Leicestershire County Council

Health and Wellbeing Board Annual Report 2017

Foreword

I would like to pay tribute to the excellent work of Ernie White, CC, former Chairman of the Health and Wellbeing Board who sadly passed away at the beginning of 2018. Ernie was a great advocate for health and wellbeing, passionate about the subject and particularly about the positive impact that sport and physical activity has on health and wellbeing.

2017 has been a difficult year across health and social care and I thank staff across the partnership for the effort that they have put into their work on a daily basis. We have seen real improvements in processes and team working and these are starting to bring positive changes in the services we deliver. I am confident that we will continue to make progress during 2018.

After a challenging year, it is always useful to look back and note the achievements that have been made and the improvements in performance. It is easy to lose sight of these and I welcome the opportunity to celebrate our hard work provided by this report. I would particularly highlight:-

- The roll out of our award winning Lightbulb Service, bringing together housing related services across all seven Leicestershire districts and providing a customer centred standardised delivery;
- The development of a new falls pathway for Leicester, Leicestershire and Rutland;
- Our self-care communications campaign, focused on lifestyle improvements including getting active, healthier eating and reducing the risk of diabetes.

Looking ahead, we look forward to leading integration work within Leicestershire, to reduce duplication and improve consistency in services for the people of Leicestershire. We will continue to be focused on achieving the best health and wellbeing outcomes for our local population.

Pam Posnett

Interim Cabinet Lead Member for Health

Section A: Introduction

The purpose of this report is to look back at the past year (2017) 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 of the Health and Wellbeing Board and its subgroups, 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 2017.
- A look ahead to 2018 which will involve continued focus on delivery of the Better Care Fund Plan and the refresh of the Joint Strategic Needs Assessment.

Section B: Health and Wellbeing Board Progress in 2017

1. Pharmaceutical Needs Assessment

We have a statutory requirement to prepare a Pharmaceutical Needs Assessment (PNA) for Leicestershire and publish it by March 2018. The PNA will:-

- identify the pharmaceutical services currently available and assess the need for pharmaceutical services in the future;
- inform the planning and commissioning of pharmacy services by identifying which services should be commissioned for local people, within available resources, and where these services should be;
- inform decision making in response to applications made to NHS England by pharmacists and dispensing doctors to provide a new pharmacy.

In September, a 60 day consultation on the PNA commenced. It closed on 31 December. The responses to the questionnaire will now be analysed and a summary of feedback from attendance at meetings and patient groups will be included in a consultation summary report. This summary will be used to populate the consultation results section of the PNA document. The consultation report will be taken into account in further developing the gap analysis and recommendations sections of the final PNA document.

We look forward to seeing the final version of PNA at our meeting in March 2018.

2. Health and Wellbeing Board Achievements and Outcomes

Better Care Fund Refresh

Throughout the year, we received regular updates on the refresh of the Better Care Fund. In March, the Government announced that it had allocated additional resources to the County Council for adult social care. The Better Care Fund policy framework required this to be incorporated into the Better Care Fund Plan and we were pleased to be able to allocate this money to support hospital discharge, adult social care service capacity and the Home First Workstream of the Sustainability and Transformation Plan.

In July, we were made aware of the greater focus on improving delayed transfers of care (DTOC). In September we were told that plans that did not meet the NHS DTOC target, such as ours, would automatically be rated as not approved. A revision to the DTOC target, to make it compliant with NHS requirements, was agreed by partners in October.

It is statistically unlikely that the revised DTOC target will be met although we have been assured that due to the improved DTOC performance there would be no impact

on the Improved Better Care Fund allocation during 2018/19. Nonetheless, we will continue to be closely monitoring performance to ensure that the actions being taken are having the desired effect. The Integration Executive will also have a continued focus in this area.

Summary Care Record

We recognise the need for improved record sharing between different parts of the NHS and between the NHS and social care. We have therefore taken an interest in the development of the summary care record. This shares important summary information about patients and the care they are already receiving in an electronic record, based on source data from GP records, with other health and social care professionals, subject to the patient having given their explicit consent. We have all agreed to act as champions for the Summary Care Record and give consent to our data being shared through this means.

