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Rutland County Council

Catmose, Oakham, Rutland, LE15 6HP
Telephone 01572 722577
Email: democraticservices@rutland.gov.uk

RUTLAND HEALTH AND WELLBEING BOARD

ANNUAL REPORT 2022-2023

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Rutland County Council

Rutland Health and Wellbeing Board

Annual Report 2022-23

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Foreword from the Chair

Welcome to the annual report of the Rutland Health and Well-being Board for 2022-2023.

This year has been extremely busy as Rutland embraced the changes in the Integrated Care System and became a 'Place'. This has brought opportunities to be grasped but also some challenges.

I would like to take this opportunity to thank all the members of the Rutland Health and Wellbeing Board for their hard work, commitment and enthusiasm to our partnership. I would also like to thank all the residents of Rutland who have engaged, challenged and encouraged the work of the Board.

Special thanks go to the officers of the board who work tirelessly behind the scenes namely Sarah Prema and her team at the ICB, Adrian Allen and the team at Public Health and all the officers at RCC. I would also like to add a personal thanks to Dr Viv Robbins, Sandra Taylor and Katherine Willison, who spent many hours working towards the vision of the Joint Health and Wellbeing Strategy.

We look now to a new year and I'd like to remind everyone that the Board's meetings are open to the public and can be viewed online.

Councillor Samantha Harvey

Chair of the Rutland Health and Wellbeing Board 2022-2023

The Role of the Health and Wellbeing Board

The Rutland Health and Wellbeing Board (HWB) is a formal statutory committee of the local authority. The aim of the Board is to improve the health and wellbeing of our local population and reduce health inequalities. The HWB has a statutory duty, with the Integrated Care Board (ICB), to produce a joint strategic needs assessment and a joint health and wellbeing strategy for the local population.

The HWB is chaired by the Portfolio Holder for Health, Wellbeing and Adult Care. Membership includes representation from the local authority, health, public health, police and from the Voluntary and Community Sector.

Place as defined in the NHS Long Term Plan is the local authority boundary of Rutland County Council. Rutland falls within the wider health and care footprint of the Leicester, Leicestershire, and Rutland (LLR) Integrated Care System (ICS)

The last twelve months have presented organisations with major challenges including post Covid 19 recovery, the war in Ukraine, the cost-of-living crisis and significant savings needing to be made by health and local authorities.

In the face of these challenges, there continues to be effective collaborative working by partners to achieve good health and wellbeing outcomes for the population of Rutland and users of Rutland Primary Care services. An area where this is highlighted is the consistently low numbers of Rutland residents remaining in hospital when there is no clinical need. This is made possible through collaborative working across adult social care and health partners.

The Joint Health and Wellbeing Strategy/The Place Based Plan 2022-2027

The Vision

To nurture safe, healthy, and caring communities in which people start well and thrive together throughout their lives. The strategy has seven priority areas for action plus a Communications and Engagement plan to support delivery:

Rutland Health and Wellbeing Delivery Action Plan

This is a working document with a range of activities planned, or in place, to achieve the outcomes we are aiming for.

Highlights from what has been achieved over the last 12 months detailed below:

Best Start for Life (Priority 1)

Launch and delivery of the LLR 1001 Critical days. The first 1001 days include pregnancy and the first two years of a child's life. There is clear, compelling evidence that this is a significant and influential phase in development. What happens during this period lays the foundation for every child's future health, wellbeing, learning and earnings potential. It sets the groundwork for children's developing emotional wellbeing, resilience, and adaptability; the competencies they need to thrive. During this period the foundation occurs, of health and wellbeing whose benefits last a lifetime – and carry into the next generation. The Family Hub provides several services to support this including Safe Sleeping courses and Health Visitor clinics.

Launch and Promotion of the LLR ICON Training

The ICON programme and the different interventions within it was conceived in 2016 which included the study of effective interventions and research into the prevention of Abusive Head Trauma (AHT). Research suggests that some lose control when a baby's crying becomes too much. Some go on to shake a baby with devastating consequences. The evidence-based

programmes studied provide a simple message that supports parents/care givers to cope with infant crying. ICON is all about helping people who care for babies to cope with crying. ICON stands for ….

- **I** – Infant crying is normal
- **C** –Comforting methods can help
- **O** – It's OK to walk away
- **N** – Never, ever shake a baby

New **0 to 19 Public Health** contract and offer in September 2022, including 11+ Teen Health Service unique for Rutland.

