Leicestershire County Council

Meeting: **Health and Wellbeing Board**

Date/Time: **Thursday, 5 January 2017 at 2.00 pm**

Location: **Guthlaxton Committee Room, County Hall, Glenfield**

Contact: **Ms. R. Palmer (Tel: 0116 305 6098)**

Email: **rosemary.palmer@leics.gov.uk**

Membership

Mr. E. F. White CC (Chairman)

John Adler	Angela Perry
Karen English	Cllr. P. Posnett
Mr. Dave Houseman MBE, CC	Cllr. P. Ranson
Dr Andy Ker	Toby Sanders
Dr Satheesh Kumar	Mike Sandys
Dr Mayur Lakhani	John Sinnott
Chief Supt Andy Lee	Trish Thompson
Paul Meredith	Jane Toman
Rick Moore	Jon Wilson
Mr. I. D. Ould CC	

AGENDA

Item		Report by	
1.	Minutes of the meeting held on 6 December 2017 and Action Log.		(Pages 3 - 8)
2.	To advise of any other items which the Chairman has decided to take as urgent elsewhere on the agenda.		
3.	Declarations of interest in respect of items on the agenda.		
4.	Position Statement by the Chairman.		

Strategy

5.	Outputs of the Board Development Session held on 15 December.	Director of Health and Care Integration	(Pages 9 - 14)
6.	STP Delivery Update.	Better Care Together	

There will be a verbal update for this item.

7.	CCG Operational Plan 2017 - 2019.	West Leicestershire and East Leicestershire and Rutland CCG	(Pages 15 - 18)
8.	Better Care Fund Refresh 2017-18.	Director of Health and Care Integration	(Pages 19 - 28)
9.	Summary Care Record Solution for Care Planning	West Leicestershire and East Leicestershire and Rutland CCG	(Pages 29 - 42)
10.	Parity of Esteem.	Director of Public Health	(Pages 43 - 54)
11.	Unified Prevention Board update and Terms of Reference.	Director of Public Health	(Pages 55 - 62)

Performance

12.	Health and Wellbeing Board Annual Report.	Director of Public Health	(Pages 63 - 86)
13.	Better Care Fund Quarter 2 Performance Report.	Director of Health and Care Integration	(Pages 87 - 118)

14. Date of next meeting.

The next meeting of the Health and Wellbeing Board will be held on 16 March 2017 at 2.00pm.

15. Any other items which the Chairman has decided to take as urgent.

Agenda Item 1

Minutes of a meeting of the Health and Wellbeing Board held at County Hall, Glenfield on Tuesday, 6 December 2016.

PRESENT

Mr. E. F. White CC (in the Chair)

Karen English	Mr. I. D. Ould CC
Mr. Dave Houseman MBE, CC	Cllr. P. Posnett
Dr Andy Ker	Cllr. P. Ranson
Dr Satheesh Kumar	Toby Sanders
Chief Supt Andy Lee	John Sinnott
Paul Meredith	Jane Toman
Rick Moore	Jon Wilson

Apologies

Dr Mayur Lakhani, Supt Mark Newcombe, Mike Sandys and Trish Thompson

In attendance

335. Minutes and Action Log.

The minutes of the meeting held on 17 November were taken as read, confirmed and signed.

The Board also noted the Action Log, which provided an update on actions agreed by the Board at its previous meetings.

336. Urgent Items.

There were no urgent items for consideration.

337. Declarations of interest.

The Chairman invited members who wished to do so to declare any interest in respect of items on the agenda for the meeting.

No declarations were made.

338. Leicester, Leicestershire and Rutland Sustainability and Transformation Plan.

The Board considered a report of Better Care Together which set out the draft Sustainability and Transformation Plan (STP) for Leicester, Leicestershire and Rutland (LLR). A copy of the report marked 'Agenda Item 4' is filed with these minutes.

Arising from discussion the following points were raised:-

(i) The Board commended officers on producing an accessible document which was easy to read. The importance of listening to the outcome of public engagement and consultation was emphasised. It was also suggested that engagement with the public should focus on the positive health offer that would be made for each locality.

(ii) Concern was expressed that the draft STP did not make reference to patients who accessed services outside of LLR. In addition, the STPs of neighbouring areas included proposals to change service provision in those hospitals which were used by Leicestershire residents. The Board was advised that, as STPs were only now being published, it had not previously been possible to access them. However, the STP programme office was working with neighbouring areas to assess the impact of their plans.

(iii) The draft LLR STP included proposals for outpatient services for patients who had initially been treated in an out of county hospital to be provided in Community Hospitals. For example, there was a proposal for Kettering Hospital to offer outpatient services in Lutterworth. It was confirmed that these proposals would not have an impact on patient choice.

(iv) The draft STP stated that Leicester was unusual in that it had three big acute hospitals for the size of population it service. It was suggested that a chart comparing service provision in Leicester with that of other, similar sized areas would be useful. The Board was advised that there were similar numbers of staff in Leicester to comparator areas, but the need to maintain safe services across three sites often resulted in the triplication of services and staff being spread too thinly.

RESOLVED:

That the draft Leicester, Leicestershire and Rutland Sustainability and Transformation Plan be noted.

339. Sustainability and Transformation Plan: Role of the Health and Wellbeing Board.

The Board considered a report which provided an overview of the proposed role of the three Leicester, Leicestershire and Rutland Health and Wellbeing Boards within the new Sustainability and Transformation Plan governance and delivery arrangements. A copy of the report marked 'Agenda Item 5' is filed with these minutes.

Members of the Board welcomed the proposals, which demonstrated the strength of partnership working across health and social care.

RESOLVED:

(a) That the proposal to take on a greater role in relation to the Sustainability and Transformation Plan, as described in paragraphs 8 to 14 of the report, be approved;

(b) That the five specific functions for the Health and Wellbeing Board outlined in paragraph 10 of the report be approved;

(c) That the specific areas of service reconfiguration and new model of care focus for each Health and Wellbeing Board set out in the table in paragraph 12 of the report be approved;

(d) That the areas that would remain within the governance of other parts of the system be noted.

340. Date of next meeting.

It was noted that the next meeting of the Board would take place on Thursday 5 January at 2.00pm.

3.00 - 3.25 pm CHAIRMAN
06 December 2016

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No.	Date	Action	Responsible Officer	Comments	Status
254(e)	07/01/16	Receive progress reports on the CAMHS Transformation Plan, including performance information with regard to the outcomes framework on a regular basis.	Paul Meredith	Next progress report is scheduled for meeting on 1 June 2017.	GREEN
266(c)	10/03/16	Submit a report to the Health and Wellbeing Board in July setting out a timed and quantified plan for addressing issues related to Parity of Esteem	Jim Bosworth/ Mike McHugh	Progress report circulated to the Board for information in September 2016. Report scheduled for January 2017	GREEN
286(b)	05/05/16	Consider the following items relating to health and social integration at future meetings of the Board:- • Lightbulb Business Case; Health and Wellbeing Outcomes for Social Prescribing; Summary Care Record Solution for Care Planning; Joint Commissioning Work Plan.	Rosemary Palmer	The Board has already considered reports on the emerging approach to Social Prescribing, Joint Commissioning and the Lightbulb Business Case. The Summary Care Record will be considered by the Board in January.	GREEN
326c)	17/11/16	Develop a delivery plan and performance framework for the Joint Health and Wellbeing Strategy to monitor progress against the Strategy and reported to the Health and Wellbeing Board in due course.	Mike Sandys	The delivery plan and performance framework for the Joint Health and Wellbeing Strategy will be reported to the Board in March 2017.	GREEN
327(b)	17/11/16	Hold a meeting of the Health and Wellbeing Board on Tuesday 6 December at 3pm to discuss the STP including governance arrangements and the role of the Health and Wellbeing Board.	Rosemary Palmer/ Toby Sanders	Meeting set up and reports submitted for consideration.	GREEN
330(b)	17/11/16	That regular , targeted updates from the LLEP, Housing Services Partnership and Safer Communities Partnership Board be submitted to the Health and Wellbeing Board to ensure that they are aligned with the work of the Board.	Mike Sandys	This will be addressed through the performance framework, with targeted reports being submitted to the Board when appropriate.	GREEN

No.	Date	Action	Responsible Officer	Comments	Status
330c)	17/11/16	Submit a report outlining progress with the development and delivery of the Suicide Prevention Strategy to a future meeting of the Health and Wellbeing Board.	Mike McHugh	Report scheduled for March 2017.	GREEN
330(d)	17/11/16	The Director of Public Health to ascertain whether the health profiles included prisoners and to clarify the underlying prevalence for drug use in Leicestershire.	Mike Sandys	Population estimates include all prisoners imprisoned in England and Wales with a sentence of 6 months or more. Prisoners are treated as a special population in the population estimates as it is assumed that movements of people into and out of prisons are not picked up by GP registers used to estimate internal migration. Leicestershire has a similar mix of opiate and non-opiate users in treatment compared to the national average; they tend not to be in treatment as long as the national average but Leicestershire is below the national average for those opiate users abstaining after treatment.	GREEN
333(b)	17/11/16	Public Health and Healthwatch to discuss whether specific cohorts of patients be targeted for further analysis of their views.	Vandna Gohil/ Mike Sandys	Discussions between Public Health and Healthwatch Leicestershire regarding how to take this work forward are ongoing as part of the 2017/18 workplan for Healthwatch Leicestershire.	GREEN

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Agenda Item 5

Leicestershire County Council

HEALTH AND WELLBEING BOARD: 5 JANUARY 2017

REPORT OF THE DIRECTOR OF HEALTH AND CARE INTEGRATION

OUTPUTS OF THE DECEMBER BOARD DEVELOPMENT SESSION

Purpose of report

1. The purpose of this report is to summarise the discussion that took place at the Health and Wellbeing Board Development Session on 15 December, to present the outputs from that session and to outline the next steps that will be taken to progress actions arising from the session.

Link to the local Health and Care System

2. This report relates to the Health and Wellbeing Board's role in delivering the Sustainability and Transformation Plan (STP) and also considers the need for the Board to develop a more comprehensive method of engagement with the other Health and Wellbeing Boards in Leicester and Rutland and the public, as local health and care services are transformed.

Recommendation

3. The following recommendations are made to the Health and Wellbeing Board:-

   (a) That the actions proposed in paragraph 9 of this report be approved and that a report outlining progress with their delivery be submitted to the meeting of the Board in March 2017;

   (b) That the Director of Public Health be asked to develop a prevention wrap-around offer for the Integrated Locality Teams and report on progress with this to a future meeting of the Board;

   (c) That individual partners be asked to progress the proposals outlined in paragraph 12 which relate to their organisation and that this be the focus of a Development Session for the Health and Wellbeing Board during Spring 2017.

   (d) That officers be asked to develop a refreshed communications plan for the Health and Wellbeing Board, based on the Board's role as set out in paragraph 13 of this report;

   (e) That officers be asked to develop a communications campaign for the Board related to self care and supporting people to stay safe, well and independent in Leicestershire;

(f) That the Better Care Together/STP Programme Management Office be recommended to consider learning from the integration model developed in Salford;

(g) That the Better Care Together/STP Programme Management Office be recommended to consider using the Public Health Prioritisation Tool to determine commissioning and decommissioning decisions across the health and social care system.

Policy Framework and Previous Decisions

4. The Health and Wellbeing Board agreed on 6 December 2016 to take on a greater role in relation to delivery of the STP in line with the governance arrangements proposed across Leicester, Leicestershire and Rutland.

Background

5. The Health and Wellbeing Board holds an annual development session towards the end of the year to consider partners' commissioning intentions the following year and to ensure that risks, issues and pressures are discussed and addressed jointly.

6. The purpose of this year's development session was:-
   a) To receive an initial briefing on the STP areas where the Health and Wellbeing Board will have a lead role;
   b) To consider the Health and Wellbeing Board's role in relation to the STP;
   c) To ensure that priorities for 2017/18 are aligned with the STP;
   d) To ensure partners have an overview of commissioning intentions across the system for the forthcoming financial year and to consider risks and issues across the partnership arising from these.

STP Lead Areas

7. Board members received an initial briefing on integrated locality teams and community hospital reconfiguration; the two STP priority areas where the Board will take a lead role in confirming and challenging plans for implementation on behalf of the other Health and Wellbeing Boards in Leicester, Leicestershire and Rutland.

8. The discussion that took place following the two presentations sought to clarify further the role of the Board and identified the following principles:-

   General

   (i) To ensure that the roles of the Health and Wellbeing Boards and Health Overview and Scrutiny Committees do not duplicate each other;

   (ii) To ensure that there is a common understanding across the Health and Wellbeing Boards in Leicester, Leicestershire and Rutland of their roles in delivery of the STP and that appropriate arrangements are in place for engagement between the three Health and Wellbeing Boards;

   Integrated Locality Teams

(iii) To ensure a balance between a consistent offer for all eleven localities while allowing some element of local flexibility;

(iv) To involve the wider partnership, such as District Councils, the Police, EMAS and the voluntary sector from the start of the programme, both at locality leadership level and, where appropriate, at Programme Board Level;

(v) To build in evaluation of the effectiveness of the model from an early stage using Public Health expertise to develop the methodology for this;

(vi) To take the lead in the development of the prevention wrap-around offer for integrated locality teams;

Community Health Services

(vii) To develop key communications messages relating to the benefits of the community services offer for each locality;

(viii) To consider giving individual members of the Board a role in communication and engagement.

9. Arising from discussion of these principles, the following specific actions for the Board have been identified:-

Action	Date for Completion
Review the protocol between the Health and Wellbeing Board, Health Overview and Scrutiny Committee and Healthwatch Leicestershire in the light of the STP arrangements.	January 2017
Produce a protocol defining how the three Health and Wellbeing Boards in Leicester, Leicestershire and Rutland will engage with other on the STP.	February 2017
Work with STP communications leads to develop key communications messages for the two lead areas, setting out the benefits for each locality and clarifying:- • The role of the STP; • The role of the Health and Wellbeing Board; • The role of individual organisations; and • The role of individual members of the Health and Wellbeing Board in communications and engagement.	February 2017
Update the guidance on declarations of interest for Board Members, recognising that some Board members will have senior roles in delivering the STP and will not be able to participate in confirm and challenge sessions relating to their areas of responsibility.	January 2017

10. Actions relating to the role of the Integrated Localities Programme Board, in terms of engaging the Police, EMAS, District Councils and the Voluntary Section in the programme and ensuring evaluation is built in at an early stage have been referred to that Programme Board to progress.

Commissioning Intentions

11. Each partner with commissioning responsibilities was invited to give a brief presentation of the key risks and pressures they faced in the coming year and to outline where they felt these would have an effect on the wider health and care system.

12. Set out below are the key points that were raised, where a corresponding action was identified to help mitigate the risks:-

    (i) Leicestershire County Council was developing a Whole Life Disability approach. There was an opportunity for joint working with Integrated Locality Teams in this area.

    (ii) Looked After Children were highlighted as a financial pressure for the County Council. Leicestershire Police indicated that it had a similar concern, particularly in terms of the impact on their resources of children who were missing from home or from a care placement. This therefore presented an opportunity for joint working, with a focus on the emotional health and wellbeing needs of children.

    (iii) There was an opportunity for joint working on cyber crime, particularly in relation to frail older people who were increasingly vulnerable to this type of crime. This could be through the Police providing development sessions for GPs or through links to the social isolation communications campaign that was currently ongoing.

    (iv) The 101 service provided by the police was being reconsidered in terms of how it served vulnerable people. It would be helpful if this could be considered in the light of the Leicester, Leicestershire and Rutland Integrating Points of Access project for health and care customer call centres. There are opportunities to identify any potential for joint working around demand management and the provision of alternative support for vulnerable people who would otherwise generate an emergency call.

    (v) The District Councils acknowledged that articulating consistent offer describing how District Councils supported prevention and demand management (which was easier for partners to understand) would help with managing demand on the system.

    (vi) All partners were reminded of the need to build on initiatives that were already in place rather than to develop new ones or overlay developments. This would help to ensure that partners were not duplicating work which was already in place. To that end, consideration should be given to the integration model developed by Salford where the mapping of services had identified overlaps in service provision which could then be addressed.

(vii) It was suggested that, as the Housing Enabler for Hospital Discharge had provided to be effective, it should be extended to community hospitals.

(viii) It was noted that the pathways set out in the draft STP relied on social care being available to support them. Given the current funding pressures in social care, it was important that this risk was reflected in risk analysis and risk registers.

(ix) The role of public health in providing an evidence base and evaluating services, particularly pilots, was important. Public Health had developed a prioritisation tool which enabled a judgement to be made on the relative importance of the issues which needed to be taken into account when making commissioning decisions. This tool was subsequently circulated to all members of the Board with a view to consistent tool being used across the health and social care system.

Role of the Health and Wellbeing Board in Communications and Engagement.

13. Through discussion of the commissioning intentions, it became apparent that the Health and Wellbeing Board had a wider communications and engagement role than simply in terms of the STP lead areas. This was defined as follows:-

(i) To raise public awareness of the changes needed in the health and care system and how partners are collaborating to deliver them;

(ii) To explain what budget reductions and service reconfiguration would actually mean to patients, service users and their carers;

(iii) To provide assurance of how the health and social care system will continue to deliver quality services in the context of diminishing resources, including through improved partnership working;

(iv) To ensure consistent messages are in place across the health and social care system and to liaise with the other Health and Wellbeing Boards in Leicester, Leicestershire and Rutland accordingly.

