Kirklees COUNCIL


# Kirklees Director of Public Health Annual Report - 2014

# Contents

# Foreword

Welcome to the 2013/14 Public Health Annual Report for Kirklees. All Directors of Public Health are required to produce an independent annual report on the health of their population, highlighting key issues.

In recent years the Joint Strategic Needs Assessment has provided that annual information. This year, Dr Judith Hooper, Kirklees Director of Public Health, has produced a separate Annual Report to focus attention on the Joint Health and Wellbeing and Economic Strategies, which are interlinked, in that both strategies focus on building resilience in people, communities and businesses, in order to increase independence. These strategies are of crucial importance in seeking to make Kirklees a better place in the future i.e. healthy people enjoying a greater quality of life for longer via a strong and growing economy. This focus is particularly important when set against a background of decreasing resources.

The recommendations in this report address the organisational and personal challenges across a wide range of factors and subjects.

For all who are passionate about better public health: elected members, the Chief Executive and Directors, Health partners, the Local Authority's and Health's workforces, we need to do all we can to make public health everyone's business.

Dr Judith Hooper has provided us with a report with a thoughtful direction for the future, which highlights the need to build capacity, by building confidence and resilience in our communities.

I would like to acknowledge the work of Dr Hooper, who has had a long and successful career and now approaches retirement, and particularly thank her for her valued insight, leadership and support.

Cllr Viv Kendrick

Chair, Kirklees Health and Wellbeing Board

# Executive summary

This report continues the long tradition of public reports on the state of local health by the Medical Officers of Health (latterly the Director of Public Health) to the Council, partners and local people. Since 2007 in Kirklees, such reports have been published as Joint Strategic Needs Assessments.

This, my last report as DPH, is very different. I hope to inspire Kirklees to become more resilient and thus healthier by sharing concepts and what is known to work with local examples.

Given the challenges facing the public sector in rising levels of need, expectations and shrinking resources there is a real need to rethink the relationship between the state and the citizen. This report is a contribution to that rethinking in two very different ways:

1. To give a framework for building capacity for adapting to change as positively as possible, whether as individuals, groups of people forming communities or organisations of people working together. This builds confidence and thus resilience.
2. To give road maps of what we can do in Kirklees to have a real and extensive impact on the health and wellbeing of local people. Starting with building resilience across three levels I then review all aspects of daily living from the food we eat, the transport we use, the planning of our environment. This is to help all of us whether citizens or in the public sector or working elsewhere to rethink what can I do to improve the health of myself, my family, my community, the people I serve, the place I work. So we can all create and take up opportunities to improve local health.

*The 2014 Joint Health and Wellbeing Strategy* is to improve local health and wellbeing and reduce inequalities no matter where they live. So that local people can:

1. Control and manage life challenges by being resilient, feeling safe and positively included.
2. Navigate through life: being able to participate and contribute to the community.
3. Have a safe, warm, affordable home in a decent physical environment in a supportive community.
4. Take up opportunities that have a positive impact on their health and wellbeing.

We are building a coherent way of working and action plan between the JHWS and the Kirklees Economic Strategy (KES) to achieve:

***Thriving local communities, growing local businesses, high prosperity and low inequality - where local people enjoy better health throughout their lives.***

This report contributes to the implementation of the JHWS and the KES by presenting some important concepts and what we can do locally to achieve those outcomes.

Dr Judith Hooper,
Director of Public Health
September 2014

**What is health and wellbeing?**

I start by reiterating that health is a resource for daily living, which enables us to carry out our daily tasks, socialise, be physically active, cope emotionally with life and bodily pain. Wellbeing is our sense of mental and social functioning at a moment in time. This is both internal to me and how I feel my life compares with others according to social norms. There are a wide range of factors that affect our health and wellbeing, as shown by the Rainbow diagram, from genetic makeup through norms of behaviour to the wider contexts of life.Underpinning our health and wellbeing is how able we are to adapt in the face of adversity and carry on "normally" i.e. our resilience.

## Chapter 1 How life has changed: Public health challenges in the 1900s vs the 2000s...how much and how little has changed

During my time as the DPH for Kirklees since 2002, 2 major challenges to tackle have been the tragedies of infant deaths and the Influenza pandemic of 2009, specifically in the local major outbreak that occurred in Dewsbury. I have reviewed these against reports of these same challenges in the 1900s.

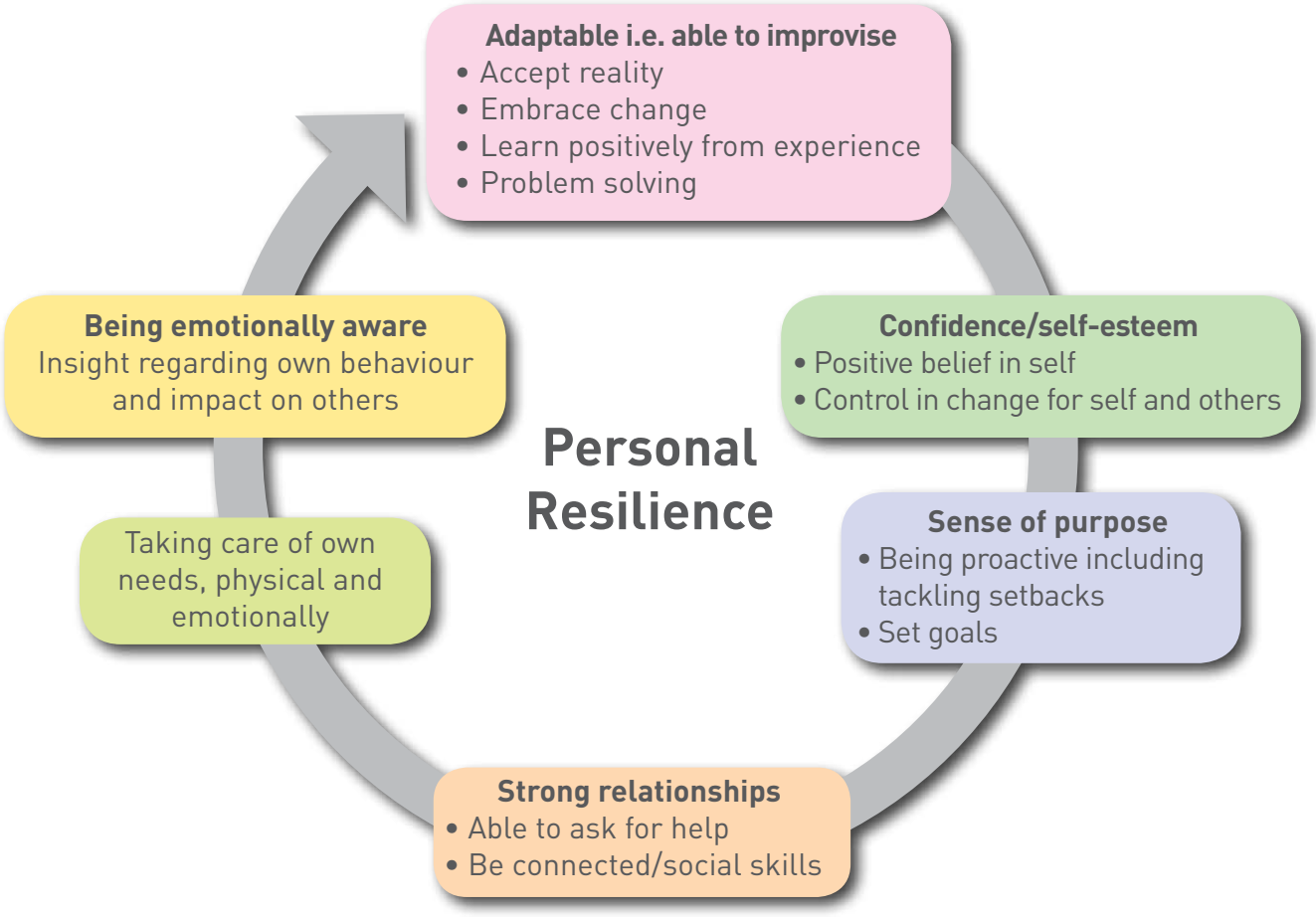
*"Great progress has been made during the last 50 years (since the 1900s) in the reduction of infant deaths, and this progress has not been brought about by any single scientific discovery or social reform, but more by a combination of factors...if one of these factors may be emphasised more than another it is the steady improvement through the years in the education of the mother in the feeding and care of her child. In this improvement...the work of the 'Health Visitors' has played an important part."* Medical Officer of Health 1950s

*"Clearly there are many factors affecting the health of the pregnant woman and her baby. Some can be changed and some cannot. Of course access to good quality support and care is crucial but so is how we cope with our lives. In how we deal with life's challenges we are heavily influenced by the world we have been brought up in, the relationships we have and the security we feel in ourselves. All of this gives us the resources to be resilient or not i.e. our ability to adapt and manage changes".* Director of Public Health 2014

Of course the world we now live in is so different to 100 years ago. In this context key differences such as people's expectations of the health service and its ability to respond as well as that of other agencies; access to advice from 'experts' with conflicting points of view on topics such as infant nutrition and weaning, all of which present a modern challenge compared to the 1900s when there was a single voice of 'authority'. Of course there are changes in most of the content of the conversations between the health visitor and the local mothers and the environment they live in. However, in thinking about the nature of those conversations, both scenarios emphasise the overwhelming importance of working with local people to understand where they are coming from, what they are thinking, what their priorities are across their rainbows and support them in being as positive as they can be in making as healthy a choice for them and their families as possible.

While the rate of the tragedies of infant deaths in Batley and Dewsbury has not fallen to the national level as yet, it is declining but we still need to support the families in north Kirklees to have as healthy pregnancy, birth and infancy as possible by working with them.

Being ***personally resilient*** means adapting in the face of adversity compassionately and continuing to function "normally." It includes letting go, learning and growing as well as finding healthy ways to cope. Coping is the way we deal with stressful events or stress itself, by attitudes or behaviours. Resilience is then learning from this and moving on "normally".



### Features of personal resilience

***Community resilience:*** Where communities thrive in the face of change or adversity as they adapt to fulfil their potential.

***Organisational resilience:*** enabling employees to be able to succeed personally and professionally in the midst of a high pressured, fast moving and continuously changing environment. This helps them function more effectively in all areas of their lives, both inside and outside the workplace. This ultimately enhances the health and wellbeing of people in the communities where they operate and recruit. Ensuring the resilience of the workforce is even more important in an adverse socio-economic climate to enable the organisation to thrive.

This shows a progression from individual resilience to social interactions and networks as well as the opportunities to build resources for managing life and thus be resilient. The progression is well shown in the JHWS rainbow of health and wellbeing and is paramount in both the JHWS and the KES.

***What is the motivating force between individuals and their community to be resilient? Compassion***

Human beings are a profoundly social species who depend on the safety, care and support, affection and encouragement of others to survive and thrive. Such interactions, when compassionate, help us to develop a sense of purpose, meaning and hope (amongst other things) as well as shape our thinking and thus behaviours. Compassion is core to resilience in individuals and core to building resilience in communities. **Compassion creates the ambition for the greater good.**

Compassion has three parts:

1. **Thinking:** *"I understand you."*
2. **Emotional:** *"I feel for you."*
3. **Motivated:** *"I want to help you."*

A real challenge is that it seems the dominant values in current mainstream society and the media are the opposite of qualities associated with compassion. To face this challenge is to:

- Start to talk of resilience and compassion to ourselves and in our social interactions and across the cultures of agencies and social groups.
- Think about the three parts to compassion and use the key tips in cultivating compassion as individuals and see what happens.
- Look at the key tips in the report.

### What can we do locally?

To build resilience in both individuals and communities we need to transform the support at the front line to enable people to be independent rather than dependent, as much as feasible. This is the heart of the Joint Health & Wellbeing Strategy which says systems need to change to:

- Be person centred not service centred.
- Increase independence and resilience in local people.
- Involve individuals and communities in creating and delivering solutions effective for them.
- Prevention and early intervention i.e. stopping issues starting, detecting them early to take action.
- Promote collaboration, shared responsibility.

Key actions to support personal resilience are given including for young people.

How support is given is as important as what is provided: those that show respect and earn the trust of the community help to enhance resilience for people living in adversity.

Actions that support this are:

- Providing non-judgemental spaces (where people feel respected and valued).
- Building self-esteem (by positive affirmation of the individual).
- Listening and responding to needs (using active listening skills).
- Recognising and releasing capability (encouraging the individual to draw on their own strengths and find own solutions in a supportive environment).
- Friendliness (warmth and compassion).

There are a number of core themes to building community resilience, these are outlined in the report with examples of local activities.

A specific example of building personal resilience is enabling people to self care or self manage their health issues. See box:

***Self care*** is being able to answer these questions

1. What's important for me, what's important for my health?
2. What can I do to help myself?
3. Do I know what to do if I get stuck?
4. What on-going support do I need?
5. What skills do I need to keep well?
6. Do I have the information / knowledge about my condition or situation, and how it affects me now and in future?

Successful services support their users to self care by enabling their users to:

- Be *active partners* with their care providers so they are fully involved in decision making.
- *Talk confidently* with their health and social care providers about their needs.
- Develop a *self-authored care plan* which includes self-assessment so they can identify their priorities and feel ownership of the plan.
- *Manage risk taking* in maximising their independence and choice.
- *Access networks* to be able to talk to others in the same situation about wider needs.
- Have *support from significant others* in their life / carers.
- Experience *timely, consistent and effective support*.

The key themes for action to become really person centred and support self care are: skills for the front line staff and their managers to change the style of interaction and the systems to support self care; helping the users to become skilled to self care as much as feasible for them; resources ie tools, information, support systems; self authored care plan that is used by the person and in their interactions with the various services; organisational culture and system changes so the skills, information and support networks and widely known and used.

There are a number of self care resources and services already in place across Kirklees, the core ones are described in this report with their impacts. Self care is effective both in increasing people's confidence and resilience but also their health functioning and is efficient by saving resources. This is shown by a comprehensive case study of a service that was designed on self care principles and its impact on those who attended and the use of the services.

**Chapter 3 Working across the whole of the health and wellbeing rainbow - Making health everyone's business**

In making health everyone's business we have developed a way of thinking and planning to help us all take the most effective and efficient action to improve local health and reduce inequalities. The JHWS presents a series of questions to do this, based on public health thinking and principles. The Food programme is used to illustrate this approach, which has been successful in a number of significant plans.

I then present the action needed to have a real impact on the wider factors affecting health, beyond individual make up and behaviours, as shown in the Rainbow, see introduction. These factors range from having the best start in life to spatial planning as an enabler of better health. as I have already said, underlying all this is building resilience.
Being resilient, feeling safe and positively included and contributing to resilient communities is crucial to health and wellbeing both individually and at population levels in any setting.

### *Creating a Kirklees food culture that is good for people, places, health and the environment*

*Food is important for health*, "we are what we eat". Sadly food contributes greatly to avoidable differences in health between people due to a range of factors as shown in the rainbow of food poverty.

*Food, place and the economy:* Because food is so universal it plays a powerful role in regeneration and a great place to eat helps make a great place to live. Indeed thriving creative food and drink outlets are a marker of culture, as well as creating open social spaces for real encounters.

*Food and sustainability:* Food has a huge impact on the environment, economy and social cohesion. Some of the most serious environmental problems are related to food production and consumption, including climate change, water pollution, soil degradation, and loss of habitats and biodiversity. So public procurement practices focussing on a sustainable agenda around seasonal and local produce can enhance sustainability.

*What can we do locally:*

1 Tackle inequalities in food and health: improving the skills of less skilled communities in growing, harvesting, preparing and eating good food. Link food with physical activity.

2 Promote sustainable food procurement: linking local producers to local procurers, increasing job opportunities through acquiring food skills.

### *Best start in life*

Resilient, healthy, young people who enjoy life to the full are more likely (and ready) to make a productive economic contribution. Conversely, a strong and sustainable economy has a positive influence on the wider factors affecting health, such as learning, readiness for work, household incomes and housing, both having increasing resilience underpinning them.

So building resilience starts with parents who can nurture, support for those who are more challenged by their circumstances. Then using all avenues including peer support to enable young people to become resilient as possible, this includes close working with schools on the journey of joining up commissioning as well as schools based behaviour and wellbeing programmes. These will increase the employability of young people and their life chances of self-respect, purpose and ability to share.

### *Helping people find good jobs and stay in work*

The strategic direction for the local economy is The Kirklees Economic Strategy (KES) is to:

- Improve resilience, competitiveness and profitability for business.
- Enhance employment prospects, skills and incomes.
- Create a great quality of life and environment where all people are connected to economic opportunity and live in strong and thriving communities, helping to reduce inequalities in the future.

This is via working across a wide range of partners, private, public and voluntary. Adapting commissioned services to deliver social value means maximising the benefits of the service above and beyond those delivered directly.
The Council can use it's links with local businesses to promote a health workplace and support access to tools for others to use.

### *Health and spatial planning*

Bringing the impacts on health and wellbeing into the world of planning is opening up real opportunities for improving local health. Spatial planning improves the "liveability" of areas and enables a place-based approach to improving health and wellbeing. It also links closely into the active travel and green space sections described below. Planning can be an enabler in addressing issues related to the ageing population, social isolation and cohesion of communities. Building on the new guidance for planning the right intelligence can be provided into planning discussions; provide evidence of what works to improve health outcomes. This is via an integrated health, economic and environmental assessment.

### *Active and safe travel*

Active travel ie using oneself as a mode of transport through walking and cycling contribute hugely to health. By using fewer vehicles also improves air quality and also can reduce social isolation. Walking in local centres helps to bring communities together; increasing connectivity and can stop older and vulnerable people from becoming isolated. People are at the heart of thriving neighbourhoods where we all want to live, walk and play. So reclaiming the streets for people feels important as part of our relook at planning. Action needs to happen locally and at West Yorkshire level via the Combined Authority.

### *Warmer and safer homes*

A warm safe home is essential for health and wellbeing, and more and better housing is also supportive of the local economy and private sector jobs. A lot has already happened locally to improve home energy efficiency, awareness of how to do this needs to continue as well as look at renewables. Home is the most common site for accidents in children and older people. Reducing the risk of falls is clearly important for a frail person to be able to live in their own home.

### *Access to green and open spaces*

Open spaces and green infrastructure encourages physical activity, supports positive emotional wellbeing and enables people to build social capital. Every 10% increase in exposure to green space reduced the risk of expected health problems by five years.

Access to open spaces and sports facilities is associated with more physical activity, including links with physical activity and food production, this can weaken the impact of deprivation on health. so we need to support local people and their groups to keep greening their neighbourhoods.

## Recommendations

### *Resilience*

1 Build a resilient and compassionate way of thinking and working as individuals, communities and organisations, using the evidence based frameworks in this report.

2 Promote the culture of resilience as a golden thread throughout management staff practice to build personal resilience in all staff.

3 Change the culture of our organisations to one where facilitating resilience and so self care is at the heart of what they do, this means:

- See people and communities as assets – valuing them and building on their strengths.
- Be person centred and focus on what is important to the patient / service user.
- Support people to be independent rather than dependent at whatever point they come into contact with our staff or services.
- Involve people in the decision making about the care and support they receive.
- Use the JHWS strategic thinking framework and the rainbow to see the opportunities for building resilience and self care
- Look at ways of skilling the workforce to motivate and coach compassionately.

4 Promote a range of options to support people and their carers to develop and maintain the skills they need to self care.

5 Involve local people in the design, development and delivery of services, including evaluation, to ensure they meet the needs of those who use them.

6 Focus on workplaces whether public, private or voluntary to assess and build resilience in their people and systems.

***Food***

7 Develop more opportunities to enable food growing amongst communities, schools and individuals.

8 Ensure that food is procured locally as much as possible.

9 Reduce the number of fast food takeaways, particularly within deprived areas.

10 Develop a social enterprise to represent all food growers and food skills/training interventions, and ensure that food businesses and growers, including new enterprises are made aware of business support that can help them.

11 Improve engagement with private sector organisations, including supermarkets.

12 It is really important to continue to:

- Promote the 'eat well, move more, feel great' message across Kirklees.
- Work to improve the update of good quality school meals via the Food for Life Partnership.
- Promote the Healthy Choice Award within small businesses.
- Develop 'Cook and Eat' programmes.
- Promote the uptake of breastfeeding, complementary feeding and the Healthy Start vitamin scheme.
- Tackle food poverty by working with food banks.

***Best start in life***

13 Further develop an effective Integrated Commissioning system for families through the Children, Young People and Families Integrated Commissioning Group, and based on intelligence.

14 The Healthy Child Programme is fully integrated into its commissioning plans. This includes working with the growing new relationships with schools to support their effective contribution to an integrated world for children and their families so they tell their story once.

***Helping people find good jobs and stay in work***

*Helping businesses to prosper and grow*

15 Working with the private sector and other partners to deliver the KES will be vital to ensuring we have the strong and growing businesses and new enterprises that in turn support good jobs, incomes and associated health and wellbeing benefits.

16 Health and economic partners should further build and deepen their relationships and work jointly to deliver initiatives where they both have a contribution to make and benefits to accrue. These include areas such as local food enterprise, Tour de France legacy, housing, the health and social care sector, business support and engagement, and green infrastructure. This could start by the Health and Wellbeing Board considering the impact of the decisions it makes on the local economy.

17 Develop the manager's support forum using the model of 'Reconnect' Better Health at Work Self Help Group to support managers and in turn support employers. This includes implementation of the Workplace Wellbeing Charter and includes employees health and wellbeing.

18 Support the implementation of the National Institute for Health and Care Excellence evidence on healthy workplaces.

19 The Council and partners should consider the Social Value Act 2012.

20 The Council and partners s hould support adult education, particularly literacy and numeracy courses for those needing it, along with lifelong learning.

21 The Council should act as a role model for a resilient workplace with the key features of organisational resilience .

### *Spatial Planning*

22 Continue to develop an 'Integrated Health, Economic and Environmental Impact Assessment' approach to planning applications and wider developments locally. Work across the Leeds City Region to ensure consistency for potential developers.

23 Ensure that the health elements of the National Planning Policy Framework and Guidance are integrated into the Kirklees Local Plan.

### *Active and safe travel*

24 Work to achieve political support for the 'active travel' agenda in policy and action.

25 Road Design - Ensure that road design and the built environment prioritises pedestrians and cyclists e.g. develop segregated cycling routes where feasible; linking places of interest e.g. schools, shops, health services. Development of the Living Streets concept.

26 Safety - Work to improve the perception of the safety of walking and cycling; continue to deliver pedestrian safety in schools; work to reduce excess driving speeds and anti-social driving; HGV driver training and 'cycle friendly' vehicle design.

27 Continue to develop the Greenway networks, particularly to join up utility trips.

28 Grow tourism and the visitor economy based on promotion of the Tour de France route in Kirklees and enhancing local leisure cycling options (e.g. mountain bike trails, bike hire).

29 Work with businesses to develop 'active travel' interventions.

30 Air Quality – Promote zero emission 'last mile' delivery; use evidence based intervention to improve air quality; 'Eco' driving training for taxi drivers.

### *Warmer and Safer Homes*

31 Promote what people can do to make their homes warmer and more energy efficient.

32 Continue to invest in interventions to tackle fuel poverty.

33 Review of effectiveness of services already provided to prevent and deal with consequences of falls.

- Improve the ability to target interventions, information and awareness raising activities with those 'at risk' of falling in Kirklees, by utilising the range of data already collected.
- Develop a co-ordinated approach to ensure specific information and advice about falls prevention is targeted at individuals at risk such as training for staff e.g. in care homes.
- Develop a programme of evidence based exercise sessions that can be undertaken within communities, within the home etc.

### *Access to Green and Open Spaces*

34 Continue to support the Kirklees Green Infrastructure Delivery Plan.

35 Develop an understanding of the reasons for existing green spaces being underused, and from this develop ways of encouraging greater use e.g. more effective communication of where green spaces are and their uses, providing people with the necessary skills to utilise green spaces and addressing access issues.

36 Encourage a 'Green Streets' approach to urban areas in order to address poor air quality, improve the aesthetic appearance of the built environment and reduce the risk of flooding and protect vital local green spaces to maintain their health benefits.

# Introduction

# Introduction

**This report continues the long tradition of reports spanning decades to the Council and NHS from the Director of Public Health, previously the District Medical Officer. These covered a range of topics, including the health challenges facing the various communities of the boroughs, district council and since 1974, Kirklees. Since 2007 such reports are published as the Joint Strategic Needs Assessments.**

In this, my last Annual Health Report for Kirklees, I start by comparing the health challenges at either end of the 20th century, the 1900s vs 2000s which reveals some interesting comparisons.

### 1 How life has changed: Public health challenges in the 1900s vs the 2000s... how much and how little has changed

This chapter compares what happened in the first decade of the 20th century with what happened in the first decade of this century for two serious health problems: infant deaths and infectious diseases, illustrated by Smallpox and Influenza. This illustrates that while circumstances may change hugely, the type of action needed has not, just the way they are delivered.

### 2 Helping ourselves to better health and wellbeing

This chapter looks at how individuals, families, communities and organisations become more resilient in adapting to and making the best of change. I am using the focus of 'helping myself to better health' to illustrate how resilience can be built. I give an example of the impact of a service based on self-care principles, can have on the user and resources used. This includes a series of 'road maps' for tackling health and wellbeing challenges, focusing on how we do more for ourselves and creating even more opportunities locally for us to help ourselves.

### 3 Working across the whole of the health and wellbeing rainbow

Over the years a system wide view of thinking has developed to improve local health and wellbeing. This is most recently captured in the Joint Health and Wellbeing Strategy for Kirklees that links to the Kirklees Economic Strategy. In this report I use food as the main example of what this thinking is and how it helps bring about change. I present the Kirklees priorities for the wider factors affecting local health and wellbeing then what more we can do using evidence from locally and elsewhere.

Firstly though I am sharing some recent thinking about what **wellbeing** is, and thus its relationship to **health**. This sets the scene firmly for thinking about the whole person in their context and how their thinking and behaviours are shaped to create their attitudes and behaviours that affect their ability to adapt to change while functioning normally, i.e. be resilient.

In these themes I am sharing what we can, and are, doing differently to the past and the way of working that is increasingly taken up by the Council and its partners. This marks a real change in the relationship between citizen and state from dependency to independency, as much as possible. Cynics may say this is because of the financial challenges, but I hope this shows that this way of working is better for the health and wellbeing of local people.

I hope it is helpful in supporting us all to think laterally and beyond our normal boundaries to improve local health and wellbeing.

Director of Public Health
September 2014

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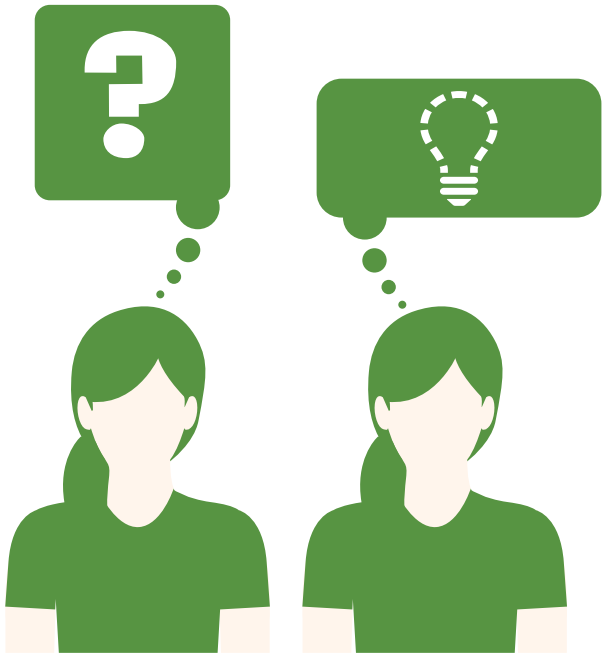
Kirklees Council Human Resources Team
Kirklees Council Community Development Team
Kirklees Council Children and Young People's Services
CCG Falls Prevention Team

# What is health and wellbeing?

**In trying to understand what we can do locally to help people to better health we need to be clear what health and wellbeing are.**

Over the years we have used this definition of health in Kirklees[1].

Health is the extent to which an individual group is able to:

- Satisfy basic human needs.
- Change or cope with their environment.
- Realise aspirations.

So health is a resource for everyday life and a positive concept emphasising social and personal resources as well as physical capabilities.

It allows people to "be all they can be" irrespective of differing capabilities, experiences or cultures. It can apply to a person who uses a wheelchair, someone who has limited intellectual capacity or a world class athlete.

So the main aspects of good health are being able to:

- Undertake your work or other regular daily activities e.g. cooking and cleaning, looking after the children.
- Join in social activities with family, friends, neighbours or other groups.
- Carry out basic physical tasks e.g. climbing the stairs, walk to the shops, bathing or dressing yourself.
- Not feel bodily pain or have pain interfere with daily life.
- Feel peaceful and happy rather than down in the dumps, sad or nervous.

There is a wide gap in the levels of good health experienced across different groups. Where such health differences are unnecessary or avoidable, then they are described .as health inequalities. The test of whether the gaps in health between people are health inequalities is the extent to which people have:

- Control over factors that prevent their ill health that allow them to make positive choices.
- The access to opportunities to control such factors and so change them.

Underpinning these is the strength of resilience these individuals have.

**Wellbeing exists in two ways[2]:**

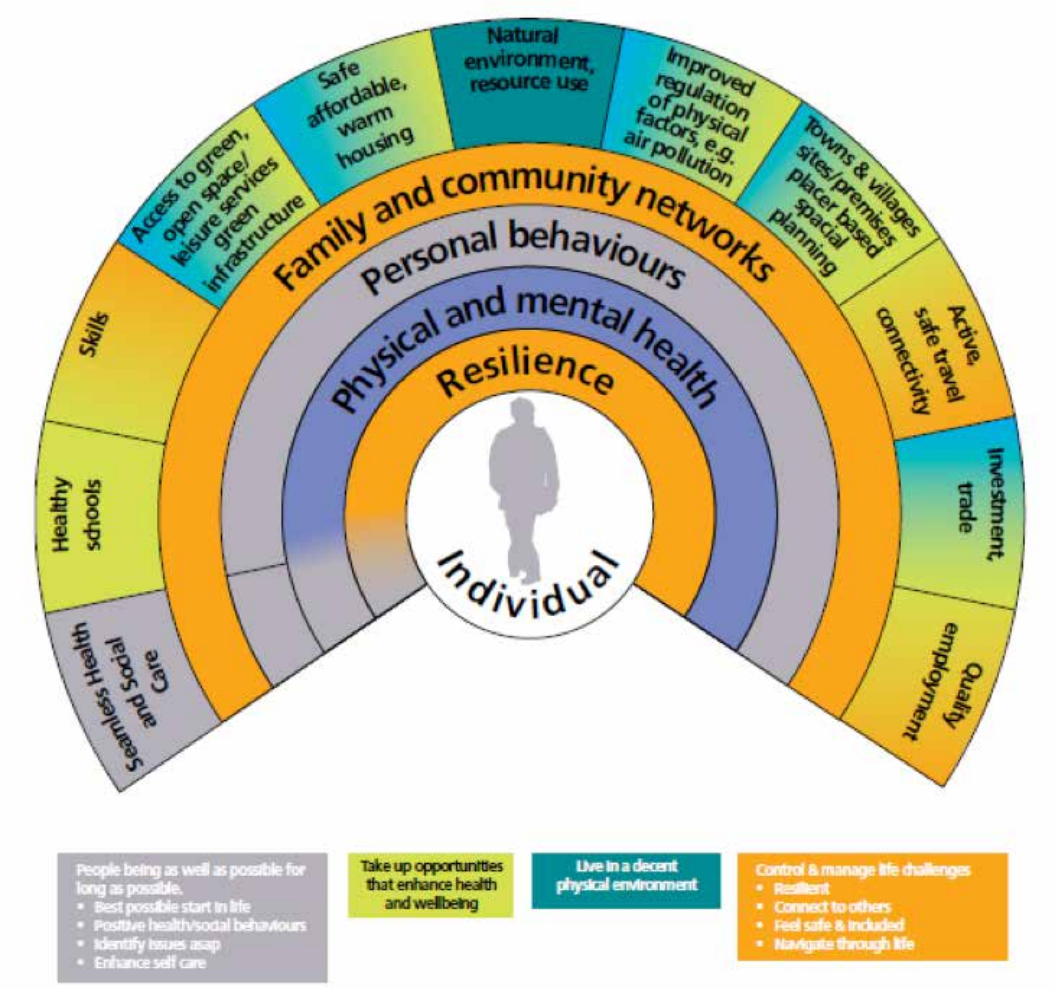
1. An individual's experience of their life at a moment in time with core dimensions of[3,4]:
   - Feeling good - positive emotions.
   - Feeling at ease with oneself, sense of control and purpose.
   - Functioning well - positive relationships, social connections.
   - People assessing how well their lives are going, e.g. being happy in their work.
2. A comparison of life circumstances with social norms and values. Life circumstances include health, education, work, social relationships, physical and natural environments, housing, safety and security.

This means that wellbeing is our sense of mental and social functioning at a moment in time both internally and how life compares with others according to social norms. This complements health as our capacity and capability to carry out daily living. Wellbeing is closely related to resilience as we shall discover.

