Wellbeing Plan
- Confirm its role in providing strategic leadership for delivering the plan
- Endorse moving the plan into implementation phase.

## **8. Contact Officer**

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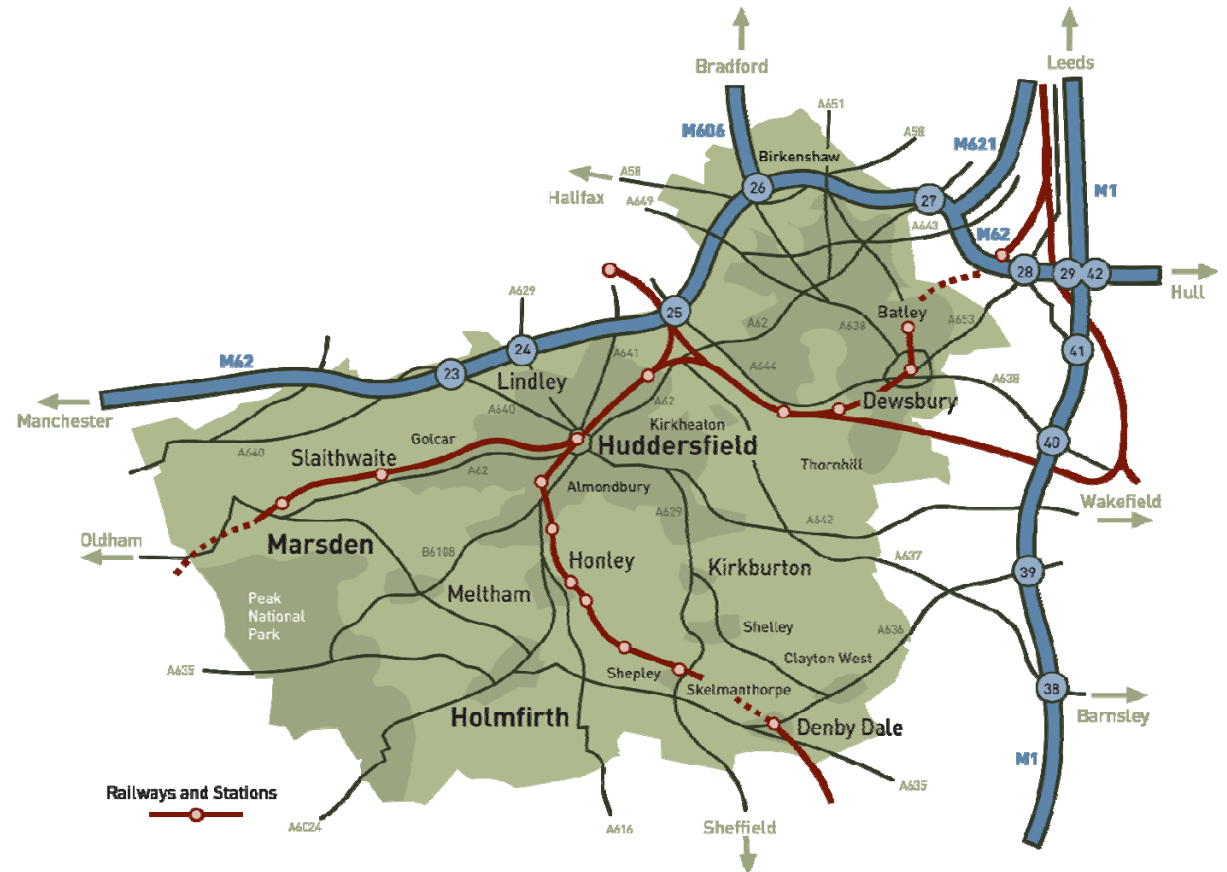
# Kirklees Health and Wellbeing Plan

2018 - 2023

**NHS**  
Greater Huddersfield  
Clinical Commissioning Group

**NHS**  
North Kirklees  
Clinical Commissioning Group

**Kirklees**  
COUNCIL



**Locala**  
Community Partnerships

**NHS**  
The Mid Yorkshire Hospitals  
NHS Trust

**NHS**  
Calderdale and Huddersfield  
NHS Foundation Trust

**NHS**  
South West Yorkshire Partnership  
NHS Foundation Trust

# Introduction

Around 431,000 people live in Kirklees with main population centres of Huddersfield, Dewsbury and Batley. The population has grown by 8.4% since 2002 and is expected to increase by a further 9.9% by 2031 with the largest growth in very young and older adult age groups.

'Kirklees' as an administrative boundary isn't what our residents identify with, rather the villages, towns and local communities that make up the Borough. The starting point for the development of this plan to improve the health and wellbeing of the *whole* population, is grounded within recognising the strength of our diverse communities and the people that live here.

Despite some significant improvements in some of the indicators of good health and wellbeing like life expectancy, we still have some significant challenges, and the inequalities across our borough are still a significant predictor of the health and wellbeing outcomes for people. Our vision is that:

*No matter where they live, people in Kirklees live their lives confidently and responsibly, in better health, for longer and experience less inequality.*

Our health and wellbeing plan brings together partners to focus on the people who live in Kirklees (adults and children) and how, working collectively, we can improve the health and wellbeing of the whole population. This will be our starting point. We will overcome challenges of organisational and professional barriers to ensure people get access to the best quality support to start well, live well, and age well.

Building on our work to date, the foundation of our approach will be:

- Working with **nine** local communities of **30,000 – 50,000 populations** across Kirklees, bringing together **NHS, social care, wider council services, and voluntary and community sector** organisations tailored to the needs of those diverse communities and building **resilience and connectedness** within those communities which with our residents identify
- A focus on **prevention and early intervention** and tackling the underlying cause of poor health and wellbeing
- Empowering people to stay independent and providing **more support in the community or at home**
- Delivering high quality **acute and specialist** services for our whole population working with a **single group of hospitals**, the West Yorkshire Associate of Acute Trusts and a **single group of mental health providers**, the West Yorkshire Mental Health Services Collaborative
- A Kirklees approach to commissioning services once across the Council and two Clinical Commissioning Groups (CCGs) through a single **integrated commissioning board**
- A single Kirklees **integrated provider board** to ensure services are delivered in a coordinated and integrated way with local communities and across Kirklees
- A commitment to **openness, transparency and involvement** of our communities and workforce in our conversations and decisions to deliver our ambition

Railways and Stations



# Our ambition for population health and wellbeing

Based on our priorities, we'll be focused on making impact in the following areas and use this as a barometer for improvement in population health and wellbeing. To make the biggest impact for our population and to deliver a system impact we will focus on prevention and early intervention with each of our population cohorts to:

✓ Make **healthy weight the norm** for the population in Kirklees, increasing the proportion of the population of who are a **healthy weight in childhood and adulthood**, starting with increasing the proportion of **babies born in Kirklees at a healthy weight**

Increase the proportion of people who feel **connected to their communities**, reducing the proportion of people who feel **lonely or socially isolated** and **reducing the prevalence of mental health conditions** amongst our population

✓ Increase the proportion of people who feel **in control of their own health and wellbeing**

✓ Narrow the gap in **healthy life expectancy** between our **most and least deprived communities**

Striving to deliver these ambitions is a significant undertaking running beyond the duration of this plan.

However, working together as a Kirklees system to deliver this plan, we will make a big impact for our population by 2023.

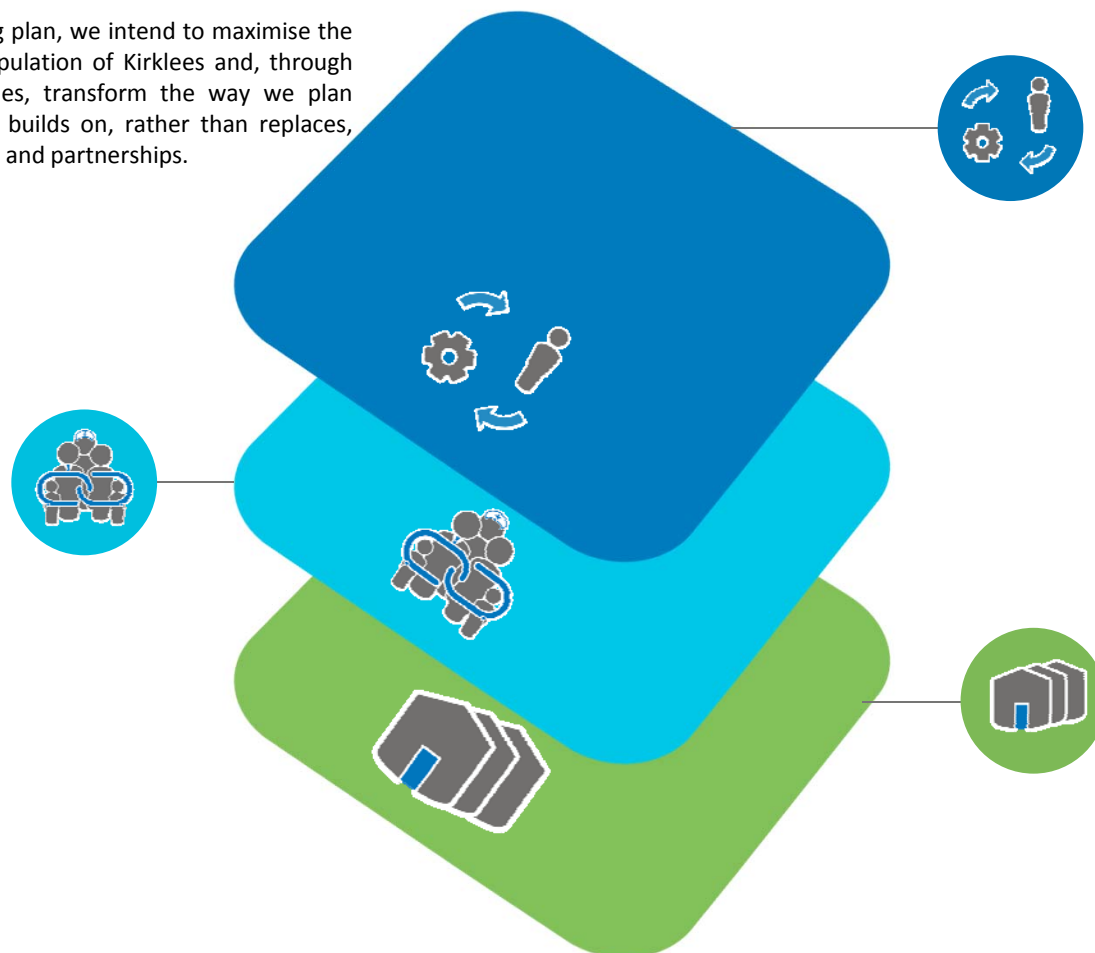


# Setting this plan in context

In developing a joint health and wellbeing plan, we intend to maximise the value of our collective action for the population of Kirklees and, through collaborative working on shared priorities, transform the way we plan deliver services for our population. This builds on, rather than replaces, plans already in place led by organisations and partnerships.

## Kirklees place plans

- [Kirklees Joint Health & Wellbeing Strategy \(2014-2020\)](#)
- [Kirklees Economic Strategy \(2014-2020\)](#)
- [Tackling Poverty in Kirklees Strategy and Action Plan \(2016-18\)](#)
- [‘A Place to Live’ - Joint commissioning strategy for accommodation for people who experience mental health problems in Kirklees](#)
- [Mental Health Crisis Care Concordat - Kirklees Action Plan](#)
- Kirklees integrated commissioning strategy (draft)
- Kirklees Suicide Prevention Plan (2017-2020)
- Kirklees ‘Whole Life Approach’ for Mental Health & Wellbeing 2017-2021 (draft)



## System and ICS plans

- [West Yorkshire & Harrogate Health and Care Partnership, Next steps to better health and care for everyone \(January 2018\)](#)
- [West Yorkshire & Harrogate Suicide Prevention 5 Year Strategy \(2017 - 2022\)](#)
- [West Yorkshire & Harrogate Sustainability and Transformation Plan Draft Proposals \(October 2016\)](#)
- [Calderdale, Kirklees, Wakefield and Barnsley \(CKWB\) Transforming Care Partnership Plan](#)

## Organisational plans

- [Kirklees Council Corporate Plan](#)
- Greater Huddersfield and North Kirklees CCGs Joint Operational Plan (draft)
- [5 Year Strategic Plan for Calderdale & Huddersfield Foundation Trust](#)
- Locala Strategy (draft)
- SWYFT Strategy (draft)
- [Mid-Yorkshire Trust Strategy](#)
- [Greater Huddersfield Primary Care Strategy](#)
- [North Kirklees Primary Care Strategy](#)

# Case for change

Like health and care systems across the country, Kirklees faces some challenges which means we can't stand still. Continuing to provide support in the way we do now will not meet our ambition to improve the health and wellbeing of our population, tackle some of the underlying inequalities we face, nor maintain and improve the quality of care and support. Increasing demand and changing demographics alongside funding challenges means that trying to provide services in the same way is no longer sustainable. For some outcomes, we perform less well than other areas and need to improve, for others we are comparable or rank more favourably than other areas. However, these are still significant issues such as children living in poverty, obesity in children adults, which have become the 'norm'. We are ambitious for our population and will work with our diverse communities to change these norms and create places in which everyone can start, live and age well.

## Health & Wellbeing

- Over half of adults are overweight, with one in five obese.
- 1 in 8 adults over 50 is a smoker, this increases to 1 in 6 under 50
- 1 in 3 adults has a mental health condition, up from 1 in 5 in 2012
- Kirklees has more full-term babies born with low birth weight than the national average
- 91,000 are in the segment most poorly motivated to look after their health
- There are an estimated 7,500 to 8,300 adults with a learning disability living in Kirklees. People with learning disabilities are far more likely to die early and to die of a preventable disease
- 60,000 households (1 in 3) are living in poverty
- 46% of respondents to Your Place Your Say (2011) said their home was not suitable for their needs
- Dementia in over 65s is expected to rise by nearly 60% by 2030

## Care & Quality

- The most common causes of death in Kirklees are circulatory disease (31%), cancer (26%) and diseases of the respiratory system (14%)
- Services are fragmented and people don't get the best experience. We know this from engagement work we've done with our local communities, formal consultations and feedback gathered by our colleagues in Healthwatch Kirklees
- Demand for health and care services is increasing
- Whilst we have some high quality services, we also still have issues with the quality of some services across the spectrum including NHS services, care homes, domiciliary care and children's social care which we are working to address

## Finance & Efficiency

- There are significant financial pressures across Kirklees.
- NHS organisations working in Kirklees are working to deliver planned efficiencies of over £70m in 2018/19 alone
- Kirklees Council also has a significant savings programme totalling £83m between 2017 - 2020, there is a savings target of £4m in 2018/19 for adult social care, alongside an expected volume growth totalling £3.6m
- Using our total health and care budget of over £700m\* to best meet the outcomes of the Kirklees population

\* Estimated Gross Value Added (balanced GVA). Analysis undertaken by Kirklees Council, March 2018.