14. There was also a need for a more focused communications and engagement campaign relating to self care. The following suggestions were put forward:-

- The sharing of self help resources across partners, particularly those hosted on websites (such as the County Council's self help guide to equipment);

- The development of a multi-agency campaign with links to tips and resources for keeping safe, well and independent in Leicestershire ("Help Yourself Leicestershire"). This could take the form of a digital calendar of daily tips, for example. It could also be a project for DeMontfort University's next hackathon.

- To make the most of existing roles such as Local Area Co-ordinators and Voluntary Sector partners who can direct members of the public to self help resources.

Resource Implications

15. The actions arising from this report will be delivered within existing resources. The communications actions will be scoped and discussed with the Leicestershire County Council communications team and communications teams across Leicester, Leicestershire and Rutland to establish any resources constraints.

Conclusion

16. The Development Session has shown that, during 2017, the Board will need to develop its role in terms of promoting smarter working between agencies and the conversation it has with members of the public.

17. The Board is pleased to assume a leadership role for the two STP areas it has been asked to lead on, on behalf of Leicester, Leicestershire and Rutland, and will adjust its terms of reference, workplan and communications plan accordingly.

Background papers

Report to the Health and Wellbeing Board on 6 December – Sustainability and Transformation Plan: Role of the Health and Wellbeing Board http://ow.ly/t8yY307oG6O

Circulation under the Local Issues Alert Procedure

None

Officers to Contact

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Relevant Impact Assessments

Equality and Human Rights Implications

18. The role of the Health and Wellbeing Board is to collectively tackle health inequalities and to make sure that all people can access health and care when they need to. Individual proposals coming before the Health and Wellbeing Board will be subject to an equalities and human rights implications assessment.

Agenda Item 7

NHS
East Leicestershire and Rutland
Clinical Commissioning Group

NHS
West Leicestershire
Clinical Commissioning Group

HEALTH AND WELLBEING BOARD: 5TH JANUARY 2017

REPORT OF EAST LEICESTERSHIRE AND RUTLAND CCG AND WEST LEICESTERSHIRE CCG

CCG OPERATIONAL PLAN

Purpose of report

1. The purpose of this report is to provide the members of the Health and Wellbeing Board with an overview of the CCGs Operational Plan.

Link to the local Health and Care System

2. This report relates to:-
   a. The Joint Health and Wellbeing Strategy;
   b. The Better Care Fund;
   c. Better Care Together workstreams;
   d. The Sustainability and Transformation Plan;

Recommendation

3. The Board is asked to note the contents of this report.

Policy Framework and Previous Decisions

4. This report and the subsequent LLR Operational Plan has been produced in accordance with guidance from NHS England as part of the planning and contracting round for 2017/18 -2018/19

Background

5. In accordance with NHS England timelines, the final version of the LLR Operational Plan was submitted to NHS England on 23rd December 2016.

6. Leicester City CCG, East Leicestershire and Rutland CCG and West Leicestershire CCG have worked collaboratively to produce the plan, which, as per guidance, aligns to the LLR Sustainability and Transformation Plan.

Development of the Plan:

7. NHS planning and contacting guidance was released in September 2016 that required CCGs to produce a two year operational plan.

8. The content aligns with the Better Care Fund plan intentions, for which a separate plan will be produced following guidance anticipated in the New Year.

Content:

9. The format of the plan is significantly different to that of previous years: stipulated as such by NHS England to show how implementation of the Sustainability and Transformation plan. It is anticipated a public facing document will be produced for publication.

10. There are differences in the degree of detail in Gant charts in the plan which is attributable to the maturity of the workstreams.

11. Key Actions form the bulk of the plan and are as below (mapped to the STP programmes of work and the national Must Dos).

12. The table below shows the 9 National Must Dos and the LLR Workstreams that are responsible for oversight of the delivery of these areas and how our plan states they will be achieved:

National Must Dos		
2017/18 and 2018/19 'must dos'	Outline	Workstreams for Key Actions
1. STPs	Achieve and implement agreed trajectories and milestones for full achievement by 2020/21	All BCT workstreams
2. Finance	• Deliver CCG and NHS provider organisational control totals • Moderate demand growth and increase provider efficiencies • Support self-care and prevention • New care models • Redesign and reform	Planned Care Integrated Teams Home First LLR Prescribing CHC Estate Reconfiguration Self Care and Prevention Ceasing Minor services
3. Primary Care	Sustainability of general practice through the implementation of the General Practice Forward View	Primary Care
4. Urgent & Emergency Care	• Deliver the four hour A&E standard and implement the five elements of the A&E improvement plan • Implement the Urgent and Emergency Care Review • Meet the four priority standards for 7-day hospital services for all urgent network specialist services	Urgent Care

.....9 'must do's continued	Outline	Workstreams
5. RTTs and Elective Care	• Deliver the NHS Constitution that standard more than 92% of patients wait no more than 18 weeks from referral to treatment • Deliver patient choice • Streamline elective care pathways • Implement national maternity services review 'Better Births'	Planned Care Long Term Conditions Childrens and Maternity
6. Cancer	• Implement the cancer taskforce report • Deliver the NHS Constitution 62 day cancer standard • Make progress in improving one-year survival rates	Long Term Conditions
7. Mental Health	Deliver in full the implementation plan for the Mental Health Five Year Forward View for all ages	Mental Health – Children and Adults
8. People with Learning Disabilities	Deliver Transforming Care Partnership plans with local government partners	Learning Disabilities
9. Improving Quality in Organisations	Implement plans to improve quality of care Measure and improve efficient use of staffing resources to ensure safe, sustainable and productive services	BCT enabling workstreams End Of Life Care

13. LLR Quality work areas listed include Patient Experience, achieved through Experience led commissioning; Patient Safety including Learning lessons to improve care; Infection Prevention and Control with a focus on anti microbial prescribing, C Diff and MRSA investigations and Contract Quality Assurance where CQUINS are used to drive standards higher.

Next Steps

14. Work will continue to refine areas of the plan that are not as well developed as others.

15. We will ensure robust programme monitoring is in place that will assist with delivery of the plan and report into individual organisations on a monthly basis.

Consultation/Patient and Public Involvement

16. Public consultation on aspects of the plan has occurred in line with CCGs statutory consultation and engagement responsibilities.

17. Further consultation will be required as plans develop further.

Resource Implications

18. Resource implications of the plan are listed in the plan document.

Background papers

None

Circulation under the Local Issues Alert Procedure

The report relates to Leicester, Leicestershire and Rutland

Officer to Contact

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List of Appendices

Appendix A: LLR Operational Plan

Relevant Impact Assessments

Equality and Human Rights Implications

19. Due regard has been paid to the public sector equalities duty in the development of this plan. Individual proposals will be subject to a full equalities assessment

Agenda Item 8

Leicestershire County Council

HEALTH AND WELLBEING BOARD: 5 JANUARY 2017

REPORT OF THE DIRECTOR OF HEALTH AND CARE INTEGRATION

BETTER CARE FUND PLAN REFRESH 2017/18 – 2018/19

Purpose of report

1. The purpose of this report is to provide the Health and Wellbeing Board with an update on the work in progress to refresh and prepare the Leicestershire Better Care Fund (BCF) plan for 2017/18 – 2018/19.

Recommendation

2. The Board is requested to:

   a) Note the content of the report;

   b) Provide feedback on current progress and next steps to finalise the plan.

Policy Framework and Previous Decisions

3. The Health and Wellbeing Board approved Leicestershire's current BCF plan in May 2016.
   http://politics.leics.gov.uk/documents/s118710/Better%20Care%20Fund%20Plan%20Submission%20and%20Assurance.pdf

4. The day to day delivery of the BCF is overseen by the Leicestershire Integration Executive as agreed by the Health and Wellbeing Board in March 2014. (http://politics.leics.gov.uk/ieListDocuments.aspx?CId=1038&MId=3981&Ver=4). The Integration Executive Terms of Reference have been refreshed, and were approved by the Health and Wellbeing Board in November 2015.

5. NHS England issued BCF implementation guidance in July 2016 https://www.england.nhs.uk/wp-content/uploads/2016/07/bcf-ops-guid-2016-17-jul16.pdf which set out the requirements for quarterly reporting along with the draft templates and analytical tools that are required to be used for this purpose.

Background and Milestones

6. NHS planning guidance was published on 22nd September 2016 and covers a two year planning period 2017/18 - 2018/19. One of the key differences this year is that the production of CCG operating plans, and the associated contract setting with NHS providers has to take place by 23rd December 2016, which is three months earlier than usual.

7. It is recognised that for Local Authorities (LAs), planning timescales for 2017/18 and beyond are linked to the autumn statement (issued late November) and publication of

LA allocations (these are imminent at the time of preparing this report), so the planning process and timescales for NHS partners and LAs are not in alignment.

8. The NHS planning guidance confirms the continuation of the BCF, and the ongoing requirements for integration policy implementation by 2020.

9. Specific national guidance about the preparation of BCF plans for 2017/18 – 2018/19 is still pending at the time of writing this report and may not be published before the end of 2016.

10. It is anticipated that a draft BCF submission will be required to be submitted to NHS England by approx. 26th January 2017, with a final submission date TBC (potentially late February/early March 2017).

11. The assurance process for the BCF, which takes place both at regional and national levels, is anticipated to conclude by May 2017.

BCF Refresh 2017/18: Strategic and Policy Context

12. BCF national policy requirements, BCF national conditions, BCF metrics, CCG commissioning intentions, and key LA duties with respect to integration and the Care Act set the strategic framework for the BCF plan refresh.

13. Locally, the introduction of the Leicester, Leicestershire and Rutland (LLR) Sustainability and Transformation Plan (STP) essentially reframes priorities and financial plans across the LLR health and care economy.

14. Keeping people out of statutory and acute provision wherever possible, sustaining adult social care within new models of care locally, ensuring there is a cohesive plan for data integration at population and care planning levels, implementing seven day services, improving hospital discharge and developing an infrastructure and platform for joint commissioning remain high priorities within the integration agenda nationally and locally.

BCF Refresh 2017/18 – Financial Context

15. National CCG and LA allocations, the financial model of the LLR STP, the council's Medium Term Financial Strategy (MTFS) and respective CCG operating plan financial targets/control totals for 2017/18 – 2018/19 all set the financial framework for the Leicestershire BCF plan.

16. The financial pressures on individual organisations are considerable and increasing so the negotiation of the BCF refresh is set in this context.

17. Ahead of the publication of the BCF guidance for 2017/18-2018/19 work is already well underway locally to refresh the plan.

18. An initial financial refresh of the plan has been undertaken through liaison with CCG integration and finance leads, linking the BCF plan to:

    a) STP planning assumptions and workstreams.

    b) CCG commissioning intentions.

    c) LA assumptions – in particular Adult Social Care services/finances and the council's MTFS and transformation plans.

d) NHS planning guidance.

e) CCG operating plan submissions.

19. The key features of this work to date have been as follows:

- Resolving the allocations for District Councils for the Disabled Facilities Grants component of the plan.
- Agreeing the adult social care protection levels for the 2017 – 2019 BCF plan.
- Understanding the implications of the BCF financial allocations into CCGs and LAs for 2017/18 and 2018/19, including any uplift related to inflation or growth.
- Assessing the opportunities for generating further savings and headroom within the BCF plan from 2017/18 onwards, recognising the significant financial pressures affecting all partners.
- Assessing the overall affordability of the plan.
- Determining the plan's contribution to key metrics across LLR such as emergency admissions avoidance and improving delayed transfers of care.
- Ensuring alignment with STP activity, capacity and financial planning, CCG operating plan assumptions, and the new urgent care pathway.
- The implications of new models of service which will come into effect from 2017/18 onwards, and which rely on existing/redesigned Leicestershire BCF components/investments, for example:
    a. Integrated Locality Teams across LLR (new workstream of the STP)
    b. Integrated discharge support (per the business case received at the Integration Executive on 1st November).
    c. The "home first" reablement model (emerging workstream of the STP)
    d. The new LLR urgent care model, which being commissioned with effect from April 2017.
- Assessing the impact of individual components of the plan, and the impact of the BCF plan overall, on
    a. The BCF national conditions and metrics
    b. The overall vision for health and care integration in Leicestershire and across LLR.

BCF Refresh: Status at 22nd December 2016

20. On 13th October, a multiagency workshop of the Leicestershire Integration Operational Group took place where the group discussed the strategic context of the refresh including how to align the plan more effectively with emerging STP priorities and workstreams.

21. The workshop broadly reviewed the components of the current plan categorising those likely to be considered recurrent, those which are subject to further evaluation/

decisions, those which should be removed due to being non-recurrent or decommissioned, and any emerging new areas to consider.

22. It should be noted that the majority of the BCF plan is attributed to core NHS and LA services, with some components dating back to 2011/12

23. Any changes need to be incorporated into contracts and any decommissioning/re-commissioning activities are subject to the usual processes and governance depending on the lead commissioners (e.g. consultation/lead times/notice periods/procurement decisions etc.).

24. From the workshop in October an action plan was created to identify a number commissioning lines of enquiry and key decisions needed. The group identified those which were likely to be taken by 23rd December (e.g. in time for CCG operating plan submissions), and those that are planned to be addressed later, e.g. from Q4 2016/17 onwards.

25. Follow up meetings were held on the 10th November and 8th December to review progress with the action plan and confirm the position line by line across the BCF plan.

Indicative Financial Refresh

26. The following sections outline the key assumptions that have informed the refresh so far and an indication of areas where further information is expected to be confirmed during Q4 of 2016/17.

a) It has been confirmed that CCGs will be required to allocate 1.79% uplift in 2017/18 and a 1.9% uplift in 2018/19 (linked to inflation) per the national CCG allocations for the minimum pooling requirements for the BCF.

b) For ELRCCG this equates to approx. an additional £278.52k (figure to be confirmed when the split between County and Rutland is finalised) and for WLCCG this equates to £368.6k for 2017/18.

c) It is assumed the same approach will apply in 2017/18 as in the previous two years of the BCF, in that:

- Partners are expected to pool their minimum BCF allocation and show a scheme level breakdown of how this has been prioritised to meet the BCF policy, conditions and metrics.

- The financial template provided by NHS England for the submission of the BCF (to be made available once the BCF guidance is published) will be pre-populated with the respective CCG and LA allocations, which together form the basis of the minimum pooled budget.

d) Pending the outcome of LLR Urgent Care Procurement the refresh assumes that both County CCGs will require all their existing BCF urgent care service allocations to support the new model of urgent care from 2017/18.

e) The components of the plan that associated with core discharge support services operating across UHL, LPT and adult social care, are essential to support system flow and improving our local DTOC performance.

f) However these investments and services are subject to redesign leading into 2017, via the County's integrated discharge redesign business case.

g) The components of the plan that are associated with rehabilitation and reablement services are currently being reviewed by CCG commissioning/contracting leads with a view to identifying which should be earmarked in relation to the redesign work linked to the emerging STP home first workstream.

h) The BCF investment lines associated with case management for people for Long Term Conditions (LTC) in both CCGs ("proactive care" in WLCCG and "integrated care" in ELRCCG) are assumed to be a core component of the future Integrated Locality Teams development in LLR.

i) CCG contributions for the Supporting Leicestershire Families (SLF) service have been removed from the 2017/18 BCF financial plan. It has not been possible for the service to provide the outcome data CCGs have requested in the timescales required for BCF refresh decisions, so the BCF plan currently assumes no SLF investment from CCGs for 2017/18.

j) CCG commissioning intentions for Local Area Coordination (LAC) are subject to further confirmation via the LAC evaluation and business case – work currently in progress through governance channels in both CCGs.

k) A business case for the new (LLR-wide) falls pathway is expected by the end of January. Some non-recurrent enabling investments have been agreed from the 2016/17 BCF plan, to aid preparation of the new service. Additional non-recurrent investment for 2017/18 may be required subject to further confirmation.

LA/Adult Social Care Services Considerations

l) The government's comprehensive spending review of 2015 indicated that, from 2017/18, additional allocations would be made via LAs for the BCF with a view to increasing the LA allocation specifically to support adult social care.

m) LA allocations for 2017/18 should be known by the time this report is presented and a verbal update will be given when the report is presented.

n) Adult Social Care Protection – a working session with senior representatives from Adults and Communities and CCGs was held on 1st November to review financial assumptions for the Adult Social Care investments within the plan.

o) It was agreed that the initial cut of the 2017/18 BCF plan should assume the same level of adult social care protection as in 2016/17 (£17m).This figure may require adjustment following confirmation of points above.

p) Disabled Facilities Grants (DFG) Allocations (for major adaptations in the home) will continue to be routed via the BCF. DFG allocations totalling £2.85m have been included in the plan from 2017/18 onwards.

q) This reflects the inclusion of an additional £1m which must be committed to DFG allocations in 2017/18 in the Leicestershire plan, compared with the levels committed to this component in 2016/17.

r) This is due to the fact that partners withheld £1.3m of the DFG allocation in 2016/17 due to the late notification of BCF guidance and a late change in the composition of the allocation affecting DFGs.

s) This position is being resolved for 2017/18, as we anticipate the BCF national guidance will clearly reinforce this requirement.

t) The funding levels associated with this component of the BCF plan will require further confirmation following the publication of 2017/18 LA allocations, and following reaching final agreement with District Councils based on their forecasting information (work currently in progress).

