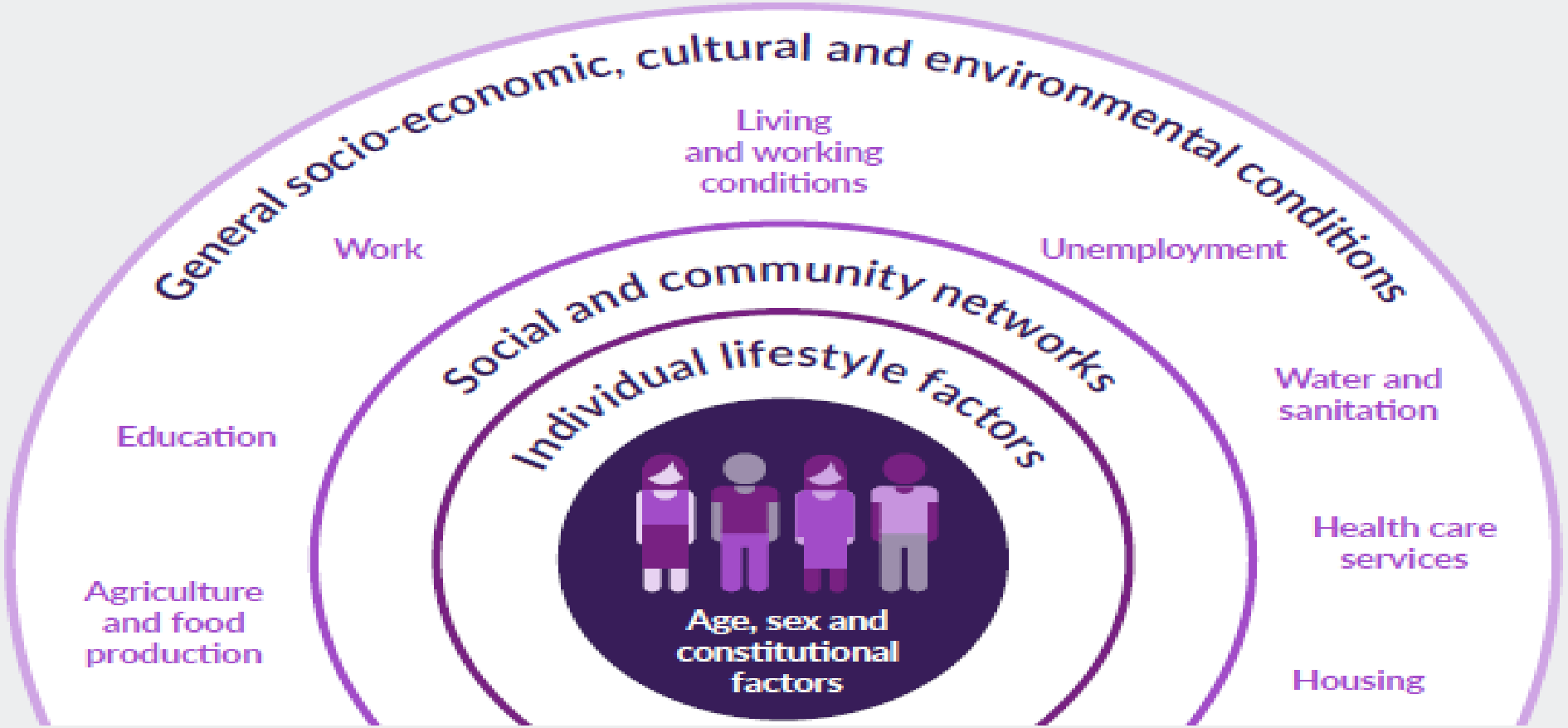
Health and Wellbeing Board Development Session
December 5, 2019

Welcome
Councillor Lee Breckon (Chair)

An Overview of the Leicestershire Joint Health and Wellbeing Strategy 2017 – 2022

Mike Sandys
Director of Public Health

Figure 1 What affects our health?



Source: Dahlgren and Whitehead (1993), cited in The King's Fund (2013)

Shared Vision and Board Principles

Developed in response to the consensus that the Health and Wellbeing Board needs:

- More effective collaboration to get the best outcomes and use of resources
- A joint vision and shared aims and ambition
- To take a proactive approach to the issues particularly where progress is not on track

Outcomes Based Approach

1. The people of Leicestershire are able to take responsibility for 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 potential and have good health and wellbeing;
4. People plan ahead to age well and stay healthy and older people feel they have a good quality of life;
5. People know how to take care of the mental health and wellbeing of themselves and their family

Outcome 1

The people of Leicestershire take responsibility for their own health and our communities inspire and enable good choices for all

We will:

- Use our influence to improve the external factors that affect people's health and wellbeing focussing on housing and employment.
- Inform and advise people on how to stay well and provide targeted support for those most at risk of poor health and wellbeing
- Provide care closer to home and enable local communities to help themselves through strong and vibrant community networks
- Recognise, value, involve and support carers of all ages

Outcome 2

The gap between health outcomes for different people and places has reduced

We will:

- Improve our understanding of the people with the worst health outcomes and most at risk; who they are and where they are
- Use evidence to improve the targeting of activity to reduce health inequality between people and places based on local need
- Work in partnership to improve outcomes for people with disabilities throughout their lives

Outcome 3

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

We will:

- Ensure the best start in life for children and their families
- Work proactively in partnership to keep children and young people safe and free from harm and sexual exploitation
- Support those families identified as most troubled to become self-sufficient and resilient
- Ensure children with special educational needs and/or disabilities, and their families receive personalised, integrated care and support to become increasingly independent.
- Ensure children in care experience good physical and mental health