We had some concerns that feedback from GPs regarding the quality of the Summary Care Record had not been addressed, however we were subsequently assured that GP practices could submit a request for changes to be made to the template and that, where this was not possible, reasons would be given.

Radio Wellbeing

We were really pleased to hear about the development of a community radio station, created by the voluntary sector, to promote health and social care issues in Leicestershire. It will do this by aligning its content to the health and wellbeing priorities of partners. The application for an OFCOM wide-area license has recently been approved and the station should be fully operational by September 2018. All partners are providing support in terms of content and integrating the radio station with existing IT programmes. The County Council is also providing practical support to help the station become operational. We look forward to the next stage of development for this exciting project.

3. Self-Care Communications Campaign

In November we launched a ‘Self-Care’ communications campaign across the county, working with partner organisations.

One of our key priorities is ‘Supporting people to avoid ill health, particularly those most at risk, by facilitating solutions, shifting to prevention, early identification and intervention’. Our Joint Health and Wellbeing Strategy for 2017-2022 outlines a vision to “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”

Self-care covers many areas, but overall it is about an individual looking after themselves in a healthy way. It can include getting people to live healthier lives by

quitting smoking, drinking sensibly or exercising more. The term is also used to cover taking medications, treating minor ailments and knowing when and how best to seek help.

Our campaign focuses on lifestyle improvement including getting active, healthier eating and reducing the risk of diabetes. It will also support and integrate the work of existing individual campaigns that address key areas of self-care and are seasonal including falls prevention, staying warm and celebrating safely.

The initial areas of focus included:

- **Healthy living** – Encouraging **activity** through walking, promoting **healthy eating** and raising awareness of **how to stay safe and well.**.
- **Long term conditions** – **diabetes**. In 2017, Leicestershire performed significantly worse than the England average for recorded diabetes.
- **Self-care options** – signposting to **local healthcare services** and awareness of county wide opportunities to engage in a healthier lifestyle.

4. The work of our subgroups

a. Integration Executive

Integration and the Better Care Fund

The Better Care Fund (BCF) is a pooled budget of £52million between the Clinical Commissioning Groups (CCGs) and the County Council targeted at improving the integration of health and care. The Health and Wellbeing Board has responsibility for approving the BCF for submission to NHS England and plans arising from this.

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.

Our performance and achievements in relation to the BCF during 2017 is set out below:-

- The national delayed transfer of care target set by NHS England is that no more than 3.5% of occupied bed days should be coded as delayed nationally, by November 2017. In Leicestershire, this translated to no more than 6.84 bed days delayed per 100,000 population by November 2017. In November, there was a total of 8.0 average days delayed per 100,000 against the target.
- Health and care partners across Leicester, Leicestershire and Rutland (LLR) are working hard to deliver improvements to transfer out of hospital and reduce delayed transfers of care. In Leicestershire, we have focused in particular on delays affecting patients in community hospitals and our mental

health and learning disabilities services. An LLR wide action plan is in place which has been based on analysing LLR's position against the high impact changes framework for hospital discharge.

- A major local development within the action plan is the new Integrated Discharge Team (IDT), which started in July 2017 at University Hospital Leicester. The IDT is an integrated multi-disciplinary and multi-agency discharge service within some of the busiest wards at the Leicester Royal Infirmary, providing expert discharge advice and assistance to get people home as soon as they are well enough to leave the acute hospital. The IDT attend a daily board round where patient's progress is discussed and pathways towards discharge identified. If the team feel that the patient's needs are 'simple' (e.g. care package re-start) they advise and support the ward team to complete the required actions. If the patient requires assessment, or a change of services then the IDT becomes involved in the case.

- Integrated Urgent Response – during 2016/17 LLR partners worked towards a new model of integrated urgent care in line with the NHS England Five Year Forward View, through our participation in the national Urgent Care Vanguard programme. The work culminated in a procurement for a new model of service commencing in April 2017, which had the following key design principles – responsive, accessible person-centred services as close to home as possible; services wrap care around the individual, promoting self-care and independence, enhancing recovery and reablement, through integrated health and social care services that are innovative and promote care in the right setting at the right time. Also that urgent care services will consistently be available 24 hours per day, seven days a week in community and hospital settings and that clinical triage and navigation is a central part of the integrated urgent care offer, reducing demand on ambulances and acute emergency services.