# Case for Change: Celebrating success and building on opportunities

Despite some of the challenges facing Kirklees linked to changing demographics, growing demand, inequalities, and financial sustainability, there is nonetheless much to celebrate and to build upon as we progress our plans to improve the health and wellbeing of the population of Kirklees.

Our strengths and opportunities include:

- A real commitment to prevention and creating communities in which people can start well, live well and age well.
- Huge assets contributing to positive health and wellbeing in our communities including a Premier League football club Huddersfield Town and Super League Rugby League team Huddersfield Giants, Gold rated University of Huddersfield and other high-performing educational establishments, world leading engineering and manufacturing companies, leisure facilities, parks and green space, galleries, theatres, festivals and Creative Kirklees.
- An asset base of people supporting people including 60,525 unpaid carers providing thousands of hours of support each day, 86,000 people regularly volunteering at least once a week, over 100 registered voluntary and community sector organisations in addition to over 1000 unregistered organisations.
- Strong relationships between the staff and organisations providing health and wellbeing support to our population – these operational relationships will be the bedrock for implementing our vision for the future.
- An energy to change things for the people we serve – many initiatives of varying sizes are taking place all over the district, led by the frontline workforce to improve the outcomes of people using services.
- Experience and a strong record of integrated working through commissioning, contracting and provision of services e.g. Care Closer to Home and Thriving Kirklees . Kirklees was one of the first areas to be peer reviewed in respect of integration, the review found identified some of our strengths upon which we continue to build.
- The emergence of forums to enable integration and closer working (Integrated Commissioning Board, Integrated Provider Delivery Board and Kirklees Health & Care Executive Group) which ensure we focus on the needs and outcomes of Kirklees people.

## Preparation for Parenthood (PFP)

An example of our focus on prevention, early intervention and integration of support is our Preparation for Parenthood course.

Preparation for Parenthood (PFP) is a 6-week interactive education course for all first-time parents in Kirklees. It is delivered by the Nurturing Parents Partnership (Kirklees Council, Locala, Calderdale and Huddersfield NHS Foundation Trust, and Mid Yorkshire Hospitals NHS Trust). The course helps future parents understand the physical and emotional aspects of parenthood as well as what is best for their baby's wellbeing and social and emotional development. It also provides an opportunity for peer-support.

We have helped more than 1,000 parents since the course started in October 2015. Participants say they feel better prepared for becoming parents, understand how having a baby may change a relationship and how their baby's brain develops. A large proportion of people on the course also make friends with others on the course and stay in contact with them.

# Our principles

Our focus for delivering our vision in Kirklees is through prevention and early intervention, working within the Strategic Framework of our [Joint Health and Wellbeing Strategy](#).

## Guiding principles

There are set of guiding principles that shape everything we do through our partnership in Kirklees and in representing Kirklees in the West Yorkshire & Harrogate Health and Care Partnership. This set of principles support us to work as a group of organisations and sectors across Kirklees to deliver the best outcomes to our population.

- We will be ambitious for the people we serve and the staff we employ
- The partnership belongs to its citizens and to commissioners and providers, council and NHS so we will build constructive relationships with communities, groups and organisations to tackle the wide range of issues which have an impact on people's health and wellbeing.
- We will do the work once – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict
- We will undertake shared analysis of problems and issues as the basis of taking action
- We will apply subsidiarity principles in all that we do – with work taking place at the appropriate level and as near to local as possible

## Our shared values and behaviours

- We commit to behave consistently as leaders and colleagues in ways which model and promote our shared values:
- We are leaders of our organisation, our place – Kirklees, and of West Yorkshire and Harrogate;
- We support each other and work collaboratively;
- We act with honesty and integrity, and trust each other to do the same;
- We challenge constructively when we need to;
- We assume good intentions; and
- We will implement our shared priorities and decisions, holding each other mutually accountable for delivery.



# Population planning

Kirklees is a collection of diverse communities, people who live here identify and find the most meaning in their local communities. This is why we are committed to working closely with these communities to understand their needs, plan and deliver services *with* them, and make these communities places in which health and wellbeing can flourish.

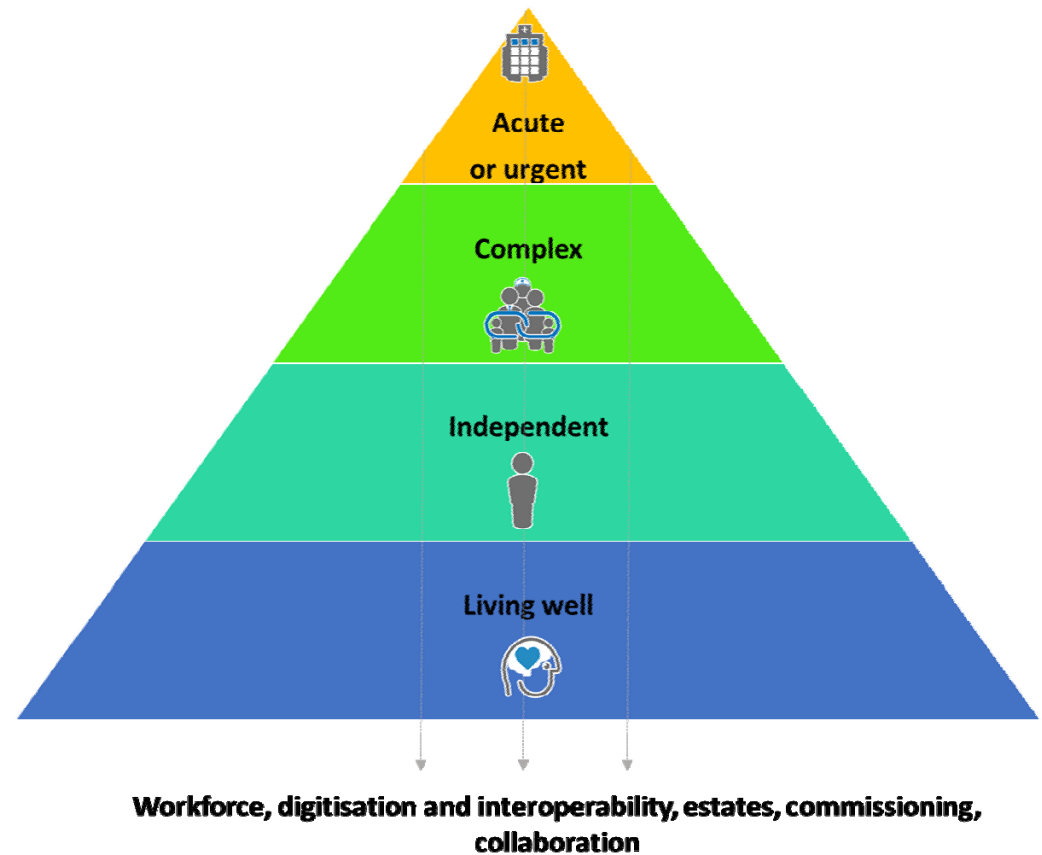
Amongst partners who commission and deliver health and wellbeing services in Kirklees, there is a real commitment to making improvements for our population, working with local communities collectively. This will mean building on some of our successes to collaborate further – integrating commissioning and how we buy services, integrating service provision to deliver seamless services to people in local communities and most importantly working with our local areas to create a community of coproduction in which people have a role in their own health and wellbeing, that of the community and in shaping local services.

We have some strengths upon which to build, already we know that 1 in 4 adults in Kirklees volunteer on at least a monthly basis with the 65-74 age group the most active in volunteering. We know that volunteering is strongly associated with social connectivity, wellbeing and resilience.

Within these communities, our population will be characterised by four main groups of people who will have different needs in relation to their health and wellbeing. These populations are:

- Living well
- Independent
- Complex
- Acute or urgent needs

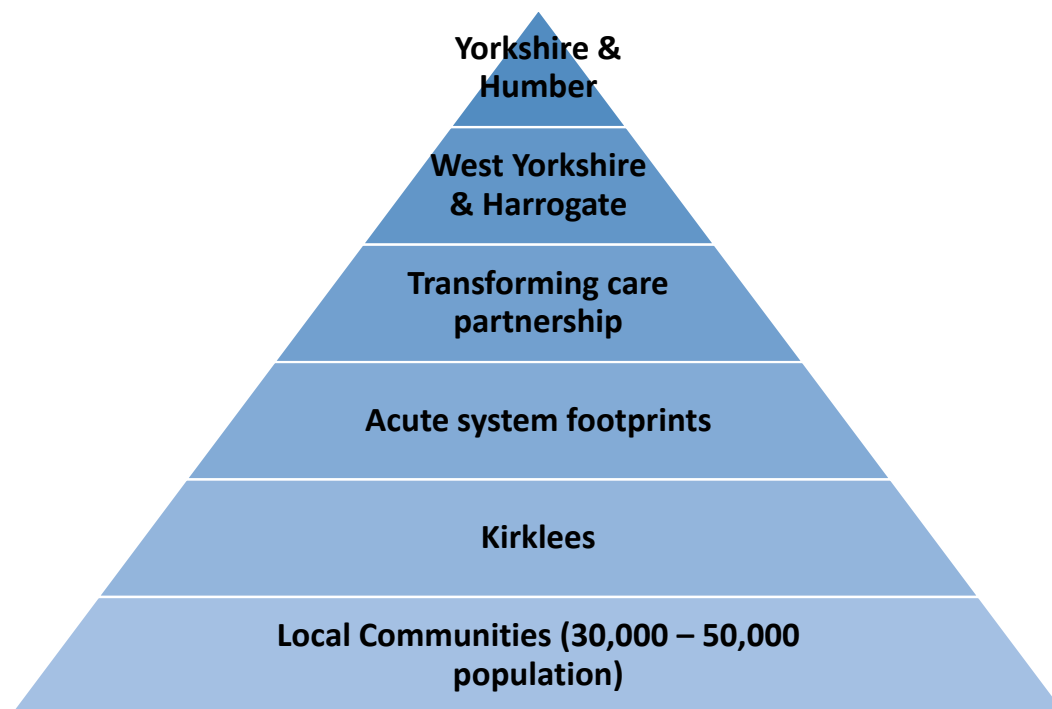
We are committed to using a **population health management** approach in Kirklees in which we can use our data and intelligence sources to better deploy our resources to meet the needs of our communities. This includes segmentation, stratification and impact modelling to identify local 'at risk' cohorts of the population – and, in turn, designing and targeting interventions to prevent ill-health and to improve care and support for people with ongoing health conditions, and reducing unwarranted variations on outcomes.



# Starting with our populations and communities

Population characteristics	Our focus	What we know about this group	
<b>Living well</b>	<ul style="list-style-type: none"> <li>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.</li> <li>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).</li> </ul>	<ul style="list-style-type: none"> <li>Keeping people well, physically and emotionally through the creation of healthy places which promote healthy behaviours and of resilient, connected and vibrant communities</li> <li>Reducing risk factors associated to healthy behaviours or social factors, often linked to inequalities</li> </ul>	<ul style="list-style-type: none"> <li>There are 91,000 adults living in Kirklees who are in the segment most poorly motivated to look after their health</li> </ul>
<b>Independent</b>	<ul style="list-style-type: none"> <li>A significant proportion of our population are living with conditions or social factors impacting their health and wellbeing, who are largely managing independently or with informal support</li> <li>Within this cohort, people will be accessing GP support or outpatient appointments specific to their needs</li> </ul>	<ul style="list-style-type: none"> <li>Enable this population group to manage their own health and wellbeing through access to information, advice, support and digital opportunities</li> <li>Ensure holistic support for physical and mental health and wellbeing needs</li> </ul>	<ul style="list-style-type: none"> <li>84% people over 50 has a long-term condition (67% people under 50). Half of these people are managing alone</li> </ul>
<b>Complex</b>	<ul style="list-style-type: none"> <li>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</li> <li>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.</li> </ul>	<p>Create a new offer for people with complex needs which will:</p> <ul style="list-style-type: none"> <li>Focus on strengths and assets in planning support</li> <li>Reduce duplication between services and number of times a person has to tell their story</li> <li>Focused on planned and preventative interventions rather than a reactive need for unplanned acute and urgent services</li> </ul>	<ul style="list-style-type: none"> <li>Approximately 30,000 people over 65 are living with three or more long-term conditions</li> </ul>
<b>Acute or urgent</b>	<ul style="list-style-type: none"> <li>At any time, some proportion of our whole population will have acute or urgent needs which need swift and/or specialist interventions</li> </ul>	<ul style="list-style-type: none"> <li>Ensure that where people require urgent, acute or specialist care, this will be the right intervention provided in the right setting in a timely way</li> </ul>	<ul style="list-style-type: none"> <li>On an average day (taken on 03/10/17) there are 437 A&amp;E attendances and 8,744 routine and urgent GP appointments across Kirklees</li> </ul>

# Planning on different footprints



We can largely meet the needs of our communities and particularly for our living well, independent and complex populations by planning and delivering services on a local community or Kirklees-wide basis. Some of the most acute or specialist interventions need to be planned and delivered on a larger geographical footprint.

A fundamental part of being able to deliver improved outcomes for the population is planning and working with partners on different footprints.

As a principle, we will work as close to our population as possible. Change needs to happen as close to people as possible. Kirklees has a number of diverse communities which people recognise as the place they live. Whilst we need to work on different footprints to plan and deliver the best quality services and outcomes, and some services may need to be planned and accessed outside of our local communities or Borough, the needs of our population in Kirklees will always be the starting point for considering any changes to this. Where this is wider than Kirklees, we will work with wider partners to ensure the needs of Kirklees residents are met to best effect.

## Planning and delivery

- Local communities – for many health and care services, evidence nationally and internationally points to planning and delivery being best focused around populations of 30,000 -50,000 people.
- Kirklees-wide
- Transforming Care Partnership footprint
- Acute footprints (Calderdale and Huddersfield and Wakefield and North Kirklees)
- Integrated Care System formerly Sustainability and Transformation Partnership (West Yorkshire & Harrogate)
- Yorkshire & Humber (e.g. Yorkshire Ambulance Services)
- Individual organisations – focused on the delivery of key priorities to ensure that the organisation is serving its population most effectively (for many of our organisations, this is wider than Kirklees) and ensuring that the organisation is functioning in the most efficient and effective way.