### The scope of health and wellbeing: the rainbow

Over the years I have used the rainbow of health and wellbeing as a useful diagram of all the factors that affect our health wellbeing in daily living[5]. This starts from each of us as an individual, our sense of control and coping, our state of physical and mental health; our own behaviours.

All of which are influenced by the attitudes and behaviours of our family and our communities in which we live, work and play. All of these, in turn, are influenced by the opportunities available to us both as individuals and communities such as housing; education, health care, work, food, transport and the natural environment.




**The Kirklees Rainbow for Health & Wellbeing and Economy**

From the above, fundamental to health and wellbeing is our sense of control over our lives. This is in the choices that we have to make and the relationships that we have with others to give and receive. Having control means our ability to adapt to life's changes as well as we can i.e. be resilient. This theme is the basis of this report.

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Chapter 1

# How life has changed: Public health challenges in the 1900s vs the 2000s...how much and how little has changed

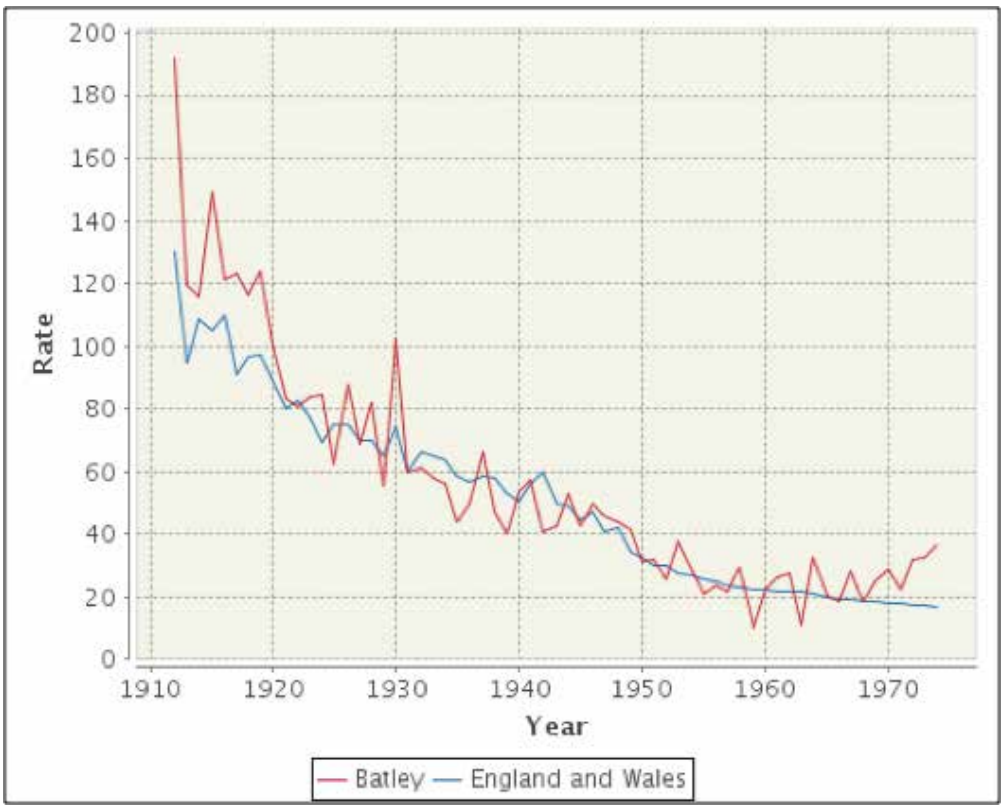
# How life has changed: Public health challenges in the 1900s vs the 2000s...how much and how little has changed

Public health practice and its importance is centuries old. In the past decade, Kirklees faced two very significant public health challenges: infant death rates in Dewsbury and Batley being far higher than nationally; a major outbreak of swine flu in Dewsbury during the 2009 pandemic. Both of these events have their story repeated in the 1900s in a very different culture with very different standards of living. In this part of the report I am drawing out the stories of the 1900s and 2000s to celebrate how things have improved, but also to illustrate how the basic responses remain the same.

## Infant deaths across the 20th century

Infant deaths was the major public health problem in Batley until the 1920s, well above both that of comparable towns at 190 deaths in the first year of life per 1000 live births, compared to 130 deaths per 1000 nationally[1].

**Infant deaths per 1000 live births in Batley and nationally between 1912 and 1975** *1




* When Batley was no longer a separate Council.

The Local Government Board in London sent an Inspector to analyse the problems in 1906 who stressed the 'retrograde' sanitary policy of the Batley Sanitary Board, in their refusal to replace dry privy midden toilets with water closets in working class housing on the unstated but obvious grounds of expense. A fulltime Medical Officer of Health was appointed for Batley in 1909 as was the first Nurse (today known as Health Visitor). Her role was the front line in the struggle against infant deaths.

She visited the homes of every mother and gave talks to women's organisations. She organised a successful 'Baby Show' at the Town Hall where 500 babies participated and she also organised cooking classes at the Technical School. She noted that there was still considerable local opposition to the abolition of dry privy middens and open ash pits and painted a depressing picture of squalor on many of her visits:

*It was not usually possible to prepare any food with safety in the home , which was in many cases dirty and in every case fly-infested...flies persist in crawling round the eyes and mouth of the baby when it is ill and especially if it is so ill as to be unconscious...When the scavengers (health department workers) began to spray the privy middens with Izal, several complaints were made to the Health Department that since the middens were sprayed all the flies swarmed into the living rooms of the houses and became a nuisance.*

So help from the Nurse was not always welcomed. This first Nurse resigned at the end of 1909, finding 'the burden of work too heavy', and admitting that she did not feel able *'to go through the diarrhoea season again'*.

Also in 1909 the recruitment of soldiers for the Boer war revealed a dire state of poor health across the nation. There followed national measures to increase the health of the nation: medical inspection of schoolchildren, school meals, trade boards to regulate wages in 'sweated industries', means-tested old age pensions - all increasing state interference, and the possibility of *"working class resentment at the bossy instructions of well-meaning middle-class do-gooders"*.

A fully trained nurse / midwife took up post in Batley to continue the work. Although she was personally challenged by some mothers who she felt were "cases of wilful and persistent neglect" towards their children she did feel encouraged by her initial visits, and had hopes that the much desired drive towards 'national efficiency' would be promoted:

*The work is most encouraging, and grateful mothers often tell me of the good done to the baby by some trifling change made at my suggestion. A greater and more intelligent interest in their children is awakening among the mothers. And it is from this class that we hope to raise a healthy, sturdy, clear-brained working class to safeguard the future of Batley...The recent improvement in sanitary accommodation must have the effect of raising the moral tone and self-respect of the lower classes in Batley and should help them to lift the management of the home and of domestic life to a higher level.*

Up to 60 home visits were made weekly. Husbands were cited who drank or were unemployed as a problem in many households. She stressed the need for 'kindly sympathy' towards their wives. In 1913 summer diarrhoea struck again and 16 babies in Batley died from it:

*In every case the house was full of flies. The excess of flies was often due to waste food being put in the ash pit or ash bin, or being thrown out onto the road for birds. More commonly food being left uncovered throughout the whole day was a possible cause but unfortunately so few houses are supplied with pantries and it is usual for food to be kept on a shelf at the stair head, or in a cupboard next to the fireplace where the heat quickly causes decomposition, or, as is not unusual, the food to be kept in the table drawers... I have waged war on the dumb teat...mothers try to hide them from me...The work is progressing and there is a wide scope for it to be very much extended, but it is impossible without assistance.*

The frequent grating tone of scorn and callous contempt for 'feckless mothers' shown by some local doctors was giving way to sympathy and concern.

*"Now is the time for the nurse to advise, warn or encourage with what tact and diplomacy she may possess…there are an increasing number of mothers who claim and count on the visits of the Nurse and depend on her to set things right if the baby is not so well…*

*Feeding bottles to be washed and left 'just so'. Soiled clothing to be put into disinfectant, with a word of warning as to the danger of leaving them even for a moment exposed to flies; and sometimes if the baby was so wasted with disease that the mother hardly dare undress it, we would stay and give the necessary bath, all these as much for object lessons as for the sake of helping the overworked mothers…*

*Enough cannot be said in praise of many mothers who stayed up day and night with their babies, hardly daring to catch an hour's restless sleep for fear the baby would become worse…*

*These were eager for any word of advice and carried out to the letter all instructions, more than grateful for our visits and help."*

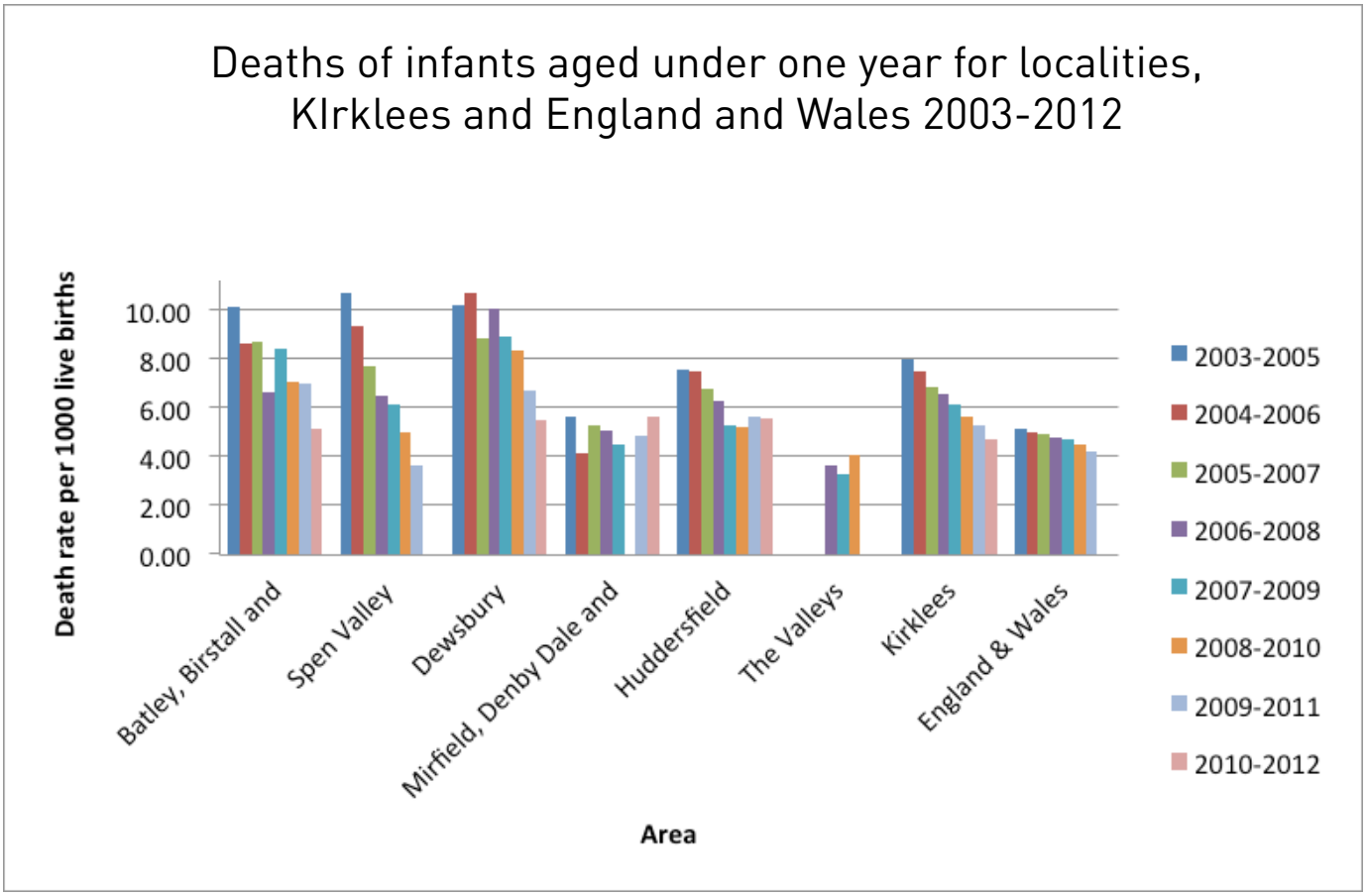
Privy middens were at last swept away, replaced by water closets. The work of the Nurse was on a truly heroic scale and their role in educating the women of Batley in improved 'mothercraft' was of seminal importance. There was a change in attitude from harsh medical condemnation of maternal neglect and fecklessness, to the more compassionate, 'kindly sympathy' that came from an understanding of the real problems.

So the infant deaths rate in Batley fell to the national level of 80 per 1000 by 1922. Indeed from the 1930s until the 1950s infant deaths in Batley were similar or lower than the national level.

The 1950 Medical Officer of Health reported: *"Great progress has been made during the last 50 years in the reduction of infant deaths, and this progress has not been brought about by any single scientific discovery or social reform, but more by a combination of factors… if one of these factors may be emphasised more than another it is the steady improvement through the years in the education of the mother in the feeding and care of her child. In this improvement…the work of the 'Health Visitors' played an important part."*

**So what is the story of infant deaths in Batley recently?**

Tragically, by 2008 the rate in Batley was greatly above the national average i.e. nearly 9 per 1000 live births vs. 5 per 1000 nationally, similarly in Dewsbury. Thankfully this is now dropping but not fast enough as yet[2].




***Why are these tragedies happening?***

In my reports on Infant deaths in 2008 and 2011, I reviewed data available from the NHS about care of mother and baby, insight gained from local women who had recently become mothers and community midwives. I cited the main factors linked to Kirklees infant deaths seemed to be[3,4]:

- Ethnicity:

  White babies were more likely to be born prematurely i.e. before 31 weeks.

  Pakistani origin babies were more likely to have congenital abnormalities and be carried to term.
- Over half of the babies had a low birth weight i.e. under 2.5kg, linked to poor diet, smoking and prematurity.
- Sibling history of congenital abnormality or infant death, mainly in Pakistani families.
- Booking for antenatal care later than 16 weeks of pregnancy.
- Smoking especially by white mothers.
- Being a single mother.
- Multiple births e.g. twins.

Clearly there are many factors affecting the health of the pregnant woman and her baby. Some can be changed and some cannot. Of course access to good quality support and care is crucial but so is how we cope with our lives. In how we deal with life's challenges we are heavily influenced by the world we have been brought up in, the relationships we have and the security we feel in ourselves. All of this gives us the resources to be resilient or not i.e. our ability to adapt and manage changes, see Chapter 2. The reality is best shown from the perceptions of local women in Batley about these factors from 2008-09:

***Thinking about advice and support:***

Suspicion regarding advice from professionals:

*"... over cautious by what we've been told because my great grandmother had nine kids and they all lived, some of them still are. I can't see her not eating stuff like that when she was pregnant."*

*"... with everything now, just in case somebody sneezes they would sue the Government so I think it's just wrap everybody up in cotton wool and they'll all be alright. We were all alright when we were growing up."*

Attitudes to personal behaviours and available support:

*"...it's just an addiction isn't it...(smoking), it's because I need it, I crave a cigarette and that's it, because I am addicted to it."*

*32 year old woman quit smoking for over a month and used the pilot smoking club to help her quit the habit in March. "I found the group really inspiring. The guest speakers were an asset and the information I received helped me to deal with the hurdles you come across when quitting smoking."*

Coping with pregnancy and recently becoming a mother, perceptions were:

- Lack of clear information about what to do; health messages keep changing – so tend to ignore/ discount all messages.
- Main support/ advice from family and friends (or 'no-one'); not from professionals.
- Felt services not supportive, despite individuals being seen as helpful, due to lack of time, *"midwives are lovely but rushed off their feet".*
- Some women who need most support feel judged e.g. lone parents, young parents, those experiencing violence.
- After birth focus seemed on the baby, whilst women's needs are paid less attention.
- Guilt as an overwhelming emotion, especially if 'failed' to breast feed as overwhelmingly felt want to do best for their baby.

Similar conversations with the local midwives, revealed the following in 2008[5].

- They felt overwhelmed with paperwork to the detriment of engaging with women and discuss key behaviours (smoking, diet, etc.).
- Time pressure at appointments: clinical imperatives mean little time for women's concerns or for discussion re health messages; preparation for birth and after birth.
- Issues of housing, poverty and domestic violence seen as overriding; so concern re safety issues in many households and need for education.
- Lack of time to provide quality support post birth, especially following rapid discharge incl supporting start of breast feeding.
- Support usually only by midwife – other services not involved.
- Unable to provide extra time for women with high level of need.
- Health visitors picking up previously non identified social and health needs.

***In summary***

Women and midwives were often dissatisfied with the same things. Both had good ideas about improvements to contribute to service redesign but needed help to implement these ideas. Professionally led approaches to behavioural change will be of limited impact: community based and peer led approaches need to be part of the solution. Overall the message from mothers was: **Listen to me and I'll listen to you,** until we've helped women with their concerns about job, housing, relationships etc. they won't be ready to do anything about their health concerns.

***What happened?***

Using this research, a social marketing process* resulted in the development of a pilot project, Auntie Pams to support pregnant women in North Kirklees consisting of:

- An accessible town centre venue run by trained volunteers recruited from the key target group.
- Volunteer peer support for young pregnant women, engaging them early in their pregnancy and offering a link into traditional services by responding to their agenda, and supporting and referring as needed.
- Holistic support earlier in pregnancy including guidance on social needs as identified by the women. See p86.

A staged approach was used to build the trust, confidence and skills of women to address their needs, access services together with peer supporters to build confidence and ultimately feel more secure in doing things independently, see p93. These volunteers were trained to answer questions and signpost appropriately about a range of issues which were important to the women, such as:

- Housing.
- Jobs.
- Benefits.
- Food.
- Available support networks.

Based on the insight, the profiles of the volunteers are:

- Recruited from Batley and close surrounding areas.
- Recruited using psychometric tests: communication, empathy skills etc.
- Available to offer advice and signpost to services available.
- Trained in motivational interviewing.
- Range of ages from early 20s upwards.
- Mothers themselves.

Auntie PAM's
Supporting Mums-to-be

Following the report, a number of other issues were tackled locally; such as having somewhere safe to go to talk about becoming pregnant especially if it feels quite a challenge; conversations and workshops about genetic closeness, rethinking maternity care and much closer links between midwives and the local children centre teams to support mums and families. More recently the re-design of maternity care has led to a rethink on how community midwifery can best be delivered and support as normal a birth as possible.

This is the Kirklees Safe and Healthy Pregnancy programme, which is an integrated model of service delivery, emphasising a community-based, midwife-led, women and family-centred approach. Kirklees commissioners are supporting maternity service providers to develop a Midwife-Led Unit (MLU) on Dewsbury Hospital site. This Unit will provide a crucial element of the integrated, community-based women-centred service, complementing that provided in Huddersfield.

By working with other services and sectors in (virtual) integrated teams and settings, a wide range of issues that impact on women's health and wellbeing and those of their babies and families can be tackled. This includes a 'nurturing parent' programme to support parents from pregnancy through to their child's 19 birthday at key stages of their child's development. This supports parents to form strong emotional attachments to their child, helping them understand their baby's communication needs, their developmental stages and the development of their independence and self-reliance as they grow. See page 86.

The Healthy Child Programme (0-5 years) offers every family a programme of screening tests, immunisations, developmental reviews, information and guidance to support parenting and the making of healthy choices. So each family receives support that is appropriate for their needs – with the most vulnerable families receiving more intensive interventions and co-ordinated support packages. This is led by health visitors and includes Children Centre teams, GPs, midwives, community nurses and volunteers. See page 86.

*Social marketing is about understanding the person (the citizen, the community, the patient, the professional, etc.) and understanding their behaviour (what people actually do and why). It considers what/who influences behaviour and what incentives and barriers exist to changing that behaviour. This helps ensure services and interventions are citizen/person centred, so they are delivered in the right way at the right time and in the right place for the right people and involve the recipients in the planning and delivery.

***What is life like in Batley for young women before starting a family?***

*Once you leave [school] there's nobody does anything outside school, that's with your mates anyway. So it's a bit like there's nothing else to do apart from go and get drunk. (Female 16-18)*

From talking with young Batley women in 2008 there were some common low opinions of 'things to do round here':

- This widened into a low opinion of Batley in general.
- Leading to low self-confidence in relation to being a Batley girl, due to anxiety about outsiders' impressions of Batley.
- They had very limited experience of expressing themselves through physical activity or creative/ artistic groups.

Further work was done with young women in Batley to explore these opinions further and find out what sorts of things they would be interested in doing. It quickly became obvious that the girls needed activities that would improve both their physical activity levels and their emotional health especially confidence and self-esteem. Dance sessions appealed the most, resulting in a public show.

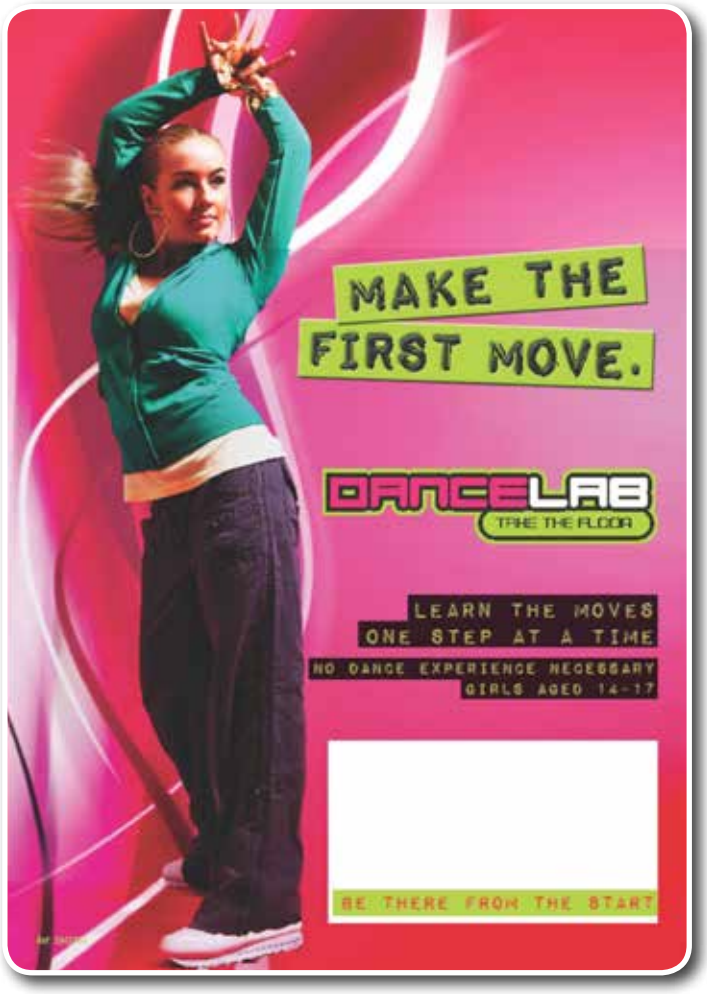
*I talked to my mum and my friends about it (Dance Lab). My mum thinks it's a really good idea as she says I'm getting fat! Everyone liked the idea of it, it's something to do, a cool idea.*

The design and delivery of Dance Lab was planned with them with the strong sense of:

- Disbelief it would happen.
- Need for it not to be 'rubbish like everything else'.
- Need not to get hopes up – which would then be dashed.

Summer taster sessions across Batley gave a chance for girls to "have a go" without committing themselves any further. Then girls were able to register an interest for the autumn weekly sessions. These were delivered from the Young Batley Centre, a centre acceptable to the group as safe and with the right facilities. Kirklees Council's Dance Programme facilitated the sessions having found the right tutor, and the Young People's Service found a group supporter where links to other services might be needed.

The evaluation showed that the Dance tutor was the key to them engaging in the activity, developing their skills and increasing their confidence. Due to issues around initial commitment a single friendly familiar face 'like them' helped personalise the experience and increased the belief that they could achieve.

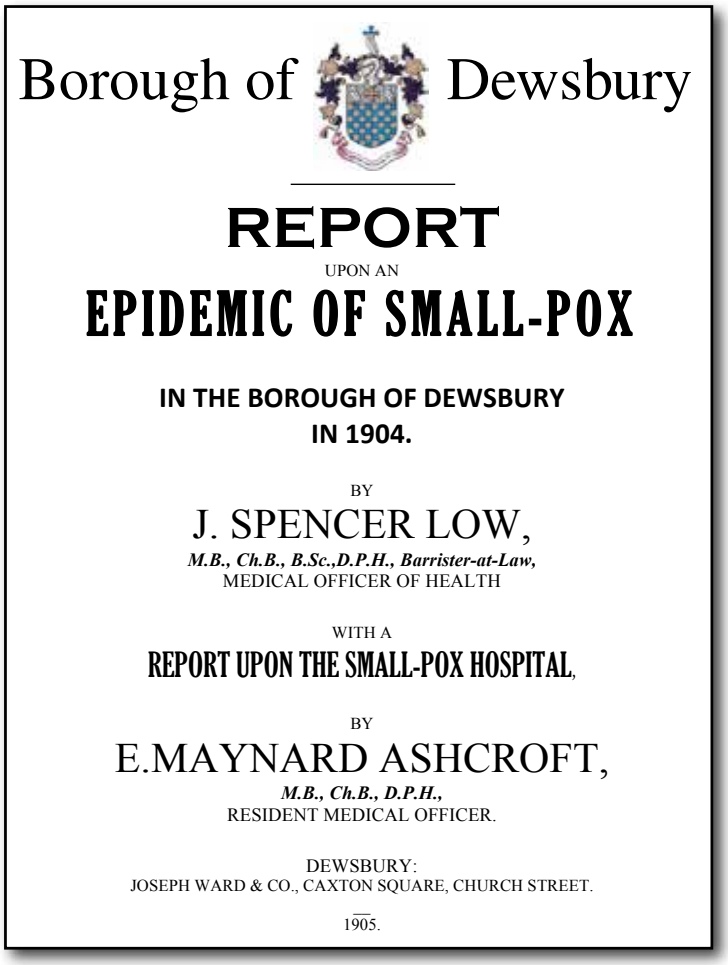


The group maintained a core number, with members gradually building confidence and maintaining attendance. New skills were learned, culminating in a public performance at Lawrence Batley Theatre in December 2009. The girls group continued initially within the Young People's Service, as Saturday sessions. In additional to learning a new skill, they improved their personal health behaviours e.g. increased levels of physical activity as well as their levels of self-esteem which was identified as a major barrier to positive behaviour changes. As a result of the evaluation of Dance Lab, a manifesto was developed which now informs the planning and commissioning of physical activity interventions targeting young girls so that such activities can meet the needs of this group.

***So are there differences between the actions taken in 1900s and 2000s?***

There are key differences such as people's expectations of the health service; access to advice from 'experts' with conflicting points of view on topics such as infant nutrition and weaning, all of which present a modern challenge compared to the 1900s when there was a single voice of 'authority'. There are changes in most of the content of the conversations between the health visitor and the local mothers and the environment they live in. However, in thinking about the nature of those conversations, both scenarios emphasise the overwhelming importance of working with local people to understand where they are coming from, what they are thinking, what their priorities are across their rainbows and support them in being as positive as they can be in making as healthy a choice for them and their families as possible.

While the rate of the tragedies of infant deaths in Batley has not fallen to the national level as yet, it is declining but we still need to support the families in north Kirklees to have as healthy pregnancy, birth and infancy as possible by working with them.


Borough of Dewsbury

REPORT

UPON AN

EPIDEMIC OF SMALL-POX

IN THE BOROUGH OF DEWSBURY
IN 1904.

BY

J. SPENCER LOW,

*M.B., Ch.B., B.Sc.,D.P.H., Barrister-at-Law,*
MEDICAL OFFICER OF HEALTH

WITH A

REPORT UPON THE SMALL-POX HOSPITAL,

BY

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*M.B., Ch.B., D.P.H.,*
RESIDENT MEDICAL OFFICER.

DEWSBURY:
JOSEPH WARD & CO., CAXTON SQUARE, CHURCH STREET.

1905.

# Infectious diseases then and now

Infectious diseases are now much less of a threat to health than in the 1900s due to much better living conditions, immunisation and antibiotics for non-viral infections. They remain a challenge because of increasing resistance to antibiotics especially for Tuberculosis, Gonorrhoea and changes in the makeup of viruses so that vaccines need to be continually refined to make immunisation effective.

The principles of infection control are:

- Immunise, before the disease starts or at least all those in contact as soon as possible.
- Notification of being infected and recent close contacts.
- Rapid diagnosis of suspected cases.
- Isolation of the person with the infection to be cared for by people who are immunised.
- Decontaminate all clothing, bedding and furnishings in the house of the person with the disease.
- Observation of the contacts and possibly quarantine.

The basics of infection control are the same now as they were in the 1900's as shown by the following events.

**The Dewsbury smallpox epidemic in 1904[6]**

In the early 1900s there was some understanding of the nature of infections, but not necessarily widely understood. The health care system was spilt between the Poor Law system, the local government and voluntary, charitable or private institutions. Between 1903 and 1905, 700 people contracted smallpox principally in Dewsbury, of which 67 died i.e. about 10%.

By October 1904, in Dewsbury Borough 531 people had been infected and 55 had died. To remedy this terrible situation on Oct 21 1904 the Dewsbury Smallpox prevention order was issued by the Local Government Board due to *"the disinclination of the Guardians of the Poor of Dewsbury Union to do their duty under the Vaccination Acts and Regulations of the Local Government Board"*. This was mainly due to poor provision of resources to vaccinate but also inadequate disinfection and insufficient staff. The performance of their duties was taken over by Dewsbury Corporation. Seemingly the Guardians were the equivalent of the NHS in those days ....but a bit less efficient. The Corporation appointed the Dewsbury Medical Officer of Health (MoH) in October 1904 who instigated a more rigorous system of management, thus the epidemic closed in February 1905.

**What is smallpox[7]**

Smallpox has existed for at least 3,000 years, is caused by a virus and was one of the world's most feared diseases until it was eradicated by a collaborative global immunisation programme led by the World Health Organisation. The last known natural case was in Somalia in 1977. Since then, the only known cases were caused by a laboratory accident in 1978 in Birmingham, England, which killed one person and caused a limited outbreak. Smallpox was officially declared globally eradicated in 1979.

Early symptoms include high fever and fatigue, then a characteristic rash, particularly on the face, arms and legs. The resulting spots become filled with clear fluid and later, pus, and then form a crust, which eventually dries up and falls off. Smallpox was fatal in up to 30% of cases. It becomes infectious once the fever develops especially during the first week of illness, although can remain infectious until the last scabs fall off up to 17 days later. Smallpox virus spreads by coughing, sneezing or shedding in the skin

**Why did this epidemic occur?**

The MoH's report cites the following as the main factors causing the epidemic:

***Lack of widespread understanding*** about the spread of this disease and the effectiveness of immunisation as well as inadequate control measures until October 1904 were the main causes. So the public were confused about how the disease was spread and often disbelieving about the effectiveness of immunisation.

***Exposure to those infected:*** victims of smallpox calling at houses to tell their friends they had smallpox, friends visiting those suspected of smallpox before they were removed to secure facilities; one man attended a fete on the day he went to hospital, infecting 15 people. In all these scenarios further people were infected. A fire broke out at the local hospital, a lot of spectators gathered to watch. A number then got smallpox; other spectators did not become ill but took the pox virus home and infected
11 of their families.

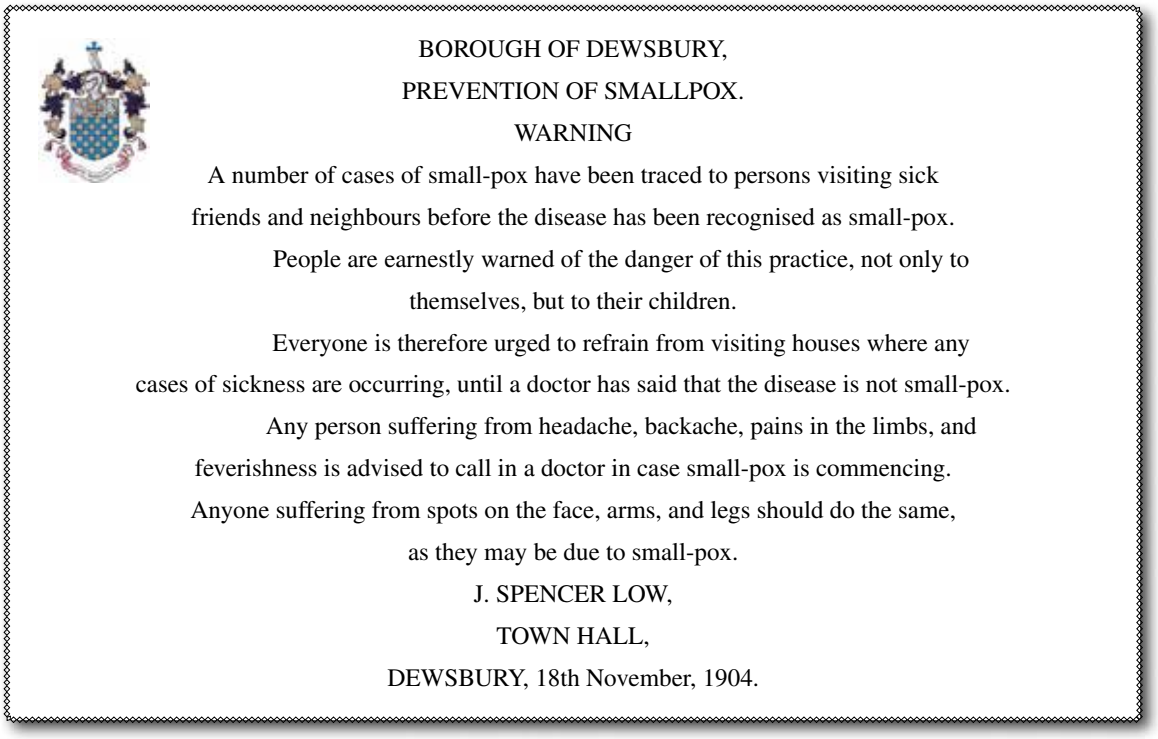
Funerals were often a source of infection. As the smallpox hospital was adjacent to the cemetery the sanitation officers coffined the body and supervised the funeral...with the family witnessing the ceremony from some distance.