Outcome 4

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

We will:

- Improve the diagnosis and management of long term conditions
- Plan for the ageing population and the needs of the increasing number of frail, elderly people
- Enable older people to keep safe, well and healthy with independence and connection to their community
- Encourage people to plan for the end of their life and support their choices

Outcome 5

Mental health and wellbeing is given equal priority to physical health and wellbeing throughout the life course

We will:

- Provide positive mental health promotion and improve awareness of risk factors
- Improve access to mental health services for all ages
- Increase the early detection and treatment of mental health and wellbeing needs of children and young people with
- Improve dementia diagnosis and support

What is population health management and what can population health insights tell us about priorities for Leicestershire?

Dr Ursula Montgomery
Chair, East Leicestershire and Rutland CCG
&
Professor Cheryl Davenport
Director of Health and Care Integration

Population Health...

...is an approach aimed at **improving the health of an entire population**

It is about improving the physical and mental health outcomes and wellbeing of people, whilst reducing health inequalities within and across a defined population

It includes action to reduce the occurrence of ill-health, including addressing wider determinants of health, and requires working with communities and partner agencies

Population Health *Management*...

...improves population health by **data driven planning and delivery of proactive care to achieve maximum impact**

It includes segmentation, stratification and impactabilty modelling to identify local 'at risk' cohorts - and, in turn, designing and targeting interventions to prevent ill-health and to improve care and support for people with ongoing health conditions and reducing unwarranted variations in outcomes

Taking a population health management (PHM) approach is intended to achieve better health and care outcomes and tackle inequalities

As such, it is core business for health and wellbeing boards and their placed based populations

THE POPULATION HEALTH MANAGEMENT (PHM) APPROACH IN LLR

PHM is not a separate process or project

It is about the way we work and collaborate at all 3 tiers of the health and care system to achieve the best possible outcomes for our population(s) - e.g. LLR - wide, in the Place of Leicestershire, or at the Neighbourhood level.

PHM is not new

However the NHS Long Term Plan and the move to Integrated Care Systems means we need to adopt this approach much more successfully and systematically than before – which involves:

- Reaching a better understanding of the characteristics and needs of our population(s), using data and insights gathered from across multiple agencies
- Segmenting the population, to identify groupings for targeted interventions
- Applying the most optimum and cost effective interventions to our population(s), whether these are to be targeted or universally applied
- Changing health and care pathways, and the way our workforce operates, to deliver the optimum interventions
- Measuring the impact on population health and wellbeing outcomes

See Also Handout Appendix A – Key PHM Messages for LLR

PHM activities at System Level in LLR

We are already undertaking a number of PHM activities in LLR

However we have not embedded PHM as business as usual, either operationally or culturally, and we have some significant gaps to address in our tools, resources and ways of working, in order to deliver this comprehensively.

System (LLR) - led by Better Care Together Strategy & STP PMO

- **LLR population segmentation**
- **STP Outcomes Dashboard**
- **Identification of LLR Priority Outcomes – by January 2020**
- **To include targeted work on health inequalities across LLR**

PHM activities at Place Level in LLR

Place – led by the HWB Board's Joint Health and Wellbeing Strategy & Public Health

- Population segmentation at Leicestershire Level
- Multiagency, integrated view of local population's health and wellbeing needs
- Insights from (for example) Leicestershire Health Profiles and JSNA (e.g. see new material on frailty and multimorbidity)
- Lead focused areas of work within/across the partnership in response
- Delivery of targeted resources, communications and interventions to improve health and wellbeing outcomes for place based population(s)
- Identify Priority Outcomes at Place (the what) and then reflect in and action via the Joint Health and Wellbeing Strategy (the how)
- Place based Outcomes Dashboard to track progress

Overview of existing PHM activities at Neighbourhood Level in LLR

- Implementation of “PCN Intelligence Packets” (PIPs)
- Stratifying the population in each PCN (via ACG tool)
- Case finding for GPs and neighbourhood teams - case loads/types for active care coordination, those to signpost and refer to social prescribing
- Targeting interventions to segmented populations including multimorbidity
- Examining variation at the scale of 30-50k population, and by GP practice
- Measuring the impact on admissions avoidance/emergency admissions
- Measuring levels of referral/adherence to referral criteria and overall and demand management for planned care,
- Tracking the impact of interventions on selected cohorts of patients

LLR PCNs Intelligence Packets

…….moving from our existing clinical data sets
to achieve an integrated set of insights about our population(s)

This Neighbourhood level PHM work is already in progress
led by Primary Care and the Mids and Lancs CSU

PCN Intelligence Pack, currently combine 3 main components…

NHS
Midlands and Lancashire
Commissioning Support Unit

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LLR INTELLIGENCE PACKS

QUALITY AND OUTCOMES FRAMEWORK

BIG RETURN DATA

LLR INTELLIGENCE PACKS

LLR Intelligence Pack

Midlands and Lancashire Commissioning Support Unit

Click the Arrows to navigate to....

