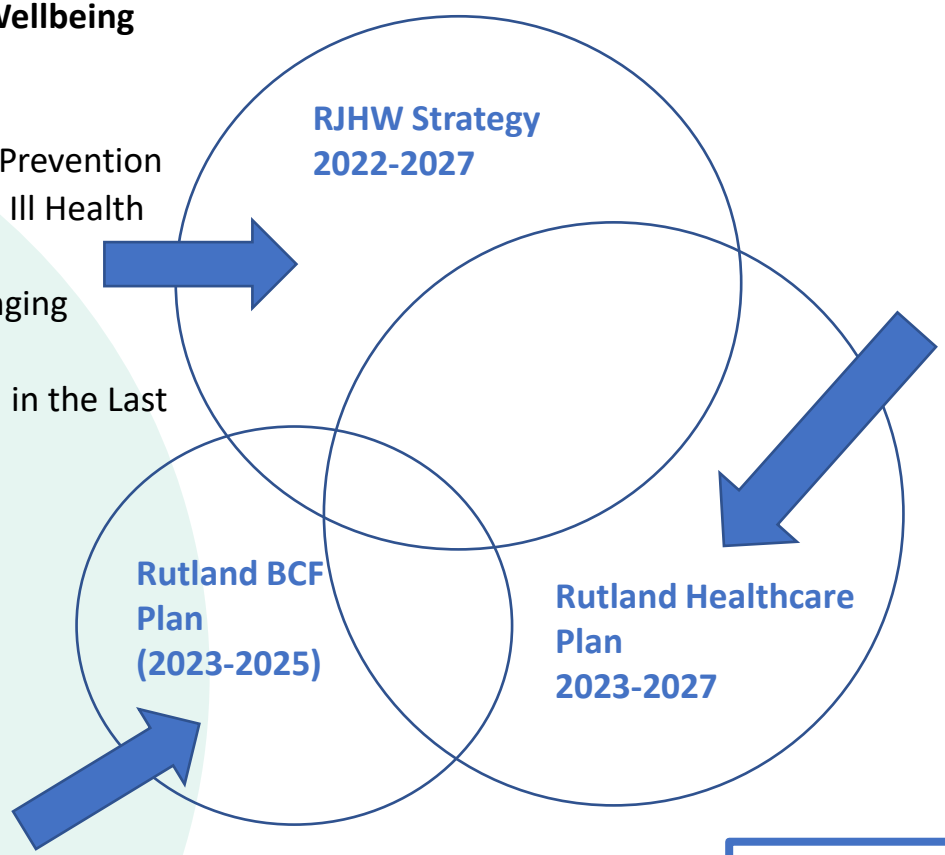
Priorities of Rutland Joint Health and Wellbeing Strategy 2022-2027

- Best Start for Life
- Staying Healthy and Independent – Prevention
- Healthy Ageing and Living Well with Ill Health
- Equitable Access to Services
- Preparing for our Growing and Changing Population
- Ensuring People are Well Supported in the Last Phase of Their Lives – Dying Well
- Cross-Cutting Themes



Priorities of the Rutland Place Healthcare Plan 2023 – 2027

- 1. Preventing Illness
- 2. Keeping People Well
- 3. Right Care, right time, right place
- 4. Integrated Community Health and Wellbeing Hubs
- 5. Optimal Pathways for Elective Care
- 6. Learning Disabilities and Autism
- 7. Mental Health
- 8. Women's Health, including Maternity
- 9. Childrens and Young People
- *Local Demographic focus from above:*
  - ***1. Older Peoples Health***
  - ***2. Access to Healthcare***
  - ***3. Armed Forces Community***

Priorities of the Rutland Better Care Fund Plan 2023-2025

- Improve discharges
- Reduce pressure on emergency, acute and social care
- Support intermediate care, unpaid carers and housing adaptations

Integrated Governance, Delivery and Reporting

- Health and Wellbeing Board oversight of all
- Various Rutland specific Delivery Groups / Subgroups – Health and Social Care, VCSE and Community membership
- Regular partnership reporting monthly / quarterly
- Specific Delivery Plans for each of above sets of priorities

Greetham parishes pilot project (Staying Healthy and Independent - Prevention)

Purpose

- Work with a small community (4 x villages) on an asset-based community development approach.
- This acts on findings from the Rutland Health Inequalities Needs Assessment, targeting hidden need, deprivation and inequalities in population groups.
- The project aims to empower local residents to build on what they already have in their local communities to have active, supportive, healthier communities where they work together to bring about change, they want to see.

