Briefing Paper for District Health and Wellbeing Forums

SECTION 1: HEALTH AND CARE

1.1 Transforming Health and Care across Leicester, Leicestershire and Rutland (LLR)

Since 2014 we have been engaged in the Better Care Together Partnership www.bettercareleicester.nhs.uk.

A five year plan has been developed to change the local health and care system so that more care is delivered in community settings in the future, and to reduce the over reliance on hospital care, particularly urgent care.

The Better care Together Programme is led by a multiagency partnership board whose representation includes the Chairs of all 3 Health and Wellbeing Boards in LLR.

During 2016/17 there are some new policy and planning requirements affecting the NHS and Local Government in particular:

- A new place-based five year sustainability and transformation plan (STP) is to be developed by the end of June.
- A digital roadmap for the NHS - setting out how technology across the health and care system will develop to achieve paperless NHS systems, interconnectivity between NHS systems, AND interconnectivity between NHS and social care systems - so that care records and care management is digital and accessible across organisational and professional boundaries.

For our local area, the planning footprint for the STP and the digital roadmap will be LLR. The STP will incorporate work to date on the Better Care Together plan, but will also be expected to cover broader elements, such as the wider determinants of Health and Wellbeing including prevention.

The STP will focus on a small number of system wide priorities in order to make our health and care system sustainable, including financially sustainable in the future.

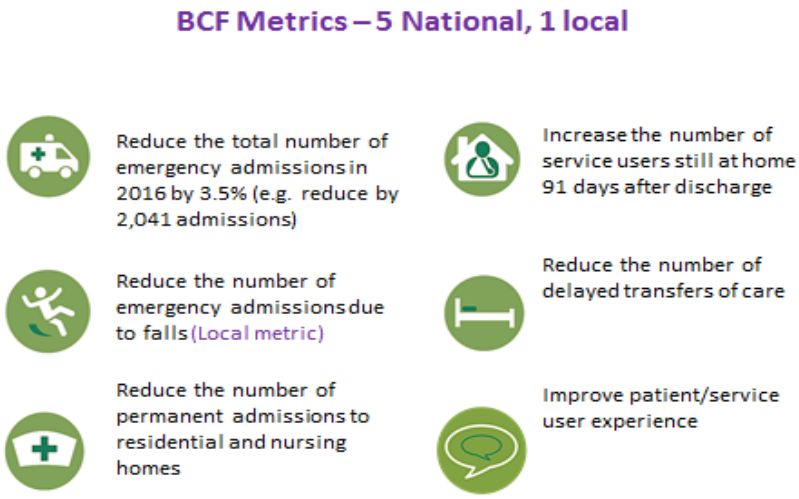
The digital roadmap will build on the existing technological systems already in place in LLR, improving access to a digital shared care record and moving towards a smaller number of NHS IT systems, that have the required interconnectivity.

1.2 Our Integration Programme and the Better Care Fund – Leicestershire

Since 2015 each Local Authority has been required to set out a local plan, approved by the Health and Wellbeing Board, to improve the integration of health and care, and to fund this using a pooled which operates between the Local Authority and the local clinical commissioning groups. This is known as the "Better Care Fund". In Leicestershire in 2016/17 this represents a £39m pooled budget. Each BCF plan must demonstrate how it will deliver to national requirements and plans are assessed against these requirements annually and quarterly by NHS England.

The National requirements of the Better Care Fund are:

1. Delivery against prescribed BCF metrics



(Appendix 1 of the supplementary packet provides a more detail description of each of the metrics)

2. How a proportion of the fund will protect adult social care services;
3. How data sharing and data integration is being progressed using the NHS number *(the NHS number is the unique identifier for each individual which is used on all NHS records);*
4. How an accountable lead professional is designated for care planning/care co-ordination;
5. Delivery of Care Act requirements;
6. How a proportion of the fund will be used to commission care outside of hospital;
7. How seven day services will be supported by the plan;
8. That the impact on emergency admissions activity has been agreed with acute providers;
9. That there is a locally agreed proactive plan to improve delayed transfers of care from hospital;
10. That Disabled Facilities Grant (DFG) allocations within the BCF will be used to support integrated housing solutions including the delivery of major adaptations in the home;
11. Approval of the BCF plan by all partners, assured via the local Health and Wellbeing Board.