- Care Homes Dashboard
- A&E Dashboard
- Emergency Admissions Dashboard
- Bed Bureau Dashboard
- All Outpatients Dashboard
- Outpatient First Appointment Dashboard
- Outpatient Top 10 Specialty Dashboard
- Advice & Guidance Dashboard
- PRISM Dashboard
- E-Referrals Dashboard
- Urgent Care Dashboard
- Home Visiting Service Dashboard

Go Back to Front Sheet

User Guide → USER GUIDE

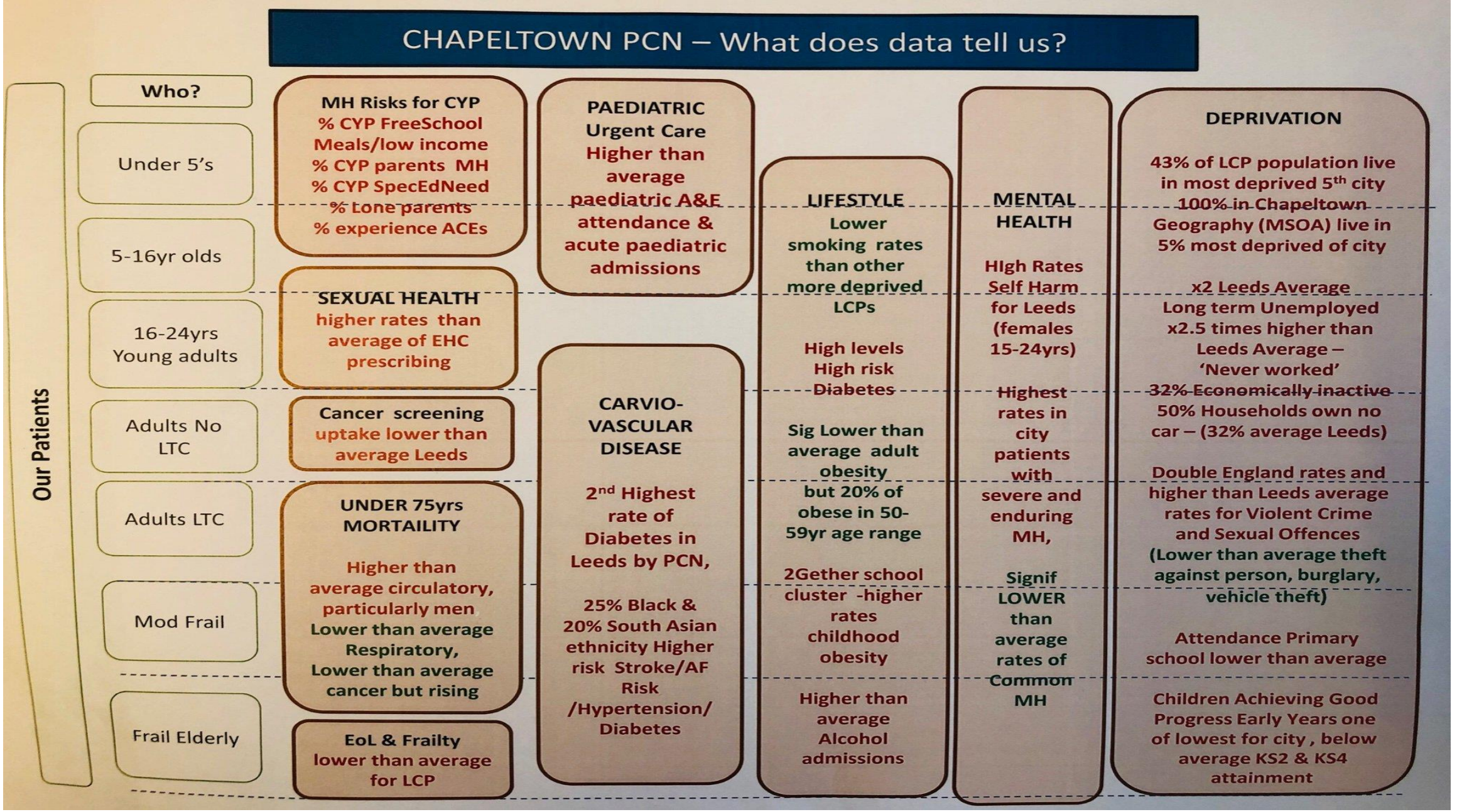
Data Source Information → Data Schema

Click Below to Filter By: Financial Year & Locality

Financial Year: 2018-19

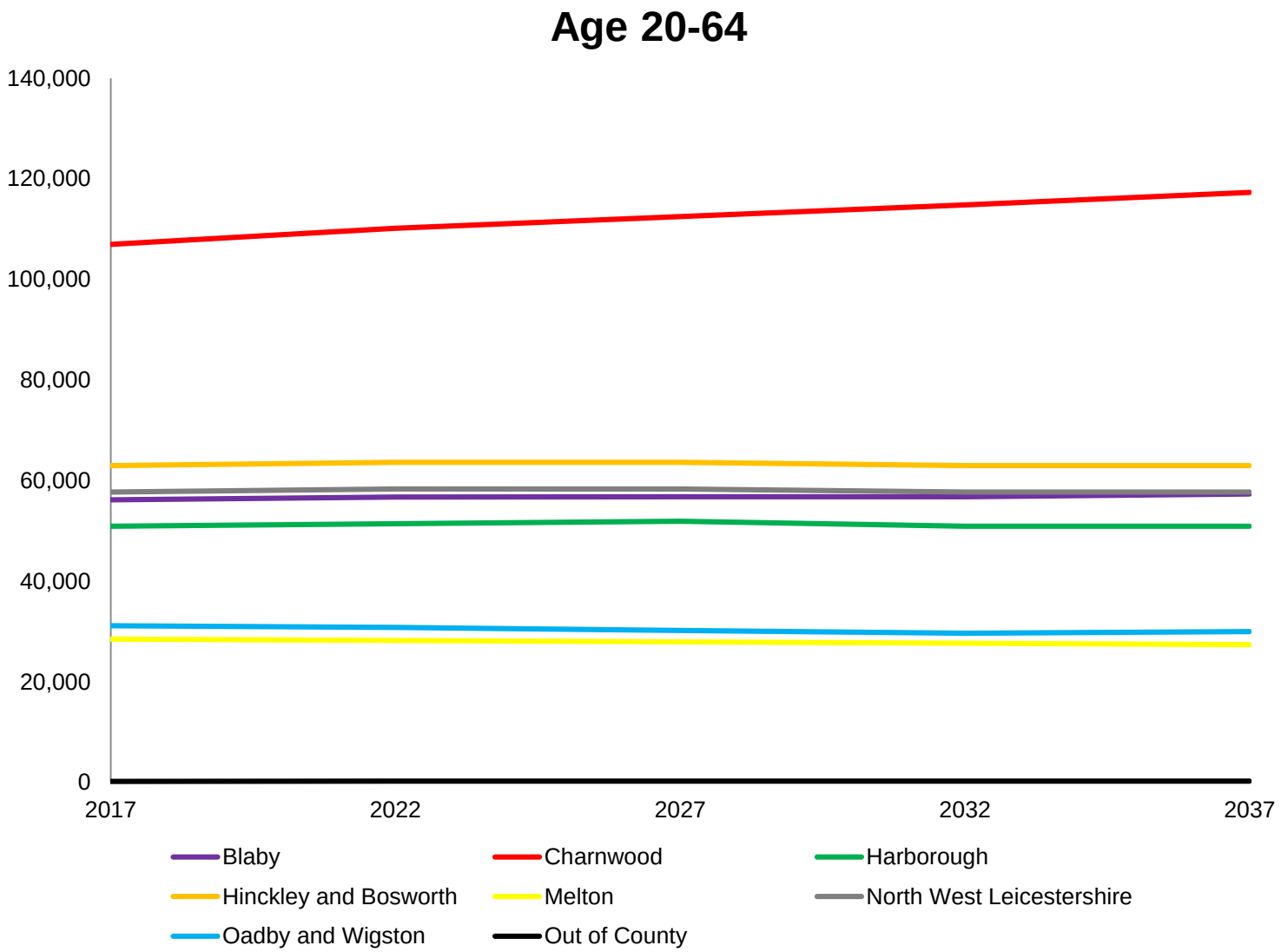
PCN: MILLENNIUM PCN

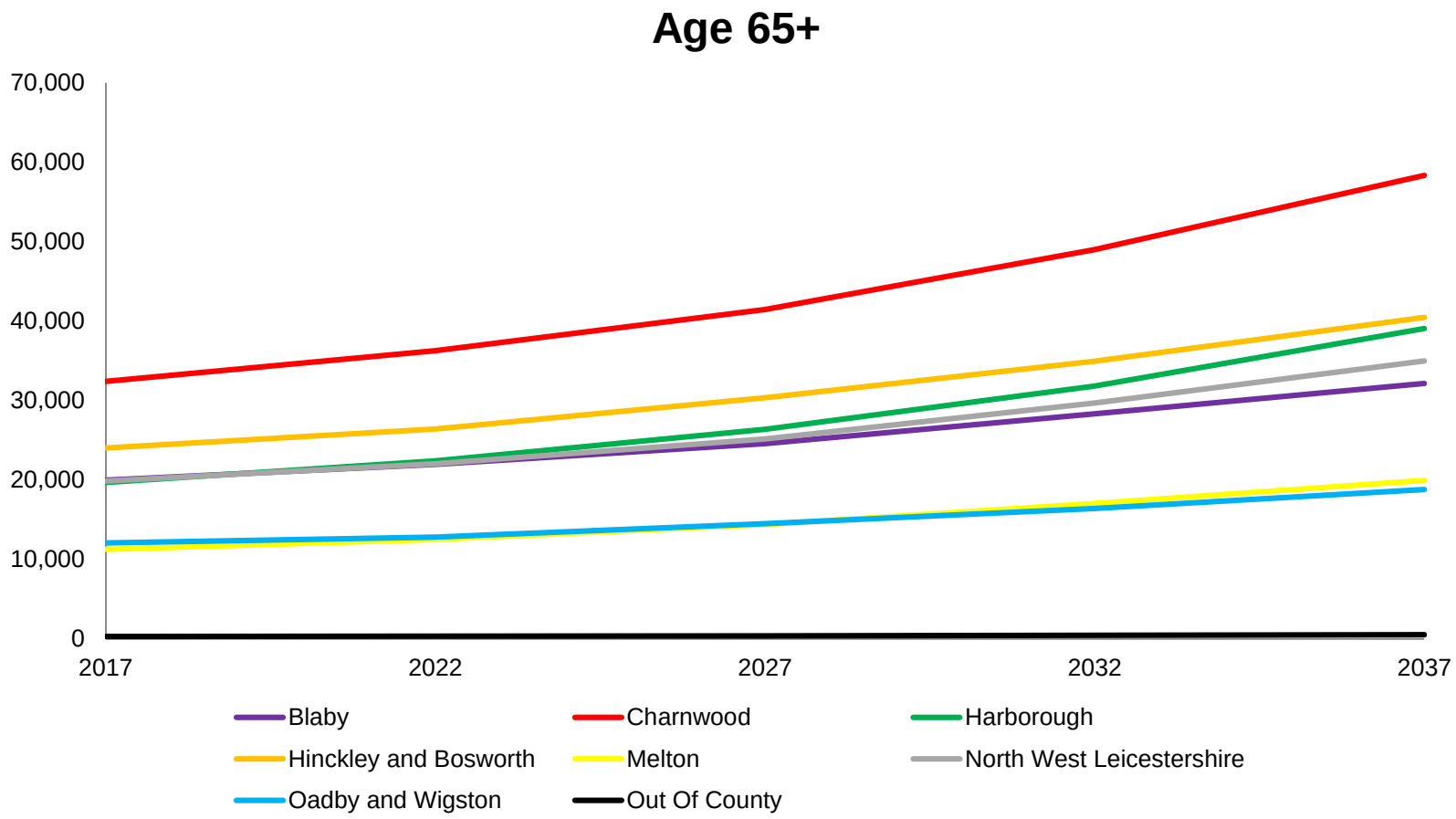
How could an integrated set of PCN insights look, including wider determinants data?


