Rutland Health & Wellbeing Board

Joint Health & Wellbeing Strategy Annual Report 2017/18

Contents

1. Introduction

This report provides an overview of the progress by Rutland's Health & Wellbeing Board against the Joint Health and Wellbeing Strategy 2016-20.

1.1 The Role of the Health & Wellbeing Board

Rutland's Health and Wellbeing Board (HWB) is a formal committee of the Council charged with promoting greater integration and partnership between bodies from the NHS, public health and local government. It has a statutory duty, with East Leicestershire and Rutland Clinical Commissioning Groups (ELRCCG), to produce a Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy for their population of Rutland. Underneath the Board sit two further committees:

- The Integration Executive: responsible for overseeing strategy and operational delivery of health and social care integration within Rutland, and more specifically the Better Care Fund Programme;
- The Children's Trust: responsible for setting the direction and vision for the delivery of children's health and care services within Rutland, with partners holding each other to account.

The Board draws upon the Strategy to provide leadership and manage change across health and social care. We influence the health agenda more broadly across the partner organisations and across the county. Priorities have been identified to focus on making health and social care services effective and ensuring they meet the local needs.

At the outset of the current Joint Health and Wellbeing Strategy, members of Rutland's Health and Wellbeing Board agreed a set of principles which drive our shared priorities. These are:

- Ownership of the Board is shared by all its members (with commitment from their nominating organisations) and accountability to the communities it serves for delivering our priorities;
- Commitment to drive real action and change to integrate services and to improve services and outcomes;
- To target resources and prioritise the most vulnerable;
- Support people to maintain their independence and educate them to look after themselves, encouraging people to make informed healthy choices;
- Share success and learning to make improvements cross-organisationally for the wider benefit of Rutland;
- Be open and transparent in the way that the Board carries out its work - listening to service users/patients and the public, and acting on what they tell us
- Take advantage of Rutland's small size to utilize our resources and assets;
- Represent Rutland at LLR, regional and national platforms to ensure Rutland's voice is heard.

2. The Joint Health & Wellbeing Strategy

The current Joint Health and Wellbeing Strategy was signed off in 2016 by Rutland's Health & Wellbeing Board and sets out our priorities for improving health and wellbeing in Rutland.

Our vision:

Integrated health and social care services to support our communities to live healthy, independent and safe lives.

The Strategy is aimed at all ages, from good health in pregnancy, through to dignity at the end of life. It also seeks to ensure that everyone can have the same opportunity to live a healthy independent life, as we know that some groups currently have poorer health outcomes and/or reduced life expectancy.

The purpose of the Strategy is to enable:

a. all Health and Wellbeing Board (HWB) partners to be clear about our agreed priorities for the next three years

b. all members of the HWB to embed these priorities within their own organisations and ensure that these are reflected in their commissioning and delivery plans

c. key agencies to develop joined-up commissioning and delivery plans to address these priorities

d. the HWB to challenge and hold member organisations to account for their actions towards achieving the priorities within the strategy

e. members of the HWB to work with and influence partner organisations outside the HWB to contribute to the priorities agreed within this strategy; including engaging residents and local businesses.

3. Progress against our Priorities

The following section sets out our progress against the priorities the Board set itself in 2015. The impact under each priority has been set out using the latest available data, however it should be noted that for a number of data sets there is a time lag which means that we are measuring changes which have occurred prior to, or at the beginning of, our work against the Joint Health and Wellbeing Strategy, and consequently, we would not expect the full impact of our efforts to be seen within the data until future years.

Priority 1 - Extend healthy life expectancy

Where do we want to get to?

Overall our goal is to reduce the gap between life expectancy and healthy life expectancy. For men, we want to reduce this by 2.5 years over the next ten years. For women, we want to stop the gap increasing any further and reduce it by 1 year over the next ten years.

What have we done so far?

We have prioritised a clear focus on prevention activities both primary and secondary, and allocated a proportion of Better Care Fund monies and activity to this as well as Public health funding. Specific work has included:

- Development of the Rutland Information Service – a single public facing website to find out about services, organisations and activities throughout the county.
- Commissioning of the Rutland Community Wellbeing Service – an overarching service which includes a range of prevention, support and interventions to improve people's wellbeing and health.
- Implementation of the LLR Sports Strategy via Active Rutland - encouraging participation in activities and sport across age ranges and abilities, and enabling as many people to access physical activity as possible by providing a wide range of options and access points, including activities specifically aimed at older people.

Impact

The data currently available for healthy life expectancy in Rutland only goes up to 2016, and therefore does not cover the period the Joint Health & Wellbeing Strategy. The data indicates that for both men and women overall life expectancy increased slightly between 2013-15 and 2014-16 by 0.4 years and 0.2 years respectively. Retaining life expectancy in Rutland at a higher level than national average. Healthy life expectancy fell during the same period for both men and women: from 71.1 years in 2013-15 to 68.8 years in 2014-16 for men; and from 70.6 years in 2013-15 to 70.2 years in 2014-16 for women. Consequently, the gap between life expectancy and healthy life expectancy has increased – this is a continuation of the trend which led the Board to set this as a priority within our Strategy.