Line by Line BCF Refresh Work

u) Every BCF scheme has been scrutinised by partners in the Integration Operational Group over three working sessions held between October and December 2016.

v) In particular to identify where further commissioning confirm and challenge could be applied including identifying where additional savings could be made in 2017/18.

w) Where these have been identified based on specific agreed commissioning intentions for 2017/18, these have been factored into the indicative position as at 13th December.

x) Mandatory/Statutory BCF allocation components (such as Care Act statutory duties including carer respite services, Care Act assessments, and Disabled Facilities Grants etc.) have all been included as part of the line by line refresh of the BCF undertaken by the BCF operational group.

y) An initial workplan of areas that should be the subject of further commissioning review activity in 2018/19 has been created, with a focus on where partners can foresee additional savings/VFM could be achieved.

z) Should there be any material changes needed to the above assumptions following publication of the BCF guidance these will be taken into account in the next iteration of the BCF plan/financial plan.

27. As at 13th December the BCF plan shows proposed expenditure proposed of £39.8m against a budget of £39.1m.

28. These figures are based on the 2016/17 BCF allocation. The baseline budget for 2017/18 will be confirmed in January, following publication of the BCF guidance, and confirmation of CCG and LA allocations associated with the BCF from 2017/18 onwards.

Key Risks

29. Key risks affecting the refreshed plan at this stage include

a) Whether a risk pool is required for emergency admissions performance – BCF guidance is likely to state this is required only if the BCF is expected to deliver a reduction in emergency admissions beyond CCG operating plan assumptions.

b) Lack of headroom within the plan generally, including lack of reserves and contingencies to deal with any unforeseen pressures.

c) A number of service lines are currently awaiting confirmation of CCG commissioning intentions and procurement decisions.

d) The BCF guidance has not yet been published.

e) CCG and LA financial plans are under huge pressure.

f) The CCG related inflation uplift for the BCF minimum contribution will add to this pressure.

g) Early indications are LA allocations will not include an uplift for the BCF in terms of LA contributions, to be confirmed on publication of the guidance.

h) Districts have not yet formally approved the figures proposed for 2017/18 for their DFG allocations.

i) The refreshed plan shows £517k of existing pressures check figure

BCF National Conditions and Metrics

30. It is believed that the number of national conditions within the BCF will be reduced from eight to possibly three or four in the BCF guidance for 2017/18, with quarterly reporting to NHSE.

31. However local areas will still be expected to show progress towards those other elements of integration policy, which previously were listed as BCF national conditions.

32. In terms of metrics for the BCF plan we anticipate the following metrics will all continue to be the nationally required metrics, with quarterly reporting the NHSE.

a) Reducing the number of total emergency admissions

b) Impact of reablement at 91 days

c) Improving DTOC

d) Reducing permanent admissions to care and nursing homes

33. In terms of trajectories for the metrics it is important to ensure that those emergency admissions which are planned to be avoided via schemes funded by the BCF are clearly defined and fully aligned to CCG operating plan targets for 2017/18 (and the wider LLR activity assumptions within the STP).

34. In terms of governance LLR-wide oversight of urgent care performance including emergency admissions and DTOC is led by the A&E Board, however an element of County level performance reporting is needed both operationally (in terms of addressing local performance matters) and strategically (in terms of assurance on BCF delivery).

35. There is no intention to duplicate the role of the A&E delivery board so the refreshed BCF narrative plan for 2017/18 will articulate how the reporting and assurance of BCF metrics will operate at both County level and system (LLR) level.

36. A BCF Trajectories Workshop to be held early in 2017 will inform the baseline and trajectories for 2017/18 for each of the national BCF metrics. There are a number of interdependencies for this work including:

a) STP activity assumptions
b) National BCF guidance

c) CCG operating plan assumptions for 2017/18 – 2018/19
d) BCF plan refresh progress for 2017/18 – 2018/19

Stakeholder Engagement, Briefings and Governance

37. A schedule of activities is already well underway to engage with a wide range of stakeholders about the refresh of the BCF plan across all partners, and seek joint approval of the plan, including ultimately by the Leicestershire Health and Wellbeing Board in Q4 2016/17.

38. In terms of governance timelines and next steps, the Integration Executive will hold a workshop on January 19th to review the refreshed plan in detail and the CCG Boards and Health and Wellbeing Board are expected to receive the final BCF plan for approval during March 2017.

39. Further engagement with other CCG governance groups to inform refreshing the plan will take place between January – March 2017.

Review of National BCF Guidance

40. It should also be noted that the East Midlands Regional BCF adviser held a preparatory workshop for refreshing BCF plans on 12th December, and representatives from Leicestershire attended this meeting

41. The Integration Team and Integration Operational Group will assess the BCF guidance as soon as possible when published, provide a summary and brief the Integration Executive.

42. This review will consider

- Any proposed immediate adjustments needed to the first cut plan to meet guidance requirements or mitigate impact of guidance risks.
- The implications of national submission/assurance milestones.
- Specific recommendations for the Integration Executive

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Relevant Impact Assessments

Equality and Human Rights Implications

43. The BCF aims to improve outcomes and wellbeing for the people of Leicestershire, with effective protection of social care and integrated activity to reduce emergency and urgent health demand.

44. An equalities and human rights impact assessment has been undertaken which is provided at: http://www.leics.gov.uk/better_care_fund_overview_ehria.pdf

Partnership Working and associated issues

45. The delivery of the BCF plan and the governance of the associated pooled budget is managed in partnership through the collaboration of commissioners and providers in Leicestershire.

46. Day to day oversight of delivery is via the Integration Executive through the scheme of delegation agreed via the Integration Executive's terms of reference which have been approved by the Health and Wellbeing Board.

47. The delivery of the Leicestershire BCF ensures that a number of key integrated services are in place and contributing to the system wide changes being implemented through the five year plan to transform health and care in Leicestershire, known as Better Care Together http://www.bettercareleicester.nhs.uk.

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Agenda Item 9

HEALTH AND WELLBEING BOARD: 5TH JANUARY 2017

REPORT OF LLR BETTER CARE TOGETHER IM&T

SUMMARY CARE RECORD AND CARE PLANNING

Purpose of report

1. The purpose of this report is to update the Health and Wellbeing board on the Summary Care Record and Care Planning.

Link to the local Health and Care System

2. This initiative supports the Joint Health and Wellbeing Strategy by encouraging the use of patient record sharing to improve the quality of service that patients receive. It is currently not covered by the Better Care Fund. It is a core part of the IM&T Better Care Together Workstream and it links in with other clinical workstreams such as End of Life. It supports the Sustainability and Transformation Plan by being an integral part of the Local Digital Roadmap. Project will be delivered though the governance of Leicester City CCG and will be linked to the LLR Record Sharing Board.

Recommendation

3. The Health and Wellbeing Board is recommended:-
   a) To note the presentation attached as Appendix 1 to this report;
   b) To support the delivery of the Summary Care Record v2.1 to improve electronic care planning in services across LLR.

Policy Framework and Previous Decisions

4. The improvements in digital technology are supported by the Five Year Forward View, Personalised Health and Care 2020.

5. The Five Year Forward View makes a commitment that, by 2020, there would be “fully interoperable electronic health records so that patient’s records are paperless”. This was supported by a Government commitment in Personalised Health and Care 2020 that “all patient and care records will be digital, interoperable and real-time by 2020”.

Background

6. Each local area in England was instructed by NHS England to develop a Local Digital Roadmap (LDR) to deliver the Five Year Forward View of ensuring paperless at point of care by 2020 within healthcare settings. The LDR is designed to align with the Sustainability and Transformation Plans (STP). Therefore, within LLR the LDR will support the digital transformation change for the BCT Clinical Workstreams. The LDR

comprises of a 5 year capabilities plan to ensure digital technology projects are planned in to help deliver the strategy. A key component of the LDR is record sharing and the requirement to have digital care plans for patients who require them.

7. A number of options were considered with regards to Care Plans led by the BCT End of Life workstream in conjunction with the LLR IM&T Board. It was agreed to move forward with enhancing national technology that is available to all health providers. This has led to the further development of the Summary Care Record (SCR) in the form of Version 2.1. Summary Care Records are currently being used by 98% of GP practices in the country and 100% of GP practices within LLR. All NHS providers have the capability of viewing the SCR. All NHS patients are automatically enrolled within the SCR unless they opt out. Patients are asked for consent prior to access of the SCR data.

Proposals/Options

8. The proposal is to enable SCR Version 2.1 with additional code-sets to the core SCR to all GP practices within LLR. It is envisaged that this work will be completed by March 2017 through funding received by the Estates Transformation and Technology Fund. Further work will need to take place to encourage providers to access the SCR as part of the health care professional workflow.

9. SCR is a national system and is available for free. However, there is a cost to implement the solution. Although it has limitations it is found to be the most appropriate and cost effective solution currently available. Other solutions such as wider use of the TPP SystmOne and the MIG can help to plug some of the technology gaps that SCR currently has. Organisations with access to TPP SystmOne can have access to the full patient record of the patient originates from a GP practice that has TPP SystmOne. However, if patients are not from a TPP SystmOne practice the MIG can be used to share parts of the GP record.

10. SCR Version 2.1 dataset will be defined in conjunction with the BCT clinical leads to meet their Care Planning requirements. The dataset will then be used to set what information will be shared as part of Care Plans. This will then be enabled at GP practices. Providers that currently have access to the SCR will have the ability to view Version 2.1 data through their current access of Version 1.

Consultation/Patient and Public Involvement

11. A patient representative as part of the BCT programme has been part of the discussions to implement SCR as an initial care planning solution. Further communication will be required from GP practices to patients that have Care Plans to ask them for consent to share SCR Version 2.1 data with additional information to core data of the SCR Version 1.

Resource Implications

12. Funding for phase 1 of the project (implementation of SCR V2.1 at GP practices) is funded through the Estates Transformation and Technology Fund. Leicester City CCG will be the lead commissioner on behalf of the three CCG's in LLR.

Background papers

https://digital.nhs.uk/scr

Circulation under the Local Issues Alert Procedure

None

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List of Appendices

Appendix 1 - Presentation

Relevant Impact Assessments

Equality and Human Rights Implications

13. Due regard to equality, diversity, community cohesion and human rights in our decision-making process has taken place by NHS Digital on behalf of the NHS regarding the Summary Care Record.

Crime and Disorder Implications

14. N/A

Environmental Implications

15. Should reduce paper being used

Partnership Working and associated issues

16. LLR organisations have worked in partnership for this solution through the LLR IM&T Enablement Group.

Risk Assessment

17. This will form part of the project implementation and covered within the governance of Leicester City CCG.

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'It's about our life, our health, our care, our family and our community'

Better care together
Leicester, Leicestershire & Rutland health and social care

Summary Care Records (SCR) use in Care Planning for Patients in LLR

Rutland County Council healthwatch Leicester City Council Leicestershire County Council NHS

What is the Summary Care Record?

The SCR is an electronic record of important patient information, created from GP medical records. It can be seen and used by authorised staff in other areas of the health and care system involved in the patient's direct care.

- National database of core patient data (Version 1):
  - Current medication,
  - Allergies and details of any previous bad reactions to medicines
  - The name, address, date of birth and NHS number of the patient
- Patients can opt out of sharing core patient data, if they do not opt out it is automatically uploaded to the national database
- Information is secure and the patient is asked for consent by the healthcare professional prior to being accessed

How is it used?

- 100% of all GP practices are currently using SCR
- All providers in LLR have access to SCR
- SCR can be accessed outside of the LLR boundaries
- 82% Community Pharmacies technically live with SCR
- Actively used in UHL pharmacy to support cross referencing of medications and understanding allergies prior to dispensing medicine
- It can be integrated with existing clinical systems or accessed via a stand alone web browser
- Professionals need a smartcard to access the SCR

Summary Care Records Version 2.1

Summary Care Records Version 2.1 is an enhancement to Version 1 and is currently optional for organisations to enable. The benefits of Version 2.1 is that it allows additional datasets to be added to SCR Version 1.

- Version 2.1 can help to create a digital patient **Care Plan**
- Version 2.1 data is not automatically uploaded to the national database so it requires patients to consent to share at the GP practice
- Will be enabled in GP practices by March 2017

What are we planning to do?

- Project manage and implement SCR Version 2.1
- Define the dataset that will be used for sharing in SCR Version 2.1 working with Better Care Together Workstream Leads
- Work with GP practices to gain consent to share additional information on SCR Version 2.1 for defined groups of patients
- Ensure that providers view and use information on Version 2.1 at point of care

Current Limitations

- SCR is currently not available in Social Care
- Data can only be updated at the GP practice
- Patients have to opt in to share their record at the GP practice prior to it being available to other services
- Not all health and care professionals currently use SCR

Mitigation

To address the limitations LLR will do the following:

- Maximise the use of MIG technology
- Maximise the use of TPP SystmOne

These are other data sharing methods that will use the same data sets as the SCR but have less limitations

Interoperability

Interoperability is the ability of different IT systems and software applications to communicate, exchange data, and use the information that has been exchanged.

- Currently limited between current suppliers within LLR
- NHS England have defined FHIR (Fast Healthcare Interoperability Resources) as a common set of standards for software companies to use
- MIG provides some interoperability in LLR
- Rollout of data sharing between TPP and EMIS to start in 2017

What will it mean for Patients and Professionals

Patients

- Core data can be seen by various care professionals
- Reduces to need to remember what medication you are on
- Reduce the need to have paper copies of the care plan

Improves quality of care

Professionals

- Have electronic access to core patient data to help patient care
- Remove the need to ask the patient what medication they are on or specific questions regarding their care plan

Next Steps

- Ensure that Care Planning remains a core part of the Local Digital Roadmap
- Review implementation in Social Care
- Ensure healthcare providers actively use the Summary Care Records as part of care planning
- Review future options for dynamic care planning where all healthcare professionals and patients can add information to their plan

Agenda Item 10

Leicestershire County Council

HEALTH AND WELLBEING BOARD: 5 JANUARY 2017

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

PARITY OF ESTEEM

Purpose of report

1. The purpose of this report is to update the Health and Wellbeing Board on local progress to address 'Parity of Esteem' and specifically to present a timed and quantified plan for addressing the physical health needs of people with serious and enduring mental illness (SMI).

Link to the local Health and Care System

2. Oversight of the Parity of Esteem agenda sits with the Better Care Together Mental Health Partnership Board and ultimately with the Health and Wellbeing Board.

3. Reducing the gap in health and wellbeing outcomes is a key aspiration of the NHS Five Year Forward View and must be reflected in local Sustainability and Transformation plans.

4. Achieving Parity of Esteem across the entire health and care system will be an important means of supporting the aspiration to reduce the local gap in health and wellbeing outcomes. The NHS Five Year Forward View- Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21 asks '*How will you improve mental health services, in line with the forthcoming mental health taskforce report, to ensure measureable progress towards parity of esteem for mental health?* (https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf)

Recommendation

5. The Health and Wellbeing Board is recommended to note the contents of this report.

Policy Framework and Previous Decisions

6. A paper on Parity of Esteem was discussed at the March, 2016 Health and Wellbeing Board (HWBB) meeting and an updated paper for information was produced in September, 2016.

7. Both papers generated support for a broad approach to addressing Parity of Esteem locally but with specific focus on:
   (i) improving access to mental health services in acute settings and
   (ii) enhancing the physical health status of people with serious and enduring mental illness (SMI). A multi-partnership Parity of Esteem group led by

Leicestershire County Council's Public Health Department has been established to take this work forward.

8. As there are a number of local work streams currently developing and rolling out plans to improve access to mental health services in acute settings (e.g. Acute Care Vanguard, Crisis Concordat, Suicide Prevention Strategy and Future in Mind programmes), the Parity of Esteem group is now focussing on addressing and enhancing the physical health status of people with SMI.

Background

9. Parity of Esteem means '*valuing mental health equally with physical health*' (NHSE definition, 2015). It means that a person's physical and mental health needs are understood to be of equal importance, and treated as such. In reality it is impossible to separate our physical and mental health from one another although many of us, health professionals and public alike can still see them as very separate.

10. A particular concern relates to the health needs of people with SMI as they experience poorer health and die earlier than average. People with SMI have the same life expectancy as the general population had in the 1950's i.e. between 10 and 17 years lower than expected[1][2]

11. SMI includes diagnoses which typically involve psychosis (losing touch with reality or experiencing delusions) or high levels of care, and which may require hospital treatment. The two main types are schizophrenia and bipolar disorder (or manic depression).

12. The estimated prevalence of SMI in the UK is **0.8%.** This equates to approximately **5,200** sufferers in Leicestershire.

13. About 60% of the excess mortality in people with mental illness is felt to be avoidable[3].

14. The root causes of the poor health and premature mortality in people with SMI are a combination of[4]:

    - **Lifestyle Choices** – Prevalence of cardiovascular disease risk factors is very high amongst the SMI population due to smoking, obesity and diabetes.

    - **Poverty** – Such factors are more common in areas of socioeconomic deprivation where mental disorders are also most prevalent; as presented by Professor Sir Michael Marmot in his review "Fair Society, Healthy Lives".