- As part of the work done by the LLR Falls Steering Group, a new falls pathway has been designed. Each of the stages within the pathway has been developed into an agreed level of service that forms part of the LLR Falls Prevention and Treatment Strategy. The current programme of work includes:

    - The new falls triage and assessment process has continued across the county showing great improvements in access to therapy for patients and patient outcomes.

    - Leicestershire Partnership Trust and the County Council's Adult Social Care department are working together to develop seamless therapy and falls prevention training to care home staff.

- A needs analysis is underway for falls prevention activity across the county involving the voluntary sector.
- A video explaining how the eFRAT tool work has been developed. It explains how the app benefits both professionals and patients by ensuring that the most appropriate course of action is taken for each individual who has had a fall, to help them maintain their independence and remain in the community.

- LLR was chosen as the demonstrator site for an important East Midlands Academic Health Science Network (EMAHSN) project. This is an NHS England funded project, developing tools to help people at risk of falling look after themselves and have access to monitoring devices and equipment that will help them to maintain independence when at high risk. The work will run in tandem with the local falls programme.
- Integrated Points of Access – we currently have multiple points of access that receive referrals for health and social care community based services and admissions into and from acute hospitals. Through our integrated care work we have highlighted the need to simplify these points of access. Working together, adult health and social care teams want to provide integrated, high quality services, delivered in local community settings (where appropriate to do so). We see the creation of a single point of access for adult services as key to supporting this ambition. The aim of integrating adult service points of access is to make it as simple as possible to access health and care services without having to go through multiple services and organisations. This will not only achieve a more consistent and efficient service, bringing joined up care services to our citizens, it will also support professionals delivery care in Home First and Integrated Locality Teams to coordinate care and support in each local area.
- An options appraisal approach report was produced over the summer which outlined the key activities and outputs that would need to be considered to enable the County Council and partners to produce an options appraisal about the future assistive technology (AT) across the county. This was discussed with partners in September and it was agreed to scope a market appraisal. The market appraisal will be informed by customer segmentation and the target outcomes for customers and their families or carers. Income streams associated with AT and self-funders will also be a key consideration. In developing the future strategy, the work will also consider how solutions could assist with other functionality that supports the delivery of integrated health and care in the home and how the developments within the LLR Digital Roadmap could interface with AT.

- A new dementia service was procured across LLR during 2017, which launched in October 2017. The service offers pre and post diagnostic support and guidance for people with memory issues and/or diagnosis of dementia and to offer support and guidance also to their carer(s). The service also provides support to health and social care professionals through good partnership working and the establishment of proactive relationships.

b. Unified Prevention Board

The Unified Prevention Board oversees the development and delivery of prevention activities underpinning the health and wellbeing strategy for Leicestershire and more recently ensuring the objectives of the new Sustainability and Transformation Partnership (STP) prevention work stream are closely aligned with the Leicestershire prevention strategy, and are jointly delivered locally as needed across Leicestershire.

Between April and September 2017 the UPB discussed and agreed four key outcome pillars that it was felt all partners contributed to in helping residents maintain their own health and wellbeing. These are:

- Keep Well;
- Keep Safe;
- Stay Independent; and
- Enjoy life

Three cross-cutting programmes of work were identified as the focus in developing the unified prevention offer:

- Joined Up Communications – in June the self-care campaign and accompanying strategy was agreed. This covered many areas, but overall was about an individual looking after themselves in a healthy way. This aimed to re-enforce national and local public health messages, drive support and participation in self-care and to encourage behaviour change and perception through self-care actions and increase awareness and understanding of how to navigate the healthcare system