Any changes to healthy life expectancy will emerge over the longer-term and so the impact of our interventions will not be immediately clear through this indicator. Going forward, additional proxy indicators which demonstrate both earlier diagnosis of long-term conditions, and delayed onset will be used to predict impact on healthy life expectancy. For example, under Priority 2, data indicates that smoking has reduced in Rutland and consequently the impact of this longer-term may be a reduction in the physical health problems associated with smoking.

What's next?

We will continue to build on this prevention focus, exploring further activities and support which can be put in place to empower individuals and communities to take a more proactive role in their own care and to support themselves across both health and social care.

At a community level, we are establishing a one-off Healthy Rutland Small Grant Scheme with Public Health monies to enable local grass-root organisations to bid for funding to support prevention activities within their communities.

Active Rutland are continuing to develop their programme of activities, including work during 2018/19 with businesses and workplaces in Rutland to improve wellbeing amongst Rutland's employees.

Priority 2 - Reduce health inequalities

Where do we want to get to?

Our focus is on reducing a number of specific inequalities:
i. Reduce the levels of children living in poverty to 6% by 2020

ii. Close the gap in levels of smoking by routine and manual workers and the rest of the Rutland population by 2% by 2020.

iii. Reduce the employment gap between all adults, and those with learning disabilities and mental health conditions by 5% by 2020.

What have we done so far?

We have undertaken a number of key pieces of work to restructure services to maximise accessibility for our residents, including:

- Development of a new Children's Centre building linking a greater range of children and families' support under one roof, and assisting with transport for families who would otherwise not be able to access.
- Reviewing the provision for children and young people's emotional wellbeing and mental health, linking with the Future in Mind Mental Health Transformation funding, ensuring a range of services for all levels of emotional wellbeing and mental health needs across the county.
- Commissioned specific community-based, non-clinical mental health support in Rutland for adults with low level mental health problems.
- Developed digital opportunities with increased use of telecare, text, webchat and telephone support for improved access to health and care services, including the Community Wellbeing Service.
- The Council's Inclusion Development Worker develops employment and training opportunities for those with disabilities and supports individuals to access them, within the wider pathways to employment.
- Recommissioned Rutland's Smoking Cessation Service, within the wider Community Wellbeing Service, to make it more accessible.

Impact

i Children in Poverty
The current available data on children in poverty indicates that levels have so far remained stable, going forward we intend to measure not only the number of children living in poverty, but also the impact of this through child development, health outcomes and the educational attainment to provide a more rounded picture of our impact.

ii *Smoking prevalence in adults (18+)*
Nationally, smoking prevalence generally and in routine and manual occupations has declined year on year since 2012. The proportion of adults smoking in Rutland has decreased from 12.3% in 2016 to 9.3% in 2017, for routine and manual workers the proportion has decreased from 26.2% in 2016 to 15.9% in 2017. This also means that the gap between the general population who smoke and routine and manual workers who smoke has also decreased. Rutland has improved from being similar to the national

average in 2016 to significantly better in 2017. Rutland is now the 4th best performing area nationally.

iii *Reducing the employment gap between adults and adults with disabilities*
Data for 201617 indicates that the gap in the employment rate between those with a long-term health condition and the overall employment rate remained similar, with the gap between those with Learning Disabilities and the overall employment rate increasing slightly. However, during the period since the JHWS was written, the overall general employment rate in Rutland has improved, and is on an upward trend. This suggests that both employment rates for those with long-term conditions and those with Learning Disabilities will need to also improve in order to at least stay with the same gap.

What's next?

We will continue to develop our support for children and young people in Rutland, and in particular for those who are more vulnerable. This work will be led by the Children's Trust.

The smoking cessation service runs as part of our wider Community Wellbeing Service, and our local data indicates that improvements in smoking cessation in Rutland are continuing. As such our response to smoking cessation will remain as is.

We will continue our work to support individuals to achieve their goals and aspirations by our value-based practice approach within Adult Social Care. To build capacity with our Inclusion Worker, we have established additional capacity through a new Support Internship Job Coach under the Rutland Adult Learning & Skills Service to support internships for individuals aged 16-24 who have Education, Health and Social Care Plans. The role will work with employers to establish suitable and sustainable internships and with young people to ensure that they are able to access them.

Priority 3 – Integration of health and social care services to support those most at risk

Where do we want to get to?

The key to integration is seamless services that address people's needs as a whole individual. This in turn reduces duplication and ensure greater overall support. We want a consistency in response and approach to care regardless of whether service users are receiving care and support from health or from social care, with the emphasis on enabling choice and control and sustaining independence, enabling people to age well, whatever their circumstances.

What have we done so far?