Who is involved in delivery

- Partners across Rutland working with resident 'Community Connectors' in a volunteering capacity.

How we work together

- Partners are actively engaged across health and care and are brought in for different elements of the project as required.
- The Staying Healthy Partnership oversees progress and developments.

Improvement and outcomes

- The project is in the early days with 10 Community Connectors signed up.
- Intended outcomes include:
    - A more active community support network, helping people live healthier and at home for longer.
    - The community identifying and working together to bring about change they want to see.
    - Residents living alone and with limited confidence are supported in connecting with the community.

Anticipatory Care (Older Peoples Health)

Purpose
To develop a local community-based team and integrated care model, that focuses on the pro-active de-escalation of individuals in the community who are at risk of admission to hospital, to enable individuals to keep well in the community with support wrapped around them.

Who is involved in Delivery?
- Mainly delivered at Rutland Memorial Hospital by Rutland Memory Clinic **(NHS LPT)**, RISE Team, Admiral Nurses **(RCC Social Care),** a dedicated MDT facilitator **(RCC Social Care)** and Dementia Care co-ordinator **(Rutland Health PCN)**.

- Outreach provision is also delivered at Barrowden and will be starting in Greetham soon which is in direct support/response of the findings of the Rutland Health Inequalities Report developed by partners in Public Health – to support hard to reach communities.

How we work together
- Local data via NHS LPT from Waiting Lists for assessments for the local Memory Clinic is being used to identify the local population cohort in scope of support i.e. current focus is those with or at risk of Dementia, this drives joint prioritisation between partners.

- An MDT approach, involving a Holistic assessment, personalised care plan development for the individual with support from a dedicated care co-ordinator who is at the centre of this process to enable joint up working.

- Regular reviews are undertaken by the MDT facilitator through MDT working and alongside Dementia Care co-ordinator to ensure any changes in need are reflected in the plan and future interventions and support going forward.

Improvement and Outcomes:
- Number of MDT discussions coordinated/clinics held inc. number of organisations involved
- Total number of individuals discussed/supported
- Dementia diagnosis rate change (expected improvement)
- Emergency admissions/bed days

Social Prescribing (BCF Priority: Reduce pressure on emergency, acute and social care)

Purpose

The aim is to support people to maintain their independence, driving preventative practice and benefiting those who may otherwise frequently attend primary or secondary health care services.

Who is involved in Delivery?

- Delivered by Social Prescribing staff that are embedded with the Rutland RISE Team.

How we work together

- Referrals from a variety of sources are received into RISE Team enabling collaborative working with the local community and a wide range of health, social care, and voluntary sector professionals. This ensures the optimum support is progressed.
- The Joy Social Prescribing software is used across the RISE Team to manage referrals collaboratively across partner organisations that deliver care locally.
- RISE core principles that guide how we work together:
    - Increase people's control over their health and lives.
    - A holistic approach focussing on individual need.
    - Promotes health and wellbeing and reduces health inequalities in a community setting, using non-clinical methods.
    - Addresses barriers to engagement and enables people to play an active part in their care.
    - Utilises and builds on the local community assets in developing and delivering the service or activity.
    - Working in a preventative pre-eligible way.

Improvement and Outcomes:

- RISE holds between 80-100 active cases, receiving 80+ referrals each month.
- Customer satisfaction is consistently at 92%.
- Social Prescribing is firmly embedded in Rutland as an essential element of improving health and wellbeing, promoting people's quality of life and reducing the need for health and social care.