Rutland
County Council

East Leicestershire and Rutland
Clinical Commissioning Group

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Rutland Joint Health & Wellbeing Strategy

2016 - 2020

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Chair's Foreword

Cllr Richard Clifton, Portfolio Holder for Health

To be inserted.

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1. Introduction

Rutland's Joint Health and Wellbeing Strategy sets out our priorities for improving health and wellbeing in Rutland. The aim is to improve healthy life expectancy, and to maximise independence, choice, health and wellbeing for everyone.

The Health and Wellbeing Board will draw upon the Strategy to provide leadership and manage change across health and social care, and to 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 needs of the Rutland's population.

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:

- all Health and Wellbeing Board (HWB) partners to be clear about our agreed priorities for the next three years
- 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
- key agencies to develop joined-up commissioning and delivery plans to address these priorities
- the HWB to challenge and hold member organisations to account for their actions towards achieving the priorities within the strategy
- 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.

Partner organisations of the Rutland Health and Wellbeing Board include:

- Rutland County Council (Local Authority, including Public Health)
- East Leicestershire and Rutland Clinical Commissioning Group (NHS)
- NHS England
- Leicestershire Constabulary
- Rutland Healthwatch
- Local housing providers (represented by Spire Homes)
- Rutland Voluntary and Community Sector (represented by Rutland Citizen's Advice)

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2. Our Vision

This Strategy sets out our priorities for health and wellbeing across health and social care services for all our communities of all ages in Rutland. Our vision encompasses that of the Rutland Children's Trust Children, Young People and Families Plan 2016-19; the RCC Adult Social Care Strategy 2015-20; and the ELR CCG Community Services Strategy. Our vision is for:

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

3. Principles

Rutland's Health and Wellbeing Board operate to a set of principles, to which all partners are agreed and which drive both the shared priorities and work within home organisations:

- Shared ownership of the Board by all its members (with commitment from their nominating organisations) and accountability to the communities it serves for delivering our priorities;
- Commit to driving real action and change to integrate services and to improve services and outcomes;
- 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.

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4. Our Priorities

Priority 1 - Extend healthy life expectancy

Why is it a priority?

Whilst overall life expectancy has been rising in recent decades, the number of years people live in good health (healthy life expectancy) has remained similar. Healthy life expectancy in Rutland is similar to the England average for men, and better for women. However, the gap between life expectancy and healthy life expectancy in Rutland is 12.5 years for men and 15.6 years for women, with the gap for women increasing year on year between 2009 and 2014. The number of older people nationally living with more than one chronic condition has risen by over 10 per cent in the last decade.[i] This means that a sizeable proportion of Rutland's older people will be affected by poor health for a significant number of years – requiring additional support and care from their families and from services.

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.

How are we going to achieve it?

- Use a tiered approach to prevention and addressing people's needs: ensuring universal services promote wellbeing and self-help to prevent need; target services for those at risk to reduce need; and offer reablement, rehabilitation and recovery services to delay further need for those who already access services.
- Focus health & wellbeing interventions on those aged 45-65 to improve health life expectancy at a time when lifestyle and health changes still make a difference.
- Focus on getting children and adults active and keeping them active for longer to protect against a range of health conditions. Obesity levels for adults in Rutland are currently higher than for England and levels of overweight and obesity in children similar to national levels. Reducing obesity levels will save lives as obesity doubles the risk of dying prematurely.
- Reduce long term conditions through the promotion of health messages that set out risks and encourage people to take responsibility for their, and their families' health.

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Priority 2 - Reduce health inequalities

Why is it a priority

Some groups in our communities have poorer health or are more likely to have poor health outcomes in the longer term. This includes children living in poverty; routine and manual workers; people with disabilities; and military families. There are pockets of deprivation in Rutland with the wards of Martinsthorpe, Exton and Greetham within 60% most deprived areas in England. 7.3% of children under 20 live in poverty in Rutland. There are higher levels of smoking amongst routine and manual workers (20.5% compared to 11.6% in the general population). There are higher levels of life limiting long-term conditions amongst routine and manual workers.

