Discussing the Joint Health and Wellbeing Strategy for Leicester – Priority 3: Support independence
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Joint Health and Wellbeing Strategy

- Major output of the Health and Wellbeing Board
- Based on the Joint Strategic Needs Assessment (JSNA)
- Focusing on priority health outcomes where we can make the biggest difference
- Takes into account multi-agency health inequalities improvement plan
- Was developed in the context of a recession and significant financial challenges across partner organisations
- Engagement with stakeholders, patients and the public is key
- Includes some areas where we have made progress, and some areas which are more of a call to action
- Strategy approved April 2013

Support independence

Why?

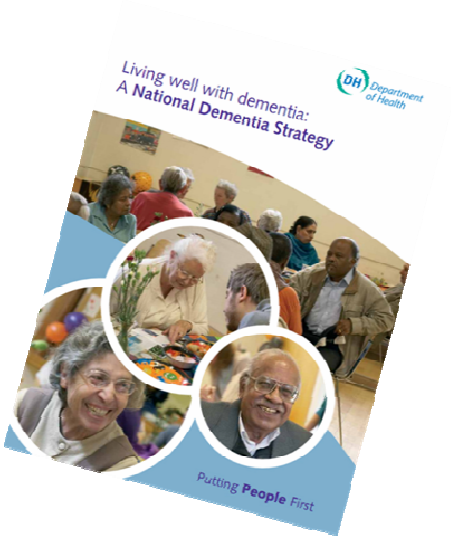
- It is estimated that there are about 37,200 (11.3%) people aged 65 and over in Leicester. Around 5,400 of these are aged 85 and over
- The 2011 census shows over a quarter (32,447) of city households in 2011 included a person with a long term health problem or disability limiting day-to-day activities
- More than 11% of people in Leicester are estimated to have high blood pressure
- Almost 7% of people are currently registered with diabetes and it is four times more common among South Asian people
- There are an estimated 3,000 people with dementia in Leicester - about 800 new cases occur in a year
- Approximately 30,000 people in the city are carers

Support independence

What we aim to achieve:

•Support independence for:
- people with dementia
- carers
- people with Long Term Conditions
- older people

Dementia



Progress

•Leicester, Leicestershire and Rutland (LLR) Dementia Strategy
(5 x Work Streams) reflects the National Strategy (Living Well with Dementia)

•**Early identification of dementia by GPs**
Clinical pathway agreed & GP training completed

- Dementia Advisors across LLR

•**Improved hospital care**
UHL CQIN – early identification of dementia on wards

•**Improved quality in care homes**
Quality Assurance Framework in place

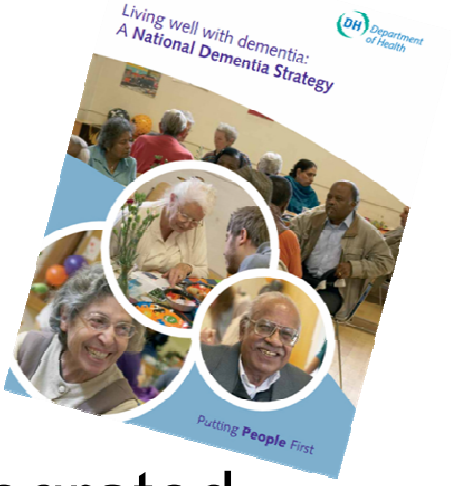
•**Improved community support**
Improved access to information, redesigned ICAT & CMHT

- Provision of carers training, Memory café's & Integrated Crisis Response

•**Workforce development**

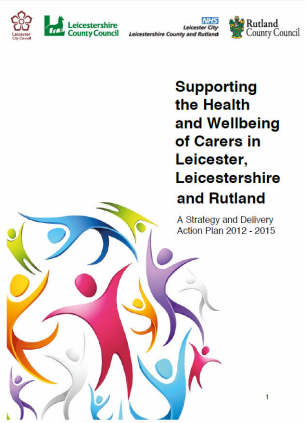
Dementia

More to do



- To continue to deliver the actions detailed in the LLR Dementia Strategy, especially integrated pathways of care
- Creation of Dementia friendly communities
- To raise awareness within the BME community

Carers



Progress

•LLR Carers Strategy – reflects the priorities of the National Strategy

- Carers are recognised and supported as an expert care partner
- Are able to enjoying a life outside caring
- Not financially disadvantaged
- Mentally and physically well; treated with dignity
- Children will be thriving, protected from inappropriate caring roles

Carers

More to do

- To improve carers' satisfaction by:
  - Delivering the actions set out in the LLR Carers Strategy
  - Supporting early self-identification and involvement in local care planning and individual care planning
  - Enabling carers to fulfil their educational and employment potential
  - Personalised support for carers and those receiving care
  - Support carers to remain healthy

Long term conditions

Progress

Optimising the care of people with long-term conditions in primary and community care and decreasing to reliance on acute care where it is appropriate, for example:

•Diabetes – more care will be provided by GP's and community services

•COPD – increasing detection and management including the use of telehealth

•CVD – improving outcomes through early detection and optimising management

More to do

- Upskilling primary care staff to deliver the above

- Developing focused interventions based on risk stratification and a case management approach for those patients at risk of admission to hospital

- Integrated care approach that supports people with a menu of services at different stages of their life

Older people

Progress:

•2012-Integrated Care Board - high level support: LCC/LPT/UHL
- Reviewed acute/community care pathways
- 20 proposals for actions
- GP survey

•2012 – Single Point of Access

•2013- Integrated Care Strategic Delivery Group

•2013 – Integrated Crisis Response Service (ICRS)

•Health and Social Care Coordinators

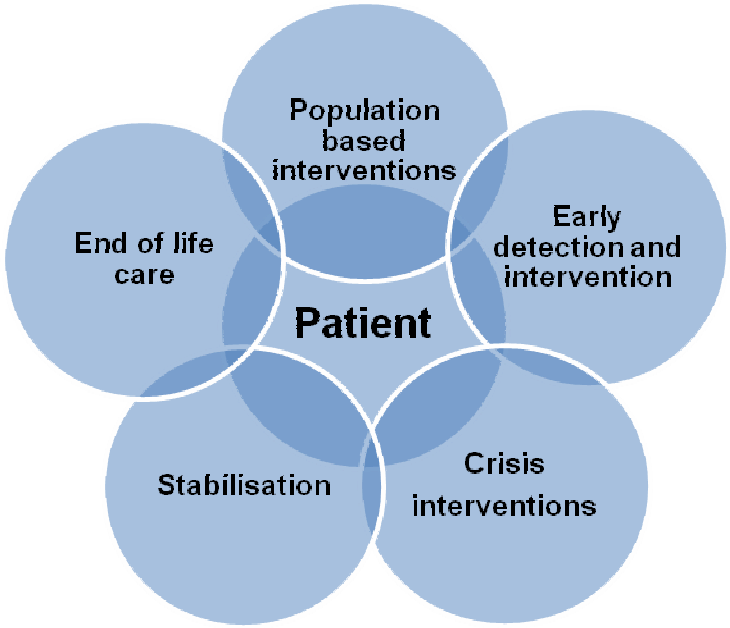
•Procurement of External Support to model range of commissioning and contracting options

•Pioneer application

More to do: integrated model of care, based around services for different points in people's lives to support the national voices definition of integrated care:

"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me"

Model of integration:



Above model is designed to maintain independence for as long as possible; reduce the need for hospital care; and deliver early preventative services. Integration Pioneer application made to support delivery

Questions for discussion

- What do we do well?
- What needs to change?
- How can we deliver this – ie how could your organisation contribute?
- What else needs to be done?