Report No:164/2022
PUBLIC REPORT

RUTLAND HEALTH AND WELLBEING BOARD

11 October 2022

JOINT HEALTH AND WELLBEING STRATEGY UPDATE

Report of the Portfolio Holder for Health, Wellbeing and Adult Care

Strategic Aim:	All	
Exempt Information	No	
Cabinet Member(s) Responsible:	Cllr S Harvey, Portfolio Holder for Health, Wellbeing and Adult Care	
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DECISION RECOMMENDATIONS
That the Committee: 1. Notes the further development of the JHWS Delivery Plan through the content of this report

1 PURPOSE OF THE REPORT (MANDATORY)

1.1 The Joint Health and Wellbeing Strategy (JHWS) is a statutory responsibility of the Health and Wellbeing Board (HWB) and falls under its governance.

1.2 The purpose of this report is to update the board on the progress of implementation of the JHWS across the six priority areas and the key enablers.

2 IMPLEMENTATION OF THE STRATEGY

2.1 Rutland's Joint Health and Wellbeing Strategy was formally approved at the 5 April Health and Wellbeing Board.

2.2 The overall aim of the joint strategy, which will be delivered across five years, is for 'people to live well in active communities.' It aims to 'nurture safe, healthy and caring communities in which people start well and thrive together throughout their lives.' In order to achieve its objectives, the Strategy is structured into seven priorities following a life course model.

2.3 At the May Integrated Delivery Group (IDG) meeting, leads were nominated for each of the JHWS priorities at both HWB and IDG level, with the aim of supporting the balanced and collaborative delivery of the strategy via IDG and the HWB.

2.4 Since the last HWB each of the priority areas have established delivery groups to take forward the work plan for each of the strategic priorities. Each of the subgroups report in to the IDG which in turns reports to the Rutland Joint Health and Wellbeing Board.

2.5 During October 2022, a robust governance process will be finalised that supports the continued monitoring of the implementation of the Rutland Joint Health and Wellbeing Strategy.

2.6 **Appendix A** is the Quarterly Highlight Report for each of the strategic priorities and enablers detailed within this report.

2.7 **Appendix B** is an Outcomes Summary Report which sets out the most recent Public Health data for indicators relevant to each Strategy priority. It highlights whether Rutland rates are below, similar to or above national rates, or it compares Rutland to a group of 16 similar areas in the country. The reports are used by priority teams for targeting and prioritisation.

3 PROGRESS ON STRATEGIC PRIORITIES

3.1 Priority One: Enabling the Best Start in Life

3.1.1 This strategic priority is supported by the Children and Young People's Partnership Board. The key deliverables within this priority now form an integral part of the role and remit of this Board.

3.1.2 The key deliverables of this priority are:

- Healthy child development in the first 1001 critical days (conception to 2 years old)
- Confident families and young people
- Access to health services

3.1.3 The achievements to date include:

- Completion of baseline assessment of Early Intervention services via Early Help System Guide
- Completion of High-Level Implementation plan and formation of multi-agency steering group; first meeting held and terms of reference agreed
- Commissioning of visuals and graphic design components to aid brand launch and raise awareness of hub offer for families and professionals

3.2 Priority Two: Staying Healthy and Independent – Prevention

3.2.1 At the August meeting of the IDG it was agreed that a Staying Healthy subgroup would be formulated to support this strategic priority and report to IDG. This group is in the process of being established.

3.2.2 The key deliverables of this priority are:

- Options appraisal for developing a prevention front door for Rutland.
- Implementation low level of prevention offer in all front-line staff through LLR Healthy Conversations training (Making Every Contact Count Plus (MECC+))
- Review the oral health needs of Rutland

3.2.3 The achievements to date include:

- Agreed at IDG to establish a Staying Healthy Group as a subgroup of IDG
- IDG approval to develop an options appraisal for a prevention front door.
- Social prescribing platform implemented for the RISE team.
- MCC+ plus training delivered to RISE team.
- Oral health needs assessment has been started

3.2.4 The key focus for the next period is:

- Develop options appraisal for prevention front door and assess capacity, infrastructure and resource to scope and implement a coordinated prevention front door for Rutland.
- Further embed MECC+ across Rutland and Ensuring all frontline staff see prevention as a core part of their role in Rutland and attend MECC+ training.
- Complete oral health needs assessment for HWB Jan 2023

3.3 Priority Three: Healthy Aging and Living Well with Long Term Conditions

3.3.1 This strategic priority is supported by the establishment of the Integrated Neighbourhood Network which meets monthly and reports to the IDG.

