Rutland County Council

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

Ladies and Gentlemen,

A meeting of the **RUTLAND HEALTH AND WELLBEING BOARD** will be held in the Council Chamber, Catmose, Oakham, Rutland LE15 6HP on **Tuesday, 10th October, 2023** commencing at **2.00 pm** when it is hoped you will be able to attend.

Yours faithfully

Mark Andrews
Chief Executive

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Although social distancing requirements have been lifted there is still limited available seating for members of the public. If you would like to reserve a seat, please contact Democratic Services at democraticservices@rutland.gov.uk. The meeting will also be available for listening live on Zoom using the following link: https://us06web.zoom.us/j/87586875196

A G E N D A

1) WELCOME AND APOLOGIES RECEIVED

2) RECORD OF MEETING

To confirm the record of the meeting of the Rutland Health and Wellbeing Board held on the 27th June 2023.
(Pages 7 - 18)

3) ACTIONS ARISING

To review and update the actions arising from the previous meeting.

No.	Ref.	Action	Person
1.	3	*Mark Young to distribute the mental health pathways once they had been approved.* The Strategic Director for Adult	**Emma Jane Hollands**

		Services and Health requested that the action be carried forward for the attention of Emma Jane Hollands, Head of Community Care Services. Action to be completed by the 18th July 2023.	
2.	5	The Chair, Councillor Ellison confirmed that she would circulate a copy of the independent review undertaken by the Rutland Health & Social Care Policy Consortium regarding the ICB's implementation of the guidance to the Director of Public Health and the Chief Strategy Officer, LLR ICB.	**Councillor Ellison**

4) DECLARATIONS OF INTEREST

In accordance with the Regulations, Members are invited to declare any personal or prejudicial interests they may have and the nature of those interests in respect of items on this Agenda and/or indicate if Section 106 of the Local Government Finance Act 1992 applies to them.

5) PETITIONS, DEPUTATIONS AND QUESTIONS

To receive any petitions, deputations and questions received from Members of the Public in accordance with the provisions of Procedure Rule 73.

The total time allowed for this item shall be 30 minutes. Petitions, declarations and questions shall be dealt with in the order in which they are received. Questions may also be submitted at short notice by giving a written copy to the Committee Administrator 15 minutes before the start of the meeting.

The total time allowed for questions at short notice is 15 minutes out of the total time of 30 minutes. Any petitions, deputations and questions that have been submitted with prior formal notice will take precedence over questions submitted at short notice. Any questions that are not considered within the time limit shall receive a written response after the meeting and be the subject of a report to the next meeting.

6) QUESTIONS WITH NOTICE FROM MEMBERS

To consider any questions from Members received under Procedure Rule 75.

7) NOTICES OF MOTION FROM MEMBERS

To consider any Notices of Motion from Members submitted under Procedure Rule 77.

8) LEICESTER, LEICESTERSHIRE & RUTLAND (LLR) INTEGRATED CARE SYSTEM

A. RUTLAND HEALTH PLAN: UPDATE

30 MIN

To receive a presentation from Debra Mitchell, Deputy Chief Operating Officer, Leicester, Leicestershire and Rutland Integrated Care Board.
ITEM FOR DISCUSSION

9) JOINT STRATEGIC NEEDS ASSESSMENT: UPDATES & TIMELINE

15 MIN

To receive a verbal update from Adrian Allen, Assistant Director – Delivery, Public Health.
ITEM FOR DISCUSSION

10) JOINT HEALTH AND WELLBEING STRATEGY: UPDATE

10 MIN

To receive Report No. 148/2023 from Katherine Willison, Health and Integration Lead, Rutland County Council.
ITEM FOR INFORMATION
(Pages 19 - 82)

A. COMMUNICATION AND ENGAGEMENT PLAN

10 MIN

To receive Report No. 150/2023 from Katherine Willison, Health and Integration Lead, Rutland County Council.
ITEM FOR INFORMATION
(Pages 83 - 108)

B. AREA SEND INSPECTION REPORT

10 MIN

To receive Report No. 151/2023 from Dawn Godfrey, Strategic Director of Children and Families.
ITEM FOR INFORMATION
(Pages 109 - 122)

C. RUTLAND MENTAL HEALTH NEIGHBOURHOOD STRATEGY AND ACTION PLAN

10 MIN

To receive Report No. 149/2023 from Emma Jane Hollands, Head of Community Care Services.
ITEM FOR APPROVAL
(Pages 123 - 136)

11) BETTER CARE FUND: 2023-2025

10 MIN

To receive Report No. 146/2023 from Katherine Willison, Health and Integration Lead, Rutland County Council.
ITEM FOR INFORMATION
(Pages 137 - 170)

12) RUTLAND HEALTH AND WELLBEING BOARD: TERMS OF REFERENCE ANNUAL UPDATE

10 MIN

Annual review and update of the Terms of Reference for the Rutland Health and Wellbeing Board.
ITEM FOR REVIEW
(Pages 171 - 176)

13) REVIEW OF FORWARD PLAN AND ANNUAL WORK PLAN

5 MIN

To consider the current Forward Plan and identify any relevant items for inclusion in the Rutland Health and Wellbeing Board Annual Work Plan, or to request further information.

The Forward Plan is available on the website using the following link:
https://rutlandcounty.moderngov.co.uk/mgListPlans.aspx?RPId=133&RD=0
(Pages 177 - 180)

14) ANY URGENT BUSINESS

5 MIN

To receive any items of urgent business, which have been previously notified to the person presiding.

15) DATE OF NEXT MEETING

Tuesday, 16th January 2024 at 2.00 p.m.

---oOo---

DISTRIBUTION

MEMBERS OF THE RUTLAND HEALTH AND WELLBEING BOARD

Name		Title
1.	Diane Ellison (Councillor) CHAIR	Portfolio Holder for Adult Care and Health, RCC
2.	David Williams	Group Director of Strategy & Partnerships Leicestershire Partnership NHS Trust & Northamptonshire Healthcare NHS Foundation Trust

3.	Dawn Godfrey	Strategic Director of Children and Families (DCS), RCC
4.	Debra Mitchell	Deputy Chief Operating Officer, LLR ICB
5.	Duncan Furey	Chief Executive Officer, Citizens Advice Rutland
6.	Ian Crowe	Armed Forces Representative
7.	Janet Underwood (Dr)	Chair, Healthwatch Rutland
8.	Kim Sorsky	Strategic Director for Adult Services and Health (DASS), RCC
9.	Liam Palmer (Sgt)	Leicestershire Police
10.	Louise Platt	Executive Director of Housing, Care and Support, Longhurst Group
11.	Mike Sandys VICE CHAIR	Director of Public Health for Leicestershire & Rutland, LCC
12.	Sarah Prema	Chief Strategy Officer, LLR ICB
13.	Tim Smith (Councillor)	Portfolio Holder for Children's Services, RCC

OFFICERS ATTENDING

Name		**Title**
14.	Adrian Allen	Assistant Director - Delivery, Public Health
15.	Emma Jane Hollands	Head of Community Care Services
16.	Jane Narey	Scrutiny Officer, RCC
17.	Karen Kibblewhite	Head of Commissioning, RCC
18.	Katherine Willison	Health and Wellbeing Integration Lead, RCC
19.	Mitch Harper	Strategic Lead – Rutland, Public Health
20.	Penny Sharp	Strategic Director for Places, RCC
21.	Susan-Louise Hope	Strategic Lead – Rutland Commissioning, Public Health

FOR INFORMATION

Name		**Title**
22.	Angela Hillery	Chief Executive, Leicestershire Partnership NHS Trust

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Rutland County Council

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

Minutes of the **MEETING of the RUTLAND HEALTH AND WELLBEING BOARD** held in the Council Chamber, Catmose, Oakham, Rutland, LE15 6HP on Tuesday, 27th June, 2023 at 2.00 pm

PRESENT

1.	Diane Ellison (Councillor) CHAIR	Portfolio Holder for Adult Care and Health, RCC
2.	David Williams	Group Director of Strategy & Partnerships Leicestershire Partnership NHS Trust & Northamptonshire Healthcare NHS Foundation Trust
3.	Dawn Godfrey	Strategic Director of Children and Families (DCS), RCC
4.	Debra Mitchell	Deputy Chief Operating Officer, LLR ICB
5.	Ian Crowe	Armed Forces Representative
6.	Janet Underwood (Dr)	Chair, Healthwatch Rutland
7.	Kim Sorsky	Strategic Director for Adult Services and Health (DASS), RCC
8.	Mike Sandys VICE CHAIR	Director of Public Health for Leicestershire & Rutland, LCC
9.	Raymond Payne (Councillor)	Portfolio Holder for Children's Services, Homelessness and Housing Policy, RCC
10.	Sarah Prema	Chief Strategy Officer, LLR ICB

APOLOGIES:

11.	Duncan Furey	Chief Executive Officer, Citizens Advice Rutland
12.	Louise Platt	Executive Director of Housing, Care and Support, Longhurst Group

ABSENT:

13.	Liam Palmer (Sgt)	Leicestershire Police

OFFICERS PRESENT:

14.	Adrian Allen	Assistant Director - Delivery, Public Health
15.	Emma Jane Hollands	Head of Community Care Services
16.	Jane Narey	Scrutiny Officer, RCC
17.	Karen Kibblewhite	Head of Commissioning, RCC
18.	Katherine Willison	Health and Wellbeing Integration Lead, RCC
19.	Mitch Harper	Strategic Lead – Rutland, Public Health

IN ATTENDANCE:

20.	Mrs Jennifer Fenelon	Chair of the Rutland Health & Social Care Policy Consortium
21.	Richard Wilding	Business Intelligence Team Leader, Leicestershire County Council
22.	Andy Brown	Business Intelligence Team Leader, Leicestershire County Council
23.	Mayur Patel	Head of Integration and Transformation, Leicester, Leicestershire and Rutland Integrated Care Board.

1 WELCOME AND APOLOGIES RECEIVED

The new Portfolio Holder for Adult Care and Health, Councillor Diane Ellison welcomed everyone to the meeting and introduced herself as the new Chair of the Health and Wellbeing Board. Apologies were received from Louise Platt and Duncan Furey.

2 RECORD OF MEETING

The minutes of the Rutland Health and Wellbeing Board meeting held on the 21st March 2023 were approved as an accurate record.

3 ACTIONS ARISING

Action 1
Katherine Willison to see if the falls data could be broken down into 'institutionalised falls' i.e. hospitals, care homes and 'domestic falls' i.e. an individual's home.
Item was on the agenda.

Action 2
The Health and Wellbeing Integration Lead confirmed that she would email the details of the professional stakeholders to members of the Board and that the Communication and Engagement Plan, including a summary document, would be discussed at the next Board meeting.
Item was on the agenda.

Action 3
Debra Mitchell to liaise with Mitch Harper to ensure that JSNA work streams were included in the Integrated Delivery Group's plan.
The Deputy Chief Operating Officer, (Leicester, Leicestershire and Rutland Integrated Care Board (LLR ICB) confirmed that the action had been completed.

Action 4
Mitch Harper to meet with representatives from NHS England Dentistry to:
review the data from a Rutland perspective.
share the approved Rutland Oral Health Needs Assessment and the other chapters from the Joint Strategic Needs Assessment (JSNA).
update the Rutland Health and Wellbeing Board at the next meeting.
The Strategic Lead – Rutland, Public Health confirmed that the action had been completed.

Action 5
Sarah Prema to share a draft copy of the Joint 5 Year Forward Plan with the Rutland Health and Wellbeing Board asap
The Chief Strategy Officer, LLR ICB confirmed that the action had been completed.

Action 6
Sarah Prema and Paul Sheldon to find out what palliative care facilities were available at RMH.
The Chief Strategy Officer, LLR ICB confirmed that there was 1 flexible use palliative care bed at Rutland Memorial Hospital.

Action 7
Councillor S Harvey and Mike Sandys to meet to decide what information they would like NHS England to present at the next Health and Wellbeing Board regarding HPV vaccinations.
The Director of Public Health confirmed that he had met with Councillor S Harvey but that he would discuss a vaccination update to the Board with the new Chair, Councillor Ellison.

Action 8
A review of what each IDG subgroup was responsible for and how they should report back to the Health and Wellbeing Board would be discussed at the next meeting of the IDG and an update provided at the next meeting of the Health and Wellbeing Board.
The Deputy Chief Operating Officer, LLR ICB confirmed that she would discuss this further with the new Chair, Councillor Ellison.

Action 9
Mark Young to distribute the mental health pathways once they had been approved.
The Strategic Director for Adult Services and Health requested that the action be carried forward for the attention of Emma Jane Hollands, Head of Community Care Services. Action to be completed by the 18th July 2023.

ACTION: Emma Jane Hollands

Action 10
Dr Underwood to distribute Healthwatch Rutland's report regarding the dementia support services and the experience of Rutland residents once checked and approved.
The Chair of Healthwatch Rutland confirmed that the action had been completed.

Action 11
The Clerk to distribute to members the draft agenda plan for the proposed meeting on the 27th June 2023 to ensure all items were included.
The Clerk confirmed that the action had been completed.

4 DECLARATIONS OF INTEREST

There were no declarations of interest.

5 PETITIONS, DEPUTATIONS AND QUESTIONS

The Clerk confirmed that a deputation had been received from Mrs Jennifer Fenelon on behalf of the Rutland Health & Social Care Policy Consortium. The deputation had

been approved by the Chief Executive and the Monitoring Officer and had been added to the website and circulated to committee members in advance of the meeting.

---oOo---
Mrs Fenelon joined the meeting at 2.09 p.m.
---oOo---

- Mrs Fenelon addressed the Board with the details of her deputation.
- The Chair, Councillor Ellison confirmed that she would circulate a copy of the independent review undertaken by the Rutland Health & Social Care Policy Consortium regarding the ICB's implementation of the guidance to the Director of Public Health and the Chief Strategy Officer, LLR ICB.

ACTION: Councillor Ellison

- The Chair re-iterated that the Board continued to work in close collaboration with stakeholders such as Rutland Healthwatch as part of the Integrated Delivery Board to ensure that the voice of residents was heard in such matters as community healthcare and integrated services.

---oOo---
Mrs Fenelon left the meeting at 2.15 p.m.
---oOo---

6 QUESTIONS WITH NOTICE FROM MEMBERS

There were no questions with notice from members.

7 NOTICES OF MOTION FROM MEMBERS

There were no notices of motion from members.

8 ELECTION OF VICE CHAIR

- The Deputy Chief Operating Officer, LLR ICB nominated Mike Sandys, Director of Public Health for the role of Vice Chair and this was seconded by the Chair of Healthwatch Rutland, Dr Janet Underwood.
- There were no other nominations.

RESOLVED
That the Board:

a) **APPROVED** Mike Sandys as the Vice Chair for the Rutland Health and Wellbeing Board for the municipal year 2022/2023 on the provision that he accepted the nomination.

9 LEICESTER, LEICESTERSHIRE & RUTLAND (LLR) INTEGRATED CARE SYSTEM: UPDATE

A) <u>5 YEAR JOINT FORWARD PLAN</u>

A verbal update was received from Sarah Prema, Chief Strategy Officer, Leicester, Leicestershire and Rutland Integrated Care Board. During the discussion, the following points were noted:

- The 5 Year Joint Forward Plan had been shared with the members of the Rutland Health and Wellbeing Board and feedback from the Board members had been incorporated into the plan.
- A statement from the Chair of the Rutland Health and Wellbeing Board would also be included in the updated version of the 5 Year Joint Forward Plan.
- A delivery plan, which had also been shared with Board members, was being finalised and this would detail how the individual elements of the plan would be delivered.
- An engagement period with the community had been held and feedback from the public had been incorporated into the plan.
- NHS England had reviewed the plan submitted by the LLR ICB and confirmed that it was a comprehensive plan whose content met the required guidance.
- The updated 5 Year Joint Forward Plan would be published on the 30th June 2023 and it was anticipated that the final plan would be presented to the LLR ICB on the 13th July 2023 for final approval.
- The 5 Year Joint Forward Plan would then be reviewed and refreshed on an annual basis.

B) HEALTH AND WELLBEING PARTNERSHIP STRATEGY

A verbal update was received from Sarah Prema, Chief Strategy Officer, LLR ICB. During the discussion, the following points were noted:

- The Health and Wellbeing Partnership Strategy had been discussed by the Rutland Health and Wellbeing Board and was due to be approved by the Health and Wellbeing Partnership in August 2023.
- The Deputy Chief Operating Officer, LLR ICB confirmed that the strategy's Implementation Plan would focus on place and would be reviewed annually.
- An update on the strategy's Implementation Plan would be provided at the October meeting of the Rutland Health and Wellbeing Board.

---oOo---

Due to technical issues, the Chair called a short adjournment of the meeting at 2.29 p.m. The meeting re-started at 2.38 p.m.

---oOo---

10 JOINT STRATEGIC NEEDS ASSESSMENT: UPDATES & TIMELINE

A) ARMED FORCES: PERSONNEL AND FAMILIES SURVEY REPORT

Report No. 93/2023 was received from Adrian Allen, Assistant Director – Delivery and Mitch Harper, Strategic Lead – Rutland, Public Health. During the discussion, the following points were noted:

- The Strategic Director of Children and Families informed attendees that RCC Officers had gone to Cyprus to work with armed forces colleagues to identify the SEND children who would be coming to Rutland when the 1st Battalion Royal Anglican Regiment arrived at Kendrew Barracks.
- Each SEND child had been assessed regarding the level of support needed and school places had been identified.
- The Armed Forces Service Pupil Premium paid to schools was a very small amount.

- A Single Point of Contact (SPoC) for the armed forces families had been created and this was run by the Leicestershire NHS Partnership Trust on behalf of the LLR ICB.

RESOLVED
That the Board:

a) **NOTED** the findings of the survey and **APPROVED** for specific recommendations to be taken to the Staying Healthy Partnership for consideration and to determine next steps and actions.