Despite smallpox being the topic of conversation for months, sometimes a case was concealed, and one person was fined 10s or 14 days in prison for not notifying 2 cases in his house. Tragically he, his wife, his 2 sons (one of whom died) and a neighbour became infected.

***Not immunising:*** immunisation in the first couple of days of being infected minimises the impact of the disease, hence the need for accurate diagnosis and contact tracing.

The local population were not entirely convinced of the effectiveness of this so for example about 50% of children were immunised. So in houses where there was one case, about 50% of the occupants became infected in households where they were not immunised - vs - virtually none where the other occupants were immunised. A school inspection revealed that 19 per 1000 children had smallpox, of those who had been immunised none had smallpox.

Fortunately those in the essential services had been immunised such as the doctors, nurses, police, teachers, postmen, tramway employees.



BOROUGH OF DEWSBURY,

PREVENTION OF SMALLPOX.

WARNING

A number of cases of small-pox have been traced to persons visiting sick friends and neighbours before the disease has been recognised as small-pox.

People are earnestly warned of the danger of this practice, not only to themselves, but to their children.

Everyone is therefore urged to refrain from visiting houses where any cases of sickness are occurring, until a doctor has said that the disease is not small-pox.

Any person suffering from headache, backache, pains in the limbs, and feverishness is advised to call in a doctor in case small-pox is commencing.

Anyone suffering from spots on the face, arms, and legs should do the same, as they may be due to small-pox.

J. SPENCER LOW,

TOWN HALL,

DEWSBURY, 18th November, 1904.

BOROUGH OF DEWSBURY,

SMALL-POX AND VACCINATION.

1. Small-pox is one of the most loathsome and terrible of diseases.
2. Unvaccinated children under one year old who get small-pox nearlyalways die.
3. Doctors and nurses who are more exposed to the infection of small-pox than any other class, do not suffer from small-pox, because they are always recently vaccinated.
4. The only trustworthy protection against small-pox is efficient vac-cination. The good effects of vaccination done in infancy wear out in time. Vaccination should therefore be done again.
5. As small-pox is now so prevalent in Dewsbury, everyone who has not been vaccinated within the last few years should be vaccinated again.

If everyone in Dewsbury were vaccinated to-day, the epidemic would be overin a fortnight.

6. It is better to have four vaccination marks on your arm, than hundreds of pock marks on your face and all over your body, besides possibly losing your eyesight.
7. You are advised to ask your friends who have been in the Small pox Hospital what they thought of the difference between patients who had been vaccinated when they were children, and those who had never been vac-cinated at all.
8. Arm-to-arm vaccination is now done away with, and there is no fear that any other disease can be given by vaccination, if the arm is kept free from dirt and irritation.
9. An unvaccinated person is a danger, not only to himself, but to his neighbours.

By order of the Sanitary Committee,

H. ELLIS, Town Clerk.

J. SPENCER LOW, Special Medical Officer

TOWN HALL, DEWSBURY,

October 25th, 1904.

**But official action was also variable in efficacy until October 1904.**

***Observation of contacts***

Up to October 1904 there wasn't enough staff to keep an eye on the contacts of cases and make sure they didn't leave before being disinfected and vaccinated. If they refused to be immunised then it was impossible to continue to observe them and notification of being infected was the only way of finding out what had happened to them.

***Communication between the local Medical Officers of Health (MoH)***

Infection recognises no human boundaries, so infected people moved between areas infecting others. Cases spilled over in to the neighbouring council areas, noting the number of corporations i.e. 7 involved in this epidemic: Dewsbury Borough, Ravensthorpe Urban District, Thornhill Urban District, Soothill Nether Urban District, Soothill Upper Urban District and Batley Borough, Heckmondwike Urban District.

So follow up of contacts of an infected person could be difficult, as people with smallpox visited someone afterwards reported to have been sent to hospital with smallpox from another district or attended the funeral of a person who died from smallpox in another district. Keeping comprehensive track of this, even with the good cooperation between each District's MoH was well-nigh impossible.

***Diagnosis***

After October 1904 a case was notified to the MoH who then visited to confirm the diagnosis. Before then there could be considerable delay between the suspicion of smallpox and action being taken. The Sanitary Inspector then called at the house of the newly diagnosed individual to remove them to hospital, and make enquiries of any contacts.

***Disinfection***

Meanwhile the ambulance, contact conveyance and bedding van were summoned to remove the individual, contacts and bedding. Then the whole house was disinfected. The contacts went to the contact station where they:

- Had a hot bath, then waited wrapped in blankets for their clothes.
- Their clothes were steam disinfected.

It took one hour for a family of 3 children to be disinfected.

This turned out to be very popular, especially the hot bath.

When a case was notified after 10pm, then the sanitary inspector would watch the house all night to ensure no one entered or left until all the above happened in the morning (one householder was caught secreting his bedding away during the night).

*Before October 1904:* Sulphur was burnt in the infected room and steam was used to disinfect the bedding in that room. No further action was taken.

*After October 1904:* A whole house was sprayed with a disinfectant (formalin). All articles where possible were steam disinfected, otherwise sprayed with formalin.

***Support to the contacts of people with smallpox***

The council supplied coals and food to contacts while they were stopped from going to work, until risk of disease had passed.

***Information to the public***

The MoH issued notices to the public as handbills and placards all over the Borough re the dangers of smallpox and benefits of immunisation as clearly mass immunisation was essential. See p.29

The final word comes from Dr Spencer Low, the MOH to the Sanitary Committee of the Borough of Dewsbury in April 1905:

*"I am glad to take this opportunity of thanking you for the cordial manner in which you have supported every preventative measure which I have suggested to you. Without such support I doubt whether I should be in a position to report upon the epidemic as a thing of the past. Perhaps consideration of some of the points to which attention is drawn in this report may influence the future behaviour of smallpox in the Borough."*

**A personal note on smallpox**

In 1978 the last reported case of smallpox in the world occurred at a Birmingham medical school, where I was a final year medical student. Tragically 3 people died as a consequence of this, of which one was directly due to smallpox, the others due to being closely linked to this person developing smallpox. The legislation and infrastructure existed then to remove the person with the disease and their close contacts to an isolation hospital. The wider repercussions were:

- A friend was the junior doctor who stood with the professor of infectious diseases being horrified at what appeared under the electron microscope, so they went with the person into the isolation hospital.
- Other friends were contacts from the workplace of the person diagnosed so were confined to their homes and had food delivered daily on the front doorstep without contact for a number of weeks. These contacts were not allowed out of house or anyone to enter, under threat of prosecution.

Thankfully smallpox is no longer a threat, but others have emerged. Ebola being the current major threat to the people of Africa.

## What happened in 2009 with the world wide pandemic of swine flu?

### What was the infection?

Influenza is a virus - as is smallpox - and has no cure. It is infectious by sneezing and coughing hence *"Catch It Bin It Kill It"* used as the prevention message.

**What is influenza?[8]**

Influenza or 'flu' is a respiratory illness associated with infection by influenza virus. Symptoms frequently include headache, fever, cough, sore throat, aching muscles and joints

There are two main types of virus that cause infection: influenza A and influenza B. Influenza A usually causes a more severe illness than influenza B. The influenza virus is unstable and new strains and variants are constantly emerging, which is one of the reasons why the flu vaccine should be given each year.

The swine flu virus in 2009 affected young people more than older, those being obese or having respiratory disease and especially pregnant women, unlike normal flu, and was very infectious. This type was fortunately usually mild in other groups i.e. the impact was symptoms of high temperature, cough for a short period of time, with a death rate of about 3 in 1000. The previous major influenza global scare was Severe Acute Respiratory Syndrome in 2003, (SARS) which started in China and quickly spread to over 20 countries before being contained. It affected 8100 people of who 774 died, which is a relatively high death rate[9].

This swine flu pandemic was clearly a global emergency. So there had to be national management of diagnosis and treatment, resulting in national oversight of pandemic management systems, information and communication.

### So how to alleviate the impact of this infection?

Basically the story was the same as for smallpox in 1904:

- *Take precautions... "Catch It, Bin It, Kill It"* i.e. decontaminate by washing hands regularly and throw used tissues away.
- Ability to make accurate *diagnosis*.
- *Notification:* If get symptoms then ring for clinical advice and testing for accurate diagnosis.
- *Isolation;* don't leave the house, unless really necessary. If visited health care then staff tried to isolate potential cases. Stay at home while symptomatic. Others to avoid contact with people who may have it.
- Observation of symptoms in *contacts*, to enable fast diagnosis.
- *Immunise,* when available. This remains the mainstay of limiting spread beyond the above controls but as these viruses change then it can take up to 6 months to develop an effective vaccine, unlike smallpox which was stable so the vaccine was available when needed.
- *Reliable information* from a trusted source.

In early July 2009 there was an outbreak in a Dewsbury school of 200 people exhibiting symptoms. This was within 3 days of the first symptomatic cases. The school was closed, causing concern both in local communities and to all the families affected. The infection spread via families to another school and out into the local communities within a couple of days.

Local GPs were swamped with up to 70-80 patients each daily for the first few days after this started. In the next 3 weeks there were 75 hospital admissions with symptoms, 14 confirmed with swine flu, 1 death due to swine flu and 1800 prescriptions for the anti-viral drugs and health staff themselves developed symptoms of swine flu.

In this pandemic, the mainstay was good communication to the public, services and workplaces. The Public Health system promoted the key messages and relied on public good sense to hear the message re *"Catch It, Bin It, Kill It"* and be sensible about isolating symptomatic cases.

## What were the key elements of controlling this Pandemic locally?

***Information*** for the public and businesses about what the risks were, what they could do to prevent getting swine flu and what to watch out for. The public information about *"Catch It Bin It Kill It"* was very effective in changing people's behaviour. There were reports of people reinforcing this message amongst themselves, which was most helpful. Even so early on, GP surgeries were swamped by calls from anxious people demanding tests and antiviral drugs. The public became calmer as evidence emerged that the illness was not so severe.

However the national sources of information were inconsistent in their advice to the public, such as the advice for schools from the government website was for Avian flu dated 2006, a virus that was much more severe in its impact. Information developed before the pandemic was for an anticipated more severe strain H5N1 and the speed of evolution of the 2009 pandemic meant that such information had not been updated as rapidly as would have desirable. So making sure the right information given to the public about the infectious time period of the virus, the severity of impact, those more likely to get the disease and suffer severe effects was not available until sometime into the pandemic globally. The national planning seemed to be for a more severe pandemic than actually this was.

Fortunately the World Health Organisation (WHO) had this information within a couple of months so this was used locally. This led to a real tension between the national messages and the reality that this disease did not warrant as severe a response. This was keenly felt by the public and many of the people working in the systems i.e. a sense of "cry wolf".

This real dissonance between the national public information sources meant that a local summary of key information had to be produced from a range of sources to maintain a credible source for the public locally.

***Notification, isolation and treatment:*** Information for people providing services re how to diagnose, manage any cases, and information to give to their users.

Prompt ***diagnosis*** was needed as in any infection, but complicated by the symptoms being very similar to a number of other viruses, begging the question" does this person really have swine flu?" The number of people with such symptoms eventually swamped the ability to take samples to ensure an accurate laboratory diagnosis. One of the national decisions was to give the antiviral drug to everyone with symptoms and their contacts, not those most at risk from complications, unlike some other countries. This seemed to link to the national planning being for a more severe pandemic than the one that occurred.

Therefore when an outbreak really did occur there was real strain on NHS resources to cope with the numbers wanting these drugs, such as in the Dewsbury situation.

The need for quick decisions could be very difficult to obtain to contain a local outbreak, due to the complex modern health services with reduced local autonomy and national direction; very different from the situation in 1900 where the Council and MoH were in charge. However given the context of the Dewsbury outbreak local decisions were made to do what was needed to contain the situation. For example: not waiting for all 200 suspects to be tested before announcing this as a major outbreak. Immediately on confirmation from 3 cases we instigated the outbreak control measures of isolation, increased environmental cleaning, protective personal equipment i.e. face masks, and giving the antiviral drugs to those most susceptible.

The ***working with key local agencies*** such as the GPs, pharmacists and community groups such as the mosques were really essential. Having the support of the local NHS commissioner, Kirklees PCT, was essential for them to lead the NHS response advised by local Public Health Leaders i.e. myself as DPH, communicable disease control consultant and the lead infection control nurse. The Council systems were also involved in the decision making re planning and action, as well as communication to their staff, schools and communities via the local councillors.

Given the ***technology available for communication*** but even more importantly the excellent working relationships between the local NHS organisations, the local pharmacists, the Council, the press and a host of voluntary groups, we got the right messages out very fast to the right people and the public. Given the difficulty in making the diagnosis and the confusion with other viruses, the only local information we had on the activity of this virus on the community was the number of antiviral drugs being issued, as well as hospital activity data. Anecdotal evidence from GPs confirmed that there appeared to be fewer cases relating to this outbreak after the first week, which was clearly the aim of the outbreak control actions.

Early on GP surgeries were swamped by calls from anxious people demanding testing and antivirals. The local public became calmer as the message was reinforced that the illness was not so severe. So the outbreak was thankfully contained quite quickly.

## What's the difference between 1904 and 2009?

The diseases discussed above were very different in their impact thankfully but were both very infectious so have similar issues regarding how to contain their spread. This depends on accurate information repeated consistently in many forms, including between local people and groups. Fortunately infections are much better understood by everyone than in 1904. Of course sharing of information is much easier to and from the public due to technology, also alerting of cases and contacts between professionals enabling them to identify, isolate and treat where feasible limits the spread much faster.

However, some people remain sceptical about immunisation, just as technology helps the rapid spread of accurate information; it also facilitates the spread of rumour and misconceptions. So communication is even more critical than before.

As the Ebola epidemic is spreading across West Africa, this reminds us that prompt public health action is essential. Possibly the biggest challenge is the mobility of the public between countries, as shown by the speed of spread of SARS and this pandemic.

Overall, it appears that very little has changed during 100 years in managing the local main challenges to health. The key elements of success are:

1. Understanding the factors relating to the health challenge i.e. what is causing it and what can be done to prevent it occurring, treat it or alleviate the consequences - so there is consistency in the messages to the public and systems managing the health challenge.
2. Working with communities themselves to design and deliver solutions to their problems.
3. Understanding the cultures of the relevant communities in order to ensure the right messages are effectively understood.
4. Identify and involve key players in the community to help to communicate the message.

The authority of the Director of Public Health in such public health crises remains paramount as the independent local health adviser to the NHS and the Council, similar to 1904 for the MoH. That authority has be used wisely in working with a diverse range of expertise, perceptions and customs to get people on board and make the right decisions based on the information available at that time.

The SARS epidemic of 2002 resulted in the same principles being applied in Toronto and other centres where the infection occurred. It is now happening in Africa with Ebola virus. Thankfully the 2009 pandemic did not require such drastic measures to be implemented. I hope this will never have to happen again in this country, but it probably will and we must continue to be prepared.

In other words human nature does not change merely the context in which we live.

## References

The main sources of information in compiling this report are:

- A report from a local historian Stuart M. Archer, who sent me the story of infant deaths in Batley in 2008, after I had produced the report on Infant Deaths in North Kirklees. I am most grateful for his compilation of the picture then in Batley reproduced here.
- The report on the smallpox epidemic of 1904, by the Medical Officer of Health of Dewsbury Corporation, my direct predecessor.
- Regarding swine flu, the sources are from my reports to the PCT Board and the debrief reports compiled on the management of the whole pandemic locally as well as my debrief report on the Dewsbury outbreak.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Chapter 2

# Helping ourselves to better health and well-being.

## What can we do and what help do we need from others?

# Helping ourselves to better health and well-being.

## What can we do and what help do we need from others?

The 2014 Joint Health and Wellbeing Strategy is about both improving health and wellbeing and reducing inequalities[1]. This means local people can:

1. Control and manage life challenges by:
   - being resilient.
   - feeling safe and positively included.
2. Navigate through life: being able to participate and contribute to the community.
3. Have a safe, warm, affordable home in a decent physical environment within a supportive community.
4. Take up opportunities that have a positive impact on their health and wellbeing.

To achieve this requires a fundamental rethink in how the public sector works with others to support local people and places, as potential demand increasingly outstrips those resources.

This rethink and need for action leads to:

- Focusing on the development of resilience at different levels of society, which has multiple benefits such as improved emotional wellbeing, healthy behaviours, economic and environmental gains, and influence the narrowing of inequalities[2].
- The impact of social networks upon population health, and a shift to recognise communities by their strengths or assets and untapped potential as opposed to their needs[3,4].
- Improving the health and wellbeing of the population and reducing dependency on existing health and social services – these are key aims of the Health and Wellbeing Board.

These are relevant to any organisations concerned with people and place, not only the Council, NHS commissioning and provider organisations[2] .

Using the concepts of health and wellbeing from the introduction to this report, I share how different the future can be for local health and wellbeing, in a practical sense. At the heart of this Report is how individuals strengthen their resilience and strengthen local networks and groups, including strengthening relationships in the workplace, which in turn increase effectiveness and thus productivity. This is important for economic resilience too.

I present the elements of resilience for individuals, communities and organisations, and what could be done to strengthen these. I then focus on personal resilience through looking at how people with health challenges can look after themselves as effectively as possible with support as needed, enabling them to feel in control and resilient to change. Finally, I present self care as an example of building resilience in the individual, with a detailed case study of a service that did just that, to inspire other services to rethink how they build resilience in their users.

### What is resilience?

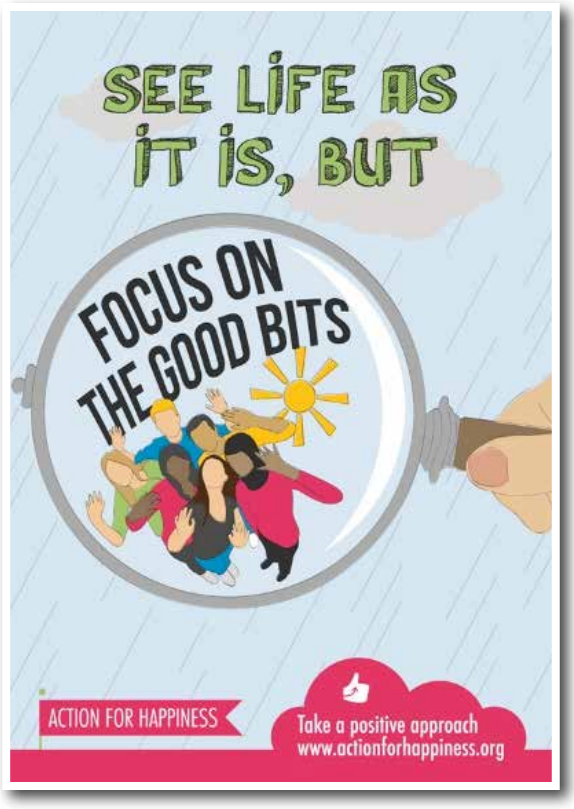
In travelling through life's journey, we have a whole range of choices from our personal rainbow (see Introduction). These depend on the opportunities that we can take, the circumstances we find our lives in, the information and support we have and our own abilities to be adaptable i.e. to be resilient.

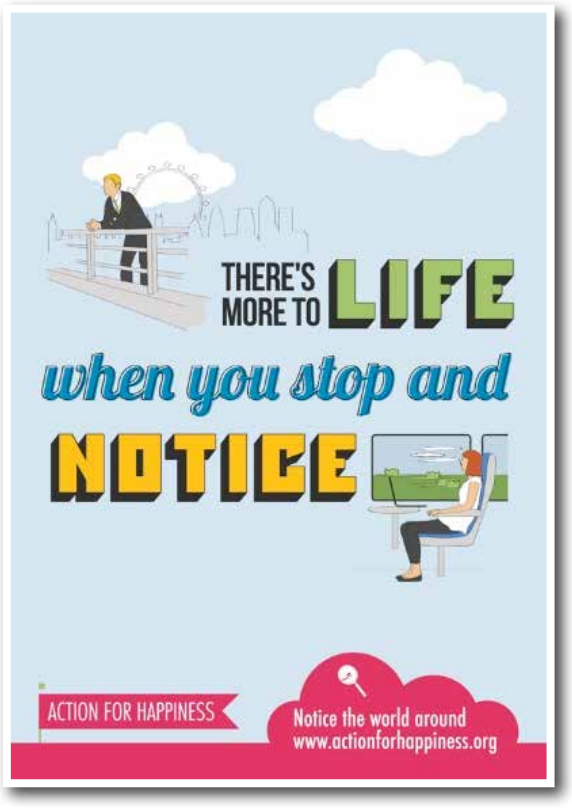
We cannot always predict what life throws at us, but we can nurture a range of skills and resources to help us respond flexibly, recover more quickly and learn and grow from these experiences[5]. There are helpful ways of learning from adversity that strengthens our resilience (see Learning From Adversity box).

**Learning from adversity**

Finding a way to put a negative experience into perspective, such as thinking of those in worse situations and/or finding a way to make sense of it can help. Finding some benefit arising from the difficulty can help too though may only be possible some considerable time later. This is not denying what has happened nor putting an unrealistic positive spin on it. Trying, where possible, to find some good from negative events that can help people to cope and move forward positively i.e. be resilient.

So it is important to *"take time, reflect how I coped with that difficulty and why, then find benefit from what has happened"*. Even if this may take months or years.




Most people think that if they become successful, then they'll be happy. But recent discoveries in psychology and neuroscience show that this is the wrong way round: **happiness fuels success**, not the other way around. When we're positive, our brains are more motivated, engaged, creative, energetic, resilient and productive[5].

People who take 8 sessions of mindfulness* meditation training will on average be 20% happier one month later than a control group. They have better responses in their immune system. Such training can lead to structural brain changes including increased grey-matter density in the hippocampus, known to be important for learning and memory. These brain areas are linked with self-awareness, compassion and introspection[5].

[2]Mindfulness is being able to observe our emotions and thoughts as they arise and being able to accept and work with difficult emotions. Noticing our difficult emotions as they arise gives us the chance to step back and decide what to do with them, rather than being controlled by them - such as lashing out or shutting down. Then we can learn to endure the discomfort that often accompanies them. Emotions like fear or anger come with strong motivations to act or avoid and resisting these motivations is often uncomfortable. Mindfulness helps us work this discomfort through. See www.getselfhelp.co.uk www.bemindful.co.uk

Resilience is affected by the shaping from our early experiences as a child in our family. This affects how we each choose to interpret events and manage our emotions as well as what and how we think, and then how we behave or react. To change our behaviours we need to[6]:

1. Be ***capable of change***, both physical and mental (the latter being able to think through or reason).
2. Be ***motivated***, which includes being able to reflect on experience and plan to do things, as well as what we do with our emotions and impulses.
3. Have the ***opportunity to change***. This stems from our environment and social context that shapes our thinking.

This emphasises the crucial links between ourselves and the people that are important to us, noting and reflecting on how they tackle change i.e. how resilient they are. This is framed by our personal experience and ability to spot the opportunities from across our personal rainbow.
So there are 3 levels of resilience.

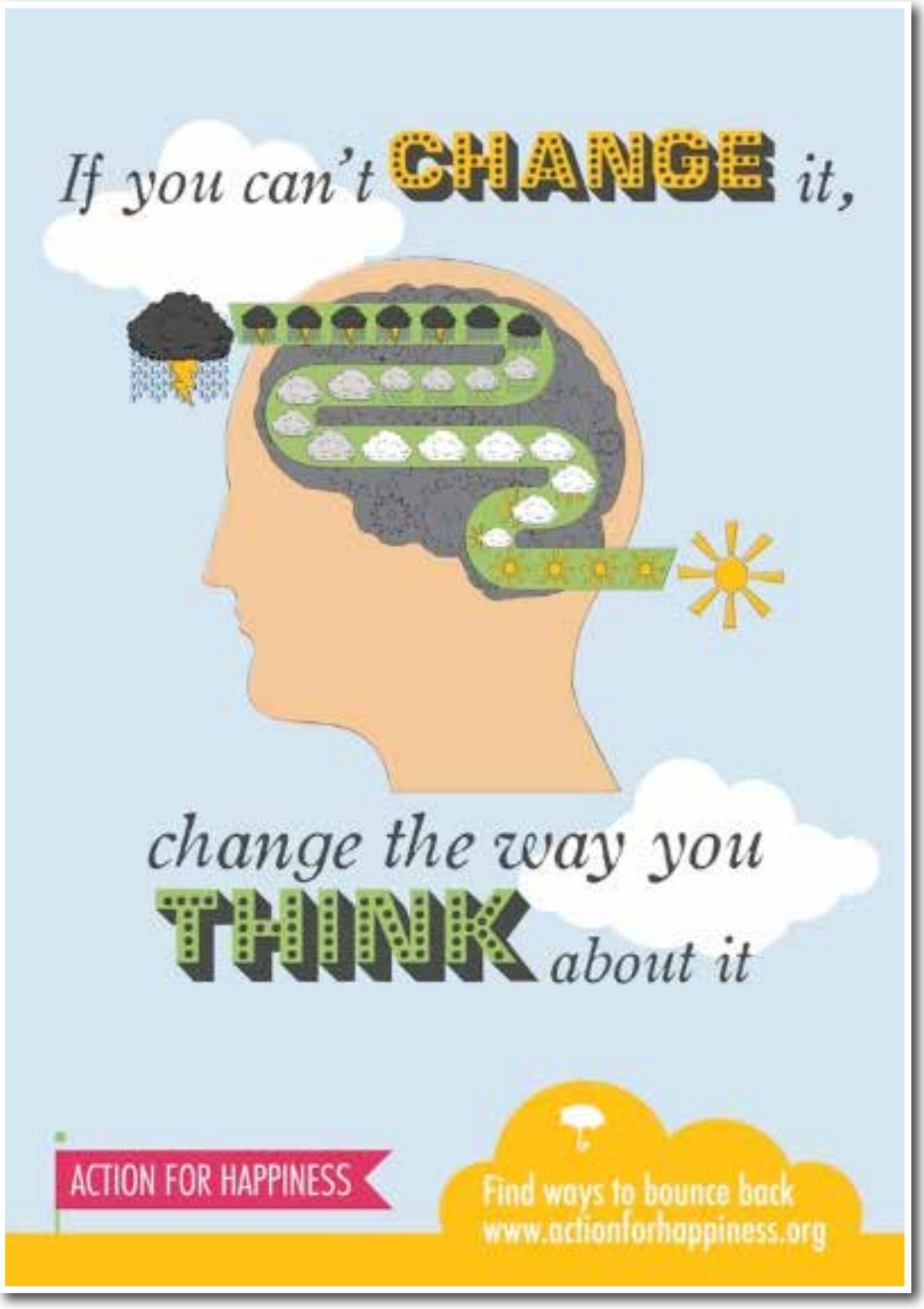
**The 3 levels of resilience:**

1. ***Personal resilience***: adapting in the face of adversity compassionately and continuing to function "normally." It includes letting go, learning and growing as well as finding healthy ways to cope[5,7]. Coping is the way we deal with stressful events or stress itself, by attitudes or behaviours. Resilience is then learning from this and moving on "normally".
2. ***Community resilience***: Where communities thrive in the face of change or adversity as they adapt to fulfil their potential[3].
3. ***Organisational resilience***: enabling employees to be able to succeed personally and professionally in the midst of a high pressured, fast moving and continuously changing environment. This helps them function more effectively in all areas of their lives, both inside and outside the workplace. This ultimately enhances the health and wellbeing of people in the communities where they operate and recruit. Ensuring the resilience of the workforce is even more important in an adverse socio-economic climate to enable the organisation to thrive[8,9].

As individuals live and work within communities and organisations, all 3 levels are closely linked. For example, *communities and organisations* provide the social networks and opportunities to build self-esteem and purposeful lives which are essential components of personal resilience. Likewise, communities and organisations are dependent on the contribution of healthy, resilient individuals[3,10].

*Community and organisational* resilience also directly overlap (for example, thriving businesses may provide financial investment to facilitate thriving communities; strong communities might protect local business).

This shows a progression from individual resilience to social interactions and networks as well as the opportunities to build resources for managing life and thus be resilient. The progression is well shown in the rainbow of health and wellbeing from the Joint Health and Wellbeing Strategy[1] - see introduction for more detail.


If you can't CHANGE it,
change the way you
THINK about it
ACTION FOR HAPPINESS
Find ways to bounce back
www.actionforhappiness.org

## Key themes of personal, community and organisational resilience

The key themes of the 3 levels of resilience are clearly linked. We can use these to guide effective action, see Action for Happiness website for lots of ideas[5] or www.bangor.ac.uk/mindfulness

| Personal resilience[4,7,8,11,12] | Community resilience[3,4] | Organisational resilience[8,13,14,15] |
|---|---|---|
| **Adaptable i.e. able to improvise:**<br>• Accept reality.<br>• Embrace change.<br>• Learn positively from experience and that of others.<br>• Problem solve.<br><br>**Confidence and self-esteem:**<br>• Positive belief in own abilities.<br>• Strong sense of self-worth<br>• Control in making change happen for self and others.<br><br>**Sense of purpose so every day is meaningful:**<br>• Being proactive including tackling setbacks.<br>• Remain hopeful.<br>• Set goals.<br><br>**Strong trusting relationships:**<br>• Able to ask for help.<br>• Be connected/gain social skills.<br><br>**Taking care of own needs, physical and emotionally**<br><br>**Being emotionally aware** so Understand origins of own emotions via mindfulness<br>Having **insight** regarding own behaviour and impact on others | **Engaged individuals**, able to access resources and develop skills to build community resilience.<br><br>**Inclusive culture** that promotes trust, understanding and collaboration between groups of people.<br><br>**Cultural resources** building on life experiences of the community.<br><br>**Strong links to other places and communities** enabling access to additional resources and networks of power.<br><br>**Financial resources** (investment in community development).<br><br>**Localising economy**<br>Educational opportunities relevant to potential for local jobs.<br><br>**Physical structure**<br>Including natural and built resources. | **Personal development:**<br>• Autonomy and control in the workplace.<br>• Work not characterised by monotony and repetition.<br>• Skills to cope with pressure.<br>• Opportunities for learning and development.<br>• Employment security.<br>• Effort matched with reward.<br><br>**Social networks:**<br>• Strong workplace relationships between teams and managers.<br>• Social interaction based on compassion.<br><br>**Culture:**<br>• Management style promotes mutual trust and respect.<br>• Clear values communicated and practised throughout.<br>• **R**ecognition and acknowledgment of staff.<br>• Principles of procedural justice observed.<br><br>**Health:**<br>• Safe, comfortable physical environment.<br>• Promotion of healthy behaviours and signposting to mental health services. |

For children and young people, additional themes are autonomy (especially girls), being reflective rather than impulsive, humour, emotional expression (in boys), positive adult role models; good school experience; support from outside the family. Key family factors include a close bond with at least one person; nurturing and trust; lack of separation; sibling attachment[16].


**What is the motivating force for individuals to be resilient within their community?**
**Compassion**

Human beings are a profoundly social species who depend on the safety, care and support, affection and encouragement of others to survive and thrive. Such interactions, when compassionate, help us to develop a sense of purpose, meaning and hope (amongst other things) as well as shape our thinking and thus behaviours. This means compassion is core to resilience in individuals and core to building resilience in communities, as set out in the box above. It is the glue between us as individuals and our communities that we live, play and work in.

***Compassion creates the ambition for the greater good[17,18].***

Compassion has three parts[17]:

1. *Thinking:* "I understand you."
   Empathy: making sense of your feelings and in response my emotions; non-judgmentally accepting and validating your experience.
2. *Emotional:* "I feel for you."
   Sympathy: moved emotionally by your emotions. Sensitivity: listening.
   Tolerance of distress: of others and my own.
3. *Motivated:* "I want to help you."

***So the skills needed for compassion are[18]:***

*Wanting to care*, as this is the basis of compassion. To want to help others rather than only think of oneself is humility and leads to better social relationship, less conflict and greater resilience.

*Sensitivity:* listening and noticing when others need help, so being socially aware.

*Sympathy:* being moved emotionally by another's distress so results from being sensitive and wanting to care.

*Tolerate distress/empathy:* i.e. moving beyond sympathy: actively listening, working out with the other what might be helpful for them, despite distress in them and recognising how that affects one's own emotions. So imagine what it is like to be in that person's shoes and being able to ask *"what are their options?"* Otherwise if we cannot face it because of our own emotional reaction, then we may either turn away and/or act to turn off someone else's distress as fast as possible.