3.3.2 The key deliverables of this priority are:

- Timely and well-coordinated support enabling people living with ill health to live well, without ill health dominating, postponing deterioration, ageing well.
- Tailored support to help individuals live well with changing health circumstances through MDT working
- Collaborative coordinated care – recruitment to neighbourhood facilitator underway
- Integrated and multidisciplinary working through the monthly Rise team MDT meetings is supporting people with complex health needs.
- Cross-boundary inequality of access to support for people diagnosed with dementia
- Active work on falls prevention in care homes, using a personalised approach

for greater impact.

- To develop a falls prevention strategy specific to each Care Home environment, creating a culture of individualised care for best practice.

3.3.3 The achievements to date include:

- Integrated and multidisciplinary working through the monthly RISE (Rutland Integrated Social Empowerment Service) MDT meetings are supporting people with complex health needs.

- WHZAN pilot has commenced with nine Rutland care homes. The Whzan Blue Box is an all-in-one telehealth case. It measures vital signs, records photos, and performs multiple assessments. This enables signs of deterioration or illness in a resident to be identified earlier, for a clinical response or carer support

- Recruitment of neighbourhood facilitator – interviews taking place this month

- Rutland social prescribing platform live from 1st Sept 2022.

- 3 conversations innovator site identified some staff to codesign cohort of people to work with

- Dementia UK have introduced a new national project called Closer to Homehttps://www.dementiauk.org/get-support/closer-to-home/Families are now able to access wherever they live.

- RCC falls prevention Occupational Therapist [OT] is currently working with two Care Homes to create a bespoke falls prevention strategy for each home.

- Three of the Rutland Care Homes now have a dedicated Falls Prevention Champion, with the plan for there to one in each care home. The Champions meet weekly with RCC OT, to discuss practice, training, and staffing. Falls cases and falls patterns across the care home are reviewed and actions plans discussed. The OT identifies and recommends environmental adaptations and assistive technology which could support in reducing falls risks.

- Good hospital discharge performance – high reablement success and minimising use of interim beds means patients successfully going straight home. MiCare capacity is good and we have not had to use an interim bed since before June – but no weekend social worker could potentially cause us problems.

- The Rutland Care Provider forum has been ongoing since last December, with the last forum occurring Wednesday 7th September. Attendance at these forums varies, but the last one was 50% of care homes and 33% of home care providers (this includes all spot and framework). The next forum in December will hopefully be face to face which should encourage some attendance.

- All Rutland providers are engaging with the capacity tracker. All care providers, bar one, have updated the tracker within the past 2 weeks.

3.3.4 The key focus for the next period is:

- Looking at further development of the successful Rise adults MDT meeting model to children's and safeguarding focused meetings.

- Evaluation of Whzan pilot

- Neighbourhood facilitator to identify individuals to benefit from proactive care management through a population health management approach.

- Onboarding all partners and content of the RIS to the Rutland social prescribing platform

- Training and support for partners to use the social prescribing platform

- Comms for the public to be aware of the social prescribing platform

- Further engagement with staff across neighbourhood to join the 3 conversations innovator site

- Admiral nurses support through virtual clinics, with the hope this can also become face to face

- Carers strategy going to cabinet Oct 18th, 2022, for approval. This is an all age LLR strategy with a Rutland specific delivery plan.

- Dementia. LLR strategy currently being reviewed following covid. Diagnosis rate is due to severe backlog at memory services, due to staffing issues and the service being closed during Covid. Referrals into memory service remain high. Memory services are wanting a room available in Oakham to have a memory clinic local to the area

- LD- Following Covid, Face to face annual health checks is priority due to communication and support required.

- Falls A third Care Home identified for the programme. Initial meetings to take place October 2022.RCC OT to continue to promote and encourage other providers to join the programme. RCC OT to look to collate data relating to this service.

3.4 Priority Four: Ensuring Equitable Access to Services for all Rutland Residents

3.4.1 This strategic priority is supported by the Rutland Strategic Health Partnership Board.

3.4.2 The Key deliverables of this priority are:

- Understanding access issues

- Increasing access and availability to diagnostic and elective services closer to home.

- Improving access to primary and community health and care services

- Improve access to services and opportunities for people less able to travel, including through technology

- Enhance cross boundary working across health and care with key neighbouring areas

3.4.3 The key achievements to date include:

- A plan has been agreed for Rutland PCN to deliver an enhanced access service on a rotational basis across the four GP sites which will provide pre-bookable, same day access and preventative services Monday to Friday 6.30 - 8.00pm and Saturday 9.00 - 5.00pm. This service is due to commence on 1st October 2022.

