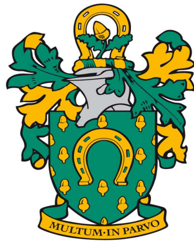


Rutland
County Council

East Leicestershire and Rutland
Clinical Commissioning Group

# RUTLAND JOINT HEALTH AND WELLBEING STRATEGY 2013 - 2016

**Appendix 1 REPORT NO. 213-2013**

**AUGUST 2013**

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## INTRODUCTION

The Health and Social Care Act 2012 places a duty upon Rutland County Council to set up a Health and Wellbeing Board, a Shadow Board was formed in 2011 and the Board has since been approved as a Statutory Committee of Rutland County Council.

Partner organisations of the Rutland Health and Wellbeing Board (as at June 2013) include:

- Rutland County Council (Local Authority, including Public Health)
- East Leicestershire and Rutland Clinical Commissioning Group (NHS)
- Lincolnshire and Leicestershire Local Area Team Commissioning Board (NHS)
- Local Healthwatch (represented by Rutland Local involvement Network until later in 2013)
- Spire Homes
- Rutland Health and Social Care Forum (Voluntary and Community Sector)

The Rutland Health and Wellbeing Board has developed a Joint Strategy; this is a statement of the Board's vision, priorities and goals based on the findings of the Rutland Joint Strategic Needs Assessment (JSNA) 2012. The JSNA was consulted on widely; this included a well-represented Stakeholder event during 2012. Other local evidence based information such as our organisational plans have been used to inform the strategy, including:

- East Leicestershire and Rutland Clinical Commissioning Group Organisational Plan for 2013-2014
- Lincolnshire and Leicestershire Local Area Team NHS Commissioning Board Organisational Priorities
- Rutland Children, Young People and Families Plan 2012-2015
- Rutland County Council Strategic Aims and Objectives
- Spire Homes Organisational Priorities
- Staying Healthy in Rutland Strategy 2011
- Common emerging issues identified by Rutland Local Involvement Network
- Common emerging issues identified by the Rutland Health and Social Care Forum

The Board will expect that the commissioning plans of Rutland County Council and the local NHS are consistent with this strategy, as required by the Health and Social Care Act 2012.

This strategy is not meant to cover everything that impacts on health and wellbeing but areas that the Board aims to tackle in partnership. 4 overarching themes have been identified; these are all issues that influence health and wellbeing currently and will even more so in years to come. The themes prioritise a number of lifestyle risk factors that are known to be specific problems for Rutland; this understanding derives from evidence based information outlined above.

## CONTEXT

Rutland is a healthy place; it is also the happiest place to live in England[1].

Most measures indicate good general health and life expectancy is higher than the national average. Levels of socio-economic deprivation in Rutland are amongst the lowest in the country.

However, Rutland is changing - as the population grows older and young people with disabilities live longer, there will be additional challenges to keeping Rutland a healthy place to live. For example, heart disease, cancer and respiratory problems will become more common and demand on health and social care services will grow. Prevention and early intervention will be essential in this context, including tackling lifestyle risk factors for the major killers, such as smoking, excessive alcohol intake, obesity and lack of exercise.

Health inequalities also persist in Rutland and there are pockets of deprivation which can prove to be a challenge in relation to the delivery of health and wellbeing services. Ill health is often more prevalent in people who are vulnerable and/or disadvantaged, for example through poverty, disability or older age, and many of these groups often find it difficult to engage with statutory services. Tackling inequalities in health and wellbeing outcomes continues to be a challenge and driver for change.

## AIM OF THE STRATEGY

- To reinforce our relationship as a Board
- Set out our joint commissioning intentions in a meaningful way

## OUR VISION

‘To continuously improve the health and wellbeing of the people of Rutland, and ensure Rutland remains the healthiest place to live in the UK’

[1] Office of National Statistics 2012: The Integrated Household Survey and the Opinions and Lifestyle Survey

To realise this vision the Board will:

- Recognise unmet local need
- Be transparent and accountable to the public
- Offer high quality services that are value for money
- Reduce dependence on health and social care services
- Work in a more integrated way to deliver services

## OUR PRINCIPLES

**Empowerment** based on:

- ❖ A shared responsibility
- ❖ Communities looking after themselves
- ❖ Encouraging people to make informed healthy choices
- ❖ Communication – sharing success and learning

**Provision** based on:

- ❖ Prioritising the most vulnerable
- ❖ Doing more for less
- ❖ Listening to service users and the public, and acting on what they tell us
- ❖ Taking advantage of Rutland's small size to utilize our resources and assets so we can target those most in need

## OUR PRIORITIES

The Rutland Health and Wellbeing Board wrote a strategic statement to outline Rutland's broad priorities; these have been linked to themes which the board wishes to tackle. The links are demonstrated in a table on page 6.