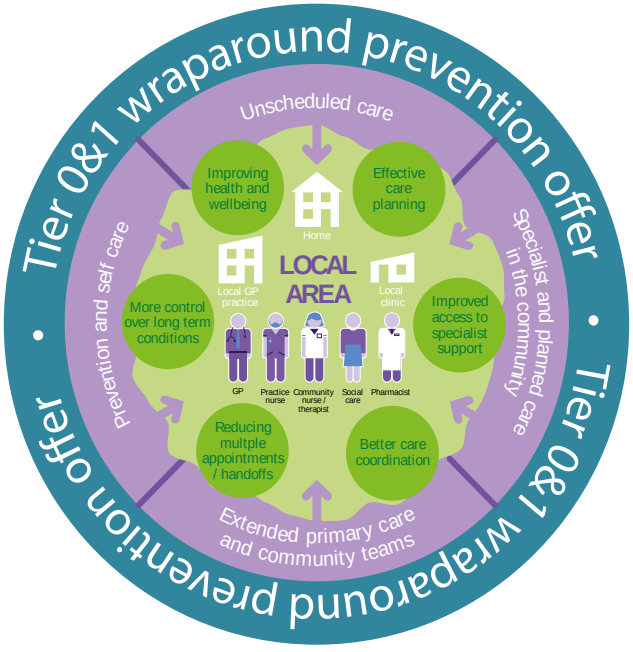
- Lessons Learned from key integration programmes – In September the board focused on learning from a project called Braunstone Blues which brought together all three blue light services in an area of high service need to support the community and to develop positive outcomes

- Healthy Workforce = Healthy Leicestershire – In November the UPB endorsed a programme of work across the partner organisations to make their workforces happier and healthier by encouraging activity and fitness in the work place.

From October to December, the UPB has been working on requirements to support the social prescribing model for Leicestershire. The local definition for social prescribing was agreed in April 2017 as:

“A mechanism for empowering people to help themselves and link individuals that need it, with non-medical sources of support within the community. It will ensure that the response given is appropriate to the individual and allows them choice and influence over their wellbeing”.

In 2017 work began to develop the social prescribing model as the wrap-around prevention offer to support Integrated Locality Teams (ILT). This will initially focus around pockets of need e.g. people with multiple long-term conditions.



- Tier 0 focuses on building community capacity enabling to support themselves; building skills and infrastructure enabling them to rely less on specific services.

- Tier 1 focuses on supporting people to remain independent, supporting good health and wellbeing and offering information and advice services to support self-help.

First Contact

First Contact and First Contact Plus is the front door for this offer linking patients to a wide range of county and locality based support services. The scheme offers access to a range of low level preventative services through a single point of contact.

From April 2017, the warm home service was integrated into First Contact Plus. The aim of this service is to minimise the effects of fuel poverty and cold homes on people's health and well-being whilst raising awareness among professionals and the public about the impact of fuel poverty and how to keep warm at home. There are two levels of support available.

Local Area Co-ordination

As well as First Contact, Local Area Co-ordinators helps link people to their community helping to engage with support provided by charities, district councils and volunteers and volunteering opportunities. In 2017 the service was expanded and there are now 22 co-ordinators in place across Leicestershire.

Lightbulb

The countywide roll out of the Lightbulb integrated housing support service took place in October 2017. This brings together housing related services across all seven Leicestershire districts/boroughs that cover the county and will provide a customer centred standardised delivery. Staff recruited to the new service had a 'Big Welcome' event in September to induct them and welcome them into the new culture and new way of delivering the service.

The service also includes the hospital housing discharge service based at Leicester Royal Infirmary and the Bradgate Mental Health Unit, working closely with the integrated discharge team to support patients with a range of housing solutions so they can return home from hospital.

Lightbulb became an award winning service, having won the Best Collaborative Working Initiative at the Association for Public Service Excellence (APSE) Annual Service Awards in September 2017.

Case Study:

Mr S had a lot of difficulty with walking due to chronic ulcers on his legs. This made it impossible to climb the stairs and therefore, to access the bathroom due to its small size and difficult lay out. Mr S was confined to a downstairs existence with a bed located downstairs and unable to access the bathroom or toilet.