- Following recruitment of a care co-ordinator through the ARRS, and in conjunction with the PCN Direct Enhanced Service (DES) the PCN have agreed plan that proactively seeks to identify patients who are housebound/frail elderly to care plan and reduce the risk of falls and deterioration in condition.

- The PCN now has 180 blood pressure monitors to support patients to monitor the blood pressure at home, negating the need to be referred on to secondary care.

- After the success of the diagnostic pilot, the PCN have been contracted to deliver four diagnostic tests locally on an ongoing basis and further diagnostics are being considered such as Doppler tests. This avoids patients having to be referred into secondary care and also ensure that the patients are seen quicker, closer to home.

- RCC CC Property Services have identified a potentially suitable site at Oakham Enterprise Park for mobile MRI. Discussions are ongoing.

- A business case is being formulated to look at some Dermatology activity to be considered for delivery in a community setting whether that be in a community hospital or GP practice

- LPT / ICB Reviewing demand and capacity for a plain film and ultrasound provision moving forward, of which Rutland Memorial Hospital is included within this review.

3.5 Priority Five: Preparing for our Growing and Changing Population

3.5.1 This strategic priority is supported by the establishment of the Rutland Health Strategic Health Developments Board which meets every six weeks and reports in to the IDG.

3.5.2 The key deliverables of this priority are:

- Planning and developing 'fit for the future' health and care infrastructure

- Health and care workforce fit for the future

- Health and equity in all policies, in particular developing a healthy built environment aligned for projected growth

3.5.3 The key achievements to date include:

- Maximisation of the additional role's reimbursement scheme. Recruitments, including 7 clinical pharmacists joining a PCN-formed academy in collaboration with Nottingham University to train as advanced practitioners (diagnostic skills and more autonomous than clinical pharmacists - benefits to patients, workforce, and practices).

- Rutland Health PCN are being engaged as part of phase 1 of LLR programme to develop Clinical/Estates Strategy. Planned 16-week development

- Oakham business case is in the process of being finalised for the utilisation of S106 funding to convert one of the three patient waiting areas into additional clinical space.

3.6 Priority Six: Ensuring People are Well Supported in the Last Phase of their lives.

3.6.1 This strategic priority is supported by the LLR End of Life and Palliative Care Task Force that meets monthly and feed in to the IDG.

3.6.2 The key deliverables of this priority are:

- Each person is seen as an individual

- Each person has fair access to care

- Maximising comfort and wellbeing

- Care is co-ordinated

- All staff are prepared to care

- Communities are prepared to help

3.6.3 The key achievements to date include:

- A joint strategic needs assessment end of life and palliative care has been undertaken for Rutland which will inform the strategy and work programme moving forward with an LLR End of Life strategy to be in draft form by March 2023

- System-wide launch of ReSPECT V3 planned for 2023 - this will include training and comms to system partners.

- A proposal has been written that will support Rutland to become one of the first Compassionate Counties in the country. It aims to facilitate and broker various parts of the communities which includes organisations to create a better understanding of death, dying, and bereavement and to enable social action to happen in communities for example Bereavement Help Points, Compassionate Neighbours.

- Compassionate Neighbours are trained volunteers who provide support to palliative patients and their families in the local area for a few hours (3-4) each week. They provide simple but valuable emotional and practical support for patients, their carers and loved ones, with activities such as keeping a patient

company whilst their carer takes a break, chatting over lunch in a local café, or perhaps just having a phone call

- A review has also been undertaken against the RCPG Daffodil standards that seeks to inform Rutland's end of life and palliative care workplan ensuring prioritisation, personalisation, planning for end of life and palliative care in the integrated systems of care within Rutland.

4 CROSS CUTTING THEMES - ENABLERS

4.1 As a part of the formulation of the strategy there was an acknowledgement that some areas cut across many of the priorities and also so integral to their delivery that they should be seen as enablers. The enablers sitting within the Rutland Joint Health and Wellbeing strategy are:

- Supporting good mental health
- Reducing health inequalities
- Covid recovery and readiness
- Communications and engagement

4.1.1 Supporting Good Mental Health

4.1.2 The aim here is to move towards an integrated neighbourhood-based approach to meeting mental health needs in Rutland by developing of a neighbourhood mental health delivery plan. Working with a number of local, community partners, both statutory and non-statutory based on the local assessment of needs, which brings together and coordinates a neighbourhood network approach to delivering improvements to mental health in Rutland.

