Agenda Item 14

HEALTH AND WELLBEING BOARD: 29 MAY 2025

REPORT OF THE INTEGRATION EXECUTIVE

JOINT HEALTH & WELLBEING STRATEGY PROGRESS UPDATE ON LIVING & SUPPORTED WELL AND DYING WELL

Purpose of report

1. The purpose of the report is to provide an update to the Health and Wellbeing Board (HWB) on progress in relation to the Living & Supported Well and Dying Well strategic priorities of the Joint Health and Wellbeing Strategy (JHWS) 2022-32.

Recommendation

2. The Board is requested to:

   a. Note the progress being made in relation to delivering against the Living and Supported Well & Dying Well strategic priorities;
   b. Note the progress being made in relation to delivering against the cross-cutting priorities.

Background

3. One of the statutory requirements of the HWB is to produce and deliver a JHWS. A Joint Strategic Needs assessment (JSNA) was carried out to provide the evidence base to identify the health and wellbeing needs of the local population. The JSNA along with contributions from key partners and stakeholders, helped to inform the JHWS priorities.

4. The ten-year JHWS was approved in February 2022 and aims to improve the health, wellbeing and equity outcomes of Leicestershire. The strategy follows a life course approach:

   a. Best Start for Life;
   b. Staying Healthy, Safe and Well;
   c. Living and Supported Well;
   d. Dying Well.

5. Three HWB subgroups deliver the priorities within each specific life course. A fourth subgroup was established in January 2023 to specifically address the mental health needs across Leicestershire, recognising it cuts across all life courses and requires a greater focus.

6. Reducing health inequalities remains a cross-cutting theme and underpins the work of all four subgroups.

7. The Integration Executive is responsible for overseeing the delivery of the Living and Supported Well and Dying Well strategic priorities of the JHWS and has a role to play in delivery of the cross-cutting priorities. The two priority areas including the sub-priorities are listed below.

   - **Living & Supported Well:**
     a. Upscaling Prevention and Self-Care;
     b. Effective Management of Frailty and Complex Care.

   - **Dying Well:**
     a. Understanding Need;
     b. Effective Transitions;
     c. Normalising End of Life Planning.

8. A report on progress was presented to the Health and Wellbeing Board in May 2024.

9. This report provides an update on progress since the last report, challenges that would benefit from input from the Board, and plans for the next 12 months in continuing to deliver against the Living & Supported Well and Dying Well priorities of the JHWS.

Progress against the Living & Supported Well and Dying Well priorities of the JHWS

10. The table below details the progress being made against each of the priority areas and commitments:

JHSW Priority 1: Upscaling Prevention and Self-Care

Activity	Detail	Beneficiaries	BCF Investment 24-25	Commitments
Care Co-ordination	A Health and Social Care proactive care approach using risk stratification within the community enabling patients to receive the 'right care, at the right time, at the right place'. 19.5 FTE	6486	£724,160	Empower patients to self-manage their long-term condition(s)
Falls – care homes	Reducing the amount of fallers in the care homes with the highest incidences	1381 approx	Core funding	Reducing the number of falls within care homes
Falls – DHU car	Responding to falls in the community to support at home avoiding admission to hospital	1214 referrals	Ageing Well	Reducing admissions due to falls
DFG's	Disabled Facilities Grants help towards the costs of making changes to peoples' home so they can continue to live there.	385	£3,834,762	People living with disability and long-term conditions have access to the right housing, care and support.
Mental Health relationship officer	Supporting people being discharged from Mental Health facilities to remain in the community, prevent readmission and to enable self-care	69	£262,053	Provide joined up services that support people and carers to live independently for as long as possible

LD short breaks	Providing a stay in an appropriate setting away from home for a short time to give a carer a break from caring	133	£985k	Supporting people and carers to live as independently as possible and implementing the LLR Carers strategy
First contact plus	First Contact Plus is an online tool which helps adults in Leicestershire find information about a range of services all in one place.	9989	£199k	Improving access to health and care services
Assistive Technology	Offering a wide range of equipment to maintain independence at home	929	£1 million	Patients self-manage their long-term condition(s) through digital approaches, assistive technology, accessible diagnostics and support
Housing Enablement Team	Integrated housing offer within clinical care settings, focused on delivering health and wellbeing outcomes for patients to maximise opportunities to contribute towards safe and timely discharges from hospitals	2160	£286,760	People living with disability and long-term conditions have access to the right housing, care and support
Urgent Care Centres	Provision of walk-in clinics focused on the delivery of urgent ambulatory care in a dedicated medical facility outside of a traditional emergency department	144,000	£2.65 million	Work to improve access to health and care services including primary care and appropriate funding support