[1] Chang, C.K., et al., All-cause mortality among people with serious mental illness (SMI), substance use disorders, and depressive disorders in southeast London: a cohort study. BMC Psychiatry. 10: p. 77

[2] Chang, C.K., et al., Life expectancy at birth for people with serious mental illness and other major disorders from a secondary mental health care case register in London. PLoS One. 6(5): p. e19590

[3] Hoang U., Goldacre MJ., Stewart R., Avoidable mortality in people with schizophrenia or bipolar disorder in England. Acta Psychiatrica Scandinavica 2013. 127: p. 195-201

[4] Parity of Esteem Overview and Report, East Midlands Clinical Senate, November, 2016

- **Ineffective Prevention** – Prevention is not targeted at the SMI population. The standard approach of prevention for the general population is ineffective in patients with SMI and substance misuse.

- **Poor Access to Effective Care** – Access is hindered through a lack of reasonable adjustments. Often lack of engagement is described unhelpfully as patients being 'hard to reach' rather than a service that may not meet the illness specific needs of the individuals concerned.

- **Poor Commissioning of Services** – Physical as well as mental healthcare services have been commissioned separately and services have not been routinely co-produced with SMI service users and their carers.

- **Stigma** – Healthcare Professionals and staff can also have preconceived ideas about people with SMI which commonly leads to so called 'Diagnostic Overshadowing', a misinterpretation of symptoms as being part of the mental illness hence leading to delay in diagnosis of physical co-morbidities.

- **Iatrogenic Risk Factors** – All anti-psychotics are diabetogenic and obesogenic to varying degrees. Prescribers of the drugs which cause or exacerbate physical disorders can fail to take responsibility for mitigating these risks and involve the patients and carers to allow fully informed choices to be made.

- **Ethnicity** – The worse prognosis for patients with SMI is even more pronounced in certain ethnic minority groups and a UK study is currently looking into the exact causes of this in detail so the prognosis can be improved.

Progress so far:

15. There is considerable work already under way within individual partner organisations to address the physical health needs of people with SMI e.g. Quality Outcomes Framework (QOF) and Quality, Innovation, Prevention & Productivity (QIPP) programmes in Primary Care and the national SMI Commissioning for Quality and Innovation (CQUIN)s in Leicestershire Partnership Trust. There is a clear need to align these initiatives and to harness and share good practice and information amongst key partners.

16. A scoping exercise was recently carried out looking at current provision and activity. Local data is captured in appendices 1 and 2. This information has been triangulated with feedback from local providers and partners to produce a timed and quantified action plan which has now been agreed (Appendix 3).

Resource Implications

17. This work will constitute business as usual for partner organisations

Circulation under the Local Issues Alert Procedure

18. None

Officer to Contact

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Relevant Impact Assessments

Equality and Human Rights Implications

19. Work to achieve Parity of Esteem by its nature will address and challenge discrimination and will have a positive impact on equality and human rights

EAST LEICESTERSHIRE AND RUTLAND CCG

NHS
East Midlands Clinical Networks

Shining the light on PARITY OF ESTEEM

Parity of esteem for people with severe mental illness

The life expectancy of people with mental health problems is **significantly lower** than average. Men with a mental health problem die **11 years** earlier than average and women die **10 years** earlier than average.

People with schizophrenia are:

2x more likely to die from cardiovascular disease.

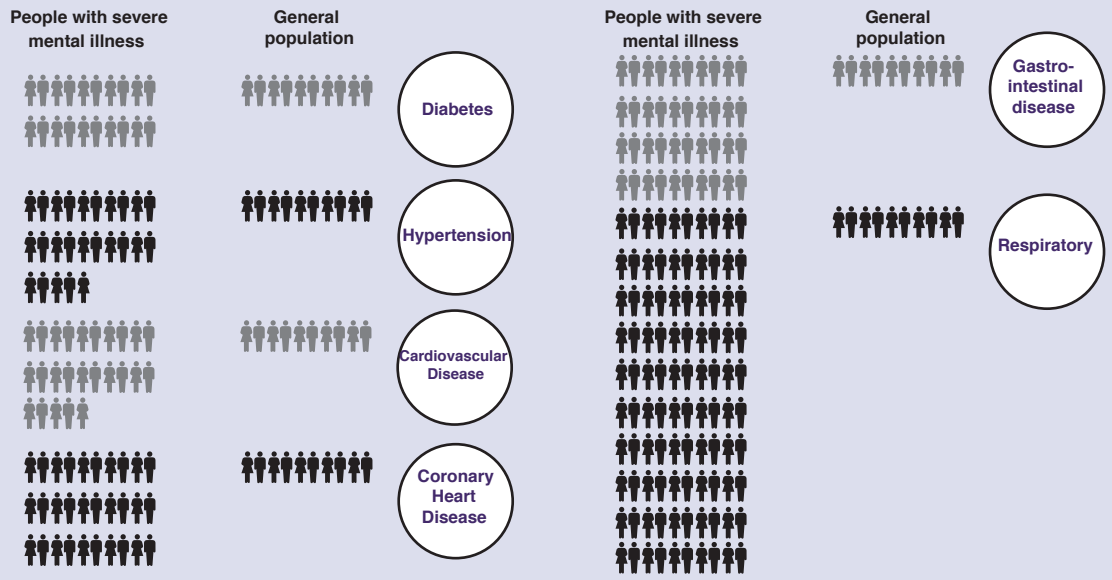
3x more likely to die from respiratory disease.

Smoking is the single biggest factor in **reduced life expectancy** in people with psychosis

40% of this group are smokers

42% of all cigarettes are smoked by someone with a mental illness.

Relative physical health risks for people with SMI



Severe mental illness in primary care 2014 - 2015

EAST LEICESTERSHIRE AND RUTLAND CCG

Patients diagnosed with SMI

2,138

0.66%

SMI Prevalence

E.Mids CCG Range (0.61% - 1.04%)

England (0.88%)

5 change in patients diagnosed with SMI since March 2014 (-0.1%)

SMI patients with NO comprehensive care plan

633

34.2%

580 exception reported

E.Mids CCG Range (13.7% - 38.5%)

England (22.8%)

Patients with schizophrenia, bipolar affective disorder and other psychoses

NO record of blood pressure

435

23.5%

349 exception reported

E.Mids CCG Range (9.6% - 24.4%)

England (18.5%)

NO record of alcohol consumption

605

32.7%

529 exception reported

E.Mids CCG Range (11.3% - 32.7%)

England (19.7%)

Woman aged 25 - 64 NO record of cervical screening in last 5 years

147

25.4%

115 exception reported

E.Mids CCG Range (9.6% - 24.4%)

England (28.4%)

Patients on lithium therapy

NO record of serum creatinine & TSH in last 9 months

33

9.2%

20 exception reported

E.Mids CCG Range (2.1% - 10.5%)

England (6.6%)

NO record of lithium levels in the therapeutic range in last 4 months

46

20.3%

46 exception reported

E.Mids CCG Range (8.5% - 23.2%)

England (17.4%)

68.9% of people with serious mental illness have NOT received the complete list of physical checks

Physical checks include: body mass index; blood pressure; cholesterol (aged 40 and over who do not have established CVD); blood glucose or HbA1c (aged 40 and over) ; alcohol consumption and smoking status.

Comparative emergency admission rates for long term conditions

	Crude admission rate per 10,000 population: SMI	Non SMI	Admission Rate Multiplier
Cardiovascular Disease	753.0	90.2	8.3 (CCG Range 5.4 - 11.9)
COPD	304.0	17.7	17.2 (CCG Range 4.7 - 17.2)
Diabetes	28.1	5.0	5.6 (CCG Range 2.3 - 28.8)

Parity Of Esteem

Produced by East Midlands Clinical Networks

WEST LEICESTERSHIRE CCG

NHS
East Midlands Clinical Networks

Shining the light on PARITY OF ESTEEM

Parity of esteem for people with severe mental illness

The life expectancy of people with mental health problems is **significantly lower** than average. Men with a mental health problem die **11 years** earlier than average and women die **10 years** earlier than average.

People with schizophrenia are:

2x more likely to die from cardiovascular disease.

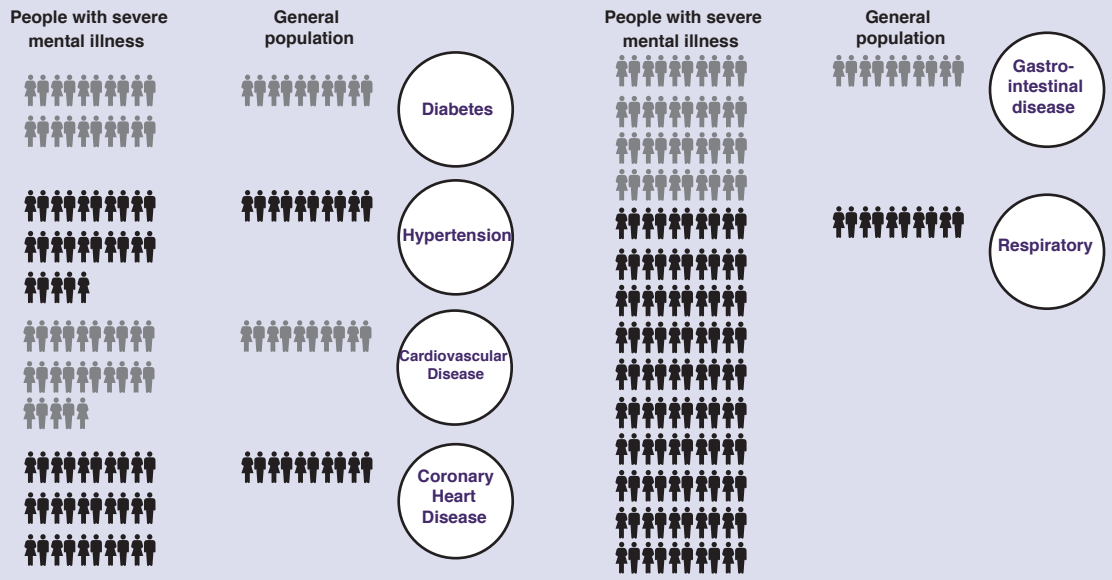
3x more likely to die from respiratory disease.

Smoking is the single biggest factor in **reduced life expectancy** in people with psychosis

40% of this group are smokers

42% of all cigarettes are smoked by someone with a mental illness.

Relative physical health risks for people with SMI



Severe mental illness in primary care 2014 - 2015

WEST LEICESTERSHIRE CCG

Patients diagnosed with SMI

2,699

0.72%

SMI Prevalence

E.Mids CCG Range (0.61% - 1.04%)

England (0.88%)

106 change in patients diagnosed with SMI since March 2014 (3.3%)

SMI patients with NO comprehensive care plan

756

32.7%

664 exception reported

E.Mids CCG Range (13.7% - 38.5%)

England (22.8%)

Patients with schizophrenia, bipolar affective disorder and other psychoses

NO record of blood pressure

412

17.8%

331 exception reported

E.Mids CCG Range (9.6% - 24.4%)

England (18.5%)

NO record of alcohol consumption

642

27.8%

536 exception reported

E.Mids CCG Range (11.3% - 32.7%)

England (19.7%)

Woman aged 25 - 64 NO record of cervical screening in last 5 years

193

27.1%

157 exception reported

E.Mids CCG Range (9.6% - 24.4%)

England (28.4%)

Patients on lithium therapy

NO record of serum creatinine & TSH in last 9 months

21

5.6%

13 exception reported

E.Mids CCG Range (2.1% - 10.5%)

England (6.6%)

NO record of lithium levels in the therapeutic range in last 4 months

81

21.5%

59 exception reported

E.Mids CCG Range (8.5% - 23.2%)

England (17.4%)

64.2% of people with serious mental illness have NOT received the complete list of physical checks

Physical checks include: body mass index; blood pressure; cholesterol (aged 40 and over who do not have established CVD); blood glucose or HbA1c (aged 40 and over) ; alcohol consumption and smoking status.

Comparative emergency admission rates for long term conditions

	Crude admission rate per 10,000 population: SMI	Non SMI	Admission Rate Multiplier
Cardiovascular Disease	548.4	87.0	6.3
COPD	137.1	18.6	7.4
Diabetes	55.6	5.2	10.7

CCG Range 5.4 - 11.9

CCG Range 4.7 - 17.2

CCG Range 2.3 - 28.8

Parity Of Esteem

Produced by
East Midlands Clinical Networks
NHS

Appendix 3

LLR Plan: Parity of Esteem re physical health needs of people with Severe and Enduring Mental Illness (SMI)

Issue	What is issue?	Organisation Responsible	Action	Timescale
Clarify responsibilities	Responsibility for physical health status of patients with SMI is unclear e.g. LPT Vs primary care	LPT/Primary Care/CCGs	Get agreement that patients' prescribing body is responsible for physical health checks. ?Agree at next POE meeting	March, 2017
Quality Outcomes Framework (QOF) **And** (Quality, Innovation, Productivity and Prevention) **QIPP** Primary care indicator targets management of patients with SMI	Currently high 'exception rates in QOF data (more so in Leicestershire that Leicester City).	Primary Care, CCGs	Explore approach to QOF in Leicester City. More detailed assessment of QOF reporting Consider using primary care QIPP (as in WL CCG) or other examples of good practice	March, 2017 March, 2017 March, 2017
CQUIN Commissioning for Quality and	Current CQUIN focuses on in-patients. Need to consider patients under	LPT/CCG	Support LPT to take on new CQUIN from April, 2017:	March, 2017

Innovation payment Secondary care indicator targets management of patients with SMI	care of community mental health team. Also consider using CQUIN to enhance co-operation with primary care		3a, Improving physical healthcare to reduce premature mortality in people with SMI: Cardio metabolic assessment and treatment for patients with psychoses 3.b Improving physical healthcare to reduce premature mortality in people with SMI: Collaborating with primary care clinicians	
IT solutions	Lack of shared IT systems across LPT, primary care and UHL	Primary Care/CCGs/LPT	LLR IM&T BCT Enablement Group	June, 2017
Lifestyle Interventions e.g. smoking cessation, exercise referral	Variable access to lifestyle interventions in primary care (Clearer access in secondary care/LPT through Make Every Contact Count-MECC)	Public Health/CCGs	Explore options to improve access e.g. • Lifestyle Hub • First Contact Plus • Social Prescribing • Recovery College Further utilise opportunities in MECC	June, 2017 June, 2017

Miscellaneous	(1) Alcohol consumption not systematically recorded	Primary Care/ LPT	Develop agreed comprehensive checklist	March, 2017
	(2) Role of mental health facilitators-MHFs can be very valuable but service is sporadic across city and county	CCG	Explore role and capacity of MHFs	March, 2017
	(3) Potential to have physical health care support/liaison in LPT (reverse of current situation	CCG/LPT	Discuss possible embedding of physical health care support worker in LPT	June, 2017

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Agenda Item 11

Leicestershire County Council

HEALTH AND WELLBEING BOARD: 5 JANUARY 2017

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

UNIFED PREVENTION BOARD UPDATE AND TERMS OF REFERENCE

Purpose of report

1. The purpose of this report is to update the Health and Wellbeing Board on the progress of Unified Prevention Board (UPB) schemes and propose a change to the terms of reference of the UPB to widen its scope and become an initial mechanism to integrate services within the sphere of prevention.

Link to the local Health and Care System

2. The UPB is a subgroup of the Health and Wellbeing Board accountable for ensuring the delivery of the existing jointly funded prevention programmes outlined in the Better Care Fund (BCF), approving the scope and overseeing the development and delivery of the key new prevention projects within the BCF.

3. It also provides a mechanism to ensure delivery against Sustainability Transformation Plan strategic priorities relating to early intervention and prevention and facilitates bringing together prevention activity across partners to develop a single vision for community based prevention through cross-partnership working.

Recommendation

4. That the terms of reference for the Unified Prevention be approved.

Policy Framework and Previous Decisions

5. In May 2016 the Health and Wellbeing Board agreed that the Unified Prevention Board would report directly to the Health and Wellbeing Board recognising that specific elements of work associated with Better Care Fund deliverables/metrics will also be subject to monthly assurance via the Integration Executive.

Background

6. The Unified Prevention Board is co-chaired by the Director of Public Health and by the District Council lead chief executive for health.

Current Situation

Operational Delivery

7. The UPB currently concentrates on the progress of the schemes funded through the BCF and oversees the development and delivery of the key new BCF projects. The current situation with regard to the BCF funded schemes is as follows:-

8. Assistive Technology

(a) The aim of Assistive Technology is to provide Support to the prevention agenda allowing people to remain at home with assistive equipment including standalone and telecare equipment linked to monitoring centres (Lifelines). Assistive Technology supports carers, hospital discharges and prevents hospital admissions including an emergency duty service which can fit equipment on the day of discharge if required.

(b) The Assistive Technology team is currently undergoing a management restructure within Adults and Communities with an informal consultation currently taking place on the current Development of Equipment, Adaptations & AT Strategy 2016-20.

(c) Leicestershire County Council's Assistive Technology Contract is under regular monitoring with review meetings taking place with contracts and compliance. Currently county and districts have separate offers regarding the "Lifeline" telecare equipment with work now being conducted to unify the offer.

9. Falls Pathway

(a) The Falls Programme is a piece of work to develop a consistent approach to the prevention and treatment of falls in residents over the age of 65 in Leicester, Leicestershire and Rutland. The programme aims to bring together both prevention and treatment to ensure that residents are supported to stay independent and injury free for as long as possible, with treatment aimed at restoring them to their previously enjoyed level of independence rather than becoming reliant on care.