# Kirklees priorities

Whilst there is significant work taking place to improve the health and wellbeing for the population in Kirklees, we believe by putting our energy into some key priorities, we will make the greatest impact for the whole population, and tackle the health inequalities experienced in some of our communities.

## Tackling the underlying causes

### 1. Create communities where people can start well, live well and age well

- Create resilient, connected and vibrant communities using all available assets
- Promote connectedness and reduce social isolation and loneliness
- Increase proportion of the population moving of poverty and increase opportunities outside of the low wage economy
- Early intervention to start well – pre-natal support and the first 1000 days
- Increase proportion of the population at a healthy weight and the ability to make healthy choices the easy choice
- Increase proportion of non-smokers in Kirklees and increase numbers of people supported to quit smoking

## Improving outcomes and experience

### 2. Create integrated person centred support for the most complex individuals

- Drive forward the development and implementation of the primary care networks model (*to do this, must first ensure the resilience and engagement of primary care*), the integrated model for intermediate care, end of life, and the model for care homes support

## Using our assets to best effect

### 3. Develop our people to deliver the priorities and foster resilience

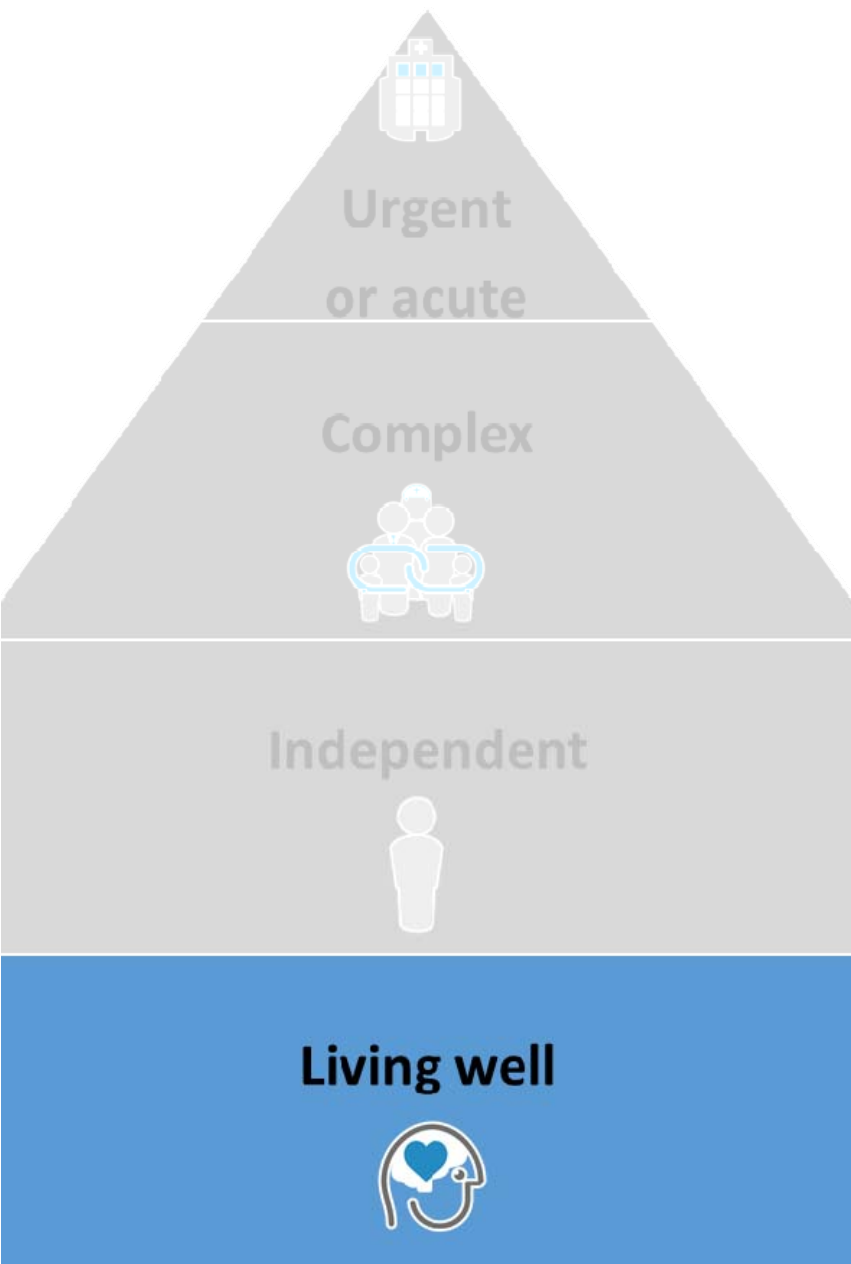
- Equip people the resources to stay independent and live well
- Change the conversation – focus on strengths, assets and responsibilities (Making every contact count)
- People who use and provide services work together to shape support
- Develop and nurture relationships and support people to change existing behaviours to deliver better outcomes

### 4. Develop estate to deliver high quality services which serve the needs of the local communities

- Using estate and facilities to generate social value and support the future model of provision
- Rationalising, sharing space to support collaborative and integrated working

### 5. Harness digital solutions to make the lives of people easier

- Raise the digital literacy of the population
- Focus on the solutions which will make people's lives easier, maintain independence, and support efficiency



## Living Well

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### Our objectives:

- Increase the numbers of people in Kirklees moving out of poverty and increase numbers employed outside of the low-wage sector
- Increase access to safe, affordable housing
- Support communities to be resilient and make the best of our local assets, supporting our thriving VCS
- Increase the proportion of healthy pregnancies, reducing the numbers of babies born at a low birth weight
- Increase opportunities to live well – access to green space and opportunities to exercise
- Increase numbers of people who feel connected to their communities, with a focus on those most vulnerable: younger people, older people, people with mental health conditions, and carers who may be socially isolated
- Champion better public mental health and tackle stigma
- Increase proportion of the population who are non-smokers
- Increase the number of adults and children undertaking the recommended amount of physical exercise and eating a healthy diet
- Increase health literacy amongst the population with a focus on those living in the most deprived communities
- Increase in engagement and uptake of screening and immunisation programmes, with a focus on more disadvantaged populations

# Living well: tackling the underlying causes of poor health & wellbeing

The Kirklees Joint Health and Wellbeing Strategy and the Kirklees Economic Strategy are recognised as fundamentally interlinked and supportive of one another. In order for people to start, live and age well in Kirklees, the underlying factors impacting health and wellbeing must be addressed.

## Housing

Access to safe, affordable housing is a key determinant of health and wellbeing in the population. There are several strands of work to deliver this:

- [Housing Commissioning policy](#) is focused on delivery of three outcomes:
  - An appropriate supply of homes and jobs to meet the needs of a growing and aging population
  - Improved places to live by reducing inequalities and worklessness
  - Improved life chances for people by supporting them to find and keep an affordable, good quality home
- A series of accommodation strategies to support vulnerable groups including:
  - [People with mental health conditions](#)
  - People with learning disabilities
  - Older people

## Poverty and low wage economy

A successful economy that offers good jobs and incomes for all of our communities makes a huge contribution to prosperity, health and wellbeing of all age groups. Likewise, confident, healthy, resilient people are better able to secure a job and are more productive in the workplace. In the long term these goals will help prevent poverty. The Council is leading a strategy and action plan [Tackling Poverty in Kirklees](#) which is focused on the four Ps:

- Pockets: Policies to boost household resources now
- Prospects: Policies to improve long term life chances of individuals and their families
- 'Prevention: Policies to prevent people sliding into poverty
- 'Places': Policies that provide the backdrop of services that allow people to enhance their job prospects
- Kirklees Council will continue to lead by example and act as a champion for the local living wage both in its own area and the wider region beyond.

## Healthy places

The [Kirklees Local Plan](#) and [Kirklees Economic Strategy](#) proposes a strong focus on creating 'Quality Places' as part of which, people have the opportunity of a healthy lifestyle, this includes:

- Avoiding allocating land for development in areas with the worst air quality
- Allocating and protecting employment opportunities in the areas of greatest deprivation
- Considering green infrastructure
- Recognition that the planning process can influence choices over food, diet and lifestyles choices when considering new proposals for such uses and can influence the range of services provided within a particular centre



Urgent  
or acute

Complex



Independent



Living well





# Living Well: Creating connected, resilient and vibrant communities

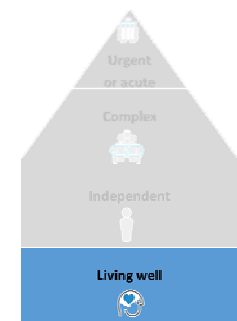
In order to have the most impact in communities, we are integrating and growing our community capacity resources offered through Community Plus, Local Area Coordinators, Schools as Community Hubs, Thriving Kirklees (0-19 services) and creating an Integrated Wellness Model. The next step is to align this to the creation of local neighbourhoods of communities of 30,000 – 50,000 people with health and care services wrapped around networks of general practices. This will enable greater connection between our statutory health and care services with the wider community support and ensuring that people have their needs met with the right solutions rather than an unnecessary statutory response. This will support us to tackle issues such as social isolation and loneliness in our communities.

Our focus is on helping and supporting people and families who might be struggling to lead a better life by connecting them with local resources, groups and individuals. We believe this approach will serve to make our communities stronger and happier in the long term, preventing and reducing the demand on health and social care, and encouraging them to do more for themselves and empowering them to make their own choices.

- Support people to stay stronger - by identifying their vision for a good life and their plans how to get there
- Build local partnerships - explore what peer and neighbourhood support and community networking groups there are, and connect individuals to them
- Focus on building relationships - focus our work in the places that need it the most, and encourage people to become more self-sufficient.
- Build a supportive community - establish what local resources are already in existence, including groups and volunteers, and look at ways we can support them and connect them with local people
- Promote local opportunities - establish where there are gaps in the community and support the development of new community provisions.

## Through this approach we will

- Improve the links between GPs and other health and care services to ensure that people are getting support from the right place for non-medical needs e.g. loneliness and isolation
- Strengthen the links between schools and wider services
- Provide impact and community intelligence to ensure services to better meet needs of people in communities
- Support people to stay safe, well and connected finding non-service solutions to problems wherever possible
- Support early intervention and prevention through community capacity building, identifying and responding to the health and wellbeing needs before they become complex or long-term needs
- Prevent, reduce and delay ill health and complex conditions
- Co-ordinate care and collaborate across services so people stay more in control of their own lives
- Improve quality of local services
- Improving individual outcomes to ensure people feel more in control, feel safer and able to make informed decisions, feel more connected to and able to contribute to their communities



# Living well: promoting healthy living

Healthy behaviours including not smoking, moderate alcohol consumption, good nutrition, physical activity and safe sex have a positive effect on health. While the health of younger people tends to be less immediately affected by their behaviour, occupation or wealth, unhealthy behaviours in youth and early adulthood significantly determine a person's health in later life so prevention and early intervention throughout the life course is vital.

## Smoking prevention

Smoking remains the highest risk factor for death in our region. As part of our work with the West Yorkshire Cancer Alliance we are committed to reducing smoking across the region from 18.6% to 13% by 2021.

A crucial part of this is taking a system-wide approach to creating a smoke-free Kirklees and creating an environment in which smoking

We will continue and expand smoking cessation support across the health and care system to ensure a Kirklees-wide focus on helping people to quit smoking in every intervention with our services.

Taking an early intervention approach is key to our success – tackling smoking in pregnant women and preventing children and young people from taking up smoking.

## Promoting healthy diet and physical exercise

Poor diet and lack of exercise has become a norm amongst our population, prevalent in both children and adults. Being overweight or obese continues to be the most significant contributing factor to the burden of disease. We are committed to tackling this as early as possible and supporting people to live well. Our focus is to:

- Promote Healthy Weight via Building Healthy Public Policy
- Promote Infant Feeding and Early Nutrition
- Improve Food and Nutrition for Older People
- Co-produce a Supplementary Planning Document for Hot Food Take-Aways
- Improve Insight and Intelligence, in particular in relation to Food Poverty
- Build on the 'place-based' approach in Ravensthorpe and share the learning to facilitate the implementation of this approach in other schools and communities

## Drug and alcohol usage

Kirklees has higher than average alcohol consumption and liver disease mortality rates in males. Those who are middle aged and have higher incomes are more likely to consume alcohol more frequently, but problematic drinking patterns are more prevalent in those with low household incomes. Drug misuse among adults and young people has fallen steadily in Kirklees, reflecting the national picture, although use of legal highs has risen.