*Non-judgemental:* managing one's own emotions towards someone so we can accept and validate their experience.

***So what does compassion mean in our daily lives and how does this link to our sense of control and resilience?[18]***

Practising compassion is a skill that helps us to increase our own sense of emotional awareness and insight, learn from the experience of others, gain social skills, ask for help ourselves and be connected and build positive relationships. All this increases our own resilience and that of the people around us. See case studies p56,59,63,93 for examples of compassionate support.

So compassion works in and through social relationships. In turn social relationships are shaped within specific social norms of thinking and behaviour which may (or may not) be conducive to compassion. This means compassion can be supported or blocked within different social and cultural groups. A real challenge is that it seems the dominant values in current mainstream society and the media are the opposite of qualities associated with compassion. Tragically this has appeared in the Francis review of events at Mid Staffordshire hospital last year, resulting in the NHS talking explicitly about compassion in care

[19].

**Cultivating compassion for myself: key tips[17]**

- *Look for commonalities:* Seeing yourself as similar to others increases feelings of compassion. A recent study shows that something as simple as tapping your fingers to the same rhythm with a stranger increases compassionate behaviour.
- *Calm your inner worrier:* When we let our mind run wild with fear in response to someone else's pain (e.g. What if that happens to me?) we inhibit the biological systems that enable compassion. The practice of mindfulness can help us feel safer in these situations, facilitating compassion.
- *Encourage cooperation, not competition,* even through subtle cues: A seminal study showed that describing a game as a "Community Game" led players to cooperate and share a reward evenly; describing the same game as a "Wall Street Game" made the players more cutthroat and less honest. This is a valuable lesson for teachers, who can promote cooperative learning in the classroom.
- *See people as individuals* (not abstractions): When presented with an appeal from an anti-hunger charity, people were more likely to give money after reading about a starving girl than after reading statistics on starvation — even when those statistics were combined with the girl's story.
- *Don't play the blame game*: When we blame others for their misfortune, we feel less tenderness and concern toward them.
- Notice and savour *how good it feels to be compassionate*. Practicing compassion and engaging in compassionate action bolsters brain activity in areas that signal reward.
- To cultivate compassion in kids, start by *modelling kindness*: research suggests compassion is infectious, so if you want to help compassion spread in the next generation, lead by example.
- *Curb inequality:* Research suggests that as people feel a greater sense of status over others, they feel less compassion, thus inhibit a sense of control in others.
- *Don't be a sponge:* When we completely take on other people's suffering as our own, we risk feeling personally distressed, threatened, and overwhelmed; in some cases, this can even lead to burnout. Instead, try to be receptive to other people's feelings without adopting those feelings as your own.

## Building your own resilience

Building individual resilience depends on some core themes as well as compassion. There are a number of ways that this can be achieved.

Key themes in being resilient[7,12]

***1. Being adaptable i.e. able to improvise***

**Staunch acceptance of reality** Accept setbacks are part of life. So problem solve i.e. be clear what is in your control, what is not and so plan and take action in a compassionate way, including for oneself.

**Embrace change** Accepting and even anticipating change makes it easier to adapt and view new challenges with less anxiety.

**Keep learning from experience** Think back on how you've coped with hardships in the past. Consider the skills and strategies that helped you through rough times. You might even write about past experiences to help you identify both positive and negative behaviour patterns to guide your behaviour in the future.

**Problem solving and action:** Don't ignore your problems or try to wish them away. Although it can take time to recover from a major setback, traumatic event or loss, know that your situation can improve if you actively work at it.

***2. Confidence and self esteem***

**Positive belief in abilities** (self-efficacy) so learn from personal experience, seeing how others succeed, have positive self-talk, balance own emotions.

**Strong sense of self-worth** with strongly held values or core beliefs. Includes identifying self as a survivor not as victim.

**Control in life** making change happen.

***3. Sense of purpose so every day is meaningful***

Having the drive and direction to help you to persist and achieve in the face of setbacks: so be proactive.

**Positive thinking so remain hopeful.** You can't change what's happened in the past, but you can always look toward the future. Humour can help. Do 3 positive things a day. You can't change the situation – but you can think about it differently. Believe in yourself – problems = challenges to be solved.

**Set goals** to help you look toward the future with meaning. Do something that gives you a sense of accomplishment and purpose every day.

***4. Strong relationships and social support***

**Able to ask for help** rather than trying to cope on your own.

**Get connected.** Building strong, positive relationships with loved ones and friends can provide you with support and acceptance in both good times and bad. Build links by doing volunteer work, getting involved in your community, or joining a faith or spiritual community or join a sports team.

***5. Active in coping with adversity using various tools***

Be aware of emotions and behaviours of others, how they affect you and the environment you are in. Once you understand the cause of your emotions, you understand the cause of your reaction and then can identify what might be the most useful things to do. Practising mindfulness is a real help in this.
See www.getselfhelp.co.uk
See www.bemindful.co.uk

**Take care of yourself.** Tend to your own needs and feelings, both physically and emotionally. Do activities and hobbies you enjoy. Include physical activity in your daily routine. Get plenty of sleep. Eat a healthy diet. To restore an inner sense of peace or calm, practice stress management and relaxation techniques, such as yoga, meditation, guided imagery, deep breathing or prayer, the 5 ways to wellbeing[20].

***6.Environment***

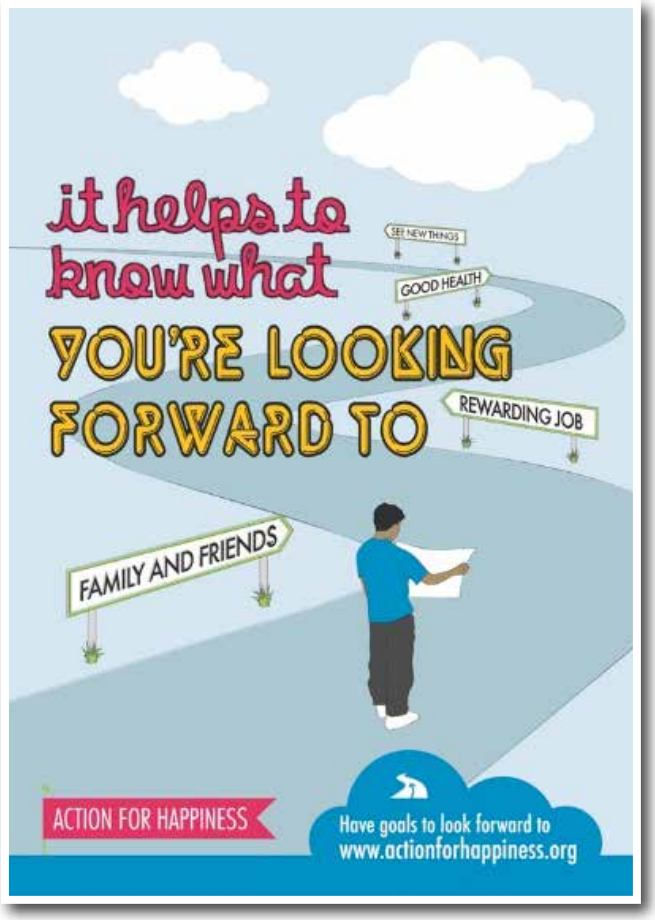
Be aware of what opportunities are around you wto be connected, take care of yourself.

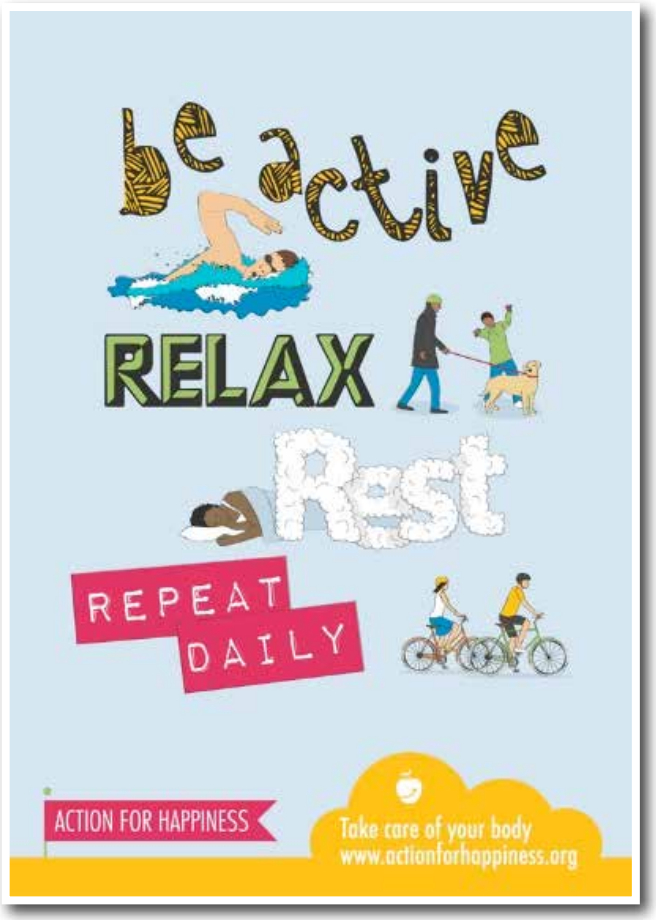
Is your work environment safe, pleasant and supportive in helping you manage mental health issues? Be physically active, eat well and create an environment for "healthy minds" for good work.

To face this challenge is to:

- Start to talk of resilience and compassion to ourselves and in our social interactions and across the cultures of agencies and social groups.
- Think about the three parts to compassion and use the key tips in cultivating compassion as individuals and see what happens.

In building organisational resilience, one of the factors that really help is a positive managerial culture in workplaces, part of which will include compassion to help build the resilience so needed in organisations now, as demand outstrips resources.




**Positive emotions** - like joy, interest, pride and gratitude - don't just feel good in the moment - they also **affect our long term well-being.** Research shows that experiencing positive emotions in a 3-to-1 ratio to negative ones leads to a tipping point beyond which we naturally become more resilient to adversity and better able to achieve things. The evidence linking an upbeat outlook to increased longevity is stronger than the evidence linking obesity to reduced longevity[5].

Each time a person experiences a positive emotion their own thinking and their capacity to think more widely about problems increases, thus increasing their psychological resilience. Over time this builds up to increase resourcefulness in an upward spiral.

## Building community resilience

Resilience can be *'a muscle that must be developed in advance and consistently exercised...'*[4]

Individual resilience is closely linked to connecting with others of their communities. They are mutually dependant. The key is what motivates people to contribute to a community. Is it to help others positively in similar areas or life experience i.e. living in a certain area or having a specific issue e.g. a long term condition or is it for self-gain, possibly with a negative impact on others, or both? To be constructive, a sense of the 3 parts of compassion is crucial, see p41.

| What do individuals need from the community to develop resilience? | What can individuals give to build community resilience? |
|---|---|
| **Supportive peers / friends** so individuals are:<br>• Compassionate: I think, feel and want to help.<br>• Non-judgemental.<br>• Able to tolerate distress.<br>• Caring / want to care.<br>**Inspiring and supportive role models**<br>**Be accepted, trusted and respected by society**<br>**Opportunities to:**<br>• Meet and learn positively from others in similar situations.<br>• Access resources to adapt thinking, understand and manage emotions.<br>• Include the 5 ways to wellbeing into life [20].<br>• Develop a common sense of purpose and interdependence. | • Add to the **diversity** of experience and thinking in the community.<br>• Offer **compassionate** practical **support** to others.<br>• Help to build social network **'connectors.'**<br>• Share coping skills-spread their resilience: **make it infectious.**<br>• **Offer opportunities** to build community-by volunteering e.g. local businesses, arranging community activities.<br>Including natural and built resources. |

**Helen's road to fitness**

Two years ago Helen's partner passed away very suddenly. This came as a huge shock. Helen stopped hiking as it brought back too many memories.

Helen's doctor was keen for her to get active again and prompted her to try something new. On her first walk on her own she saw a sign for a three month trial membership at her local Leisure Centre and her road to fitness began. Within six months Helen began working out with a Personal Trainer. After twelve months Helen had lost 39 kilos and gone down five dress sizes. She'd also made new friends including one who shared her dream to visit the Grand Canyon in America. The trip is now booked and will include a range of physical activities including hikes around the canyon and white water rafting and even a mule ride.

Helen's new goal is to lose a further 10 kilos so she is at the required weight for the mule trek and Kirklees Active Leisure are supporting her to achieve this next goal to enable her to go on a trip of a lifetime.

A useful framework for working with communities is "Wellbeing And Resilience Measurement" [21]. This suggest distinct stages in working with communities, including assessing assets and evaluating the impact of actions:

1. Measuring how the area has fared and is faring.
2. Identifying assets and vulnerabilities.
3. Benchmarking – to disentangle local trends from national trends.
4. Understanding and planning – drawing on this analysis to identify priorities for action, allocating resources or dis-investing.
5. Implementing a plan.

The reference has case studies to show how this can be used effectively. This can be adapted for use depending on the context of the work. Indeed many of the later examples in this report reflect these stages in varying ways, see p48.

*From working with local service users and carers about current services and how could they better meet their need, we were told that they valued:*

- *Being less dependent on external help for managing their issues and conditions.*
- *Having opportunities to self care as a real choice in the support they are offered.*
- *Being able to identify their own needs.*
- *Being able to make their own decisions.*
- *Having opportunities to access information via technology, apps and other mediums.*
- *Having opportunities to give feedback on the services and support they receive.*
- *Being able to identify the impact on their health and well-being and where change is possible.*
- *Feeling confident to manage their condition including their treatment.*

*This entirely fits with supporting local people build their ability to adapt and manage change, i.e. their resilience.*

## What needs to change locally to build /enhance personal resilience?

At the heart of our resilience is how well we can take advantage of the opportunities available to us and whether those opportunities are accessible. Multiple challenges in life really tests our resilience. Any offered support should be aware of the context and challenges facing individuals. So be really person centred.

To build resilience in both individuals and communities we need to transform the support at the front line to enable people to be independent rather than dependent, as much as feasible. This is the heart of the Joint Health & Wellbeing Strategy which says systems need to change to:

- Be person centred not service centred.
- Increase independence and resilience in local people.
- Involve individuals and communities in creating and delivering solutions effective for them.
- Prevention and early intervention i.e. stopping issues starting, detecting them early to take action.
- Promote collaboration, shared responsibility.
- Integrated commissioning and provision of health and social care so people receive coordinated care.
- Manage demand and future need.

The key strands of individual, community and organisational resilience are supported and complemented by the other strategic pillar for Kirklees, the Economic Strategy[22], with its focus on the resilience of businesses and the economy (economic resilience).

How support is given is as important as what is provided: those that show respect and earn the trust of the community help to enhance resilience for people living in adversity. Ideas that support this are[23]:

- Providing non-judgemental spaces (where people feel respected and valued).
- Building self-esteem (by positive affirmation of the individual).
- Listening and responding to needs (using active listening skills).
- Recognising and releasing capability (encouraging the individual to draw on their own strengths and find own solutions in a supportive environment).
- Friendliness (warmth and compassion).

Trust and respect, involving and listening to people, must therefore be key features of any service that seeks to increase clients' personal resilience[24]. This includes services that are not directly focussed on resilience (e.g. housing, employment advice, education) and yet can be delivered in a way that enhances rather than diminishes resilience.

## The personal resilience themes can be introduced to individuals in a number of ways.

1 **Promote the culture of resilience** as a golden thread throughout management staff practice to build personal resilience in all staff by:

***Personal development:***

- Providing tools and resources to assess your resilience
- Identify what you can do about improving your skills in being resilient and compassionate. This is for both staff and service users including information technology / web links such as MiPod for Council staff.
- Seeing people as assets so help users be aware of strengths thus their sense of responsibility. Using the self-care 6 questions is a real help here. See p53.
- Communication skills such as the ability to give and receive feedback; active listening; open questioning; reflective questioning; identifying a problem and then helping a person with the solutions; helping people move on; rapport building, being realistic and honest. This could be through Every Contact Counts or Motivational Interviewing training led by Public Health and other training.
- Reflective supervision, coaching and mentoring.
- Develop coaching as a leadership style and system across organisations / systems.
- Encouraging staff to use networks as ways of sharing experience in resilience.

***Management systems / culture, including social networks and health:***

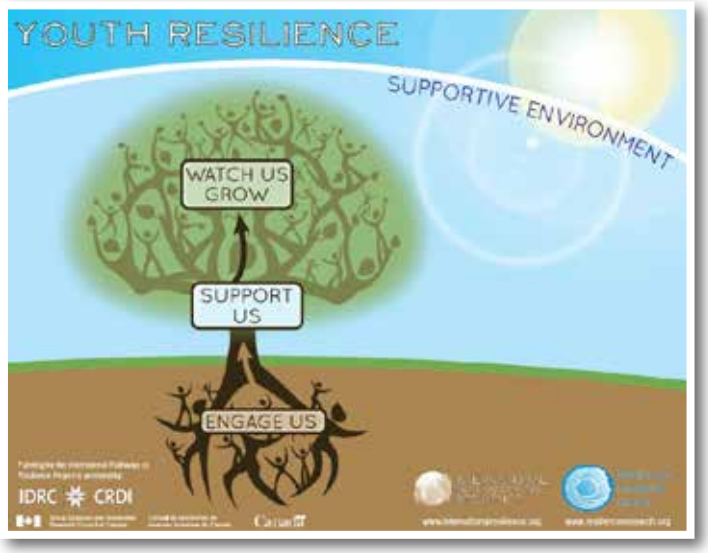
- Ask people what / who has helped them and how they can build on that, can these relationships be strengthened? Are there others that might help?
- Organisational development plans to increase resilience and compassion in the workplace culture.
- Change of mind set from service led to user led, and from doing to supporting / enabling i.e. self care.
- Building resilience themes into appraisals.
- Enhance coaching / supervision systems to help staff build positive, compassionate relationships including valuing own staff.
- Acting as role models within organisations and across networks.
- Recruit for values / skills that support resilience, so as to have more people that live these values.
- Develop peer led / buddy schemes to support colleagues and service users.
- Identify teachable / shareable moments of resilience with each other.
- Undertake a self-assessment against the national Workplace Wellbeing Charter[9].
- Promote activities that promote health and wellbeing - such as physical activity, eating well and being creative, also help promote positive emotions and hence resilience. Promoting mindfulness is a real help in being more emotionally aware and thus resilient (see earlier).
- Self care approaches and interventions (e.g. the self care hub, care navigators, expert patient programme, carer support, health trainers), and therapeutic services (e.g. Improving Access to Psychological Therapies, Cognitive Behavioural Approaches). See later in this chapter.

Self care is described in detail in the next section as this is a major part of the redesign of health and social care. The core principles described there should also apply to any service.

## 2 For young children

Specifically for young people, the 2 core themes of "connect us" and "support us" reinforce the above and also others such as: Resilience Research Centre (2014). Pathways to Resilience [online][26].

- Positive parenting and appropriate support from other significant adults (such as carers, teachers, relatives and youth workers) can help a young person develop their self-esteem and self-confidence. For example, the SCIE Resource Guide on Promoting Resilience in fostered children and young people provides practical advice for professionals to help children build their self-esteem, sense of purpose and relationship skills[25]. The emerging Nurturing Parent programme is designed to support resilience of both parents and their children - see p85.
- How safe does a youth feel in their home and community?
- Provide them with unconditional positive regard. They will mess up and that's ok, help them to learn from their mistake; be compassionate especially leaving your problems at home.
- Be consistent, they appreciate knowing you will react in the same way each day.
- Give youth power and choice: so explain why rules are in place and be consistent in enforcing them. Rather than tell them to do something, give them a choice.




## 3 Build community resilience

As community resilience means communities thriving in the face of change or adversity while they adapt to fulfil their potential then[3]:

- What would help communities 'flex' and build their muscles? Especially those communities that have remained the same for long periods of time?
- Then, what motivates communities to identify unknown assets and create positive change? This is where the links to others is important - for inspiration as well as opportunities.

*"If you have got that community feeling then you don't feel isolated, which then goes back to the depression and the not being healthy, like I said you need people to talk to even if it is a stranger, if you can come into the centre and just express the way that you are feeling to a member of staff or get some help or whatever, that is a part of the community, that's what we do, that's how we help, we are local people working in the local community and we are here to offer a service but if you didn't have that opportunity, you then feel isolated stuck in your house all day and you then become depressed so it's a circle really. You do want to be part of the community because otherwise you will be isolated".*

There are some actions that are known to help sustain community resilience[3,11,27]. These are shown below with many examples of local working:

1. Helping communities to identify assets, signposting to community resources, sharing success stories and exploring the reasons why they succeeded. Ask, Ask, and Ask... Asking questions rather than giving answers invites stronger participation as does a listening conversation.

2. Raise aspirations: getting people to see they can do things and they have skills i.e. value them for their strengths not their deficits. This helps them develop more skill and get them motivated to act. *The Welcome Centre runs a volunteer programme which recruits volunteers from vulnerable groups and helps them to develop their skills and confidence which in turn has helped people to get in to work. One Good Turn is another organisation which does. Better in Kirklees focusses on helping vulnerable people to access activities and to become involved in giving back to their community through identifying people's strengths and skills.*
3. Working within the cultures and social norms of behaviour of the community.

*Funding single sex, and similar, projects where appropriate: e.g. a south Asian bereavement project; Hum Tum which supports people with learning disabilities and their carers from the South Asian community; a Sudanese community project; a project for the elderly Polish community.*

4. Networking between local groups and organisations: Local leaders who realise the importance of relationships with other stakeholders, organisations whether voluntary, statutory or other. So helping the communities to learn and think differently.

*Organisations are encouraged to work together and to share skills. "Better in Kirklees" set up community networks in North Kirklees to encourage organisations to do just this and so far 90 organisations have signed up. Four medium to large organisations are funded as Development Hubs to further this initiative and work towards being seen as local leaders. 'Gearing Up' events occur for the Voluntary and Community Sector (VCS) around funding, sustainability, good governance etc. which provide great networking opportunities.*

5. Learning: especially entrepreneurial skills, leadership skills for communities.

*The Council work with VCS organisations to be aware of learning opportunities available to them including opening up some of the Council's training such as a Step Ahead programme. This focusses on leadership and management; successful organisations are almost always ones which are very well led and managed.*

6. Supporting the creation of sustainable groups around community issues. Sustainability is crucial so organisations are helped to look at their running costs, how they can charge and raise other funds to support themselves.

*Many groups are supported to be set up each year. Council officers explore with potential organisations why they want to set something up, what the need is, who they think will attend etc. For example a group funded to support retired and working farmers. This arose because the Farming Community Network was concerned about the levels of mental ill-health issues in the farming community. These issues arise from the pressures of being a modern day farmer, who have higher than average rates of depression and suicide. A monthly peer support group is now run by volunteers who also signpost people to other support services when necessary.*

7. Strengthen public and voluntary sector partnerships.

*The Council work with the VCS increasingly in a co-productive way and on an equal footing. We are moving away from the attitude of we're the Council and the funder and therefore we have more control, to one of equal partnership. The VCS has suggested where the partnership could be improved i.e. less bureaucracy, sharing of council resources when they are not being used, and a more transparent relationship etc.*

8. Resourcing: skills or localised micro funds to seed voluntary sector activity including guidance on how local businesses can contribute financially/donate funds for community projects.

*Council funding helps set up activities and support some ongoing costs, where at least 50% of funds are coming from the organisation itself, so reducing the need for Council funding. An example is two business connectors in Kirklees as part of the lottery funded "Business in the Community" project. They support organisations to work with businesses and to benefit from their expertise, knowledge and in some cases funding and/or equipment. We work closely with the Business Connectors and ask them to work with many organisations that come to the Council for funding.*

9. Focus on both people and places i.e. the infrastructure of an area.

*It is important to work with not only people who run community centres and other local physical assets, people who make things happen in communities and other stakeholders such as councillors. One example is Rawthorpe Community Centre. This is a single storey building on a large estate in Huddersfield. There are a few people very actively involved in this centre combined with a local Councillor. So a community building is being used by residents in the area, who deliver and facilitate services for local people on their doorstep.See the case study overleaf about how residents of Firthcliffe came together with the local school and council engagement staff to develop community networks and identify community buildings such as the school for multiple uses.*

10. Do not ignore the quiet communities, they may be those with close ties that stifle aspiration or have very little internal links.

*"Local Services 2 You" concentrates on identifying and supporting people who are isolated in the Deighton and Brackenhall area. There are some great examples of people who did very little outside their home and whose health was poor who are now engaged and taking part in local activities, which are helping to improve both their mental and physical health.* See p95.

11. Pulling in resources and activities from the wider community to implement the action plan, not just plan it.

*There are lots of opportunities to engage with the VCS on implementing an action plan. A member of the Council's Community Partnership team was recently involved in a sexual health consultation in two ways: Knowing where to go to engage with the African Caribbean community, so helping their opinions shape what should happen.*

12. Strengthening essential infrastructure e.g. make sure communities are well connected elsewhere - transport networks, virtual networks.

***"Community conversations"*** *was created by Kirklees Council as an online tool for voluntary and community organizations in Kirklees to share what they know and make new connections (both with each other and with local service providers). The content on the site comes from lots of different organisations and the blog features on other web sites. Community organisations, volunteers and people whose work involves supporting voluntary groups are all authors on the blog.*

These asset-based approaches seek to bolster wellbeing at individual and community levels, helping to increase resilience to any wider corrosive effects of social norms. For example, peer mentoring can build resilience in children and young people, and has been used widely to reduce bullying and its affects. Adults in a community can be trained to coach or mentor a young person to help them develop their resilience. There are good examples of this success such as in youth offending and employability programmes.

Befriending groups support social connectedness, and self care approaches should support individuals to get connected. Programmes such as the Physical Activity & Leisure Scheme for those with long term conditions provide opportunities for connectedness whilst also providing opportunities for physical activity, thus building some of the elements of resilience. See p67.

Various evaluations have shown that personal resilience increases in those participating i.e. feeling competent, engaged, life having a purpose, optimism and self-esteem.

Watch this website link to the success of some of the food growing work in Kirklees The film captures the impact food growing has had on individuals, the community, the environment
and the economy.

https://www.youtube.com/watch?v=cjxMktcoYw0&feature=youtu.be

These are just a few examples of the work of the Council in building resilience locally. The ward work of the councillors cannot be underestimated in its significance and contribution.

**Developing community capacity and relationships in Firthcliffe, Liversedge**

Residents in Firthcliffe have been involved in identifying how they can improve their health and wellbeing. Free fun and healthy community events were held at various locations and included face painting and healthy food. Questionnaires and group discussions helped capture residents views about their health, lifestyle and how to improve their health.

Following the events local residents were encouraged to act as 'connectors' to involve more residents and an eight week Cook and Eat programme and Get Fit sessions for young people took place.

**Help for steroid users in Kirklees**

Partnership working between Lifeline services and Kirklees Active Leisure has benefited steroid users. Lifeline staff have delivered training to Kirklees Active Leisure staff which has helped them have an increased awareness of steroid use and also made them feel more confident in signposting people to Lifeline. Lifeline are then able to offered people access to support, needle disposal services and learning groups. KAL staff have also been able to help raise awareness of the key ways that muscle and size can be gained without the use of performance enhancing drugs.

**Women sharing talent**

Women sharing talent, a weekly project in Batley helps to support women to manage anxiety and depression and build their self-esteem and confidence. Creative opportunities to experience artwork have helped the women feel more positive. A community event was also held at Batley Town Hall to share the talent and also celebrate International Women's day.

The meetings offered a range of activities for the women to get involved in, as well as peer support and opportunities for them to make friends and meet people from other backgrounds.

A variety of groups participated in the project including Khoosh Women, Batley Creative Writers Group, PKWA women, Friends in the Square, Batley Girl Guides, Lepton Women Church Group, Talking Zebra's and Yorkshire Adabee Forum. Over 163 adults and 45 children took part in the project.

**It's up to you**

It's up to you is a new initiative that encourages people to share their ideas for projects, and bid for the funding to deliver those projects.

At a community event, local people can then vote for the projects they most want to see happen. It's up you pilot events have been held throughout Kirklees where community groups could bid for up to £500 and individuals for up to £100. Offering small amounts of money means that the scheme is open to more people and more ideas, and projects are aimed at a local level.

Some of the ideas funded included a Jiu-jitsu club, books for a school library, a memorial garden and 'cook and eat' classes – all run by and for local people.

Bob, who is currently unemployed, submitted an idea to the scheme to develop a gardening project in his local community. Bob was offering his time and requested £100 to buy gardening equipment to allow him to help elderly and vulnerable neighbours who are unable to maintain their own gardens. Bob hopes he can develop a business as a community gardener and is hoping through volunteering he will be able to increase his skills and confidence to see if he can develop this further.

Bob said *"I feel I can offer my time and labour free and would like to support people who have little or no family and I would like to put something back into my community by helping others."*

*It's up to you is a great way to give people a say on what goes on in their communities. More events will be taking place to give others a real life experience of making community–based decisions and allocating a budget.*

Fundamentally, if every interaction an individual has with services and interventions is an experience that builds a positive feeling, then their personal resilience will develop. For example, a session with the Council customer service centre about benefits may not be able to immediately provide financial relief, but when it is delivered compassionately and with respect then the individual feels supported and cared for, thus developing a positive rather than a negative emotional experience and thus more control, *"I can cope and do this myself."*

## Building resilience through self care

Self care is one of the key approaches to supporting people to be more resilient i.e. increasingly independent, self-sufficient and resourceful. Thus better able to help themselves, no matter their level of dependence. Combining self care with effective prevention and early intervention helps people to live as well as they can and maintain their dignity for as long as possible. The added benefit is reducing demand for expensive, intensive social care and health support packages or even when these are required, taking a real person centred approach the individual feels more informed, more able to make decisions about their care and feel in control.

Self care is something that is important for everyone in daily life. It's knowing what you can do to manage your needs, feeling in control of those needs and taking responsibility for your own health and wellbeing. So self care is being able to answer the 6 core questions - see box.

We all do this every day and as a result can feel in control over our lives. But when we fall ill in any way, often we need to know more about what the problem is and what can be done and what we ourselves can do. Without knowing this we lose control, become dependent on someone else and may begin to feel quite anxious about the future.

For someone with a long term condition such as heart disease, diabetes, long term pain then staying healthy is not so easy. Their challenge is retaining that control over their condition and their lives by being able to answer those questions.

### Why is self care important?

Currently 1 in 4 people in Kirklees live with a long term condition[28]. This refers to a range of conditions that can be managed, but often not cured, such as diabetes, arthritis, asthma and cardiovascular disease. People with long term conditions spend on average just four hours a year with a health professional and the remaining 8,756 they manage their condition themselves[29]. People with long term conditions are the highest users of health and social care services, so taking a self care approach to care means users feel more in control and have less need to use services[29]. See p.46

**The self care core questions**

Self care is being able to answer these questions

1. *What's important for me, what's important for my health?*
2. *What can I do to help myself?*
3. *Do I know what to do if I get stuck?*
4. *What on-going support do I need?*
5. *What skills do I need to keep well?*
6. *Do I have the information / knowledge about my condition or situation, and how it affects me now and in future?*

So in trying to think what are the important things affecting my own health a useful tool is the rainbow of health, see introduction. It might be useful to think what helps and what are the barriers to what I want to do?

Having drawn out what are the important things, then which of these are changeable?

Do I need help in knowing what can be done to change these factors? Is this more information?
Is this learning from others? What can be feasible?

Do I need to talk to someone about what can be changed?

Then I can decide what I can do to help myself and what help I need from elsewhere, whether via the internet or speaking to someone or joining a group. From this I can set goals to aim for over the next few days, few weeks, few months...

**Regaining control over ill-health**

Gwen is 88 years old. She received support from the re-ablement service following eye surgery to remove a cancerous lump. Gwen also had a racing heart, water on the lungs and a bad cough. She was starting to make progress but there were concerns about her ongoing care.

A Care Navigator met with Gwen and talked about support. The Care Navigator helped Gwen employ a home care service, find a befriender, use a supermarket shopping service and have meals delivered.

A supporting people service was also arranged to help Gwen manage her bills and get back on top of things.

Gwen also had a lot of medication to take to manage her long term health conditions. A Health Trainer spoke to Gwen about her tablets, arranged to have them delivered in blister packs and gave Gwen information and help to improve her diet. Gwen is managing her condition well and continues to live in her own home thanks to the support she now receives.

**From dependency to volunteering**

Sophie suffers with ME (Chronic Fatigue Syndrome), Fibromyalgia, Endometriosis and chronic pain. When the ME is bad she can be completely immobile and cannot get out of bed for hours. Since she was diagnosed with ME she has put on weight mainly because she isn't able to make healthy meals and has been relying on pre-packaged microwaveable foods as they are easy to prepare.

A health trainer visited Sophie to find out what her key issues were and what could be done to help her manage her health. The health trainer also helped Sophie to identify things that she did well.The health trainer helped Sophie to do more to help herself and address what is important to her. A programme was developed for Sophie which included relaxation techniques, how to pace her activities and how to have a more healthy balanced diet.