JHWS Priority 2: Effective Management of Frailty & Complex Care

Activity	Detail	Beneficiaries	BCF Investment 24-25	Commitments
System one shared access	Support services to access real time data across the IDT and MH teams to better communicate with each other on the status of patients	125 staff	£15k	Improving access to health and care services
Integrated HART reablement and therapy teams	Reablement in a person's own home to maximise independence and reduce care needs including the integrated locality teams for therapy and HART	4436 HART 19,000 Therapy	£1.7 million HART £5.4 million Therapy	Provide joined up services that support people and carers to live independently for as long as possible aiming for a 2 day start for all requests
Home first teams	Support for those in hospital to return home or to a discharge to assess bed and step-up support for those in the community needing support	6421	£2 million	Delivering an effective health and care integration programme that will deliver the Home First step-up and step-down approach for Leicestershire.
Domiciliary care	Support from independent providers for care packages in the home	4105 people 623,483 hours	£15 million BCF and iBCF contributions	Reducing the number of permanent admissions to residential and nursing homes.
Royal Voluntary Service discharge support	Supports people leaving hospital on pathway 0. Ensuring safe and timely discharge, ongoing support in the community and reducing risk of readmissions	792	£108k	Effective health and care integration programme that will deliver the Home First step up and step-down approach for Leicestershire.

High dependency beds	Commissioned D2A beds for those with high-dependency needs	N/A	£229,630	Reducing the number of permanent admissions to residential and nursing homes.
Nursing care	Supporting people with health and care needs in short and long-term nursing placements	237	£4.8 million	Supporting the creation of an integrated health and social care workforce
Residential respite	Providing a stay in a care home for a short time to give a carer a break from caring	151	£976,170	We will provide joined up services that support people and carers to live independently for as long as possible, including those with dementia
Community response service / HART urgents	Interim support service that provides quick targeted interventions to those in the community that need it to remain at home and avoid admissions	550	£1 million	Offer a two-hour crisis response for people that may otherwise need to attend hospital, reducing admissions and increasing community care capacity

Progress against the Dying Well Priority of the JHWS

11. End of life planning is delivered across Leicester, Leicestershire and Rutland and delivery is supported by a series of workstreams. Deliverables are not only aligned to the JHWS commitments but also to workstreams. These are listed below:

- Workstream 1: Health equity in Palliative and End of Life Care (Y1A1)
- Workstream 2: Data review and standardisation / Shared Care Record
- Workstream 3: Training and workforce development
- Workstream 4: Improving ReSPECT and Advance Care Planning
- Workstream 5: Communication, information & engagement

- Workstream 6: Service provision and care transfer
- Workstream 7: Improving access to Anticipatory Medication in the community

JHWS Priority 1: Understanding Need

JHWS Priority	JHWS Commitment	Key Intervention	Workstream
Understanding the need	We will carry out a Joint Strategic Needs Assessment chapter looking at end of life specifically We will use our better understanding of needs through the EoL JSNA chapter to consider other aspects of end-of-life planning	UndertakAs part of the End of Life LLR strategy led by ICB (final sign off due July 2025) an assessment of local PEoLC needs was undertaken in each of our three upper tier local authorities, to inform the development of this Strategy. These Joint Strategic Needs Assessments (JSNAs) reviewed the population health needs of the people of LLR in relation to end of life care and support. This involved looking at: • the issues that determine the end of life; • the health needs of the population; • the policy and guidance supporting end of life care and support; and • the existing services and the breadth of services that are currently provided. The full JSNAs can be found at: Leicestershire County Council	1
	We will seek to gather views from people to understand what dying well means to them and how this could be achieved	Public engagement began in August 2024. Findings from the engagement were analysed to build into the refresh of the strategy and the draft strategy was updated based on feedback received	5

JHWS Priority 2: Effective Transitions

JHWS Priority	JHWS Commitment	Key Intervention	Workstream
Effective Transitions	We will seek your views on what planning and services for late and end of life should look like and how you should be informed about your choices	A health equity audit to examine how health determinants, access to services, and related outcomes are distributed across the population was developed as part of the JSNA	1
		Gain common understanding of current challenges relating to access of patient information and shared care records between settings / organisations, scoping interventions required from Year 2 onwards.	2
		Review of patient and professional information and engagement (platforms and language) to include family and carer support has begun to feed into the deliverables from the strategy	5
	We will ensure there is a clear transition in care planning from living with long term conditions into the later and end of life	Pilots have taken place within VW's for frailty to include delivery of palliative care needs for this cohort	7
		The mapping of current service provision and identify gaps in service is still being developed and will become part of the Neighbourhood models of care delivery	6
	We will ensure there is appropriate support for carers following the bereavement of a loved one so they can have a supportive transition into the next stage of their lives	Review of patient and professional information and engagement (platforms and language) to include family and carer support.	5
		Pilot a new approach to AM in the community to include delivery to patient's home. Underpinning improvements are required around the authorisations process (underway), education and training (recognising dying / deterioration / symptom management), access to equipment (eg. Syringe drivers), formulary – routes and quantities.	7