Themes have been prioritised on the basis that one organisation alone cannot address all the causes or offer all the solutions. They require partners to work together.

<table>
<tr><th>Priorities outlined in the Rutland Health and Wellbeing Strategic Statement 2012-13</th><th>Themes carried forward to this strategy</th></tr>
<tr><td>Starting well – improving the health of children, young people and their families</td><td>Giving children & young people the best possible start</td></tr>
<tr><td>Living well – addressing lifestyle risk factors, including improving access to health improvement services</td><td rowspan="2">Enable people to take responsibility for their own health</td></tr>
<tr><td>Carers – Including informal care and care for and by young people</td></tr>
<tr><td>Long term conditions – early intervention and long term support in chronic illness</td><td rowspan="4">Help people to live the longest healthiest life they can</td></tr>
<tr><td>Mental health and wellbeing – including impact of social and economic pressures on mental health</td></tr>
<tr><td>Tackling the wider determinants of health</td></tr>
<tr><td>Meeting the needs of an aging population – improving and supporting independent living and complex care needs including dementia</td></tr>
<tr><td>Access - including geographical and social barriers</td><td>Making health and social care services more accessible</td></tr>
</table>

| Theme | Priority | Goals | Plans | Outcomes | Responsible Subgroup |
|---|---|---|---|---|---|
| **1. Giving children & young people the best possible start** | Vulnerable Families<br><br>Some families experience problems due to financial, health or relationship difficulties. Some children are growing up in families which are unable to support them adequately either practically or emotionally. | To identify and target vulnerable families<br><br>To improve support for families with multiple problems<br><br>To focus resources on those families most in need<br><br>To reduce child poverty | Please see Children's Trust action | Please see Children's Trust action | Children's Trust |
| | Vulnerable Teenagers<br><br>Ensure a smooth transition into adulthood.<br><br>The teenage years are a critical period of growth and change. They are an important time for making significant life choices and decisions. | Provide a holistic offer of recreational and learning opportunities that enhance young people's social, emotional, health and personal development outside of the school curriculum. | Please see Children's Trust action | Please see Children's Trust action | Children's Trust |
| | Emotional health and wellbeing of children, young people and their families | Support all children, young people and families to address their emotional health and wellbeing. | Please see Children's Trust action | Please see Children's Trust action | Children's Trust |

| Theme | Priority | Goals | Plans | Outcomes | Responsible Subgroup |
|---|---|---|---|---|---|
| | | Identify and target those families with specific emotional health and wellbeing needs through early intervention.<br><br>Improve support for families with complex health problems.<br><br>To influence and encourage partnership working across a variety of sectors to promote positive mental health for the people of Rutland. | Please see Staying Healthy Action Plan | Please see Staying Healthy Action Plan | Staying Healthy |
| **2. Enable people to take responsibility for their own health** | <u>Obesity</u>:<br><br>Childhood and adult obesity prevalence poses a significant risk to the health of the population and the increased use of health services | To increase the percentage of children and adults who are a healthy weight by providing a range of interventions focussed on physical activity and healthy eating | Please see Staying Healthy Action Plan | Please see Staying Healthy Action Plan | Staying Healthy |
| | <u>Smoking</u>:<br><br>Smoking remains the largest preventable cause of ill health and premature death in Rutland | To further reduce the prevalence of smoking by helping smokers to quit and influencing young people not to start in the first place | Please see Staying Healthy Action Plan | Please see Staying Healthy Action Plan | Staying Healthy |

