ANNEX 1 – Detailed Scheme Descriptions

Unified Prevention Offer

Scheme ref no.
UPO
Scheme name
Unified Prevention Offer
What is the strategic objective of this scheme?

Case for Change
Intervening early can have a major impact on the health and wellbeing of individuals, and can prevent or reduce the need for more costly care later on.

The LLR five year strategy places self-care and prevention at the heart of the care system with models of care designed to:

- Support people to live well and cope well
- Promote health wellbeing, and independence
- Reduce the need for traditional health and care services where possible.

In Leicestershire, prevention is a central strand of our Joint Health and Wellbeing Strategy, and form the base of our local delivery model per the care pyramid on p xx.

It is also an area where we believe collaboration is essential to achieving successful outcomes and a greater quality of life for the citizens in Leicestershire and to achieve the best value for money for the Leicestershire pound across agencies.

Historically commissioning for prevention is fragmented across the health and care system in Leicestershire and self-care interventions are not systematically embedded in commissioning specifications and models of care. The offer to the public in terms of how to access this kind of support, whether from statutory and non-statutory agencies, can also be unclear and inconsistent across Leicestershire's communities.

We have considered evidence from other areas of the country where prevention is more targeted, consolidated and cost effective and we can see many opportunities to achieve these benefits in Leicestershire.

By investing in the bottom tier of the care pyramid as a priority we will also provide the necessary infrastructure for other elements of the BCF plan and LLR five year plan to function effectively in the medium term, so our priorities in this part of the BCF plan are absolutely crucial to achieving our overall vision of health and care integration.

Desired outcomes:
We want people and communities to:

- Be able to access a range of support early, through social and community networks
- Be empowered to take control of their health and wellbeing
- Live healthier and independent lives
- Maintain their independence within their community for longer.
- Place less reliance on statutory support.

Given the above case for change and desired outcomes, partners in Leicestershire have committed to creating a new, targeted unified prevention offer for Leicestershire's communities, with joint commissioning for joint outcomes.

By 2018 we aim to 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 NHS partners

This is underpinned by Leicestershire County Council's new Communities Strategy http://www.leics.gov.uk/index/community/communities_strategy.htm which focuses on building community capacity to help more people help themselves by taking a more active involvement in their quality of life, and using more of what's on offer locally to do so.

By investing in prevention we expect to see a reduction in the number of people accessing services in crisis or inappropriately and when people have a need for a health or care intervention that they can quickly return to their optimum independence within a supportive community.

BCF Plan Response to the Self-Care, Education and Prevention Case for Change

The Unified Prevention Offer theme focuses on improving self-care, education and prevention. This will be achieved by:

- Consolidating existing prevention services
- Enhancing carer assessments and carer health and wellbeing services
- Introducing a new integrated housing offer
- Introducing Local Area Coordination
- Developing a business case based on our vision for a new unified prevention offer across agencies.
- The implementation of the Leicestershire County Council Communities Strategy.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

UPO – Protection & Consolidation of Existing Preventative Services

We already have local examples of where an integrated, targeted approach has proved successful including support to Carers, Supporting Leicestershire Families, First Contact and Housing Related Support for older people.

The Supporting Leicestershire Families service is delivered through a partnership pooled budget, targeting vulnerable families in need of support across a range of issues. These can include domestic abuse, financial difficulties, school attendance issues, unemployment, ASB and parenting issues among others. The service brings together the County and District Councils, the Police, the NHS and other agencies in order to turn families lives around.

To date over 450 families have benefitted from this service, with a significant amount of success, including national recognition for the delivery of the national Payment By Results scheme which aims to increase school attendance, reduce crime/ASB and support families back to employment.

The headline outcomes achieved to date include:

- A 66% reduction in domestic abuse for families where this was an issue,
- A 47% reduction in ASB for families where this was an issue,
- An 18% reduction in families being at risk of homelessness where this was an issue,
- A 17% reduction where children had a significant issue with school attendance,
- An 11% reduction in children having violence or aggression issues within the household.

The Carers Health & Wellbeing Service is well established in GP practices in the pilot areas; monitoring figures show 265 referrals in the 2 pilot areas over the first 15 months. The full roll-out across the County starts in April 2015, the projected volume for the service is to work with approximately 650 new carer referrals to the service per annum.

As a result of this service; carers were more aware of preventative services available to them, felt better supported, that information was in one place and that they would access the GP less regarding carer needs/issues.