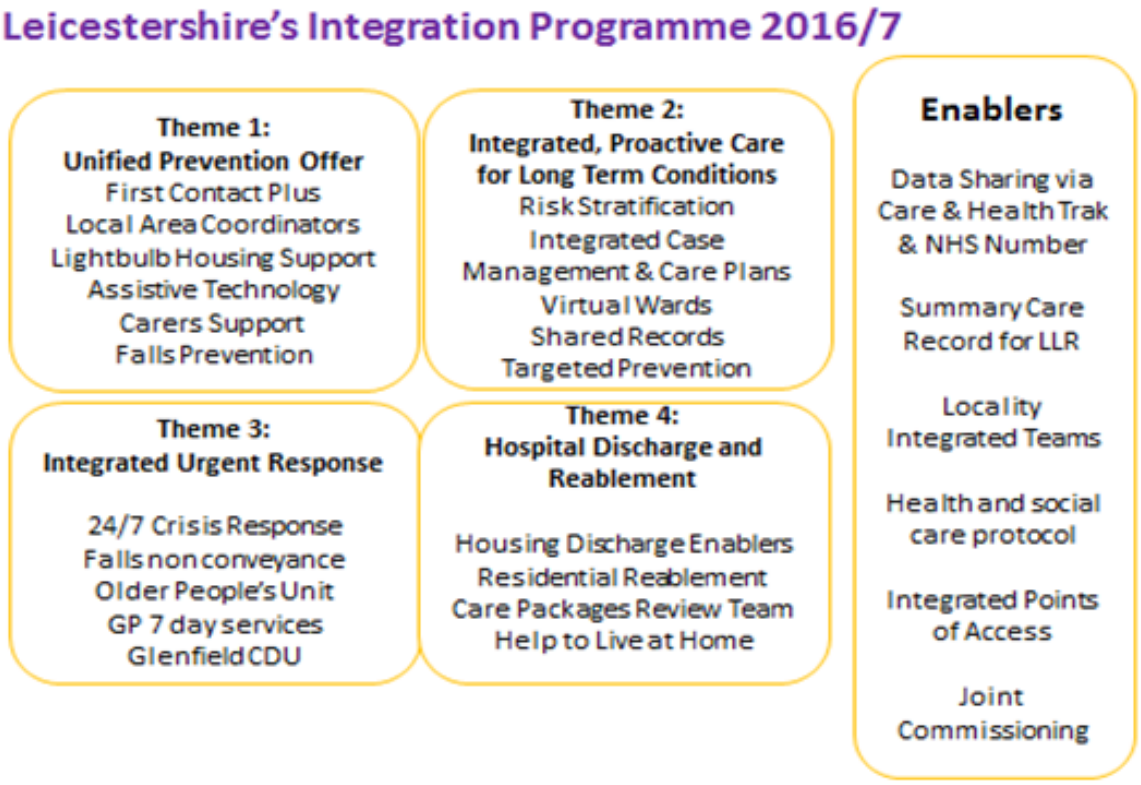
1.3 Overview of the Leicestershire Integration Plan 2016/17

The Leicestershire Vision for Integration is: *We will create a strong, sustainable, person-centred, and integrated health and care system which improves outcomes for our citizens*.

The aims of the 2016/17 the Integration programme are:

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.**

The Integration Programme has four themes, within which individual projects are developed and delivered, and is supported by a range of enablers. The diagram below, which is an extract from the BCF plan, summarises the components.



- **Theme 1** - Unified Prevention Offer - a range of social prescribing interventions, which can be navigated using "First Contact Plus." These include local area coordinators based in communities helping vulnerable people, support to carers, housing solutions, and falls assessment clinics.

- **Theme 2** - Long Term Conditions - is targeted to improving the identification of people with Long Term Conditions with integrated and proactive case management across health and social care.

- **Theme 3** - Integrated Urgent Response - contains schemes targeted to reducing emergency admissions. These include a community based assessment service for frail older people, the crisis response and falls services which provide rapid response and care at home instead of in hospital, seven day services within GP practice, and an improved pathway of care for people at risk of admissions for respiratory and cardiac problems.

- **Theme 4** - Hospital Discharge and Reablement - is targeted to support people to be maintained in the community following a hospital admission, to prevent readmissions, avoid or delay permanent admission to residential care. There is a multiagency plan for sustaining good performance on delayed transfers of care from hospital which includes:
    - Follow up service for home care packages two weeks after discharge
    - Housing offer targeted to improving hospital discharge
    - Improved LTC case management in localities
    - A range of community based care alternative pathways to avoid admission/readmission
    - A new domiciliary care service "Help to Live at Home" being implemented from November 2016.

1.4 Supporting Information for Leicestershire's Better Care Fund Plan/Pooled budget

Our "BCF plan on a page" can be found at Appendix 2 of the supplementary packet. This shows our journey during 2015/16 illustrating some of our key achievements along with a summary of what we are focusing on for 2016/17.

If you would like to read our full BCF plan we have provided this document for your reference (BCF Public Summary) which can be found at Appendix 3 of the supplementary packet

The 2016/17 BCF spending plan, is at Appendix 4.