Through working with the health trainer Sophie understands what to do if she experiences a set-back. She also has a good understanding of where to access information about her conditions including using the Kirklees Persistent Pain website and different services within the community. Sophie feels much more confident and in control of her long term health conditions as a result of the support she received and is now looking into becoming a volunteer.

## The benefits of self care

Local and national evidence shows that people who have learnt to manage their long term condition effectively are often healthier than those who rely on others to make all the decisions for them, see case study[29]. The use of self care approaches can increase people's sense of control and reduce people's dependence on professionals, meaning they have[29,30,31]:

- Better control over symptoms.
- Confidence in managing their condition (self-efficacy).
- Reductions in pain, anxiety and depression levels.
- Improved quality of life with greater independence.
- Reduce days off work by 50%.
- Increased participation in community activities.

When people are confident and in control of their condition, this can impact on the use of services:

- Care planning can save 210 admissions per year in a GP practice of average list size[32].
- Visits to GPs can drop by up to 40%[29].
- Outpatient visits can drop by 17%[29].
- A&E visits can drop by up to 50%[29].
- Hospital admissions can drop by up to 50% and reduce length of stay[29,33].
- Medicines use is reduced by up to 35% and used more effectively[30,34].
- Also see Kirkburton case study, see p65.

**Working in partnership in care planning**

Mr P, a 42 year old Indian man was diagnosed with type 2 Diabetes in 2008. At diagnosis his HbA1c (overall blood sugar) was 8.4% (ie at diabetic level) and although his blood pressure has remained within target, his cholesterol was also raised at 5.5; he was overweight and a smoker.

Right from the start, after a motivational interview with the nursing staff, involving him in his results and setting targets, Mr P was keen to change things himself rather than just accepting medication and doing nothing.

As a result of the Care Planning approach, over time, Mr P stopped smoking with help from a Smoking Cessation trained Nurse. He also really benefitted from a DESMOND* course, making a lot of changes to his diet due to his learning there. He decided to go to PALS and now attends the gym three times a week. He began to enjoy physical activity and also took up cycling. At regular Care Planning reviews, targets and goals were discussed. Mr P made his own decisions about how he can try to meet them. The decision to start a Metformin tablet was entirely his so he is likely to take it regularly. He chose not to take a statin to control his cholesterol, preferring to concentrate on diet and physical activity, reducing it from 5.5 to 5 mol/l. Not perfect yet, but he knows the score and prefers to keep trying.

His choices resulted in bringing his blood sugar back under control (has been between 6 and 6.7 for some time now), a weight loss of 3.1 kg, cholesterol under reasonable control, ex- smoker status and a love of exercise. He maintains everything on only 1 tablet a day.

Mr P is proud of his achievements and now requires very little input from the nursing staff. He required no input at all from Doctors, making the Care Planning approach very cost effective in the long run. He expressed his gratitude to the Nursing staff, he brought them a small gift and said,

*'I'd like to thank you for working with me over the last few years to help me to do things my way'.*

* DESMOND is a peer education and support programme for people with diabetes.

## What do systems need to do to help people help themselves as much as feasible?

The JHWS is all about doing things differently so refocus health and social care to help people do more to help themselves, whatever their level of vulnerability or ill-health. This means that in Kirklees:

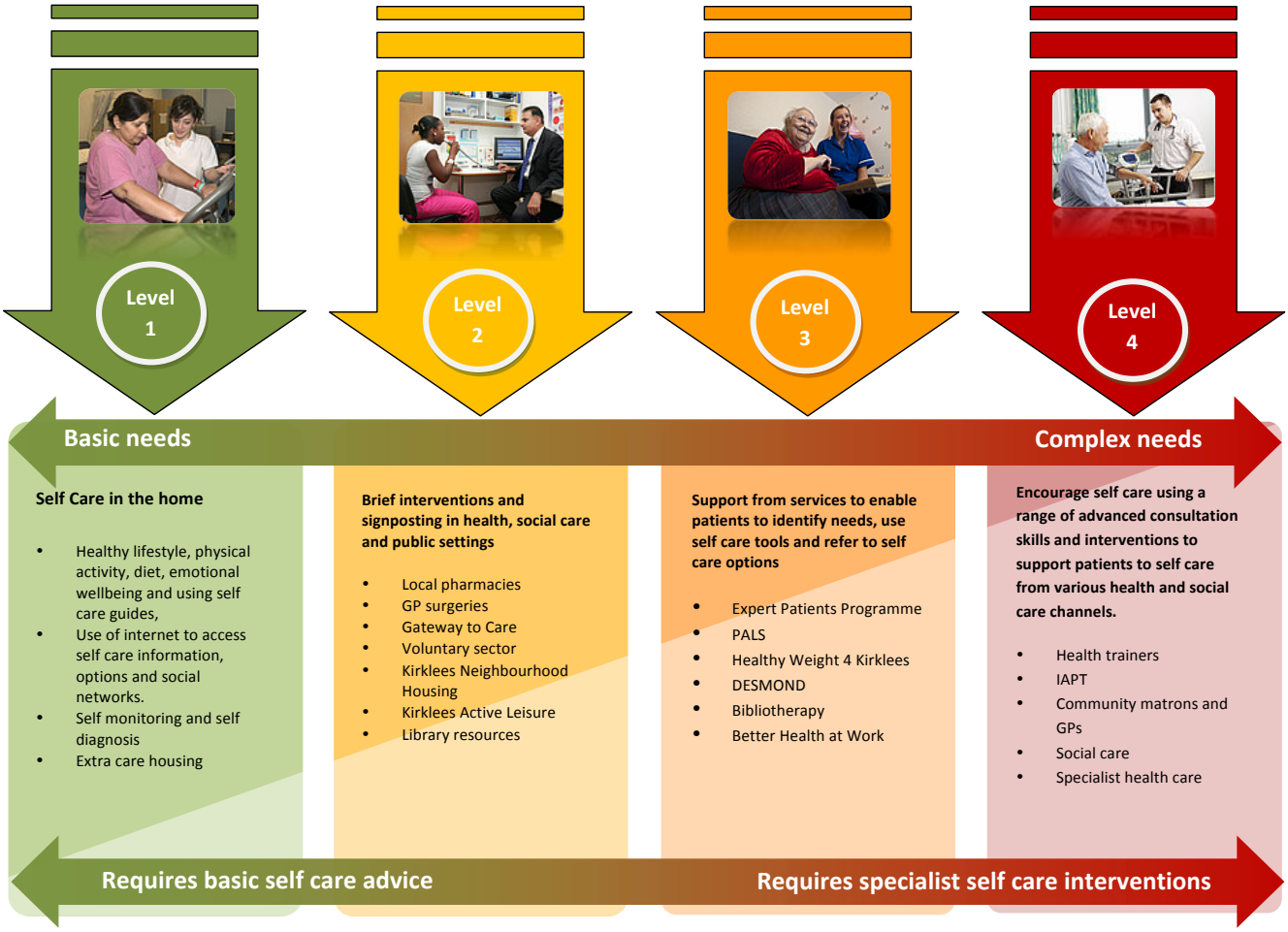
***People with long term conditions are increasingly independent, self-sufficient and resourceful to confidently manage their needs, thus reduce dependency on the health and social care system and improving their wellbeing and lifestyle.***

To help local people achieve this by answering the self care questions, then systems need to transform so their users:

- Can increase their sense of control in their lives.
- Feel confident to assess and address their health and well-being needs.
- 'Are able to accept living with their health condition.
- Are able to problem solve, make changes and manage their thinking, moods and behaviours positively.
- Live as active participants in their communities, using their own assets as much as possible.
See p46,48

There are a range of resources available now to an individual living in Kirklees, see fig1. Those relevent to a person depend on thier ability to answer the self care questions. This in turn depends on their own experience and knowledge as well as support from significant others.

Fig 1 Spectrum of Self Care



**Taking back control over pain**

Anna has chronic pain from damaged vertebrae in her spine, osteoporosis and depression. She self-referred into the Kirklees Health Trainer service.

Anna presented with a lot of pain and was hardly able to walk. Due to a stomach condition, she was unable to take pain killers but was on intravenous medication for the osteoarthritis. The pain contributed to her depression and she would sometimes spend days in bed because of it.

The health trainer worked with Anna to identify some personal goals. The health trainer also signposted Anna to the Kirklees Pain Management Solutions Service, Expert Patient Programme (EPP) and the Practice Activity and Leisure Scheme (PALS). See p.65,67.

By the fourth meeting, Anna's pain and mood had significantly improved. She had been seen by a pain specialist and had received treatment which had improved her pain. The self-help advice Anna had received from the Health Trainer service had helped her to eat more healthily and she had lost a few pounds in weight. Anna was also exercising on a regular basis and doing her breathing techniques.

The health trainer supported Anna to form her own conclusions about her condition which helped Anna decided how to cope with her situations. Anna now realises that she is in charge of her own emotions and capabilities.

*"Since the 6 meetings I have had with her, I have felt like I want to beat the depression I have had for nearly 30 years. If it was not for the health trainer, I could have gone on for the next 30 years still in fear of moving on and not being happy. I now wake each morning using the techniques she has taught me over the last couple of weeks and already I am seeing a massive improvement in the way I look at life."*

*(Health Trainer client)*

*"I learnt new skills through relaxing rather than just relying on medication."*

*(Pain Self-Management Service Patient)*

*"I felt they helped me understand my problem and gave me a more positive outlook for my future and lifted my self-esteem."*

*(Pain Self-Management Service Patient)*

*"It has helped me to change my lifestyle, learning to pace myself and relax more."*

*(Pain Self-Management Service Patient)*

**Feedback from EPP participants**

- *It opened up new ways of dealing with having a long term medical condition and a new sense of fulfilment which in turn made me think about applying for tutor training.*
- *I communicate better with my husband and doctors.*
- *I can plan my life and try to be more positive using my mind.*
- *Feel less isolated and can tackle life.*
- *Can work towards my action plan with support.*
- *More understanding of various emotions and have the ability to tackle them.*
- *I can relax properly and switch off.*
- *To try communicate better with my husband and doctors.*
- *Not to be so hard on myself.*
- *I found out about other sources like PALS and Gateway to Care.*
- *It opened up new ways of dealing with having a long term medical condition and a new sense of fulfilment which in turn made me think about applying for tutor training.*
- *It is not about taking the pain away or fixing you, it's about helping you to manage what you can and can't do and giving you the tools to do this i.e. taking small steps and only doing what your body will allow.*

## Expert Patient Programme

This is a self-management programme for people living with a long-term condition. It supports people by:

- Increasing their confidence.
- Improving their quality of life.
- Helping them manage their condition more effectively.

The course is free and consists of six consecutive weekly sessions, with each session lasting around 2 1/2 hours. Topics covered include:

- Dealing with pain and extreme tiredness.
- Coping with feelings of depression and low mood.
- Relaxation techniques and exercise.
- Healthy eating.
- Making decisions.
- Weight management.
- Communicating with family, friends and professionals.
- Planning for the future.

The sessions are each run by two tutors who both have a long term condition. In Kirklees there are 31 trained volunteer tutors.

### What is an expert patient?

People living with a long term condition often understand their condition better than the practitioners who work with them. There is evidence that, with proper support, people with a long term condition can take the lead in managing their condition[30]. This helps to improve their health and quality of life, and reduces their incapacity (lack of strength or ability).

An expert patient is someone who:

- Feels confident and in control of their life.
- Aims to manage their condition and its treatment in partnership with healthcare professionals.
- Communicates effectively with professionals and is willing to share responsibility for treatment.
- Is realistic about how their condition affects them and their family.
- Uses their skills and knowledge to lead a full life.

### Who participates in the local programme?

More women than men attend the programme, 2 women to every 1 man. Two thirds are White British. The programme attracts a wide age range, 18-85+ years, mostly 45-74 years.

### Impact of EPP

The EPP programme uses a wellbeing star to measure changes in outcomes for participants. Participants score themselves 1 to 5 (5 being the most positive outcome or that people don't perceive that their condition has an impact on that particular domain) on 8 domains:

- Lifestyle
- Looking after yourself
- Managing your symptoms
- Work, volunteering and other activities
- Money
- Where you live
- Family and friends
- Feeling positive

**The % change in participants scoring 4 or 5 on the Wellbeing Star domains before and afterthe Expert Patient Programme**

| Wellbeing Star Domain | Lifestyle | Looking after yourself | Managing Symptoms | Work & voluntary | Money | Where you live | Family and Friends | Feeling Positive |
|---|---|---|---|---|---|---|---|---|
| % Change in proportion scoring 4 or 5 | +39% | +29% | +37% | +29% | +13% | +10% | +25% | +49% |

Typically, each domain shows a reduction in the proportion of participants scoring poorly and an increase in higher scores on the Wellbeing Star measure on completion of the Expert Patient Programme, although this varies by domain.

## The Health Trainer Service

Health Trainers work with people on a one-to-one basis that has a long term condition to manage their health better. They are trained to use motivational techniques and positive lifestyle changes to help people:

- Identify their health needs.
- Recognise the triggers that set off their condition
- Care for themselves better and achieve their goals.
- Make changes to their life to make them healthier and happier.
- Help identify barriers that might prevent them from making healthier choices and look at ways to overcome them.

Referral can be via a health and social care practitioner or by self-referral.

**Who participates?**

Health trainers see more than 1,000 people per year. Although they can see anyone with a long term condition they most commonly see people with:

- Mental Health issues (22%)
- Chronic pain, including arthritis (22%)
- Diabetes (8.4%)
- Asthma (5%)

**Impact of the service**

As part of the intervention people are encouraged to set goals, of those who did:

- 37% fully achieved the goals they set.
- 23% partially achieved their goals.
- 4% didn't achieve their goals.

The service measures people's level of confidence to manage their condition or address their own health needs, called self-efficacy. Levels of confidence are assessed at the first appointment and again on discharge from the service. 91% of participants improved their confidence and ability to cope as a result of working with the health trainers, on average by 30%.

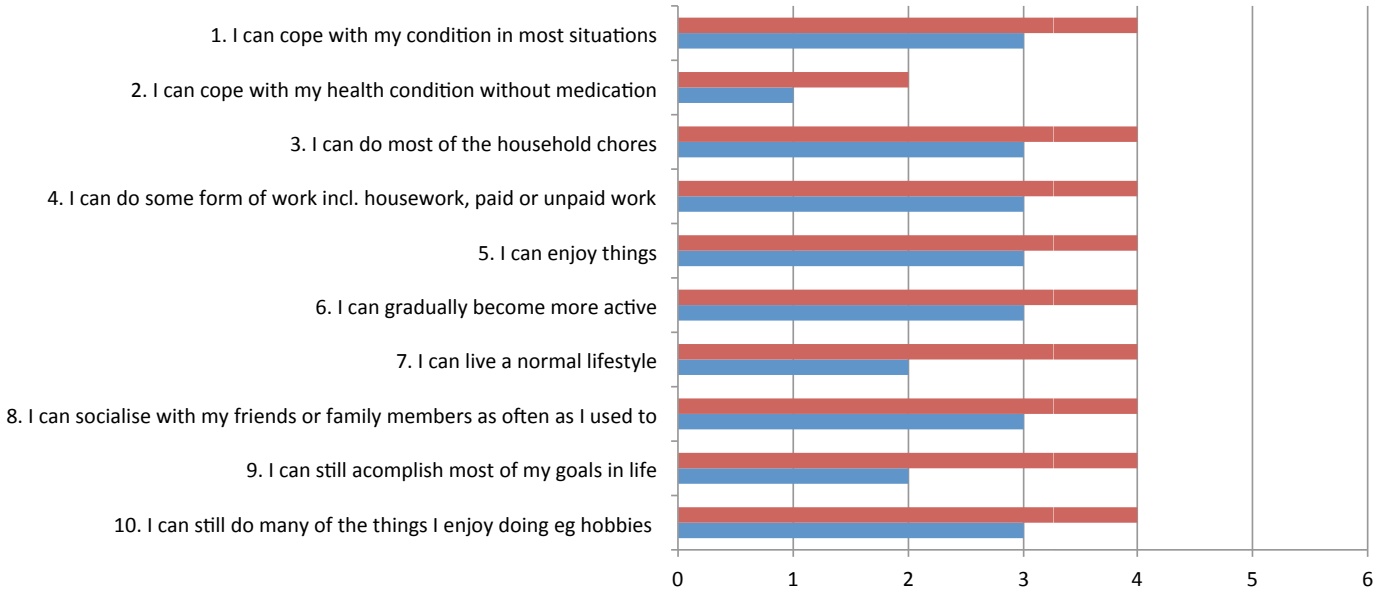
*Can I please start by thanking the people who made these sessions available, and most importantly may I say a thank you to my health trainer? Since the 6 meetings I have had with her, I have felt like I want to beat the depression I have had for nearly 30 years. If it was not for the health trainer, I could have gone on for the next 30 years still in fear of moving on and not being happy. I now wake each morning using the techniques she has taught me over the last couple of weeks and already I am seeing a massive improvement in the way I look at life.*

*I am very grateful for everyone's kind and professional work. I hope anyone else with depression is lucky enough to get the help I did. Thank you.*

*When I started with this service I was not sure that anything could help me. Within 3 months I have found that putting into practice all (or most) of the things we have talked about in my sessions has had a huge impact (for the better) on my whole life and my thinking about my future. So I shall keep up with what I have learned and hope to have a much brighter future than I had anticipated.*
*This service has helped me immensely thank you.*

**Self efficacy Average Score per question pre and post Health Trainer contacts ***

**Despite my condition:**




* The lower the score the more positive a person feels.

**Adult social care** enables people to help themselves by providing a range of services including advice, information, assistive technology and equipment. The approach is early intervention, prevention and reablement, all of which focus on enabling people to self care or, where they do need statutory support to meet assessed needs, to have control and choice as to how that support is provided. So all those with eligible needs receive a personal budget and they can take this in money or as a service or a mix of both.

The Self Directed Support pathway aims to address peoples' enquires at the first opportunity through the Single Point of Access (SPA). Should the person need more in-depth advice and support then they are referred to the Early Intervention services such as Care Navigation, Health Trainers, Sensory Services or Volunteering. The intervention of one or more of these services helps the person to find low level options or alternatives such as engaging in community activity, setting personal goals to achieve self care management of long term health conditions, using assistive technology. For those who need practical assistance to regain skills, confidence or to find different ways of self managing in their home, the Reablement service is provided for a period of up to six weeks.

Of the 4,950 referrals to the above between April and June 2014:

- 33% of enquiries are addressed at the Single Point of Access 2. 57% are then addressed at the Early Intervention and Reablement services (this includes those with eligible needs for social care)
- 10% have a formal assessment. This is for those for whom reablement services are not deemed appropriate. This is less than in 2013-14, when the formal assessments were 24% of enquiries.
- Of those going through a period of reablement, 73% do not require ongoing support at the time of discharge.

Given the insight from local people about their experiences of services then there is scope for services to become more self care friendly. Self care does not mean leaving the person to just get on with it, but supporting them to answer the 6 questions and know where to get the help they need, when they need it.

**How can services become more self care friendly?**

From experience, nationally and locally there are a number of features that systems and services need to think about in making themselves self care friendly. They need to ensure their users[35,36,37,38]:

- Are ***active partners*** with their care providers so they are fully involved in decision making.
- Can ***talk confidently*** with their health and social care providers about their needs.
- Can develop a ***self-authored care plan*** which includes self-assessment so they can identify their priorities and feel ownership of the plan[34].
- Can ***manage risk taking*** in maximising their independence and choice.
- Can ***access networks*** to be able to talk to others in the same situation about wider needs.
- Have ***support from significant others*** in their life / carers.
- Experience ***timely, consistent and effective*** support.

So we need to ensure that all the above features are part of all health and social care systems, whether as commissioners or providers. To really increase the number and range of services that have these features there are four groups of actions to change the way systems interact with local people from reviews of existing evidence[36]. There are excellent recent reviews of the evidence behind person centred / self care from the National Voices website[37].
The most effective actions are listed below.


***1.Local people can develop skills to self care***

The practitioners in services and systems need to support users / patients to:

- Identify their own needs regularly, including providing information and updating their care plan.
- Be confident to manage their treatment safely and deal with any setbacks.
- Make decisions.
- Increase their healthy behaviours i.e. eat healthily, physical activity, safe sexual activity, not smoking.

So local people and practitioners increase their skills such as self-advocacy, goal setting, motivational support to increase self-awareness, resilience, negotiation, problem solving, understanding psychosocial needs, identifying and managing risks, and creating a self-authored management plan.

***2. Local people can access appropriate resources***

- Easily accessible timely and consistent information which offers positive support advice and support e.g. patient question prompts, patient decisions tools, access to their own records, telephone helplines, tele monitoring and tele counselling.
- Information / technology to support the development of skills, knowledge, getting help and monitoring health.
- Be aware of support networks, processes and pathways available to them e.g. group based programmes such as EPP both generic and conditions specific.

This is by accessing networks so people, their families and carers can talk to others in similar situations e.g. Expert Patient Programme; Physical Activity and Leisure Scheme; DESMOND for people with diabetes; Pain Management programmes, see case studies. Also they can access useful information technology such as "Connect to Support" development of skills, knowledge, sites that can identify where to get help and tools to monitor one's own health.

### 3. *Local people can have the support to answer the 6 questions*

- Be able to create a self authored care plan. See p.54
- Be involved in the planning, design and delivery of support and care, including evaluation.
- Behavioural and cultural change occurs in systems Wide understanding of what self care is; to ensure this thinking is embedded everywhere by asking how the 6 questions would be answered by services.

### 4. *What and how should behavioural and cultural change occur in organisation to embed self care?*

- Accept that to keep people at lowest level of need requires a really different way of thinking and working through using the self-care 6 questions, skills, tools and resources.
- Real understanding of self care vision, 6 questions and principles and why they are important for the whole organisation in the benefits it brings.
- Use of patient question prompts and patient decision aids.
- Integration of health and social care so:
  - -Consistent approach to self care including person centred needs assessment.
  - -Better coordination of support and communication i.e. people tell their story once.
  - -Continuity of care[38].
  - -Care plans coproduced and used with the patient / carer.
  - -Consistent clear care pathways / processes to support users to self care.
- Awareness of networks / resources that are available to support patients / carers. Such as Expert Patient Programme, PALS, voluntary groups locally.
- Improve variable quality of staff skills, recruit people with the right behaviours, understanding and engagement with individuals so invest in training programme that supports:
  - -Communication skills especially comparison[39].
  - -Use of consistent self care core skills, tools and resources.
  - -Consistent care pathways.
  - -Working with the person as a whole and as an equal partner.
- Develop IT to record assessment, monitor actions, outcomes that is shared / owned by the patient.

Above all, communicating effectively at the front line with an individual, throughout services and across communities to help individuals to assess their needs, and develop and gain confidence to self care.

**An example of a service that focused on self care**

Chronic pain has long been identified as one of the greatest impacts on local health in both size and severity, as well as cause of work absence over the past decade in Kirklees DPH Annual Reports and JSNAs. To address this, a service was piloted in South Kirklees to address the issues facing people with chronic pain. This Kirklees Pain Self-Management Service was designed on the self care questions outlined above.

The case study shows the potential to identify a way of providing a service in a different way that better meets the needs of people with chronic pain and saves money.

## What usually happens with people who have chronic pain?

People with chronic pain are high users of health services and their choice of services is often limited to their GP or more invasive secondary care interventions that have varying levels of effectiveness. It is not uncommon for people to live with chronic pain for a long time trying different medications before they are referred on to other options, when they are, they can end up in a number of places before they find the right person with the right expertise to meet their needs.

Patients were asked about their experience in 2009 to inform the redesign of services for people with chronic pain in Huddersfield. It highlighted some of the issues for service users:

*"Pain is invisible, we all look fine sitting here."*

*"For those not knowing about it, they don't 'see' the pain. Others cannot realise what effort is put in to just doing everyday things."*

*"It's getting through the system to get to the person you need but you don't always know who you need."*

*"You have to be so demanding to be able to get help."*

*"I have had so many pain killers the doctor doesn't know what else to give me."*

*"Every time we think of pain, we go to a GP. We are centred around GPs... We cannot access services unless GP refers us, you need to break that bond."*

The Council's Scrutiny Committee comprehensively reviewed support for people with chronic pain in 2008-09 and reported that[40]:

1. Inequalities in the management of pain exist for a variety of reasons:

- There are currently no clearly defined and agreed pathways in place for pain.
- Many patients receive pain killers to treat pain or are passed to specialist services for further assessment and pain relief intervention. This results in patients being more dependent as both the patient and service are not focused on preventing pain related disability, but just the pain itself.
- Waiting times for services such as physiotherapy are long and not easily accessible for all. Some patients wait for a long time to have conditions addressed; with chronic pain becoming more disabling before any specialist services become involved. Earlier intervention would help prevent disability and the onset of long term conditions.
- The variation in knowledge and skills of GPs, health professionals across the NHS and the patients themselves in the management of pain, resulting in a patchy level of service across Kirklees.

2. Where patients are more aware of their treatment options, they are:

- Better able to make well informed judgements about what is best for them and their lifestyles.
- The current, more traditional methods and services available for pain focus more on the symptoms of pain, rather than a more holistic assessment of the person with the pain and its impact on their lifestyle.

Some of their conclusions were:

- Consistent pain services across Kirklees should be based on person centred and holistic approaches to pain management and which are easily accessible and community based rather than in hospital based settings.
- More support to patients so they are aware of all treatment options for pain, in order that they can make better choices in managing their pain.
- Ongoing, educational and professional development is available for GPs and other health professionals that are involved in pain management, to increase their knowledge of self-management options available for patients. Such as the Expert Patient Programme or Health Trainers, (though they usually knew about PALS which started in 1994.

**What was the self care service?**

The Kirklees Pain Self-Management Service was a community based multidisciplinary service serving a population of 90,000. The core team consisted of a medical professional who specialised in chronic pain management, physiotherapist and a Health Trainer. A Physical Activity Development Officer (from the PALS service) was also part of the team and offered group based activity sessions tailored to the needs of people with chronic pain. All members of the team were trained in motivational interviewing and cognitive behavioural approaches. Individuals were referred into the service by their GP and were asked to "opt in" to the service by completing and returning an assessment before an appointment was issued. This approach was important so individuals realised they were partners in their care and they needed to commit to make the changes agreed, otherwise the intervention would not be successful. Anyone attending the service saw all 3 members of the team in the initial appointment and then a combination of members of the team depending on their own specific needs.

Over a 3 year period 215 individuals attended the pilot service, all with chronic pain of whom 62% had multiple pain sites. Their most common needs included walking about, fitness, pain relief, sleep and managing emotions. They were offered a range of information and support (including written) and saw the appropriate member of the team for their needs to build their resilience and be able to manage their pain better through adopting useful skills, developing new ones with a compassionate focus. Group work was also an option.

**What was the impact on those using the service?**

- Satisfaction: high, 92% patients satisfied / very satisfied with the service.
- Understand self care principles: 86% had increased understanding of their condition and how to manage it.

*People who used the service experienced:*

- Emotional distress improved by 52% *.
- Levels of long term pain reduced by 35% *.
- Levels of energy, ability to do strenuous physical activity, social interaction, ability to do their job each increased by approximately 35% *.
- Improved confidence to self-manage their pain, an average of 46% improvement (self efficacy).
- Improved continuity of care receiving the most appropriate level of care, at the most accessible location, 97% felt the team understood their needs.

* these were assessed using the Dolotest.

People who use services said...

*"I feel I've been empowered to manage it, I've had a few bad episodes I only take the pain killer right at the beginning – that's another thing, learning how to take medication and when. If it got out of control I wouldn't hesitate to get back in touch and make another appointment."*

*"But when I saw the Doctor and the Physio I thought wow, I'd been lifted up, I felt at last there was some hope. They were so confident and experienced and understanding and a desire to get this sorted. No rubbish talk. Very factual, I got the impression they could structure what they were saying according to the patient. I'm very verbal and in tune with my body, and they were able to latch on to that and they tailored their approach. They worked out what pain level I'd had and pain relief is such a specific area, most GPs just give you tablets and this just masks the pain."*

*"Encouraged myself to cope with pain and be proactive with exercise."*

*"I was given exercises. Prior to that I thought exercise would not make any difference, but I was proved wrong. Now I do them all the time."*

*"I felt they helped me understand my problem and gave me a more positive outlook for my future and lifted my self-esteem, I will always be grateful to all the team for their help."*

*Use of services*

The following referrals were made from the pilot service to health care and other services:

26% PALS service.

6.7% Referral to diagnostics e.g. MRI / X-ray, DEXA scan for assessing bone density.

4% Improving Access to Psychological Therapies.

4% Other i.e. appliances, podiatry.

2.8% Better Health at Work for support in their workplace.

2.3% Physiotherapy Service.

1.9% Occupational Therapy.

1.4% Falls and Balance service.

0.9% Pain Medicine Specialist Clinic in hospital.

There was also a 50% reduction in visits to their GPs in the 6 months after discharge.

Their GPs were asked *what they would have done with the patients they referred, if this service was not available?*

50% Referred to Pain Medicine Specialist Clinic.

45% Referred to Physiotherapy.

30% Medical treatment.

20% Further Tests/ Investigations/ Scans.

10% Referred for Acupuncture.

None of the GPs would have referred their patients to any of the self care services available i.e. Expert Patient Programme, PALS, IAPT or Health Trainers if the Kirklees Pain Self-Management Service was not available. This suggests a lack of knowledge about what self care can do for people. There remains a very medical approach to managing people with chronic pain and it can be difficult for people with chronic pain, or any long term condition, to know what is available to support self care and to be referred to the appropriate support service.

**Analyses of costs**

The cost of these referrals if the pilot did not exist would have been £27,600 for every 100 patients. This will be an underestimate in respect of savings because it ignores potential savings from reductions in secondary care interventions such as injections and spinal procedures or medications use.

The direct cost of 4 attendances at the pilot pain service was £312 per patient, compared to £405 for 4 attendances at the hospital based pain clinic, a difference of £93. Reducing medication or better prescribing is another opportunity to reduce costs and those attending the pilot service reduced or stopped many of their medications.

So potentially for every 100 patients who attend the pilot pain service there was a saving of £27,600 and £9,300 i.e. £36,900 that can be reinvested to provide care in a different way. Even more importantly were the positive outcomes for the users.

**Patient choice about their medication**

One of our Clinical Commissioning Groups ran an incentive scheme for a 12 month period to get practices to review pain medication. A total of 426 patients had their medication reviewed with their GP and completed an assessment on the value of the drug and whether the medication improved their quality of life.
As a result:

40% patients opted to make a change.

30% stopped drugs.

10 % switched to cheaper options.

Total saving in 12 months for these 426 patient £197,000

This was a 4% drop in the drugs budget for pain in the local Clinical Commissioning Group, compared to an increase in the drugs budget in the other local Clinical Commissioning Group that did not have the incentive scheme. The Yorkshire and Humber drugs budget for pain also increased by 20% over the same period.

## PALS (Practice Activity and Leisure Scheme)

This is celebrating 20 years this year, with over 26,000 people with a long term health condition attending to date.

**What is it?**

It helps people with a range of long term health conditions become more active with a view to improving health, wellbeing and quality of life. It provides:

- A programme of activities over 45 weeks, with over 175 appropriate weekly activity opportunities available, ranging from more traditional group activities such as gentle circuits, flex and stretch, walking, cycling and swimming to more creative sessions e.g. dance, chair activity and tai chi along with home based activities, community based activities and active living programmes.
- A specialist graded activity programme is also available with 25 classes running per week.

It links with all GP teams along with a number of hospital departments e.g. Cardiac Rehabilitation, Physiotherapy, Stroke Units and other Health Care Specialists. Linked to the PALS project there are 71 volunteers (Physical Activity Motivators –PAMs) who assist delivery and 91 who deliver on the projects behalf (Health Walk and Nordic Walk Leaders). All these volunteers work as part of the PALS on a weekly basis with a total of 326 hours. The volunteer value of the 163 volunteers is in the region of £216,676 each year (using Lottery volunteer values / rates).

**Who participates in the programme?**

During 2013/14 there were 2362 patients referred of whom 81% attended first appointment. There were 3 women to 2 men, 4 in 5 were of white origin.

| Referral Criteria | Times Selected |
|---|---|
| A. Low self-esteem, mild anxiety or depression | 1160 |
| B. At risk of /have CHD (must have two or more risk factors) Please indicate | 560 |
| C. Hypertension: | 953 |
| D. Asthma and other respiratory problems | 511 |
| E. Joint pain, back pain, arthritis, osteoporosis or similar | 1496 |
| F. At risk of/have diabetes | 705 |
| G. Stroke | 182 |
| H. B.M.I >25 Please state | 1604 |
| I. Fallen / at risk of falling | 159 |
| J. Chronic / Persistent pain | 468 |

62% felt they needed the support of the programme for the full 45 weeks, 12% left the scheme to be active elsewhere and 26% had other reasons usually due to poor / deteriorating health.

| Achieved outcomes |
|---|
| 88% were physically active at 12 months |
| 68% active 2-4 times/week at a moderate intensity post PALS |
| 77% positive health changes due to attending the scheme |
| 98% being satisfied with PALS |
| 67% improved confidence and understanding of how to improve their health |

Other impacts include:

- Reductions in blood pressure.
- Reductions in BMI.
- Increases in confidence/self-esteem.