The First Contact Scheme enables the County Council, district councils, NHS, Emergency Services, voluntary sector and many other agencies to work together to ensure vulnerable adults, across Leicestershire are receiving appropriate support.

Staff members from agencies involved in First Contact frequently come into contact with vulnerable adults, either during home visits, telephone calls or work with them in other settings. Additional support may include:

- Help managing their finances and benefits
- Practical help around the home – anything from gardening to personal support
- Smoke alarms/home fire safety checks
- Support with antisocial behaviour/hate crime
- Assistive Technology (e.g. Lifelines)
- Information about local groups, social activities, home library services and adult learning

Currently on average we have 250 referrals a month through First Contact. There are plans in place to extend this service to GP practices and it is anticipated that this number will increase by 10% per quarter.

However in order to feel confident that we are reaching more vulnerable people in time to make a difference - both to them as individuals and their impact on the health and care system - we need to consolidate our efforts and raise our ambition.

We are already investing a proportion of the pre-existing “social care allocations” in a menu of prevention services. We will continue to fund some of these services from within the BCF while we plan for and transition to the new model. These include the existing services to carers, extra care housing for older people and timebanking.

Adult social care are in the process of finalising a consultation on the future of their prevention services, http://www.leics.gov.uk/prevention_service_consultation_document.pdf so this also forms part of the initial consolidation of the prevention offer.

UPO1 – First Contact

The First Contact Scheme enables the County Council, district councils, NHS, Emergency Services, GP practices, voluntary sector and many other agencies to work together to ensure vulnerable adults, across Leicestershire are receiving appropriate support.

Staff members from the different agencies involved in First Contact frequently come into contact with vulnerable adults, either during home visits, telephone calls or work with them in other settings. When working with a vulnerable adult, there is an offer to complete a simple checklist, to find out if that person needs any additional support – this may include:

- Help managing their finances and benefits
- Practical help around the home – anything from gardening to personal support
- Smoke alarms/home fire safety checks
- Support with antisocial behaviour/hate crime
- Assistive Technology (e.g. Lifelines)
- Information about local groups, social activities, home library services and adult learning

Leicestershire County Council delivers the service on behalf of the different agencies involved in the scheme.

The target audience covers all vulnerable people within Leicestershire aged 18 and above. Currently the First Contact team deal with an average of 250 referrals per month, this is anticipated to increase following further full roll out to GP practices by approximately 10% each quarter.

The First Contact scheme has been in existence since September 2010 and is delivered within the community.

UPO2 – Carers Service

Support to carers to help maintain their health and wellbeing, including providing practical information and advice, the expanding carers assessments requirement in line with the Care Act and supporting carer respite are essential strands of our prevention offer, without which many more demands would be placed on long term care across the health and care system due to carer breakdown.

The initial phase of our BCF plan for Carers will protect respite services, extend the existing very successful carers health and wellbeing support programme across all GP practices in the county and make provision for the initial uptake expected from the Care Act for Carers Assessments.

The target audience for the services are all the carers within Leicestershire. The number of carers in Leicestershire based on the 2011 census data is estimated to be 70,708. (editing note from Tony D – need to update with latest care act modelled figures)

However, it is likely that carers previously unknown to services will continue to be identified through the Health and Wellbeing Service and the introduction of the Care Act.

The Carers Services within the Leicestershire BCF provide support through the following interventions:

Carers Support Fund	A one off, non means tested, annual payment of up to £250 paid directly to carers to contribute to the costs of taking a break from their caring responsibilities following assessment to determine eligibility by the LCC Customer Services Centre. This has been in place since 2002. The total fund per annum is £355,000 which includes £85,000 from the BCF, with approximately 400 carers receiving

	funding per annum.
Carers Health and Wellbeing Service	Working with GP surgeries, the service identifies and support carers, promoting the range of support on offer to carers in Leicestershire. The service works with approximately 650 carers per annum and is provided in partnership by Leicestershire Community Projects Trust (LCPT) and the Carers Centre.
Carers Respite	The BCF provides additional funds to the overall carers respite budget, supporting community or home based breaks for carers supporting those with mental illness and dementia over the age of 65. The services are contracted to Age UK, Rethink and East Midlands Crossroads and have been provided since 2002. The funding provides respite to 260 carers per annum.
Specialist support to people with dementia and carers	Provides continuity of support for people with dementia and their carers on a 1:1 basis and through group activities, from diagnosis to the end of life. This includes the delivery of advice and information and emotional support. The service is commissioned from the voluntary sector, currently provided by Alzheimer's Society, and has been in operation since December 2012. The specification has been developed according to number of hours of service delivery, rather than numbers receiving support. This is due to the fact that some customers require an hour, others may need much more intensive 1-1 support. Therefore, we expect the providers to deliver 13,720 hours per annum.
Carers Assessment	Part of the BCF includes specific resources allocated for aspects of the Care Bill, including carers assessments. The BCF has provisioned for 2,800 assessments, which aims to address the 39.3% required from the Care and Support Impact Assessment.