CHAPELTOWN PCN – What does data tell us?
Our Patients
Who?
Under 5's
5-16yr olds
16-24yrs Young adults
Adults No LTC
Adults LTC
Mod Frail
Frail Elderly
MH Risks for CYP
% CYP FreeSchool Meals/low income
% CYP parents MH
% CYP SpecEdNeed
% Lone parents
% experience ACEs
SEXUAL HEALTH
higher rates than average of EHC prescribing
Cancer screening uptake lower than average Leeds
UNDER 75yrs MORTAILITY
Higher than average circulatory, particularly men
Lower than average Respiratory,
Lower than average cancer but rising
EoL & Frailty lower than average for LCP
PAEDIATRIC Urgent Care
Higher than average paediatric A&E attendance & acute paediatric admissions
CARVIO-VASCULAR DISEASE
2nd Highest rate of Diabetes in Leeds by PCN,
25% Black & 20% South Asian ethnicity Higher risk Stroke/AF Risk /Hypertension/ Diabetes
LIFESTYLE
Lower smoking rates than other more deprived LCPs
High levels High risk Diabetes
Sig Lower than average adult obesity
but 20% of obese in 50-59yr age range
2Gether school cluster -higher rates childhood obesity
Higher than average Alcohol admissions
MENTAL HEALTH
HIgh Rates Self Harm for Leeds (females 15-24yrs)
Highest rates in city patients with severe and enduring MH,
Signif LOWER than average rates of Common MH
DEPRIVATION
43% of LCP population live in most deprived 5th city
100% in Chapeltown Geography (MSOA) live in 5% most deprived of city
x2 Leeds Average
Long term Unemployed x2.5 times higher than Leeds Average – 'Never worked'
32% Economically inactive
50% Households own no car – (32% average Leeds)
Double England rates and higher than Leeds average rates for Violent Crime and Sexual Offences
(Lower than average theft against person, burglary, vehicle theft)
Attendance Primary school lower than average
Children Achieving Good Progress Early Years one of lowest for city , below average KS2 & KS4 attainment

What about population insights related to adult social care?

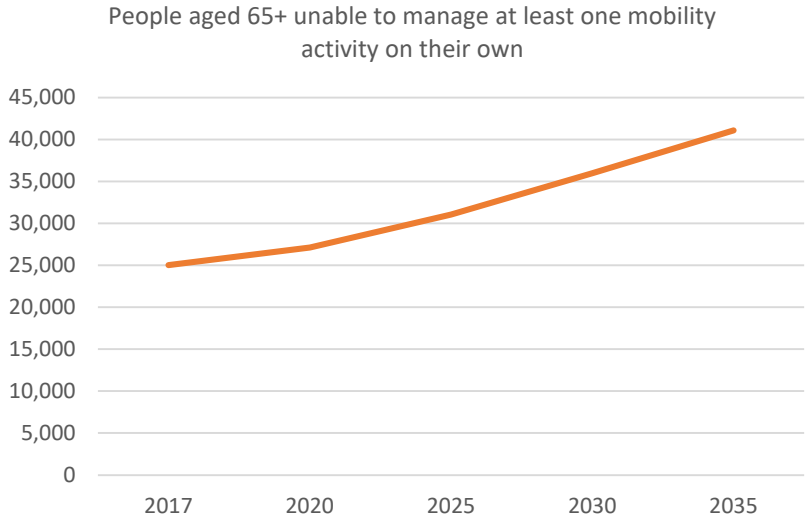
Population Change Forecasts 2017-2037




Age 65+
70,000
60,000
50,000
40,000
30,000
20,000
10,000
0
2017
2022
2027
2032
2037
Blaby
Charnwood
Harborough
Hinckley and Bosworth
Melton
North West Leicestershire
Oadby and Wigston
Out Of County

Those in need of help at home

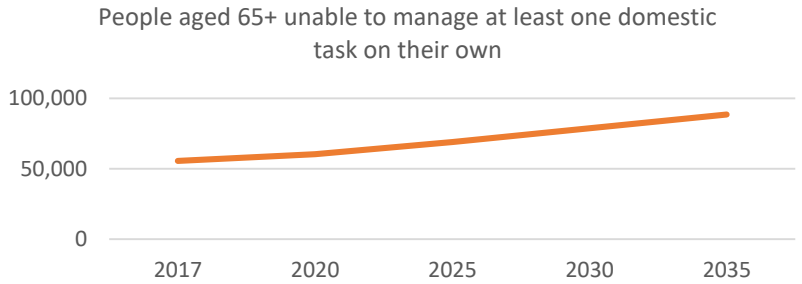
Mobility



- The number of people aged 65 and over who are unable to manage at least one mobility activity on their own in Leicestershire is predicted to increase 64% from 25,035 in 2017 to 41,082 in 2035.