| Theme | Priority | Goals | Plans | Outcomes | Responsible Subgroup |
|---|---|---|---|---|---|
| | Alcohol:<br><br>Excessive alcohol consumption is associated with significant short and long term harm to health. | To reduce the harm caused by alcohol, tackling both binge drinking and longer term drinking in excess of recommended levels. | Please see Staying Healthy Action Plan | Please see Staying Healthy Action Plan | Staying Healthy |
| 3. Help people live the longest healthiest life they can | Frail Elderly Population:<br><br>Our elderly population is above the national average in number and rising, have increasingly complex health and social needs. | To have an integrated Health and Social care service that is able to identify and assess those with complex needs who are at risk of losing their ability of independent living, and thus put in place short and long term support | Please see Complex Needs Action Plan | Please see Complex Needs Action Plan | Complex Needs |
| | Dementia:<br><br>People with dementia, are currently often unrecognised, and will require increasing health and social care in future. | To have Health and Social services that both encourages and enables those who are worried about or at risk of, developing dementia (and their carers), to receive appropriate assessment , treatment and support. | Please see Complex Needs Action Plan | Please see Complex Needs Action Plan | Complex Needs |
| | Cancer:<br><br>Whilst we have a good cancer care and screening record across the county generally, we | To ensure all of our population , but especially those in deprived groups, not only have access to, but also are encouraged to use the health services that provide | Please see Staying Healthy Action Plan | Please see Staying Healthy Action Plan | Staying Healthy |

| Theme | Priority | Goals | Plans | Outcomes | Responsible Subgroup |
|---|---|---|---|---|---|
| | need to ensure this is maintained and is more equitable, especially in the more deprived groups. | both care, early diagnosis, and screening in cancer. | | | |
| | Depression and Anxiety:<br><br>This is a common problem, especially in the elderly and isolated.<br><br>There is a recognised social stigma that prevents people looking for help. | To increase awareness and use of current and future services within primary care, social care and voluntary sector that support and help those with stress related problems, depression and / or anxiety. | Please see Complex Needs Action Plan | Please see Complex Needs Action Plan | Complex Needs |
| | Wider Determinants of Health:<br><br>Good quality housing, fuel poverty, homelessness, environmental and social impacts critically affect a person's health and wellbeing. | To ensure that a combination of regulatory powers, partnership working and funding opportunities are used to mitigate and where possible eliminate the effects of the wider determinants of health on the health and wellbeing of our population<br><br>Continue to recognise the strong links between health and wider determinants, in particular housing. | Please see Staying Healthy Action Plan | Please see Staying Healthy Action Plan | Staying Healthy |

| Theme | Priority | Goals | Plans | Outcomes | Responsible Subgroup |
|---|---|---|---|---|---|
| **4. Making Health and Social Care Services more Accessible** | Living Independently:<br><br>Some people experience difficulty in accessing the health and social care support that they need to live as independently as possible in the community of their choice. | To enable people to remain living in the community of their choice for as long as possible through:<br>a. Supporting carers to care for family and friends within the community<br>b. Listening to service users, carers and providers of services in order to improve the experience that people have of health and social care services<br>c. Providing the right information to service users and their carers at the right time to help them to make informed choices about their care and support | Please see Complex Needs Action Plan | Please see Complex Needs Action Plan | Complex Needs |
| | Hospital Discharges:<br><br>People may stay in hospital longer than is medically required<br><br>Avoidance of hospital admissions | Maximising the opportunities for people to receive care and treatment within the community rather than in hospital or other residential setting.<br><br>Ensuring that people do not stay in hospital beyond the point | Please see Complex Needs Action Plan | Please see Complex Needs Action Plan | Complex Needs |

| Theme | Priority | Goals | Plans | Outcomes | Responsible Subgroup |
| --- | --- | --- | --- | --- | --- |
| | | where they have been deemed medically fit for discharge (moved from (moved from living independently) | | | |
| | <u>End of Life Care:</u><br><br>Most people would prefer to die at home given a choice | Continue to provide the current level of service available to support patients and their carers and families during the process of agreeing care pathways with their GP and other providers. | Please see Complex Needs Action Plan | Please see Complex Needs Action Plan | Complex Needs |

**An Equality questionnaire has been completed, a full equality impact assessment was not required.**

## A large print version of this document is available on request

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