Health Ageing and Living Well with Ill Health (Priority 3)

We work collaboratively as a place across Rutland to ensure coordinated, joined up and accessible services. The Joy platform (www.rutland.gov.uk/joy) was introduced in September 2022 with the app now operational in our Rutland GP practices. Joy also has a public facing platform which enables people to self-refer and to stay up to date with our local services. This support ensures people to stay independent, promoting the key role they play in their own care, monitoring and managing their conditions.

A Social Care Portal for online referrals which incorporates a self-assessment tool for Therapy Services is in the final stage of development. The portal aims to seamlessly direct referrals to the right therapy offer linking directly to the Joy platform. This ensures the right professionals are involved in the person's care and support from the start, preventing duplication and telling their story twice.

Active Rutland are now fully operational on the Joy Platform. Active Rutland are a physical activity development team, who work with a collection of wider partners who all contribute to make Rutland an active place to live, work and visit. A successful bid to extend and recruit to a new Exercise Referral Coordinator was secured, two new community venues established, and two new steady steps classes are being delivered in the community.

The New Rutland Anticipatory care pilot for early identification / diagnosis of individuals who may develop dementia is in early-stage development. An initial list of 200 patients has been identified as a possible cohort to engage with this pilot and initial plan for engagement events across Rutland. This includes proposals for a memory assessment clinic in Rutland.

Home First

As demands upon health and social care services continue to rise, delivering the right services at the right time and supporting people to go home and stay home after a hospital stay is a National Challenge.

Rutland's Hospital and Reablement Team plays a vital role facilitating discharges home from hospital, preventing crisis admission and is an essential tool in managing the demand on care capacity. The team focuses on a home first approach, with individuals returning home to receive assessment, care and support and achievement of individualised goals.

Delivered at the right time, reablement can reduce, delay, or remove the need for ongoing care and support. For the last 2 years a 7-day reablement services has been operational with

a qualified therapist available to ensure the right decisions are made and the right services are accessed. An individual receives an assessment within 48 hours of returning home from hospital.

The effectiveness of Rutland reablement service can be seen by the following data:

April to November 2022, 78 individuals received home based reablement. Of those 78, 75 individuals left the service with no ongoing support needs.

The success in our home first approach of go home and stay home can be seen by the following data:

63 out of 68 individuals who accessed this service remained at home 91 days after discharge from hospital. The national average is 79.1%. Rutland have exceeded this from April – November 2022, attaining over 90% for 4 of the 8 months.

As a measure to address winter pressures, from January to April 2023 four additional beds are available at Rutland Care Village, to support individuals who are leaving hospital but are not quite ready to return home and require additional support first. This will include discharges at weekends with therapy support.