Reports from patients also state reduced feelings of loneliness and isolation, increased functionality which supports independent living and improved social networks.

Thoughts from the volunteers i.e. Physical Activity Motivators / Walk Leaders:

*"My personal satisfaction is from helping others through encouragement and support to become more active, whilst maintaining my own health and fitness."*

*"Volunteering in an active role has helped my Angina problems and general health."*

*"Diagnosed with Rheumatoid Arthritis, my mobility went from active to nil, PALS and being a PAM really helps."*

**Customer comments**

*"I hadn't done any exercise since I left school. Now I go swimming four times a week."*

*"I really enjoy the level one class. The exercise is just right for me and we always have a chat and a laugh."*

*"I feel confident enough to try new things."*

*"Because I feel so much better after the class I am much more motivated to stay active."*

*"It used to be a struggle just to get up in a morning I feel so much better about myself now that I have started to lose weight."*

*"I can't believe I waited so long to get started. PALS changed my life. My blood pressure is down and I don't need medication anymore - cholesterol down to normal too. I exercise up to 3 times a week and I absolutely love it. I made new friends and the staff are great."*

*"Over the last 15 months PALS has changed my life completely. I have lost 4 stone in weight and look forward to my classes and meeting new friends. I would say anybody given the chance to join PALS take it and you will feel better in yourself."*

*"I can now walk up the stairs to the class, plus do some of the warm up standing. My mobility and strength has improved, I really feel I have achieved something."*

**Recommendations**

- Build a resilient and compassionate way of thinking and working as individuals, communities and organisations, using the evidence based frameworks in this report.
- Promote the culture of resilience as a golden thread throughout management staff practice to build personal resilience in all staff.
- Change the culture of our organisations to one where facilitating resilience and so self care is at the heart of what they do, this means:
  - See people and communities as assets valuing them and building on their strengths.
  - Be person centred and focus on what is important to the patient / service user.
  - Support people to be independent rather than dependent at whatever point they come into contact with our staff or services.
  - Involve people in the decision making about the care and support they receive.
  - Use the JHWS strategic thinking framework and the rainbow to see the opportunities for building resilience and self care
  - Look at ways of skilling the workforce to motivate and coach compassionately.
- Promote a range of options to support people and their carers to develop and maintain the skills they need to self care.
- Involve local people in the design, development and delivery of services, including evaluation, to ensure they meet the needs of those who use them.
- Focus on workplaces whether public, private or voluntary to assess and build resilience in their people and systems.

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Chapter 3

# Working across the whole of the health and wellbeing rainbow

# Working across the whole of the health and wellbeing rainbow -
## Making health everyone's business

In this section of the report I am presenting the action that we need to take to have a real impact on the wider factors affecting health, beyond individual make up and behaviours, as shown in the Rainbow, see introduction.

Before doing that, I am sharing a way of thinking and thus working that has proved to be really useful in getting the right action for the right people. The Kirklees Food programme is used as the example of where this way of thinking has been applied effectively, particularly given the wide variety of factors that affect our choices of what we eat; thus the action that we need to take in bringing about change.

### So what do we need to think about in taking action to improve local health and wellbeing and reduce inequalities?

Over the years we have been developing a system wide view of thinking to take action*.
This is most recently captured in the Joint Health and Wellbeing Strategy for Kirklees (JHWS)[1].

This thinking is a series of questions to help us all take action that has the best impact as efficiently as possible, by drawing on various sources of resource. These are based on a public health way of thinking based on outcomes and evidence for change.
See box.

**Thinking public health... thinking Kirklees health and wellbeing across the systems**

**Think population** not just individuals
**Whole person** view... the rainbow of health and wellbeing
**3 levels of prevention** of ill health / poor wellbeing, i.e.
1 stop ill health occurring
2 stop ill health recurring
3 reduce/prevent the consequences when ill health does occur

**What difference are we making for whom** esp. health and wellbeing?
***How do we know*** i.e. what works and what local impact?
What are ***avoidable gaps*** in health that we can affect?
***Who else*** needs to be involved in answering these?

**And to do this successfully means**
Linking people / systems around outcomes.
Spotting opportunities.
Relationships, relationships, relationships.
Turning data into information into intelligence + evidence of what works.
Working with communities across systems, disciplines and professions.

*see the Kirklees JHWS for full detail of the strategic thinking framework.

# What does Kirklees Council need to do to really improve local public health and reduce inequalities?

### What difference are we making for whom?

Public health coming back to local government is a major step forward in being able to connect work on the wider factors affecting local health and wellbeing across the Council and its partners. The underlying theme throughout this report is resilience. Being resilient, feeling safe and positively included and contributing to resilient communities is crucial to health and wellbeing both individually and at population levels in any setting, see chapter 2.

The specific factors that significantly affect local people are described in the Kirklees Joint Strategic Needs Assessment (JSNA)[2]. In taking action about these factors, they are grouped together in the Kirklees JHWS[1] and Kirklees Economic Strategy[3] as opportunities that have a positive impact on local health and wellbeing through:

- Having the best possible start in life.
- Healthy schools and pupils.
- Finding good jobs and staying in work.
- Active and safe travel.
- Safe, warm, affordable home in a decent physical environment.
- Access to green and open spaces.
- Spatial planning as an enabler of better health.

There is widespread understanding in Kirklees that for healthy people to enjoy a great quality of life, a strong and growing economy is essential. 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.

The importance of both health and the economy, and the connections between them (e.g. both the Economic Strategy and the JHWS focus on building resilience in business, communities and people in order to increase independence) have been recognised as central to setting future priorities and guiding action for Kirklees Council and its partners. So there is a shared vision between both Strategies:

**Kirklees is a District combining great quality of life and a strong and sustainable economy – leading to thriving communities, growing businesses, high prosperity and low inequality and where people enjoy better health throughout their lives.**

### What can we do locally?

In having the Joint Health and Wellbeing Strategy and the Kirklees Economic Strategy as the two main foci for action then we need to review what has been successful locally and evidence from elsewhere tells us about possible local action. So this section presents action for the future, building on the needs and priorities identified in the Joint Strategic Needs Assessment of 2013[2] and based on evidence developed from a recent Kings Fund major review of action to be taken by Local Authorities in improving local public health[4].

As well as its broad role in supporting health and wellbeing by contributing to more and better jobs and reducing inequalities, there are areas where action can jointly support KES and JHWS objectives. Many of these are woven across the recommendations of this review and they include:

- Supporting local food enterprises and procurement from them by local food purchasers.
- Building on the Tour de France to promote active travel, tourism, profile and investment.
- More, better, warm, affordable housing – supporting the economy and quality of life.
- More and better quality jobs, skills and progression routes in the health and care sector.
- Ensuring that regulatory functions are done in ways which also make businesses aware of support on business growth and healthy workplaces – improving health and productivity.
- Enhancing green infrastructure to support physical activity, emotional wellbeing, quality of place and investment.
- Using integrated health, economic and environmental appraisal to inform the design of and decision making on key strategies and projects/developments.

Similar to the JHWS, the KES puts forward a strategic thinking framework to take a more comprehensive approach to examining growth, beyond traditional monetary indicators to include dimensions that reflect the quality of life of all participants in an economy and how greater inclusiveness is achieved. Opportunities for community asset building will strengthen local economic development. People's resilience will be improved by creating their own solutions, as well reducing dependence on the public sector.
We will roll out these frameworks with the relevant networks to ensure the outcomes of both strategies are included in all relevant service planning.

# Creating a Kirklees food culture that is good for people, places, health and the environment

The Kirklees Food strategy aims to reduce avoidable gaps in health and economic development.

1. If people ate a healthier diet they would live longer lives in better overall health, whilst also making a larger contribution to the local economy. This is particularly the case in deprived areas and for people with long term health conditions and other vulnerabilities.
2. The key benefits of local and seasonal food procurement are economic in supporting local businesses and those who work in them. The principal environmental benefit is a reduction in traffic and carbon emissions[5].

This section uses the headings from the JHWS strategic thinking framework. These are:

**1. What difference are we making for whom?**

**2. What are avoidable gaps in health that we can affect?**

**3. What factors affect this issue?**

See www.kirklees.gov.uk/jhws

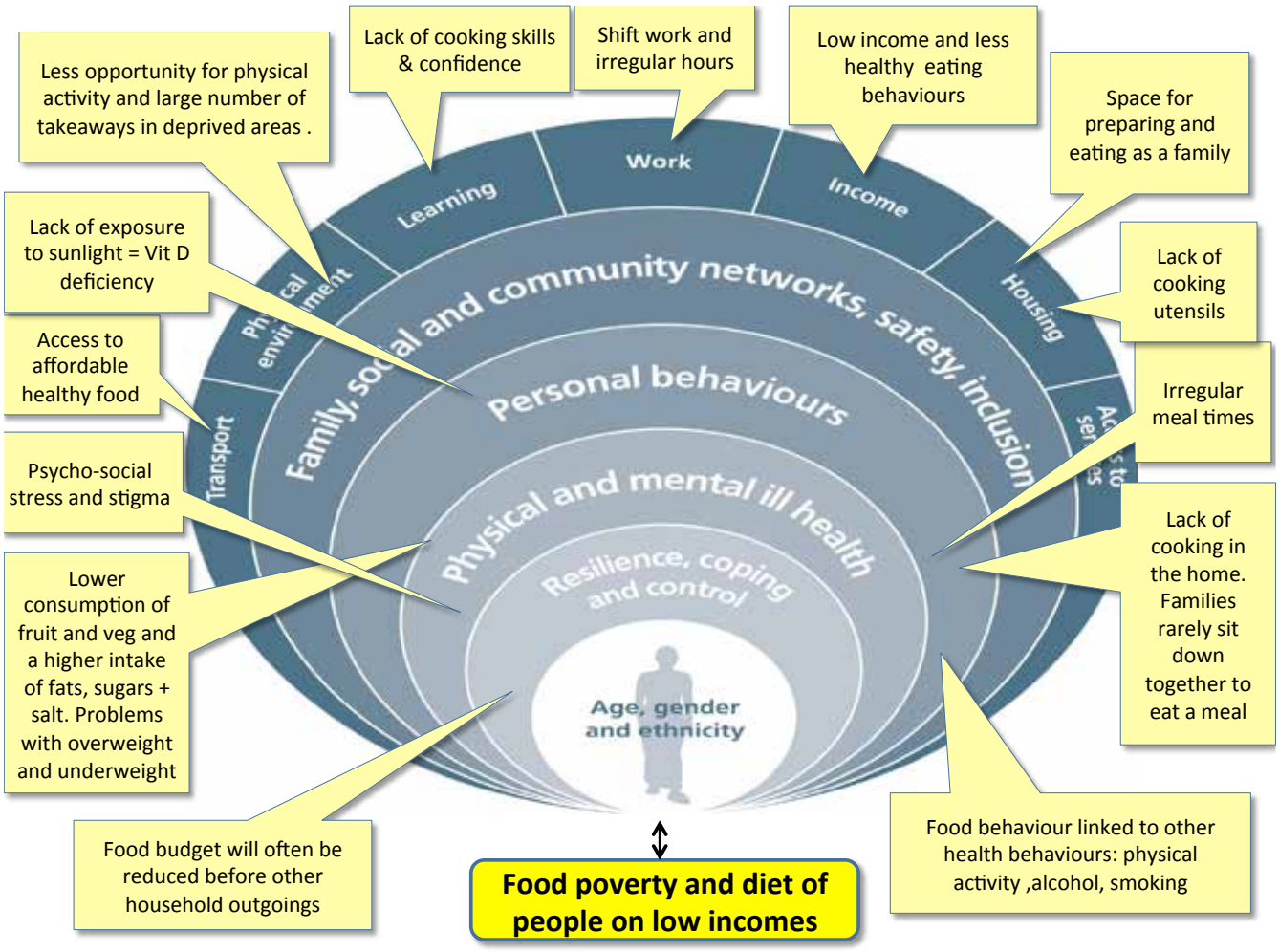
**Food is life, "you are what you eat."** It is essential to our health and is a major part of our economy and culture. Food culture never stands still. It is influenced by social changes, political thinking and by the amount of money people have in their pockets. The availability, production, distribution, preparation, consumption and the waste generated by food has increased attention recently. This is due to concerns about the environment, safety, food poverty, impact on health (both behavioural and physical) as well as about how we are raising our children. Campaigns about school dinners, obesity and food safety coupled with the growth of farmers' markets, growing projects and fairs show people are increasingly keen to have a better food culture. Meals eaten outside the home account for 20% of the calorie intake of women and 25% for men.

Of these takeaways account for a quarter, producing foods that are often high in saturated fat and salt and low in fibre, which contributes to poor health[6].

Studies have found a direct link between a fast-food rich environment and poorer health and particularly obesity[7].

**Food and health:** A poor diet is too much saturated fat, salt or sugar, and not enough fruit and vegetables. The type of food we eat shapes our future health and wellbeing, our mother's nutrition directly affects us before we are born, in childhood and in later life[2]. Locally, women of child bearing age and those in more deprived groups were most likely not to cook using basic ingredients in the past week as well as most likely to eat takeaways[2]. Over time more local people have diet related conditions. Diabetes is a chronic, and largely preventable, disease that can lead to cardiovascular disease, blindness, kidney failure etc. and has nearly doubled locally in 10 years, to 7.9% in 2012[2]. Over 30% of all CHD and cancer cases are linked to poor dietary habits and are therefore preventable[8,9]. Maintaining a healthy diet throughout life, coupled with physical activity and not smoking are the most important ways to protect against illness and premature mortality.

**Sadly food contributes greatly to avoidable differences in health between people due to a range of factors as shown in the rainbow of food poverty.**




**Food, place and the economy**: Because food is so universal it plays a powerful role in regeneration and a great place to eat helps make a great place to live. There is compelling evidence for the beneficial inter-dependence of producers, wholesalers, retailers and community residents when a thriving local economy in food is achieved[10]. The Economist's Liveability Index places the quality of food and drink outlets as a measure of a city's culture, alongside galleries and concert halls[10]. Food also creates social spaces, in food markets, in chairs outside cafés and plays an increasingly important role in facilitating informal encounters in an increasingly online world. Creative, independent food outlets selling food made with passion and care can breathe life into areas.

**This is described as the "opposite of broken windows theory" – cafes and restaurants, like parks and gardens present an opportunity for bottom-up regeneration and can help reduce health and economic inequalities.**

**Food and sustainability:** Food is a major issue in the politics of sustainable consumption and production because of its impact on the environment, economy and social cohesion. Some of the most serious environmental problems are related to food production and consumption, including climate change, water pollution, soil degradation, and loss of habitats and biodiversity. There are substantial economic, environmental and social benefits to be gained from public procurement practices which focus on a sustainable agenda around seasonal and local produce5. Such procurement policies are being implemented in Kirklees, see below.

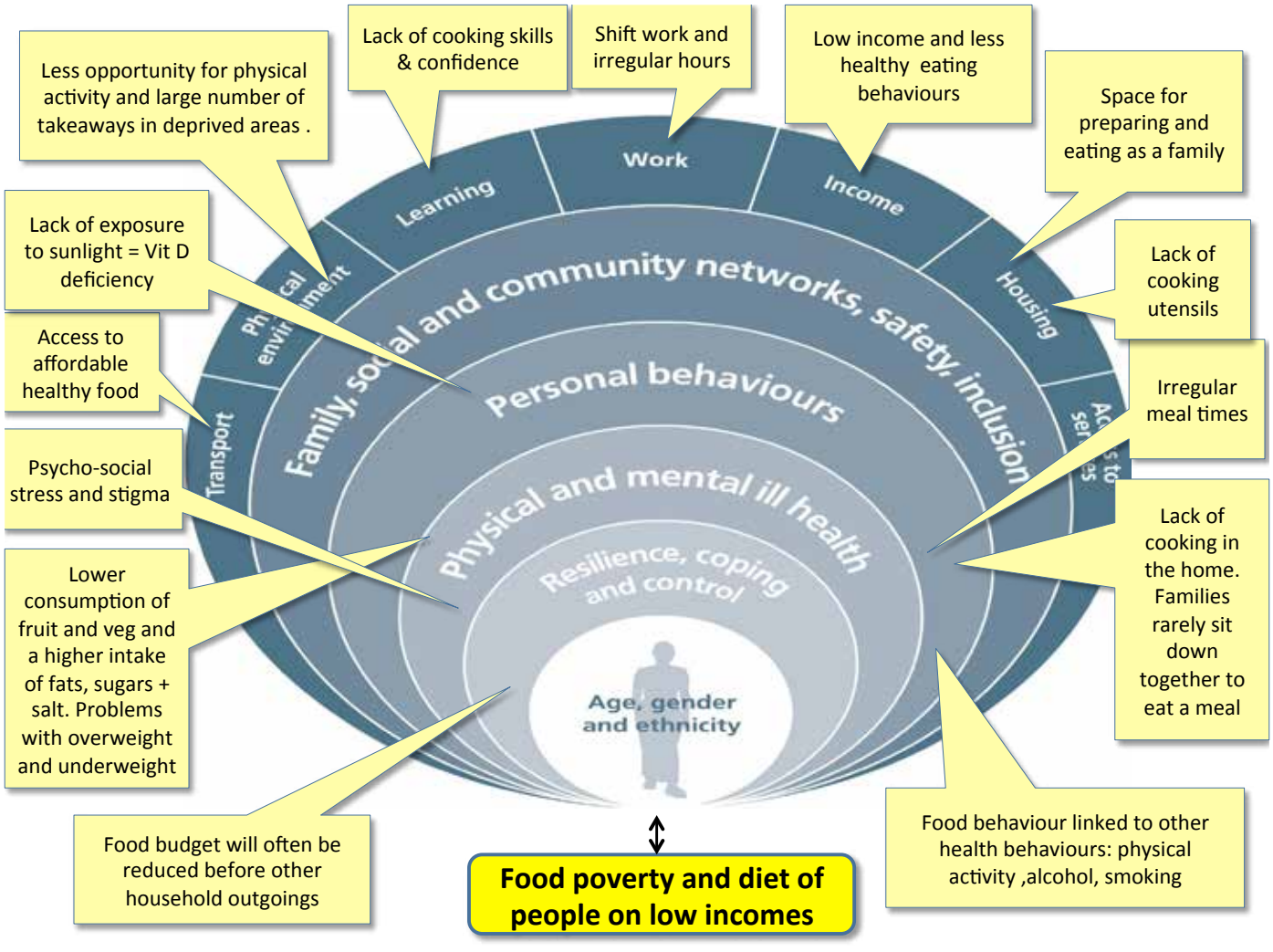
## 4. How do we know what works?

## 5. Who else needs to be involved including the target group?

See www.kirklees.gov.uk/jhws

The contribution of food to both individual health and wellbeing as well as the economy of places is clearly shown below in the rainbow of a sustainable food economy.

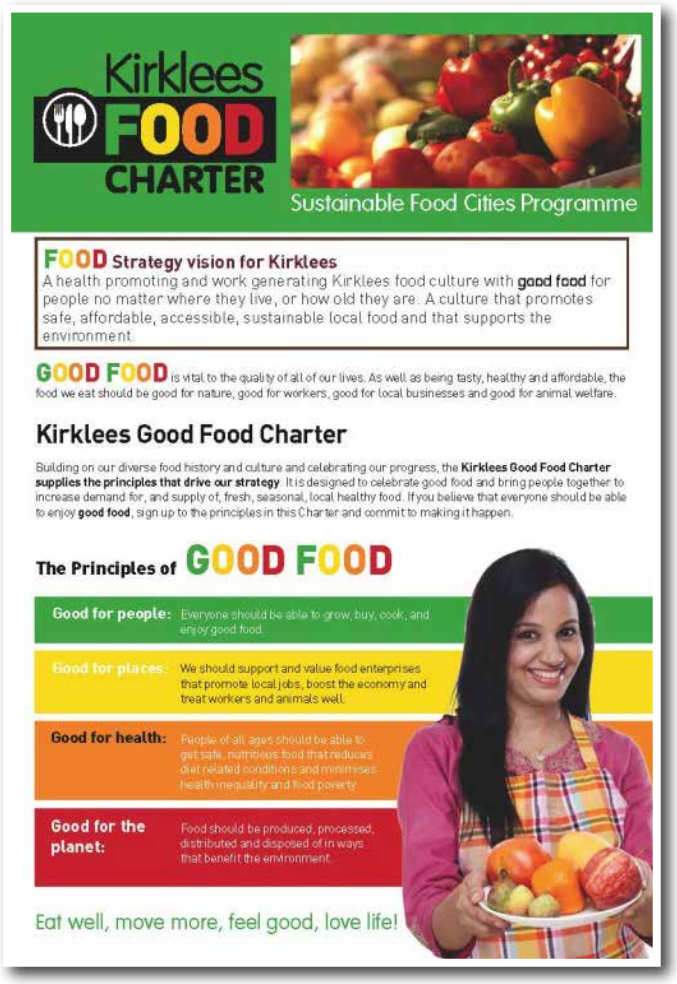
This thinking underpins the links between the Joint Health and Well Being Strategy[1] and the Economic Strategy [3], and outlines evidence based impacts on the Kirklees population through our local food strategy. Two clear foci for action are described below.



### 1. System-wide improvements to food culture via the Kirklees Food Charter

***Vision:*** A health promoting and work generating Kirklees food culture with opportunities for good food for people no matter where they live, or how old they are. A culture that promotes safe, affordable, accessible, sustainable local food and that supports the environment.

*A Kirklees Food Culture that is good for people, places, health and the environment.*




***Our food strategy*** aims to deliver healthy, safe, local, sustainable, affordable food accessible to all. It demonstrates our determination to tackle food poverty and health inequality, promote good health for people of all ages and support our communities to control their own food destiny. It is linked to strategies to reduce childhood and adult obesity and promote physical activity and active travel. It is also designed to promote communities developing their own solutions and planting, growing and cooking their own, or locally produced, food, reflecting the priority of the Kirklees Health and Wellbeing Board (HWB) to transformation Kirklees food culture.

***Tackling inequalities in food and thus health:*** as we all know, minimising avoidable gaps in health between people needs action on the conditions in which people are born, grow, live, work and age and the structural drivers of these conditions at the global, national, regional and local levels. The people who are already most exposed to vulnerability and disadvantage feel the effects of recession more strongly, for example being less able to cook from basic ingredients (whatever the reason i.e. lack of time, kit or skills), coupled with having insufficient confidence growing food from scratch. So there are 40 growing projects in areas of multiple deprivation and for vulnerable groups. Food poverty is being tackled by ensuring local food banks provide both healthy food and food training. Across Kirklees we promote healthy eating and generate the local food businesses that will help regenerate areas such as Dewsbury, and provide the innovative street food and "artisan" businesses increasingly in demand.

***Our food charter*** encompasses this vision and outlines the principles behind our food strategy. When read with our draft physical activity charter it outlines our approach to promoting early intervention and prevention across the life course and promoting the **"eat well, move more, feel great"** message that is bringing together all our work on transforming the obesogenic environment in Kirklees.

**Get Fit With the Giants**

This free 12-week programme is a partnership project between the Huddersfield Giants and Kirklees Public Health. It includes activity sessions, healthy eating advice and support to out of condition men over 30 who want to lose weight, get fitter and healthier.

Inspired by Rugby League's professionals, the programme encourages men to make changes to their lifestyle. Men work in groups to set and achieve goals, take part in training sessions led by a coach and find out the facts about topics such as weight management and nutrition. They also learn how they can support and motivate each other to lose weight, get fitter and tackle difficult issues such as stopping smoking.

Since July 2013, 95 men have completed the programme. A shopping trip as part of the course was introduced in January 2014.

Brian, a 40ish man, who weighed 133kgs wanted to lose weight. His job as a long distance lorry driver restricted him from taking regular physical activity.

Working hard throughout the course by week twelve he had lost weight and was weighing 125.3kg. As well as a weight loss, he had managed to reduce his waist size from 50" to 46.5" and reduce his diastolic blood pressure to an ideal level.

He now attends walking football when he is not driving and makes an effort to achieve 150 minutes of moderate activity a week.

The 'Get Fit' programme continues to run and plans are currently in place to expand the reach of the programme.

**Local people growing food**

Working with communities revealed that not only are people concerned about childhood obesity and lack of physical activity, they want to do something about these by learning to grow their own food and increase physical activity through gardening and community growing. A food survey in one area of Kirklees revealed that residents were keen on growing their own food, but having somewhere to grow food and finding out how to grow food were the key issues that the residents needed help with. These projects received funding via various means to initiate their community needs so:

In one project alone – 4,490 people have had some involvement in their project. It has created 59 volunteer opportunities, 2 jobs and 1 volunteer has progressed into studying horticulture at a local college.

Supported communities continue to transform known 'dumping sites' into attractive places people want to spent time growing food in. This has increased the amount of green space in communities and generated a sense of community pride.

View this film to hear about success of some of the food growing work in Kirklees. The film captures the impact food growing has had on individuals, the community, the environment and the economy.

https://www.youtube.com/watch?v=cjxMktcoYw0&feature=youtu.be

### 2. Promoting sustainable food procurement

Our Food Strategy is designed to promote a change in our food culture towards one that promotes health, develops the local economy and protects the environment. Our initial focus has been to improve procurement by promoting local, healthier businesses as outlined in Table 1 below.

Table 1: Economic Impact of Sustainable, Local Food Procurement in Kirklees

| Stakeholder | Inputs | Activities | Outputs | Outcomes |
|---|---|---|---|---|
| Local suppliers (wholesalers, farmers, retailers) | Time<br>Skills<br>Infrastructure | Production/delivery of produce to Food For Life Partnership (FFLP) and other standards<br>Employment of local people<br>Making links in the local economy and community | Volume of supplies for school meals, hospitals<br>Increase in number of local employees | Improved security of market and income<br>Expanded business and new small businesses of higher quality<br>Enhanced local reputation and town centre regeneration |
| Local employees | Time<br>Skills | Working for local suppliers to deliver to school meals contract | Employment<br>Wages | Opportunities for local employment<br>Increase job security and opportunities for advancement<br>Well-being impacts of working locally |
| Local community | Time and effort | Purchase of local produce (other than school meals)<br>Utilise community space/shops | | Wellbeing gains from buying/supporting local food<br>Improved food choice and knowledge from engagement with local producers |
| Local society/local authorities | Money<br>Skills | Application of FFLP procurement standards<br>Support to local suppliers in tendering for contracts | Quantity of school meal ingredients which are local , seasonal, organic<br>Number of local suppliers<br>Uptake of school meals | Improved public perception of the quality of school meals and local food<br>Savings from cheaper local supplies<br>Increase council tax payments due to reduced local unemployment and increased economic activity in the local area |

## 6.How do we know what the local impact is of what works?

See www.kirklees.gov.uk/jhws

**How do we know our food programme is effective: Examples of changes we have made**

Developing a strong local food culture has huge benefits. Children that eat well tend to maintain a life-long habit, thereby increasing their independence, reducing the chance they will be overweight or obese and being more physically active and promoting the local economy. So far we have:

- Worked with farms and food growers to promote understanding of the food chain and how food is produced 'from Farm to Fork'.
- Supported food growing projects across our schools and housing estates – over 40 growing sites developed in partnership with KNH.
- Prioritised sustainable development and improved procurement – 179 out of 182 schools now receive Food for Life silver standard meals, see p83.
- Improved school meals and used a life-course based approach to improve food in early years, hospitals and care settings.
- Driven up food standards and promoted healthy choices in small businesses via the Healthy Choice Award – 550 awarded so far.
- Promoted food skills training so people can control their own nutritional status and cook and grow their own healthy food.
- Developed a small grants scheme to support over 50 food skills training and small growing projects.
- Promoted breastfeeding, complementary feeding and the healthy start vitamin scheme to support child and maternal health – recent evaluation of the vitamin scheme shows most mothers and children in receipt of vitamins live in the lowest 40% of areas of deprivation.
- Developed programmes to tackle childhood and adult obesity and are targeting these in schools with the most overweight and underweight children.
- Ensured we tackle food poverty by working with food banks to train staff and users in food and nutrition and ensured that healthier food is available.
- Designed a website and communications strategy to link together individuals, services and communities.
- The Food Initiatives and Nutrition Education (FINE) project is a joint initiative between public health and environmental health. This delivers healthy eating and cook and eat training to paid workers/volunteers to support people in Kirklees to make healthy, sustainable, food and lifestyle choices. Over 1,000 people have attended the 'Key Messages in Healthy Eating' training and 216 participants have completed and achieved their cook and eat accreditation (see above). Over 50 businesses have attended FINE Take-away Master classes to help them reduce sugar, fat and offer healthier meals.
- Kirklees markets have received FINE training and are improving their offer of local, sustainable food.

**Healthier eating and improving cooking skills**

Residents in Rawthorpe were keen to improve their confidence and skills around preparing, cooking and eating healthy meals.

A Community Engagement Officer helped develop a programme over a number of weeks which included 'cook and eat' sessions, information about healthy eating, the 'eat well' plate and tips on making recipes healthier. Through the 'cook and eat' sessions people were able to try out foods they'd never eaten before and had been reluctant to buy, as this would be a waste of the household budget if their family didn't like them.

Following the successful initial sessions three people went on to take part in the 'FINE' training course. They are now qualified as 'cook and eat' instructors and continue to share their knowledge with other residents.

**The Food for Life Partnership** (FFLP) transforms food culture in schools by working with the Catering Service and Public Health to promote healthy, local, sustainable food. It is also supports local businesses by promoting sustainable local food procurement from Kirklees based suppliers.
The FFLP mission is 'to reach out through schools to give communities access to quality local and organic food, and to teach the skills they need to cook and grow fresh food for themselves. We want all young people and their families to rediscover the pleasure of taking time out to enjoy good food that makes them feel healthy and connected to the changing seasons.' The outcomes are:

- To promote healthier eating habits amongst pupils.
- To improve pupil awareness of food sustainability issues.
- To influence food habits at home and in the wider community.
- To improve pupil attainment and behaviour.
- To increase school meal take-up.
- To build the market for local and organic food producers.

The Food for Life Programme delivered wider annual benefits of over £3 for every £1 spent in the local economy5. The full benefits of an FFLP approach to school meals can be expected to be significantly higher than this because this figure does not take account of any of the health, educational or cultural benefits of a whole school approach to food. In Kirklees, 179 out of 180 schools are serving FFLP Silver Catering Mark Standard meals; these are sourced from primarily local sources so it is likely that a large number of local jobs are supported via our approach to food, with a significant multiplier effect throughout the community.
An example of its impact in Kirklees is described below.

**Transforming School food culture in Field Lane Junior and Infants School, Batley**

Blog written by Ms Islam, class teacher

"Our topic was 'Food Around The World' and in class the children were learning about different countries of the world. To extend the children's learning from the classroom, in Mighty Master Chef we looked at the food eaten around the world. We cooked a variety of dishes such as Italian pizza, Indian naan bread, French quiche, Mexican burritos, Canadian 'ants on a log' etc. and looked at where our ingredients come from and how it might have got to our shops for
us to buy.

Before cooking, we had a recap session where we reminded ourselves of the importance of good hygiene, correct handling of knives and cutting methods etc. We used visual aids and demonstrated saturated fats and looked at sugar content in fizzy drinks and talked about the dangers of tooth decay. Leaflets to support what we had talked about were given out to further the children's learning at home. Throughout the sessions the children were expected to make all the food themselves with guidance. The children's thoughts and feelings were paramount throughout the sessions and every child was asked to write their thoughts/comments at the end of the session. These comments have been included in the recipes so that the children can feel proud they have made a contribution."

Furthermore, FFLP has provided schools with an opportunity to promote community cohesion across the generations. In some schools community gardens have given retired people living nearby the school somewhere to visit, walk and hold events. Other schools have held local farmers markets or coffee mornings.

*After we got involved with the community allotments, it brought everyone together ... it helped us get to know each other – Ms Islam*

**Developing our approach – What more needs to be done?**

We have successfully built a strong Food Partnership, and it includes a wide range of public and voluntary sector partners. To build on this approach we are considering further key actions:

- More work with food businesses and takeaways to make food healthier, through award schemes, training, advice and where necessary inspection and regulation.
- Reduce the amount of fast food that students consume during breaks and on journeys to and from school, by working with schools.
- In the development of the new Local Plan, include ways to regulate the number and concentration of outlets such as:

  -Planning permission for fast food outlets should include consideration of the potential impacts on prevention and reduction of cardiovascular disease.

  -Restrict planning permission on outlets within walking distance of schools.

  -Review and amend class of use orders for the concentration of fast food outlets.
- Build a social enterprise to represent all food growers and food skills/training interventions. This will link small growers to suppliers, provide opportunities for shared learning. It will help growers to share/market surplus food. It will also help food growing projects to have greater access to public procurement; local food events as well as support better co-ordination across Kirklees. A social enterprise needs to be bottom up, and will require the council to relinquish control and let a thousand flowers blossom.
- Further increase procurement of food from local suppliers by large bodies, including hospitals and the health sector, educational establishments and the private sector.
- Greater private sector engagement – we have strong links with markets, the small farming sector and a range of growing projects. However these are a small percentage of the local food industry. So future plans involve greater engagement with the retail sector including supermarkets, both to encourage their offer of healthier, local and sustainable food but also to help them contribute to the activities of the food partnership. We also need to ensure that businesses in the sector are aware of and able to access business support that can help them to grow further and prosper.