B) UPDATE AND INFORMATION FROM THE MEETING HELD WITH NHS ENGLAND

A verbal update was received from Mitch Harper, Strategic Lead – Rutland, Public Health. During the discussion, the following points were noted:

- The Strategic Lead – Rutland confirmed that a meeting had been held with NHS England – Dentistry.
- The data had been reviewed from a Rutland perspective and that NHS England recognised Rutland as a place in its own right and separate from Leicester and Leicestershire.
- The Rutland Oral Health Needs Assessment and the other chapters from the Joint Strategic Needs Assessment (JSNA) were shared with NHS England.

C) CHAPTERS FOR REVIEW

Report No. 94/2023 was received from Mike Sandys, Director of Public Health and Hanna Blackledge, Lead Analyst, Public Health Business Intelligence, Leicestershire County Council.

- A presentation was received from Richard Wilding and Andy Brown, Business Intelligence Team Leaders from Leicestershire County Council – copy attached.

---oOo---
Due to technical issues, the Chair called a short adjournment of the meeting at 3.11 p.m. The meeting re-started at 3.17 p.m.
---oOo---

- Employment levels in agriculture, forestry and fishing in Rutland had fallen.
- Housing standards and the growth in population within Rutland should be investigated further.
- The Head of Commissioning informed attendees that the local housing market needs assessment was currently being updated and that this data should be included in Rutland's Demography and Growth Needs Assessment.
- The report needed to include clarification as to what a 'healthy life expectancy' actually was.
- 35% of adult Rutland residents lived alone and concern was raised regarding future care options for single adults but it was confirmed that this would link into the LLR Carers' Strategy.

RESOLVED
That the Board:

a) **APPROVED** Rutland's Demographic and Growth Needs Assessment and asked that the relevant board subgroups considered the recent demographic changes and trends and how these could be taken into account in future service plans and commissioning strategies.

11 JOINT HEALTH AND WELLBEING STRATEGY

Report No. 95/2023 was received from Katherine Willison, Health and Integration Lead. During the discussion, the following points were noted:

- A 12 month review of the delivery plan would be completed and then shared with the Health and Wellbeing Board.
- The Joint Health and Wellbeing Strategy Outcomes Summary report identified good and bad performance areas in Rutland.

RESOLVED
That the Board:

a) **NOTED** the further development of the JHWS Delivery Plan.

b) **NOTED** the latest Rutland Outcomes Report.

A) FALLS DATA: UPDATE

A verbal update was received from Katherine Willison, Health and Integration Lead. During the discussion, the following points were noted:

- The public health data dashboard, between March 2021 and March 2022, recorded 55 hip fractures in Rutland of residents aged 65+, which equated to 5 hip fractures per month.
- Rutland County Council's data recorded 5 hip fractures over the past 10 weeks from 1 March 2023.
- Further analysis of the data from Public Health, DHU (Derbyshire Health United) Healthcare Falls Response Service and RCC's Falls Prevention Service was required to ensure that the correct support services were in place.

RESOLVED
That the Board:

a) **APPROVED** the Health and Integration Lead to undertake a 6 month study of falls data regarding Rutland residents for presentation to the Rutland Health and Wellbeing Board in January 2024 to identify pathways for better understanding and context.

B) HEALTH AND WELLBEING COMMUNICATION AND ENGAGEMENT PLAN

Report No. 83/2023 was received from Katherine Willison, Health and Integration Lead. During the discussion, the following points were noted:

- Stakeholders had contributed to and finalised the Health and Wellbeing Communication and Engagement Plan and these were detailed in Appendix A.
- A summary of the plan had been produced for ease of access by professionals and members of the public.
- The Delivery Plan would be updated on a regular basis.
- The Strategic Director of Children and Families stated that Rutland County Council's Children's Services had not been involved in the development of the communication and engagement plan and neither had any children or young people.

RESOLVED
That the Board:

a) **NOTED** the content of the report.

b) **AGREED** that the Communication and Engagement Plan should be updated, following input from RCC Children's Services, children and young people and brought back to the Rutland Health and Wellbeing Board for approval.

C) RUTLAND HEALTH AND WELLBEING BOARD ANNUAL REPORT 2022/23

Report No. 96/2023 was received from Katherine Willison, Health and Integration Lead. During the discussion, the following points were noted:

- The annual report was part of the Communication and Engagement Plan to raise the profile of the Rutland Health and Wellbeing Board.
- The following amendments were requested:

    - 'The Joy platform was introduced in September 2023' should be amended to read 'September 2022' (Page 5).
    - Web link to Rutland's Joy platform should be added (Page 5).
    - 'Forward from the Chair' should be amended to 'Foreword from the Chair' (Pages 1 and 2).

RESOLVED
That the Board:

a) **NOTED** the Rutland Health and Wellbeing Board (HWB) Annual Report 2022-23, which had been approved by Councillor Samantha Harvey, Chair of the HWB during 2022-23 and Kim Sorsky, Strategic Director of Adult Services and Health.

b) **APPROVED** the Rutland Health and Wellbeing Board (HWB) Annual Report 2022-23, following the requested amendments, for publication on the websites of Rutland County Council and Healthwatch Rutland.

---oOo---
Mayur Patel joined the meeting at 4.13 p.m.
---oOo---

D) PRIMARY CARE STRATEGY

Report No. 97/2023 was received from Mayur Patel, Head of Integration and Transformation, Leicester, Leicestershire and Rutland Integrated Care Board. During the discussion, the following points were noted:

- Next steps would be to publish the strategy in an easily understandable format and then put it into action.
- Conversations should be held with the 4 GP practices located in Rutland regarding the implementation of the Primary Care Strategy so that Rutland could be an exemplar to other local authorities.
- Further work needed to be done on connecting people to the right health professionals and services and this would include national programmes to improve communication and patient access.

RESOLVED
That the Board:

a) **NOTED** the Primary Care Strategy for Leicester, Leicestershire and Rutland.

---oOo---

Mayur Patel left the meeting at 4.30 p.m. and the Chair proposed that the meeting be extended for a period of 15 minutes for the agenda to be completed. This was unanimously agreed.

---oOo---

12 BETTER CARE FUND

Report No. 98/2023 was received from Katherine Willison, Health and Integration Lead. During the discussion, the following points were noted:

- Improvements were being implemented across Rutland regarding access to health and GP services so that the number of unplanned hospitalisations reached its target moving forward.
- The BCF Plans for 2023-2025 would be submitted to NHS England on the 28th June 2023 and would be presented to the Rutland Health and Wellbeing Board at the October meeting.

RESOLVED
That the Board:

a) **NOTED** the Rutland 2022-23 Better Care Fund End of Year Report, submission of which to the BCF national team on 22 May 2023 was signed off by the Chair of the Health and Wellbeing Board.

b) **NOTED** the update on the 2023-24/25 programming period.

13 UPDATE FROM THE SUB-GROUPS

A) CHILDREN AND YOUNG PEOPLE PARTNERSHIP

A verbal update was received from Dawn Godfrey, Strategic Director of Children and Families. During the discussion, the following points were noted:

- The last meeting of the Children and Young People Partnership (CYPP) was held on the 15th June 2023.
- All priorities were progressing as planned.
- Workforce pressures and capacity issues for RCC and health colleagues continued.
- The Council was awaiting confirmation of funding regarding grant funded posts.
- A joint local area inspection of SEND services had recently been completed and the OfSTED/CQC inspection report was expected in July 2023. Further details would be provided at the next meeting of the Health and Wellbeing Board.

B) INTEGRATED DELIVERY GROUP

A verbal update was received from Debra Mitchell, Deputy Chief Operating Officer, LLR ICB. During the discussion, the following points were noted:

- The next meeting would be held on the 13th July 2023.
- An update on woman's advocate would be received.
- Emergency admissions data would be reviewed.
- Emma Jane Hollands, Head of Community Care Services briefed attendees on the Proactive Care Project – copy of presentation attached.

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At 4.45 p.m. the Chair proposed that the meeting be extended for a further period of 15 minutes for the agenda to be completed. This was unanimously agreed.

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C) RUTLAND MENTAL HEALTH NEIGHBOURHOOD GROUP

A verbal update was received from Emma Jane Hollands, Head of Community Care Services. During the discussion, the following points were noted:

- The Rutland Mental Health Neighbourhood Group Strategy and Action Plan would be presented to the Health and Wellbeing Board in October.
- Increased number of people reporting mental health concerns due to relationship or bereavement issues.
- Rutland Primary Care Network has been nominated for Primary Care Network of the Year.
- LLR voluntary sector event held on 21st June 2023.

D) STAYING HEALTHY PARTNERSHIP

A verbal update was received from Adrian Allen, Assistant Director - Delivery. During the discussion, the following points were noted:

- The partnership was working on the outcomes following the two workshops held.
- Pilot projects were progressing well.
- The Armed Forces Survey would be reviewed so that future work could be identified.

14 REVIEW OF FORWARD PLAN AND ANNUAL WORK PLAN

The work plan was discussed and updated accordingly.

15 ANY URGENT BUSINESS

There was no urgent business.

16 DATE OF NEXT MEETING

Tuesday, 10th October 2023 at 2.00 p.m.

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The Chair declared the meeting closed at 4.53 pm.

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SUMMARY OF ACTIONS

No.	Ref.	Action	Person
1.	3	*Mark Young to distribute the mental health pathways once they had been approved.* The Strategic Director for Adult Services and Health requested that the action be carried forward for the attention of Emma Jane Hollands, Head of Community Care Services. Action to be completed by the 18th July 2023.	**Emma Jane Hollands**
2.	5	The Chair, Councillor Ellison confirmed that she would circulate a copy of the independent review undertaken by the Rutland Health & Social Care Policy Consortium regarding the ICB's implementation of the guidance to the Director of Public Health and the Chief Strategy Officer, LLR ICB.	**Councillor Ellison**

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Report No:148/2023
PUBLIC REPORT

RUTLAND HEALTH AND WELLBEING BOARD

27 June 2023

JOINT HEALTH AND WELLBEING STRATEGY: UPDATE

Report of the Portfolio Holder for Adult Care and Health

Strategic Aim:	Protecting the vulnerable	
Exempt Information	No	
Cabinet Member(s) Responsible:	Cllr D Ellison, Portfolio Holder for Adult Care and Health	
Contact Officer(s):	Kim Sorsky, Strategic Director for Adult Services and Health	01572 758352 ksorsky@rutland.gov.uk
	Mike Sandys, Director Public Health RCC	0116 3054259 mike.sandys@leics.gov.uk
	Debra Mitchell, Deputy Director of Integration and Transformation, LLR CCGs	07969910333 debra.mitchell3@nhs.net
Ward Councillors	n/a	

DECISION RECOMMENDATIONS
That the Board: 1. Notes the further development of the JHWS Delivery Plan. 2. Notes the latest Rutland Outcomes Report.

1 PURPOSE OF THE REPORT

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 progress of the JHWS Delivery Plan.

1.3 The report also highlights elements of the Rutland Outcomes Report for consideration

2 BACKGROUND AND MAIN CONSIDERATIONS

2.1 The overall aim of the joint strategy is 'people living 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.

2.2 Appendix A provides a **high-level summary of progress across the JHWS's priorities**. This includes activities to achieve all elements of the strategy, the lead, the timescale, how success will be measured and also importantly also risks, mitigations and issues for escalation and discussion. The leads also use coloured rating to show whether or not progress is on target and where activity is yet to start and where outcomes have been achieved and the action can be closed. Note this is an evolving plan and will be updated and amended as required.

2.3 **Joint Health and Wellbeing Strategy – 12 Month Review**

A review of the first 14 months of the JHWS has been completed. This has highlighted that much progress is being made in all Priority areas. Recommendations include more use of specific goal setting in order to measure and demonstrate outputs with more clarity, and more focus of the impact that workstreams are having on Rutland residents. We will also produce an addendum to the Delivery Plan which is more accessible and user friendly for the public. See Appendix C for the review document.

Following a planning session in August, a new Lead is in place for Priority 6 - Ensuring people are well supported in the last phase of their lives. There is now momentum for this priority and work is progressing, linking with LLR End of Life Task Force.

The **Communication and Engagement Plan** is included in the delivery plan for consistency. This supports the delivery of the strategy. See Report No. 150/2023 also included in the agenda pack. A high-level audit of communications and engagement's broader strengths, assets and communication channels with partners has been completed by the Co-Production and Engagement Lead. This will enable planning of communications with the knowledge of what partners are able to use and disseminate. See appendix D for the JHWS Communication and Engagement Plan Strengths and Assets Audit Report.

2.4 Appendix B is an **Outcomes Summary Report** which provides additional context by setting out the most recent Public Health data available for indicators relevant to each of the Strategy's priorities. It highlights whether Rutland rates are below, similar to or above either national rates or the rates in a group of 16 similar areas of the country, offering greatest detail on indicators of concern. These data are released with a time lag, so the impact of the early work undertaken to deliver the strategy will not initially be reflected here. The reports will be used ongoing by priority teams in their targeting and prioritisation.

There have been no updates to performance in any of the 7 priority areas since last HWB in June 2023. Consideration is being given to the timing, frequency and type of updates on performance for HWB to make the information more meaningful.

3 ALTERNATIVE OPTIONS

3.1 The JHWS is a statutory responsibility and has been consulted on publicly.

4 FINANCIAL IMPLICATIONS

4.1 In common with previous JHWS, the strategy brings together and influences the spending plans of its constituent partners or programmes (including the Better Care Fund), and will enhance the ability to bid for national, regional or ICS funding to drive forward change.

5 LEGAL AND GOVERNANCE CONSIDERATIONS

5.1 The JHWS meets the HWB's statutory duty to produce a JHWS, and the ICS duty for there to be a Place Led Plan for the local population.

5.2 JHWS actions will be delivered on behalf of the HWB via the CYPP and IDG.

6 DATA PROTECTION IMPLICATIONS

6.1 Data Protection Impact Assessments (DPIA) will be undertaken for individual projects as and when required to ensure that any risks to the rights and freedoms of natural persons through proposed changes to the processing of personal data are appropriately managed and mitigated.

7 EQUALITY IMPACT ASSESSMENT

7.1 Equality and human rights are key themes in embedding an equitable approach to the development and implementation of the Plan. An RCC high level Equality Impact Assessment (EqIA) has been completed and approved.

7.2 The initial Equality Impact Assessment sets out how the Strategy, successfully implemented, could help to reduce a wide range of inequalities. It is acknowledged that the strategy and delivery plan are high level and therefore additional equality impact assessments will be completed as appropriate as services are redesigned or recommissioned within the life of the strategy.

8 COMMUNITY SAFETY IMPLICATIONS

8.1 Having a safe and resilient environment has a positive impact on health and wellbeing. National evidence has also shown that more equal societies experience less crime and higher levels of feeing safe than unequal communities. The JHWS has no specific community safety implications but will work to build relationships across the Community Safety Partnership and to build strong resilient communities across Rutland.

9 HEALTH AND WELLBEING IMPLICATIONS

9.1 The JHWS is a central tool in supporting local partners to work together effectively with the Rutland population to enhance and maintain health and wellbeing.

10 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

10.1 The JHWS provides a clear, single vision for health and care with purpose of driving

change and improving health and wellbeing outcomes for Rutland residents and patients. The progress against the plan set out in this paper supports the HWB in tracking and steering delivery.

11 BACKGROUND PAPERS

11.1 There are no additional background papers.

12 APPENDICES

12.1 Appendices are as follows:

A. JHWS Delivery Plan September 2023

B. JHWS Outcomes Summary Report September 2023

C. JHWS Communication and Engagement Plan Assets and Strengths Audit Report August 2023

D. JHWS 12 Month Review August 2023

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

Priority 1: The Best Start for Life

Senior Responsible Officer (on HWB) **Dawn Godfrey**

Responsible Officer (on IDG) **Bernadette Caffrey**

GREEN = On Track

AMBER = Off track but mitigations in place top recover

RED = Off track and at risk

GREY = Not Started

BLUE = Complete

Ref	What Do We Want To Achieve?	How Are We Going To Do It?	Lead Organisation	Timeframe for Delivery (Month/Year)	Level (System, Place or Neighbourhood)	How Will Success Be Measured?	Progress for August 2023	Progress for September 2023	Key Identified Risks	Mitigations	Sept 2023 Project RAG Status
1.1	**Healthy child development in the 1,001 critical days (conception to 2 years old)**										**GREEN**
1.1.1		Clear 'Start for Life' offer for parents. The Family Hub programmes will be critical to bring activity together and ensuring an integrated offer across the 0 to 19 (25) years pathway. Information sharing agreements to be agreed. Watch - Family Hub programme receiving oversight from the Rutland CYP Partnership.	RCC/PH /Mina Bhavsar (ICB commissioning officer). Sham Mahmood. Public Health.	2022-24	Place and system	Family Hub operating 0 to 19, (25 yrs. SEND), clear, accessible , seamless and integrated services for families in place and achieving positve outcomes for children and young people. Quantative, qualitative feedback from parents on feeling supported through 1,001 critical days.NHS provider meeting KPis in 0 to 11 years Healthy Child contract and offer.			Engagement		**GREEN**
1.1.2		Healthy lifestyle information and advice for pregnant women or those planning to conceive, including: a) implementation of MECC+ healthy conversations across prevention services b) Targeted communication campaigns c) Increase awareness of postnatal depression and social isolation through midwifery and 0-10 children's public health service d) Immunisations in pregnancy (flu/covid) e) Ensuring women are also reached who have chosen to give birth out of area. Link to 2.1.1 Communications 2.2.3 Healthy conversations 7.1.1 Perinatal mental health support.	LPT/UHL	2022-23	Place and system	* Women healthier during pregnancy: reduction in overweight/obese or smoking. * Improved rates of immunisation for mothers (notably flu/Covid). * Women aware of the risk of Post Natal Depression and isolation. Better able to prevent and seek support where required. * Wherever women give birth, they have access to information about health in pregnancy and access to support.			Lackof capacity and increased demand in key partner agencies		**GREEN**
1.1.3		Local implementation of the Maternity Transformation Programme considering: Improving quality and safety for mother and babies. Improving quality of pathway Implementing neonatal critical care review, improving access to perinatal health services. Link to above actions. LLR LMS Transformation Funding	LPT/UHL	2023-24	Place and System and Neighbourood. Working toward 6% perinatal access to increase access from 6% to to 10% by March 2023	Mothers in Rutland are happy with the services available to them. Positive change in longer term trends around low birth weights and infant Mortality. .Maternity service patient satisfaction surveys · Qualitative feedback re maternity service access, including cross border · Location of Rutland births · Low birth weight for term babies · Infant mortality					**GREEN**