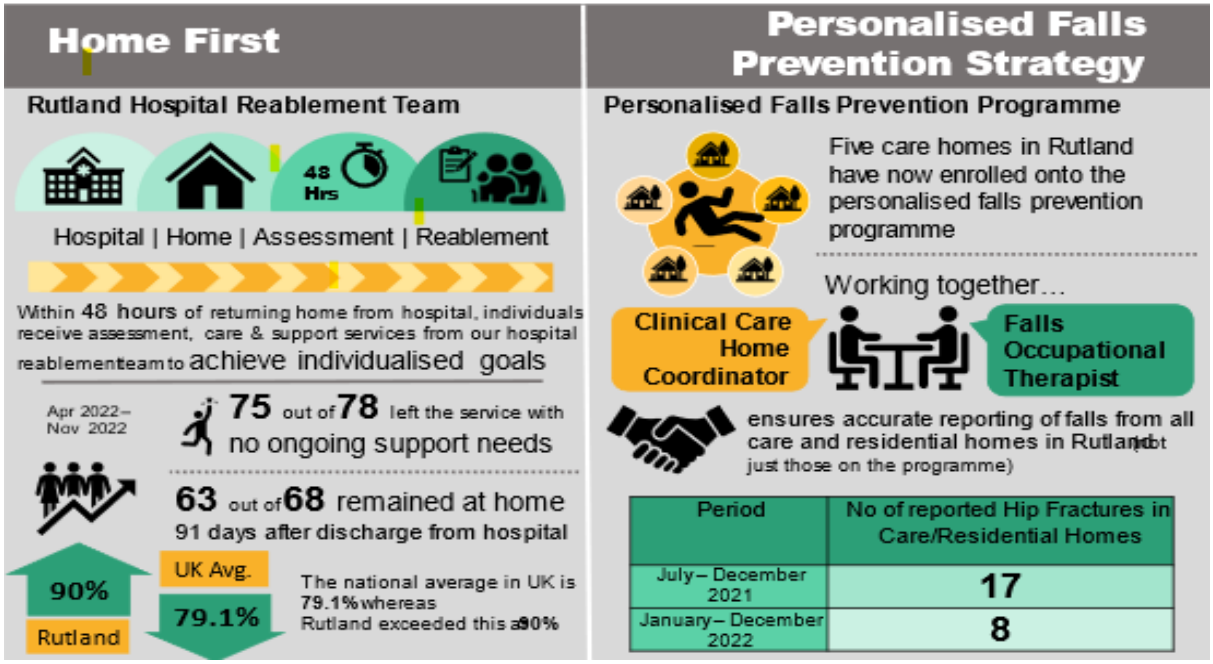
Personalised Falls Prevention Strategy

Five care homes have now enrolled onto the personalised falls prevention programme and progressed in their programme development to stage two. Our dedicated Falls Occupational Therapist is working collaboratively with the Clinical Care Home Coordinator to ensure accurate reporting of falls from all care and residential homes in Rutland, not just those enrolled onto the programme.

Data has been collected since July 21. Analysis has started to look at the impact of the programme and initial figures are positive:

Period	No of reported Hip Fractures in Care/Residential Homes
July – December 2021	17
January – December 2022	8

Falling amongst our most vulnerable cannot be fully eradicated, however this programme is demonstrating a reduction in the impact/severity of falls.



Equitable Access to Services (Priority 4)

In 2022/23 good progress has been made against the Equitable Access strategic priority. Key points to note are that primary care access and appointments have been restored to over and above pre pandemics levels within all four practices. In October 2022 we saw the launch of enhanced access at a Primary Care Network (PCN) level which meant primary care access was extended Monday to Friday till 8pm and Saturdays from 9:00 – 5pm. A mixture of pre-bookable and same day appointments for prevention, proactive and long-term condition management.

After an incredibly successful pilot, the PCN achieved the continuation of a diagnostics project which involved the local provision of four key diagnostic tests locally, such as Spirometry (assessment of lung function), FeNO (Fractional Exhaled Nitric Oxide), 24-hour Electrocardiography and 24-hour Blood Pressure which reduced referrals into secondary care and post covid back log as well as significantly reducing the time patients have to wait. 2022/23 also saw the initiation of work to be continued in 2023/34 such as the exploration of an MRI (Magnetic Resonance Imaging) hub and scoping and feasibility of long-term plans for Rutland Memorial Hospital.

Preparing for Our Growing and Changing Population (Priority 5)

Rutland Strategic Partnership Group drive planning and oversee delivery of strategic healthcare improvement for the local population. This group has overseen key discussions with developers around opportunities for Primary Care. It aims to achieve joint solutions on the Stamford and Rutland border to inform a clearer understanding of the most appropriate direction locally. Rutland PCN are being supported to develop their clinical and estates strategy, which will be key to understanding future direction of Primary Care in Rutland.

A major piece of work over the last 12 months has been to develop a vision and plan for the future of RMH and bring care closer to home. There has been a robust feasibility study to understand the opportunities for future infrastructure investment.

Reducing Health Inequalities (Priority 7.2)

The health inequalities priority aims to development understand of and reduce health inequalities within Rutland. The Needs Assessment on health inequalities has been completed, providing a more comprehensive understanding for partners across Rutland. Additionally, a Health and Wellbeing Board development session on health inequalities took place in January 2023, bringing partners together to discuss an approach to take forward.

For 2023/24, the priority workstream will progress into planning and action, building on what is already in place. The needs assessment and development session have provided us with the insight and engagement needed to develop plans addressing health inequalities. Predominantly, this will include an approach to balancing universal provision alongside some level of targeting to those population groups and small geographical areas most in need. The Staying Healthy Partnership will be the subgroup to facilitate action across Rutland.