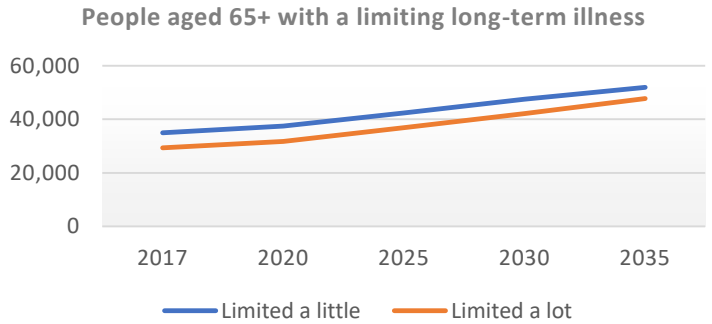
- This includes activities such as: going outdoors and walking down the road; getting up and down stairs; getting around the house; getting to the toilet; getting in and out of bed.

Managing Domestic Tasks



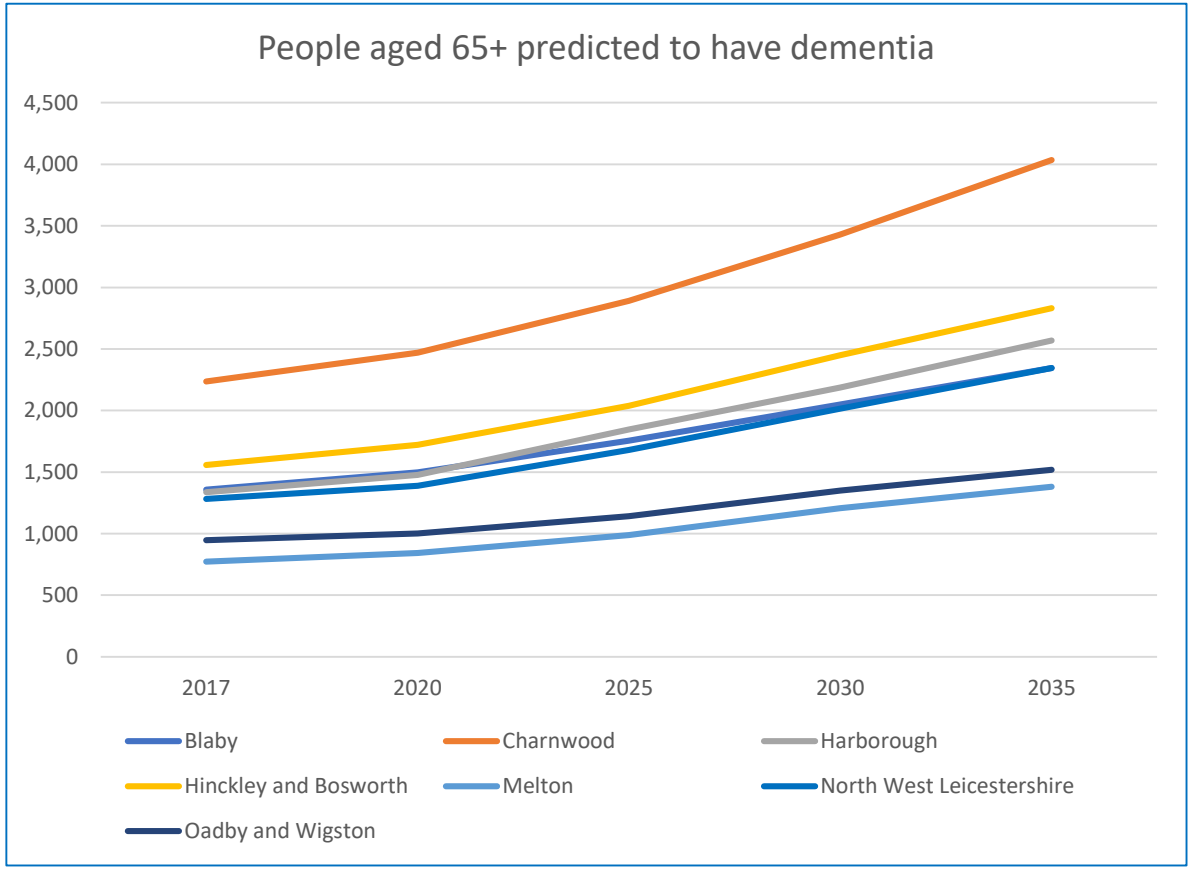
- The number of people aged 65+ who are unable to manage at least one domestic task on their own in Leicestershire is predicted to rise 59% from 55,629 in 2017 to 88,531 people in 2035.

People aged 65+ with a limiting long-term illness



The number of people aged 65+ in Leicestershire whose life is limited a little is expected to increase by 49% between 2017 and 2035, and those who are expected to increase a lot is expected to increase by 63% over the same time period.