**Recommendations**

1 Develop more opportunities to enable food growing amongst communities, schools and individuals.

2 Ensure that food is procured locally as much as possible.

3 Limit the number of fast food takeaways, particularly within deprived areas.

4 Develop a social enterprise to represent all food growers and food skills/training interventions, and ensure that food businesses and growers, including new enterprises are made aware of business support that can help them.

5 Improve engagement with private sector organisations, including supermarkets.

6 It is really important to continue to:

- Promote the 'eat well, move more, feel great' message across Kirklees.
- Work to improve the update of good quality school meals via the Food for Life Partnership.
- Promote the Healthy Choice Award within small businesses.
- Develop 'Cook and Eat' programmes.
- Promote the uptake of breastfeeding, complementary feeding and the Healthy Start vitamin scheme.
- Tackle food poverty by working with food banks.

# The best start in life

Even before a child's life begins the choices parents make and the things that they do influence outcomes for their child when it is born and later in life. How a baby's brain and its early skills develop is influenced by how it is fed, how young the mother is and whether it is being born into a safe and stable home environment. Warm, positive and healthy parenting can help to create a strong foundation for the future, building resilience and positive self-esteem from an early age[2]. So for Kirklees families we want to support their children and young people to:

- Be mentally and emotionally healthy.
- Be safe from maltreatment, neglect, violence and sexual exploitation.
- Be safe from bullying and discrimination.
- Be ready for school and for transition from school to college, higher education, training or work.
- Achieve personal and social development and enjoy recreation.
- Be resilient by developing self-confidence and successfully dealing with significant life changes and challenges.
- Live in decent homes and sustainable communities.
- Have access to transport and material goods.
- Live in economically active households.

This supports the aspirations of the JHWS[1] and links to the KES[3]. Resilient, healthy, young people who enjoy life to the full are more likely (and ready) to make a productive economic contribution. Conversely, a strong and sustainable economy has a positive influence on the wider factors affecting health, such as learning, readiness for work, household incomes and housing, both having increasing resilience underpinning them.

## Early life

The international marker of child health is infant death. In Kirklees infant deaths dropped overall over the past 10 years, especially in Dewsbury and Spen, though less so in Batley, Birstall and Birkenshaw, see chapter 1. Infant deaths are strongly linked to low birth weight, mother smoking during pregnancy, not breast feeding and congenital abnormality especially in Pakistani origin families so reflect norms of behaviour in communities[2]. So key factors that affect early life are:

- Strong parent–child attachment and positive parenting, resulting in better social and emotional wellbeing among children.
- Care that helps to keep children healthy and safe.
- Healthy eating and increased activity, leading to a reduction in obesity.
- Prevention of some serious and communicable diseases.
- Increased rates of initiation and continuation of breastfeeding.
- Readiness for school and improved learning.
- Early recognition of growth disorders and risk factors for obesity.
- Early detection of, and action to address – developmental delay, abnormalities and ill health, and concerns about safety.
- Identification of factors that could influence health and wellbeing in families.
- Better short and long-term outcomes for children who are at risk of social exclusion.

To tackle these factors and address the local outcomes, Maternity Services, Health Visiting Services, School Nursing Services and the Nurturing Parent Programme (see below) need to integrate into an holistic Healthy Child Programme from 9 months through to 19 years of age[11,12].

**A volunteer's story**

Jill attended the Auntie Pam's volunteer recruitment and training process, **see p14 this draft**. She explained that her four children had been placed in foster care because of some poor lifestyle choices she had made. Jill was very quiet, lacking in confidence and self-esteem. She said she was trying to get the children back and thought the support at Auntie Pam's would help her and give her the opportunity to share her experiences, good and bad, with other women. Jill completed the training and built strong relationships with other volunteers, and in time shared her experiences and listened to other volunteers' experiences.

During the last six months Jill acknowledged how her behaviour affected her children, she learnt from this, re-engaged with services and slowly built relationships with her children. This resulted in the children being returned to her care. Jill has had some uncertain times where she needed to gain a more positive belief in her abilities as a mother and embrace the change that children bring. She has done this and over the last few months has blossomed - she looks healthy, happy and is taking care of herself and her family.

As part of the integrated Healthy Child Programme, the **'nurturing parent'** programme will support parents from pregnancy through to their child's 19th birthday at key stages of their child's development. The overall outcome is to build self-reliance and resilience in children, young people and families by supporting parents to bond, nurture and communicate with their child. This is by helping them understand their child's development from conception to adulthood and build better relationships with their children through attachment; communication; play, stories in order to build better positive, protective behaviours and confidence. The programme will use the stages in a child's development from pregnancy, through the first year of their baby's life and key transitional stages (generally 1-5, 5-11, 11-16).

The **'nurturing parent'** programme will build on existing delivery (e.g. antenatal classes which prepare parents for birth, Family Nurse Partnership, The Child's Journey), evidence of good practice and 'insight' into behaviours by engaging parents. This is so they can prioritise the issues they want to address through the programme and in designing and delivering their own methods, content, venues, etc.

At present, **health visiting** is commissioned by NHS England (NHSE) until October 2015, when the responsibility transfers to Local Authorities. We are starting to work on co-commissioning with NHSE and intend to implement an integrated Healthy Child Programme. This is a programme of screening tests, immunisations, developmental reviews, and information and guidance to support parenting and healthy choices.

Healthy choices and healthy behaviour, particularly of mothers before and during pregnancy, directly affects us before we are born, in childhood and later life. Our food programme will continue to promote breastfeeding, complementary feeding and the healthy start vitamin scheme to support child and maternal health, see p79.

Pregnant women and, subsequently, parents and their children, need to be able to walk to local amenities, open spaces and play areas, in order to increase their opportunities for physical activity for both themselves and their children. Relevant policies and plans in both the Council and wider partnership need to look at how they support walking, active travel and access to green and open spaces and (especially) access to safe play areas for children and young people, see p88 this draft.

Smoking before and during pregnancy and continuing to do so in the presence of children and young people, profoundly affects their health throughout life. The tobacco control programme is focussing on preventing young people from taking up smoking and tobacco use, targeting young people in income deprived homes and school settings (see below), women of childbearing age and pregnant women[2].

***What has already been done?***

A new ***maternity service*** specification has been developed and agreed with providers in north Kirklees and Wakefield. This specification describes the commissioning expectations for maternity services as an integrated model of service delivery, emphasising a community-based, midwife-led, women and family-centred approach. By working with other services and sectors in integrated teams and settings, a wide range of issues that impact on women's health and wellbeing and those of their babies and families can be tackled.

Support for ***parents who are teenagers*** includes the Family Nurse Partnership (FNP) whose outcomes are to increase the number of healthy pregnancies; to improve child health and development and to improve parents' economic self-sufficiency. Pregnancy and birth are key points when most families are highly receptive to support and extra help. It is a structured programme offered to at risk, first time young parents from early pregnancy until the child is 2 years old. Specially trained nurses and midwives, experienced in working with families in the community, provide an intensive preventive home visiting programme. Each nurse is expected to recruit a caseload of approximately 25 mothers. They have specific skills and knowledge in areas such as building a therapeutic relationship, motivational interviewing, attachment, behaviour change and using the guidelines and materials.

Good US evidence, over 25 years, shows significant and consistent benefits for families including:

- Improvements in women's prenatal health.
- Reductions in children's injuries.
- Fewer subsequent pregnancies and greater intervals between births.
- Increases in fathers' involvement.
- Increases in employment.
- Reductions in welfare and food stamps.
- Improvements in school readiness.
- Cost savings over childhood of £5 for every £1 invested.

It also showed that maximum return on investment depends on:

- Highly educated registered nurses and midwives delivering home visits to low-income mothers who are pregnant for the first time.
- Staying with the intervention model tested in the randomised trials.
- Services that are delivered at sufficient scale to benefit from basic operational efficiencies, i.e. each team (each serving at least 100 families by the end of year one).

Local monitoring shows:

- 45% of clients smoked at recruitment around 16th week of pregnancy, by 36 weeks this was 40%.
- 'Ages and Stages' developmental assessment at 4 months show that babies in the local FNP were slightly behind in the developmental milestones than national FNP e.g. in problem solving (locally mean score 52.6 vs national 52.8), personal and social skills (locally mean score 50.5 vs nationally 51.1) and communication (locally mean score 52.4 vs nationally 52.9).

- By 10 months, babies in the local FNP improved more than nationally. In problem solving (locally mean score 55.2 vs nationally 54.9), personal and social skills (locally mean score 55.2 vs national 54.9) and communication (locally mean score 54.5 vs national 53.9).
- Starting breastfeeding rates for FNP mums locally to Dec 2013 were 62% vs 54%; in 2012 vs 58% nationally.
- Immunisation rates achieved 100% coverage by age 2, vs 75% nationally.
- Contraception use was higher than nationally at all stages of the infant's development. At infant age 6 months, 87% locally used contraception most of the time, vs 85% nationally. This rose locally to 95% when the infant was 12 months vs 86% nationally, when the child is in toddlerhood it was 100% locally vs 90% nationally.

## Support for more vulnerable families

Kirklees has a well-established Troubled Families programme (called 'Stronger Families' in Kirklees). This reaches 1,115 families. Around 40% of these families have high needs, meeting at least 2 national criteria (in italics below) and 3 or more local criteria. The issues that make families eligible for Stronger Family support include:

- *Poor/inconsistent school attendance.*
- *Crime and anti-social behaviour.*
- *Out of work.*
- Domestic violence and abuse.
- Mental health.
- Substance misuse.

So far, 443 families (about one in three) had a six month period with:

- No under 18 crime.
- No recorded family anti-social behaviour.
- No children with less than 85% school attendance.
- No children with 3 or more temporary exclusions.
- No children with a permanent exclusion from school.

In addition:

- 19 families had a member who had made progress to work.
- 11 families had a member who gained continuous employment.

### *1. Safe and Healthy Pregnancy*

This programme includes:

- Ante- and postnatal health, high quality women and family-centred community based integrated maternity services.
- The Nurturing Parent Programme (see above).
- Healthy Child Programme - 0-5 screening tests, immunisations, developmental reviews, and information and guidance to support parenting and healthy choices; see above.
- Family Nurse Partnership - an evidence-based programme of intensive support for first time teenage parents over the first 2 years of their baby's life, (see above).

### *2. Building resilience*

Develop support, skills and advice for everyone about building resilience. Some support is universal to all families and schools e.g.
health visiting but much is targeted to need.

### *3. Early intervention and vulnerability, including ill children (0-25)*

Parents and families of especially vulnerable children can access the support they need to combine high levels of emotional warmth and practical care with high levels of supervision to develop children who are confident, autonomous, empathic and resilient.

### 4. *Children with complex needs, therapies, Autistic Spectrum Disorder and Statement of Educational Needs*

Services work together, with a focus on the expressed needs of the child and young person, delivered by a 'team around the family' model. An Education, Health and Care Plan (EHCP) will be written together with the child and their family, keeping their outcomes and needs at the forefront, and being clear what social care, education and the NHS can do to support the family to achieve these outcomes and meet their needs.

### 5. *Looked after children*

This supports effective help offered at an early stage which might prevent a child or young person becoming looked after. Once children or young people become looked after, the focus is to improve their health and educational attainment including by developing a virtual school, increased choice and scope of placements within Kirklees amongst other actions.

### 6. *Linked programmes*

The other programmes of work include Troubled (Stronger) Families, Early Intervention and Targeted Support Services (Safeguarding and from Children Centres), Early Years and Childcare and Targeted Youth Support Services (integrated provision for Not in Education, Employment or Training and vulnerable teenagers). As these programmes require close collaboration between a range of organisations across different sectors for effective delivery, it is important that these programmes are brought into the view of the Integrated Commissioning Group between the Council and NHS Commissioners.

## Healthy schools and pupils

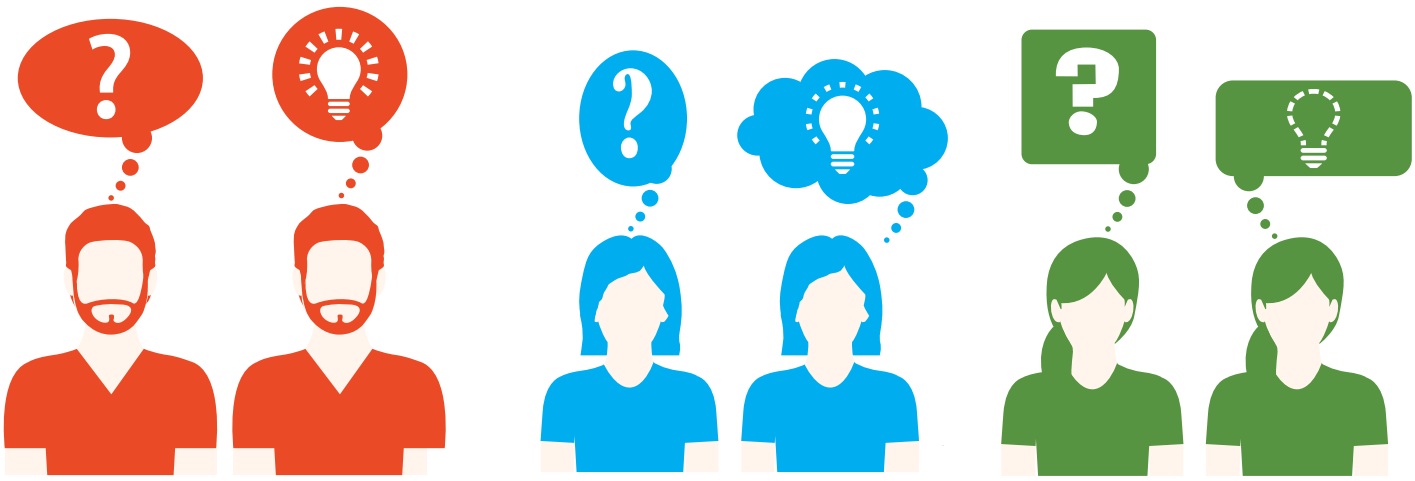
Education is the gateway to better jobs, better understanding of options available to make life choices and thus control over personal resources. So education profoundly affects health and wellbeing. Indeed, attainment at age 16 is a powerful indicator of their chances of achieving future health and economic wellbeing[2,13].

More 16 to 18 year olds in Kirklees remained in learning, rising to 87% in June 2012, same as nationally. Those 16 to 18 years olds not in education, employment or training (NEET) was 1 in 12 (8%) in 2012/13, especially in Dewsbury and Batley[2]. Educational attainment continues to improve in Kirklees. In 2012[2]:

- Early Years Foundation Stage, nearly 7 in 10 (68%) pupils achieved a good standard, compared to 6 in 10 (64%) nationally and up from 55% in 2008. Differences exist between the sexes, different ethnic groups and areas of Kirklees.
- 62% of pupils achieved five or more GCSEs grades A*- C including English and Maths; higher than the national average of 59% and markedly higher than 2009 (47%).

How young people feel about themselves, those around them and their opportunities to improve their circumstances, influences the choices that young people make, and in some cases their entire life course. Locally, 1 in 4 of 14 year olds were sometimes or never happy with themselves as a person, 1 in 5 felt they did not have someone to talk to about their problems, particularly in Batley[2].

Like any important setting, school is crucial for supporting the resilience and thus wellbeing of young people, and thus for health and wellbeing.



**Building health and wellbeing in young people in Rawthorpe through a local youth club**

A junior youth club was launched at Rawthorpe at a community building with support from the Community Engagement team and Kirklees Neighbourhood Housing, but attendance had dropped down to two or three attendees each session. However, the youth club has now been restarted following a community event, healthy cooking sessions and a sports activity partnership with the Moldgreen rugby club.

Attendance has now improved and seven new volunteers are now working with the young people. Local community volunteers are keen to keep the youth club running and have taken responsibility for the health and wellbeing of young people in their community.

**What has already been done?**

Historically, the National Healthy Schools Standard supported schools as health promoting settings by attaining 41 criteria. These covered food, physical activity, emotional health and wellbeing and Personal, Social, Health, Citizenship Education. Healthy schools were encouraged to take a 'whole school/community approach' to health improvement for students, staff including engagement of young people in planning and delivering any action linking to the local community.

Last year a commissioning approach replaced the above, having been piloted in 2 schools locally. This Enhancement model is identifying health needs, thus health outcomes. Individual schools or clusters identify priorities locally through the JSNA and other relevant local data and national priorities for children and young people. The benefits to schools of this approach from the Kirklees pilot were:

- A planning model to prioritise jointly with other head teachers serving the same communities.
- A commitment to a joint priority (parenting support) identified through local intelligence, to implementation of evidence-based interventions and to some resource sharing.
- Networking opportunities for learning, capacity and taking action with other schools and with wider partners, commissioners and services.
- Working in a more co-ordinated way with other public health programmes such as Tobacco, Sexual Health and WOCBA, including access to Auntie Pam's outreach, see p24.
- Resources from the Parenting Support Service.
- An opportunity to develop the role of schools as commissioners in the wider commissioning system of the NHS and Council.

The benefits to the Kirklees Children's Trust partnership included:

- Joining together to improve local outcomes for children, young people and their families by schools willing to work as a cluster and jointly prioritise with wider partnership input and support.
- The increasing autonomy of schools for their budgets means a school cluster's financial resource in areas of high deprivation could be considerable. Jointly commissioning with schools allows the partnership to ensure such resource is part of a wider commissioning approach.
- The approach and framework helped schools use evidence-based intelligence and prioritise according to this. So focus on need and what works.
- Potential to jointly fund shared priorities e.g. Parenting Support.

Feedback from the Kirklees pilots suggested that engaging schools in a cluster commissioning 'cycle' helped schools focus on more upstream, longer term and jointly agreed priorities. Given the move to integrated commissioning, schools should join this wider system to increase local impact but use the limited commissioning capacity.

**What needs to happen next?**

There are over 190 schools in Kirklees and through education reforms have gained an unprecedented level of independence and autonomy from Local Authority influence. The budgets held collectively by schools now exceed the Council's total budget for the first time in history. So the learning from the commissioning pilots is helpful in sharing the commissioning process with the Council and NHS integrated commissioning system. This is to make best use of this public money for Kirklees families.

***Helping schools commission*** effectively leads to improved outcomes, prevention, early recognition of issues and early intervention. This must be a priority for the Children's Trust partnership and for integrated commissioning, in order to reduce the need for intensive, more costly longer term services.

Partners need to help schools to develop their understanding of their local health and wellbeing needs by using qualitative and quantitative intelligence to contribute effectively to Kirklees' emerging integrated commissioning and planning processes.

***School-based health behaviour and wellbeing programmes,*** such as food, physical activity, smoking and sexual health, need to be evaluated in terms of their effectiveness in helping young people take up health and wellbeing-enhancing behaviours and in preventing them from taking up health-damaging behaviours. Existing evidence points to a need for programmes to focus on the interdependent factors affecting these behaviours, such as self-esteem and self-confidence raising, leading to more resilient and self-reliant children and young people e.g.
see p40.

Schools' workforce capability and capacity need to be considered and developed based on existing capacity as well as assessment of local population health and wellbeing assets and needs. Without ongoing support, schools may not have the capacity to embed and sustain an evidence-based approach to planning and commissioning for improved education, health and wellbeing outcomes for children and young people.

There is much potential to build stronger connections between schools, businesses, employability and resilience. Increasingly employability skills such as communication, teamwork, enterprise and initiative, creativity and a positive attitude are as important as qualifications to employers, and will help young people to secure better jobs and incomes. These same attributes are also vital as life skills and are part of what makes up individual and community resilience. The Kirklees Economic Strategy makes clear the importance of enhanced relationships between schools and business, apprenticeships, skills at all levels and routes into quality employment[3]. Achieving those goals will also support improved long term health and wellbeing outcomes, associated with better education, skills, employment and incomes.

**Recommendations**

1. Further develop an effective Integrated Commissioning system for families through the Children, Young People and Families Integrated Commissioning Group.
2. This group develops a systematic approach to commissioning based on intelligence and ensures that the Healthy Child Programme is fully integrated into its commissioning plans. This includes working with the growing new relationships with schools to support their effective contribution to an integrated commissioning approach.

# Helping people find good jobs and stay in work

Whilst the economy is driven by the private sector, local authorities affect employment and training, both directly and indirectly. Kirklees Council directly employs approximately 7,000 equivalent of full time staff, excluding schools. There are also others working in services commissioned by the Council as well as the important role the Council plays in supporting local employers. Workplace injuries and stress can be bad for health, but being unemployed often leads to poor physical and mental health, affecting both the individual concerned, and their family. Being in work improves people's health. It is important to think of workplaces in their wider context. Workplaces do not only consist of buildings. The workplace for some people might be the taxi in which they earn their living, the bus they drive, etc. In 2013 there were 39,440 key benefits claimants of working age in Kirklees, and in 2014, there were 9,092 Job Seekers Allowance claimants[14]. This varies widely across Kirklees, with the highest levels being within the most deprived areas of Kirklees.

**What has already been done?**

***Having a strategic direction for the local economy***

With major cuts to core local government funding, raising revenue from business rates and the building of more new homes will be important elements of how the Council can support these goals. Business growth that supports jobs, incomes and spending will in turn create more business opportunity and healthier, more inclusive communities, creating a virtual circle.

The development of the Kirklees Economic Strategy (KES) is led by Kirklees Council, working with an array of private, public and voluntary sector partners[3]. The strategy intends to:

- Improve resilience, competitiveness and profitability for business.
- Enhance employment prospects, skills and incomes.
- Create a great quality of life and environment where all people are connected to economic opportunity and live in strong and thriving communities, helping to reduce inequalities in the future.

The Economic Strategy is for the whole of Kirklees, not just Kirklees Council. The Council needs to work with all partners to achieve the outcomes of generating wealth that supports economic progress and connect to people and communities. These include businesses, public bodies, the voluntary and community sector, Kirklees College and the University of Huddersfield.

*Obviously if there's stuff there, funding there available it'll set you on the right path, there's certain courses that are funded for and you're going to enjoy doing, you'll find an opportunity you'll have doors open for you, then that's just like a guide and you find your own way from there but you need someone to open the door for you to begin with.*

Kirklees Council and NHS Kirklees (2010) CLiK Qualitative Research: Young Adults aged 18-24 Not in Education, Employment or Training (NEET)

**Cabbies Action for Health case study**

Taxi drivers in Batley improved their health and wellbeing by taking part in the Cabbies Action for Health project. They had been struggled to engage with healthy lifestyle initiatives due to the long working hours and tiredness after their shifts.

70 people attended a health engagement event one evening at Noor ul Islam Mosque in Batley, where they learned about healthy eating, healthy exercise and emotional health using the five ways of wellbeing, see chapter 2. Participants were encouraged to share the information with others by using water bottles with the five ways of wellbeing printed on them bottle to extend conversations to others.

The event enabled the taxi drivers to socialise and enjoy the experience, as well as building up their confidence to realise their own ability and understand key health messages. The event was aired live on a local radio service to more than 500 households which helped them increase their knowledge about health and wellbeing.

Gym membership was also part of the project and some of the drivers met regularly to go to the gym. They all reported weight loss and an improved sense of wellbeing. The taxi drivers who attended the cook and eat sessions said they felt they would be more likely and more confident to be involved in food preparation in the home with their families. Comments from the participants include: 'Enjoyed cooking, meeting friends' 'Learnt about the eat well plate' 'We now use different colour cutting boards for vegetables and meat' and 'I learnt using less salt and oil'.

### *Helping people stay in work*

Organisations need to help their employees develop their resilience, which ensures that they are able to succeed personally and professionally in the midst of a high pressured, fast moving and continuously changing environment. Reviews from a range of successful companies showed the following as critical success factors to having a resilient organisation, see box.

**Key features of organisational resilience**
see p40 [15,16,17]

**Personal development**

Autonomy & control in job

Work not characterised by monotony and repetition

Skills to cope with pressure

Opportunities for learning and development

Employment security

Effort matched with reward

**Social networks**

Strong workplace relationships between teams and managers

Social interaction based on compassion

**Culture**

Management style promotes mutual trust and respect

Clear values communicated and practised throughout

Recognition and acknowledgment of staff

Principles of procedural justice observed

**Health**

Safe, comfortable physical environment

Promotion of healthy behaviours and signposting to mental health services

Within Kirklees Council, the main causes of sickness absence are: musculoskeletal problems (30%) and mental health issues (29%). The Occupational Health and Wellbeing Service (Employee Healthcare) works with managers and HR Specialists to reduce sickness absence, improve attendance and reduce the impact of ill-health, working alongside Kirklees IAPT (Individual Access to Psychological Therapy). The range of support includes:

- Provision and access to individual 1:1 counselling.
- Physiotherapy assessment, treatment and 1:1 rehabilitation. Medical opinion on eligibility for ill-health retirement, liaising with GPs and Specialists.
- Health MOTs for those concerned about their health and wellbeing.
- Assisting employees to make best use of existing services and networks both internal and external to the organisation to improve their well-being (their families and community).
- Occupationally based immunisation programmes/ screenings (Hepatitis A & B), seasonal flu immunisations.
- Integrating into organisational development services and initiatives (training programmes, coaching, adult learners etc.). Providing training programmes such as DIY to Well-being, Positive Mental Health, from the Institute of Occupational Safety and Health (IOSH), Managing Safely.
- Workplace assessment and advice on workplace adjustments.

**What needs to happen next?**

***Implementing the Kirklees Economic Strategy (KES)***

The KES contains five priorities. These are driving business growth, through supporting the engineering and innovative manufacturing sector, and supporting innovation and enterprise across business in all sectors. Also facilitating business success, through infrastructure and quality places and focussing on skills and employment as the glue that binds together individual needs and private sector success.

***Adapting commissioned services to deliver social value***

A key tool in delivering the KES is the Social Value Act18 which places a duty on public bodies to consider social value ahead of procurement. The term 'social value' means ways of maximising the wider benefits from the delivery, procurement or commissioning of goods and services, above and beyond those directly related to those goods and services. So the focus widens from the immediate bottom-line price or cost to making a wider benefit than would otherwise be achieved. In other words, 'social value' is getting the best possible outcomes for local people. We need to work with different sectors including business and voluntary organisations, to help keep and increase spend locally e.g. boosting the Kirklees economy, create more jobs and get people more involved in how they organise and manage their own lives. It can be argued that social value should be at the heart of the way a local council operates.

The Council has a Social Value Policy Statement which was agreed by Cabinet in December 2013. The implementation programme is testing out different ways of working to help this become integral to the way the council and partners work with other sectors such as VCS and business. A local guide for procurers and commissioners has been developed.

As part of the organisational development programme, Council staff have reviewed their own behaviours, particularly towards each other. This includes being sensitive to how they challenge others; being aware of one's own verbal and non-verbal communication; having respect for the views, opinions professions and expertise of others. Supporting this thinking across all staff groups will help to create a more harmonious, pleasant working environment and is more conducive to employees feeling comfortable and relaxed within their workplace, which in turns leads to a possible reduction in sickness absence.

**The Primrose Hill Solar Village:** an initiative to create a solar village including 121 solar-powered homes as part of an overall regeneration scheme for the area. This included existing houses managed by Kirklees Neighbourhood Housing and new homes being built by Yorkshire Housing Group. Local jobs were created and skills increased. This included training a local solar thermal installer in solar PV installation and the establishment of a new team with demonstrated experience in installing solar PV and solar thermal systems on social housing properties. More than £400,000 in external funds was brought into the Kirklees community.

As Social Value thinking gets embedded, the Council needs to look at how it can maximise equitable employment opportunities, focusing on those least likely to be able to access the jobs market e.g. people classed as Not in Education, Employment or Training.

### *Building skills to create a resilient workforce*

Workforce, skills and employment is one of the five priorities in the Kirklees Economic Strategy. Building skills aids employability, career progression and life chances, thereby reducing inequalities and ensuring there is the workforce necessary to deliver economic growth in the future.

Enhancing skills is also vital to business success; evidence shows that higher skills contribute to productivity and growth, which in turn support more jobs and higher incomes. Some sectors, such as engineering and manufacturing, have an ageing workforce and need to be able to recruit young people into the sector, with apprenticeships one important way of achieving this.

Investing in the education and skills of people at the bottom of the skills ladder will pay long-term dividends for the economy and enhance individual well-being. Lifelong learning is an important intervention that reduces health inequalities. The value of education in midlife is greatest for those with the poorest education when they left school. Providing literacy and numeracy courses for adults who struggle with this should be part of the action in this priority, along with engagement of further and adult education institutions in the community[19].

**Back to work**

Sally attended Auntie Pam's in obvious distress. She had no nappies for her child and no food. She was extremely introverted and had disengaged with other services. She was seen by an Auntie Pam's volunteer who helped her access a food bank, get nappies and together they contacted the right people to check her welfare entitlements.

When Sally visited Auntie Pam's the following week she spent a long time with a Pam's volunteer discussing her health and wellbeing. She continued to attend Pam's for the next six months. With each her self-worth and confidence increased and she built relationships with volunteers and other Auntie Pam's service users. Sally set goals to stop smoking and to return to part time work. Sally was full of pride when she visited Auntie Pam's to say she was now an Avon representative, the relationship with her family improved and she became more optimistic about her future.

## Recommendations

### *Helping businesses to prosper and grow*

Working with the private sector and other partners to deliver the KES will be vital to ensuring we have the strong and growing businesses and new enterprises that in turn support good jobs, incomes and associated health and wellbeing benefits.

Health and economic partners should further build and deepen their relationships and work jointly to deliver initiatives where they both have a contribution to make and benefits to accrue. These include areas such as local food enterprise, Tour de France legacy, housing, the health and social care sector, business support and engagement, and green infrastructure. This could start by the Health and Wellbeing Board considering the impact of the decisions it makes on the local economy.

The Council and partners should consider the Social Value Act 2012.

The Council and partners should support adult education, particularly literacy and numeracy courses for those needing it, along with lifelong learning.

The Council should act as a role model for a resilient workplace with the key features of organisational resilience see p40.

As part of Kirklees Council's offer to businesses, it could:

- Develop the manager's support forum using the model of 'Reconnect' Better Health at Work Self Help Group to support managers and in turn support employers. This includes implementation of the Workplace Wellbeing Charter and includes employees health and wellbeing[20].
- Support the implementation of the National Institute for Health and Care Excellence evidence on healthy workplaces[21].

# Health and spatial planning

Spatial planning improves the "liveability" of areas and enables a place-based approach to improving health and wellbeing. It also links closely into the active travel and green space sections described below. Planning can be an enabler in addressing issues related to the ageing population, social isolation and cohesion of communities. It is really important to think 'Health Impact Assessment' in assessing the impact of planning decisions especially in areas of high levels of deprivation. For example: what is the relationship between density of fast-food outlets and areas of deprivation? Both nationally and locally, strong links exist with more deprived areas having more fast food outlets per 100,000 people[22].

## What has already been done?

Bringing health and wellbeing into the world of planning is opening up real opportunities for improving local health.

### *Strategic and policy development*

- The March 2014 National Planning Practice Guidance states that local planning authorities should ensure that health and wellbeing, and health infrastructure are considered in local and neighbourhood plans and in planning decision making[23].
- Bringing the JHWS outcomes and system thinking into the development of the Local Plan will help maximise health and wellbeing benefits in the planning framework.
- As of May 2014, developers are required to submit a planning application for new betting shops where there is to be a change of use. Previously, betting shops were placed in the same category as banks and estate agents, meaning that if a betting shop took over a building of this type, they would automatically receive approval. Other business types such as restaurants and public houses will no longer be able to change their use to betting shops without planning permission. Oldham have implemented this new legislation into their planning practices and have been successful in declining planning applications from betting shops on this basis.

### *Building Development*

The initial agreement has been to involve Public Health staff in reviewing pre-planning applications. Feedback from this helps developers to consider potential health issues at the design stage on relevant schemes e.g. open outdoor areas within larger business developments to provide amenity space for workers.

### *Environmental Permits and Planning Consultations*

Health can be affected by planning developments and industrial activities. These are regulated through the planning process and environmental permits. Health impact assessments have mainly focused on environmental permit applications and major infra-structure projects such as nationally significant infrastructure.

### What needs to happen next?

***Mainstream an 'integrated health, economy and environmental assessment'*** approach by building on the experience so far in considering health impact. There should be a regional consensus for this approach to ensure that all districts apply the same principles when considering planning applications.

- Planning application reports for larger developments include a section on health which will assess the impact of a scheme in terms of health and the National Planning Policy Framework (NPPF)[23]. This will encourage planning officers to emphasise health considerations in the short to medium term prior to the adoption of a Local Plan. This could use a local adaptation of a Spatial Planning and Health Group checklist[24] or in big developments assess the impact on health systematically.
- Consultation with Public Health on larger scale developments. Although developers do not currently have to adopt the recommendations made, over time, this influencing role can contribute to the production of Supplementary Planning Documents (SPD), as and when the evidence emerges in terms of the effect of planning decisions upon health. This will be dependent upon robust policy development within the Local Plan; informed by the JSNA and the JHWS.
- Ensure that, where appropriate, new buildings are air quality neutral. This means that the emissions of

Further *use of the 'integrated impact assessment'* process to support a place based approach to improving health and wellbeing needs a focus on health intelligence. This means:

- Provide access to, and interpretation of, health intelligence focussing on local issues both as evidence for the Local Plan, and also for planning decision taking. This includes the JSNA.
- Further evidence of what works to improve health outcomes, from transport, the natural environment, homes and how to support the creation of healthy living environments which encourage physical activity and support community engagement and increasing social capital.
- The implementation of locally based "age-friendly environments" that improve independence, participation and wellbeing of older residents.