SECTION 2 – PUBLIC HEALTH AND PREVENTION

2.1 Public Health

A great deal of work is being done to help us save £3m from the public health grant in response to the national reduction in the level of that grant. In addition to work on reducing the spend on health checks, and a switch to an on-line Chlamydia screening service, Public Health are redesigning the smoking cessation service.

There will still be a universal service across Leicestershire, but the intention is that the current face-to-face service will be replaced by one using telephone, text and on-line web chat style support, including the use of Skype. This service is due to be in place by the turn of the year.

2.2 Prevention Review

In February 2016 Leicestershire County Council engaged the consultancy firm Peopletoo, to develop a broad medium term strategy for early help and prevention services to support a new target operating model (TOM) that is efficient, enables the delivery of strategic outcomes and that represents value for money.

The work was completed and resulted in an Early Help and Prevention Strategy, and findings from a review into the current provision of early help and prevention services across Leicestershire County Council.

The strategy encompasses a vision for early help that, by 2018 we will have a comprehensive offer for community based prevention for the citizens of Leicestershire, funded by bringing together all the resources available to Local Councils and partners.

The strategy sets out a clear direction of travel that outlines a more integrated approach across the Council, and indeed Leicestershire, for the provision of early help and prevention activity. The strategy seeks to build upon the good practice and existing strategies of the Council; identifying areas where these can be further developed e.g. the Council's Commissioning and Community strategies. The strategy will deliver savings of just over £3m in the course of the current MTFS.

The strategy also describes the way by which the Council's related assets and services could be refocused on better supporting outcomes through new and modern ways of providing early help and prevention e.g. through greater use of Local Area Co-ordinators.

Governance Proposal and Outline Programme Approach

In order to deliver the implementation plan outlined within the report, it is proposed that the eight workstreams set out in the recommendations of the strategy are configured as a programme. The workstreams are:

- Commissioning
- Information and Advice
- Local Area Co-ordination
- Assistive Living Technology
- Children's centres
- Partnerships
- Communities Strategy

The Senior Responsible Officer (SRO) for this programme is the Director of Public Health as corporate lead.

The lead for member for health within the County council, and chair of the Health and Well Being Board, Mr White CC, will be the lead member for the prevention review.

2.3 BCT/STP Prevention Strategy

Work continues on embedding prevention within Better Care Together and the Sustainability and Transformation Plans of the NHS.

A BCT prevention strategy sets out the need for the NHS to get prevention (the more secondary care focussed areas) within the clinical workstreams like children's and maternity. It also recognises that the role of local government, with districts and boroughs being key in that, on planning, transport, housing, etc will make a real difference to the health of the population.

Rob Howard, consultant in public health, has worked with Harborough, Melton and Blaby Councils on making the most of the potential health gain through developments like Lubbersthorpe and local plans and would welcome other districts using public health expertise in health impact assessment to really improve the health of the population.

SUPPLEMENTARY PACKET

APPENDIX 1 – BCF Metrics

The following table explains the definition of each of the BCF metrics, and the rate of improvement partners are aiming for in each case. Some metrics rely on data produced annually or quarterly, hence the narrative indicates the likely position based on most recent data available.

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 630.1 per 100,000 based on the 2015/16 target of 670.4 per 100,000 and a 90% confidence level that the trajectory is decreasing. Current performance is on track to achieve the target for 2015/16. As part of the development of a four year adult social care strategy, detailed analysis of this metric has taken place and the target set accordingly. In 2014/15 there were 710.5 permanent admissions per 100,000 people. In 2015/16 this is likely to reduce to 669.6 per 100,000 people.