Ref	What Do We Want To Achieve?	How Are We Going To Do It?	Lead Organisation	Timeframe for Delivery (Month/Year)	Level (System, Place or Neighbourhood)	How Will Success Be Measured?	Progress for August 2023	Progress for September 2023	Key Identified Risks	Mitigations	Sept 2023 Project RAG Status
1.1.4		Implementation of 0-19 Healthy Child Programme, to support Rutland's Family Hub Programme. Including: 0-10year mandated child development checks (including 3-4month and 3.5year checks), a digital offer, evidence-based interventions for children (antenatal, breastfeeding, dental care and peer support for developing active, resilient children, awareness around shaking and head trauma (ICON)), and safeguarding. Consideration of accessibility of related health health services, including dental. Specific consideration for military population.11plus Public Health Teen Health contract and Offer for young people in Rutland	Public Health Rutland	From Sept 2022	Place and system	Positive development of children 1-10, in areas covered by the dashboard metrics .New Born Visits within 14 days • Breast milk is baby's first feed • Breastfeeding initiation and continuation rates • 2.5 year development checks (fine, gross and motor skills) • Healthy Together 2.5 year development checks (communication, fine and gross motor skills) • Early Years Foundation Stage Progress Check between 2-3 years of age, including communication and language, physical development and personal, social and emotional development • Attainment of a Good Level of Development (GLD) at the end of reception year, taking into consideration children eligible for Free School Meals (FSM) • Immunisation rates in under 2years • School readiness at the end of foundation year (especially those receiving Free School					**GREEN**
1.1.5		Further investigation into -High proportion of low birth weights at term in Rutland. -Children and Young People's dental care in Rutland, including dental education and access to services.	Rutland Public Health	2022-23	Place	Better understanding of the factors contributing to these patterns. Stronger evidence base for next steps to tackle these issues. Oral Health JSNA chapter · .Low birth weight for term babies · Infant mortality • Children with visibly obvious tooth decay at age 5years					**GREY**
1.2	**Confident families and young people**										**GREEN**
1.2.1		Implementation of 0-19 Healthy Child Programme, 11-19year element, which supports the Rutland Family Hub programme - including face to face offer for families, a digital offer, health promotion campaigns including via schools, health behaviours survey, safeguarding, evidence-based interventions for healthy, active resilient children and young people who are able to transition effectively into adulthood. Specific work on transitions for children with LD (up to the age of 25years.) Integrated offer that include a whole family approach,(fathers/grandparents), and is supported by local and vountary groups and communities. 1.4 for vaccinations 2.1 communication campaigns 4.4.1 Digital inclusion 7.1.3 Children and Young People's mental health needs	Rutland County Council	From Sept 2022	Place and system	Happy and successful young people 11-19, receiving support and interventions early and when and where they need it. Provider meeting the KPIs. * Immunisation uptake (Covid, HPV, school leavers booster especially for those in care) * Proportion of children at a healthy weight (NCMP data at reception and year 6) * Under 18year conceptions * Health behaviour survey results indicating positive lifestyle choices and access to a trusted adult * A&E attendance for under 18years * Rate of hospital admissions caused by unintentional and deliberate injuries (Children aged 0-14yrs) * Educational attainment * Proportion of young people not in education, employment or training * Specific split of data from those with LD including qualitative feedback on transition from CYP service to Adult Services for those with additional needs.			Capacity within key partner organisaitons to engage in and deliver programme.		**GREEN**

Ref	What Do We Want To Achieve?	How Are We Going To Do It?	Lead Organisation	Timeframe for Delivery (Month/Year)	Level (System, Place or Neighbourhood)	How Will Success Be Measured?	Progress for August 2023	Progress for September 2023	Key Identified Risks	Mitigations	Sept 2023 Project RAG Status
1.2.2		Targeted, coordinated support for Rutland's most disadvantaged or vulnerable children, representative of Rutland's demograpic, to access their Early Years and Inclusion Offer and provision. Reduce the impact of Adverse Childhood Experiences on children and their families by embedding a 'trauma informed approach' to the workforce. Integrated Early Help, SEND, Health and Social Care offer	RCC,	2022-23	Place	Families who are disadvantaged or with additional needs have their needs identified early, and feel supported, and less likely to need specialist services.Adverse Childhood Experiences have less impact on children and families - through prevention and support to manage/recover. * 0-5 year development indicators specifically for target groups * Healthy lifestyle indicators reviewed for specific groups including immunisation uptake for SEND in over 14years * Proportion of annual Looked After Child Reviews carried out by Looked after Children Nurses * Proportion of Strengths and Difficulties Questionnaires (SDQ) undertaken for Looked After Children * Proportion of Education and Health Care Plans completed					**GREEN**
1.3	**Access to health services**										**GREEN**
1.3.1		Increase health checks for SEND children aged 14years and over ensuring that status is built into the education and health provision set in a Child's Education and Health Care Plan. Funding RCC - DSG HNF. CHC CCG	ICB /LPT	2022-23	Place	Children with SEND are having their health checks in a timely fashion. This is helping those working with them to do this more successfully. * Immunisation uptake especially in SEND over 14s * Proportion of SEND Health check completed					**GREEN**
1.3.2		Increase immunisation take-up for children and young people where this is low, including identifying sub-groups where take-up is lower and understanding why.	ICB/ LPT	2022-23	Place and system	It is clear where immunisation take-up is lower than average (including among which demographics), and changes to delivery help to increase take-up to match or exceed comparator averages. * Review into immunisation uptake across Rutland * Immunisation uptake rates (Covid, HPV, school leavers' booster especially for those in care)					**GREEN**

Ref	What Do We Want To Achieve?	How Are We Going To Do It?	Lead Organisation	Timeframe for Delivery (Month/Year)	Level (System, Place or Neighbourhood)	How Will Success Be Measured?	Progress for August 2023	Progress for September 2023	Key Identified Risks	Mitigations	Sept 2023 Project RAG Status
1.3.3		Coordinated services for children and young people with long term conditions (LTCs) and SEND. Long term condition support for children and young people with asthma, diabetes and obesity including access to appropriate medication, care planning and information to self-manage their conditions, and to relevant support services. To include learning from the Leicester City CYP asthma review and take-up of Tier 3 weight management services. 3.2 Integrated care for LTCs 7.1 Integrated Neighbourhood Team development ND Pathway programnme, and Key Worker programme. To explore early planning for ASD/ADHD families between GP and schools.	LPT	2022-24	Place and system	* Report with review of Leicester City Evaluation in context of Rutland needs					**GREEN**

Priority 2: Staying Healthy and Independent: Prevention

Senior Responsible Officer (on HWB) **Mike Sandys**

Responsible Officer (on IDG) **Adrian Allen**

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Ref	What Do We Want To Achieve?	How Are We Going To Do It?	Lead Organisation	Timeframe for Delivery (Month/Year)	Level (System, Place or Neighbourhood)	How will Success Be Measured?	Progress for August 2023	Progress for Sept 2023	Key Identified Risks	Mitigations	Key points for Discussion or Escalation	Sept 2023 Project RAG Status
2.1.2	Working in collaboration with the VCF sector to further strengthen relationships across the sector.	a) The VCF forum coordinated by Citizens Advice Rutland (CAR), also working with wider bodies and services e.g. Parish Councils, and statutory and commissioned services. Sharing intelligence, skills and resources; mutual aid; joint responses to community needs and funding opportunities. b) VCF groupings with a shared focus e.g. deprivation, armed forces. c) Community development encouraging the formation and confident operation of new groups in Rutland for shared interests. d) Mapping of the Rutland voluntary and community sector to understand its strengths and areas for development. e) Collaboration, with statutory and commissioned services, around sustainable improvement for households with multiple and/or complex needs impacting health and wellbeing.	CAR, RCC	Jun-23	Place	* VCF forum participants * Collaborations including events, shared resources, joint services, grants obtained * Mapping of Rutland voluntary and community sector			low uptake of survey by VCSE groups	CAR have allowed a 3 month data collection period and we will invest staff and volunteer time to drive up participation.		**GREEN**
2.1.3	Increase the level of volunteering across the county.	Working through the Citizens Advice Rutland (CAR) volunteering marketplace, making sure we are building on positive experiences in the pandemic.	CAR	Sep-23	Place	* Number of volunteers registered * Number of matches made * Number of hours of volunteering committed			The demand for volunteers is not met as numbers of available volunteers is lower than needs of VCSE sector.	CAR are running an ongoing campaign on social media, local radio, pop up stalls and monthly VCSE calls to try to increase the number of volunteers in county.		**GREEN**
2.1.4	Building Community Conversations	Explore the potential application of innovative models to empower individuals and communities, including: the Healthier Fleetwood model in which facilitated conversation spaces enable communities/groups with a common interest to meet informally to discuss opportunities and issues and progress improvements; and Camerados, an approach designed around people looking out for each other.	CAR	Mar-24	Place	* Feasibility study on implementation of potential community models in Rutland * Qualitative feedback that community conversations are taking place * Number of participants in the model						**GREY**

Priority 3: Living Well with Long Term Conditions and Healthy Ageing

Senior Responsible Officer (on HWB) **Kim Sorsky**

Responsible Officer (on IDG) **Emma Jane Perkins**

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										progress for May 2023	Key Identified Risks	Mitigations	May 2023 Project RAG Status			
12 month Action Plan						progress from May 2023 - April 2024										
Action	Aims	Responsible	Due Date	Progress to April 2023	Outcomes	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
All aspects of 3	Community Engagement events . Information regarding Age UK, CAR & voluntary services &Community Safety &Shared Calendar of events	CAR (Katy Brown) / Hugh Crouch (community Safety) / Mark Young (MH)/ Lisa Hamilton (MDT Lead)	ongoing	5 Events since January = approx 25 people jan = Braunston & Tesco/ Feb = Langham, March = Greetham & Ryhall, April = Saxon Gardens over 55's Oakham & Ketton & Stretton & Uppingham Market Rutland show = June. April & May & September Market Places Oakham & Uppingham	Receipt of information on services including villages and rural areas. Identify and connect to those vulnerable and carers increase number of volunteers	Rutland Show / Exton	Currently looking into more possible locations for community events over the winter. Community Safety have secured response fund monies to help tackle crime and disorder									
	digital volunteers	Jane Kibble/ S-J Sharman?	?	?	recruitment of 4 vols for Rutland - outcomes??	Currently on hold due to Age UK gaining funding to run weekly sessions from Tesco	Currently on hold due to Age UK gaining funding to run weekly sessions from Tesco	Tesco sessions ongoing through Age UK								
	LLR pathfinders project - all care homes to complete DSPT and have NHS email and access to DSCR	LHis	ongoing	Phil Eagle update to add here	care home can see DSCR and are able to communictae via NHS email securely	6 care homes in Rutland are known to have an NHS email address but cannot find out who to gain further information from in Phil's absence.	Doug and Matthew now in post at LHIS and are coordinating all of the digital wrork around care homes									
	all providers to have digial care records to allow secure and access to peoples care records across the system	LHIs	Mar-24	Phil Eagle update to add here	secure access to records across the system - patient only telling story once and acurate up to date assessment can be made	Unable to receive updates since Phil Eagle has left post	Unable to receive updates since Phil Eagle has left post									
	VAR Christmas Appeal	VAR	Dec-23		Ensure as many of the vulnerable, elderly and young people in our community receive a gift, assistance or help this Christmas. More important that ever due to the ongoing cost of living crisis.		Small amount of funding secured for a storage container. Will endeavour to gain further support from businesses in the community.									
	Home safety checks by the Fire Service	Fire Service	Ongoing	Home safety check referal on the JOY platform	Carry out 600 per year	81 home safety checks completed in June	57 home safety checks completed in July									
	Warm Pack	Fire Service	Winter 2022	25 packs given to vulnerable adults. Fire service looking at doing this in winter 2023 as well.	25 vulnerable adults issued with a warm safety pack	In discussion	Jamie Dawes confirmed that warm safety packs will be offered again this coming winter 23.									
	Empower people towards self care - through the development of a digital front door for ASC	Mat Wise	autumn 2023	self assessment portal for therapy	reduce demand on duty and direct people to right therapy offer	Pilot testing went live in June. Advertised in Stamford Mercury in June.	Two self-referral assessments carried out through the portal in July.									
	Below Waist Pilot Rutland pre-hab pilot	Pre-hab pilot project group	Jun-23	Group has met to discuss linking GP referrals for below the waist operation to prehab support whilst on the waiting list Laura Rutland PCN looking at patients suitable for this project - currently found 11 patients and 6 have been refered to Rise (40%)	Patients as fit as possible before operation / or not needing the operation / assistive technology and environment checked prior to discharge General assessment of the needs to ensure the person has all environment sorted and healthy lifestyle – diet and exercise to max potential of the surgery and to improve outcomes on while on waiting list	Meeting to be held end June. We are receiving referrals into RISE but need to join up more with hospitals on waiting lists.	Laura has made cotact with around 15 patients but only around two want the referral through Joy to RISE. We have also extended our protocol to include ensuring patients have had pre-op blood tests and are recording weight and BMI and smoking status. Lots of people electing to have help after their surgery rather than before. Monitor going forwards.									
	All care home residents having a personalised care plan in place including Respect form. Care home engaged in a weekly MDT	Karen Payter & Eilidh Potter	ongoing	initial meetng taken place with care homes 50 MDTs held in April 2023	all residents are supported to live their best life and end of life wishes are known number of care homes residents with a frailty assessment/score	48 MDTs held in June	40 MDTs held in July	46 MDTs held in August / Personalised Care Plans = 9								
	Implement a proactive framework for identifying and managing frailty, using care coordinators to target support for Housebound and/or frail patients in collaboration with RISE team (22/23) action from strat health plan We aim to implement a proactive framework for identifying and managing frailty, using care coordinators to ensure that all patients are offered 1. Shingles vaccination 2. Screening for dementia 3. Structured Medication Review 4. Referral to integrated care coordinator 5. Falls prevention advice and referral 6. Proactive management of long term conditions and care planning	PCN Manager Nicola Turnbull	ongoing	75% completed just now doing the last few patients who require falls assessment	Implement a proactive framework for identifying and managing frailty, using care coordinators to target support for Housebound and/or frail patients in collaboration with RISE team (22/23) action from strat health plan We aim to implement a proactive framework for identifying and managing frailty, using care coordinators to ensure that all patients are offered 1. Shingles vaccination 2. Screening for dementia 3. Structured Medication Review 4. Referral to integrated care coordinator 5. Falls prevention advice and referral 6. Proactive management of long term conditions and care planning											
	Personalised falls prevention programme - Therapy project for support to care homes to prevent falls and reduce the number of fallers in Rutland	DHU & Jane Kibble	Jun-23	Number of care homes engaged in falls project and resulting reduction in number of fall initial conversations around sharing the names of the fallers the DHU car attend to Jane Kibble for a therapy triage	prevention of a repeat fall reduction in the number of people haiving a hip fracture in Rutland	Jane presented at Royal College of Occupational Therapy recently and have been asked to publish their work and also to present at Bedford University. Gaining local and national recognition. DHU car - trying to get data on when it comes into Rutland and what it provides but are not gaining information from them. Data is not showing anyone being picked up. It appears that the car isn't actually coming into Rutland.										