The Housing Support Co-ordinator helped Mr S to apply for a Disabled Facilities Grant. Mr S was assessed as having to make a large contribution to the grant for the works required. However, this was not possible as they had

already incurred debts they were struggling to pay off due to retiring early because of ill health and continued mortgage payments. They were supported to apply for Carers Allowance for Mrs S which reduced the contribution to the grant and they applied to Leicester Charity Link for a grant to make up some of the shortfall. They referred Mr S onto Grocer Aid charity as Mr S had been a Baker for most of his working life. They supplied Mr S with most of the contribution money to the grant and will provide a quarterly amount of money going forward for a hardship allowance. Work on the required adaptations to their home has been completed and Lightbulb has been able to give Mr S access to bathing facilities for the first time in many years. Mr and Mrs S are delighted with the outcome as this has given Mr S his dignity back and has improved his mental health. Mrs S was very pleased to be helped through the process and by the partner charities involved.

c. Children and Families Partnership

Work throughout the year has continued on producing a Children and Young People's Plan for Leicestershire. A workshop of the Partnership was held in August for partners to look at creating a strategic document which partners could commit to. At this workshop, partners agreed that the vision for the Children and Families Plan would be:

"Children and young people in Leicestershire are safe and living in families where the can achieve their full potential."

Partners also reviewed the five outcomes within the Plan and agreed that these should be:

1. Ensure the best start in life
2. Safe and free from harm
3. Support families to be self-sufficient and resilient
4. Ensure families receive personalised, integrated care and support
5. Enable children to have good physical and mental health.

The draft Plan was presented to the Partnership meeting in September, and was also circulated to members of the Health and Wellbeing Board for approval. Further progress was reported at the Partnership meeting in November. Leads for each of the outcomes have now been agreed, and task and finish groups were due to take place before the next meeting in January where a development session was being held to provide an update on each outcome and to finalise the work to produce the Plan. Following this, a one page document highlighting the key elements of the Plan would be finalised and presented.

Public engagement on the outcomes within the Plan has taken place. Further engagement would take place, in particular with children and young people, to ask how the priorities within the Plan could best be delivered.

Although the main focus for the Partnership this year has been the production of the Plan, other items have been discussed, including details of the transformation of the Children and Families Department. A work programme for meetings in 2018 has been developed and includes a wide range of items

5. Health and Wellbeing Board Development

We held two Development Sessions for the Board during 2017. These enable us to comment on and contribute to a number of cross cutting strategies such as Integrated Locality Teams, the Children and Families Plan and the Whole Life Disability Strategy as well as to share commissioning intentions for 2018. It is clear from these sessions that Board members had concerns around the duplication of work, governance arrangements and the need for consistent partnership models, commissioning approaches and information sharing. We felt that the Health and Wellbeing Board could collectively do more to mitigate risk and track progress in delivering our priorities. This will be the focus of our development sessions during 2018.

6. 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:-

<u>Fibromyalgia: It's not in my head</u>

Healthwatch Leicestershire launched a survey to gather experiences of people suffering from Fibromyalgia. They were overwhelmed with the volume of responses and in total 950 individuals with Fibromyalgia completed their survey. 291 responses from LLR, 605 from individuals living elsewhere in the UK and 54 individuals did not provide information of where they live.

The report was presented to the Health and Wellbeing Board at the June meeting and highlights how people feel about services, for example:

- Fibromyalgia impacts on individual's quality of life and limits their chances for education, employment and social life. Individuals are sometimes left unable to

perform routine chores and look after personal care needs such as eating, bathing and dressing.

- The majority of respondents had not experienced misdiagnosis, however, that over half of respondents from LLR and the UK were not offered information by the NHS on living with Fibromyalgia.
- The length of time taken for a diagnosis contributes to their isolation and frustrations. Despite waiting a long time for diagnosis, there were contradictory views on individual experiences with their GP.
- Nearly a quarter of LLR respondents and almost a fifth of UK respondents stated that they did not see their GP regarding Fibromyalgia because they feel their GP is not supportive or knowledgeable of their condition.

Healthwatch Leicestershire in partnership with the Shuttlewood Clarke Foundation and University Hospitals of Leicester NHS Trust, produced a jointly badged Top 10 Tips poster for those living with the condition. Copies of the poster were mailed to GP practices across Leicester, Leicestershire and Rutland to display and use as a reference.