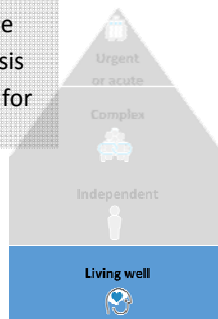
We will continue to ensure a Kirklees-wide focus on helping people with support and advice to manage alcohol and substance misuse including:

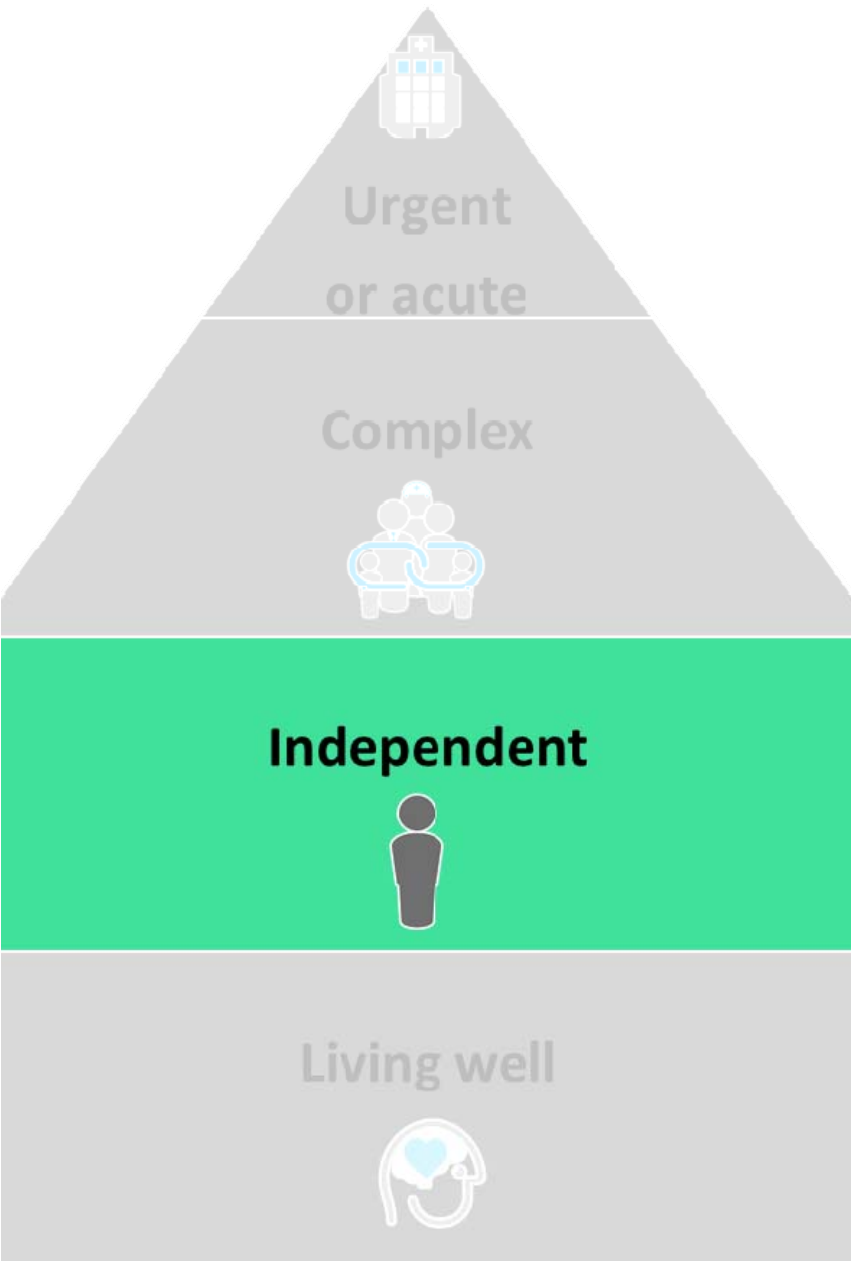
- Increasing access to advice, support and mutual aid for all
- Support to vulnerable people such as homeless people or those with mental health issues
- Provision of support to families of people with alcohol or substance misuse problems



# Living well: promoting healthy living

Early intervention	Social isolation	Suicide prevention	Screening programmes
<p>In taking a life course approach, our focus is working with expectant mothers and families to ensure children get the best start in life. We will focus on antenatal support and the first 1000 days of a child's life. Implementation of the Better Births aspirations through the <a href="#">Local Maternity System</a> will support this and we'll be trialling models to increase continuity of person caring for women during pregnancy.</p> <p>We will focus on healthy pregnancy and support expectant mothers to make healthy choices during pregnancy. This will continue to build on the advice and support locally through <a href="#">Auntie Pam's</a> and the tailored support offered through our Thriving Kirklees service, offering intensive support to vulnerable parents.</p>	<p>Explore the impact of intergenerational work on reducing loneliness amongst older people in residential settings, for example, bringing services such as nurseries, youth clubs, and care homes under the same roof.</p> <p>Our community capacity building work and integrated wellness model will be refocused on social isolation an loneliness in communities, identifying the signs and connecting people into local groups, assets and resources.</p> <p>Proactively engaging with people who are about to retire from paid employment will continue to strengthen our volunteer network and prevent isolation and loneliness in this group.</p> <p>We have access to additional funding through the West Yorkshire &amp; Harrogate ICS to support our work on social isolation.</p>	<p>In line with national aspirations, we aim to prevent suicides in Kirklees and reduce the numbers of people taking their own life by 10% by 2020/21. In Kirklees, the main risk factors for suicide include living alone, being male, being unemployed, misusing drugs and/or alcohol and living with mental illness. Building a partnership approach to tackle suicide is crucial to ensure a population based approach is taken. We have a suicide prevention action plan in place which details our actions across a wide-range of partners to prevent suicide and self-harm locally, underpinning our work collectively as part of the <a href="#">West Yorkshire &amp; Harrogate Suicide Prevention Strategy</a>.</p>	<p>Inequalities across Kirklees mean that there is often a low take-up of screening programmes in our more disadvantaged communities and as a result, poorer outcomes. An increase in engagement and uptake of screening and immunisation programmes particularly in more disadvantaged populations with a focus to diagnose more cancers earlier (Stage 1 and 2) and reduce the number of acute emergency presentations of cancer is a focus for the two local cancer networks, working as part of the West Yorkshire &amp; Harrogate Cancer Alliance. This will include the FIT for bowel cancer screening. Working alongside partners in the West Yorkshire Cancer Alliance, we aim to deliver a new 28 day to diagnosis standard for 95% people investigated for cancer symptoms.</p>





## Independent

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### Our objectives:

- Increase proportion of people with long-term health conditions who feel confident in managing their health and wellbeing
- Increase digital and technological options to support self-care and maintain independence
- Recognise carers as an enormous local asset and create an environment where carers feel confident to identify themselves
- Increase numbers of people accessing secondary prevention programmes
- Provide access to regular care as needed by individuals – including health checks and health management plans where required
- Take a holistic approach to people and support the person rather than treat the condition
- Increase numbers of people with a mental health condition who are supported to live well
- Increase ability of people to access primary care to support their long-term health needs
- Access to planned care support will be user-led and available in a range of different ways

# Independent: maintaining independence

A key focus is to maintain the independence of people and ensure, as far as possible, people have the resources to manage their own health and wellbeing needs. This includes the ability to self-manage their own health conditions, access community based support to maintain resilience and independence and specific actions to ensure the health and wellbeing needs of carers are met.

## Self-care

A crucial part of our strategy is to enable people to manage their own health and wellbeing. To do this we will:

- Ensure that people have access to a range of information and advice to support resources to better understand their health and wellbeing needs
- Continue to develop our established expert patient programmes to support people with a long-term health condition to control and manage their health
- Utilise new digital developments such as apps (My Health Tools and others) and expand our capacity and capabilities in relation to telehealth, telecare and assistive technology to enable people to take control of their health and wellbeing and maintain their independence

## Social prescribing

[Better in Kirklees](#) provides a social prescribing service to adults with one or more long-term health conditions and to unpaid carers, helping to support people to meet their outcomes and connect them to their local community and local services.

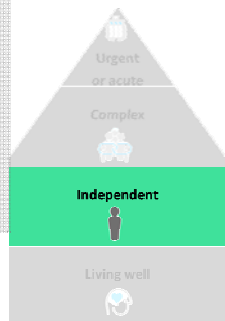
This service can connect people to a range of activities in their communities and improve their physical and emotional wellbeing through opportunities such as art classes, peer support groups, gardening, exercise clubs and social groups.

We will continue to develop initiatives such as Creative Minds which uses creative approaches and activities in healthcare; increasing self-esteem, providing a sense of purpose, developing social skills, helping community integration and improving quality of life. These projects are led by our Mental Health Trust through community partnerships to co-fund and co-deliver projects for local people.

## Supporting Carers

Carers are a fundamental and significant part of our population, with over 60,000 adult carers, and 1 in 12 children with some caring responsibility, the support we offer to carers is vital to ensure that this often unseen support network has its own health and wellbeing needs met, both as an individual and as a carer. We will:

- Embed the Carer's Charter across organisations
- Make Kirklees a dementia friendly place
- Recognise that carers are an enormous local asset
- Support carers to recognise when they are actually carers
- Work with local businesses to help them recognise and support carers
- Support more carers' break schemes
- Enable 'hidden carers' (those not in touch with formal support services) to find support and advice
- Work collaboratively and creatively with carers to address the health and employment outcomes
- Utilise local assets to signpost carers to emotional support



# Independent: improving health and wellbeing

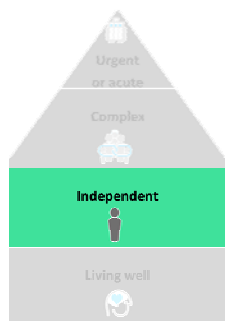
Our focus in supporting our independent population is not only to maintain independence but to prevent further issues developing and people developing more complex needs. This is essential for both physical and mental health and whilst our focus is holistic in supporting people's mental and physical needs, we are continuing to develop specific support in these areas, particularly as we know that people with mental health conditions and learning disabilities are much more likely to experience poor physical health.

## Support for physical health

- To continue and expand smoking cessation support across the health and care system to ensure a Kirklees-wide focus on helping people to quit smoking in every intervention with our services
- Physical activity and healthy diet support / weight management
- In addition to national screening programmes for cancer, we are focused on the early detection of ill-health and support to prevent the development of more serious conditions including:
  - Atrial Fibrillation detection and management to reduce the chances of suffering a stroke
  - Swift cancer / non-cancer diagnosis and support
  - Implementing the national diabetes prevention programme to prevent new cases of Type 2 diabetes
  - Roll-out of Healthy Hearts campaign to prevent Cardiovascular Disease, learning from the success of our colleagues in Bradford
- For people identified as having low to moderate frailty, we are rolling out a programme (starting with a pilot in North Kirklees) to provide 'Companions to Care', supporting people to navigate through the health and care system and prevent social isolation and loneliness
- Continue to raise awareness of health checks and ensuring accessibility of health checks for those communities where we know take-up is low
- Access to primary care has increased and extended GP access provision will expand to 100% of the Kirklees population by October 2018, making appointments at the GP surgery easier to obtain in a timely way

## Support for mental health and emotional wellbeing

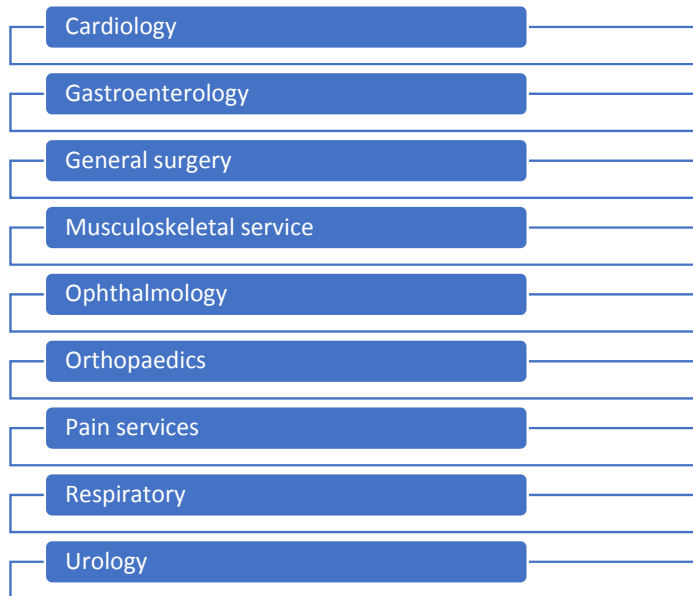
- We have expanded the Improving Access to Psychological Therapies (IAPT) service to improve access for people with low level mental health issues, to ensure more people can get the support they need in line with the national standard waiting time and will continue to develop the service to ensure that this is meeting the needs of the local population, particularly those people with long-term physical health conditions.
- Increased funding and therefore access to assessments for Autistic Spectrum Conditions (ASC) to ensure people get the support they need
- We are launching a one-stop shop phone service for children and young people with emotional and mental health needs
- Piloted a scheme to provide support to school pupils with autism and mental health needs
- There are a range of statutory, voluntary and third sector early intervention and prevention as well as recovery-based services for service users and their carers in Kirklees. The Kirklees Recovery College is a key part of this work. We will continue to develop these services to meet the needs of service users and carers across the borough. By focusing on these services, we aim to reduce crisis episodes and development of more complex mental health and wellbeing issues.



# Independent: Outpatient Transformation

While more and more care for long-term conditions is done in primary care, there are still large numbers of outpatient 'follow-up' appointments every year where people return to hospital to have their progress reviewed, or undergo regular tests and obtain results. Working locally and as part of the West Yorkshire and Harrogate Health and Care Partnership, we are focused on how a large proportion of this work could be done differently with care provided closer to home either through an appointment with the GP or at a community service, telephone calls and online consultations. This should free up time for the treatment of new people, and would save people time and money by not having to travel to hospital when they don't need to.

In Kirklees, we work on outpatient transformation across our two hospital footprints with partners in Calderdale and Wakefield respectively. Both Trusts are reviewing and redesigning the outpatient offer, working with clinicians across primary and secondary care and working with patients and service users. Key aspects of both programmes is the use of **e-consultation and virtual care solutions, managing capacity and demand**, and **referral support**. Given the significant number of specialities and large volume of activity, some specialities have been prioritised initially for review and redesign:

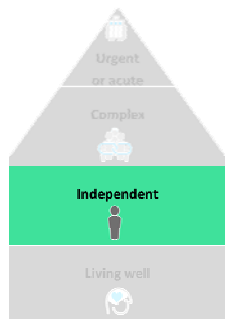


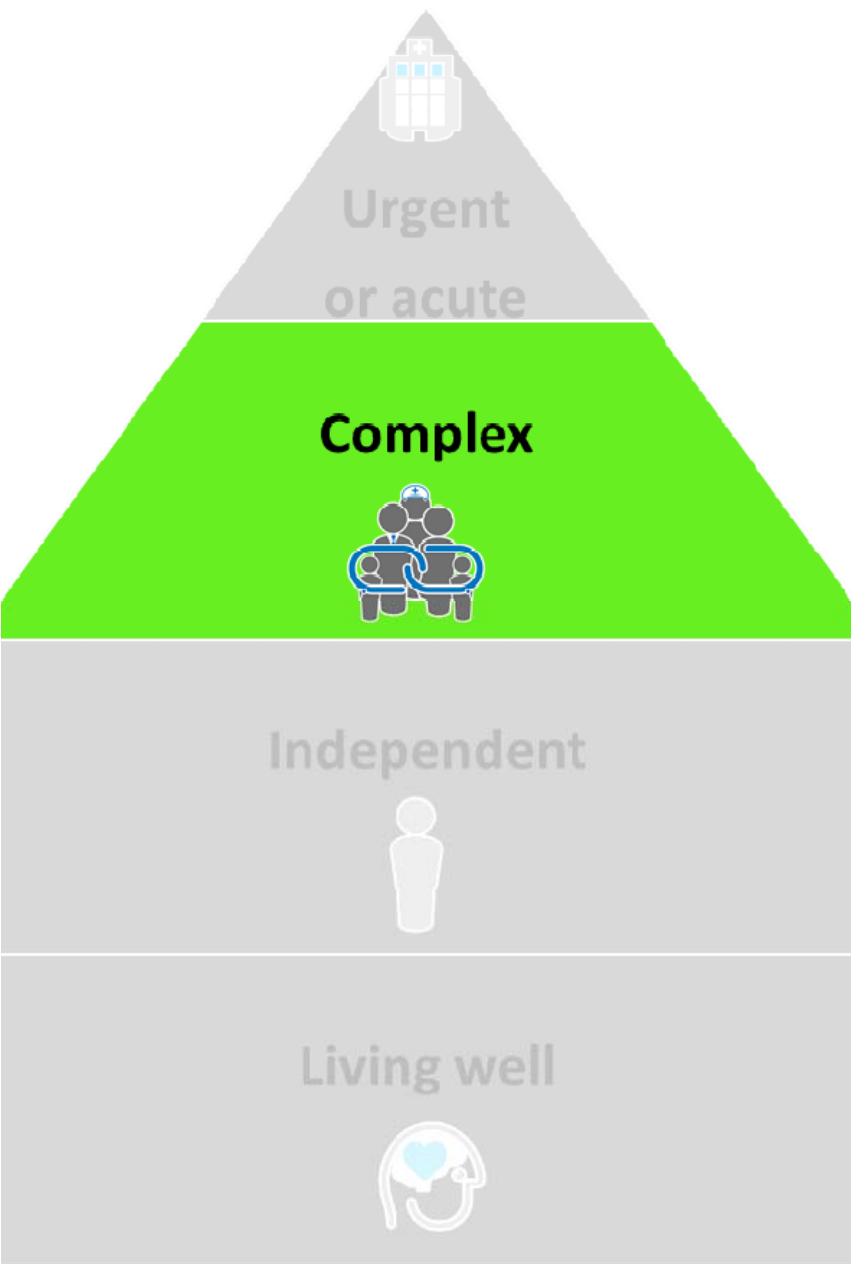
## Cardiology: Rapid Access Arrhythmia Clinic

The one stop rapid access arrhythmia clinic enables patients to be seen quickly by a highly skilled multi-professional team, having their consultation, investigations and diagnosis in one visit to the hospital. This reduces the need for multiple unnecessary appointments.

### Key aspects of this service are:

- It provides quick access - patients are seen within two weeks
- Investigations are done the same day
- There is prompt diagnosis and treatment
- Consultations include lifestyle advice & guidance and signposting to other services
- Patients leave with an individualised long-term management plan





## Complex

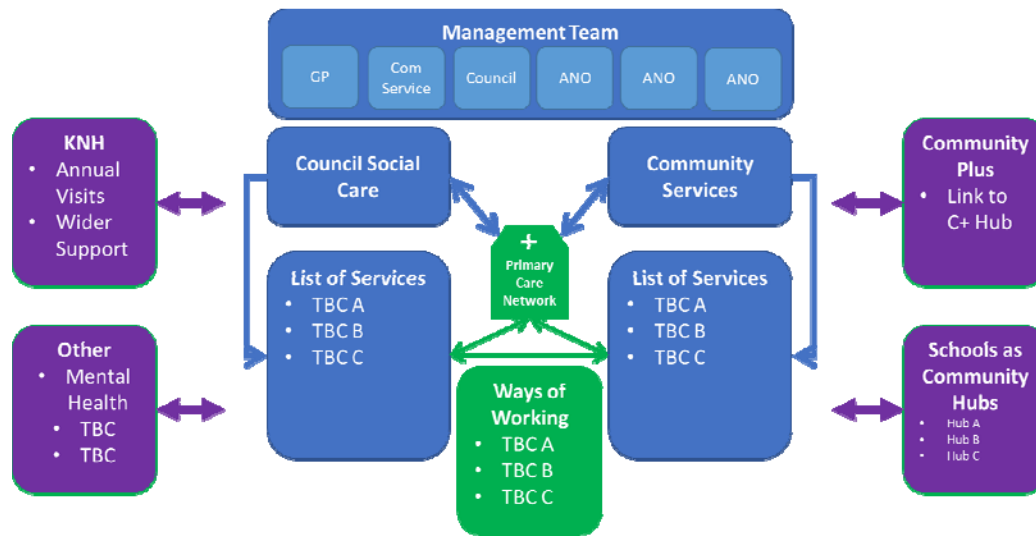
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### Our objectives:

- Integrate health, social care and wider community based services to provide seamless support to complex individuals in the community
- Improve the outcomes of people with complex needs through better coordination of services and continuity of care
- Increase numbers of people supported in the community rather than a hospital setting, where appropriate
- Get people home sooner with the right support, following a stay in hospital, acute mental health wards, or intermediate care services
- Increase numbers of people receiving rehabilitation support alongside reablement to prevent hospital admission, or following hospital admission
- Increase numbers of people supported in care homes where this is their place of residence, rather than admitted to hospitals and acute mental health inpatient facilities unnecessarily
- Improvement in the quality of care pathways for patients at end of life and their families, ensuring best value for money, and reducing duplication across services
- Increase proportion of people who are able to be supported at home, rather than admitted to care homes and nursing homes
- Increase numbers of people in control of their support through personal health and care budgets
- Increase numbers of people with a learning disability and/or autism living in the community



# Community based support and delivery system: Primary care networks



Delivery of place based systems of care is one of our five Kirklees priorities. These 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.

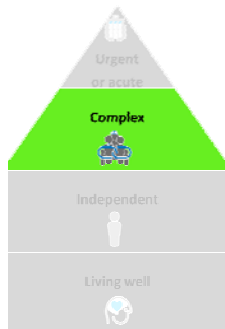
It is expected that there will be nine of these in Kirklees covering the whole population.

We will work with our staff and communities to identify 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.

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 diagram shows 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.

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.



# Strengthening primary care

In order to create a primary care networks model in nine local communities, we need to ensure that we have resilient primary care services to work with, and wrap services around. General Practice in particular is under significant demand pressure, coupled with some challenges to the workforce. The business model across wider primary care services has often made engagement at a Kirklees level difficult. A focus on populations of 30,000 – 50,000 will mean that these partners are better able to engage in service development in their local communities

## Creating resilience in General Practice: work to date

- Developed GP Federations (a single federation in each of NK and GH)
- Invested in the infrastructure of the federations using the £3 per head funding available to CCGs
- Created GP networks which support our plan for geographically based primary care networks (led by the GP Federations). These have been agreed with GPs in Greater Huddersfield
- Implemented extended access to planned and urgent GP appointments (covering 50%+ of the population)
- Commenced support for implementing the 10 High Impact Actions in General Practice
- Implemented new roles e.g. clinical pharmacist time for all 37 practices in Greater Huddersfield

## Creating resilience in General Practice: future work

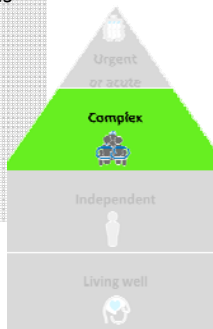
- Finalise the GP networks in North Kirklees around which to build the primary care networks
- Implement extended access to planned and urgent GP appointments (covering 100% of the population by October 2018)
- Roll-out of programme of hands on support to practices to implement the 10 High Impact Actions in General Practice (led by the federations)
- Full roll-out of the Referral Support System (OSCAR and TRISH) across practices in North Kirklees
- Using transformation funding, enable GPs and new primary care networks to engage and co-produce the primary care network model with wider partners and communities

## Engaging wider primary care services

In addition to the significant role general practice has to play in the development of integrated care models, there is a significant opportunity to ensure closer working with wider primary care services in building resilient, connected and vibrant communities, shaped around local populations and networks of 30,000 – 50,000 population including:

- Community pharmacy
- Community optometry
- Community dental services

There are 99 pharmacies across Kirklees (plus a further nine distance selling). The [Kirklees Pharmaceutical Needs Assessment 2018 -2021](#) found that there is a reasonable and adequate choice in all areas, when examined by Council wards. Pharmacies are valuable assets in the local community with skilled staff able to offer advice and support as part of the wider health and care economy.



# Integrated care models for the whole of Kirklees

Alongside developing primary care home within local communities of populations of 30,000 – 50,000 people, we are committed to integrating care for our population with complex needs on a Kirklees-wide basis. There are a three key areas in which we're working on delivering integrated services for people with complex needs:

## An integrated model for end of life care

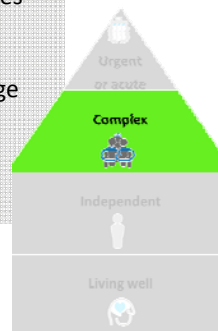
- Led by Kirkwood Hospice, an End of Life Provider Alliance will be established to support the delivery of an integrated package of community end of life services across Kirklees, to meet the needs of people requiring end of life care and their families and carers.
- The expectation is that this will support further improvement in the quality of care pathways for patients and families and ensure best value for money and reduced duplication across services.
- Whilst some services will be delivered across a Kirklees footprint, there will also be a focus on delivering services through local neighbourhoods of 30,000 – 50,000 to support the needs of those communities
- Through this model, we will ensure that as many people as possible have the best chance of dying in their preferred location
- By working in an integrated away, we will reduce the number of gaps in service provision and increase clarity of services for people using services and wider stakeholders.

## An integrated model for intermediate care and reablement

- A joint intermediate care and reablement draft model has been developed with commissioners and providers
- This 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.
- There is 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 will be an expansion of existing community reablement services, with investment into reablement services to provide rehab support workers for daily rehab.
- There will be a dual role for reablement support workers (rehab and home care support) with additional therapy support to care for a further 20 patients at home. The service will provide a step down from hospital and step up from primary care

## An integrated model for care homes support

- We are commissioning a new proactive and reactive service to individuals within care homes through a multi-disciplinary care home support team.
- This will also include physical health, social care with the addition of 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 service for people living in care homes will be the ability to be supported in the place they live and achieve their outcomes
- The impact of the service for the system includes reductions in non-elective admissions and readmissions to both acute and mental health inpatient beds, and will support timely discharge from inpatient services.



# Supporting people with complex needs

## Children with complex needs

- Implement a model to ensure that children and young people who have an Education, Health and Care Plan receive integrated, seamless support covering the whole spectrum of services, e.g. educational support, therapy services such as physio and speech and language, mental health services, personal budgets, ensuring a continuum of support to improve outcomes
- Delivery of an all age disability service model and outcomes outlined in our [Children with a Disability Health and Social Care Commissioning Strategy](#)
- Further develop community care for children and young people to ensure early identification of need resulting in the delivery of early interventions which will support families to manage their own health and wellbeing
- Deliver our priorities for children and young people's mental health and wellbeing through our [Kirklees Future in Mind Transformation Plan](#)

## Transitioning from children's to adult services

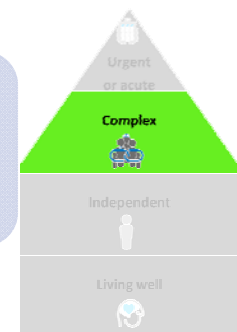
- Around 150 children with a disability or special educational needs (SEN) turn 18 and enter adulthood each year
- Ensure that services provision allows for seamless transition from CAMHS to adult mental health services. This applies in particular to areas of self-harm, eating disorders, ADHD and substance misuse
- Ensure that pathways for Young people transitioning into Adult service in both hospital and primary care are seamless and young person and family focused
- One integrated team approach across all agencies to minimise fragmented care improving pathways for children, young people and families
- Ensuring young people's voices are heard when transitioning from children's to adult services

## Adults with learning disabilities

- Working with our colleagues in Calderdale, Wakefield and Barnsley, our [Transforming Care Partnership plan](#) is focused on:
- Providing support and accommodation in the community, reducing inpatient beds, delivering an almost 60% reduction across the partnership
- Developing a range of specialist community services that are flexible and responsive to manage crisis better and prevent admission
- Developing capable communities to enable people to live in their own homes
- Developing a better understanding of our local populations with complex needs and how best to support them in a crisis
- Ensure people with a learning disability and/or autism have the opportunity to live meaningful and fulfilled lives

## Frail people

- We are developing a Frailty Services across Kirklees, 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 required, and supporting needs of carers. This will ensure:
  - 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.
  - Frail older people have access to opportunities that have a positive impact on their health and wellbeing



# Managing the social care market

Providers of social care support to people in their own homes or in care homes are a vital part of our health and care economy. Our [Kirklees Market Position Statement](#) recognises some of the demographic and financial changes faced by the social care market for current and new providers. Changing demographics which will present both challenges and opportunities for the care market. The value of the care market in Kirklees is estimated to be around £240m with 40% spent by Kirklees Council, 15% by the NHS on continuing healthcare support, and the remaining 45% purchased by individuals funding their own support of varying levels of complexity 'self-funders'. Approximately 10% of Council spending is used for personal budgets and direct payments, allowing people to take control of this funding to purchase their own support to meet their outcomes.