										progress for May 2023	Key Identified Risks	Mitigations	May 2023 Project RAG Status			
	Monitoring deterioration in a persons health using:-Whzan – NEWS2/Restore Mini	RCC - Karen Payter	ongoing	external evaluation of project ongoing - 8 care homes included in this pilot peer support meetings held monthly. Pilot has identified long wait times to access GP contact	using NEWS residents are able to avoid hospital admission as deterioration is identified early and treatments received	As a result of Rutland using Whzan from February to June - we've made a saving of approx £295K on reducing hospital admissions from our care homes. Apart from the monetary saving, this has prevented many residents from having the distress of being admitted to hospital.										
	sensory based falls tech in care homes	LLR falls group - jane kibble		10% of homes with digital falls tech in place by March 2023	preventing falls via use of tech	All of our care homes have some level of tech but level of tech varies dependent on roll-out.										
	digital transformation - utilising the digital switchover as a catalyst to transform care technology in Rutland.	Jane Kibble and Longhurst	Jun-23	Longhurst Group have been successful in securing the contract and commenced mobilisation	Digital switchover rollout for those using monitoring services - Rurality and network/signal coverage may raise an issue?	Received information from BT regarding digital switch over. Started to share information with partners to raise awareness of Rutland and neighbouring county events	Event took place on 19th-20th July at RCC Oakham / 20th July in Melton and 27th July in Stamford									
	Micare support those discharged from hospital :- discharge to home first assessment on discharge to ensure right level of care and support provided and reduce those needing acute care	micare	oingoing	35 D2A cases April 2023 avg stay on reablement is 25 days with 100% effectiveness 100% people still at home 91 days following discharge EDT - 3 calls in April	people are supported to regain health and well being through effective reablement and are supported to stay at home for as long as possible and prevent hospital admissions	44 D2A cases Jun 23. Average days for reablement is 18 days. Percentage of Discharges at home 91 days later 100% EDT calls 3	22 D2A cases July 2023. Average days for reablement is 17 days. Percentage of discharges at home 91 days later 95%. EDT calls: 0	49 D2A cases August 2023. Average days for reablement is 21 days. Percentage of discharges at home 91 days later 88.9% EDT calls 3								
	Ensure residents are fully aware of the community and health and well-being offer in Rutland and understand how to access it - use of joy for accessing community and professional support	Rise	ongoing	vista, housing Mot and Assistive tech teams using joy to improve referal route following use of the self assessment portal for therapy.	increased use of joy will supprt self referral/access to services and be able to track outcomes for people	Lisa continues to make contact with local groups to discuss coming on to the Joy platform. Also raising awareness	Lisa continues to add services to Joy and in contact with Joy regularly to feedback any suggestions to improve experience	Annual leave slowed down addition of services in August - to resume in September								
	Increase and enhance social prescribing for wellbeing, focussing on personalised, strengths-based care assessment and planning via the joint RCC and PCN 'RISE team' and other local providers. Number of referrals to Rise integrated neighbourhood team via the joy platform	Rise	ongoing	number of referals to joy April 2023 =39 discussed drop in numbers with PCN and plan in place to raise comms and activity - 29 from GPs, 10 from other professionals or self referrals	increased referrals to community and professionals to access preventative services and support those supported by rise have increased outcomes demonstrated via ONS4	Number of referrals to Joy in June = 55 . GP referrals: 35 / Referrals from other professionals or Self-referrals: 20	Number of referrals to Joy in July = 51 . GP referrals = 22 / Referrals from other professionals or self-referrals = 29	Number of referrals to Joy in August = 70. GP referrals = 37 / Referrals from other professionals or self-referrals = 33								
	Increase and enhance social prescribing for wellbeing, focussing on personalised, strengths-based care assessment and planning via the joint RCC and PCN 'RISE team' and other local providers.	RISE		* Increased social prescribing referrals * Social prescribing platform users and activity * Development of signposting network * Number of groups/activities referred to by RISE team * Patient changes to ONS4 scores (a 4-element self-assessed measure of wellbeing) * Evaluation of the impact on social prescribing including understanding the impact on GP practices by service users	a) Promote clear routes for wellbeing enquiries/ requests for support through Rise front door and RIS.Link to' prevention front door.' b) Enhance social prescribing tools by developing: * Consistent assessment frameworks for use across agencies. * Social prescribing signposting network. * Service maps for consistent referral. * Social prescribing platform managed by RISE, aiding referral between agencies and monitoring of pathways and outcomes											
	Admiral nurses using JOY as a direct referral from GPs	Jane Lee	May-23	Admiral nurses have made contact with JOY to discuss direct referral from GPs	Easier referral from the GP to the admiral nurse service rather than the current Prism referal.	No referrals through Joy in June. June referrals have been self-referrals, Memory Service and ASC referrals	Two referrals from JOY in July - one from GP and one from care coordinator at PCN									
	monthly MDTs taking part in all 4 GP practices - following the LLR MDT framwork	Lisa Hamilton	Aug-23	Lisa started in post 18/4/23	those requiring an MDT approach to support are discussed at each MDT as appropriate	Lisa met with Rutland PCN manager and practice managers from Rutland GP surgeries for initial discussions re. MDT's	Discussions ongoing regarding MDT format									
3.2 Integrating services to support people living with long-term health conditions	Prompt safe hospital discharges	RCC hospital team	ongoing	**March** - discharged 42 people - 11 left on same day as becoming med fit of the 42 - 23 discharged within 48 hours - ave discharge delay is 2.6 days - **APRIL** - Discharged 36 people, 6 left on the same day as becoming medically fit. Of the 36 discharged in April, we supported 22 discharges within 48 hours. April avg discharge delay is2.5 days	people spend as little time as needed in an acute setting and return to the community as soon as med fit to do so. This improves outcomes of reablement and rehabilitation	Discharged 43 people, 11 of whom left on the same day as becoming medically fit. Of the 43 discharged in June, we supported 23 discharges within 48 hours. For June our average discharge delay was 2.5 days.										
	VAR - expansion of support beyond the community transport services - now based at OEP	VAR	ongoing	Lisa met with Tom Walters to discuss	more support availble to vulnerable people in Rutland	9,556 miles driven with around 502 journeys in June.	9,838 miles driven with around 525 journeys in July	9,753 miles driven with around 511 trips in August								
	Men and Women in Sheds Project	Age UK	Ongiong	Men in sheds as been running in Rutland since 2017 and has now been broadened to include 'women in sheds'	Tackling loneliness and increasing social engagement amongst older people with a view to combating social isolation and improving health.	LLR Community Foundation grant has been awarded. We are currently identifying potential sources of ongoing funding, working with shed members to generate income through sales and to seek opportunties to work in partnership with other organisations in Rutland.	We have submitted a funding bid that will enable us to develop a dementia friendly session at the shed. We are currently waiting the outcome of the bid.	Currently recruiting additional members. Shed continues to generate income via sale of items. Funding bid has been submitted to enbale a regular dementia friendly session at the shed. Outcome of bid should be known in October 2023.								
	Digital Champions	Age UK	Ongoing		Offering people support to use digital devices such as smart phones and tablets	Weekly digital drop-in sessions commenced at Tesco Oakham every Thursday from 2-4pm from 8th June. Lisa visited to make connection with George & Martin who run the sessions	Currently supporting approximately 12 people per month at digital drop-in sessions.	Weekly digital drip in sessions continue at Tesco store in Oakham.								
	befriending support for isolated and vulnerable	Age UK	ongoing	stutgmh grant received by age uk to extend befriending project into 23/24	people in rural community have access to peer support through the befriending project	The befriending coordinator post is currently vacant. Recruitment is underway. Arrangements are in place to support current befriending activity. New referral on hold until new Co-ordiantor is in post. Lisa to get in touch with new coordinator once in post to discuss Joy platform referrals/MIABs	The Co-ordiantor post is currently vacant. We are in the process of recruiting a new Co-ordiantor. New matches will be on hold until the new Co-ordinator is in post.	New befriending Co-ordiantor has been recruited. Commences in past 2.10.2023. Induction is currently being planned.								
	Lions Message in a Bottle programme (MIAB)	Lisa Hamilton / Admiral nurses (JOY)	Aug-23	"Message bottles" ordered from Allan Gray at Rutland Lions - awaiting delivery. Lisa collected first 100 mid May. Awaiting promotional materials from Lions.	Promotion of programme to people living with long-term health conditions. Number of bottles given out.	30 MIABs given to Age UK befriending service. 10 MIABS given out to Egleton Parish. VAR will trial - Lisa to deliver to Tom.	Allan Gray provided Lisa with a few posters which we can use to display at community events. Lisa gave 30 MIABS to our PCN care coordinator, George to help to distribute through her home visits to housebound patients	Lisa delivered MIABs to VAR for them to trial with a few drivers.	Lisa provided Georgina from the Rutland PCN with more MIABs for her visits to housebound patients.							

										progress for May 2023	Key Identified Risks	Mitigations	May 2023 Project RAG Status			
3.3 Support, Advice and community involvement for Carers	Rutland carers support group - Yvonne Rawlings/age uk - meets at St John & ST Annes, Oakham last wed of the month 10.30am Our group is made up of mainly carers caring for someone living with dementia and one who has been a carer and is now widowed.	RCC carers team - Yvonne Rawlings	ongoning	carers group attendance numbers are as follows: January: 8 February: 11 March: 11 April:14	Our support group offers carers of older people suffering debilitating illness such as Alzheimer's or MS the chance to meet and mutually support each other. We offer a variety of speakers and outings which we hope will cater for all tastes. We try to steer clear of specific issues around caring as we feel that members of the group like to talk about other things on their afternoon off. However, members always have the opportunity to share and discuss problems or issues of concern.	15 people attended in June									
	Carers' Centre LLR 1. Weekly get- together with carers - skills-based learning & peer support.	Carers Centre LLR	Nov-22	Group running weekly - Together we care - Oakham Methodist Church	increase in information and knowledge through regular speakers attending the group - peer support ave number attending is between 3 - 6	Total carer attendances for June was 7. Only two sessions were held due to carers event and illness. Attendance 3 June: 3 carers / 29th June: 5 carers	Total carer attendance for July was 9 across three sessions held	This pilot has come to an end and is sadly not going to be extended.								
	2. Mental health service for carers (May) - Small groups and 1:1 - working with all LLR & carer. Understanding impact of carer role, understand if people are carers - healp them to know.	Carers Centre LLR	May-23	Small groups of 1:1	Understand the impact of the carer's role and what help is available to them target 20 people	1 carer engaged through Caring for carers group 6th June. 5 individual carers engaged through caring-for-carers 1:2:1 sessions. 2 carers received 2 sessions / 3 carers received 1 session	1 individual carer supported through Caring For Carers Group. 4 Carers supported through 1:2:1 sessions - 4 carers received two sessions each.									
	all carers are known to professionals to enable support, information and advice to be given - prevent carer breakdown and crisis (hospital admission)	RCC & PCN	autumn 2023	sync - PCN + ASC list of carers GP's and professionals discussing how to identify carers Rural CC link in community -	carers only tell their story once - all professionls are aware that a person is a carer - MDT support given All care support options are on joy platform to ease referals and signposting	PCN resumed making contact with known carers to offer support on 12/06/23. PCN will launch comms to identify new carers.	Libby to make contact with PCN to discuss									
	Information via a leaflet on discharge from hospital for carers	carers matters group - RCC carers team	Jun-23	final sign off being obtained - age uk and cheryl clegg	carers have information available on dischrge of cared for	LH Spoke with Cheryl Clegg. She understands this is still awaiting finalisation. She will update	Lisa has chased Cheryl for an update. Not receiving any response									
	LLR carers group actions - identifying unpaid carers as they are less likely to reach breaking point and require emergency assistance	rcc carers team	?	rcc carers team to link this to rutland specific actions	* workforce training - raise staff awareness of caring * primary care support pack * access to GP register information * carer GP registration form * carer passport * Mobilise - identify the unpaid carers in Rutland to provide an enhanced range of online support eg eligibility tool for carers allowance or blue badge checker or courses and support tel calls or a mini carers assessment to lead into the care act carers assessment or carers coaching programme											
	raise the profile of support via rcc carers team	RCC carers team	Jun-23	leaflet to be designed planning event 7th June in Catmose 2 - 6pm for carers week	more carers are aware of carers assesmet and support on offer	Carers event held at Catmose 7th June. Extremely well attended with around 40 professionals attending and almost 100 carers and their families										
	Carers having access to the right information at the right time	RCC carers team	Ongoing	Exploring mailchimp mailing system	Improving means of communication with carers across Rutland	Governance have said we're not able to proceed so we are exploring other options.	A request has been made for an account to enable regular communication with carers through Information Governance. Awaiting response.									
	RCC to explore signing up with Carefree to offer free short breaks to adult carers of carers.	RCC carers team	?	?	reduce carer strain	Eligible carers of 18+ who are providing 30+hrs of care are entitled to short breaks. They can talk to RCC carers team who can then make the referral.	Eligible carers of 18+ who are providing 30+hrs of care are entitled to short breaks. They can talk to RCC carers team who can then make the referral.									
	PCN Carer project	PCN	Jun-23	Carer Project PCN. Comms identify new carers - Contacting with information / RISE referral	Increasing number of carers identified and supported	Recommenced 12th June 2023. Libby will speak to Laura.	Libby to make contact with PCN to discuss									
	leicester University research project - what is it like to be a carer of someone who lives in a care home?	Leicester Uni - RCC carers team	Aug-23	advisory group to be held 1/6/23 listening event 17/7/23	understanding the difficulty of caring role before moving into the care home and the caring role after the cared for is in the care home	Rutland Grange took part in the research project. Findings not yet published.										
	Identification of young carers	RCC Children & Adults / Family Hub	Aug-23		Young carers supported in their caring role	21 young carers supported during June	9 young carers supported during July	16 young carers supported during August								
	LLR Dementia Strategy with Rutland-specific delivery plan & take note of the Healthwatch Dementia Survey	Beverley White (Leicester City) / Jane Lee = link for RCC	May-24	* Currently being written * Regular meetings * Will need cabinet sign-off	* Co-produced. * Service tailored to need. * Improve dementia care. * Raise awareness. * New WOW including digital. * Collaborative work - Health & Social care.		Posters given out to pharmacies, surgeries, RMH and partners to help raise awareness of the dementia strategy, encouraging people to have their say.	CAR kindly distributed this LLR Strategy to over 200 people on their database to help raise awareness.								
	Rutland LD Partnership Board	Alexandra Chamberlain	March 23 & quarterly	* Relaunched post-covid. * Good attendance, including people's lived experience. * Two co-chairs elected. * Action plan created - Easy Read / accessible for people with LD.	* Giving people with LD a voice. * Co-producing services and co-producing policies & recruitment. * Numbers of people attending board. * share leder findings - CPD likely to be sept 2024	LDPB held on 21st June. 34 people attended in person and 4 attended by Microsoft Teams so total attendance = 38	The nex LDPB is due to be held on21st August. LD nurse to attend with interactive bus to explain what's involved with an LD annual health check									
	Increase the % number of LD health checks completed	?		Need to develop link for reporting this data across Health and ASC partners	people with LD are regualrly monitored and support given early to ensure they are living healthy and well	Likely that data on AHC to be published in June's annual Leder Report.	LD Health checks to be completed in Q4 so updates will follow									

										progress for May 2023	Key Identified Risks	Mitigations	May 2023 Project RAG Status			
3.4 Healthy, fulfilled lives for people living with learning or cognitive disabilities and dementia	providing care and support for people with LD closer to home	RCC ASC	ongoing	ASC still adopts a close to home approach however we lack provision for residential college therefore when transitioning into adulthood tend to want to remain with the provision in place prior to 18 which results in remaining out of county. However, a number of young people we have integrated back closer to home in County. Continue to look at improved offer with regards to placing people close to home via RCC Transitions Service and Assistive Technology.	people are support to stay in Rutland rather than access support a long way from family and friends											
	Supporting people with LD/autism to access vol/work/education opportunities	rcc employment officer		Employment support officer in post to support people to gain paid employment. ASCOF data on numbers in employment as of 2022 higher in rutland than the regional/nation average. However this only covers adults with care and support needs. Not the overall population. Data to be provided every quarter	% Number in employment	11% although employment status is unknown for several people so % could potentially be slightly higher if some of these are in employment. Awaiting information from Linda Wylie	Unable to obtain this information due to staff absence.									
	dementia awareness week 15 - 21st May 2023	admiral nurses rcc	17/05/23	comms and plans for an events at catmose in place 17/5 - catmose 10 - 12 - time for a cuppa 18/5/23 - musical memory café at catmose 10.30 – 12	fundraiser for admiral nurses											
	Anticipatory Care Project - To improve educaction regarding dementia including in care homes	EJH & PCN / Admiral nurse	Sep-23	* Looking for a facility from which to run clinic. Discussions about use of RMH taking place on 18/5/23 * 288 people identified from PCN patient list to be included in this pilot	* Earlier diganosis. * Quicker support including meds, treatment etc. * increase number of those diagnosed with dementia	Lisa visited RMH to view the rooms available. Still awaiting final confirmation on rooms. PCN creating protocol to increase dementia diagnosis by GP's being able to refer to care coordinator to be contacted and do tests / be referred etc.	First Rutland Memory clinic was held on 13th July at RMH . Supported by Jane Lee, Georgina Baker & Lisa Hamilton. Second memory clinic supported by Lisa and George on Thursday 20th July									
	Carer support on zoom - For those caring for someone with dementia or memory loss	Rutland community Ventures	May - July 2023	Groups being held when?? - how many thave attended	support for carers - evaluation of the difference attending has made	5 people supported in June via zoom sessions	5 people supported in July via zoom sessions									
	Rutland Community ventures - Arts & Crafts Rutland Sailing Club - * people & carers with dementia. * Start discussions, open agenda, identifying carers.	Rutland Community Ventures and Jane Lee	February - June 2023	Groups being held when?? - how many thave attended	Jane - please add here the outcomes of these sessions	10 people attended the craft sessions in June	10 people attended the craft sessions in July. Funding awarded for further sessions in August and September									
	Dementia support - Creative communication for dementia carers - Finding different ways to communicate - sensory, music, memory boxes etc.	Carers Centre LLR	May-23	8 attended the session in Nov and 2 attended in Feb	Finding different ways to communicate, such as sensory, music, memory boxes etc.	No more sessions planned imminently	Lisa has made contact asking to be kept aware of anything planned going forward									
	Maintenance Cognitive Stimulation Therapy - A weekly group for those living with mild to moderate dementia aimed at encouragement, strengthening, maintaining, stimulating and having fun in a friendly and enjoyable setting. Pre-booking is required with a £5 fee.	Age UK	Ongoing	Groups being held weekly on Tuesdays: St. John & St. Anne's, Oakham 10:30-12pm. All Saints Church Hall, Oakham 13:30 - 15:00	Strengthening and maintaining cognition for people living with mild to moderate dementia in a fun and friendly setting.	MCST 8 sessions = 76 attendances, supporting an average of 19 guests living with dementia on a weekly basis over 2 sessions per week.	MCST 8 sessions = 63 attendances supporting an average of 18 guests living with dementia on a weekly basis over two sessions per week									

Priority 4: Ensuring Equitable Access to Services for all Rutland Residents and Patients