Communication and Engagement Plan

Supporting the Delivery of the Joint Health and Wellbeing Strategy

The Communication and Engagement plan aims to enhance the health and wellbeing of people living in Rutland by facilitating effective health and wellbeing communications. People who are using services, are living with a disability or long-term health condition are often referred to as 'Experts by Experience' or those with 'Lived Experience'. Experts by experience are involved in the big decisions about the work taking place and being part of the development of services. The benefit of co-production is building relationships with excluded groups, especially those affected by socio-economic and health inequalities, and we are working to ensure co-production and engagement are embedded in our work. The development of social networks and communities provide a focus on outcomes of support, with a greater focus on prevention. There is a focus is on digital innovation, promoting and empowering the community to make self-referrals into Adult Social Care providing efficiencies in resource and create a more personalised experience.

Contributions from the Community Sector Stakeholders

Armed Forces

The Armed Forces Covenant Duty was signed into law and became legally enforceable on 22nd November 2022. Rutland's Health and Wellbeing Board have fully supported the work of our Armed Forces Officer and the work of all Council Directorates in providing support to our large Serving and Veteran population, and their families. Notable achievements have included the launch of a Veterans' Wellbeing Hub in Oakham. Tackling loneliness and improving mental health are key aims but it has supported with financial worries to potential domestic abuse.

Another initiative has been the creation of an Intergenerational Friendship Club at Kendrew Barracks, specifically at the resident primary school. This offers the children of Service Personnel and older Veterans the opportunity to undertake various activities, socialise

together and develop friendships across the generations. This initiative has been funded by Rutland County Council, through a grant received from the Armed Forces Covenant Fund Trust and is delivered in partnership with Age UK Leicestershire & Rutland.

A third initiative in development stage is the creation of an Armed Forces Single Point of Contact (SPoC) for health matters, funded by NHS England. The SPoC would receive health-related referrals and requests in order to reduce health inequalities and improve health related outcomes of the Armed Forces community in our area.

The Voice of Healthwatch Rutland

"*Healthwatch Rutland highly values our seat on Rutland County Council Health and Wellbeing Board. Through this, we carry out our statutory role of representing the experiences and needs of Rutland residents in all aspects of health and care.*

We have been proud to represent the Rutland voice in the development of the Joint health and Wellbeing Strategy and Delivery Plan. Healthwatch Rutland staff and volunteers have embraced the opportunity to be involved throughout the whole planning and implementation cycle so far. From initial project work to identify want people need to stay healthy and well (What Matters to You?), through keeping public voice at the heart of the developing delivery plans, to shaping the priorities within individual workstreams, we have been integrated into the joint work throughout.

We see much progress particularly in the effort to better understand health inequalities in our county and work to support the best start in life through the Family Hub programme. We now look forward to a renewed focus on continuing and improving engagement and communications with the public. As one participant in What Matters to You? put it "you have to engage with people to make them feel part of the solution" and Healthwatch Rutland will be pleased to help with that."

The Four Sub-Groups of the Health and Wellbeing Board (HWB)

Integrated Delivery Group (IDG)

The purpose of the IDG is to provide leadership, direction, and assurance, on behalf of the Rutland HWB, so that the vision for integrated health and care in Rutland is delivered. Functions include proposing the scope for the programmes, driving forward, and leading on monitoring the delivery of the Joint Health and Wellbeing Strategy. The IDG supports the development of the Rutland Better Care Fund (BCF) Plan and associated metrics. HWB approves the BCF expenditure plan and leads on delivery.

Children and Young People's Partnership (CYPP)

The CYPP supports the development and improvement of services for children and young people 0 – 25 years in Rutland. It aims to ensure that all children and young people in Rutland are happy, safe, and successful and empowered to be the best they can be. The subgroup reports to the HWB to ensure that the needs of children, young people, and families in Rutland influence planning for health and wellbeing improvements. It proposes scope for plans and oversees their delivery on behalf of the HWB.

Staying Healthy Partnership

The partnership aims to progress workstreams within the Rutland Health and Wellbeing Strategy delivery plan relating to primary prevention, the wider determinants of health and health inequalities. Work has progressed on the health inequalities workstream, including the development of a Health Inequalities Needs Assessment and Board development session. Next steps for the Partnership will be developing a plan for Rutland organisations. The plan will support those most in need within the county, alongside universal provision, focusing on small geographical areas and population groups.