(b) Work undertaken so far includes:

- Trialling postural stability exercise programmes for patients identified as being at risk of falling
- Implementing an app-based Falls Risk Assessment Tool (known as the eFRAT) to support paramedics when making a decision not to convey, and ensuring sufficient information is passed to other services for further support. Following a successful trial, the eFRAT tool is now live on all paramedic smartphones, with use being reviewed during clinical supervision. The second phase, which includes an auditable database to monitor usage and action, goes live in January 2017.
- Installing a dedicated telephone line into LPT Single Point of Access to allow swift handover of non-acute patients.
- Trialling a triage and assessment process to review all referrals for falls prior to an outpatients appointment being made. The initial trial for this has demonstrated a 63% reduction in the number of outpatient falls clinics required, and it is planned to extend the trial to further evaluate the outcomes. This trial

has now been funded to the end of the financial year for more in-depth analysis of benefits and impact on improving patient outcomes.

- Proposals to accelerate work identified within the Business Case have been put forward to IFPG to enable some of this work to be accelerated

10. First Contact Plus:

(a) First Contact Plus aims to facilitate early help via information, advice or onward referral to a broad range of preventative services. A new web-based referral system has been developed which will facilitate efficient clinical referral and also self-referral and "self-help" via public facing options. Referrals include an initial 'triage' conversation with follow up calls at weeks six and twelve.

(b) The new web based referral and web page is going through final testing and minor development with partner reference groups being involved in the inbound/outbound system testing. This went live in general practice on 31st October 2016 and usage is increasing. This will be followed by a roll out to the public in January allowing self-referral into the system.

(c) During September 19 partner training sessions on new web-based system where conducted with 209 'admin-users' attending across the partnership, with further 'mop-up' sessions conducted in October 2016. Positive feedback received from attendees on both new system & website.

(d) Referrals to First Contact remain constant whilst referrals for Health Improvement have steadily increased. New opportunities are being developed with UHL via discharge process and re-launch of Make Every Contact Count (MECC). Demonstrations of the system are being given to wider partners to increase recognition of the service for greater integration.

11. Lightbulb

(a) The lightbulb pilot integrates practical housing support into a single service that will provide support shaped around an individual's needs. Keeping people independent in their homes; helping to prevent, delay or reduce care home placements or demand for other social care services, avoiding unnecessary hospital admissions/readmissions or GP visits and facilitating timely hospital discharge.

(b) The business case has been signed off by the Lightbulb Programme Board and the County Council's Cabinet and is now going through formal sign off through District Council governance.

(c) A communications plan is in place to support implementation of Lightbulb.

(d) Additional workstreams have been scoped out to support implementation (listed below) and will be started over the next three months:

- Financial modelling work with County and District Councils
- Deliverability across partner organisations
- Operational processes
- Lightbulb job roles
- Business model.

12. Local Area Co-ordination

(a) Local Area Co-ordinators (LACs) are embedded within the community to identify vulnerable or isolated people and resolve issues before they escalate to require more expensive intrusive services. The pilot scheme is currently in place across eight areas within Leicestershire.

(b) A Business Case has been developed with options appraisal for a part county or full county roll-out, to a maximum of 20 LACs. The date for completion has slipped due to Early Health and Prevention and potential funding issues, however this is now progressing for approval and a decision is expected in January 2017.

(c) The second evaluation report has been completed this will be reviewed at the next Board meeting, and findings will feed into the Business Case.

(d) The commissioned social return on investment report will be available once the full business case has been submitted for approval. This will identifies the social value that Local Area Co-ordination has had and any potential savings to the broader system.

13. Support for Carers

(a) The priorities for the Leicestershire, Leicester City and Rutland health and social care economy are to support carers to care effectively and safely; to look after their own health and well-being; to fulfil their education and employment potential; and to have a life of their own alongside caring responsibilities.

(b) The national strategy for carers has been delayed, and should now be released between December and January. Forward planning has taken place to pre-empt release of the strategy in the meantime.

(c) The Better Care Together (Frail Older People & Dementia) Carers Delivery Group has developed an action plan with several targets including:

- Increasing the number of Carers Leads/ Champions in GP practices (50% coverage as target across LLR).
- The exploration of the role of pharmacies in the identification of carers is being undertaken.
- Regarding the carers survey an extra question has been included by all three local authorities to determine how well supported carers feel specifically in relation to local authority support.
- Staff awareness raising is being undertaken in line with Carers Rights Day in November and further work is being planned to ensure resources within the department are available to support carers assessments.
- A specific focus on young carers and parent carers is undertaken on a quarterly basis.

Strategic Development

14. Following a social prescribing workshop held on 3rd November, a small Task and Finish working group was formed to establish an agreed Leicestershire definition for social prescribing, and design a proposed mechanism through which it could be offered. This reported to UPB in December, and a follow up session is being held

early in the New Year with UPB members to agree how this mechanism can be applied across all partners.

15. With the impending delivery of the social prescribing model there is requirement to ensure that the model develops in conjunction with the wider prevention intentions of all the partners (for example the Early Help and Prevention Strategy for Leicestershire County Council) and also the overarching Sustainability Transformation Plan for LLR. For this reason the Terms of Reference of the UPB have been revised to reflect its role in shaping and delivering the strategic direction for prevention across partners (attached as Appendix A).

Resource Implications

16. There are no specific increased financial/budget or other resource implications relevant to this report.

Background papers

Report to the Health and Wellbeing Board in May 2016, Outputs of the Development Session http://ow.ly/SG8g307nbPy

Circulation under the Local Issues Alert Procedure

None.

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List of Appendices

Appendix – Revised Terms of Reference for the Unified Prevention Board.

Relevant Impact Assessments

Equality and Human Rights Implications

17. The Unified Prevention Board supports the Health and Wellbeing Board to collectively tackle health inequalities and to make sure that all people can access health and care when they need to.

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TERMS OF REFERENCE
FOR THE LEICESTERSHIRE UNIFIED PREVENTION BOARD

Purpose of the Unified Prevention Board

The Unified Prevention Board (UPB) is a sub-group of the Leicestershire Health and Wellbeing Board.

Role and Responsibilities of the Unified Prevention Board

The key Objectives of the Unified Prevention Board are to:

- Develop a comprehensive offer for community based prevention for the citizens of Leicestershire by 2018.
- To become the initial mechanism through which prevention services are integrated across Leicestershire.
- Oversee the delivery of the existing jointly funded prevention programmes outlined in the Better Care Fund ensuring resources are targeted appropriately.
- Approve the scope and oversee the development and delivery of the key new Better Care Fund (BCF) projects.
- Ensure delivery against Better Care Together strategic priorities relating to early intervention and prevention.
- Bring together prevention activity across the Council and partners; developing an integrated single prevention strategy and ensure implementation of the strategy through cross-partnership working.
- Expand the scope to become a mechanism to integrate services within prevention and considering the wider national policy development promoting and driving integration.

We will do this by:

- Developing and agreeing shared definition and vision of unified prevention.
- Mapping the current resources and investment aligned to the vision.
- Developing and securing sign up to a new prevention model.
- Developing and proposing an implementation plan and investment strategy that key stakeholders can endorse.
- Developing a reporting structure for existing and planned BCF Prevention developments and programmes/ workstreams.
- Maintaining awareness of the wider prevention offer and allied services including integrated locality teams and community hubs.
- Ensuring the unified prevention plan is incorporated into the wider system plan, and reflected within the overarching Sustainability Transformation Plan for LLR.
- Focusing on performance management and ensuring programmes of work show direct performance against key performance indicators, including pay for performance indicators within the BCF.
- Developing dashboard reporting to evidence return on investment, cost effectiveness or social return on investment.

Membership of the Unified Prevention Board

The Board will include, but is not limited to representatives from the following:-

- Leicestershire County Council – Public Health, Adult and Communities, Children and Families and Chief Executives, plus a representative from the Commissioning Support Unit.
- District Councils –District health leads, housing, communities, health and welfare reform
- East Leicestershire and Rutland Clinical Commissioning Group
- West Leicestershire Clinical Commissioning Group
- Health Watch
- Leicestershire Operational Police representative
- Fire service
- Voluntary Action Leicestershire

There will be a core membership of the group and programme leads/other relevant people will be invited for appropriate agenda items.

Deputies can be provided in the absence of any members.

The core membership of the group will be reviewed as part of the annual review of the Terms of Reference.

Meeting Frequency

Meetings will take place initially monthly, with an initial review at six months, annually thereafter.

Chair

The Board will be jointly chaired by Director of Public Health and Chief Executive of The Nominated District Council.

Meeting Administration

Meetings will be administered by the Personal Assistant of the Director of Public Health. The agenda and papers will be issued no later than four working days in advance of the meeting.

Quoracy

In order to meet and conduct business six members must be present of which at least:

- one must be a Clinical Commissioning Group representative.
- one must be a Leicestershire County Council representative.
- one must be District Council representative.

Agenda Item 12

Leicestershire County Council

HEALTH AND WELLBEING BOARD: 5 JANUARY 2017

REPORT OF THE DIRECTOR OF HEALTH AND CARE INTEGRATION

HEALTH AND WELLBEING BOARD ANNUAL REPORT 2016

Purpose of report

1. The purpose of this report is to look back at the past year (2016) for the Health and Wellbeing Board and to reflect on the progress that has been made. The focus throughout the report is the progress that has been made across the partnership to improve the health and wellbeing of the population of Leicestershire.

Recommendation

2. It is recommended that the Health and Wellbeing Board:
    a. Approve the Health and Wellbeing Board Annual Report for publication;
    b. Note the progress that has been made by the Board in 2016; and
    c. Support the key workstreams that have been identified to further progress the impact of the Health and Wellbeing Board in 2017.

Policy Framework and Previous Decisions

3. The Health and Wellbeing Board's Annual Report for 2015 was approved by the Board in January 2016.

Background

4. The report includes the following information:-

    (a) An overview of some of the achievements and outcomes that have been delivered by the Health and Wellbeing Board in 2016, including those supported by the Better Care Fund pooled budget.

    (b) An update from Healthwatch Leicestershire on the progress that is being made to meet the needs of the people of Leicestershire and how their insights have contributed to the work of the Health and Wellbeing Board during 2016.

    (c) A look ahead to 2017 which will involve the refresh of the Leicestershire Better Care Fund Plan, delivery of the Leicester, Leicestershire and Rutland Sustainability and Transformation Plan and the commencement of work to refresh the Pharmaceutical Needs Assessment.

Consultation/Patient and Public Involvement

5. The report reflects on the ways that Healthwatch Leicestershire have worked with the Health and Wellbeing Board to ensure that the views of patients and the public are considered appropriately by the Board.

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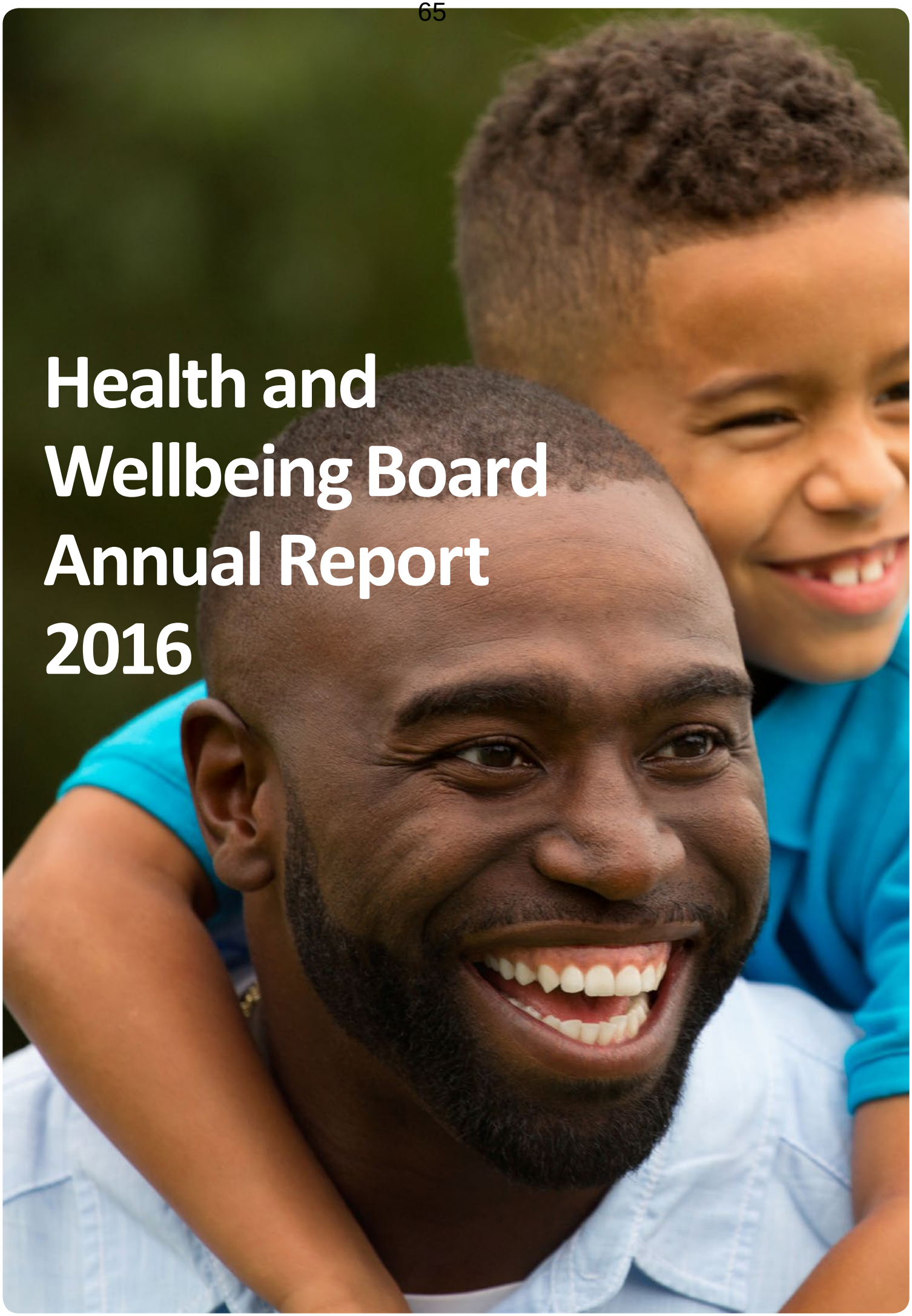
List of Appendices

Health and Wellbeing Board Annual Report 2016



Health and Wellbeing Board Annual Report 2016

Foreword

Cllr Ernie White
Lead Member for Health Leicestershire County Council
and Chair of Leicestershire Health and Wellbeing Board

At a time of major change and significant financial pressures, I am delighted to be able to say that partnership working across the health and social care system is in the strongest position I've known it to be.

Top of our agenda this year has been the refresh of the Joint Health and Wellbeing Strategy. We know that joined up working across the system is the only way that we can respond to the challenges we face and have a positive impact on the health and wellbeing of the people of Leicestershire. I have really welcomed the inclusion of five principles to govern the way in which all partners on the Board will work, and I commend them to you as a model for effective partnership working. Our principles are:-

- Putting health and wellbeing at the centre of all public policy making by influencing other agendas such as economy, employment, housing, environment, planning and transport.
- Supporting people to avoid ill health, particularly those most at risk, by facilitating solutions, shifting to prevention, early identification and intervention.
- Working together in partnership to deliver a positive, seamless experience of care which is focussed on the individual to ensure they receive the right support, in the right place, at the right time.
- Listening to our population, building on the strengths in our communities and using place based solutions.
- Having a clear strategic understanding of the roles and responsibilities of all partner organisations and how innovation and collaboration can improve health and wellbeing through support and challenge.

We started the year with some challenging discussions about the role of the health and wellbeing board and where leadership came from in the local system. We have ended the year with the publication of the Leicester, Leicestershire and Rutland Sustainability and Transformation Plan and a clear role for the Health and Wellbeing Board to confirm and challenge the development of integrated locality teams and the reconfiguration of Community Hospitals in Leicestershire. This is a new area of responsibility for the Board and it means that we can use our partnership approach and principles for working together to add real value to the delivery of the Sustainability and Transformation Plan.

Section A: Introduction

The purpose of this report is to look back at the past year (2016) for the Health and Wellbeing Board and to reflect on the progress that has been made. The focus throughout the report is the progress that has been made across the partnership to improve the health and wellbeing of the population of Leicestershire.

The report includes the following sections:-

- An overview of some of the achievements and outcomes that have been delivered by the Health and Wellbeing Board in 2016, including those supported by the Better Care Fund pooled budget.
- An update from Healthwatch Leicestershire on the progress that is being made to meet the needs of the people of Leicestershire and how their insights have contributed to the work of the Health and Wellbeing Board during 2016.
- A look ahead to 2017 which will involve the refresh of the Leicestershire Better Care Fund, delivery of the Leicester, Leicestershire and Rutland Sustainability and Transformation Plan and the commencement of work to refresh the Pharmaceutical Needs Assessment.

Section B: Health and Wellbeing Board Progress in 2016

1. Joint Health and Wellbeing Strategy 2017-2022

One of the Board's legal duties is to produce a Health and Wellbeing Strategy for Leicestershire. The strategy is a partnership document, which means that all of the partners on the Health and Wellbeing Board will work together to deliver the outcomes. Our previous strategy ended in 2016 so we have spent a lot of time this year producing a new strategy for the next five years ensuring alignment with the emerging Sustainability and Transformation Plan.