## Our focus in shaping the care market

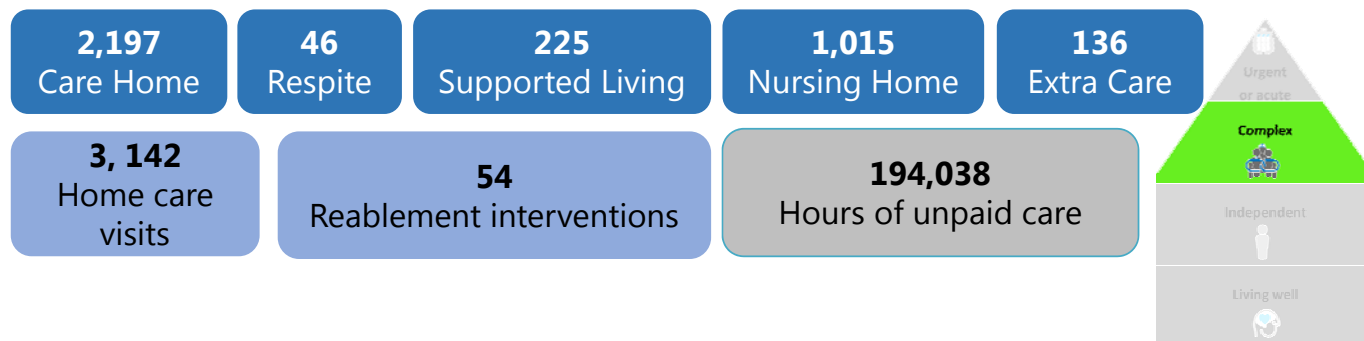
We will support shaping a care market in Kirklees where:

- Personal choice is not compromised in order to fit a service model
- People are easily able to purchase additional support
- There is a recognition of the importance of preventative support
- Investing in new or existing care organisations is encouraged
- There is a positive and person-centred approach to risk that keeps people safe whilst enabling choice and control
- Constant creativity and innovation is seen as the best way to deliver the range of outcomes desired by consumers
- Quality of the interaction takes precedent over completion of a care task
- Breadth of career opportunities in the care sector are known about and aspired to

We're committed to working with our existing and new providers of social care across Kirklees in order to meet some of the collective challenges we face. As well as shaping the market as commissioners, this includes:

- The integrated provider board will establish links with Kirklees care provider forums across care homes and domiciliary care support in order to better coordinate and integrate with these services to improve outcomes for service users and carers
- In addition to specific initiatives such as the new integrated model for care homes which is currently being commissioned, we will continue to work in partnership with care providers, seeking opportunities to upskill the social care workforce and provide appropriate support to enable the best outcomes for our service users
- Working together to ensure the best technology, digital solutions and equipment is available to reduce reliance on visits to people in their own homes
- Developing the capacity in care homes and home care services with a focus on prevention and enablement
- Promoting the personalisation agenda – increasing the number of people in control of their own needs and outcomes through personal budgets and direct payments for social care and health needs

**On a typical day, people are in receipt of a range of social care support (analysis from 03/10/17 undertaken by Kirklees Council)**





**Urgent  
or acute**

Complex



Independent



Living well



## Acute and urgent support

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### Our objectives:

- Where people require urgent, acute or specialist care, this will be the right intervention provided in the right setting in a timely way
- Ensure people can get access to primary care services in a timely way for urgent needs
- People can access urgent hospital treatment when they need it in a timely way
- Ensuring people can be treated closer to home and eliminate out of area placements for non-specialist acute mental health care
- Deliver sustainable urgent and acute services for the population of Kirklees
- Continue to ensure people can return home from hospital with the right support, as soon as possible
- Increase numbers of healthy births, reducing stillbirths, neonatal deaths, maternal death and brain injuries
- Increase alternative safe options for people to access when experiencing a mental health crisis, reducing use of police detention
- Get the best outcomes and reduce variation in outcomes for people who have suffered a serious acute episode e.g. hyper-acute stroke

# Accessing acute and urgent in the community

We are committed to ensuring that as much provision as possible is made available as close to home as possible. For urgent and acute services, this includes:

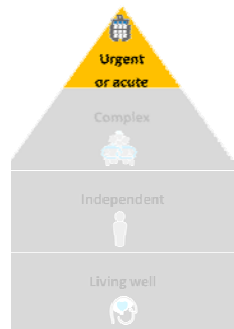
- Increasing extended access primary care – providing more access to GP appointments during core hours, extended hours (6.30 – 8.30 pm) for urgent and planned appointments, as well as provision for out of hours. We will ensure this provision covers the whole population in Kirklees by October 2018.
- 111 online has now been rolled out in Kirklees and we're testing the approach of allowing 111 to directly book people into GP appointments following a contact for an urgent need, this will be rolled out across our practices
- We're working with our partners across Yorkshire and Humber and leading on the re-commissioning of the 111 service to provide an integrated urgent care service across the whole Yorkshire and Humber region which will meet our local requirements in Kirklees
- Provision of a rapid same day response in the community available to people with complex needs for physical health needs, mental health crisis and social care needs
- Delivering early intervention in psychosis services for people experiencing first episode psychosis in line with national standards
- For people experiencing a mental health crisis, our focus is on prevention, and during crisis to support people at home wherever possible including:
  - Maintain and develop a range of crisis care services, including accommodation-based provision, which meets the needs and demands of people living in Kirklees
  - Ensure that there are good and effective crisis care planning processes in place which includes reference to patterns, triggers and capacity
  - Support people to find their own solutions to managing their crises through the use of coping mechanisms e.g. Wellness Recovery Action Plans (WRAP)
  - Implement and develop the actions of the [Kirklees Crisis Care Concordat declaration statement](#)
  - Further develop police liaison work across Kirklees (core 24 service standards)

## Managing demand for hospital services

A large part of our ambition is to continue to develop support in the community or at home, where this is appropriate. A significant proportion of our plans are focused around strengthening primary care and community services in order to offer people the best planned and unplanned care closer to home.

We know that demand for hospital services has and will continue to grow and that this is not sustainable. We also know that there are opportunities to further reduce demand on hospital services through some of our service developments outlined in this plan (including through focusing on prevention and taking an integrated primary care network approach around communities of 30,000 – 50,000 people).

To understand the impact of these interventions, we are undertaking a detailed piece of modelling and analysis during 2018 and are committed to ensuring that hospital capacity is maintained until there is evidence of robust alternative provision in the community.



# Acute and urgent: Local hospital services

Where our population needs access to hospital services, we are committed to ensuring that these are high-quality and achieve the best outcomes for our population, whilst ensuring that these services are sustainable for the future.

## Ensuring quality and safety in hospital care

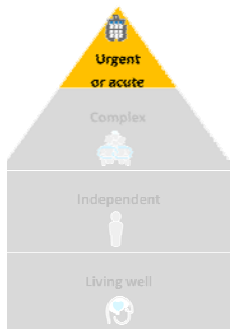
- Ensuring people stay in hospital only as long as they need to by improving our processes in hospital and working with the rest of the system including:
  - Implementing the nationally recognised SAFER bundle on hospital wards which improve outcomes for patients and support reductions in length of stay, ensuring people are not waiting in hospital beds unnecessarily.
  - Continuing to make improvements in relation to delayed transfers of care, including implementing the eight high impact actions and focus on operational and strategic system working through our A&E Delivery Boards
- We are focusing on delivering improvements in maternity care in safety towards the 2020 ambition to reduce stillbirths, neonatal deaths, maternal death and brain injuries. This includes full implementation of the Saving Babies Lives Care Bundle working through our Local Maternity System across West Yorkshire and Harrogate.
- Delivering support for people in our acute hospitals experiencing a mental health crisis through implementation of mental health liaison services and CORE 24 standards

## Sustainable hospital services

There are some real challenges facing our local hospital services in terms of sustainability, particularly given the availability of workforce with the right specialist skills.

This means that some services need to be consolidated in order to ensure that services are safe, of high quality and sustainable for the future. Alongside the need to work within the tight financial envelope, the condition of some of our hospital estate, and the opportunities open to us through advances in healthcare, means that the current way we provide hospital services to our local population needs to change. We are continuing to develop our proposals in this area.

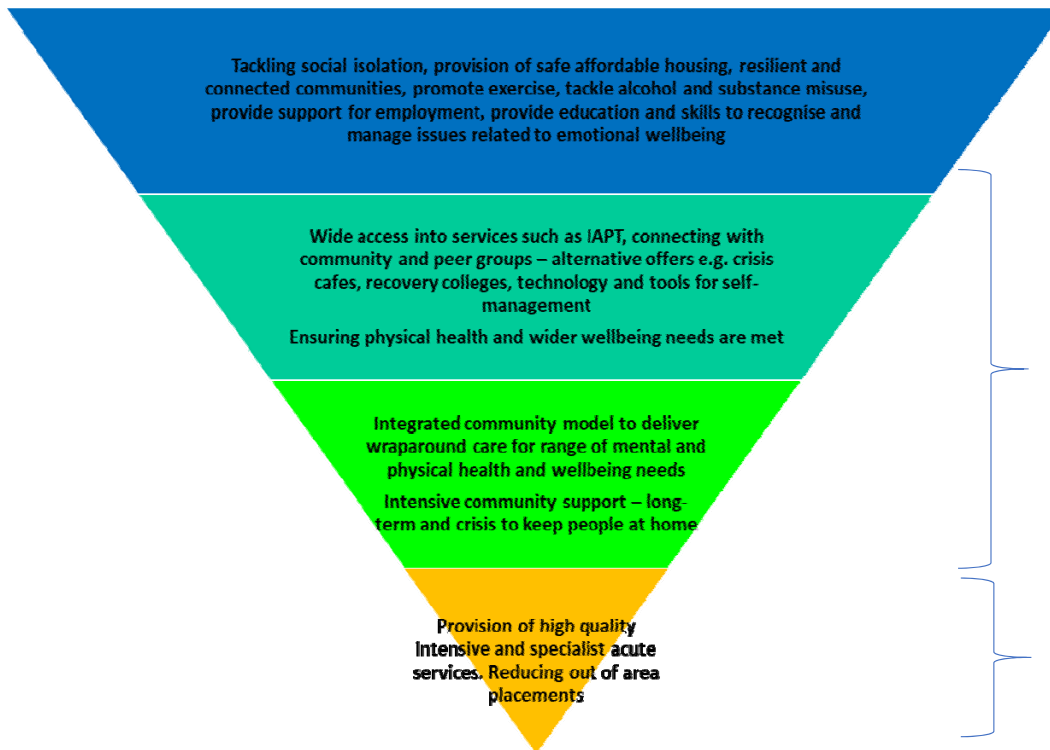
Given some of the workforce challenges facing us, we are working with partners across West Yorkshire & Harrogate through the West Yorkshire Association of Acute Trusts (WYAAT) and the West Yorkshire Mental Health Services Collaborative, in order to ensure sustainability of high quality acute clinical services for the population in Kirklees and across the region through clinical networks, eradicating any existing unwarranted variation in outcomes. This includes some of the ICS priority workstreams – mental health, stroke and cancer (through the West Yorkshire & Harrogate Cancer Alliance). We've recently taken this collaborative approach in order to ensure the sustainability of vascular services across the region.





# Acute and urgent: working regionally to achieve the best outcomes

We know that for many of our acute services, we need to plan on a wider footprint than in Kirklees. This is a key area of focus in our involvement with the Integrated Care System, to bring the best outcomes for Kirklees and West Yorkshire and Harrogate as a whole. All our energies will be focused on prevention at primary, secondary and tertiary level, however there are times when our population in Kirklees will need access to specialist acute support on an urgent or planned basis. Our objectives for acute services is to ensure that people get the best possible treatment, achieve the best outcomes and that support after an acute intervention is provided as close to home as possible.

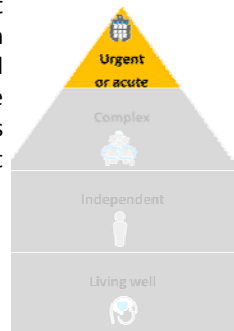


Local priorities with locally led planning and delivery (with support from WY&H ICS infrastructure)

WY&H ICS led planning and delivery, through partnerships representing local places

The diagram 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, 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 level to achieve the best outcomes for the Kirklees population and the West Yorkshire & Harrogate population as a whole. This planning and delivery is a partnership between local places – for providers through the Committee in Common of the mental health trusts operating across the ICS, and through Joint Commissioning arrangements of the CCGs and in conjunction with NHS England as responsible 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 support as close to home as possible.

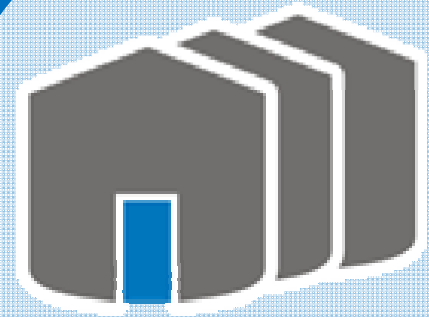




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**Enablers**



# Our People: Communities

Fundamental to the delivery of our ambition is working with our biggest asset, our people, to best effect. Supporting development of connected, resilient and vibrant communities is crucial to this.

## Changing the conversation: assets, strengths and responsibilities

To support us to start, live and age well, we need to have different conversations with our communities about how they can manage their own health and wellbeing, building on their own strengths and assets.

In order to support this, we need to ensure people have the resources to manage their own health and recognise their strengths and assets. This will mean different conversations with communities (through resources like Community Plus and the Integrated Wellness model) and with individuals, ensuring that all our services are taking a strengths-based approach to assessment and support and maximising self-management and independence.

As well as raising the profile of our priorities around those factors which determine our health and wellbeing, we need to focus on raising the health literacy of our communities experiencing the poorest health and wellbeing. By improving people's access to health information and their capacity to use it effectively, health literacy is critical to empowerment.

## Co-production

Fundamental to our plan is to put people and our communities at the centre of all we do, starting from planning and design of services. We know that where we involve the people who use services in the design of these services, we get the right outcomes. We are experienced in engaging and consulting our population about the services they use and our ambition is to enable our local communities to co-produce any changes and influence design and development of new models of care.

We want to work in a way that is open and transparent, ensuring that we have meaningful conversations with people on the right issues at the right time.

We're committed to:

- Involving our communities in the design of services
- Using information we've already obtained locally through extensive engagement and consultation exercises
- Working with our partners in the voluntary sector and Healthwatch Kirklees to get this approach right
- Undertake formal consultation and engagement where appropriate on any major service change.



# Our People: Workforce

People	Number
Volunteers	86,000 (1 in 4 adults)
Voluntary organisations (registered)	100+
Voluntary organisations (unregistered)	1000+
Unpaid carers	60,525
Paid health and social care workforce	20,573*

## Addressing our workforce shortages

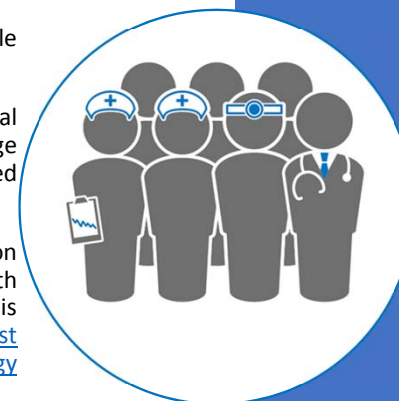
We know from our organisational and sector based analysis that there are significant issues in terms of training new workforce, retaining our existing workforce and an ageing profile in many areas.

In order to think differently about how support can be provided we have trialled new roles including nurse associates (in Mid-Yorkshire Hospitals NHS Trust), physicians associates (in Calderdale and Huddersfield NHS Foundation Trust) and Allied Health Professionals in primary care. We will continue to develop and expand these approaches.

We want to ensure our staff have the ability to work together across organisational and professional boundaries.