<u>UPO3 – Improving Community Based Prevention through Local Area Coordination</u>

Local Area Coordination
We have considered evidence from Derby and Thurrock (and related international evidence from Australia) which demonstrates that Local Area Coordination (LAC) can offer cost effective low level support to vulnerable people in communities, and provide timely and person-centred interventions to people who would otherwise rapidly escalate into placing demands on the statutory health and care system.

We have developed a business case for LAC, tailoring the model for Leicestershire, which will be implemented with effect from 2014/15 in eight localities. The service will offer low level support and case management initially to 240 individuals by March 2016, identified in conjunction with the risk stratification analysis within GP practices.

LAC aims to support people who are vulnerable through age, frailty, disability or mental health issues achieve their vision for a good life, to support people to contribute to their communities and to strengthen the capacity of communities to welcome and include people.

The main principles are:

- Supporting people to stay strong and building welcoming, inclusive and mutually supportive communities
- Thinking and acting differently, with a greater focus on strengths, individual and family leadership, personal and community resilience
- Supporting people, irrespective of service labels, to build and pursue their vision for a good life as active and valued citizens in their local communities.
- Social justice, inclusion and citizenship for all
- Positive assumptions and opportunities for all citizens in our society, including those who are labelled, isolated or excluded in our communities.

There will be an 18 month pilot for LAC, with roll-out of the service at the beginning of 2015. The project will have three areas of focus;

- Helping Individuals and Families
- Building Communities
- Supporting Integration.

Subject to an evaluation Local Area Coordination will extend its coverage across the whole of Leicestershire by 2017.

Timebank Scheme

Timebanking is a means of exchange used to organise people and organisations around a purpose, where time is the principal currency. For every hour participants 'deposit' in a timebank, perhaps by giving practical help and support to others, they are able to 'withdraw' equivalent support in time when they themselves are in need. In each case the participant decides what they can offer. Everyone's time is equal, so one hour of my time is equal to one hour of your time, irrespective of whatever we choose to exchange. Because timebanks are just systems of exchange, they can be used in an almost endless variety of settings.

Timebank has been operational since July 2012. The project is currently administered by Leicestershire County Council. The scheme will be funded in-house from April 2015.

UPO4 – Autism Pathway

The autism pathway aims to promote and maintain independence whilst avoiding institutional and hospital admissions for people with autism. The funding is separated in to two areas:

- Two **Autism specialists**, working in the Adult Mental Health Team, provide support the Care Pathway, particularly in relation to Asperger syndrome. They work with primary care to increase understanding of autism and begin to address capacity for diagnosis, and improve how people with autism and Aspergers are being assessed. This is provided directly by Leicestershire County Council and is delivered to professionals that come into contact with people with autism and Aspergers. The service has been operational since June 2013 and is planned to last for two years. In the first year the two posts dealt with 63 referrals, and the number of referrals is increasing during the second year.

- **Autism Information Hub** is an information service where dedicated staff are employed to raise awareness of autism and Aspergers across Leicestershire. The Hub is set up to provide information and advice to those with autism and to map services. Support is provided over the telephone, email and at events, as well as through the website. The service has been operational since April 2013, and provided by the National Autistic Society.

UPO5 – Assistive Technology

Leicestershire County Council has commissioned a new countywide Community Alarm (Telecare) and Emergency Responder service which became operational from July 2014.

This service provides telecare equipment and a 24 hour, 7 day monitoring. For some people who do not have access to a named contact, the provision will offer a Mobile Response service. The service incorporates people currently in receipt of a community alarm service through housing related support contracts.

The contract is for a period of three years to commence 1st July 2014. This includes a six month transition period to accommodate transferring users in receipt of community alarm services through existing contracts.