Evidence from the Joint Strategic Needs Assessment was used to identify what the main health issues are in Leicestershire. We then met with partners to discuss where they thought the Board could make the biggest impact, and which of the issues identified in the evidence would require partners to work together to improve.

A short consultation was held, aimed at finding out what other Stakeholders thought about the ideas for what should be in the strategy. Generally, the response was positive and those who contributed were in favour of the priorities and the Vision. We took on board the comments received and made some changes to the strategy as a result.

Our Vision is that "We will improve health outcomes for the local population, manage future demand on services and create a strong and sustainable health and care system by making the best use of the available resources"

In order to achieve this vision, we have set out 5 outcomes:

1. The people of Leicestershire are enabled to take control of their own health and wellbeing.

2. The Gap between health outcomes for different people and places has reduced

3. Children and young people in Leicestershire are safe and living in families where they can achieve their full potential and have good health and wellbeing

4. People plan ahead to stay healthy and age well and older people feel they have a good quality of life

"we have spent a lot of time this year producing a new strategy for the next five years"

5. People give equal priority to their mental health and wellbeing and can access the right support throughout their life course.

The Board will now work together to establish a delivery plan, which will set out how the strategy can be delivered and a performance framework to measure and demonstrate progress, which will also show how our local delivery in Leicestershire supports the overall delivery of the Sustainability and Transformation Plan across Leicester, Leicestershire and Rutland.

Our Joint Health and Wellbeing Strategy can be viewed via http://politics.leics.gov.uk/documents/s124188/JHWS%20App%20A.pdf

2. Health and Wellbeing Board Achievements and Outcomes

Approach to the Wider Determinants of Health

This year we have been keen to make sure we have a focus on the wider determinants of health; where people work, live and play and the social and economic conditions around them. We recognise the impact that these factors can have on people's health and wellbeing. We particularly welcomed the Health in All Policies (HIAP) approach described in the report. This is a collaborative approach which emphasises the connections and interactions which work in both directions between health and policies from other sectors. Central to HIAP is the concept of addressing the social determinants of health which are key drivers of health and health inequalities. We made sure that this approach formed part of the Joint Health and Wellbeing Strategy.

Leicester, Leicestershire and Rutland Discharge Workstream

We have been concerned this year with the deterioration in our previously good performance in terms of delayed transfers of care from hospital. As a result, the target in the Better Care Fund Plan has been missed for the first two quarters of 2016/17. We are pleased that the Department of Health's eight high impact interventions for discharge checklist has been

completed as an aid to the local action plan, and noted that "lack of focus on providing information to support patient choice" was identified as an area of additional work needed. The Leicester, Leicestershire and Rutland wide Discharge Steering Group is challenging partners to respond to this specifically, this group is also responsible for coordinating all actions associated with improving discharge performance and ensuring that the five new streamlined discharge pathways are implemented and work effectively as part of the overall work on urgent care redesign and system flow in Leicester, Leicestershire and Rutland. The reasons for Delayed Transfers of Care are complex, ranging from delays to Continuing Healthcare assessments for NHS funding of ongoing care, the impact of the changes in the domiciliary care services in Leicestershire during the autumn period, and problems with internal systems and flow within the acute trust itself (such as delays with medication).

Safeguarding Boards Annual Report

Every year, we consider the Annual Report of the Leicestershire and Rutland Safeguarding Children's Board and Safeguarding Adults Board. We have a protocol in place which ensures that we consider the health and wellbeing implications of these reports. This year, the Chair of the Safeguarding Boards asked to ensure that the transformation and change being brought about through the Sustainability and Transformation Plan would also improve safeguarding outcomes, recognising that there are synergies between areas of safeguarding risk and the Better Care Together workstreams. We have now asked the lead officers for the Sustainability and Transformation Plan to embed safeguarding in all its delivery workstreams.

3. The work of our Subgroups

a. Integration and the Better Care Fund

The Better Care Fund (BCF) is a pooled budget of £39.1 million between the Clinical Commissioning Groups (CCGs) and the County Council targeted improving the integration of health and care. The Health and Wellbeing Board has responsibility for approving the Better Care Fund for submission to NHS England and plans arising from its use.

The Better Care Fund 2016/17 has four themes, as follows:-

"The Better Care Fund (BCF) is a pooled budget of £39.1 million between the Clinical Commissioning Groups"

The Integration Executive is the subgroup of the Health and Wellbeing Board with responsibility for overseeing delivery of the BCF Plan on behalf of the Health and Wellbeing Board. The Unified Prevention Offer (Theme 1) reports directly to the Health and Wellbeing Board.

Our performance and achievements in relation to the BCF, as overseen by the two subgroups, is set out below:-

The **emergency admissions reduction** target for Leicestershire BCF plan for 2016/17 is for all schemes to collectively avoid 1,517 admissions (in line with CCG operating plan). By October 2016, the total number of avoided admissions across the different BCF schemes was 1,756, meaning that the target for the BCF schemes has been met.

As part of the work done by the Leicester, Leicestershire and Rutland (LLR) Falls Steering Group, a draft **falls pathway** has been designed. Each of the stages within this pathway are being developed into an agreed level of service that will form part of the LLR Falls Prevention and Treatment

Strategy, which will go live in April 2017. A business case for this proposal will be developed by the end of December.

We have developed a **Falls Risk Assessment Tool (eFRAT) app** in conjunction with the De Montfort University Hackathon team and EMAS (East Midlands Ambulance Service), based on the previously developed paper version. The new app was launched on the 31st October with 23 paramedics across LLR trialling the tool. Initial feedback has been positive and full roll-out to all paramedics will start in the middle of November. Interest from Derbyshire has been received to also use the tool in their region.

During 2016, a new domiciliary care service called **Help to Live at Home** has been procured in Leicestershire. This has involved a new specification and contract which has been co-produced between county CCGs and Leicestershire County Council. The service has been designed to support the revised discharge pathways which are now in place in LLR. It promotes reablement in the home and integrating domiciliary care providers more effectively with other health and care services, including primary care and prevention services in each locality. The new service went live on 7th November, however there have been some initial operational problems due to one provider exiting the process just before go live.

Building on the learning from the integrated commissioning for Help to Live at Home programme, and practice elsewhere in the country, the Leicestershire Integration workplan for 2016/17 includes developing an outcome based commissioning framework for **integrated commissioning** across Local Authority and NHS partners. This will have an emphasis on seeking further savings and value for money for commissioning, as well as assuring quality. Scoping work on the initial area of focus, care and nursing homes placements is underway.

During autumn 2016, proposals have been scoped for **redesigning discharge support service** to University Hospital Leicester as part of local plans to improve delayed transfers of care.

Since October 2015, the Leicestershire Integration Programme has been leading work to scope opportunities to integrate the various **points of customer access across** the health and care economy in LLR. Design work is currently in progress across all partners to agree the operational model. It is anticipated that between January and June 2017, that the existing points of access will transition to a new consistent operating model and some options for co-location are already being explored.

Review has been completed of the **Health and Social Care Protocol**. The review considered what a more flexible health and care workforce would look like, how this would fit in with regulations, and how this flexible approach would work across the three commissioners (self-funders,

"The new app was launched on the 31st October with 23 paramedics across LLR trialling the tool"

social care and health). Recommendations from the review are now being considered by commissioners including how the training system for workers using the health and social care protocol could be improved/ streamlined.

We are currently developing a model for **Social Prescribing** and a core menu of prevention services that sit behind the social prescribing "front door".

During 2016, First Contact has developed into **First Contact Plus**, our 'one-stop shop' with one simple referral form, so that partners can quickly and effectively access Leicestershire's prevention offer. The enhanced service offers signposting, information and targeted referrals to a broad range of preventative services. A new web based referral system, which will facilitate efficient clinical referral (e.g. from GPs) and also self-referral and "self-help" via public facing options. The clinical referrals system went live at the beginning of October.

First Contact Plus Case Study

A 74 year-old lady who lived in the Blaby area of Leicestershire was referred to the First Contact Plus team by a Community Advice Worker.

Once she was under the team's care a number of needs were identified, and the patient was quickly referred to several services. The service user was put in touch with the NHS Falls Clinic where she was assessed to attend the falls programme. She was then contacted by Hearing Services and given a TV loop, a personal listening device, a flashing doorbell and an adapted smoke alarm to make her home life safer and more comfortable.

In addition to these, the First Contact Plus team liaised with Age UK who provided information about their domestic services, and the patient was also sent information regarding the Community Action Partnership and local group contacts.

The Papworth Trust also carried out a check of the lady's home, which resulted in a new central heating programmer and a room thermostat being installed as there were no curtains in the main bedroom of her property.

All of these measures, which collectively made the service user's life more comfortable, were put in place as the result of integrated working between services, and will allow the patient to remain living independently for a longer period of time.

The **Lightbulb Housing Offer** is a joined up support service across housing, health and social care to keep people safe, well, warm and independent at home for as long as possible. To date, the service has been piloted in three localities. The business case for full roll-out was signed off by the Lightbulb Programme Board in September, and is currently going through formal approval through the District and Borough Councils and the County Council with a view to implementing the service across Leicestershire between April and October 2017.

A year-long evaluation was completed in September for the **Local Area Coordination** pilot. A Business Case is being developed by December 2016, with options appraisal for a part or full county roll-out.

Local Area Coordination Case Study

Contributing to the community

MK is a 28 year old lady who introduced herself to her Local Area Coordinator (LAC) after she had seen a poster in her local chemist. When she first met her LAC she had not coped well with a relationship breakdown and had recently been discharged from a mental health unit.

MK is a talented young woman, with interests in art, numerology, astrology, music and street dance. She is also a beauty therapist but was not sure if she wants to go back into this but would like to explore other things one step at a time. MK said she liked to keep busy as this stops her mind from wandering and if she is tired she sleeps better at night.

Together with her LAC she was able to explore ideas, information and options. The LAC supported her to: get a concessionary bus pass as part of her enablement plan after her stay in hospital; volunteer at a local charity shop and to support Seniors Day; enrol on an art course and complete a DIY course. She also volunteered at the LAC celebration event by facilitating a pampering session which resulted in a queue of ladies waiting at the nail painting table.

MK is now running a Saturday children's group at the library. Since her involvement with Local Area Coordination she has not had any crisis, and her family relationships (especially with her mum) have been stable. MK is now thinking of the future and talking about going back to work. Her LAC has signposted her to get support with her CV and help finding employment opportunities.

In September, we hosted an event to showcase our progress with implementing the **PI Care and Health data** integration tool. Participants from across the LLR health and care economy attended a workshop which demonstrated how the tool has been used to undertake analysis in support of system wide change in LLR. The second half of the session involved participants from across the country, who also use the PI Care and Health tool to share knowledge. Leicestershire gave the key note address at the national session where we showcased how the PI care and health tool has been used in service redesign and reconfiguration over the last 12 months.

SIMTEGR8 evaluation programme – the second phase of the evaluation programme is underway via a research partnership with Loughborough University, Healthwatch and SIMUL8. Integration care pathways are analysed using simulation modelling, stakeholder workshops and patient experience focus.

b. Supporting Leicestershire Families Executive/ Children and Families Partnership

In March, the governance of the Supporting Leicestershire Families programme moved to the Health and Wellbeing Board. We agreed to establish a subgroup with responsibility for taking this area of work forward and signed off its terms of reference in July.

The Supporting Leicestershire Families Executive met for the first time in September. By this time, the refresh of the Joint Health and Wellbeing Strategy was well underway and we had identified that there was no appropriate body to oversee delivery of the priorities relating to children and young people set out in the Strategy. We therefore took the decision in November to expand the remit and membership of the Supporting Leicestershire Families Executive and December saw the first meeting of the new Children and Families Partnership. Its first task will be to produce a Children and Young People's Plan for Leicestershire, drawing on the findings of the Joint Strategic Needs Assessment and aligned to the Joint Health and Wellbeing Strategy priorities. This work will be completed during the early part of 2017.

"In 2015/16 the Supporting Leicestershire Families Programme worked with 797 families"

The subgroup has received reports on performance of the Supporting Leicestershire Families Programme and is pleased to note that during 2015/16, it worked with 797 families, of which two-thirds of these (542) were new cases opening during the year. The families contained 3,460 individuals of which 2,048 (54%) were children, 387 of whom were under 5 years old. to tackle a range of issues including drugs, truancy, domestic

violence, health issues and anti-social behaviour, reducing the need for them to deal with several different agencies. Fifty-two percent of these family cases were closed during the year.

The Supporting Leicestershire Families Programme brings together the county and district councils, police, NHS and other agencies. 63% of the families worked with have made significant progress. The service is making a difference to families in Leicestershire and on track to support 3,000 families over five years. Feedback from families shows the scheme is having a real impact.

Case study

One of the families SLF has supported is that of mum-of-five Megan. She had experienced historic domestic abuse and was having difficulties with her teenage son Tom, who had shown offending behaviour, was using alcohol and cannabis and had been excluded from school.

Megan felt overwhelmed by the high number of agencies and professionals that were working with the family, making her anxious and feeling unable to make progress.

The SLF worker took the lead with the case, advocating on Megan's behalf to agencies and coordinating the case work. This meant that Megan now only had one professional working directly with the family and liaising with other professionals as needed.

Megan said that having only one worker who was able to provide greater support for the family enabled them to have a more personal relationship. She said the SLF worker was the first person she felt listened to what she wanted.

Megan said: "It allowed me to think about what I really wanted for my family."

Megan is now able to provide the support she feels is right for her family and they are due to go on their first family holiday for five years. Tom is back in education, receiving support for his substance misuse and attending boxing to help with his anger. Megan is looking into courses to train as a psychiatric nurse.

"63% of the families worked with have made significant progress"

4. Health and Wellbeing Board Development

Development Session

In February we held a development session for members of the Health and Wellbeing Board, facilitated by two programme managers from the Local Government Association. We had the following aims:-

(i) To reflect on our improvement journey so far;

(ii) To discuss how the Board will shape responses to the challenges facing the health and care system locally;

(iii) To bring clarity to how things are joined up between the Leicestershire "place" and LLR "place" and how improved joint working can be effected across Leicester, Leicestershire and Rutland (LLR);

(iv) To develop key themes for Board improvement.

Discussion at the development session focused on making improvements in the following areas:-

- System leadership;
- Joint Health and Wellbeing Strategy, including key priorities for 2016 onwards;
- Making the Health and Wellbeing Board more effective.

This section of the report focuses on making the Board more effective, as the other two areas are dealt with elsewhere in the report. The actions we have taken are as follows:-

- Revising the terms of reference to give the wellbeing, prevention and wider determinants components more prominence, co-ordination and drive and to recognise that the Board will lead communication and engagement on a specific and limited number of focused matters but will continue to work with other partners in the system on more routine general communications and engagement.
- To address concerns that the work of the Integration Executive had a lack of visibility at the Board, we have agreed that items which form a significant part of the integration programme should be considered by the Board rather than the Integration Executive. In 2016, this has meant that the Board has considered reports on social prescribing, the joint commissioning work plan and the Lightbulb Business Case.

- Reviewing the Board substructure so that the Unified Prevention Board reports directly to the Health and Wellbeing Board, thus raising the profile of early intervention and prevention as mechanisms to improve health and wellbeing.
- Amending the template for Board reports to ensure that discussion and decision making at meetings is focussed.
- Creating an 'information pack' of reports where no decision is needed to make the agenda for meetings more streamlined and effective.

Our website

During 2016 we developed a Leicestershire Health and Care Integration microsite (http://www.healthandcareleicestershire.co.uk/). The purpose of the website is to showcase work being undertaken as part of the Leicester Health and Care Integration Programme. This is where partners are working together to join up care, particularly for frail older people with long term conditions and other vulnerable groups, including carers.

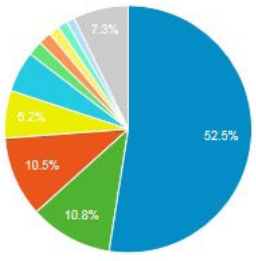
Since the launch of the website, there has been a steadily increasing amount of users accessing it. Nearly 6000 pages have been visited so far and around 900 different users have accessed the site. 59 percent of visits are from new users.

"Nearly 6000 pages have been visited so far and around 900 different users have accessed the site"

The average time people spend looking at information on the website is nearly four minutes and the most popular pages are the landing page and home page, with reducing loneliness and the newsletters pages also in the top five.

The most visited pages are as follows:-

	Landing Page	Sessions ↓	Sessions	Contribution to total: Sessions
		1,513 % of Total: 100.00% (1,513)	1,513 % of Total: 100.00% (1,513)	
☐	1. /	794	52.48%	
☐	2. /health-and-care-integration/reducing-loneliness/	164	10.84%	
☐	3. /home/	159	10.51%	
☐	4. /health-and-care-integration/	94	6.21%	
☐	5. /sharebutton.to	81	5.35%	
☐	6. /health-and-care-integration/health-and-care-integration-newsletters/	29	1.92%	
☐	7. /about-us/our-team/	26	1.72%	
☐	8. /health-and-care-integration/monitoring-and-evaluation/picarehealthevent2016/	21	1.39%	
☐	9. /health-and-wellbeing-board/	19	1.26%	
☐	10. /health-and-wellbeing-board/health-and-wellbeing-board-members/	16	1.06%	



5. Working in Partnership with Healthwatch

Healthwatch Leicestershire's (HWL) representation on the Health and Wellbeing Board provides a platform for sharing formal patient, user and public insights, evidence and intelligence to both inform the process of strategic commissioning and improve services for the benefit of the local population.