Our focus will be on shared vision, values and behaviours across Kirklees. We will work together to identify what this looks like and shape this into a coherent programme of workforce induction and training. Integrated models of care will fundamentally require people to work differently from their prescribed roles, to make this a success requires:

- Co-production of these models with staff who deliver support to people in Kirklees, empowering staff to act to deliver the best outcomes
- A programme of development to support staff and operational managers to work within the new integrated framework, challenge barriers to integrated working, and adopt an asset and strength-based approach to support planning
- A workforce strategy for Kirklees which identifies our vision, common values and behaviours that those supporting people with their health and care should exhibit, including delivery methods for doing this. This will build on our local vision for Kirklees developed as part of our [West Yorkshire & Harrogate Health and Care Partnership Workforce Strategy \(2018\)](#) and local initiatives we are already implementing
- Establishment of a Kirklees workforce group to oversee workforce developments in Kirklees and to take a single approach to, for example, engaging with Huddersfield University with regards to future training and workforce requirements. This will have strong links to the [Kirklees Skills Strategy](#) and action plan.
- Build on testing of new roles in Kirklees like nurse associate, physicians associates and use of allied health professionals such as physiotherapists, pharmacists and OTs in primary care, working with our Local Workforce Action Board (LWAB) to support us to manage our workforce challenges.



\*Estimated direct FTE employed in health and social care activities in Kirklees (analysis undertaken by Kirklees Council, March 2018)

# Digital: Enabling people to be independent

Using digital technology to make people's lives easier is one of our five priorities in Kirklees. We know that technology has revolutionised our lives and ability to managing our affairs independently and remotely. The same principles apply to our health and care. Significant developments are taking place nationally and internationally to use technology in health and care.

We believe that technology can support people to manage independently, allowing people to take control of their own needs and lead their own support.

We have been piloting an app library run by the mental health trust (SWYFT) in partnership with ORCHA, an organisation which runs the library and quality assures all the apps available for use so clinicians and people using the site know these are all approved. ORCHA has been awarded NHS innovation accelerator status.

The site has been piloted in Children and Adolescent Mental Health services (CAMHS) to support children and young people to self-care and understand and manage their own conditions. The site can be accessed by people using the service (self-access) or via a referral from a professional in the service. Take up and feedback from professionals during the first three months has been good.

The pilot has been extended to further test the impact and outcomes for service users and to expand the library to provide resources for early intervention in psychosis, smoking cessation and the Recovery College.

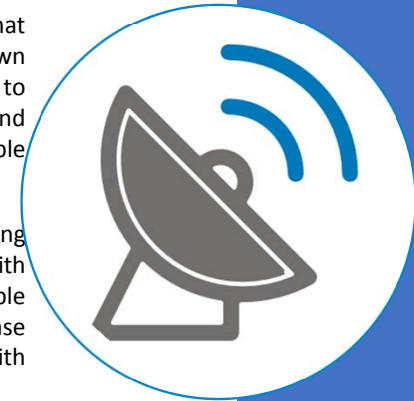
Through our involvement in the ICS, we have access to [support](#) from the Yorkshire and Humber Academic Health Science Network which has a number of nationally recognised evidence-based programmes to support improvement in care. A number of these offer opportunities for self-care including *My Diabetes, My Way, My COPD, Me and medications*. We also have a range of digital offers through My Health Tools.

We are committed to implementing digital products, such as apps, that have been proven to work and will enable people to manage their own support and conditions independently whilst offering alternative ways to access professional support when required. Increasing availability and normalising these applications as support options, will mean more people are able to manage their health and wellbeing in this way.

Telehealth, telecare and assistive technology is an area which can bring huge benefits to service users, for example in allowing people with dementia to remain independent and supported at home, or for people to monitor their conditions independently. It can often also increase efficiency, reducing costs for direct care and providing the system with greater capacity.

Through our outpatient transformation programme, we are exploring how virtual consultations and telephone consultations can be used so that people do not need to travel to hospital for an appointment unnecessarily. This will free up time for clinicians to see new people, whilst giving greater flexibility to the person in their follow-up care.

In order to deliver this transformation, we will also focus on the digital literacy of all our communities to ensure there is equal ability to access these solutions.



# Digital: Improving service delivery

Alongside using technology to enable people to stay independent, we know that the right digital solutions can make service delivery more efficient, improve the quality of professional decision-making, and improve service user experience. We're already making progress on our digital infrastructure to support this, including:

- Acute clinicians can view patients' acute clinical records.
- Primary care clinicians can view clinical records across different practices which use the same system.
- Access to view clinical records for all patients across all practices is due to be complete in August 2018.
- Primary care clinicians can view patients' acute medical records
- Following a successful pilot, implementation of technology to allow Acute clinicians to view patients' primary care medical records is underway and due to complete in 2018 and will support the roll out of electronic advice and guidance (GPs seeking secondary care advice electronically).
- GP Practices can allow patients to undertake task related functions such as booking/amending/cancelling appointments and requesting repeat prescriptions online.
- A number of GP Practices allow Patients to directly book GP appointments through 111. This is planned to be extended.
- A number of GP practices support patient/clinician online consultation and this is planned to increase.
- Remote and flexible working for GP staff is supported through provision of laptops and access for patients and wider workforce through GP Wi-Fi.
- The mental health trust is now moving to SystmOne which will provide greater opportunities for sharing records across services

## Interoperability and shared care records

West Yorkshire & Harrogate ICS, working as part of the wider Yorkshire & Humber footprint, has been successful in attracting £7.5m to support the joining up of health and care records as part of the Local Health & Care Records Exemplar (LHCRE) programme. A shared care record is a key enabler to support the delivery of integrated care, this will:

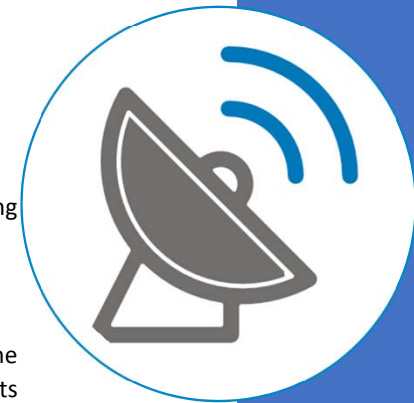
- Increase efficiency
- Improve decision-making and safety
- Improve service user experience (telling your story once)

The roll-out of the EPR system in parts of Kirklees will be a key learning and building block for our LICRE programme.

## Working more efficiently through digital technology

We are reviewing a range of digital solutions to support us in the deployment of staff e.g. in delivery of extended access GP appointments and home visits which will support us to create capacity in the system to see more service users.

We will review our current multiple contact point arrangements and identify how these can be rationalised or more integrated through different technological platforms, to improve people's outcomes and experience when contacting services. Alongside this, in order to support integrated and neighbourhood based working, we will need to develop a comprehensive directory of services (DOS) available to the public and to professionals in order to ensure the full range of services and assets in communities are available for people to view and access.



# Estates and assets

We hold a wide range of estates and assets across key partners in Kirklees. We know not all of this estate is bringing good value and some of this estate is not fit for purpose to deliver our vision for integrated community care in the future, as well as high quality acute services.

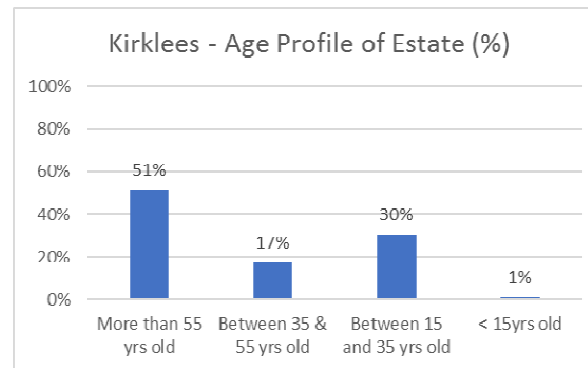
We have already commenced a process to review all of our estates across partners to understand our available resources in each of our communities. As well as developing a Kirklees Estates strategy for the future, we will identify how better we can use our assets through some of our priority initiatives like the early adopter sites for primary care home and the new integrated intermediate care services. In these cases, our estate will be used to support integrated working across organisations and teams and consider how our assets can generate social value in building strong, resilient communities e.g. sharing space with voluntary and community sector organisations.

Our neighbourhood approach (and the primary care network model) provides us with an opportunity to test some of our key principles in relation to our estate, including:

- How we can share estate to support integrated working across staff teams
- How we can use our estates in neighbourhoods of 30,000 – 50,000 to meet the needs of the local population
- How we can use our estate to generate social value and stimulate the growth and embedding of resilient, connected and vibrant communities.

## Our current estate and assets

An analysis of NHS Trust (acute and mental health facilities has been undertaken). Over 68% of this estate is over 35 years old. Similarly, we know much of our community and general practice estate is not fit for the future. We are currently undertaking a detailed piece of work, led by Kirklees Council to map the full range of our public sector estate across Kirklees which will provide us with a valuable baseline.



## Future integrated community assets

Our vision for the future is that our community resources will be built to provide communities with a wide-range of services and support, not just health and care interventions, but a wider range of community services to serve a much broader range of wellbeing and social connectedness needs. Taking inspiration from national models which have worked well, we will outline our vision for the future across partners and assess our ability to access capital to support this development.

We will establish a Kirklees forum to review our collective assets, agree a future vision and a plan to deliver this.



# Population health management

Population health management is seen as a key tool deployed in an Integrated Care System (ICS), which has most value when used to plan and deliver services within a place base. Kirklees sees this as a valuable tool in developing the planning and delivery of health and care services in the future. Our commitment to starting our planning process from population needs provides us with a solid base from which to use population health management tools.

## What is population health management?

Population Health Management improves population health by data driven planning and delivery of care to achieve maximum impact. It includes segmentation, stratification and impactability modelling to identify local 'at risk' cohorts – and, in turn, designing and targeting interventions to prevent ill-health and to improve care and support for people with ongoing health conditions, and reducing unwarranted variations on outcomes.

Through our involvement in the ICS development programme as part of the West Yorkshire & Harrogate Health and Care Partnership, we are part of a Communities of Practice in this developing area, working with national bodies including NHS England and Public Health England (PHE).

We will initially complete a self-assessment of our system maturity to deploy population health management during 2018/19 including infrastructure (leadership, population definitions, information governance, digital maturity, digital infrastructure), intelligence (supporting capabilities, analysis, reporting and decision management support), and care design (change support, workforce and leadership development, scaling innovation, patient empowerment and activation, care integration incentives, behavioural insight.)

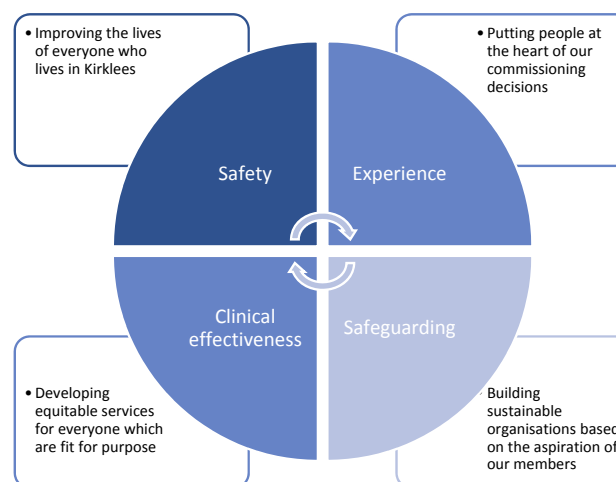
Through the ICS, Kirklees can share learning and access support and best practice locally and from national bodies to deliver the approach in Kirklees.





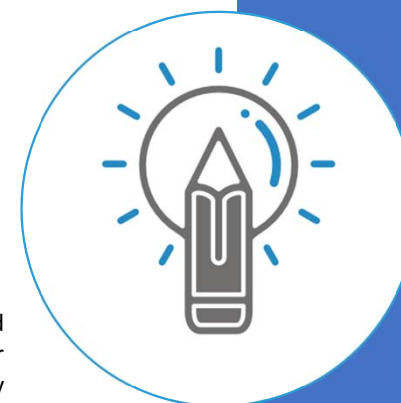
# Integrated commissioning

- There is a longstanding commitment in Kirklees to work collaboratively across the two CCGs and the Local Authority. This has taken the format of formal joint posts across health and social care, integrated governance to support development and delivery of the Better Care Fund and informal collaborative working to commission services in a number of areas, for example, children and young people inclusive of education and learning, mental health, care closer to home and hospital avoidance. Together we have created an Integrated Commissioning Strategy to underpin delivery of integrated commissioning in Kirklees, to support this plan
- The two CCGs which commission health services for the population of Kirklees (Greater Huddersfield CCG in the South of the Borough and North Kirklees CCG in the North) are now working together much more closely. The two CCGs are now operating with a joint management structure.
- We recognise that often commissioning is as fragmented as service delivery and in order to deliver our priorities, services will need to be commissioned differently to support us to achieve the Kirklees outcomes. The testing of new models of support such as primary care home, will support Commissioners in identifying where commissioning does not enable integrated provision and inform how new models of integrated care can be commissioned in future to achieve the best outcomes for the population of Kirklees.
- For those services which are provided on a wider-footprint than that of Kirklees, we work with neighbouring commissioners through formal joint structures to commission services in the best interest of Kirklees (for example the West Yorkshire and Harrogate Joint Committee of Clinical Commissioning Groups)



Improving **quality of care** is central to our approach and taking a unified approach to quality is central to our integrated commissioning strategy. This will link closely with providers of health and social care, including independent sector partners like care homes.

As part of the West Yorkshire and Harrogate Health and Care Partnership, we are a national demonstrator site acceleration of implementation of the **personalisation and choice** agenda. We have assessed our current position and are now focused on increasing personalisation and choice and extending access to personal health budgets across a range of provision including continuing healthcare, and for children and young people with complex needs.



# Funding flows and sustainability

## System recovery and financial sustainability

- The Kirklees health and care economy is financially challenged. Whilst this presents a significant task to address, the partners across the system are committed to tackling the underlying financial deficits in order to reach financial balance and ultimately sustainability. This is part of the core business of each of the organisations, and the service improvement agenda to drive changes which improve quality, cost efficiency and productivity.
- As with our operational and strategic planning, we work together where it makes sense to do so, on the most appropriate footprints. Given that the majority of health care expenditure is currently spent on hospital care, we have been working together across the acute hospitals and with our neighbouring CCGs, in Calderdale and Wakefield respectively, on system-based recovery.
- We have negotiated aligned incentive contracts for 2018/19 with both hospital trusts operating across Kirklees to ensure that financial risk is shared and owned by the system. This is a new approach.
- We have system and organisational recovery plans in place to support return to financial balance, agreed with NHS regulators.
- The new funding deal for the NHS will see funding rise by between 3.1% and 3.6% for five consecutive years from 2019/20 onwards, however there has been no funding deal agreed for social care and there is no planned increase to Council budgets.