Standalone equipment is also provided as part of the Assistive Technology service. Standalone is used describe any assistive technology device that can be used in isolation (i.e. without being linked to a community alarm or monitoring centre). Examples of standalone devices include calendar clocks, memo minders, locating devices and large button mobile telephones
Some standalone devices will trigger an alarm or pager to alert a carer that the person may need assistance. For example some pressure mats and sensors will send a signal to a pager to let the carer know that the person is getting out of bed or leaving the room or house. These devices usually have a limited range (distance) and their use may be restricted to adjacent rooms. Standalone devices are often mains or battery operated and usually do not have any installation requirements.

The service is intended to provide an effective, comprehensive and innovative approach to the use of telecare in line with Leicestershire County Council's early intervention and prevention work stream. The service will:

- Reduce risk for those living at home
- Prompt rapid and appropriate response to emergencies
- Manage specific conditions
- Delay admission to residential or nursing care
- Enable safer discharge from hospital or care
- Replace elements of an existing support plan (service substitution)
- Enhance an existing support plan in order to improve opportunities of independence, choice and control (prevention).

Assistive Technology is currently offered as an early intervention and prevention service, which means that it is not linked to FACS Eligibility.

Community alarm (telecare) services may be provided where someone does not currently meet Leicestershire County Council's FACS Eligibility threshold, where there is a clear prevention need which would lead to an unmanaged risk if not addressed by an external solution (i.e. it is recognised that some prevention needs may be met by behavioural or lifestyle changes, in particular those relating to personal health).

An average of 90-100 referrals are currently completed each month for standalone equipment and a further 120 referrals are completed for telecare equipment per month.

The Assistive Technology was established in September 2011, providing standalone technologies. A procurement exercise was undertaken in 2011/12 to establish an interim countywide community alarm (telecare) service.

UPO6 – Integrated Housing Solutions

Housing professionals and our Health and Wellbeing Board recognise the potential that housing services have to deliver better health and social care outcomes. Everyone is fully engaged in shaping and delivering different ways of working in Leicestershire to achieve this, including a range of housing providers who have been actively engaged in our work to date.

Work undertaken by the Leicestershire Health and Wellbeing Board in 2013/14 in conjunction with the Chartered Institute for Housing clearly identified how an improved housing offer to health[1] could be better targeted – e.g. in support of hospital discharge, avoiding admissions, and keeping people well and independent at home. This has led to housing innovations being prioritised in Leicestershire's Better Care Fund, with the support of all District Councils.

By embedding housing expertise within the acute sector we can ensure accommodation matters are prioritised as early as possible to promote discharge.

Through First Contact and Local Area Coordination we can reduce demand on other services such as GPs and hospital care by effectively signposting to practical housing advice and interventions across multiple agencies, using one referral form.

This will pick up important interventions such as Keeping Warm and Well at Home, and providing a range of practical support to older and vulnerable people.

Our aim is to reduce emergency admissions and prevent delayed hospital discharge through primary prevention focused on housing support.

A summary of our approach is given below:

The Lightbulb Project: **A consistent housing improvement offer across Leicestershire**	The light bulb project will develop a new consistent offer across Leicestershire and will involve pooling the resources and expertise across the County Council and all District Councils. This will provide practical support for both self-funders and those eligible for statutory support so that aids, equipment, adaptations, handy person maintenance services and energy efficiency interventions are readily and rapidly available across all tenures, including via statutory assessments by occupational therapists and for those accessing Disabled Facilities Grants (DFGs). This will reduce the time taken to provide practical help to individual service users, reduce process costs for services paid for through the public purse and support vulnerable people to access the low level practical support that helps them remain independently at home. Existing funding streams which could be redirected to deliver this service, including the DFG funding, will be scoped in 2014/15, and the service developed through negotiations and business case proposals. A business case to direct this development is in progress and will be available by the end of October 2014 which will also provide details regarding the projected volume of service users. An application has also been made for national transformation monies to support this development and our initial EOI has recently progressed to the full