Senior Responsible Officer (on HWB) **Debra Mitchell**

Responsible Officer (on IDG) **Charlotte Summers**

GREEN = On Track

AMBER = Off track but mitigations in place top recover

RED = Off track and at risk

GREY = Not Started

BLUE = Complete

Ref	What Do We Want To Achieve?	How Are We Going To Do It?	Lead Organisation	Timeframe for Delivery (Month/Year)	Level (System, Place or Neighbourhood)	How Will Success Be Measured?	Progress for August 2023	Progress for Sept 2023	Key Identified Risks	Mitigations	Sept 2023 Project RAG Status
4.1	**Understanding the access issues**										**AMBER**
4.1.1	Indentify services that are commissioned locally in Rutland via the LLR and ICB and map equivalent services available across the neighbouring borders. To include both Primary and secondary care. Identify the cohort of patients who are registered with a Rutland GP but outside of Rutland. Finding to inform future pathway design.	Identification of the number of patients who are registered with a Rutland GP but live outside of the Rutland CC boundary. Identification of patients who live inside the Rutland boundary but access GP services outside the Rutland CC boundary. Identify issues of health and social care provision across borders to inform targeted work looking at certain cohorts of patients. Check services available in Leicestershire and indentify pathways in neighbouring counties and vice versa. Indentify top ten secondary care referral specialities for Rutland patients. Identify top ten reasons for attendnace at A&E for Rutland patients. Identify top ten reasons for admission in to secondary care for Rutland patients. Identify RMH community hospital inpatient bed utilisation and occupancy rates, including Rutland patients who are admitted to a community hospital bed outside of Rutland. Operational Service mapping of key OOA pathways where there are inequalities	ICB	Jun-24	Place	Report on border issues Documented mapping of key OOA service pathways and reference to specific issues Agreement on areas of focus of inequalities as part of delivery of PCN Network DES Agreed data sets and reports available for Rutland on Aristotle.			Variability in the availability of certain data from different providers. Some data may not already be routinely collected.	Work closely with Midlands and Lancs CSU and providers to ascertain whether it is feasible to establish regular data collection to inform measurement of the metrics.	**AMBER**
4.1.2	Develop strategic relationships with cross border commissioners and providers to ensure equitable services are developed and available ensuring Rutland's residents and those registered at a Rutland GP have greater choice across boundaries and inform future strategy development of partner ICB's. Build equitable access into pathway design.	Greater understanding of services that patients access or should be able to access across borders in Peterborough, Lincolnshire, Northamptonshire and Cambridge. Check services available in Leicestershire and indentify pathways in neighbouring counties and vice versa. Established links with associate commissioners and other partner agencies to inform future commissioning arrangements. Patients will feel more informed with regards to the services that they can access, where they can access and the different services available other than an appointment with a GP. Highlighting different roles such as first contact physio, clinical pharmacist, mental health practitioners.	ICB	Apr-23	Place	Improved patient feedback from people reporting health and care inequity Established regular meetings with associate commissioners and regular two way dialect.			Rutland is much further ahead with its work around the place led plan and some of this work is only in initial stages across the boarders.	Close working to inform plans wherever possible. Sharing of our plans with border partners to ensure collaboration and alignment moving forward.	**GREEN**
4.1.3	Work with local Rutland population to understand the key issues that they identify as a patient living in a rural location such as Rutland. Publicise the wide range of services and extended roles available through primary care. Patient and public engagement to inform long term plans.	Engage with the local population with regards to the design of the enhanced access service. Address the key recommendations from the RCC Primary Care Access Survey. Engage with PPG's and Rutland HealthWatch	ICB	Apr-23	Place	Number of survey responses Patient feedback Progress against the individual recommendations outlined in the Primary Care Accesss Survey.			N/A	N/A	**AMBER**
4.1.4											
4.2	**Increase the availability of diagnostic and elective health services closer to home**										**AMBER**
4.2.1	Improving public information about locally available diagnostic and planned care services as part of increasing access including urgent care and when mobile facilities such as the mobile breast screening unit are in the area, and accessible out of area provision.	GP, PCN and Rutland Information Service having dedicated areas on their websites/directories with information that is kept up to date and active signposting to out of county equivalent services. Map all local services available.	ICB	Apr-23	Place	Local communication plan and RIS development including specific campaign on out of hours access					**AMBER**
4.2.2	Develop understanding of used and vacant space at Rutland Memorial Hospital to inform scope for potential solutions. Followed by strategic review of other vacant space that could enable health services closer to the population.	A completed estates review that identifies all areas that are curently being used, identify areas for consideration not just from a health pespective but local authority and other local businesses such as leisure centres and vountary sector organisations.	ICB	Apr-23	Place	Quantified understanding of available space and existing medical facilities' appropriateness for clinical activity			The delay to the clinical estates strategy on informing the development of local understanding.	Working as a part of the team to inform the clinical estates strategy and anticipate outcomes so that this piece of work is citied and incorporated in discussions moving forward.	**AMBER**
4.2.3	Review and identify potential solutions for Elective and Community services feasible for closer local delivery, to macimise the use of local existing estates Infrastructure whilst supporting restoration and recovery post covid including considering e.g. cancer 2 week wait, cardio respiratory services and orthopaedics and the delivery methods for such services i.e. virtual or face or face, satelite clincs. Consider longer term options for children's services (incl phlebotomy), end of life, chemotherapy and diagnostics. Consider both new and existing infrastructure sites including Rutland Memorial Hospital (RMH).	Clarity of what services are delivered by GP practices, PCN, PCL, Acute and Community Services both locally and out of county. Review waiting lists for key priority areas. Explore potential areas for consideration to support reduction in waiting times and post covid back log for elective and community services.	ICB	Apr-24	System	Review of current and potential services delivered at RMH Evaluation of AI Tele - dermatology service Increase in availability and access to services locally			The unit has special requirements and restrictions for power supply and also access to facilities for patients attending.	Additional sites for housing the unit are being considered.	**AMBER**
4.2.4	Explore the possibility for a localised Pulmonary Rehabilitation Service through the evaluation of the pilot project in train to inform local feasibility models/review in Rutland.	Establish current usage of pulmonary rehab, anticipated future requirements and commissioning a service to be provided locally if required.	ICB	Jun-23	Place	Evaluation of local pulmonary rehabilitation take-up Increased take-up of pulmonary rehabilitation by relevant patients					**RED**

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4.2.5	Develop a longer term locally based integrated primary and community offer (health and social Care HUb) and supporting infrastructure for the residents of Rutland, driven forward by a dedicated partnership Strategic Health Development Group.	Establishment of Integrated Neighbourhood Teams by: Adopting a Population Health Management approach including risk stratification Delivering co-ordinated care at a local level Multi-disciplinary teams (MDT) working to deliver better outcomes Delivering a preventative approach to care, with access to a local prevention offer including social prescribing	ICB	Jun-24	Place	Partnership agreement on way forward and dedicated plan on next steps			Estates reviews timescales across partner organisations are not aligned. There is a current pressure on current ARRS staff and housing for them long term. Solutions being considered both short and long term.	Solutions being considered for both short and long term. One possibility is the use of Joules House but this is being considered as a part of the RCC estates review.	**AMBER**
4.3	**Improving access to primary and community health and care services**										**AMBER**
4.3.1	Improve access to primary and community health care: In primary care, take steps to increase the overall number of appointments in comparison to a baseline of 2019 and to ensure an appropriate balance between virtual and face to face appointments. (NB dependency on premises constraints). Increase uptake of community eye scheme provided by local optometrists and monitor usage. In community health, understand and work to reduce waiting lists/wait times for key services such as dementia assessment, community paediatrics and mental health.	Increase the undertstanding locally of the extended primary care team and the many ways in which an appointments can be booked . Implmented enhanced access locally More appointments in total in comparison to 2019 but acknowledgement of the wide range of appointment types available. Increase in the number of patients accessing the community eye scheme in comparison to baseline. Increase referrals to the community pharmacy referral scheme. A review of key services and waiting lists/times and put appropriate and deliverable plans in place to address whilst maximising the use of out of county providers and provision of more local services where possible.	ICB	Jun-23	Place	•Increased access to GP practice appointment in comparison to 2019 •Appropriate proportion of appointments delivered face to face in comparison to Aug 21 baseline •Qualitative feedback on GP practice access across Rutland •Identified waiting lists/wait times reduced			Access to waiting list data is limited from an ICB perspective. Only have at historic CCG level	Consideration to see if this data could be sourced through GP clinical systems instead and monitored on a monthly basis.	**AMBER**
4.3.2	Informing patients. Review PCN and practice website developments and online tools including review of usage data analysis to inform further website enhancements and engagement with registered population.	Standardised format for all 4 PCN practices making navigation easier. Recruitment of a digital inclusion officer (subject to funding) to work with patients to educate on the use of NHS app and websites. How to book appointments online, online consultations. Direct work carried our with the patients and public of Rutland to communicate the many services/clinics available and the varied roles. The role of care navigators and reception staff. Informing patients when appointments are released.	PCN	Apr-23		•Evaluation of PCN and practice websites and future developments.					**GREEN**
4.3.3	Review local pathways, with focus on: a)Satellite clinics nearer to Rutland – e.g. Joint injections at RMH being explored to manage local backlog b)Community Pharmacy Consultation Service (CPCS) pilot to support increase in referrals in key areas and reduce pressures in Primary care. This will be supported by the Local Pharmaceutical Needs Assessment.	Reduction in the number of patients waiting for joint injections. Increase in the number of patients being referred to community pharmacy and reduction in appointments in primary care that relate to conditions within the remit of CPCS.	ICB	Mar-24	Place	•Review of joint injections pathway •Reduced joint injection backlog •Reduced pressure on primary care •Review of community pharmacy services •PNA complete for October 22			Access to data	Consideration to see if this data could be sourced through GP clinical systems instead and monitored on a monthly basis.	**RED**
4.3.4	Maximisation of clinical space utilisation within primary care including existing primary care premises.	Undetake a clinical estates strategy. Seek to increase clinical consultantation rooms at Oakham Medical Practice via S106 investment. Explore potential Increase in designated clinical space at Uppingham Surgery.	PCN	Jun-23	Place	•Practices with increased consulting spaces •Increased appointment capacity			The delay of the clinical estates strategy has impacted on this piece of work and is integral for its delivery.	PCN, ICB and Place leads working collaboratively to ensure that this piece of work is completed as soon as possible.	**RED**
4.3.5	Review of GP registrations in the context of seldom heard or under-served groups to increase coverage where required for communities such as the travelling community, veterans and armed forces families (i.e. health equity audit learning from Leicester City Approach).	Establish links with primary care providers for military personnel. Identiication of seldom heard or under-served groups and increase in uptake of services via targeted comms and engagement.	ICB	Mar-24	Place	•Health equity audit on GP registrations			Ensuring linkages are picked up with the public Health inequalities work.	CS now attending the Staying Healthy Partnership Board.	**GREEN**
4.3.6	Ensuring full use of specialist primary care roles tailored to needs (e.g. practice pharmacist, muscular-skeletal first contact, health coach).	Increase in number of ARRS roles year on year Increase in the number of patients being seen by these roles. Maximisation of ARRS allocation Increase in staff undertaking training and further development.	PCN	Mar-23	Place	•Employment and delivery of specialist primary care roles in Rutland •Impact on primary care capacity of specialist roles			Full committment of budget means very little scope for in year developments in 2023/24.	Ideas sort for additional areas of consideration for 2023/24 in anticipation of in year slippage being available.	**GREEN**
4.3.7	Engage with local Armed Forces Defence Medical Services (DMS) to better understand to improve local health and social care interactions with regards to local service offers and and pathways. facilities to inform changes in local Health and Care services including referral processes/documentation e.g. RMH provision.	Establish links with primary care providers for military personnel. Identication of seldom heard or under-served groups and increase in uptake of services via targeted comms and engagement. Reduction in barriers to referral to secondary care services.	Put in inequalities section links to service movements			•Qualitative feedback that local services better reflect the needs of the military population			N/A	N/A	**AMBER**

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4.3.7	Develop a single point of contact for the Armed Forces community, offering support and guidance to navigate the (local) NHS systems and prevent disadvantage	Develop and outline LLR wide model to act a as a single point of contact embedding key elements of the due regard framework. Due regard for the armed forces in health referral e.g. duty to consider this population in pathway navigation and communicating appropriate health offers locally.	ICB	Sep-24	System	National and local pilot evaluation. Metrics to be agreed.			Funding for the SPOC has been split across two financial years with an allocation that has been recieved in 2023/24. Potential that this allocation will be unable to be be spent.	Consideration being given to how this can be managed and whether this will have an impact on the pilot.	**GREEN**
4.3.8	Development of a Rutland wide partnership community transport project to look at demand and response bus service models with outline of enabling financial models. This will include current pilots e.g. Community Transport pilot in Uppingham.	****Identify lead for this****	RCC			•Pilot evaluation report of findings and recommendations •Options appraisal of community transport models including collaborative financial strategy with Parish Councils					**AMBER**
4.4	**Improving access to services and opportunities for people less able to travel, including through technology**										**AMBER**
4.4.1	Decrease digital exclusion and Increase digital inclusion by targeting people who want to use technology to improve access to services and/or reduce social isolation. a. Collaborative approach across involved agencies and services. Identify reasons for digital exclusion e.g, affordability, skills, confidence, connectivity, choice. Support to take up digital services e.g. access to medical record, booking appointments, virtual appointments, prescription ordering. b. Fit for purpose local internet infrastructure and access across Rutland including access to high speed broadband within community setting such as libraries. Advice to support household choices.	Increased number of people booking on line and using the practice websites. Increase in number of patients being seen virtually. Increase number of patients with digital access to their health care record. Provision of digital enablement sessions - training on how to use the NHS app and practice websites. Promotion of onine access at local events Consideration of a digital transformation lead within the PCN. Increase in number of location public access points for high speed broadband. Standardisation of the practice websites so they all have the same navigation for ease of use. Consideration of services that may be able to be offered virtually. Monitoring of website usage and collection of patient feedback.	ICB	Apr-24	Place	•Number of people digitally enabled. •Residents in Rutland have the option to subscribe to high speed broadband •No. of public access points for high speed broadband •Number of people with access to their GP record •Numbers of people using the NHS app to order repeat prescriptions and make GP appointments against the baseline comparator. Practice website usage data and feedback Number of people attedning NHS App training sessions			Originally a business case was going to be written for consideration against BCF underspend for the digital enablement element of this work but this is no longer available.	Instead this will be taken forward through the work of the comms and engagement group, linking in with key stakeholders, local volunteers and linking with the PCN Digital Transformation Lead.	**AMBER**
4.4.2	Identify existing issues and routes /modes to improve physical access to services from rural areas by working with RCC Transport Plan team (including through further travel time mapping for different modes of transport and times of day, to support wider planning, also considering out of area access to services and ambulance response times).	****Confirm Reporting Lead for this element****	RCC	Apr-25	Place	•Review of current transport routes and health inequalities needs assessment •Rutland travel time and bus route napping including costs			N/A	N/A	**AMBER**
4.4.3	Delivering commissioned services within Rutland. Encouraging LLR services commissioned from third party providers to be offered directly in Rutland including through venue support.	Review which third party services are provided and consister whether they are able to be delivered locally in Rutland. Increase in number of venues identified that can be used for health and social care service delivery. Identification of services that can be offered locally that were originally accessed external to Rutland.	ICB	Apr-24	Place	•More services delivered within Rutland wherever possible					**AMBER**
4.5	**Enhance cross boundary working across health and care with key neighbouring areas**										**AMBER**
4.5.1	Undertake an Out of Area contract review of LLR CCG commissioned services	Identify key contracts that are used by Rutland out of area.	ICB	Jun-23	Place	•Review of cross boundary working across health and care					**RED**
4.5.2	Phase 2 of electronic shared care records including sharing with organisations not on the LLR Care Record system, notably out of area providers and other specialist providers including Defence Medical Services. Dependency on national shared care record programme. Explore potential for future digital referral routes from out of area.	****Update from Sharon Rose Required****				Electronic shared records implemented across a range of health and care providers					**AMBER**
4.5.3	Maintain close operational working with neighbouring CCGs, Councils and associate commissioners in Lincolnshire, Northamptonshire, Peterborough and Cambridgeshire with an initial focus on Primary Care impact on local provision, and implications of UHL restructure on demand for out of area services. Consider representation on respective governance groups.	Establish links with neighbouring commissioners and providers and establish regular dialect.	ICB	Mar-23	Place	Clear links with local CCGs and LAs re cross boundary working			N/A	N/A	**GREEN**

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		New Enhanced Access service resulting in more appointments available a minimum of two weeks in advance, and a mixture of in person face to face and remote (22/23) Consider a local Enhanced Access service (part of review of access to primary and urgent and emergency care) encompassing same day access for Primary Care, Urgent Care, including (Minor Injuries), and Frailty Care Recruit dedicated Digital Inclusion and Communications resources to support development, access, and navigation of e.g., Patient Online System/NHS App services/remote consultations/ practice websites (22/23) Review GP registrations in the context of unique or under-served groups to increase registration for Health Services e.g., Armed Forces Families and Traveller Community (23/24) Develop an enhanced access model that supports access to same day appointments. (22/23) Review Minor Injury Service provision and Urgent Treatment Centre provision to ensure that it meets the needs of the local population and reduces the need for presentation at ED. (22/23) Identify the highest utilised ED's out of county and across borders in relation to Rutland residents looking at reasons for presentation and reviewing associated pathways (22/23) Expand the number of Clinical Pharmacists working locally who can treat Minor Illness such as coughs, UTI's and Cellulitis and Long-Term Conditions. (22/23)									