Dementia prevalence



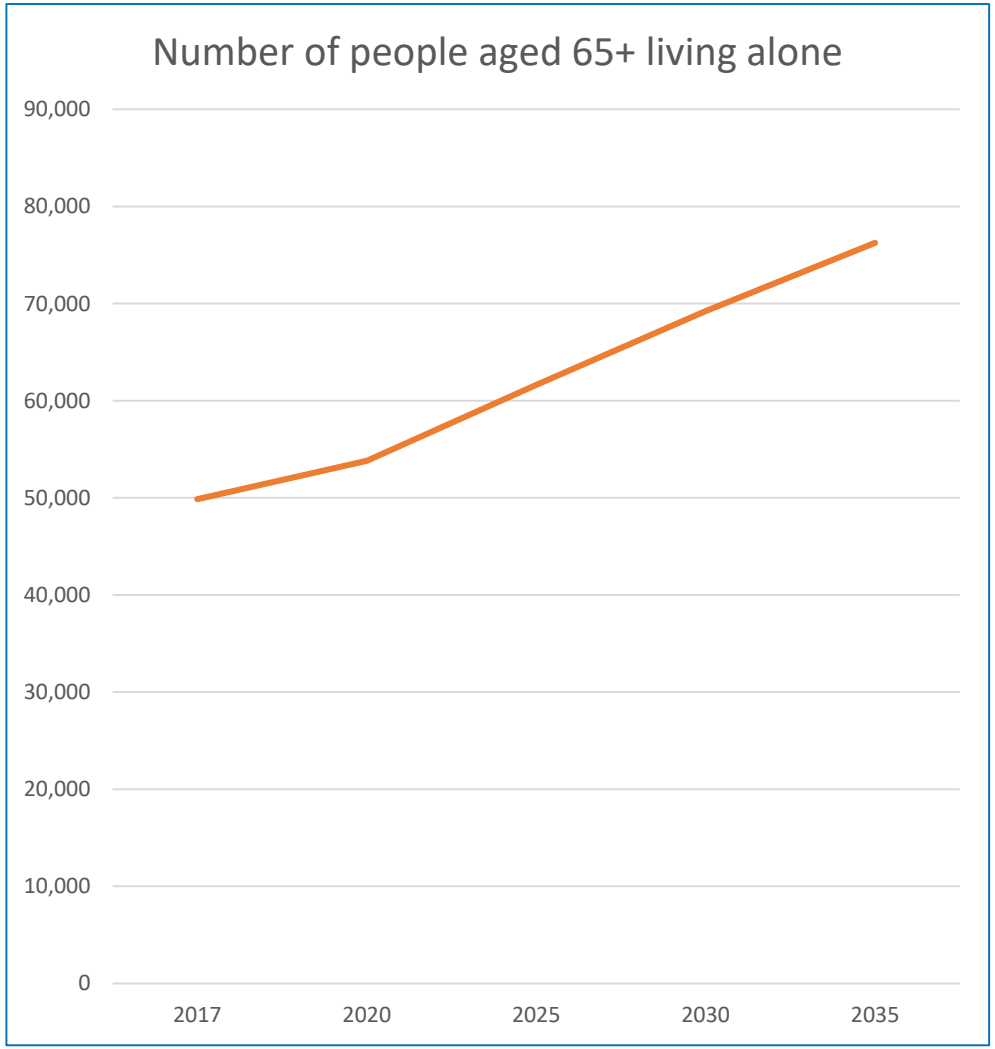
- There are currently 9,458 people in Leicestershire aged 65+ predicted to have dementia.
- This number is expected to rise by 80% to 17,028 by 2035. (POPPI)

- 1 in every 14 of the population over 65 years has dementia. (LLR Dementia Strategy).
- In Leicestershire there is a 4.3% prevalence rate of dementia in 65+ based on % of practice register (JSNA dashboard.
- The national estimate of the percentage of people in care homes with dementia is 80%.
- Local data snapshot - In December 2018 there were 1,020 people with a diagnosis of dementia 65+ funded in care homes (57% of the total 1,781 65+ placements). Note this does not include self funders or Continuing Health Care clients.

Links

- POPPI – dementia statistics
- Kings Fund – dementia friendly homes design checking list
- Build Guidance

65+ Tenure & Household Type



The number of people aged 65+ in Leicestershire who live alone is expected to increase by 53% from 49,868 in 2017 to 76,272 in 2035.

- The majority of older 65+ residents of Leicestershire own their homes outright (75%).
- Rate of home ownership ranges from 70% in Melton and North West Leicestershire to 80% in Oadby & Wigston; this cohort would be expected to fund their own care and would not be eligible to receive LCC financial support for social care.
- The next biggest category countywide is social rented (local authority) 8%; and a further 4% of people rent from another type of social landlord.

Group Work

A reminder of the main sources of data and measures for Leicestershire's health and wellbeing outcomes

- JSNA
- Leicestershire Health Profiles
- LLR STP Outcomes Dashboard
- Leicestershire Place Based Dashboard
- Primary Care Networks Intelligence Packs
- Other specific national data sets for wider determinants (socio-economic) e.g. mosaic, poverty rates, housing data
- Service/organisational specific data ASC, CFS, PH, NHS
- Data sets/measures relating to new policies and initiatives - e.g. Violence Reduction