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	application stage.
Housing as an integral part of care planning	Housing will become much more clearly linked to all aspects of the BCF and its priority care pathways, e.g. all planning and decisions around an individual's hospital discharge will include early consideration and action regarding appropriate and supportive housing options. We will build health, social care and housing considerations into assessments of customer needs right from the start, in a way that recognises the potential of appropriate housing and housing based support in delivering independence and reducing whole system costs. Partners will work collaboratively to identify and deliver housing solutions to prevent delayed hospital discharge, support reablement, offer an urgent response to avoid admission, including via the emergency department, and to maintain the independence of those with Long Term Conditions for as long as possible.
Housing Expertise for the Assertive In Reach Team in the Acute Trust	Discharge support workers within the Acute Trust will benefit from integrated housing support, based on the model developed in adult mental health (see below). District council housing expertise and support will be targeted to work alongside the existing "primary care coordinators" who are based within University Hospitals of Leicester. Working with ward staff their role of primary care coordinators is to progress discharge planning at the earliest opportunity and enable a smooth transfer back to the patient's usual place of residence or arrange for alternative support as needed. With the input of housing advice they can identify housing barriers early and mobilise the full range of support available from the Lightbulb offer such as aids, adaptations, and affordable warmth.
Tackling Barriers to Discharge in Acute Mental Health Services	In response to the analysis of delayed transfers of care by care setting (2013/14 to 2014/15), and the trend in out of area placements experienced by mental health patients in order to accommodate admissions, housing expertise from district council partners has been made available on site within the Bradgate Unit, the local acute mental health inpatient facility. This partnership has increased the overall ownership of the mental health service in tackling some of the known housing barriers to length of stay and improving patient flow within the Unit, substantially reducing delayed transfers of care the number of out of area placements. The focus of the housing expertise has been on the early detection of housing issues with inpatients, offering early planning and practical support; not just the 'bricks and mortar' options but getting to the heart of the support issues which are often associated with resolving housing difficulties for vulnerable people. Housing officers bring practical support, information and access to benefits and welfare advice, and can tackle perceived levels of stigma and risk, often the key factors in enabling someone with a challenging

	history being discharged and accepted into local accommodation. By housing officers working alongside the mental health provider and the local housing market, length of stay has reduced by circa 20%, and overspill in patient placements out of area have also reduced from a high point of 37 to between zero and three over the last month, at a time when admissions have been rising in number. The specific needs of those with mental health problems will continue to be critical part of the housing offer, given the: • Increased emphasis nationally on parity of mental health with physical health • The positive initial evaluation of the impact of this support in the first few months of its operation.

UPO7 – Protected Prevention Services

LD Short Breaks
A Short Break is responsive to people using services, parents and family carers circumstances which are regular and reliable. It is for parents and family carers to get a complete break and for people with learning disabilities to get an enjoyable break with real opportunities and choices. Social Care and Health work together to make sure there are good short breaks for people with learning disabilities and their families and carers in Leicestershire.

As part of the Better Care Together programme, Leicester, Leicestershire and Rutland are redeveloping short breaks into an integrated health and social care model.
Projections to be confirmed.

Residential Respite
Ongoing provision of residential respite to service users to prevent carer breakdown and the need for more costly services. There are 200 different settings providing residential respite. Both Leicestershire County Council and the independent market provide respite on average for up to six weeks each year.

The target audience is for people with learning disabilities, older people, physical disabilities and mental health issues to go into a home to enable the carer to have respite. The projected volume for this investment is 4,500 bed weeks per annum. This is a long established service provided/commissioned by Leicestershire County Council.

UPO Related Activities: Preventative Support for People with Long Term Conditions

People with LTCs account for 70% of inpatient bed days and we have increasing prevalence of these conditions in Leicestershire. Refer to Data Profile for East/Data Profile for West. It has been demonstrated that by offering self-management programmes to support patients to manage their own conditions unplanned hospital admissions can be reduced for some conditions e.g. diabetes education programmes. The long term conditions workstream of our LLR five year programme will embed the principles of:

- Educating patients
- Signposting to information

- Facilitating access to self-help groups in each LTC care pathway

We will also build on the progress made in the respiratory pathway where assistive technology has also proven beneficial in self-care, with remote monitoring by professionals involved in care planning.

(More information about the overall approach to supporting people with LTCs can be found in Theme 2 of the BCF on page xx)

UPO Scoping Stage: Falls Prevention: An LLR Wide Approach

Across LLR, in keeping with the five year strategy, an integrated Falls Prevention approach is being developed. There are two strands to this work.

- The first concentrates on the crisis response to a fall (see BCF Theme 3 Integrated Urgent Response on p.xx where we are implementing a hospital admissions avoidance scheme).
- The second focuses on medium term prevention which is part of the integrated unified prevention offer.

Through First Contact, Local Area Coordination and housing routes we will prioritise interventions that prevent harm due to falls in the home.

Our locality based health and social care teams will identify and work with those who have had a previous fall as an at risk group, for whom additional case management and support may be needed.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

UPO1 – First Contact

- Delivered directly by Leicestershire County Council on behalf of the different agencies involved in the scheme.