Below are some examples of how HWL and the Health and Wellbeing Board have worked together as partners to improve outcomes for local people living in Leicestershire:-

Enter and View visit to Child and Adolescent Mental Health Services (CAMHS)

The HWL Enter and View team visited the CAMHS Unit at Coalville Community Hospital on 23 February 2016 with the aim of observing the delivery of care and support given to young people, and capturing the experience of young people and staff at the unit. This visit was part of HWL's Children and Young People workstream.

At the time of the visit, the evidence was that the CAMHS Unit provides a very good standard of care, with young people confirming that they have a positive relationship with staff.

The responses from the service provider Leicestershire Partnership Trust (LPT) were included in the report, launched in 19 May 2016. On the 23 May, LPT responded to the recommendations listed in the report and issued a media release containing feedback on the report findings and recommendations.

The report was presented at the Leicestershire's Health and Wellbeing Board on 7 July 2016 and West Leicestershire Clinical Commissioning Group (WLCCG) Quality & Performance Committee on 19 July 2016.

The full report is available at: http://alturl.com/kk6nv

Young Voices Matter – Listen to Me

Healthwatch Leicestershire launched the results of the recent survey to find out young people's attitudes and experiences of local mental health and sexual health services. The 'Listen to me' #YoungVoicesMatter report reflects the views and experiences of 429 young people from the city and the county aged between 13- 25 years.

The report was presented to the Health and Wellbeing Board on 7 July 2016 meeting and highlights how young people feel about services, for example:

- The School Nurse is seen as the most trusted professional from whom young people would seek information about mental and sexual health.
- Almost half of the young people surveyed would not know or were unsure who to talk to about their mental health concerns.
- Accessibility, stigma and confidentiality are the main barriers to accessing sexual health services. The report was an opportunity for young people to talk to Healthwatch on the services that directly affect them. The report highlights that there is a need for young people to be able to better manage their own health and care.

HWL have published and presented seven recommendations to the Health and Wellbeing Board to help influence awareness and access to mental and sexual health services for young people.

The Board had some concerns about the reported issues around self esteem and anxieties relating to personal appearance. For example, many young people (both male and female) worried constantly about their personal appearance. We followed this up with Leicestershire Partnership Trust and are currently planning a joint campaign promoting good mental health and wellbeing in children and young people which will take place in the new year.

Read the report at: http://alturl.com/2zfd6

HWL has also presented the findings of the Listen to me: Young Voices Matter report to the Quality and Safety group at LPT. The presentation was well received and during the discussion linkages between the report findings, the work of LPT and the work of LCC were identified, especially around joint campaigns.

The Health and Social Care Signposting Directory

HWL in partnership with Health Care Publications produced two Health and Social Care Signposting Directory's one for residents in East Leicestershire and the other for residents in West Leicestershire.

The Health and Wellbeing Board found the directories to be very useful and asked that they be circulated across Leicestershire. Twelve thousand copies of the directories were dispatched to elected members, GP surgeries, pharmacies, hospitals, domiciliary care providers, residential/ nursing homes, various local authority departments, Meals on Wheels and other health care providers.

The directories can be accessed at:

https://issuu.com/healthwatch/docs/leicestershire __ east _ brochure _ for _ w

https://issuu.com/healthwatch/docs/leicestershire __ west _ brochure _ for _ w

6. Sustainability and Transformation Plan

The draft Leicester, Leicestershire and Rutland Sustainability and Transformation Plan (STP) was published in November 2016. We have made sure that the refresh of the Joint Health and Wellbeing Strategy has been aligned to the development of the STP and there is a good read-across between the two documents. We have formally received the draft STP and, in commenting on the document, we emphasised the importance of listening to the outcome of public engagement and consultation. We also suggested that engagement with the public should focus on the positive health offer that would be made for each locality.

To view the draft STP, please visit http://www.bettercareleicester.nhs.uk/

1. STP and the Role of the Health and Wellbeing Board

Across the local health and care system there is recognition that additional governance arrangements for the STP are needed to deliver improved clarity and connection between the local place and the Leicester, Leicestershire and Rutland tier with more visibility, shaping and recognition of the wider determinants of health in all aspects of strategic planning. It has been proposed that the three Health and Wellbeing Boards for Leicester, Leicestershire and Rutland take on this role.

The Health and Wellbeing Boards will provide a 'confirm and challenge' function, ensuring that the STP is aligned with the priorities set out within both the Joint Health and Wellbeing Strategy and the Joint Strategic Needs Assessment. The Health and Wellbeing Board will also apply this confirm and challenge approach to the implementation of the STP, particularly with regard to the pace and readiness of the individual programmes of work within it.

As part of these proposals, each Health and Wellbeing Board provide an open and transparent forum in which to:

I. Take responsibility for ensuring that the STP priorities address the key place based health and care needs of each Health and Wellbeing Board area for adults and children

II. Assure itself that partners on the Health and Wellbeing Board have adequate plans in place to deliver their required local contribution to implementing the STP

III. Assure itself, where specific proposals exist for service reconfiguration within their geographic area, that the case for change in terms of clinical model and patient benefit is clear and processes for securing patient and public involvement are robust.

IV. Take a lead role for one of the agreed STP new model of care transformation priorities. This would be on behalf of the whole of Leicester, Leicestershire and Rutland, not just the specific Health and Wellbeing Board, and would involve more frequent review, testing and leadership for the implementation plans for that specific aspect of the STP.

V. Agree any concerns or issues which the Health and Wellbeing Board wishes to escalate to the STP System Leadership Team or refer to or inform the executive of the relevant NHS body or local authority

This 'division of labour' is not intended to constitute a formal delegation of accountability or statutory responsibilities from one body to another, but rather ensure that there is consistent challenge being applied across the system in a way which avoids duplication and creates the time and space for more detailed consideration.

In terms of what this would practically mean, under these arrangements in addition to taking an overall interest in the whole of the STP, each Health and Wellbeing Board will have the following specific areas of focus:

	Leicester City	Leicestershire	Rutland
New models of care	Primary care	Integrated teams	Community rehabilitation
Service reconfiguration	UHL acute hospital sites	Community hospitals (excluding Rutland Memorial)	Rutland Memorial

2. BCF Refresh

Leicestershire's Better Care Fund plan is due to be refreshed in early 2017, in line with national policy. It will be subject to assurance via NHS England and Local Government structures regionally and nationally. Work is already underway on the refresh at the time of writing this report, and national planning guidance is expected in December 2016.

The refresh process will include:

- using a range of evaluation findings to inform models of care and commissioning intentions for 2017/18;
- assessing the Leicestershire plan against the national Better Care Fund self-assessment tool;
- reviewing the existing schemes within the Better Care Fund, and aligning them to the Sustainability and Transformation Plan;
- engaging with Clinical Commissioning Groups, the Integration Executive, Leicestershire County Council and the Health and Wellbeing Board in the development and approval of a refreshed plan.

The key metrics are expected to be reduced in 2017/18, with a focus to:

- reduce the total number of emergency admissions;
- reduce the number of permanent admissions to residential and nursing homes;
- increase the number of service users still at home 91 days after discharge;
- reduce the number of delayed transfers of care.

Each scheme funded by the Better Care Fund will be described in detail, along with trajectories for activity and a full assessment of how they meet the Better Care Fund criteria:

- building capacity for integration;
- delivering outcomes alongside value for money;
- improving patient/service user satisfaction;
- utilising a 'system thinking' approach;
- supported by all stakeholders, including the workforce; and
- supporting the Sustainability and Transformation Plans.

3. Health and Wellbeing Board Priorities for 2017

Delivery of the STP and our integration programme are likely to be our main priorities during 2017. There are also significant issues related to mental health which we have identified and area keen to see progress on next year. These are:-

- The refresh of the 'Future in Mind' Plan to transform Child and Adolescent Mental Health Services;
- The development and delivery of a plan to ensure parity of esteem, that is, that mental health is given equal priority to physical health;
- Progress with the development and delivery of the Leicester, Leicestershire and Rutland Suicide Prevention Strategy.

4. Pharmaceutical Needs Assessment

The Pharmaceutical Needs Assessment (PNA) will be refreshed in 2017 in order to be published by April 2018. It will include refreshed data, based on the 2015 Joint Strategic Needs Assessment and public engagement.

It is intended that the PNA will be refreshed either jointly or in alignment with Leicester City and Rutland.

Agenda Item 13

Leicestershire County Council

HEALTH AND WELLBEING BOARD: 5 JANUARY 2017

REPORT OF THE DIRECTOR OF HEALTH AND CARE INTEGRATION

BETTER CARE FUND QUARTERLY PERFORMANCE REPORTING

Purpose of report

1. The purpose of this report is to provide the Health and Wellbeing Board with assurance on the national quarterly reporting requirements for the Better Care Fund (BCF).

Policy Framework and Previous Decisions

2. The Health and Wellbeing Board approved Leicestershire's current BCF plan in May 2016.
http://politics.leics.gov.uk/documents/s118710/Better%20Care%20Fund%20Plan%20Submission%20and%20Assurance.pdf

3. The day to day delivery of the BCF is overseen by the Leicestershire Integration Executive as agreed by the Health and Wellbeing Board in March 2014. (http://politics.leics.gov.uk/ieListDocuments.aspx?Cld=1038&MId=3981&Ver=4). The Integration Executive Terms of Reference have been refreshed, and were approved by the Health and Wellbeing Board in November 2015.

4. NHS England issued BCF implementation guidance in July 2016 https://www.england.nhs.uk/wp-content/uploads/2016/07/bcf-ops-guid-2016-17-jul16.pdf which set out the requirements for quarterly reporting along with the draft templates and analytical tools that are required to be used for this purpose.

Background

5. The BCF plan was initially submitted to NHS England in September 2014 and was implemented during 2014/15 and 2015/16.

6. In line with the national policy requirements, the BCF plan was refreshed for 2016/17 at the beginning of 2016. The final plan was submitted to NHS England on 3rd May. Confirmation was received in July that the plan was fully approved.

7. The purpose of the BCF is to transform and improve the integration of local health and care services, in particular to:

   - Reduce the dependency on hospital services, in favour of providing more integrated community based support, such as reablement, early intervention and prevention;
   - Promote seven day working across health and care services;

- Promote care which is planned around the individual, with improved care planning and data sharing across agencies.

Financial Position at the end of Q2 2016/17

8. The BCF spending plan totals £39.4m in 2016/17. This comprises of minimum contributions from partners of £39.1m as notified by Government, and an additional locally agreed £0.3m allocation from the Health and Social Care Integration Earmarked Fund.

9. The current financial position at the end of quarter two was that a small underspend was being forecast in the BCF plan. This was mainly as a result of a negotiated reduction in contract values for a number of services in the plan.

10. At this point in the financial year, the expectation remains that the whole £39.4m will be spent.

11. A risk pool of £1m has been created within the BCF which is accessed if the planned reduction of emergency admission is not achieved. The BCF plan also contains a general contingency of £1m. The risk pool and contingency are reviewed on a quarterly basis to ensure that they remain appropriate to the level of financial risks.

12. At the end of quarter two, it was agreed to release the full £1m set aside for under delivery against the emergency admissions risk pool. It should be noted that by the end of October, the BCF had delivered the level of avoided emergency admissions that was set for 2016/17. Therefore this was not due to an underperformance of the target, however due to the continued over performance in terms of emergency admissions activity affecting both Clinical Commissioning Groups (CCG), the risk pool was still need to off-set the cost of this additional activity.

13. It was also agreed that the general contingency (£570k) and uncommitted reserve funding (£769k) be released back to West Leicestershire CCG in recognition that these funds were not committed within the BCF during 2016/17.

14. It was acknowledged that releasing these reserves now would eliminate the opportunity for these to be included in the contingencies/reserves for the BCF budget in 2017/18. Therefore all partners would need to accept the risk this poses to headroom within the BCF next year and have a shared plan for mitigations.

15. The Help to Live at Home (HTLAH) contingency pool includes £1m for potential non-achievement of QIPP savings in 2017/18 and a further £0.75m for non-achievement of MTFS savings. This contingency will be reviewed during December. It will not be possible to assess delivery of HTLAH savings against targets until at February/March 2017.

Performance against BCF Outcome Metrics at the end of Q2 2016/17

16. The BCF plan is measured against six outcome metrics. The following table explains the definition of each metric, the rate of improvement that is being aimed for, and progress at the end of quarter one.

National Metric (1)	Definition	Trajectory of improvement
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	This is a nationally defined metric measuring delivery of the outcome to reduce inappropriate admissions of older people to residential care.	The target for 2016/17 has been set at 606.4 per 100,000. This equates to fewer than 827 admissions in 2016/17. Quarter one and two data suggests 826 admissions in 2016/17 are likely. *On track to achieve target*

National Metric (2)	Definition	Trajectory of improvement
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	This is a nationally defined metric measuring delivery of the outcome to increase the effectiveness of reablement and rehabilitation services whilst ensuring that the number of service users offered the service does not decrease. The aim is therefore to increase the percentage of service users still at home 91 days after discharge.	The target for 2016/17 has been set at 84.2%. The target was set low because of the re-contracting of homecare services, including reablement, implemented in November 2016. It is anticipated that this may cause a temporary fall in performance. Quarter two data shows a rate of 90.3% *On track to achieve target*

National Metric (3)	Definition	Trajectory of improvement
Delayed transfers of care from hospital per 100,000 population (average per month)	This is a nationally defined metric measuring delivery of the outcome of effective joint working of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults. The aim is therefore to reduce the rate of delayed bed days per 100,000 population.	Reductions during 2015 in delays have focussed on interventions in the acute sector. Therefore the target was set based on reducing the number of days delayed in non-acute settings by 0.5%, while maintaining the rate of days delayed in acute settings at its current low level. The targets are quarterly and are 236.66, 231.91, 214.66, and 312.19 for quarters one to four of 2016/17 respectively. At the end of quarter two the BCF DTOC metric was 357.19 against a target of 231.91.

		Deteriorating performance A project is underway to provide assurance that delays are being accurately reported and to align reporting and targets for this metric across the health and social care system. A new model of integrated in-reach to support hospital discharge has been approved and is in the process of being implemented.

National Metric (4)	Definition	Trajectory of improvement
Non-Elective Admissions (General & Acute)	This is a nationally defined metric measuring the reduction in non-elective admissions which can be influenced by effective collaboration across the health and care system. Total non-elective admissions (general and acute) underpin the payment for performance element of the Better Care Fund.	The target for 2016/17 is 724.37 per 100,000 per month, based on a 2.49% reduction on the probable number of non-elective admissions for patients registered with GP practices in Leicestershire for 2015/16 (allowing for population growth). This equates to a combined trajectory of 1,517 avoided admissions within the BCF schemes targeted at avoiding emergency admissions. Despite BCF admission avoidance schemes performing well and already achieving the target of 1,517 avoided admissions this financial year, the number of non-elective admissions continues to rise. System-wide plans are being delivered or developed as part of BCT, STPs and Vanguard plans to stem the rise in non-elective admissions. For the period Apr-Sep 2016 there have been 30,278 non-elective admissions, against a target of 29,393 - a variance of 885. Furthermore, the forecast for the end of the 2016/17 financial year is that there could be 61,547 admissions, against a target of 58,896. This would be RAG-rated as amber. The RAG rating allows a difference of up to

		10% to be rated amber. *No improvement in performance*
National Metric (5)	**Definition**	**Trajectory of improvement**
Improved Patient Experience	Selected metric for BCF Plan from national menu: - taken from GP Patient Survey: "In the last 6 months, have you had enough support from local services or organisations to help manage long-term health condition(s)? Please think about all organisations and services, not just health." The metric measures the number of patients giving a response of "Yes, definitely" or "Yes, to some extent" to the above question in the GP Patient Survey in comparison to the total number of responses to the question.	This target was set at 62.2% for 2016/17. This is based on the 2015/16 target and a 2% increase in the number of positive replies. Current performance is 63.6% (as at July 2016). *On track to achieve target.*

Local Metric (6)	Definition	Trajectory of Improvement
Injuries due to falls in people aged 65 and over	This is a locally defined metric measuring delivery of the outcome to reduce emergency admissions for injuries due to falls in people aged 65 and over.	A realistic target was set for 2016/17 which holds the number of falls in the 65-79 age group at the 2015/16 level, while reducing those in the 80+ population by 5% allowing for population growth. The target is 419.27 per 100,000 per quarter. Q2 activity shows a rate of 374.0 which is rated green against the target. *On track to achieve target*

Progress against BCF national conditions

17. The revised policy framework and technical guidance for 2016/17 indicates that BCF plans must demonstrate assurance regarding the following:
    - Delivery against five national BCF metrics and a locally selected metric (see para 16);
    - How a proportion of the fund will protect adult social care services;
    - How data sharing and data integration is being progressed using the NHS number;
    - How an accountable lead professional is designated for care planning/care coordination;
    - Delivery of Care Act requirements;
    - How a proportion of the fund will be used to commission care outside of hospital;
    - How seven day services will be supported by the plan;
    - That the impact on emergency admissions activity has been agreed with acute providers;
    - That there is a locally agreed proactive plan to improve delayed transfer of care from hospital;
    - That Disabled Facilities Grant allocations within the BCF will be used to support integrated housing solutions including the delivery of major adaptations in the home.
    - Approval of the BCF plan by all partners being assured via the local Health and Wellbeing Board.