Board members agreed that the condition was poorly understood by all, including GPs, and felt that the 'top ten tips' section of the report was very useful.

Annual Report 2016/17

Healthwatch Leicestershire presented its Annual Review for 2016-17. This reported on the activities undertaken over the last year, and demonstrated the impact that these were having on the commissioning, provision and management of local health and social care services.

Healthwatch Leicestershire reported that they had exceeded their performance targets over the past year, and the reports and publications produced had been very well received by stakeholders and the Health and Wellbeing Board.

Check-in @ the new Emergency Department

The Health and Wellbeing Board considered a report from Healthwatch Leicestershire presenting the findings from a survey of patients undertaken at the new Adult's Emergency Department at the Leicester Royal Infirmary (LRI).

Having visited the previous A&E, Healthwatch had spent twelve hours in the new department in May 2017.

The emerging findings from the report were:

- Almost two thirds of patients had tried to seek help elsewhere before arriving at the Emergency Department, and a third of patients had been advised to attend by their GP.
- Almost two thirds (67%) of patients told us that they had arrived by car. Although 43% of patients reported to having a 'good' experience of parking, a third (31%) rated their experience as poor, sighting the distance from ED as the main issue.
- An overwhelming 85% of patients rated the check in process as 'good', with only 5% rating it as 'poor'. Although, when we asked patients if they think that they were given enough information about what will happen next, over a third (37%) said no or not sure.

A number of recommendations had arisen out of the report which UHL welcomed and responded to, in the form of an action plan, which was circulated to members of the Board. The report also received media attention including a segment on East Midlands Today.

Your views about GP Services

During the months of August and September 2017, Healthwatch Leicestershire promoted a quick poll survey with questions around GP services, such as online services for registered patients, referrals for support and treatment and support for Carers.

Healthwatch heard from 240 local people and the findings were presented at the November meeting of the Health and Wellbeing Board and outlined that:

- The majority of respondents reported that they were aware that their GP practice offers an online booking service, which many had used.
- All but a small minority of respondents said they would not mind seeing a Specialist Nurse instead of a GP.
- A majority of Carers who responded to this survey have not been able to access useful information about support.

80% of respondents to the Healthwatch survey were satisfied with their GP practice. The quick poll report was shared with East Leicestershire and Rutland CCG and West Leicestershire CCG as well as the wider health network.

The Board noted the findings to urge health and social care partners to consider actions associated to the report recommendations to improve services, systems and processes outlined in the findings report.

Section C: Looking forward to 2018

1. Delivering our Vision and Strategy

Our vision is “to 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.” To deliver this during 2018 we will be focussing on goals that have the most potential to reduce health inequalities; that require collaborative working across the partnership and which will have the greatest impact on Leicestershire people. We will also seek to make the best use of resources, aiming to invest in early intervention to avoid higher costs in the future.

2. JSNA refresh

During 2018, we will need to start the refresh of the Joint Strategic Needs Assessment (JSNA). This is the data that informs our strategy and vision so it is vital that it is kept up to date and relevant. It also helps to determine what actions the local authority, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing.

We are proposing to refresh all chapters in an iterative process over the next three years. We expect the first tranche of refreshed chapters to be completed by the summer of 2018. We will align the JSNA to Leicestershire County Council’s Strategic Outcomes Framework. Its outputs will be:

- Subject-specific chapters of an assessment of current and future health and social care needs;
- An infographic summary of each chapter;
- A data dashboard that is updated on a quarterly basis to allow users to self-serve high level data requests.

3. Better Care Fund

Although we have received confirmation that, due to the improved performance regarding Delayed Transfers of Care there will be no impact on the Improved Better Care Fund allocation in 2018/19, we will continue to monitor performance closely in this area, to assure ourselves that the actions being taken continue to have the desired effect. It will also be important to ensure that there is a continued focus on delivery of the other three metrics within the Better Care Fund, which relate to the number of permanent admissions of older people (aged 65 and over) to residential and nursing care homes, the proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement/ rehabilitation services and the total number of non-elective admissions into hospital (general and acute).