UPO2 – Carers Service

Carers Support Fund

- The fund is administered by Leicestershire County Council

Carers Health and Wellbeing Service

- Commissioned jointly to Leicestershire Community Projects Trusts (LCPT) and the Carers Centre
- Commissioned by Leicestershire County Council

Carers Respite

- Commissioned to Age UK (for dementia)
- Commissioned to Rethink (for adult mental health in Melton, Charnwood & North West Leicestershire and Hinckley & Bosworth)
- Commission to East Midlands Crossroads (for adult mental health in Oadby & Wigston, Blaby and South Leicestershire)
- All services commissioned by Leicestershire County Council

Specialist support to people with dementia and carers
- Commissioned to the Alzheimer's Society
- Commissioned by Leicestershire County Council

Carers Assessment
- Delivered by Leicestershire County Council

UPO3 – Improving Community Based Prevention through Local Area Coordination

Local Area Coordination
LAC will be delivered by Leicestershire County Council. The team will consist of a LAC Manager and eight Coordinators across the localities within Leicestershire. Job descriptions for the roles are currently being agreed as part of the development stage of the project.

Timebank
The timebank project is facilitating development of new ways of delivering services, by valuing existing community assets rather than through formal commissioning of services. Administration of the timebank service is managed directly by Leicestershire County Council.

UPO4 – Autism Pathway
- The team senior posts are employed directly by Leicestershire County Council
- The Autism Hub:
    - Commissioned by Leicestershire County Council
    - Commissioned to National Autistic Society

UPO5 – Assistive Technology
Assistive Technology telecare equipment, monitoring service and mobile response service:
- Commissioned by Leicestershire County Council
- Commissioned to Tunstall Ltd

Leicestershire County Council is responsible for carrying out assessments and agreeing the appropriate Assistive Technology that is required. They also provide the standalone technology.

UPO6 – Integrated Housing Solutions

Business case currently under development.

UPO7 – Protected Prevention Services

LD Short Breaks
- Commissioned by East Leicestershire and Rutland CCG, West Leicestershire CCG and Leicester City CCG
- Commissioned to Leicestershire Partnership Trust

Residential Respite
The services are commissioned by Leicestershire County Council and provided in residential care settings across the county.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Local Evidence	National Evidence
Evidence on impact of the wider determinants of health **LLR 5 year Strategy June 2014** Based on • LLR Mckinsey Report 2013 • EMPACT Utilisation Review 2013 • Interqual Report 2014 • National BCBV benchmarking data **Leicestershire JSNA**, Chapter on health inequalities, [Available online at http://www.lsr-online.org/reports/leicestershire_joint_strategic_needs_assessment_jsna_2012_full_length/download/7/2012%20Leicestershire%20JSNA%20Health%20Inequalities%20Factsheet.pdf] **Leicestershire's Health & Wellbeing Strategy** [Available online at http://politics.leics.gov.uk/Published/C00000135/M00003397/AI00033271/$FFAppendixD.doc.pdf]. **Leicestershire's DPH Annual Report** (2014) details the importance of tackling the wider determinants of health.	**Evidence on impact of the wider determinants of health** Significant, high quality evidence on the impact of the wider determinants of health and LA role's. Buck D, Gregory S (2013). Improving the public's health: a resource for local authorities. London: The King's Fund. World Health Organization, Commission on the Social Determinants of Health (2008). Closing the gap in a generation: Health equity through action on the social determinants of health. [Available at: http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf] [Accessed on 21/08/2014]. Marmot M. Fair Society, Healthy Lives: A Strategic Review of Inequalities in England. London: University College London, 2010. [Available online at http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review] [Accessed on 21/08/2014]. **Work and Wellbeing:** Good jobs enhance health and well-being and can promote recovery from mental illness *(DH 2010, Rickey et al 2012, Waddel and Burton 2006)* In both the short- and longer-term, being in work reduces the need for health services *(Bush et al 2009, Dewe and Kompier 2008, Gill and Sharpe 1999, NMHDU 2010, Naylor and Bell, 2010)* Employment can enhance access to wider social and economic determinants of healthy life expectancy such as a living income, secure housing, social networks, and increased agency *(Collingwood 2011, Marmot 2010, TUC 2012)* Many people living with mental illness see work as an important part of their recovery and value its place in enabling them to contribute to society, be part of social networks, build identity, and find hope or meaning *(MIND 2011, Perkins et al 2009, Rinaldi et at 2010, Shaw Trust2010)*. Despite many wanting to work, people living with mental illness are significantly disadvantaged in their attempts to gain or stay in employment *(CIPD 2011, NIC 2011, Paul and Moser 2009, Perkins et al 2009, Sayce 2011, Shaw Trust 2010)* Employment rates for people living with mental illness are between just 16% and 35% *(McDaid et al 2008, Perkins et al 2009)* and tend to be much lower than rates for people without a health condition (77%) or those with long-term physical health problems (59%) *(Black and Frost 2011, ONS 2011)* Depression and anxiety are 4 to 10 times more prevalent