In 2014/15 the percentage point gap between the overall population and those with learning disability was 69.2% and for those in contact with secondary mental health services was 74.6%.

Rutland is deprived in terms of geographical access to services - 65% of Lower Super Output Areas in Rutland are amongst the 20% most deprived areas in England [ii] Poor public transport means most families require a car. For poorer families this is a significant cost and impacts on older people no longer able to drive.

Whilst levels of mental health and wellbeing are similar to or better than the England average, there is evidence that this is worsened over that last few years. Equal focus should be given to mental wellbeing as that given to physical wellbeing.

Where do we want to get to?

Our focus will be on reducing a number of specific inequalities:

i. Reduce the levels of children living in poverty to 6% by 2020
ii. Bring the levels of smoking in routine and manual workers down to reduce gap between them 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.

How are we going to achieve it?

- Target services on those with greatest need and who are most vulnerable, including looked after children; military families; and children with special educations needs and/or disabilities.
- Provide additional support to families tailored to their needs; providing early help through the Children's Centre and the Healthy Child Programme.
- Focus smoking cessation support on routine and manual workers

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- Improve access to services by improved transport opportunities linking to the Transport Strategy for Rutland which is currently being developed.
- Develop digital opportunities with increased use of telecare, text, web chat and phone support for improved access to services.
- Identify and work with employers of routine and manual workers to improve health of these groups.

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

Why is it a priority?

There are three drivers for prioritising health and social care integration: to proactively manage the rising demand for health and social care services; to improve the experience for service users, ensuring that they receive services that meet their needs and in the most suitable setting; and to deliver efficiency savings, including by reduced duplication and inconsistencies.

People living with long term conditions do not want to be defined and preoccupied by their health conditions. Instead, they want heath and care services that are shaped to deliver the support they need reliably and efficiently so they can to get on with their lives. Although there have been significant developments in integrated working across health and social care in Rutland over the last two years, we want to take this further so that patients no longer need to repeat their histories to health and care professionals, or manage some of the navigation between care systems themselves. There are also further opportunities to empower people to play a greater role in self-managing their health and wellbeing.

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 will enable reduced duplication and greater overall support. We want to ensure a consistency in response and approach to care regardless of whether service users are receiving that care and support primarily from health or from social care.

The impact of integration will be measured through:

i. sustaining the very low proportion of individuals over 65 who move into permanent residential or nursing care.
ii. sustaining the high proportion of individuals who receive reablement services and are still at home 91 days after discharge from hospital.
iii. a reduction in emergency admissions, with a particular focus on the over 65s, and in lengths of hospital stays.

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How are we going to achieve it?

- Clearly define what integrated care means in practice, going beyond a basic level of coordinated or joined up working, and challenging partners to work together to deliver this.
- Successful delivery of the Rutland Better Care Fund programme(s), with clear articulation of Rutland's integration model in the wider LLR Sustainability and Transformation Plans and Better Care Together Strategy and support the delivery of these plans.
- Embed a coherent person-centred case planning approach for people with complex health needs which helps to keep these individuals as well as possible
- Investment in workforce training that supports the evolution of the health and care sector in line with strategic changes.
- Joint commissioning across health and social care

6. How will we measure our success?

Over the course of this strategy 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 will 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 identify the actions necessary to address specific issues raised by the Joint Strategic Needs Assessment (JSNA), Pharmaceutical Needs Assessment and Director of Public Health Annual Report to create an action plan to focus us on the tasks to be completed in support of our priorities.

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.

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[i] Nafeesa N. Dhalwani et al 2016 http://ijbnpa.biomedcentral.com/articles/10.1186/s12966-016-0330-9

[ii] *English Index of Multiple Deprivation (IMD) 2015 - Geographical Barriers to Services subdomain*

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