Priority 5: Preparing for our Growing and Changing Population

Senior Responsible Officer (on HWB) **Sarah Prema**

Responsible Officer (on IDG) **Adhvait Sheth / Jo Clinton**

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5.1	**Planning and developing 'fit for the future' health and care infrastructure**										**GREEN**
5.1.1	Work with local/ neighbouring Integrated Care Systems (ICSs) partners to share information to ensure in border and cross border population health impacts are consistently understood	•LLR CCGs PCES Population Model that shows impact on health infrastructure as a result of growth in the Rutland border • Documented population health impact of Stamford North Housing Developments outside of the border shared with partners • Routine joint dialogue between partners •Initial baseline of Non Local plan impact by Rutland LSOA • Ongoing 6 monthly reviews and updates of latest LSOA level impact vs initial baseline position •RCC and Neighbouring LPA approach to prioritisation and CIL allocation plans is in place and visible to partners •Agreed population model with robust methodology that can be used to support dynamic impact modelling by LSOA •Work with Rutland County Council to facilitate development of a set of options for a Health Campus /Medi-tech trials facility	RCC/ICB	Apr-24	Place	•Aligned fit for the future plans with neighbouring ICS's • Healthcare is confirmed as priority for infrastructure funding and recieved adequate support in line with growth and impact • Understanding of current CIL funding including trajectory of allocations and any unallocated funding • Understand where Healthcare sits in wider prioritisation of infrastructure support • Agreed updated Information requirements and timely sharing with health partners to inform dynamic modelling •RCC to undertake a Community Infrastructure Levy (CIL) policy review with due consideration of enabling greater support for local healthcare infrastructure to ensure this is a key priority area of support going forward •Health Strategic Partners Involvement in CIL review process and receipt of report on new policy implications			Risk that RCC does not approve the RMH Enhanced Procedure Suite Business Case at Full Council in Sept meaning that plans to bring care closer to residents may not be delivered. Prioritisation of CIL due to limited funding against number of schemes may result in some not being supported	None identified with no NHS Capital available Continue strategic dialogue around priorities for CIL / look at economies of scale / alternative funding sources	**GREEN**
5.1.2	Work with in county and out of county providers and commissioners to cross share plans for Healthcare to inform future local service provision	• Routine joint dialogue between partners on latest plans and possibilities for joint solutions •Aligned fit for the future plans with neighborhing Places to inform local commissioning in and out of county provision in the future • Agreed LLR representation on North Place Alliance • Ongoing Engagement with OOA senior transformation leads for Primary Care and Planned Care Transformation • Cross sharing of latest LLR and OOA CDC plans with understanding of timelines and key service offers to plans impacting Rutland residents	ICB	Apr-24	Place	•Aligned fit for the future plans with neighborhing Places to inform local commissioning in and out of county provision in the future • Documented population health impact of Stamford North Housing Developments outside of the border shared with partners • Understanding of emerging options for joint solutions on the Stamford and Rutland border • Joint messaging around direction of travel for cross border developments in place and evolving over time					**GREEN**
5.1.3	Enable a fit for the future local healthcare	• Documented PCN Clinical and Estates Strategy to inform how future clinical strategy can be supported to deliver going fwd. • Business Cases development and approvals for future Estate solutions •Undertake strategic site feasibility review of local Health Estates including Rutland Memorial Hospital •Identify venues for colocation of key services e.g., MH Staff, consideration for Rutland community nursing staff to be based in Rutland that are currently based in Melton (23/24) - Links to community hub considerations	ICB/RCC	Apr-25	System and Place	• Identified PCN clinical priorities and reccomendations for future sustainable solutions that are documented and that can inform the delivery of the Healthcare Plan • Quantified understanding of available space on site at Rutland Memorial Hospital within existing medical facilities' appropriateness for clinical activity against criteria • Develop a Business Case for RMH based on feasibility findings • Approved Business Case for RMH Enhanced Procedure Suite that enables the associated service transformation to bring care closer to home • Maximised utlisation of local estates space to meet growing health needs in the future •Documented PCN Estates Strategy to inform how future clinical strategy can be supported to deliver going fwd.			Risk that RCC does not approve the RMH Enhanced Procedure Suite Business Case at Full Council in Sept meaning that plans to bring care closer to residents may not be delivered.	None identified with no NHS Capital available	**GREEN**
5.2	**Health and care workforce fit for the future**										**GREEN**
5.2.1	Develop training for new ways of working	Ensure appropriate local development opportunities are being accessed by all roles where available i.e. Community Pharmacy Academy development programme - for Occupational Therapy, Clinical Pharmacist, Paramedic connected to Network, muscular-skeletal first contact staff and health coach	PCN/RCC	Apr-23	Place	•Completion of PCN training courses and evaluation of training and impact on patient outcomes					**Blue**
5.2.2	PCN continue to expand on its Additional Roles Reimbursement Scheme	• Recruitment of all ARRS roles outlined in the 2022/23 workforce plan for Rutland Health PCN • Looking at care co-ordination and clinical pharmacists' capacity	PCN/RCC	Apr-23	Place	Key roles being acessed and utilised by local residents					**Blue**
5.2.3	Develop Career Development Structures	• Mat to advise whether to remain, be changed or removed • Consider projects to increase career development and satisfaction for retention e.g. via delegation of health tasks	RCC			•Carer development and increased potential for workforce •Proportion of health and care staff remaining in work after 55					**Blue**
5.2.4	Promote local Career Opportunities	• Mat to advise whether to remain, be changed or removed • Increase engagement with local young people around careers in health and care, including through collaboration with schools and opportunities for work experience	RCC			•Sustainable health and social care workforce •Increase in proportion of staff in health and care sector locally					**Blue**
5.3	**Health and equity in all policies, in particular developing a healthy built environment aligned for projected growth**										**GREEN**
5.3.1	Embed Health and Equity in all strategies and policies across Rutland County Council and then partner organisations	• Core partnership working group estavblished to take this forward in an agreed timeline • To consider their impact on mental and physical health, health inequalities and climate change. This will include Health and Equity Impact assessment development and training. See 2.4. • Public Health and Health Strategic partners to support the Planning Authority on the RCC Local Plan development to maximise the opportunity for a healthy built environment aligned to projected growth in Rutland. Work will utilise the national evidence base combined with locally developed resource, for example the 'Active Together – Healthy Place Making' toolkit. • Completion of a Health Impact Assessment of the Local Plan at the appropriate point of development with clear recommendations for mitigation and/or enhancement.	PH (Mitch Harper)	Apr-24	Place	•Completion of a Local Plan Health Impact Assessment with clear and achievable recommendations •Progress against identified recommendations in the Local Plan development •Health and Equity in all policies embedded across Rutland Completion of a Health Impact Assessment of the Local Plan at the appropriate point of development with clear recommendations for mitigation and/or enhancement.					**GREEN**

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5.3.2	Explore digitisation of paper records by exploring digital record storage for practices using SystmOne to optimise space for PCN activity (23/24)	• Digitisation routes established in line with national programme requirements • Potential to embrace new national programme when that comes on stream, expected to be a scan on demand offer • Ensure that LLR act in accordance with national programmes and plans • Ability to free up space on practice site • Robust scan / digitisation facility which adheres to legal requirements	PCN	TBC	System and Place	TBC - AS to pick up discussion with ICB Digital Team around national picture and also PCN about local view on this, amber as not been able to prioritse reporting this period rather progress issue.			**TBC**	**TBC**	**Amber**

Priority 6: Ensuring People are Well Supported in the Last Phase of Their Lives

Senior Responsible Officer (on HWB) Lynette Friere-Patino

Responsible Officer (on IDG) Sammi Le-Corre

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6.1	**Each person is seen as an individual**											
6.1.1	Ensure there is choice at the end of life, in terms of place and type of care, to include continuity of care. Co-production and engagement asking and involving patients on what they want/need locally.	Identify all the services available to patients in Rutland who require end of life care and how these are accessed. Identify services outside of Rutland that may also be accessible for patients in neighbouring counties.	ICB	Oct-23	System	Identification of a centralised resource detailing all EoL services available to patients in Rutland including LLR commissioned services and Rutland specific and those over the border. Linking back to the task and finish group and ensuring that a central resource that is identified that includes health information.	Linking back to the LLR EoL Task and Finish Group and ensuring that a central resource that is identified that includes health information for Rutland residents and patients. Is there something being worked on centrally? Is their scope to have LLR Dying Matters as the central resource?					
6.1.2	Care Planning - Support individuals in achieving their wishes around end of life care, including through awareness raising about support already available for them and their carers, and how to access it, including the Integrated Community Specialist Palliative Care Service, specialist nursing, virtual day therapy, befriending support and training.	Increase advance End of Life Care Planning by using risk data tools to identify people reaching last years of their life (23/24) Increase the use of RESPECT care planning, streamlining the process to make the process easier. Link with work of priority three, including Care Home Care Planning, hospital discharges incuding the use of Micare, Befriending support, Lions Message in a bottle? and Rutland Carers Support.	ICB	Sep-23	System	Increase in the number of patients with a RESPECT Care Plan. Micare utilisation for EoL care Link with the LPT to understand linkages and establish baseline data for EoL patients accessing Micare	Identify linkages with the work of the priority three workstream, including Care Home Care Planning, hospital discharges incuding the use of Micare, Befriending support, Lions Message in a bottle? and Rutland Carers Support. Maybe links to the complex care specification. Esablish Link with the EoL T&F group to understand what is currently happening. Understand what the PCN have in their work plan/strategy with regards to EoL. Get latest RESPECT figures for Rutland and agree a target for Rutland.					
6.2	**Each Person Has Fair Access to Care**											
6.2.1	RMH Explore the possibility of delivering more end of life care services closer to home, with consideration for the use of the Rutland Memorial Hospital. What are we asking of RMH? Palliative care suite? what is the pathway? how do you access? Clarification of beds and whether they are designated as palliative or do they get flexed dependent on demand. Also consider out of hours palliative care access - quality and quantity (eg ability to respond if syringe drivers fail). Move to 6.2.3	Complete the EoL Refresh our JSNA and LLR all age end of life strategy (22/23) Understanding what the different situations are dependent on where the patient is. RMH, Hospice, Carer at home, Care homes. Include Virtual wards.	ICB	Mar-24	Place	Baseline of EoL Service and service utilisation locally.	Complete the EoL Refresh our JSNA and LLR all age end of life strategy (22/23) Understanding what the different situations are dependent on where the patient is. RMH, Hospice, Carer at home, Care homes. Include Virtual wards.			The LLR EoL strategy that was due for completion by the end of March 2023 has been delayed and now is expected to be completed by August 2023. Once this is acomplete and assessement of service delivery and poteial options for future pathway redeisgn will be conidered. This will also be informed by the refreshed JSNA chapters for EoL .	Timescales have been adjusted to reflect delays.	
6.2.2	Understand access to hospice and other services for End of Life care, and requirements for these commissioned services. Use this to improve access to hospice care, including transport issues, and facilitating commissioning where the provider is not within LLR.	Look at hospice utilisation for Rutland residents requiring EoL respite care. (Stamford Thorpe Hall Numbers GP registered and Rutland Resident)	ICB	Oct-23	Place	Baseline of hospice activity numbers for Rutland patients requiring respite hopice care including numbers to RMH palliative care suite. Move to above	Contact the Contracts team and ask how many Rutland patients have used hospice services in the last 12 months including commissioned and spot purchase beds/places.					
	Ongoing use of this to support further ReSPECT planning to benefit those people and their families. Linking in with frailty, Whazan pilot and Care home EoI Provision. Eilidh Potter and Karen Payter to link in with.	Designation of a specific end of life co-ordinator with in the PCN to undertake this piece of work to ensure that patients are ideintified through using risk stratification.	PCN	Mar-23	Place	Once baseline measures are taken, measure the increase in number of patients being indeitified and increase in the number of patients with a care plan.	EoL Care co-ordinator in place at the PCN.					
6.2.4	People in their own home	Once a person is identified at end of life we have a clear and consistent pathway and this is inclusive of CHC. 24/7 EOL Dom care, Nursing, Meds - request to be made to the Health and Care Collaborative with the proposal of putting Micare 24/7		Mar-23	Place	Baseline of people who on their RESPECT form chose to die at home and how many actually ahd those wishes met.	Undertake EoL pathway mapping for Rutland patients, their family and carers as well as professionals involved in their care. Understand the costs and benefits of increasing Micare provision up to 24/7 in Rutland.					
6.3	**Maximising comfort and wellbeing**											
6.3.1	Review pre-, peri- and post-bereavement support services, considering people in different circumstances (including armed forces, children and young people, parents experiencing the loss of a child, people with Learning Disabilities who are losing or have lost key loved ones, sudden and anticipated loss, bereavement thruogh suicide). Consider coverage across Rutland and how different services complement each other. Also consider the link to mental health services.	Strengthen our community palliative and end of life care offer (22/23) Reviewing support services and mapping. Emotional support available. Include armed forces SPOC and linkages, and armed forces practice accreditation. Bereavement supportment points and measuring data if possible. User feedback.	RCC	Mar-24	Place	Include measurements if possible and user feedback.	Understand the work of the EoL task force and where they have progressed with their original plans for a 24/7 service provision, includings support through the night.			The LLR EoL strategy that was due for completion by the end of March 2023 has been delayed and now is expected to be completed by August 2023. Once this is acomplete and assessement of service delivery and poteial options for future pathway redeisgn will be conidered. This will also be informed by the refreshed JSNA chapters for EoL .	Timescales have been adjusted to reflect delays.	
6.3.2	Timely management of medical equipment and small aids for palliative/terminal care at home - provision and removal. Consider the scope for a community run 'Emergency Hub' facility to help people with supplies needed urgently that weren't anticipated, and with advice.	Request to be made to the Health and Care collaborative to look at this as a part of their work plan as a part of the health and wellbeing hub, incorprating the work of the levelling up bid meditech centre		Mar-24	Place		Establish what services/pathways are in place at present. Collect data on current usage, types of equipment and requests.					
6.3.3												
6.4	**Care is coordinated**											
6.4.1	Detail of the pathway	Feed in to the EoL T&F Group. Pathway mapping and design and then produce a Rutland specific pathway including options that are out of county for considerations. Map against the Dying matters website and ensure that all options are detailed for Rutland patients.	EOL T&F Group	Dec-23	Place		Identify a EoL Project lead for Rutland. Link in with the EoL T&F group and understand where they are up to with the refresh of the LLR EoL Strategy and review of the Ambitions framework.					
6.4.2	Review of end of life care coordination. To include cross border coordination and hospital discharge facilitating next steps of palliative support. Information sharing supporting coordinated care.	Increase advance End of Life Care Planning by using risk data tools to identify people reaching last years of their life (22/23)	EOL T&F Group	Mar-24	Place		14					

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6.4.3	How information is shared and exploration of how the LLR care record links with those who are at EoL.	Look at what might want to be shared. Evidence and Information	Laura Godtschalk	Nov-23	System		Link in with Ali Brooks to undertsand the progress with the RESPECT forms and also link in with Sharon Rose with regards to the LLR Shared Care Record.					
6.5	**All staff and carers are prepared to care**											
6.5.1	Provide training for informal carers in end of life care, so that individuals can receive appropriate care irrespective of place, with awareness raising around advance care planning and Power of Attorney.	Ensure that there is appropppriate training available, that is accessible and that they are aware of.	EOL T&F Group	Mar-24	Place		Establish what training is available and where from Undertake a training needs analysis of all staff that have involvement in the provision of EoL services.					
6.5.2	Provide training for formal care workers to support the care of those identified . Training can help identify major life events that serve as trigger points for conversations. Support transition to palliative care phase.	Training that can be accessed through Loros. Ensure there is appropropriate training that is accessible, collect feedback on training	EOL T&F Group	Mar-24	Place	Number of poeple attending EoL training courses in comparison to baseline.	Establish a list of training courses that are available and how they are accessed					
6.5.3	Staff having 24/7 access to medication, equipment and support.	Establishment or a 24/7 EoL service.	EOL T&F Group	Mar-24	System		Link in with the EoL Task and Finish Group to see how the work has progressed with regards to the extension on the Integrated Community Specialist Palliative Care Service to include 24/7 provision.					
6.6	**Communities are prepared to help**											
6.6.1	Support a Compassionate Community approach across Rutland, developing volunteer networks skilled to work with people facing terminal illness or at end of life.	Explore the possibility of adopting a compassionate communities					Review the original proposal as I believe it had three potential models of delivery based on varying degrees of funding. Link in to the work of the Place Based Collaborative.					
6.6.2	Behavioural change campaign to work towards changing social norms, to promote greater acceptance of discussions relating to end of life. This may include the use of alternative terminology and promote conversations about getting affairs in order. Use of behaviour change wheel methodology. Moments of reflection when wider planning is possible, also around organ donation and preparation of ReSPECT forms - e.g. when will writing.	Raising awareness and reducing the taboo around the conversations around EoL. Need to identify a lead to inform the work of the Task and Finish Group.	Public Health Susan Louise Hope	Mar-24	Place		Understand what is being done via the EoL task and Finish Group. Also link in with the Comms and Engagement team to see if they have any EoL specific campaigns scheduled in. Get an update on progress with the roll out of the new RESPECT forms. Identify lead for EoL Priority Six in Rutland.					
6.6.3	Joint Strategic Needs Assessment (JSNA) to be undertaken to understand the needs of the local population (including those nearing the end of their lives, their carers and the bereaved), the services available, and the quality of care provided. A focus will be given to capturing the views of those who use and provide services. To include a comparison of progress against the National Ambitions for Palliative and End of Life Care, using the self-assessment tool. Also considering learning from the Medical Examiner if this becomes available in time.	JSNA chapter - review where we are up to with this and see how this can inform this priority.	EOL T&F Group	Mar-24	Place		Link in with Rutland Public Health to understand the progress of the JSNA. Link in with the EoL T&F Group to understand the refresh of the LLR EoL Strategy and the Ambitions Framework. Established whether a gap analysis has been undertaken on an LLR basis and consider for Rutland once the Rutland pathway mapping is completed.					

Other consideration to be included.
EoL Virtual Ward
6.2. Transport - Link to priority 4 Equitable access and ensure that it is referenced.
Also linkages to priority 5 Growth and Change, eg growing elderly frail population
All priority leads at IDG need to be aware of linkages, interdependancies with other priorities and ensure that references are made.
Inequalities links.
Linkages to the Armed Forces SPOC.
Look further at measuring success across all deliverables, baselines and reporting frequency, what are our targets for each?

Actions and Next Steps
Charlie to update
Deb re managerial lead
Claire to share slides to group
Plan to go back to IDG/H&WB Board for agreement and sign off
Interdependancies to be taken to IDG for discussion
Discussion with James Burden and the PCN with regards to their PCN ambitions, Daffodil standards and ensuring that they are reflected in the plan if required.
KW to arrange sharepoint access for additional group members.
Circulate to group for comments
New plan to go to IDG for discussion.
Jade to have a dicussion with Deb for next steps following this meeting and whether a second meeting is required.