	among people who have been unemployed for more than 12 weeks *(Rinaldi et al 2010)* The risk for mental health problems continuously rises through the first nine months of unemployment and only recedes partially afterwards *(Paul and Moser 2009)* Foresight Report, Five Ways to Wellbeing, 2008: http://b.3cdn.net/nefoundation/8984c5089d5c2285ee_t4m6bhqq5.pdf. Better health, lower crime a briefing for the NHS and partner agencies, McManus,1999, http://www.nacro.org.uk/data/files/nacro-2004120264-425.pdf. Buck D (2011) *How healthy are we? A high-level guide.* King's Fund. http://www.google.co.uk/url?url=http://www.kingsfund.org.uk/sites/files/kf/field/field_document/how-healthy-are-we-david-buck-dec11.pdf&rct=j&frm=1&q=&esrc=s&sa=U&ei=Kqr9U9uZJZCXav3GgaAD&ved=0CBQQFjAA&sig2=GkdQX3wxoROSuHEE63xh5g&usg=AFQjCNHKOyJphwyVRV3dMmFyP3rQDiIwcA. **Children and young people's mental health:** Department of Health (2011) No health without mental health: a cross-government mental health outcomes strategy for people of all ages. [Available online at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf]. [Accessed on 29/08/2014]. 'Intervening early for children with mental health problems has been shown not only to reduce health costs but also to realise even larger savings from improved educational outcomes and reduced unemployment and crime. These approaches not only benefit the individual child during their childhood and adulthood but also improve their capacity to parent. They can therefore break cycles of inequality running through generations of families.'
Self-Care **LLR 5 year Strategy June 2014** Based on • LLR Mckinsey Report 2013 • EMPACT Utilisation Review 2013 • Interqual Report 2014 • National BCBV benchmarking data **Leicestershire JSNA**, Various chapters on staying healthy, carers, various lifestyle behaviours and long term conditions. [Available online at http://www.lsr-online.org/reports/leicestershire_joint_strategic_needs_assessment_jsna_2012_full_length]. **Specific evidence on community based**	**Self-Care** Making best use of the Better Care Fund Spending to save? **The Kings Fund 2014.** http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/making-best-use-of-the-better-care-fund-kingsfund-jan14.pdf. Summarises the key evidence on primary prevention, self-care, care coordination, care management, mental and physical health needs. Naylor C et al. (2012) Long term conditions and mental health – the cost of co-morbidities. King's Fund and Centre for Mental Health. [Available online at http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf] [Accessed on 22/08/2014]. • 30% of people with a long-term condition have a mental health problem (approximately 4.6 million people) (page 5) • 46% of people with a mental health problem have a long-