Leics HWB Board Example: Mental Health

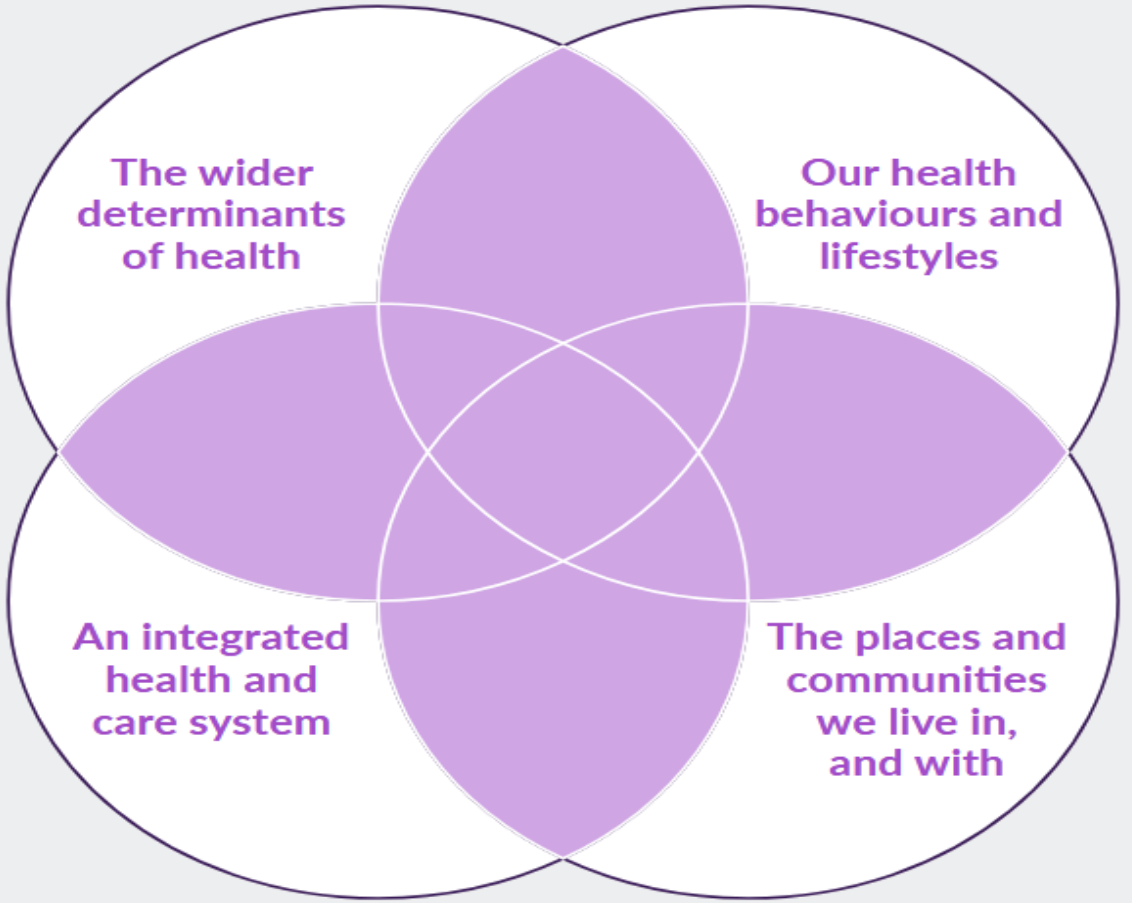
- JSNA analysis – deep dive and key insights presented at a HWB development session
- Group work on the priorities and gaps at the development session
- Multiagency Action Plan Produced –led to the focus on ACEs and the Mental Wellbeing Campaign, the need to understand the impact of the MH investment standard at place and the overall Child and Adolescent MH pathway (from early intervention to CAMHS)
- Tracking of the action plan via the Board, subsequent reports on elements of the work
- Plus work being led by integration delivery group - developing the MH community based offer with PCNs and LPT at neighbourhood level, and reflecting a sub set of priority metrics for MH in the place based dashboard

What makes for success at place?

The King's Fund identifies 4 pillars/quadrants that are needed in a population health system.

Our strategy in the Leicestershire "Place" needs to consider all 4 of these, and maximise the activity in the overlapping parts of the quadrants to achieve the best possible Impact on health and wellbeing outcomes

Figure 11 A population health system that recognises and maximises the activity in the overlaps between the pillars



Arguably we are awash with data!!!

Key questions for the HWB Board

(with reference to the existing Joint HWB Board strategy and more recent/emerging priorities)

1. **Do we have enough and/or the right types of insights and analysis about the Leicestershire-wide data already for our existing priorities, should we undertake any further focused work in addition?**
2. **Do we have a shared view of these insights - via integrated data and/or establishing one version of the truth? Are there further actions you recommend to improve this?**
3. **What should our joint priorities for improving our populations' health and wellbeing across Leicestershire be (using national policy, insights from our placed based data etc.)?**
4. **Are the ones in our current Joint HWB Board Strategy still the right ones?**
5. **Are there still key gaps?**

Potential Areas for the HWB Board to consider

- Our continued focus on improving mental health and wellbeing outcomes (per JSNA analysis and inequalities/parity of esteem)
- Delivering the optimum interventions and outcomes for those with multimorbidity and frailty (per JSNA analysis)
- Other Leicestershire “outlier outcomes” (breast feeding initiation, hip fractures)
- Tackling known variations in care/gaps in care pathways across Leicestershire to achieve more consistent delivery and outcomes across the population (involves close working with PCNs)
- The ongoing integration of health and social care (measuring the outcomes of improved integrated care in the community, via for example Home First, Neighbourhood Teams and social prescribing (NHS Plan)
- Leicestershire’s Growth Plan (housing outcomes, a key part of wider determinants)
- Adverse Childhood Experiences (early intervention to improve outcomes over the life course)
- Violence Reduction Unit (new measures and outcomes per National Policy)
- Actions to reduce health inequalities (e.g. the community based approach in Oadby and Wigston)