JHWS Priority 3: Normalising End of Life Planning

JHWS Priority	JHWS Commitment	Key Intervention	Workstream
Normalising End of Life Planning	We will offer care plans and ReSPECT plans to all vulnerable people with a take up target of 95%	Review of the audit, current uptake and quality took place as part of the initial refresh of the strategy	4
	We will develop a social marketing campaign based on insight to normalise end of life planning	Review of patient and professional information and engagement (platforms and language) to include family and carer support has begun as part of the engagement work on the strategy review	5
	We will educate our workforce so that everyone understands how to support people at end of life	Review of the training matrix, developed in 2022/23, has began to be developed with delivery suring 25-26	3
		Performance framework for the delivery of the strategy has been developed.	3
	We will improve co-ordination of care at end of life, as measured through patient feedback	Public engagement began in August 2024. Findings from the engagement were analysed to build into the refresh of the strategy and the draft strategy was updated based on feedback received	7
		Develop a live service directory.	6

Progress against cross-cutting priorities of the JHWS

JHWS Cross-cutting priorities:

- **Improved mental health**
- **Reducing health inequalities**
- **Covid-19 recovery**

HWBB priority	Activity	Detail	Beneficiaries	BCF Investment 24-25	Commitments
Improved mental health	Transforming Care Programme	A wide range of staffing and support services for those who have learning disabilities detained under the mental health act	N/A	£366,863	Prioritises Mental Health on an equal basis to physical health in plans, investment and focus also considering the links between physical activity and good mental health and how mental health is linked to other conditions.
	Improving mental health discharges	Teams working within mental health care settings enabling people to manage their conditions and maximise independence on discharge	N/A	£341,251	Teams working within mental health care settings enabling people to manage their conditions and maximise independence on discharge
	High dependency support	Providing case management, 1:1 care in a bedded setting for those with high level needs and behaviours (including dementia care)	146	£916k	Supporting key recommendations of the Dementia JSNA Chapter and LLR Dementia Strategy

	MH social workers and advocacy support	Specialist teams to support patients to recover from periods of ill health. Helping them to maximise independence with and Mental Health support	N/A	£198k	Prioritises Mental Health on an equal basis to physical health in plans, investment and focus particularly in supporting MH discharges

HWBB priority	Activity	Detail	Beneficiaries	BCF Investment 23-24	Outcomes
Reducing health inequalities	Shared care records	Shared care records assist staff to make the best decisions by having a more joined-up picture of information. This is important in providing safe, personalised, and connected care to all on an equitable basis	All		Equitable access, excellent experiences and optimal outcomes for all those using health and care services across Leicestershire
	System one unit for Mental Health	Providing a discharge unit for Mental Health settings to enable joined up discharge planning across partners and equitable outcomes across all patient bed bases.	N/A		Equitable access, excellent experiences and optimal outcomes for all those using health and care services across Leicestershire

Reducing health inequalities	Additional housing units	Supporting complex housing discharges and reducing delays by providing short-term accommodations for people who are ready to leave hospital but where home is not yet suitable	N/A	£61k	Varying services in response to differences in need within and between groups of people, that will aim to bring those experiencing poorer outcomes the opportunity to 'level up' to those achieving the best outcomes

12. Across the financial year we have seen improved performance in the following areas:

    - Reduced waits for domiciliary care package pick ups;
    - Increased reablement service capacity by 40%;
    - Discharge Pathway 2 bed usage reduced by 36% over 2 years;
    - 84% on average people have no further need post reablement with 89% people still at home 91 days post receipt of reablement;
    - Size of care packages reduced right-sized to peoples needs;
    - Discharge pathway 1 length of stay post medically optimised for discharge has reduced from 4 days to 2 days, Pathway 2 reduced from 11.5 to 7.5 days and Pathway 3 reduced from 18 days to 17.5 days;
    - Reduction of 7 days length of stay per person utilising the Hight Dependency discharge pathway;
    - Increase in people receiving housing support from the Housing Enablement Team – up more than 35% in 24/25 from 23/24 (1583 in 23-24, 2160 in 24-25);
    - Reduction in the number of people admitted to hospital after a fall from care homes – approx. 50% reduced;
    - Reduction in hip fractures due to a fall – in line with England average;
    - Fully integrated HART reablement and therapy locality teams in the County, resulting in workforce time saved 0.5 days per team per locality helping to increase capacity and reduce waiting times;
    - Better collaboration between partners and services and improved outcomes for service users integrated training sessions across partners;
    - Nationally recognised for work on the High Dependency cohort within intermediate care;

13. Whilst we have made great strides in the areas described above, Leicestershire continues to experience challenges in the following areas:

    - Overall demand on social care services continues;
    - Admissions into hospitals continued to increase in 24-25 as did admissions to care homes
    - Challenges remain around staffing meeting demand for services regardless of whether funding is available to support expansion;
    - Primary care access remains a challenge;

Next Steps

14. Over the next 12 months the focus on improvements to health and social care services in Leicestershire will focus on moving services closer to communities. This will be based on the emerging Neighbourhood models of care which will seek to deliver a wider range of care and support in peoples own homes.

15. Step-up care will be the focus of our Intermediate Care programme of work; building on the successes of the step-down focus for the past two years.

16. Proactive management of demand and a renewed focus on prevention will form part of the strategic approach of all work programmes.

17. Bedded care requirements will be partly met within 25-26 with current plans in place to bridge the gap in discharge to assess bedded requirements.

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