Priority 7a: Cross Cutting Themes - Mental Health

Senior Responsible Officer (on HWB) - 7a Mental Health **Mark Powell**

Responsible Officer (on IDG) - 7a Mental Health **Mark Young**

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7.1	**Supporting good mental health**										**GREY**
7.1.1	Increase access to perinatal Mental health support services, wherever Rutland women have chosen to give birth.	1.2.2 Healthy lifestyle information for women pregnant or planning to conceive (c) mental health.	LPT	2022/23	System	The number of people accesssing perinatal services increases.	Initial discussions with the LPT Perinatal Service Manager and the LPT Perinatal Team Manager have taken place to talk about the Perinatal Mental Health Service. We have invited them to our next				**GREY**
7.1.2	Understand the gaps in service reported by service users where children and young people need help with their mental health but have not reached the thresholds for mainstream mental health services, or have reached thresholds but are on waiting lists for CAMHS services, and ways to address these, including via new local services and low level/interim support offers delivered through library and wider commissioned and community services. Factor in anticipated future changes e.g. end of Resilient Rutland funding for children and young people's counselling in 2023.		LPT, PH	2022/24	Place and System	Gaps identified and solutions/services put in place.	A meeting with the Senior Practitioner for Family Hub Young People's Services and the Senior Practitioner for Children's Centre and Early Years Inclusion is scheduled for the the 24th of August to discuss the findings from the recent Family Hub consultation, which collected data from 100 people to explore what young people and families are accessing or experiencing difficulties accessing. A separate meeting with the Head of Early Help SEND and Inclusion, the Service Manager for Early Intervention and				**GREY**
7.1.3	Increasing local resource to respond to children and young people's mental health need through implementation of Key Worker role, Mental Health support workers support in Schools, contribution of Resilient Rutland programme (funding ending Jan 23). Support to families on waiting lists and for those requiring support but not reaching CAMHS thresholds. Parallel support for parents and carers of children and young people with mental health needs.		LA, VCS, CCG	2022/23	Place		A meeting with the Senior Practitioner for Family Hub Young People's Services and the Senior Practitioner for Children's Centre and Early Years Inclusion is scheduled for the the 24th of August to discuss the findings from the recent Family Hub consultation, which collected data from 100 people to explore what young people and families are accessing or experiencing difficulties accessing.				**GREY**
7.1.4	Transformation project for Rutland- Ensuring Mental Health services are delivered in Rutland including; a) Supporting services via funding bids: (Mental Health VCS grant scheme – crisis café - second round June 2022, Small grants - £3k - £50k - second round to open June 2022, OPCC commissioner safety fund – up to £10k) b) A clear co-designed approach to supporting farmers' and other individuals' needs linked to rurality c) A clear co-designed approach to better meeting veterans' and armed forces families' mental health needs d) A clear local plan to better coordinate care across neighbouring service areas		LPT/ CCG/ RCC	2022/23	Place and System	Funding bids are best suited to the current needs of our population and are able to demonstrate effective results. Farming community and armed forces are working closer with us to better suit their	opportunities. Having received funding in 2022 in Round 1 of the Getting Help in Neighbourhood funding for their 'Befriending Service', we met with Age UK and discussed their plans going foward. They have received further funding for this service to continue in Round 2 of the bidding. Also successful in Round 2 were Root-and-Branch Out CIC, who were successful with their Therapeutic Gardening Course bid. There are two further organisations we have provided support to as part of the 'Rutland Resilience and Prevention' funding. These are Citizens Advice Rutland for their 'Advice, Wellbeing & Mental Health (Pilot)' and Rutland Refill CIC for their 'Wellbeing and Mental Health Project'.				**GREEN**
7.1.5	Increased response for low level mental health issues. Promotion of recognised self-service self-help tools and frameworks notably Five ways to wellbeing. Expansion of capacity in local low level mental health services and closer working between involved local agencies and services, including in the voluntary and community sector and peer support, so more people access help sooner in their journey. Opportunities to develop resilience skills, e.g. through the Recovery College.		PCN, LPT, RCC, VCS	TBC	Place	Closer working across agencies/services so people receive the correct support the first time of asking, rather than go from service to service repeating their	Our new Innovator site, adopting the 3 Conversations approach, started their 13-week pilot on the 17th of July. The Community Reablement Worker will be allocated up to 10 people that are "referred" into the RISE service on the Joy Platform who are experiencing low level depression/anxiety/loneliness caused by a significant traumatic life event, inclusive of those who have personality difficulties, and or, are experiencing/experienced suicidal ideation.				**GREEN**
7.1.6	Deliver on the Long-term plan objectives for mental health for the people of Rutland: a) Move towards an integrated neighbourhood based approach to meeting mental health needs in Rutland b) Annually assessing the physical health needs of people with Serious Mental Illness (SMI) in Rutland c) Aiding people with serious mental illness into employment d) Delivering psychological therapies (IAPT - VitaMinds) for individuals as locally as possible to Rutland		LPT, PCN, RCC, VitaMinds	2022/23	System and Place	Closer and integrated working in our neighbourhood approach. Increase in numbers of people diagnosed with an SMI to receive their physical health checks. There is a national target of 60%. Increase numbers of people with SMI into	We held discussions with the PCN and LPT to implement a new Rutland Mental Health Service Development, which will comprise of the creation of a Rutland Community Mental Health and Wellbeing Team and the development of Rutland Community Facilitated Groups. The new Community Mental Health and Wellbeing Team will include the Health GP Lead in the Rutland PCN, Community Mental Health Manager (RISE), Mental Health Practitioner, Mental Health Facilitator, Mental Health Social Worker, as well as myself. We will meet weekly for a specific mental health MDT. As a result of this, there have been some changes with how some mental health referrals are allocated within the RISE team, as anything that requires additional professional support will be allocated to				**GREEN**

Priority 7b: Cross Cutting Themes - Inequalities

Senior Responsible Officer (on HWB) - 7b Inequalities **Mike Sandys**

Responsible Officer (on IDG) - 7b Inequalities **Adrian Allen**

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RED = Off track and at risk

GREY = Not Started

BLUE = Complete

Ref	What Do We Want To Achieve?	How Are We Going To Do It?	Lead Organisation	Timeframe for Delivery (Month/Year)	Level (System, Place or Neighbourhood)	How Will Success Be Measured?	Progress for August 2023	Progress for Sept 2023	Key Identified Risks	Mitigations	Sept 2023 Project RAG Status
7.2	**Reducing Health Inequalities**										
7.2.1	Complete a needs assessment to understand the current health inequalities in Rutland. The assessment will apply a rural lens, considering hidden deprivation and the resultant needs, calling on wider sources of intelligence across the community, voluntary and faith sector. The assessment will also focus on geographical inequality, inclusion health and vulnerable populations.		PH	2022/23	Place						**BLUE**
7.2.2	Embedding a proportionate universalism approach to service delivery including principles of the CORE 20 PLUS 5 and HEAT tool. Targeted support based on need including for families and communities who experience the worst health outcomes across Rutland e.g. military, rurally isolated, carers, SEND, LD children in care etc.		All	2024/25	Place and System						**GREY**
7.2.3	Strengthen leadership and accountability for health inequalities including health inequalities training with senior leaders and use of the Inclusive Decision Making framework	Ensure Rutland senior leaders are well represented at system training opportunities on health inequalities. Consider the Rutland place implications of system developments.	ICB, PH, LLR Academy	2023/24	System		LLR ICS has delivered a 6 module Health Inequalities Champion training course to 35 individuals across the partnership. Currently working out how many were from Rutland. A strong leadership team has been setup for health inequalities at system level.				**GREY**
7.2.4	Embed Armed Forces Covenant duties across all key organisations across the system but specifically in Rutland (due regard for armed forces in health, housing, and education).	Work in partnership to map progress against the Armed Forces Covenant NHS due regard framework.	RCC, ICB, Providers	2023/24	Place and System		System due regard mapping has been developed against the framework actions. Consideration needed on whether this should also be done at Place.				**GREEN**
7.2.5	Complete military and veteran health needs assessment to understand the inequalities facing this group	Refresh Inisghts data to reflect Rutland. Qualitative piece for current personnel and people coming back from Cyprus.	ICB, PH	2023/24	Place and System		Armed Forces Survey report has been produced. Findings have been agreed at the HWB and taken to Staying Healthy Partnership for next steps. Recommendations agreed. Ongoing work will review whether there is a need for a full needs assessment in addition to the survey.				**GREEN**
7.2.6	Mapping Rutland community assets, including its voluntary and community sector. Did we say remove this one as it's covered elsewhere?		RCC	2022/24	Place						**GREEN**
7.2.7	Role of anchor institutions in reducing health inequalities. Working with key Rutland organisations considering how they can support reducing health inequalities through employees, resources and estate.	Align with System working on anchor institutions across LLR. Ensure Place organisations are aligned to developments.	System and RCC	2024/25	System						**GRAY**
7.2.8	Ensuring complete and timely datasets. Collecting data on protected characteristics (including ethnicity and disabilities) to support future service needs and development		All providers	2024/25	System						**GRAY**
7.2.9	Deliver a pilot in a small area of Rutland highlighted as a priority in the Needs Assessment. Pilot to focus on an asset based approach, building on the strengths within the community.	1) Support a small community within Rutland to help themselves with some external support from partners (Greetham identified). 2) Work with the community to identify assets and work through opportunities to build on and maximise their potential.	PH / RCC	24/25	Place	An evaluation of what has changed following the project will be completed and assessed on the impact in relation to capacity and resource.	Soft engagement with partners has started, including the parish councils. Conversations are beginning with residents to identify Community Connectors, representing different demographics.				
7.2.10	Implementation of NHSE's 'Reducing Health Inequalities in Neighbourhoods' via the Direct Enhanced Service Agreement.	Within Rutland Health PCN's health inequalities plan, household patients and frailty were chosen as the population of focus. Care Coordinators will proactively contact patients in this cohort offering comprehensive health checks and support.	PCN / ICB	24/25	System / Place	Number of housebound reviews offered and completed. Number of referrals to social prescribing and falls prevention.	Refresh of the health inequalities plan has been completed and continuation of delivery. Numbers to follow.				

Priority 7c: Cross Cutting Themes - Covid Recovery

Senior Responsible Officer (on HWB) - 7c Covid Recovery **Mike Sandys**

Responsible Officer (on IDG) - 7c Covid Recovery **Adrian Allen**

GREEN = On Track

AMBER = Off track but mitigations in place top recover

RED = Off track and at risk

GREY = Not Started

BLUE = Complete

Ref	What Do We Want To Achieve?	How Are We Going To Do It?	Lead Organisation	Timeframe for Delivery (Month/Year)	Level (System, Place or Neighbourhood)	How Will Success Be Measured?	Progress for August 2023	Progress for Sept 2023	Key Identified Risks	Mitigations	Sept 2023 Project RAG Status
7.3	**Covid recovery and readiness**										**GREY**
7.3.1	Build into the commissioning processes of the authority including the EHRIA considerations, the consideration of Covid intelligence to ensure that any additional demand or shift in service access requirements are fully considered.	Ensure that the appropriate steps are built into the commissioning cycle and are identified for commissioners to consider and respond to accordingly.	RCC, PH	Ongoing	Place						GREY
7.2.2	Consider the service offer for patients with long Covid linked to longer term health issues, including accessibility.	Monitoring of deaths data for individuals with co morbidities that have been highlighted as linked to Covid. Review the access arrangements for patients needing support with long covid.	LPT/PH	Ongoing	Place						GREY
7.2.3	Making certain that the intelligence from HSA gets reported into the HWB via the Health Protection Team including an annual Health Protection Report which includes an horizon scan of any future threats to the health & wellbeing of residents	An annual report from the Health Protection Team delivered yearly to the HWB with any relevant HSC reporting being delivered on an ad hoc basis where necessary	PH	Ongoing	Place and System						GREEN

8. Communications and Engagement

Senior Responsible Officer (on HWB) **Kim Sorsky**

Responsible Officer (on IDG) **Katherine Willison/Charlie Summers**

GREEN = On Track

AMBER = Off track but mitigations in place top recover

RED = Off track and at risk

GREY = Not Started

BLUE = Complete

Ref	What Do We Want To Achieve?	How Are We Going To Do It?	Lead Organisation	Timeframe for Delivery (Month/Year)	Level (System, Place or Neighbourho	How Will Success Be Measured?	Progress for August 2023	Progress for Sept 2023	Key Identified Risks	Mitigations	Sept 2023 Project RAG Status
8.1	**Readiness to deliver the plan**										**GREEN**
8.1.1		Sustain communications working group through year 1 of the plan to support establishment of new ways of working.	RCC	Jan-23	Place	Notes taken from all working group meetings and updated action plan					BLUE
8.1.2		Deliver the plan through engagement with the public and professionals	RCC	Mar-24	Place	Customer & patient feedback through the working group. Focus groups in the community e.g. digital innovation focus group with care providers. Other groups to be identified.					GREEN
8.1.3		High-level audit of communications and engagement assests across involved partners (skills, resources, channels, and tools) to help to plan cordinated approaches to communications (assests and gaps / opportunities).	RCC	Jun-23	System		Presentation of comms and engagement report and task & finish group meeting arranged to review recommendations and next steps.				GREEN
8.1.4		Define & agree scope and coordinate with key priority leads system level communications activity and mechanisms – e.g. access to citizen panels. Ensure linkage with other communication & engagement teams: RCC Communications team (Matt Waik), Sue Veneables (insights team)	RCC	Mar-23	System	Clarity regarding remit for communications. Regular productive communication meetings.	Joint meeting with Mark Young, Alex Magliulo, Alison Kirk, Alison Corah (GP) to discuss Rutland's kickstart funding from MH collaborative for lived experienced involvement. To review ICB's lived experience framework and people & communities strategy. Further meetings to discuss scope and how we can use money to enable kickstart across Rutland.				GREEN
8.1.5		Identify SMART goals and objectives, appoint leads on these are to be delivered, measured & reviewed.					task & finish group for comms & engagement report to set SMART goals & objectives			Pending completion of high-level audit	GREY
8.1.6		Identify and deliver some 'quick wins' for local communications					task & finish group for comms & engagement report to set SMART goals & objectives				GREEN
8.1.7		Reporting to IDG and HWB on communications and engagement activity and performance.									GREEN
8.1.8		Annual report taking stock of overall performance and change									GREY
8.2	**Ensuring people have access to the information they need to maintain their health and wellbeing and to navigate change successfully**										**GREEN**
		Coordinate with ICB and places on a visual brand for health and wellbeing in Rutland				Agreement on visual brand,	task & finish group for comms & engagement report to set SMART goals & objectives				**GREEN**
8.2.1		Agree approach for collaborative communications across health and care in Rutland.	RCC	Sep-23	System		task & finish group for comms & engagement report to set SMART goals & objectives				GREY

Ref	What Do We Want To Achieve?	How Are We Going To Do It?	Lead Organisation	Timeframe for Delivery (Month/Year)	Level (System, Place or Neighbourho	How Will Success Be Measured?	Progress for August 2023	Progress for Sept 2023	Key Identified Risks	Mitigations	Sept 2023 Project RAG Status
		Ensure residents are fully aware of the community and health and well-being offer in Rutland and understand how to access it."Communication of Rutland's community and health and wellbeing offer including; a) Develop and implement a multi-channel communication plan to enhance information for signposters and for the public, including distinctive groups. This will also align with the work of the HWB and cater for those that are digitally excluded or use cross border services. b) To include enhancing the reach and scope of the Rutland Information Service (RIS) via multiple channels (web, social media, print). c) Updating the RIS online platform to meet accessibility standards and be more usable on mobile devices as this is how most users access it. d) Enhancement of online functionality for clearer routes into preventative services. "	RCC-Public Health (RIS)	Jun-23	Place	* Completed Health and Wellbeing Communication plan aligned with the HWB * Reach of communication campaigns including social media followers, posts and shares * RIS monthly visitor figures * Qualitative feedback on awareness of and access to service across Rutland					GREEN
8.2.2		Co-ordinate mechanisms to engage Rutland's population in improved communications and communications management (digital impact). Improved Learning Disability Partnership Board (27/02/23), Carers week (June), Launch of self-referall portal (1st April), Adult Social Care annual feedback survey and updated personalisation survey	RCC	May-23	System	Agreed co-ordinated approach in place.	Portal: Onward monitoring and evaluation whilst in pilot. Successful testing with internal providers, now being rolled out to selected larger care providers. Early stage planning for hard launch to the community. Personalisation feedback survey pilot has been partially paused to allow time for options appraisal to be completed awaiting final decision. LDPB - 3rd meeting held, with community safety, police & promotion of annual health checks with annual health van. LD nurse and team visited supported living Lodge Trust and Willowbrook to educate and improve health check outcomes for both people with LD and parent carers. Importance of the LD healthcare plans, agreed for resource to also visit Gretton House. Co-ordination and distribution of healthcare plans for four practices to be reviewed by LD nurse and each practice.				GREEN
8.2.3		Shared, rolling communications campaign calendar with selected campaigns prioritised and/or in common across the year – design, maintain, deliver.	RCC	May-23	System	Agreed comms campaign calandar in place	task & finish group for comms & engagement report to set SMART goals & objectives				BLUE
8.2.4		**Training: Progress training opportunities including behavioural insights, social media.** Promote the digital inclusion network, the Rutland libraries are the listed online centres. Promote digital champions training, their resources (Learn my way) and the national data bank. https://www.onlinecentresnetwork.org/resources/health	RCC	Mar-24		Number of digital champions (currently 0 awaiting training to be rolled out)	Pilot workshop completed for behavioural insights (personality tests), DMT confirmed roll out across ASC. Sharing training with partners, aim & objective improving staff wellbeing for better understanding of eachother. This will increase performance and productivity.				GREEN
8.2.5		Link to local actions building digital confidence – to consult with the proposed leads. (Join up with initiatives across LLR). Co-ordinate with digital champions in the community, co-design & promotion of the self service portal. Link to local actions building digital confidence – to consult with the proposed leads. (Join up with initiatives across LLR)	RCC								GREEN
8.2.6		Enhance the Rutland Information Service (RIS) as a key shared source of information about local services and opportunities. • Develop RIS social media presence – bringing content to the online places people visit. • Website technical code refresh for accessibility and ease of use via a mobile phone. • Using website usability testing to increase the effectiveness of RIS content. Map digital confidence To consult Identified Adult Social Care lead ensuring RIS is updated. RIS has a facebook page. https://www.rutlandhealth.co.uk/							Duplications within systems		GREY