Mental Health Neighbourhood Group

The group leads on driving, coordinating, and enabling mental health transformation, working with the HWB, local authority, local VCS partners and local health organisations. The objectives of the group include the creation of a local plan to better coordinate care and deliver an improved response for low level mental health issues. Next steps for the group are to deliver an integrated neighbourhood approach to ensure that mental health needs in Rutland are met.

Joint Strategic Needs Assessment

The Rutland Health and Wellbeing Board has responsibility for assessing the health and wellbeing needs of their population and publishing a joint strategic needs assessment (JSNA). The JSNA assesses needs based on local intelligence and insight, with clear recommendations for action. Chapters will continue to be produced on a rolling basis, aligned to the priorities set out within the Joint Health and Wellbeing Strategy.

The JSNA is a standing agenda for the Rutland Health and Wellbeing Board. Throughout 2022/23, the following JSNA chapters have been completed and approved by the board:

- Health Inequalities in Rutland
- End of life care
- Oral Health

An updated Pharmaceutical Needs Assessment was also completed and approved by the board in July 2022, which is a statutory duty.

Better Care Fund

The Better Care Fund (BCF) is a pooled budget between the Integrated Care Board and the County Council. The purpose of the fund is to promote integration and collaboration between partners to support the delivery of person-centred care and good outcomes for people and carers. The programme is overseen by the Rutland Health and Wellbeing Board.

There are 4 national conditions that all plans must meet to be approved. National condition 4 is implementing the BCF objectives. This requires a joint plan to deliver health and social care

services that support improvement in outcomes against the fund's 2 policy objectives. These are:

- Enable people to stay well, stay safe and independent at home for longer.
- People have the right care at the right time.

Commissioners should agree how services will continue to promote the independence and address the needs of people who are at risk of losing it, including admission to residential care or hospital. The focus is ensuring people are discharged in a way that maximises independence and leads to the best possible outcomes.

The BCF for 2022 to 23 was £3,189,091 incorporating NHS funding, improved Better Care Fund (BCF) local authority grant and a Disabled Facilities Grant (DFG). The plan encompasses a range of schemes aligned with Rutland's priorities of unified prevention, holistic health management in the community, hospital flows and enablers.

- Community Wellbeing Service- advice and support services including Citizen's Advice
- Social Prescribing – includes joint GP and RCC RISE Team.
- Integrated care services – includes therapy: adaptation funding offers.
- Carers support workers including Admiral Nurses supporting the carers of people living with dementia.
- Multidisciplinary staff resources to support Hospital flow including Reablement, Discharge to Assess and Crisis Avoidance to prevent admissions.

In September the Government committed additional funding to the BCF. The Adult Social Care Discharge Funds supports timely and safe discharge from hospital by reducing the number of people delayed in hospital awaiting social care. Rutland receive £268,371 from a combination of ICB funding and LA grant. This funding provided additional interim beds for Reablement in Rutland supporting weekend discharges to include a therapy response. At the time of printing, we are awaiting confirmation of funding for 2023-24.

Next Steps

The HWB will continue to review and embed the strategy across all areas, with adherence to the 5-year plan. The focus will remain on improving the Health and Wellbeing outcomes for the Rutland population and users of Rutland Primary Care Services.

One of the key aims of the strategy is to support integrated working across health and care to the benefit of Rutland people of all ages. The Leicester, Leicestershire, and Rutland Care Record (LLR CR) programme is part of the national Shared Care Record. As part of the early adopter rollout, Rutland County Council has been the first of the three LLR local authorities to start using the system, with its adult social care teams now able to access more of the information they need directly. It is anticipated this will accelerate and inform processes, save time for others including local GP practices, and improve individuals' care experience.

Care delivered out of area will not initially be accessible as part of someone's record, but sharing across borders is a future phase for the programme. The LLR CR is built to comply

with digital and information standards which will facilitate this future sharing that will be a high priority for many Rutland residents.

Other current LLR CR early adopter teams relevant to Rutland are:

- LLR hospital discharge hub
- Older people's unscheduled mental health teams
- LOROS hospice's social care and enablement team

The roadmap for wider LLR CR rollout includes connecting GP practices, community health teams, University Hospitals of Leicester teams, wider adult hospice services and community pharmacy. Work is also underway to enable information sharing with East Midlands Ambulance Service to inform urgent callouts.

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