prevention & support Leicestershire Local Area Coordination. Outline Business Case Other Local Area Coordination Evaluations; • Derby Local Area Coordination, Evaluation Report, Jo Hutchinson 2013 • Peter Fletcher Associates (2011) Evaluation of Local Area Coordination in Middlesbrough • Prevention Matters, Delivering a prevention-focused model for adult services in Buckinghamshire County Council, 2012 Leicestershire Scrutiny Review Panel on the Referral Pathway for Older People with Anxiety or Depression, 2014[Available online http://politics.leics.gov.uk/ieListDocuments.aspx?CId=135&MId=3992&Ver=4]. **DFG's Admissions Analysis by admission codes for Lightbulb Project, 2013/14 -** analysis focused on admissions due to falls, carer breakdown, housing issues, and other social care factors to identify where BCF interventions could have maximum effect **Assistive Technology:** Telecare service evaluation report 23/05/2013.	term condition (approximately 4.6 million people) (page 5) De Silva D (2011) Helping people help themselves: a review of the evidence considering whether it is worthwhile to support self-management. London: The Health Foundation. [Available online at http://personcentredcare.health.org.uk/sites/default/files/resources/helping_people_help_themselves_0.pdf] Accessed on 22/08/2014] Evidence on the continuum of self-care techniques and the need to use varying approaches for different clinical conditions. A NICE Local Practice example is available at: Self-care support for long-term conditions The King's Fund: Purdy S (2010) 'Avoiding hospital admissions: what does the research say?' Making our health and care systems fit for an aging population. **The Kings Fund 2014**. http://www.kingsfund.org.uk/publications/making-our-health-and-care-systems-fit-ageing-population The King's Fund: Naylor et al, 2013. Transforming our health care system. Ten priorities for commissioners. [Available online at http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/10PrioritiesFinal2.pdf]. Depression in adults with a chronic physical health problem: NICE Guideline 91: http://www.nice.org.uk/guidance/cg91. No health without mental health: a cross-government mental health outcomes strategy for people of all ages: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf. Living Well With Dementia: a national dementia strategy, 2009 https://www.gov.uk/government/publications/living-well-with- dementia-a-national-dementia-strategy NICE Draft Guidance - Excess winter deaths and morbidity and the health risks associated with cold homes. http://www.nice.org.uk/Guidance/InDevelopment/GID-PHG70 **Specialist Support to People with Dementia & Carers:** Alzheimers Society. 2011. Support.Stay.Save. 'every £1 spent (on community support) saves an estimated £1.20 in the cost of bed day' (Page 27). The Whole System Demonstrator (WSD) programme - largest randomised control trial of telehealth and telecare in the world, involving 6191 patients and 238 GP practices across three sites, Newham, Kent and Cornwall. http://3millionlives.co.uk/about-telehealth-and-telecare

Additional information from *No Health Without Mental Health:

Conduct disorder is the most common childhood mental disorder, for which parenting support interventions are recommended as first-line treatment. A number of studies have shown that effective parenting interventions and school-based programmes can result in significant lifetime savings. Parenting interventions for parents who have children with conduct disorder cost about £1,200 per child. They have been shown to produce savings of around £8,000 for each child over a 25-year period (14% of the savings are in the NHS, 5% in the education system and 17% in the criminal justice system. ‘

Depression is the most common mental health problem in older people. Some 25% of older people in the community have symptoms of depression that may require intervention. Symptoms of depression are common and sometimes short-lived, but for some may develop into a clinical depression. Some 11% of older people will have minor depression and 2% a major depression.82 older people with physical ill health, those living in residential care and socially isolated older people are at higher risk.83 yet these problems often go unnoticed and untreated. studies show that only one out of six older people with depression discuss their symptoms with their GP and less than half of these receive adequate treatment.84 As well as the impact on quality of life, untreated depression in older people can increase need for other services, including residential care, however, older people can respond very well to psychological and medical treatments. This includes carers of people with dementia, so that they are better supported to manage challenging behaviours.

Physical and mental health co-morbidity – getting better diagnosis and treatment of mental health problems for those with long-term physical conditions, and getting identification and treatment of anxiety or depression for those with medically unexplained symptoms. one example is the use of a ’collaborative care‘ approach when treating depression in people with type 2 diabetes in primary care. It has been estimated that introducing this nationally has the potential to save the NHS and social care around £3.4 million in four years, with a further £11.7 million of benefits to individuals from improved productivity.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The Unified Prevention Offer theme will be measured by:

- Level of First Contact Scheme referrals
- More people reporting feeling supported in the management of their long term condition
- More people actively involved in planning their care
- More carers taking up local authority assessments
- More carers taking up the GP based health and wellbeing service
- A new cohort of people benefiting from local area coordination (using outcome star)
- Less people being permanently admitted to residential and nursing care
- Housing offer KPIs (per the business case - to include reductions in mental health delayed discharged, reducing emergency admissions due to absence of housing related

support, user experience)
- Reduction in injuries due to falls
- Assistive technology take up
- (insert reference to any clinical audit/statistical process control/evaluation etc.)

What are the key success factors for implementation of this scheme?

- Clinical expertise to develop the model of care
- Robust business cases
- Effective impact assessment
- Clear KPI's and evaluation approach
- Realistic trajectory for implementation
- Recruitment timelines
- Risk mitigation plans
- Clear project management and SRO roles
- Performance management of delivery via the Integration Executive
- Relationship management and joint leadership across agencies
- Maintaining alignment with the 5 year plan
- Relationship management between County, City and Rutland BCF.

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