18. The Leicestershire BCF plan, through work during 2015/16 and to date during 2016/17, has been able to provide assurance that most of the national conditions of the plan have been met.

19. The exception to this is the question 'are support services, both in the hospital and in primary care, community and mental health settings available seven days a week to ensure next steps in the patient care pathway, as determined by the daily consultant-led, can be taken'.

20. It was agreed at this stage to state that this national condition was still in progress. This was due to the fact that work is still underway on the Leicester, Leicestershire and Rutland urgent care redesign. As this will be implemented in April 2017, it was reported that the national condition will be fully met by September 2017, to allow time for the changes to embed in.

21. The Integration Programme stakeholder presentation (available in Appendix A) provides further information on the progress against the BCF national conditions.

Process to submit the BCF quarterly report to NHS England

22. The BCF Operationalisation Guidance required that a quarterly performance template was submitted to NHS England by 25th November 2016, summarising the final position for quarter two 2016/17.

23. The appropriate representatives of the Integration Executive reviewed the completed template on 24th November and submitted the required information to NHS England on 25th November on behalf of the Health and Wellbeing Board.

Recommendation

24. The Board is recommended to note the contents of the report and that the quarter two 2016/17 BCF return was approved by representatives on the Integration Executive on 24th November, and submitted to NHS England on 25th November.

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Relevant Impact Assessments

Equality and Human Rights Implications

25. The BCF aims to improve outcomes and wellbeing for the people of Leicestershire, with effective protection of social care and integrated activity to reduce emergency and urgent health demand.

26. An equalities and human rights impact assessment has been undertaken which is provided at: http://www.leics.gov.uk/better_care_fund_overview_ehria.pdf

Partnership Working and associated issues

27. The delivery of the BCF plan and the governance of the associated pooled budget is managed in partnership through the collaboration of commissioners and providers in Leicestershire.

28. Day to day oversight of delivery is via the Integration Executive through the scheme of delegation agreed via the Integration Executive's terms of reference which have been approved by the Health and Wellbeing Board.

29. The delivery of the Leicestershire BCF ensures that a number of key integrated services are in place and contributing to the system wide changes being implemented through the five year plan to transform health and care in Leicestershire, known as Better Care Together http://www.bettercareleicester.nhs.uk

Appendix

Appendix A – Integration Programme Stakeholder Presentation

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Better Care Fund

Progress Update November 2016

Leicestershire County Council

NHS East Leicestershire and Rutland Clinical Commissioning Group

NHS West Leicestershire Clinical Commissioning Group

University Hospitals of Leicester NHS Trust

Leicester Partnership NHS Trust

East Midlands Ambulance Service NHS Trust

healthwatch

District of Harborough

Melton Borough Council

Blaby District Council

Charnwood

Hinckley & Bosworth Borough Council

North West Leicestershire District Council

Oadby & Wigston Borough Council

Some history…

- Following the introduction of BCF policy in late 2013, the Leicestershire plan was developed during 2014, with support from all partners in the health and care system.

- The plan was then subject to a regional and national assurance process during 2014. Process led by NHSE and LGA

- A refreshed BCF plan was developed for 2016/17 which built on the progress made during 2015/16.

- The BCF plan for 2016/17 was approved by NHSE in July 2016.

Reminder of BCF National Requirements

BCF National Conditions 2016/17

- BCF plans to be jointly agreed
- Protection of adult social care
  - Proportion of the plan must be targeted to maintain provision of social care services
- Implementation of 7 day services – in particular to:
  - Prevent admissions/support discharges
  - Support delivery of the national clinical standards for 7 day working
- Agreement to invest in NHS commissioned out of hospital services
- Agreement on local action plan to reduce delayed transfers of care

BCF National Conditions (2)

- Better data sharing between health and social care
  - Based on the NHS number as the identifier
- Joint assessment and accountable lead professional for high risk populations
  - Risk stratification of populations (via GP practice)
  - Integrated coordinated care
  - Designated accountable professional for complex case management
- Agreement to acute sector impact of BCF plan
  - Agreement on the financial/contractual implications of the reductions in emergency admissions to be achieved via the BCF
- BCF Governance via a Section 75 agreement

BCF Metrics – 5 National, 1 local

Reduce the total number of emergency admissions in 2016/17 by 2.49% (e.g. reduce by 1,517 admissions)

Reduce the number of emergency admissions due to falls (Local metric)

Reduce the number of permanent admissions to residential and nursing homes

Increase the number of service users still at home 91 days after discharge

Reduce the number of delayed transfers of care

Improve patient/service user experience

Our vision for Health and Care Integration in Leicestershire

We will create a strong, sustainable, person-centred, and integrated health and care system which improves outcomes for our citizens.

Leicestershire's BCF Plan Aims: 2016/17

1. Continue to develop and implement new models of provision and new approaches to commissioning, which maximise the opportunities and outcomes for integration.
2. Deliver measurable, evidence based improvements to the way our citizens and communities experience integrated care and support.
3. Increase the capacity, capability and sustainability of integrated services, so that professionals and the public have confidence that more can be delivered in the community in the future.
4. Support the reconfiguration of services from acute to community settings in line with:
   - ❖ LLR five year plan
   - ❖ New models of care
5. Manage an effective and efficient pooled budget across the partnership to deliver the integration programme.
6. Develop Leicestershire's "medium term integration plan" including our approach to devolution

Leicestershire BCF's Components 2016/17

Theme 1:
Unified Prevention Offer

Local Area Coordination
Lightbulb Housing Support
Assistive Technology
Carers Support Service
Falls Pathway

Theme 2:
Integrated, Proactive Care for Long Term Conditions

Risk Stratification
Integrated Case Management/Care Plans
Virtual Wards

Theme 3:
Integrated Urgent Response

24/7 Crisis Response
Falls non conveyance
Older Persons Unit
Acute Visiting Service
Ambulatory Care on CDU

Theme 4:
Hospital Discharge and Reablement

Housing Discharge Enablers
Residential Reablement
Care Packages Review Team
Help to Live at Home

Enablers

First Contact Plus

Adoption of NHS number

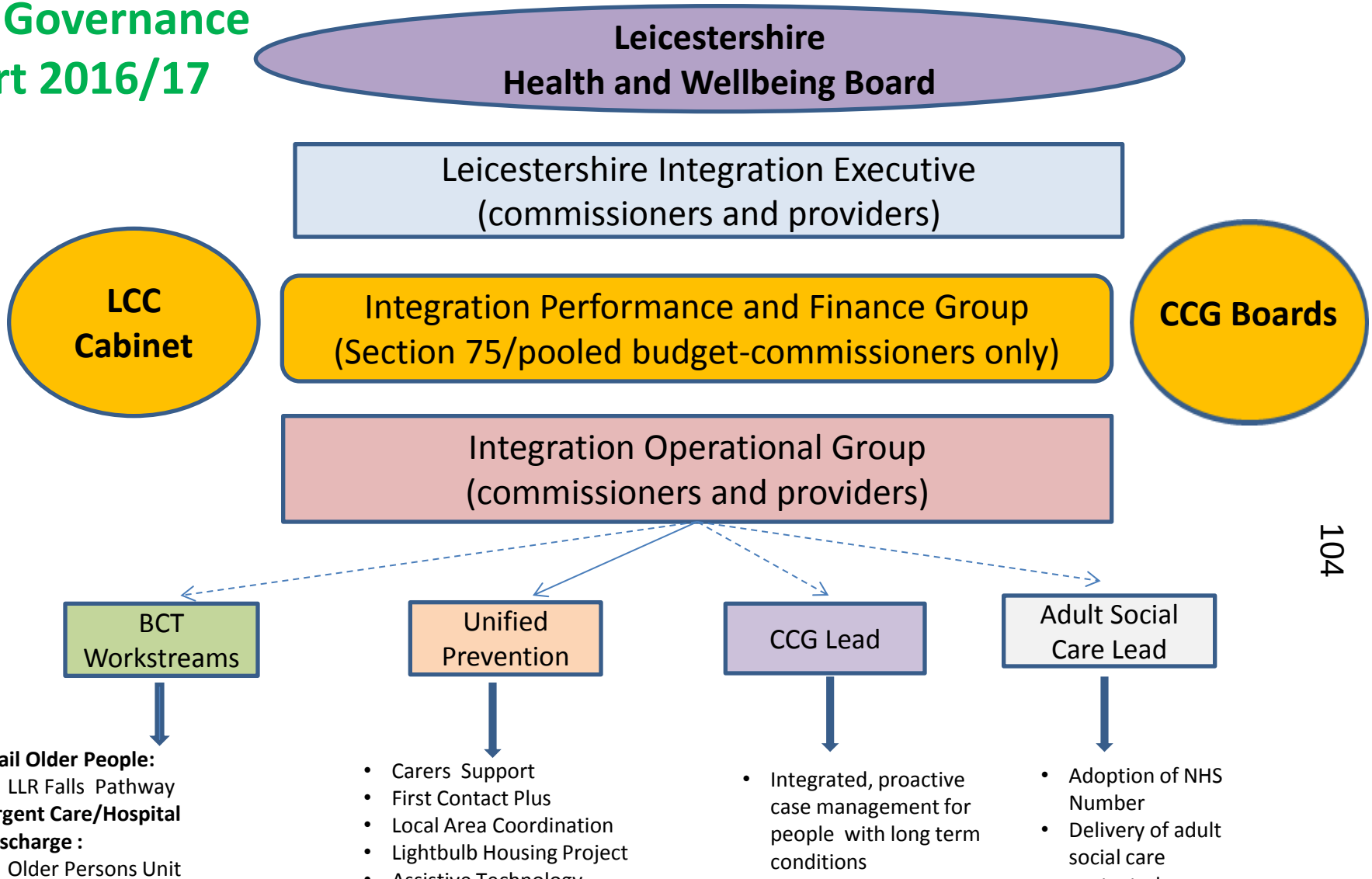
Data Sharing using Care & Health Trak

Locality Integrated Teams

Health and social care protocol

Integrated Points of Access

BCF Governance Chart 2016/17



Our progress so far in 2016/17

BCF Metrics – Progress to Date

Metric	Target	Current	Status
Permanent admissions of older people to residential and nursing care homes, per 100,000 population, per year	606.4	605.7	GREEN
Proportion of older people who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	84.2%	89.4%	GREEN
Delayed transfers of care from hospital per 100,000 population	231.91	357.19	RED
Total non-elective admissions into hospital per 100,000 population, per month	724.37	748.57	AMBER
Patient/service user experience - patients satisfied with support to manage long term conditions	62.2%	63.6%	GREEN
Emergency admissions for injuries due to falls in people aged 65 and over, crude rate per 100,000 population per month	139.76	126.85	GREEN

BCF Theme 1 – Unified Prevention Offer

- Developing a model for social prescribing and a core menu of prevention services that sit behind the social prescribing “front door”.
  - Design a core menu of effective prevention services to wrap around integrated locality teams.
  - Design a consistent approach to social prescribing – proactively targeting the menu of prevention services to specific cohorts of people who will most benefit from them in the community.

- *Social prescribing definition – a means of enabling primary care service to refer patients with social, emotional or practical needs to a range of local, non-clinical services, often provided by the voluntary and community sector.*

Theme 1 – Unified Prevention Offer

- **First Contact Plus**
  - Provides one point of contact for a range of wellbeing support
  - Facilitates early help via information, advice and onward referral to a broad range of preventative services.
  - New web-based referral system which will facilitate efficient clinical referral (e.g. from GPs) and also self-referral and "self-help" via public facing options.
  - Clinical referrals launched Nov 16.

- **Local Area Coordinators**
  - Work within the community to identify vulnerable people and resolve low level needs, to avoid escalation to require more costly/formal services.
  - Piloted in 8 areas within Leicestershire.
  - Independent evaluation completed in Autumn 2016
  - Business case being developed by December 2016 ,with options appraisal for a part or full county roll-out.

Theme 1 – Unified Prevention Offer

- **Lightbulb housing offer**
  - Joined up support across housing, health and social care to keep people safe, well, warm and independent at home for as long as possible.
  - Business case signed off by Lightbulb Programme Board. Going through formal sign-off through District and Council governance.
- **Falls pathway**
  - Developing a consistent approach to the prevention and treatment of falls in residents over the age of 65 in LLR.
  - Innovative Falls Risk Assessment Tool implemented with EMAS, now an app based tool, with Leicestershire's good practice being considered by other parts of the country
  - Business case being prepared – due end of December 2016.
- **Carers Services**
  - Support for carers to care efficiently and safely; to look after their own health and well-being; to fulfil their education and employment potential; and to have a life of their own alongside caring responsibilities.

Theme 2 – Long Term Conditions

- Integrated locality working between community nursing and social workers in place so they can jointly respond and manage their caseloads using shared operational practices and procedures – organised to support both planned care and urgent care cases in each locality.

- This model is currently being reviewed and built upon in 2016/17, now that we are implementing Integrated Locality Teams across LLR - one of the top priorities from the Sustainability and Transformation Plan

- Integrated locality teams are being developed during the latter part of 2016/17, and will initially support patients with multiple LTCs, frailty and others who are at risk of high levels of acute care costs if their care is not well managed in the community.

Theme 3 – Integrated Urgent Response: Admissions Avoidance

Five BCF schemes are in place

targeted to avoid 1,517 emergency admissions to hospital

in 2016/17.

As at the end of October 2016 these have avoided a total of 1,756 emergency admissions

Theme 3: Integrated Response: Admissions Avoidance

Integrated Crisis Response Service (2016/17 Target = 432 avoided admissions, 344 avoided by Oct)	• Social care and night nursing element • Offers up 72 hours of support in a care crisis in the community.
Older Persons Unit (2016/17 Target = 240 avoided admissions, 149 avoided by Sept)	• Rapid assessment service based at Loughborough Hospital, Oct 2014-Sept 2016. • Lessons learned fed into Urgent Care Procurement/Pathways for 2017/18.
Loughborough Urgent Care Centre extra care pathways (2016/17 Target = 120 avoided admissions, 5 avoided by Oct)	• Extra care pathways include hyperkalaemia, low risk cardiac pain, congestive cardiac failure, COPD and asthma, gastroenteritis, UTIs, cellulitis, TIA, DVT.
7 day services (2016/17 target = 3,258 avoided admissions, 1,801 avoided by Oct)	• GP referral service, providing a rapid, clinical response to patients with urgent needs at home, who are vulnerable to admission.
Ambulatory Care Glenfield CDU (2016/17 target = 66 avoided admissions, 69 avoided by June)	• 8 week pilot that tested streaming Cardio/Respiratory patients into 2 groups – likely to go home same day / likely to be admitted. • Patients likely to go home benefited from rapid decision making and effective care planning back into the community. • CCGs reviewing future service plans.

Theme 4 – Hospital Discharge and Reablement

- **Help to Live at Home**
  - A new domiciliary care service designed to support people to remain independent for as long as possible through assistance with personal care and also provide help when patients are discharged from hospital.
  - Joint commissioning for joint reablement outcomes across NHS and LA.
  - New service launched 7th November 2016.
  - A number of operational care delivery issues are being experienced at the time of writing this report
- **Integrated Discharge In-reach Team**
  - During Autumn 2016 proposals have been scoped for redesigning discharge support to university hospitals of Leicester, as part of local plans to improve delayed transfers of care.
- **Discharge Housing Support**
  - As part of the model of integrated housing support being developed in Leicestershire, housing expertise is provided at the Bradgate Unit and LRI to support discharges.

Integration Enablers

Integrated LLR Points of Access (POA)

- Why the programme
  - LLR currently has various points of access that receive referrals for community based services, providing support to a range of professionals and the public.
- The Vision
  - To bring together these multiple Points of Access to deliver a consistent way of working.
  - To support the efficient and effective scheduling and delivery of integrated community services across health and social care.
- Progress so far
  - Design work is in progress across all partners at the time of writing this report to agree the operating model.
  - It is anticipated that between January – June 2017 the existing points of access will transition to a new consistent operating model and some options for co-location are already being explored.

Integration Enablers (2)

- **Adoption of NHS number via adult social care IT system**
  - Currently there are 9,550 records of service users in receipt of adult social care services, of which 98% now have a NHS number validated by the NHS.
- **PI Care and Healthtrak**
  - A data integration tool used to track patient journey across the health and care system using the NHS number as the identifier, to analyse patient flows and pathways and measure the impact of changes to the health and care system at both population and individual levels.
  - A team of existing data analysts across the health and care system using the PI tool to create dashboards and analysis to support LLR system wide change
- **Research and Evaluation**
  - Formal independent evaluation of 8 components of our integration programme between 2015/16 and 2016/17, via a research partnership with Loughborough University, Healthwatch and SIMUL8.
  - Integration care pathways analysed using simulation modelling, stakeholder workshops and patient experience focus groups.

Integrated Commissioning

Integrated Commissioning

- Develop an outcome based commissioning framework for integrated commissioning across LA and NHS partners.
- Three immediate areas for focus are:
  - Nursing and residential homes – integrated approach to commissioning across NHS and LA – initial scoping work commenced.
  - Learning Disabilities High Cost Placements (both within and outside LLR)
  - Continuing health care

For Further Information about Leicestershire's Integration Programme

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