#### *Workforce development*

- The interplay between health inequalities and planning needs to be addressed by closer working. Mutual learning would be useful and Kirklees has been encouraging the regional network and Public Health England to take training and workforce development as a priority.
- The Community Infrastructure Levy (CIL) is a new levy that local authorities can choose to charge new developments in their area. The money raised from this levy can be used to support development by funding infrastructure that the council, local community and neighbourhoods want. When this is implemented in Kirklees it is important that decisions, regarding use of this levy, are made with a view to maximising the health and wellbeing of the people in the area.

### Recommendations

- Continue to develop an 'Integrated Impact Assessment' approach to planning applications and wider developments locally. Work across the Leeds City Region to ensure consistency for potential developers.
- Ensure that the health elements of the National Planning Policy Framework and Guidance are integrated into the Kirklees Local Plan.

NOx* and PM10* from the buildings and transport elements of major developments do not exceed local Air Quality Neutral benchmark values.

# Active and safe travel

The design and implementation of local transport plans is important in addressing preventable deaths and injuries, particularly among vulnerable groups. It is a crucial way to support people making healthier choices like cycling and walking, thereby reducing the risk of long term conditions including musculoskeletal pain, heart disease, diabetes, and other obesity-related illnesses. Higher levels of air pollution from increasing vehicle use increase cardiovascular and respiratory conditions and contribute to global climate change; the health impacts of air pollution are greater than the risks of passive smoking and transport accidents together[25]. In addition, active travel can help address social and economic isolation.

### Modes of transport in Kirklees:

- Almost 2 in 3 of journeys in Kirklees are made by car. These account for 20% of local $CO^2$ emissions[26].
- 38% of journeys to primary schools and 24% of journeys to secondary schools were made by car. Only 1% of secondary school pupils cycle to school[2].
- 23% and 10% of journeys are made by buses and trains respectively[27].
- 6.9% of journeys are made by foot and only 0.8% by cycle or motorcycle[27].

### Reclaiming streets

Environments conducive to active travel are often also conducive to the 'Living Streets' approach. Too many people cannot get to local shops and services such as libraries, schools, shops selling fresh food, post offices, pharmacists and GPs on foot, or feel safe from traffic walking around their local centre. Nationally 28% of adults felt isolated, or had a friend or loved one who felt isolated due to a lack of access to essential shops and services within walking distance[28]. This trend and the use of the internet is leading to isolation, lack of physical activity and neighbourhood decline. So we need to try and ensure that shops and local services are easily accessible by any form of transport, and are also safe to walk easily.

Walking in local centres helps to bring communities together; increasing connectivity and can stop older and vulnerable people from becoming isolated. People are at the heart of thriving neighbourhoods where we all want to live, walk and play.

### Behaviour change

Creating a supportive environment needs to go hand-in-hand with encouraging people to change their behaviour. The West Yorkshire Local Transport Plan consultation revealed that respondents[29]:

- Consider walking and cycling to be 'high priority.'
- Want segregated cycle options which provide direct routes from A to B.
- Would like cycle lanes linking residential areas and schools, then moving to shops and places of work.
- Want walking infrastructure to include access to benches for people to rest.

However people do not make active travel choices for a variety of reasons. More needs to be done to change social norms and public perceptions.
For instance the perception of cycling being dangerous can be counteracted by promoting the message that its health benefits outweigh the risk of accidents, and encouraging its cost-effectiveness to be factored in.

## What has already been done?

### *The Tour de France legacy*

The Tour de France (TdF) in Yorkshire in 2014 has been the driving force in terms of raising the profile of cycling across Kirklees. Large scale events such as the TdF and The London Olympics can inspire people to make the necessary changes to their lives.

The TdF Yorkshire Legacy Group produced the Let's Get Yorkshire Cycling Delivery Plan in the spring of this year, and Kirklees now has a Kirklees Cycling Delivery Group, which will implement the 'legacy' of the Yorkshire TdF. This delivery group consists of individuals and organisations that have a role to play in increasing the numbers of people cycling in Kirklees. Examples include:

- Highways & Engineering – ensuring that the built road infrastructure incorporates facilities for cycling.
- Planning – the built environment is conducive to safe cycling.
- Physical Activity Providers – implementing cycling interventions for the general population, e.g. SkyRides, Cycle to Health, community based activities.
- Communications – ensuring that all cycling opportunities are communicated effectively amongst target groups.
- Road Safety – ensuring that the perceptions of safety amongst potential cyclists are addressed, e.g. traffic speeds.
- Parks & Open Spaces – ensuring that parks are utilised effectively in terms of cycle usage.
- CTC (Cycle Touring Club) – National Cycling Charity – representing current and potential cyclists with the aim of getting more people cycling more often.
- Sustrans (a charity) aim of enabling people to choose cleaner, healthier, cheaper journeys.
- British Cycling – ensuring the 'grassroots to elite performance' pathways are in place.

### *Greenway network*

To promote the district as a beacon for green living, Kirklees Council is developing a Green Network. This is a planned network of green spaces used for recreation, sustainable transport, wildlife habitat and flood storage capacity. It aims to connect people and local communities with places of work, leisure and other centres, along Greenways and other paths. It includes:

- The Calder Valley and Birkby Bradley Greenway - a signed, mainly traffic-free 8 ¾ mile route between Huddersfield and Dewsbury Town Centres.
- The Spen Valley Greenway - part of the National Cycle Network (NCN) of safe and attractive routes to cycle throughout the UK, stretching from Oakenshaw to Saville Town.

### *Working with Schools*

Bikeability Training (National Standard), is currently delivered by Road Safety Officers (RSOs). This will be delivered by School Sports Partnerships and Be Cycling in the future with Pedestrian Safety Training will be continued to be delivered by RSOs.

### *Campaigns*

Walk to Work Week is an annual event co-ordinated by the charity Living Streets and is held within National Walking Month. Employees are encouraged to leave their cars at home or to park a little further away and increase the amount they walk. In addition to utility walking (daily walking to and from work), employees are encouraged to walk during their lunchtime. Workplaces register on the Living Streets website and log the amount they are walking. The winners of the competition are announced once the event has finished and individuals are entered into prize draws to encourage an increase in participation. In Kirklees, this has been a campaign to signpost employees to the Living Streets website to encourage work teams to increase their walking that week, and hopefully continue to do so after.

Bike to Work Week was an annual event organised by various partners, including: the Cycle Touring Club, Act Travelwise and Sustrans, as part of National Bike Week. National Bike Week encourages over half a million people to join in events, rethink their everyday journeys and switch to cycling as the most convenient way to get around. Locally in the last year the main focus for 'bike to work' interventions was:

- Ride for Rewards, which is a Workplace Cycle Challenge delivered via the Go: Cycling Project.
- SkyRides, which are a programme of community guided rides aimed at various levels of skills and abilities.
- Last September saw the first Cycle to Work Day, this consisted of a 'bike breakfast' in Huddersfield with discounts offered by a local coffee shop. Sadly few took this up.

***Cycle promotion, profile, tourism and the visitor economy***

The coverage and publicity Kirklees gained through the Tour de France was outstanding, with the Holme Moss climb in particular one of the iconic images of the Grand Depart. We need to build on this profile to attract more visitors and tourism, including those wishing to cycle the route, or to enjoy leisure cycling (e.g. mountain bike trails) in and around Kirklees. There will be benefit from working alongside other TdF route local authorities to ensure excellent signing and maintenance of the TdF route. Likewise there is potential to create a 'lower traffic' TdF detour routes that cover the distance and climbs of the Tour but avoids the busiest roundabouts and roads – hence improving safety and attracting more people to ride the route and visit Kirklees, for example on sponsored or challenge rides.

**What needs to happen next?**

***Local co-ordination***

Following the Tour de France event, the Kirklees Cycling Delivery Group will evolve into an Active Travel Group with a broader membership and remit to include other forms of active travel, such as utility walking as a means of transport for short journeys. **Walking is simple, free and one of the easiest ways to get more active, lose weight and become healthier.** It is underrated as a form of exercise but is the easiest way to get physical activity into daily life for all who can walk. So we should get:

1. Active travel embedded in policy, promoting the creation of safe, attractive and enjoyable local environments, with roads that prioritise 'place' over cars to increase 'walkability' and 'cycleability.'
2. Relevant policies and plans in both the Council and wider partnership to look at how they support walking and cycling[30].

Political commitment is an important element contributing to effective joined up leadership of the 'active travel' agenda.

***20 mph zones*** the use of 20mph zones and 20mph speed limits was considered by Cabinet in December 2013. It would be helpful to review any progress since as well as learning from experience elsewhere, like the implementation of 20mph limit along residential roads in some areas.

### *Living Streets/Home Zones*

Partners like Living Streets work with local communities to produce 'Community Street Audits'[28]. These involve groups of local people including residents and businesses to identify improvements which will create a safe, attractive and enjoyable local environment for all users. So review the quality of streets and spaces from the viewpoint of the people who use them, rather than those who manage them. Streets and public spaces are most successful when residents have the opportunity to influence decisions about them.

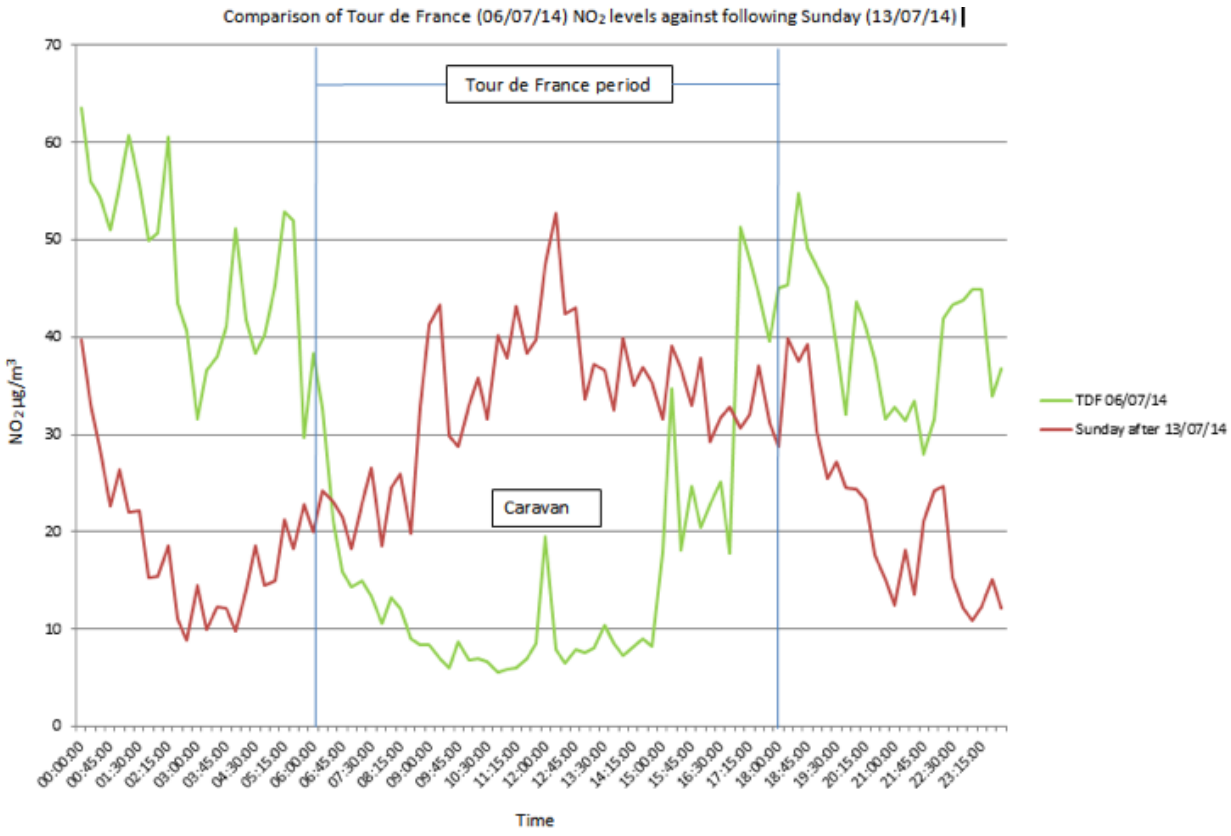
Environmental Health should review local action to ***improve air quality*** across Kirklees, working with partners across West Yorkshire, including transport planners and Public Health England.

It is interesting to note the difference in air quality in Huddersfield between the day of the TdF race and the following Sunday.

Developing the built ***environment safe for pedestrians*** includes implementing specific measures e.g. extended crossing times at pelican/pedestrian crossings, increased numbers of safe crossing points, reductions in traf fic speeds, better signed main points of interest/journey end points, like railway stations, town halls, community buildings and health centres.

***Work with employers*** to promote active travel e.g.

- Cycling to work, by increasing physical fitness contributes to better overall health and reduces the risk of cardiovascular disease and obesity and results in lower absenteeism[31]. Incentives include offering a higher mileage rate for cycling than for cars.
- Working with local hauliers to implement driver training to improve cycling awareness and developing policies such as local construction sites only using hauliers with such driver training are integrated intoprocurement processes.



- Implementation of business engagement programmes which encourage sustainable business practices, e.g. those which reduce waste and enhance air and water quality.
- Encourage car sharing schemes.
- Promoting zero emission 'last mile' delivery of as many goods and services as possible. Most of a journey is often undertaken by rail and container ships. These are often the most efficient and cost effective part of the supply chain. The last leg of this chain is often the least efficient, comprising up to 28% of the total cost to move goods. This has become known as the 'last mile problem'[32].
- Development of 'eco driving' training programmes for taxi drivers to encourage more fuel efficient driving and reducing idling at taxi ranks.
- Encourage bus transport companies to fit vertical roof exhausts and diesel particle filters.

***Develop stronger links across West Yorkshire networks***

Active travel work needs to be coordinated across West Yorkshire to obtain sufficient momentum, influence change, consistency and economies of scale. Such collaboration helped in the development of a West Yorkshire strategy for low emissions.

The West Yorkshire Combined Authority covers transport and has a central role in the development of business and the creation of new jobs. It recognises the health and wellbeing implications of its work and is keen to work closely with local authorities to maximize potential benefits. There is a developing group looking at health and it is essential that Kirklees plays its part and encourages other local authorities to be involved. Lessons from other successful examples of promoting active travel, e.g. Cycle Demonstration Towns, the Netherlands etc. could be considered here.

**Recommendations**

- Work to achieve political support for the 'active travel' agenda in policy and action.
- Road Design - Ensure that road design and the built environment prioritises pedestrians and cyclists e.g. develop segregated cycling routes where feasible; linking places of interest e.g. schools, shops, health services. Development of the Living Streets concept. Connectivity across West Yorkshire.
- Safety - Work to improve the perception of the safety of walking and cycling; continue to deliver pedestrian safety in schools; work to reduce excess driving speeds and anti-social driving; HGV driver training and 'cycle friendly' vehicle design.
- Continue to develop the Greenway networks, particularly to join up utility trips.
- Grow tourism and the visitor economy based on promotion of the Tour de France route in Kirklees and enhancing local leisure cycling options (e.g. mountain bike trails, bike hire).
- Work with businesses to develop 'active travel' interventions. Promote zero emission 'last mile' delivery; use evidence based intervention to improve air quality; 'Eco' driving training for taxi drivers.

# Warmer and safer homes

A warm safe home is essential for health and wellbeing, and more and better housing is also supportive of the local economy and private sector jobs. Living in a cold house increases the risk of cardiovascular disease, respiratory illnesses and stroke. Nationally each winter between 25,000 and 30,000 more people die than in the summer[33,34], particularly those aged over 65. In Kirklees in 2012, 1 in 6 homes were in poor condition, and 16% of householders felt that their house was not suitable for their needs[2]. Within areas of high deprivation there are correspondingly high levels of non-decent, poor quality housing, especially in the private rented and owner-occupied sector[2].

Accidental injury is one of the main causes of death for children aged 1-15 years of age in Kirklees, with homes remaining the most common site for accidents, particularly for young children and older people and those living in more deprived households[2].

About 30% of those aged over 65 will fall at least once in any given year. Currently there are more than 67,000 people over 65 living in Kirklees, 1 in 6 of the total population[2]. Based upon these figures it seems reasonable to suggest that 20,000 residents of Kirklees, aged over 65, will fall during a year, and as the population increases in life expectancy, this number will increase. By 2030, it is projected that 1 in 5 of the population will be aged over 65[2].

During 2012, 26% of calls to the Kirklees Mobile Response Service were due to falls, with the majority of these being aged 80 or over. In 2010/11 there were 2,925 hospital admissions across Kirklees due to injurious falls, with 1,523 of those people being over 65[35]. In addition, there were a further 830 admissions for falls in the over 65s without injuries. In 2010/11 there were 417 hospital admissions due to hip fracture, a rate of 503.7 all being higher than the average for England. Characteristics increasing the risk of a fall include: age; female; living in care; certain medical conditions such as osteoporosis, diabetes, dementia, visual impairment, and stroke.

## Warm homes

### What has already been done?

Cold homes are usually caused by poor energy efficiency and inadequate heating, mostly affecting those on low incomes. The award winning Kirklees Warm Zone scheme ran between 2007 and 2010 and was one of the largest scale home energy improvement programmes in the UK. It delivered significant home improvements, green skills, job creation and reductions in fuel poverty. On a house by house, ward by ward basis, Warm Zone contacted every householder to give them the opportunity to make their home warmer and more energy efficient. By completion, the total Kirklees Warm Zone capital investment was £24M. In total 51,155 households had insulation measures installed, 26,453 fire safety referrals were made and 129,986 carbon monoxide detectors were distributed and 16,111 households were referred to benefit and debt advice teams with estimated annual benefit gains of £1.65M.

The Warm Homes, Healthy People Fund ran 11/12 and 12/13. This was to reduce the levels of deaths and morbidity arising from vulnerable people living in cold housing. This was a partnership between local communities, the voluntary sector and NHS Kirklees. Support was provided to vulnerable residents (private and social housing) known to have long term health conditions made worse by cold and damp. This was made of 4,000 packs containing basic essentials to keep warm through the worst of winter and 240 home advice visits, telephone advice and referrals to practical support. People most at risk were identified through a range of mechanisms like the GP's 'Predictive Risk Toolkit', the knowledge of Locala frontline staff, community and voluntary organisations working with vulnerable people, Council databases, identifying people who receive help from 'home from hospital', integrated community care teams, home care, Gateway Workers, and 'snow heroes.'

In social housing there are schemes to tackle fuel poverty. These include fitting new gas supplies and central heating, installing cavity wall insulation in hard to treat properties, the external wall insulation programme and plans to install Solar Photovoltaic (PV) panels.

Collective switching schemes are where consumers group together to negotiate a better deal with their gas and electricity suppliers to reduce energy bills of households. The Community Energy Direct - Energy Smart programme worked with Kirklees Council and neighbouring authorities supported by the Cheaper Energy Together fund operated by the Department of Energy and Climate Change[36]. In Kirklees, 1,582 households signed up to the Collective Switch in 2013, of which 171 accepted their switch offers, 11% - comparable with other schemes. For those that switched, the average annual saving was £172 per household. The considerable resources required (in terms of public engagement) and planned Ofgen reforms of the domestic energy market to reduce the need for collective switching schemes mean that no further schemes are being organised at present.

### What needs to happen next?

The demand for social housing, including registered housing provision, far exceeds supply. Poor quality housing especially in the private rented sector, and the lack of capital funding available to tackle the £246 million required locally to bring the private sector up to standard, means that it will be a challenge to find ways to improve the quality of some of the private stock in Kirklees. A real future challenge is the change in legislation meaning that Private Sector Landlords will not be able to rent out their properties if they have an EPC level below an E from 2018. So landlords as well as homeowners should keep homes warmer by taking up the advice on how to save energy (e.g. through home energy audits and advice). Work to overlaying housing and fuel poverty data, to spatially prioritise areas for investment with co-benefits is in progress. The most vulnerable people in Kirklees need particular consideration e.g. distribution of insulation grants. An e-learning package (as developed in Bradford) for frontline staff and community workers on fuel poverty and homelessness could be useful to move this on.

## Safer Homes

### What has already been done?

Most **accidents** are preventable with improvements in the home environment, education or awareness-raising and greater product safety[4]. There is a strong social gradient in accidents[35]. Kirklees Accident Prevention Forum works with Yorkshire Children's Centre (YCC), on the prevention of unintentional injuries. The Safety Rangers programme for example, worked with over 760 Year 5 children from schools in our most deprived areas in 2013/14 to improve road safety, staying safe in the home, fire safety and basic first aid, bringing together local police, fire and road safety teams, as well as charities that offer first aid training, such as St. John Ambulance and the Red Cross. Local children's centres provide safety equipment so more than 400 low income families with very young children in 2013/14 having home safety equipment fitted along with education and advice on child safety. Recently collaboration with Kirklees Safeguarding Children Board and the local Sure Start teams helped to create a child safety e-learning resource for frontline practitioners and parents and carers.

The Mears Home Improvements – Home Energy Visits and small repairs to vulnerable householders supported them to:

- Be on the best tariff and were able to pay their fuel bills.
- Be placed on the priority register if vulnerable.
- Have small repair work done e.g. gas repairs (boilers), emergency heaters, draught proofing, and thermostatic radiator valves – ensuring that replacement boilers are the least polluting models.

A referral mechanism was started in 2011 for frontline health staff to refer on the most vulnerable residents of Kirklees, primarily with a health condition made worse by damp and cold conditions. The staff found the referral system was easy but few referrals were made because most homes they visited did not have cold and damp conditions or the residents did not want any formal help.

### Recommendations

- Promote what people can do to make their homes warmer and more energy efficient.
- Continue to invest in interventions to tackle fuel poverty.

## Preventing falls

The risk and rate of falls can be reduced through interventions such as individually prescribed exercise to improve muscle strength and balance; medication review; vision assessment and referral; and home hazard assessment. Being physically active is the most important intervention in falls prevention[37].

### What has already been done?

Within Kirklees there are a number of services which are specifically aimed at people who have fallen:

- Physical Activity and Leisure Scheme see p67 providing more generic exercise programmes and Tai Chi (proven to reduce risk of falling), there are falls prevention focused exercise programmes in 4 locations across Kirklees, giving individually prescribed exercise to improve muscle strength and balance but access is limited to those who live close by or have access to transport.
- Mears home improvement which can include a falls assessment within the home.
- Care phones which provide a means of calling for help after a fall.
- The Mobile Response service can help people who have fallen, yet do not need emergency medical help to get the support and reassurance they need to maintain their independence.
- There is a Falls Practitioner and a Falls Clinic at the Huddersfield Royal Infirmary. This service offers a comprehensive fall assessment including a review of the experience of the fall and the medical history and advice regarding action.
- Visual Impairment Rehabilitation Service supporting people with visual impairments to stay mobile and carry out daily tasks safely.
- Kirklees Integrated Equipment Services providing equipment such as walking aids.

Charities including AgeUK also work with local organisations to promote falls awareness through events such as Footprints in the Park during Falls Awareness Week.

### What needs to happen next?

To reduce falls a review should be done of the services described above and whether there is any local need to develop further specific strategies and programmes, which have been shown to reduce falls. This would involve working with the two CCGs, strategic housing, Kirklees Neighbourhood Housing and social care. It would need to link with targeted risk assessments and work with the Handyman scheme and home improvement agencies to provide support for older people, people with disabilities, and those on low incomes.

### Recommendations

Review of effectiveness of services already provided and addressing of gaps e.g.

- Improve the ability to target interventions, information and awareness raising activities with those 'at risk' of falling in Kirklees, by utilising the range of data already collected.
- Develop a co-ordinated approach to ensure specific information and advice about falls prevention is targeted at individuals at risk such as training for staff e.g. in care homes.
- Develop a programme of evidence based exercise sessions that can be undertaken within communities, within the home etc.

## Access to green and open spaces

Open spaces and green infrastructure encourages physical activity, supports positive emotional well-being and enables people to build social capital. A study in the Netherlands showed that every 10% increase in exposure to green space translated into a reduction of five years in age in terms of expected health problems[38] with similar benefits found by studies in other countries.

Access to open spaces and sports facilities is associated with more physical activity[39,40], including links with physical activity and food production (see previous section on Food and Sustainability); and decreases in long term conditions such as heart disease, cancer, and musculoskeletal conditions[41]. The effect of deprivation on health can be weakened by living in areas with green spaces[42]. However, children in deprived areas are nine times less likely to have access to green space and places to play[43]. In 2012 in Kirklees, 1 in 3 adults (37%) did the recommended levels of activity, 11% did no activity. 34% of 'women of child bearing age' (WoCBA) met the recommended levels, although adults of south Asian origin were least likely to meet these levels[2].

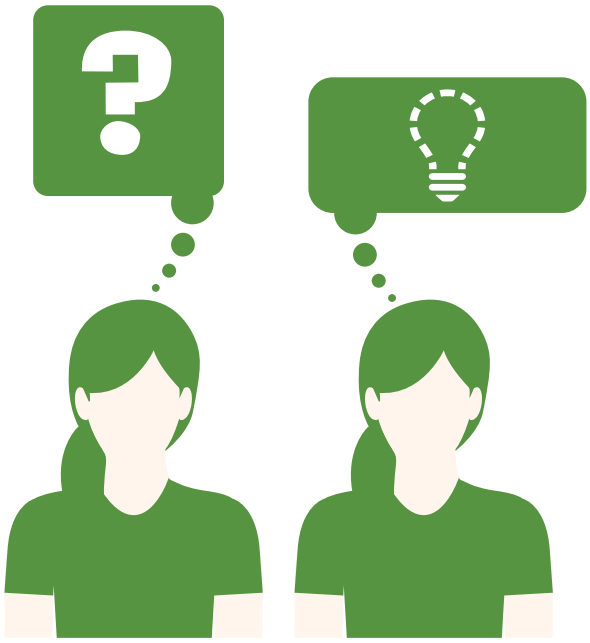
**What has already been done?**

A Kirklees co-ordination group has been developed to ensure delivery, monitoring and review of the Green Infrastructure Delivery Plan. This will give a framework for the future use, development and management of green infrastructure assets across Kirklees. It will also support the delivery of the Leeds City Region Green Infrastructure Strategy; the Leeds City Fresh Air Delivery Plan; the Kirklees Sustainable Community Strategy and the Integrated Investment Strategy. It is integral to the emerging Kirklees Local Plan (replacing the Local Development Framework), and will help direct investment and opportunities for new (and enhancements to existing) Green Infrastructure through the planning system. It will also provide a context for funding bids and help strengthen the support for individual projects.

The Green Infrastructure Action Plan includes:

- Measures to improve and extend the use and functionality of open space.
- Measures to encourage active travel and more sustainable transport.
- Measures to reduce costs and attract investment.
- Measures to increase the resilience of communities and foster community cohesion.

'Green Spaces – The Kirklees Offer' group has started work to achieve economic and social value outcomes by 'joining up' the various elements of Green Infrastructure work, ensuring that Kirklees residents are equipped with the necessary skills to utilise the surrounding green spaces more effectively. The Kirklees Economic Strategy advocates extension and enhancement of green infrastructure, including 'resource smart corridors', and recognises both its benefits to wellbeing and the economy through improving quality of place and attracting private investment.



**Plant a Tree for your Future**

'Get Out More' were commissioned by Kirklees Council in 2012 to develop a programme which involved the local community in the Dewsbury Country Park. The council focused on engaging the residents of the Pilgrim and Becketts estates in Dewsbury. The 'Pilgrim and Becketts Together' initiative builds positive relationships between the British-Pakistani and white populations of the estates.

The programme aims to enhance the wellbeing of residents of Pilgrim and Becketts estates through increased use and enjoyment of the Country Park as well as creating a sense of ownership through involvement.

Local residents were encouraged to take part in a tree planting day on 7 December 2013 and to establish a Friends of Dewsbury Country Park group to support longer term local involvement. 96 people took part in the programme with 61 taking part in the engagement activities and 35 people taking part in the community tree planting day. Some residents hadn't known that the park existed, so were completely unaware of the potential benefits of it, and the activities that could be enjoyed. Residents were encouraged to forage for wild fruit and fruit is now harvested by local people on an annual basis.

Some of the people who were involved in the Plant A Tree project have gone on to become involved in other opportunities. Many have said that historically they felt 'left out' of local discussions and developments, and that this programme had improved their relationship with the Council.

Get Out More CIC is now delivering a regular programme of outdoor activities with children and their parents from both St. Paulinus and Boothroyd schools, alternating between the outdoor areas of each school, focusing on foraging, cooking, eating and other creative activities using locally available natural resources. Kirklees Council are working with local residents to develop a 'Friends Of' group and continue to promote opportunities and developments via the Dewsbury Country Park Facebook page.

Get Out More helps people get more out of life by getting outside more. Get Out More aims to help people of all ages rediscover nature, feel better about themselves and be more motivated to get active outdoors on a regular basis. They offer a range of outdoor activities which promote the positive benefits of engaging with the environment. Projects promote physical and mental wellbeing and encourage personal development, such as increased confidence, communication and concentration, through fun and accessible outdoor activities. It began in 2009 when freelancer Annie Berrington started to develop outdoor play and learning programmes as a sole trader. The company was incorporated in March 2012 and is now a Community Interest Company, a form of social enterprise where surpluses are reinvested back into the community.

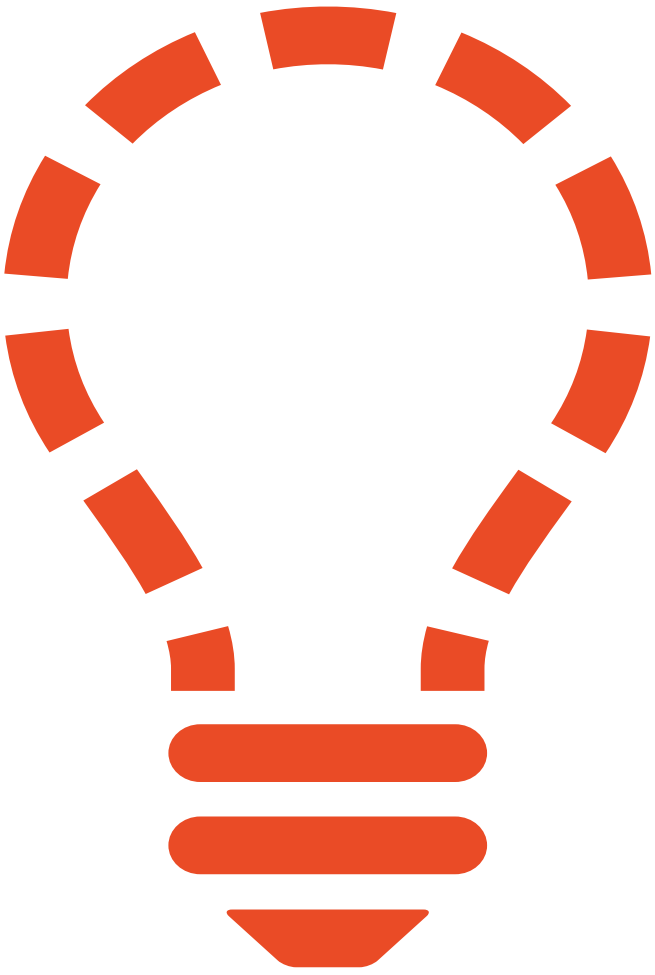
**What needs to happen next?**

The factors contributing to the underuse of existing green space need to be understood. This is from detailed understanding of local needs, cultural contexts and attitudes. These help effective targeting of local people and to encourage greater use of green space. These might include:

- More effective communication of where green spaces are.
- Providing people with the skills to explore and enjoy green spaces, and address any particular access issues.
- Partnerships or trusts with the private, voluntary sector and community groups are needed to ensure that the health benefits of parks and green spaces are maintained.
- Discussing with the CCGs how they commission and support activities such as walking groups in green spaces, consistent with the Department of Health's Let's Get Moving toolkit[41].
- Green Streets programme aims to improve quality of life by making makes areas more green; helps urban areas adapt to climate change so reducing air and noise pollution; improving health and well-being; bringing communities together. In the first broad-scale estimate of air pollution removal by trees in the US, scientists have calculated that trees are saving more than 850 human lives a year and preventing 670,000 incidences of acute respiratory symptoms .

**Recommendations**

- Continue to support the Kirklees Green Infrastructure Delivery Plan.
- Develop an understanding of the reasons for existing green spaces being underused, and from this develop ways of encouraging greater use e.g. more effective communication of where green spaces are and their uses, providing people with the necessary skills to utilise green spaces and addressing access issues.
- Encourage a 'Green Streets' approach to urban areas in order to address poor air quality, improve the aesthetic appearance of the built environment and reduce the risk of flooding and protect vital local green spaces to maintain their health benefits.



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