## Funding transformational change

Our development as a West Yorkshire & Harrogate Health and Care Partnership has been recognised nationally and the Partnership is now part of the ICS development programme. This brings a number of opportunities, including access to transformation funding.

The ICS has secured £8.9m of transformation funding during 2018/19 which has been agreed by the partnership to be distributed to key priorities in the system around primary care network development, UEC and engaging communities.

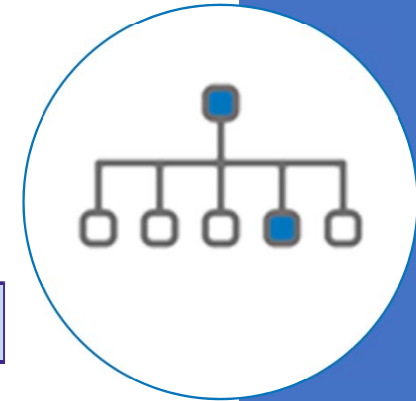
Whilst the financial position of the health and care economy in Kirklees is challenging, access to transformational funding will allow us to move ahead with our priorities at a greater pace, with the capacity required to ensure that these priorities are progressed without undermining service delivery and quality during this transformational process.



# Governance and decision-making in Kirklees

In order to deliver our ambition and priorities for Kirklees, we recognise the need for strong governance and decision-making structures to support this. The Kirklees Health and Wellbeing Board will provide the strategic leadership as the statutory body with responsibility for health and wellbeing in Kirklees. To strengthen the place-based governance arrangements, we have established the Kirklees Health and Care Executive Group with representation from the Chief Executives of the main health and care commissioning and provider organisations in Kirklees. Integrated commissioning across the Council and CCGs is led by the Integrated Commissioning Board and providers have come together to drive forward Kirklees priorities as an Integrated Provider Board, representing health, social care and third sector organisations. This is based on a partnership approach and does not replace or supersede statutory responsibilities of the partner organisations.

We are committed to involving our communities and our workforce in the design of services and delivery of our ambition for the health and wellbeing of the population of Kirklees. As part of this, we will ensure openness and transparency in all of our discussions.



# Governance and decision-making: working as an ICS

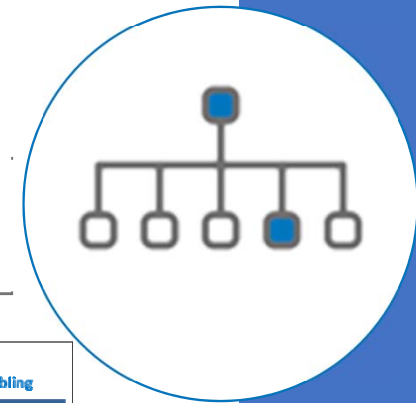
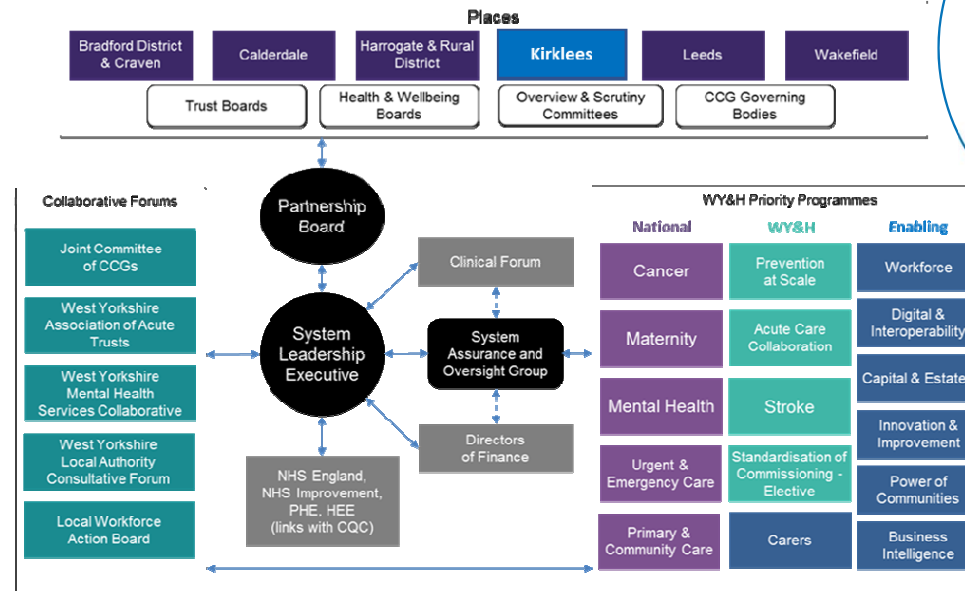
A key part of delivering this plan and our ambition for the population of Kirklees, is working as part of the West Yorkshire & Harrogate Health and Care Partnership to deliver our priority programmes. The developing Integrated Care System is built on partnership governance arrangements and the principle of subsidiarity, in that the Partnership serves local places and supports local improvements. We apply three tests to identify where we need to work together on an ICS rather than at Kirklees only level, these are:

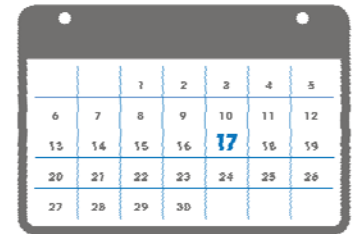
- Do we need a critical mass beyond the local level to achieve the best outcomes? – for example cancer or stroke services
- Will sharing and learning from best practice and reduce the variation in some outcomes for people across different areas? – for example the Wakefield Health and Housing partnership; the Kirklees model of identifying and supporting carers
- Can we achieve better outcomes for people overall by applying critical thinking and innovation to challenging issues? – for example establishment of ‘primary care networks’, or workforce issues.

The diagram outlines the ICS governance and accountability relationships. Kirklees, like the other places in the Partnership, is represented in all of the collaborative forums, partnership forums and within the priority programmes.

Kirklees and the other places within the Partnership are looking at strengthening the relationships through a Memorandum of Understanding. The ICS governance arrangements do not replace or override the authority of the partners’ boards and governing bodies. Each of them remains sovereign and our Council remains directly accountable to our electorate in Kirklees.

In time our expectation is that regulatory functions of the national bodies will increasingly be enacted through collaboration with our leadership within the ICS. It will work by building agreement with leaders across partner organisations to drive action around a shared direction of travel.





# Benefits, outcomes and milestones

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# Benefits and Outcomes

Starting with outcomes enables us to step back from the things we are already doing or commissioning and explore what needs to be done, by whom and with whom to achieve improved outcomes for the citizens and places of Kirklees and the people who use our services. If we achieve the outcomes in Kirklees we will know that people are starting well, living well, and ageing well.

Improving population health and wellbeing through monitoring the delivery of these outcomes will be our focus. Alongside this, all the initiatives and changes across Kirklees to improve population health and wellbeing will be impact assessed for impact and improvements to:

- **Quality of services** (included achievement of local and national standards)
- **Cost and service efficiency**
- **Equality and equity** – ensuring service change does not discriminate or disadvantage people
- **Sustainability**



## There are seven Kirklees Outcomes:



### Children

Children have the **best start in life**



### Healthy

People in Kirklees are **as well as possible** for as long as possible



### Achievement

People in Kirklees have aspiration and **achieve their ambitions** through education, training, employment and lifelong learning



### Safe & Cohesive

People in Kirklees live in **cohesive communities, feel safe and are protected** from harm



### Economic

Kirklees has **sustainable economic growth** and provides good employment for and with communities and businesses



### Clean & Green

People in Kirklees experience a high quality, clean, and **green environment**



### Independent

People in Kirklees **live independently** and have control over their lives

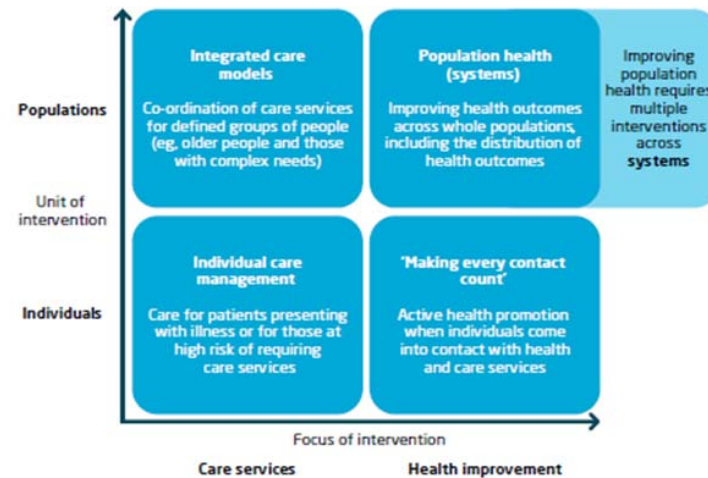
# Measuring system impact

We believe that the health and social care system can have the most potential impact on the following outcomes:

- Children have the best start in life
- People in Kirklees are as well as possible for as long as possible
- People in Kirklees live independently and have control over their lives
- People in Kirklees live in cohesive communities, feel safe and are safe/protected from harm

However, achieving these outcomes is significantly influenced by progress on the other outcomes, and that the system also has a role in contributing to these e.g. as a major employment sector contributing to sustainable economic growth and good employment and therefore all outcomes are relevant to the improvement of health and wellbeing of the population in Kirklees.

In order to focus on quality and outcomes for people, we need to shift the focus from measuring activity in the system to a more outcomes based approach. These draw on some existing performance measures (national and local) and build in new elements in order to shift the focus.

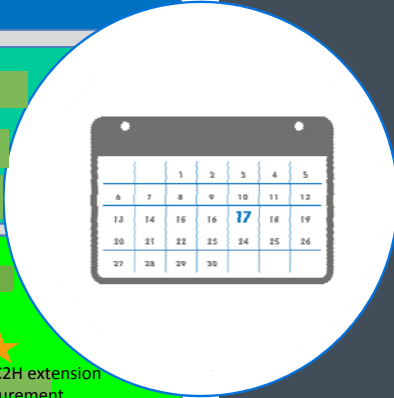
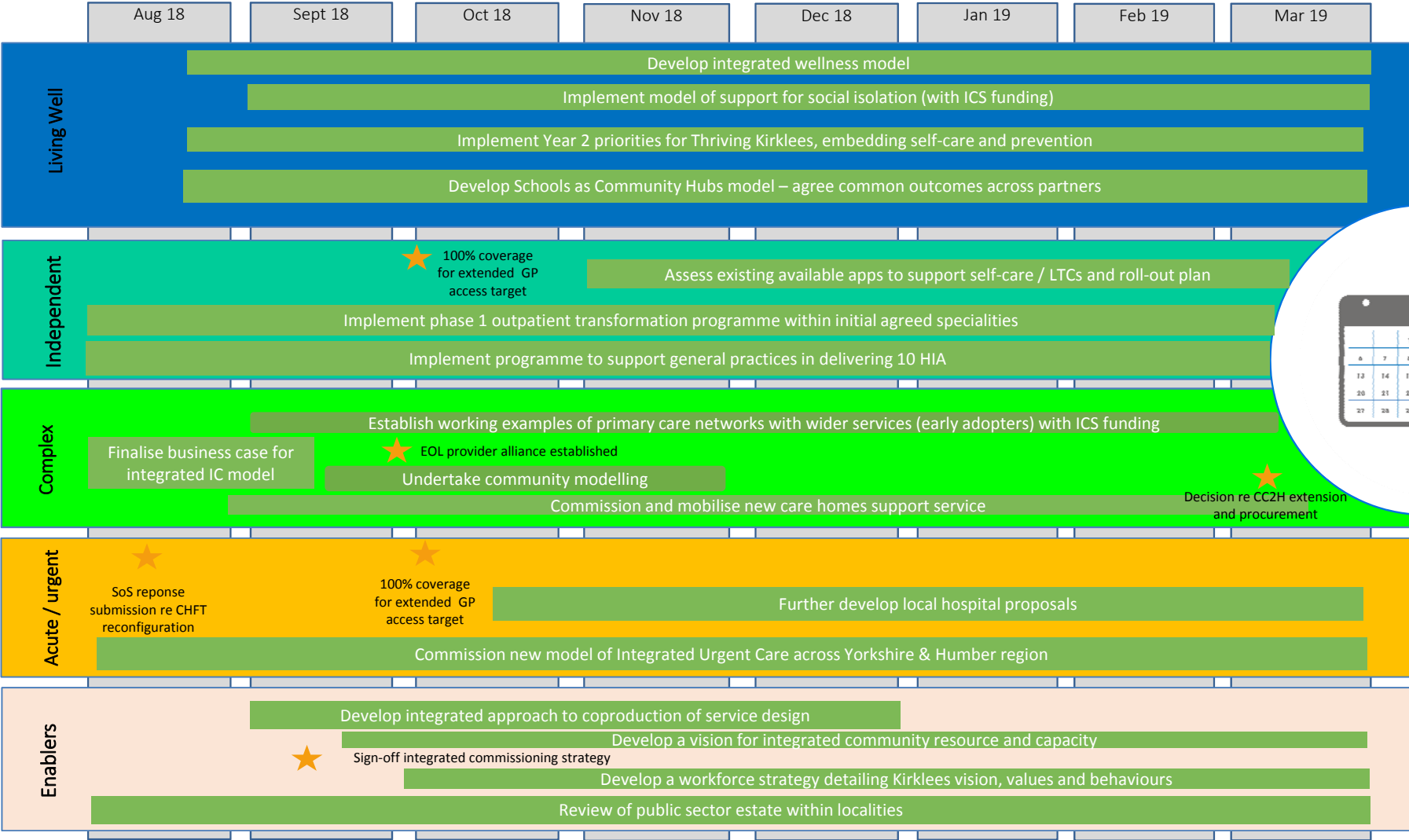


We are developing an outcomes framework which builds from the seven Kirklees Outcomes:

- Population indicators
- Supplementary indicators
- Local performance measures / individual outcomes

This has been developed by the Integrated Commissioning Board and will form the basis of how we will measure improvements in health and wellbeing in Kirklees. This will be a tool that commissioners, providers and the Health and Wellbeing Board can use to monitor our progress and will be completed by Autumn 2018.

# Short-term delivery: 2018/19





# Medium-term delivery: 2019 – 2023