4.1.3 In the last quarter, RCC has undertaken the successful recruitment of a Senior Mental Health Neighbourhood lead. A neighbourhood workshop has taken place with the focus on mental health within Rutland that has started to explore the reported inequalities, gaps and ideas around what people would like to see for mental health provision in Rutland.

4.2 Reducing Health Inequalities

4.2.1 As a part of this enabler workstream, the following priorities have been identified:

- Complete Health Inequalities Needs Assessment on Rutland
- Embed a proportionate universalism approach to service delivery
- Strengthen health inequalities leadership and accountability across Rutland

4.2.2 The strategic lead for public health has undertaken a full needs assessment of the Health Inequalities in Rutland. As a result of this insightful report a recommendation will be made for a Joint Health and Wellbeing Development session on the final report to work through the recommendations and identify areas of focus moving forward so that this can be prioritised within the Joint Health and Wellbeing Strategy Delivery Plan.

4.3 Covid Recovery and Readiness

4.3.1 As a part of the primary care covid recovery, also linking to the primary care access, the latest GPAD data shows that all four practices in Rutland have recovered to pre-pandemic appointment levels, on average, 7% more appointments than 2019 levels. 60% of appointments are face to face with a majority of decreases in DNA's with only Empingham showing an increase in July.

4.3.2 As a result of the Covid pandemic it was acknowledged that there was a disruption and displacement of proactive care for people living with long-term conditions, and as a result this would likely result in exacerbation and complications for patients and therefore this could add to further waves of demand for unscheduled care over the coming months whilst in recovery for primary care, emergency, and hospital admissions.

4.3.3 In response to this, a programme of proactive care was rolled out which looked to reduce the backlog for routine monitoring for patients within long term conditions. This is further supported by the establishment of an enhanced access service that goes live on 1st October and will give patients the opportunity to access a range of additional appointments, same day, proactive and preventative, Monday to Friday 6:30 – 8:00pm and Saturdays from 9:00 – 5:00pm.

4.3.4 In September, the autumn Covid booster programme re-commenced in Rutland, transferring from Oakham Enterprise Park, back to the PCN for delivery. Prioritisation commenced with care home and housebound patients and then;

- frontline health and social care workers
- all adults aged 50 years and over
- persons aged 5 to 49 years in a clinical risk group
- persons aged 5 to 49 years who are household contacts of people with immunosuppression
- persons aged 16 to 49 years who are carers.

4.4 Communications and Engagement

4.4.1 Communication and engagement are an integral enabler of the Rutland Joint Health and Wellbeing Strategy. All the priorities have deliverables that include communications and engagement activities within them.

4.4.2 A multi-stakeholder group has been pulled together to map all the deliverables within the plan that require communications and engagement so that we can ensure that it is joined up and there is no duplication. As a part of this group, we will also link into the system comms and engagements strategy to ensure that we articulate what can be informed at a strategic level but also what elements require a more targeted Rutland focus.

4.4.3 This work will be prioritised within the next month and by the end of October we will have a clear communications and engagement plan for all the mapped activities that sit within the Joint Health and Wellbeing Strategy delivery plan.

5 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

5.1 There has been a positive start to implementation of the 5-year strategy, with many activities taking place in the first 6 months. The Integrated Delivery Group, on behalf of the Health and Wellbeing Board will continue to drive and monitor implementation to improve the health and wellbeing of the Rutland Population.

5.2 The HWB is asked to note the following key points for discussion and consideration with regards to progress on the implementation of the Rutland Joint Health and Wellbeing Strategy:

5.3 Comments are invited on:

- The report format and governance arrangements moving forward so as to ensure that the right level of information is provided.

- Further to the completion of the health inequalities assessment for Rutland, it is recommended that a standalone JHWB development session is considered to go through the findings.

5.4 HWB are asked to note:

- Paper is going to the October Scrutiny Committee on Dental provision in Rutland.

- An oral Health Needs Assessment is planned to be carried out by January 2023.

- Recommendations from the draft End of Life and Care JSNA for Rutland will be incorporated into the work of the EoL and Palliative Care Group

6 BACKGROUND PAPERS

6.1 There are no background papers.

7 APPENDICES

7.1 Appendix A JHW Strategy Highlight Report Priority Overview

7.2 Appendix B JHW Strategy Outcomes Summary Report

A Large Print or Braille Version of this Report is available upon request – Contact 01572 722577.