The programme of work to deliver health and social care integration has been coordinated through the Better Care Fund Programme, the aims of which are:

- To progress integration and develop an integrated delivery model for health and care.
- To introduce closer working between primary, community and social care.
- To embed coherent person-centred case planning.
- To develop the workforce.
- To increase joint commissioning across health and social care.

To achieve these aims, we have undertaken a wide range of work, key to which we have:

- Instigated of a fully integrated RCC LPT hospital discharge team to ensure timely and supported return to community settings;

- Established coordination structures such as the GP Multi Disciplinary Team Meetings (MDTs) and Care Coordination roles, supplemented by a rapid response social care service;

- Introduced an Admiral Nurse service for individuals with dementia within Adult Social Care, one of only two Councils in the country to do this, linking clinical and non-clinical support for those with dementia and their carers;

- Embedded a coherent person-centred case planning approach for people with complex health needs which helps to keep these individuals as well as possible, including the development of a new care service to support those with complex care needs in their own homes, with integral district nursing support.

- Empowered staff to propose and implement change, actively developed their skills to align with the changing health and care system, and evolved new roles that offer greater job satisfaction, to maximise staff retention.

All the while maintaining Rutland's ambitions for health and social care integration at the heart of our discussions with colleagues across LLR regarding the Sustainability and Transformation Plans.

Impact

The following measures are used to establish the impact of our integration:

i. *the proportion of individuals over 65 who move into permanent residential or nursing care, with the aim being to reduce these numbers by enabling more people remain independent in their own homes whenever possible.*
Numbers of people permanently entering residential or nursing care fell from 0.5% of the over 65 population in 2014-15, to an average of 0.2% per year in the three years following, although with variation year on year with variation in cohorts.

ii. sustaining the high proportion of individuals who receive reablement services and are still at home 91 days after discharge from hospital.
We have sustained very high rates of reablement success between 2014-15 and 2017-18, with over 95% success in three out of four of those years. Over time, physical reablement for people returning from hospital has been supplemented by a number of complementary services such as a Housing MOT or support from the Community Wellbeing service, helping to ensure that people are equipped in the round to sustain their independence at home.

iii. a reduction in emergency admissions
Against a strong national trend of rising emergency admissions, the rate of emergency admissions has been maintained at a steady level in Rutland, with the 2017-18 rate only 0.5% higher than the rate in 2014-15. Non elective admissions rose by 9% in England over the same period according to national hospital activity data.

iv. a reduction in delayed transfers of care (DToCs).
Rutland has been successful in reducing delayed transfers of care by more than 60%, from 15.3 delays per day per 100,000 adults in 2014-15 to 5.7 in 2017-18. Avoiding discharge delays has also contributed to reducing the duration of emergency admissions, particularly among older people, which are prolonged unnecessarily when a delay occurs, leading to deconditioning and the potential for hospital-related infections.

What's Next?

We will continue to deliver the Better Care Fund Programme during 2018/19 to build on its success so far, continuing to monitor against the metrics shown above.

The new Health and Care Board governance structure will lead Locality, Better Care Fund and GP Primary Care Home plans and provide a platform to progress new areas of joint work between primary, community and social care that offer further opportunities to better align resources and services. This will include working together to align therapy and nursing services and providing improved support to people living with frailty.

In addition further opportunities for integration within adults' services are being explored including joint commissioning of domiciliary care and the formalisation of arrangements for the Council to lead commissioning of residential care on behalf of the CCG to provide consistent services across both, and to reduce the instances where individuals have to move service providers when their funding changes.

The next step is to extend this priority to include children's health and social care services, identifying opportunities for greater integration across both health and care delivery, and across health and care commissioning.

4. Next Steps

4.1 Updating the Joint Strategic Needs Assessment

The Joint Strategic Needs Assessment 2018 will be a new document, replacing the 2015 JSNA. Going forward, it will be refreshed on an annual basis. The JSNA will consist of:

- A set of chapters which provide an annual assessment of current and future health and social care needs.
- Infographic summaries
- A data dashboard that is updated on a quarterly basis to allow users to self-serve high level data requests

This will enable HWB members, partners and other stakeholders - including the public - to access relevant and current information about the health and care needs of people in Rutland, and to enable the HWB to ensure that its priorities remain pertinent.

4.2 Demonstrating Impact

We will continue to monitor the progress we make across the range of data available to us, including service user/patient feedback, being mindful that some impact will only become apparent over the longer-term.

We use the data which is regularly collated on a range of health indicators to tell us whether the health of our residents is improving.

We will communicate our successes and our challenges to the public so that they can hold us accountable and tell us how it feels to receive health and care services in Rutland, enabling us to continue to develop and respond over the life of this Strategy.

4.3 Timescales

The following will be taken to the Health & Wellbeing Board in June 2019:

1. Review and refresh of the Joint Health & Wellbeing Strategy
2. Health & Wellbeing Board Joint Health & Wellbeing Strategy Annual Report 2018