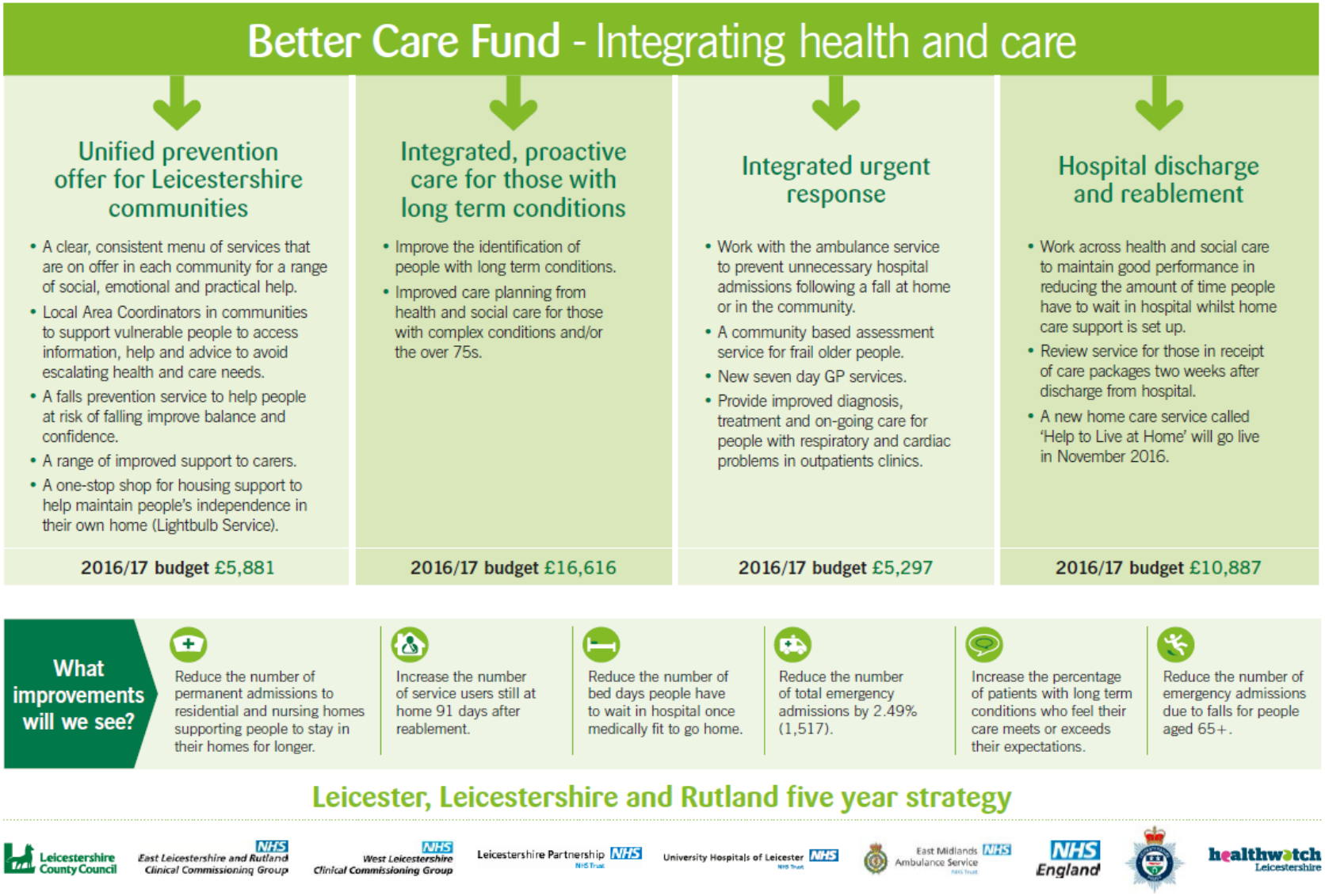
National Metric (2)	Definition	Trajectory of improvement
 **Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services**	This is a nationally defined metric measuring delivery of the outcome to increase the effectiveness 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%, based on the expected level of 82.6% being achieved in 2015/16 and a 75% confidence interval that the trajectory is increasing. The lower confidence interval has been chosen to ensure that the target is realistic and achievable. Performance is currently on track to meet the 2015/16 target of 82.0% As part of the development of a four year adult social care strategy, detailed analysis of this metric has taken place and the target set accordingly. In 2014/15 83.8% of reablement service users were still at home after 91 days. In 2015/16 this is likely to reduce to 82.6%. Due to the introduction of a Help to Live at Home scheme planned for November 2016, a conservative target has been set.

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.	Recent reductions in delays have focussed on interventions in the acute sector. We have therefore set a target 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 238.0, 233.3, 215.9, 220.7 for quarters 1 to 4 of 2016/17 respectively. As part of the development of a four year adult social care strategy, detailed analysis of this metric has taken place and the target set accordingly. Substantial improvement in the rate of days delayed has been achieved – the annual rate has dropped from 4,753 per 100,000 in 2014/15 to a probable 2,730 per 100,000 in 2015/16.

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.	In 2014/15 there were 58,479 non-elective admissions for Leicestershire residents, In 2015/16 it is likely that there will be 59,957. The proposed target for 2016/17 is 726.38 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 no more than 58,836 admissions in 2016/17. This assumption has been aligned with final CCG operational plan targets. All existing admission avoidance schemes have been subject to evaluation in 2015/16, and the results reflected in the development of a trajectory of 1,500 avoided admissions from these schemes in 2016/17.

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.	It is proposed to set this target at 63.5% for 2016/17 (data will be released February 2017). This is based on the 2015/16 target (data due for release July 2016) and a 2% increase in the number of positive replies. Current performance of 61.6% (January 2016) is below the England average of 63%.

APPENDIX 2 – BCF Plan on a Page



Better Care Fund - Our journey so far