Ref	What Do We Want To Achieve?	How Are We Going To Do It?	Lead Organisation	Timeframe for Delivery (Month/Year)	Level (System, Place or Neighbourho	How Will Success Be Measured?	Progress for August 2023	Progress for Sept 2023	Key Identified Risks	Mitigations	Sept 2023 Project RAG Status
8.3	**Raising the profile of the Rutland Health and Wellbeing Board**										**BLUE**
8.3.1		Web content conveying the role and purpose of the HWB and inviting public involvement. The role of the HWB is already on the RCC site. https://www.rutland.gov.uk/health-wellbeing/health-wellbeing-board Annual Health & Wellbeing board report in progress									BLUE
8.3.2		Visual identity for the HWB – papers, web page, social media. Minutes and papers are available on the RCC site for the public.					Promoting the Health & Wellbeing report via internal ASC staff newsletter.				BLUE
8.3.3		Social media account for HWB health and wellbeing news/messages with shared hashtags. As above?									BLUE
8.3.4		Ongoing promotion of HWB activity including public engagement opportunities in health and wellbeing change.									BLUE
8.4	**Involving the public and professional stakeholders in service design and change**										**GREEN**
		Business case setting out options for engagement activity depending on level of resourcing. This activity has been taken on by Adult Social Care Im-provement Officers in the RCC QA Team therefore business case no longer required as of March 23									**BLUE**
		Potential LGA support to develop approach to increasing engagement As above – March 23									**BLUE**
8.4.1		Modest prioritised programme of engagement activity for year 1 of the JHWS supporting delivery of JHWS priorities. Identify priority leads.	RCC	Jun-24	Place	Number of experts by exprience recruited	task & finish group for comms & engagement report to set SMART goals & objectives				GREEN
8.4.4		Establish an engagement approach, including a toolkit for partners to use, drawn from wider best practice. To include: • Approach to compensation where required. • Existing groups who could be engaged. • How to reach less often heard groups and groups facing inequalities.					In progress and reviewing ICB's policy & framework on co-production & engagement / lived experience / people & communities strategies				GREEN
		Engagement Training									GREY
8.4.5		Verifying commitment to the Think Local Act Personal, Making It Real framework and set of statements					Submitted awaiting approval from local TLAP and Making It Real				GREEN
8.5	**Communication activities to support access and support navigation of local services**										
8.5.1		Training and enducation for the general public on the use of the NHS app for booking appointment and ordering medication	ICB		Place						
8.5.2		Create a how to guide/video for practice websites to show patients how to download and use the NHS app	ICB		Place						
8.5.3		Promotion of the changing structure of local primary care and the new roles available through the additional roles reimbursement scheme.	ICB		Place						
8.5.4		Link in with LLR ICB comms to inform and influence planned LLR campaigns in 2023/24	ICB		Place						

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8.5.5		Recruit dedicated Digital Inclusion and Communications resources to support development, access, and navigation of e.g., Patient Online System/NHS App services/remote consultations/ practice websites (22/23)	PCN								
8.5.6		Creation of an infographic to demonstrate the anticipated inpact of the Rutland Health and Wellbeing Strategy and what that will mean to patients.	ICB								

Strategic Priority Area	Strategic Priority Worksream	Workstream / Project Lead	Email
Best Start in Life	1.1 Healthy child development in the 1,001 critical days (conception to 2 years old)		
	1.2 Confident Families and Young People		bcaffrey@rutland.gov.uk
	1.3 Access to Health Services		jdowling@rutland.gov.uk
Prevention	2.1 Supporting people to take an active part in their communities		
	2.2 Looking after yourself and staying well in mind and body		
	2.3 Encourage and enable take up of preventative health services		
	2.4 Maintaining and developing the environmental, economic and social conditions to encourage healthy living for all		
Living With Ill Health	3.1 Healthy ageing, including living well with long-term health conditions, and reducing frailty and over 65s falls	emmajane Hollands	ehollands@rutland.gov.uk
	3.2 Integrating services to support people living with long-term health conditions		
	3.3 Support, advice, and community involvement for carers		
	3.4 Healthy, fulfilled lives for people living with learning or cognitive disabilities and dementia		
Equitable Access	4.1 Understanding the access issues		jamesburden@nhs.net
	4.2 Increase the availability of diagnostic and elective health services closer to home		debra.mitchell3@nhs.net
	4.3 Improving access to primary and community health and care services		
	4.4 Improving access to services and opportunities for people less able to travel, including through technology		
	4.5 Improving access to services and opportunities for people less able to travel, including through technology		
	4.6 Enhance cross boundary working across health and care with key neighbouring areas		
Growth and Change	5.1 Planning and developing 'fit for the future' health and care infrastructure		
	5.2 Health and care workforce fit for the future		
	5.3 Health and equity in all policies, in particular developing a healthy built environment aligned for projected growth	Mitch Harper	mitchell.harper@leics.gov.uk
Dying Well	6.1 Each person is seen as an individual		
	6.2 Each person has fair access to care		
	6.3 Maximising comfort and wellbeing		
	6.4 Care is coordinated		
	6.5 All staff are prepared to care		
	6.6 Communities are prepared to help		
Cross Cutting Themes	7.1 Mental Health		
	7.2 Inequalities	Mitch Harper	mitchell.harper@leics.gov.uk
	7.3 Covid Recovery	Adrian Allen	adrian.allen@leics.gov.uk

Acronyms and glossary

A&E	Accident and Emergency
ACG	Adjusted Clinical Groups (tool for health risk assessment)
BCF	Better Care Fund
CAR	Citizens Advice Rutland
CIL	Community Infrastructure Levy
CCG	Clinical Commissioning Group(s)
Core20PLUS5	NHS England and Improvement approach to reducing health inequalities
CPCS	Community Pharmacy Consulting Service
CVD	Cardio Vascular Disease
CYP	Children and Young People
EHCP	Education and Health Care Plan
FSM	Free School Meals
HEE	Health Education England
HIA	Health Impact Assessment
HWB	Health and Wellbeing Board
ICON	Framework to prevent shaking of crying babies (Infant crying is normal, Comfort methods can work, Ok to take five, Never shake a baby)
ICB	Integrated Care Board
ICS	Integrated Care System
JHWS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
LAC	Looked After Child
LD	Learning Disability
LeDER	Learning from deaths of people with a learning disability programme
LLR	Leicester, Leicestershire and Rutland
LPT	Leicestershire Partnership Trust
LTC	Long Term Condition
MDT	Multi-Disciplinary Team
MECC+	Making Every Contact Count
MH	Mental Health
NCMP	National Child Measurement Programme
NEWS	National Early Warning Score
ONS4	A 4-factor measurement of personal wellbeing
OOA	Out of Area
OOH	Out of Hospital
OPCC	Office of the Police and Crime Commissioner
PCH	Peterborough City Hospital
PCN	Primary Care Network
PH	Public Health
RCC	Rutland County Council
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
RIS	Rutland Information System
RISE	Rutland Integrated Social Empowerment
RMH	Rutland Memorial Hospital
RR	Resilient Rutland
SEND	Special Educational Needs and Disability
SMI	Serious Mental Illness
TBC	To be confirmed
UHL	University Hospitals of Leicester
VAR	Voluntary Action Rutland
VCF	Voluntary Community and Faith
VCS	Voluntary and Community Sector

Joint Health and Wellbeing Strategy 2022-2025: Outcomes Summary Report

Rutland

September 2023

Business Intelligence Service
Leicestershire County Council

Victoria Rice
Research and Insight Manager – Public Health

Business Intelligence Service
Chief Executive's Department
Leicestershire County Council
County Hall, Glenfield
Leicester LE3 8RA

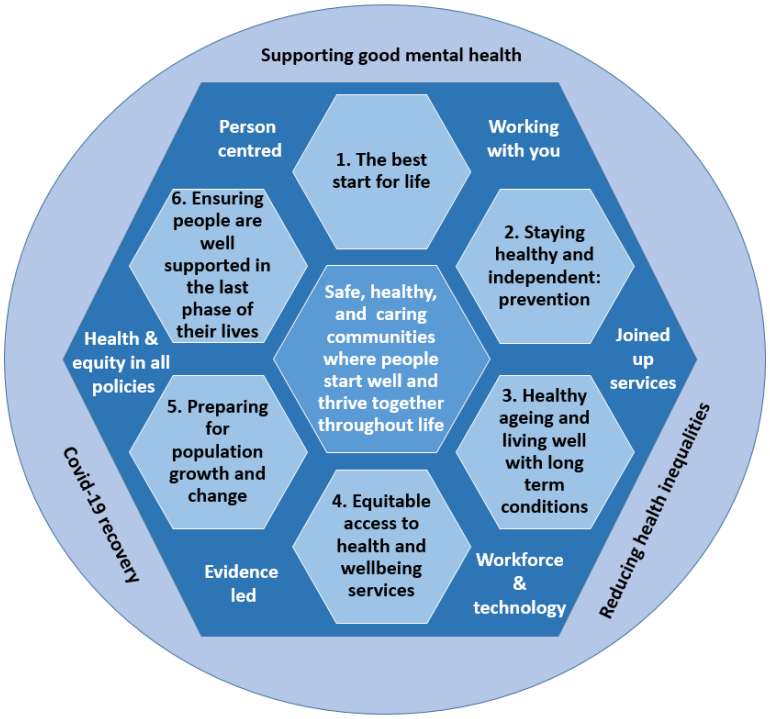
Tel 0116 305 6059
Email victoria.rice@leics.gov.uk

Produced by the Business Intelligence Service at Leicestershire County Council.

Purpose of Report

In line with the Rutland Joint Health and Wellbeing Strategy (2022-2025), this report has been produced to support and monitor the performance of indicators that are linked to each priority area within the strategy. A dashboard of indicators has also been developed to aid discussion and monitor progress.

The Rutland Joint Health and Wellbeing Strategy has six priority areas for action, with three cross cutting themes. The diagram below summarises the priorities and principles:



The outcomes summary report and dashboards will be updated on a quarterly basis to support the delivery of the Rutland Joint Health and Wellbeing Strategy. It is important to note that the dashboard will continue to be developed as the strategy evolves and the delivery plan is developed.

The dashboard sets out, in relation to each indicator, the statistical significance compared to the overall England position or relevant service benchmark where appropriate. A RAG rating of 'green' shows those indicators that are performing better than the England value or benchmark and 'red' indicates worse than the England value or benchmark.

Appendix 1 provides more details on the similar areas to Rutland.

Priority 1: Enabling the best start in life

Performance Summary

- Out of all the comparable indicators presented for the enabling the best start in life priority, nine are green, 11 are amber and one is red. Five indicators have no comparison, and two indicators are lower than national.

- Rutland performed significantly worse than England/benchmark for the following indicator:

    - **Proportion of children receiving a 12-month review** - Rutland is ranked 16th out of 16 in 2021/22. The proportion of children receiving a 12-month review has decreased from 37.0% in 2020/21 to 29.7% in 2021/22.

- Of all the indicators, Rutland ranks 1st (best/lowest performing) when compared to its similar neighbours for the following indicators:

    - **Average attainment 8 score**
    - **Children in care**
    - **Hospital admissions caused by unintentional and deliberate injuries in children (0-14 years)**
    - **Estimated number of children and young people with mental disorders - aged 5 to 17**
    - **General fertility rate**

- There is currently one indicator where, when compared to similar areas, Rutland performs in the bottom three (worse performing):

    - **Proportion of children receiving a 12-month review**

Source:
*NHS Outcomes Framework
** Office for National Statistics (ONS)

Rutland Joint Health and Wellbeing Strategy - Priority 1: The best start for life

Ranking, Best and Worst columns are compared to the nearest neighbours only. Rank: 1 is calculated as the best (or lowest when no polarity is applied).

Indicator				Value	Rank	Best/Lowest	Worst/Highest	England	DoT	RAG
A&E attendances (0 to 4 years)	P	0-4 yrs	2021/22	525.4	5/16	398.1	752.4	762.8	—	Better
Admissions for lower respiratory tract infections (aged 1 year)	P	1 yr	2021/22	Null	Null	Null	Null	167.8	—	Not compared
Average Attainment 8 score	P	15-16 yrs	2021/22	56.2	1/16	56.2	46.3	48.7	—	Not compared
C09a - Reception: Prevalence of overweight (including obesity)	P	4-5 yrs	2021/22	20.3	5/16	17.3	25.5	22.3	▶	Similar
Children in care	P	<18 yrs	2022	31.0	1/16	31.0	116.0	70.0	—	Better
Children in care immunisations	P	<18 yrs	2022	75.0	13/16	100.0	71.0	85.0	—	Similar
Hospital admissions as a result of self-harm (10-24 years)	P	10-24 yrs	2021/22	325.1	2/16	269.3	808.8	427.3	—	Similar
Hospital admissions for mental health conditions	P	<18 yrs	2021/22	Null	Null	Null	Null	99.8	—	Not compared
Neonatal mortality and stillbirth rate	P	<28 days	2020	7.4	13/16	2.4	8.1	6.5	▶	Similar
New referrals to secondary mental health services, per 100,0..	P	<18 yrs	2019/20	4,602.8	3/16	2,966.6	10,475.9	6,977.4	—	Lower
Proportion of children receiving a 12-month review	P	1 yr	2021/22	29.7	16/16	97.4	29.7	82.0	▼	Worse
Proportion of infants receiving a 6 to 8 week review	P	6-8 weeks	2021/22	83.7	13/16	97.6	10.0	81.6	—	Similar
School pupils with social, emotional and mental health needs: ..	P	School age	2021/22	2.5	6/16	2.1	3.8	3.0	▲	Better
B02a - School readiness: percentage of children achieving a go..	P	5 yrs	2021/22	70.9	4/16	71.8	63.2	65.2	—	Better
C04 - Low birth weight of term babies	P	>=37 weeks g..	2021	2.4	10/16	1.5	2.9	2.8	▶	Similar
C08a - Child development: percentage of children achieving a ..	P	2-2.5 yrs	2021/22	81.3	12/16	90.1	43.5	81.1	—	Similar
C09b - Year 6: Prevalence of overweight (including obesity)	P	10-11 yrs	2021/22	30.2	3/16	28.4	37.5	37.8	▶	Better
C05a - Baby's first feed breastmilk	P	Newborn	2020/21	86.1	2/16	88.0	68.6	71.7	—	Better
C07 - Proportion of New Birth Visits (NBVs) completed within ..	P	<14 days	2021/22	88.8	7/16	94.8	32.7	82.7	▶	Better
C11a - Hospital admissions caused by unintentional and delib..	P	0-4 yrs	2021/22	Null	Null	Null	Null	103.6	—	Not compared
C11a - Hospital admissions caused by unintentional and delib..	P	<15 yrs	2021/22	49.5	1/16	49.5	118.6	84.3	—	Better
E01 - Infant mortality rate	P	<1 yr	2019 - 21	2.4	2/16	2.3	6.1	3.9	—	Similar
E02 - Percentage of 5 year olds with experience of visually obv..	P	5 yrs	2021/22	15.1	4/13	10.3	38.7	23.7	—	Better
Estimated number of children and young people with mental d..	P	5-17 yrs	2017/18	752.2	1/15	752.2	11,023	Null	—	Not compared
C06 - Smoking status at time of delivery	F	All ages	2021/22	6.8	3/16	5.6	12.4	9.1	—	Similar
D04e - Population vaccination coverage: HPV vaccination coverage for one dose (12 to 13 year old)	F	12-13 yrs	2021/22	81.7	4/16	90.4	66.4	69.6	▼	Similar
	M	12-13 yrs	2021/22	81.7	3/16	90.0	50.1	62.4	—	Similar
General fertility rate	F	15-44 yrs	2021	45.4	1/16	45.4	63.2	54.3	—	Lower

Statistical Significance compared to England or Benchmark: Better, Worse, Higher, Similar, Not compared, Lower

Direction of Travel: ▼ Decreasing, ▼ Decreasing and getting better, ▼ Decreasing and getting worse, ▲ Increasing, ▲ Increasing and getting better, ▲ Increasing and getting worse, ▶ No significant change, — Cannot be calculated

Data Source: Office for Health Improvement & Disparities https://fingertips.phe.org.uk/

Note: Statistical Significance for indicator D04e is against benchmark goal (<80% worse, 80% to 90% similar, ≥90% better). There are concerns about the quality of the data for indicators C08a and 'Estimated number of children and young people with mental disorders'.

Produced by Business Intelligence Service
Updated September 2023

Priority 2: Staying healthy and independent: prevention

Performance Summary

- Out of all the comparable indicators presented for the staying healthy and independent: prevention priority, six are green, three are amber and one is red.

- Rutland performed significantly worse than England/benchmark for the following indicator:

    - **Population vaccination coverage: Shingles vaccination coverage (71 years)** - Rutland is ranked 15th out of 16 in 2021/22. The latest value for Rutland is 32.2%, which is significantly worse than the benchmark of 50%.

- Of all the indicators, Rutland ranks 1st (best/lowest performing) when compared to its similar neighbours for the following indicators:

    - **Percentage of adults (aged 18 plus) classified as overweight or obese**
    - **Cancer screening coverage: cervical cancer (aged 50 to 64 years old)**

- There are currently two indicators where, when compared to similar areas, Rutland performs in the bottom three (worse performing):

    - **Self reported wellbeing: people with a high anxiety score**
    - **Population vaccination coverage: Shingles vaccination coverage (71 years)**

Source:
*NHS Outcomes Framework
** Office for National Statistics (ONS)

Rutland Joint Health and Wellbeing Strategy - Priority 2: Staying healthy and independent: prevention

Ranking, Best and Worst columns are compared to the nearest neighbours only. Rank: 1 is calculated as the best (or lowest when no polarity is applied).

Indicator				Value	Rank	Best/Lowest	Worst/Highest	England	DoT	RAG
B19 - Loneliness: Percentage of adults who feel lonely often or always or some of the time	P	16+ yrs	2019/20	24.8	13/16	13.9	26.8	22.3		
C16 - Percentage of adults (aged 18 plus) classified as overweight or obese	P	18+ yrs	2021/22	55.5	1/16	55.5	69.4	63.8		
C26b - Cumulative percentage of the eligible population aged 40 to 74 offered an NHS Health Check who received an NHS Health Check	P	40-74 yrs	2018/19 - 22/23	46.1	4/16	111.5	34.9	42.3		
C28d - Self reported wellbeing: people with a high anxiety score	P	16+ yrs	2021/22	29.2	16/16	19.5	29.2	22.6		
C17a - Percentage of physically active adults	P	19+ yrs	2021/22	70.2	10/16	77.3	64.8	67.3		
C24a - Cancer screening coverage: breast cancer	F	53-70 yrs	2022	71.4	8/16	78.9	54.1	65.2		
C24b - Cancer screening coverage: cervical cancer (aged 25 to 49 years old)	F	25-49 yrs	2022	74.4	8/16	77.0	69.5	67.6		
C24c - Cancer screening coverage: cervical cancer (aged 50 to 64 years old)	F	50-64 yrs	2022	79.5	1/16	79.5	71.4	74.6		
C24d - Cancer screening coverage: bowel cancer	P	60-74 yrs	2022	77.5	2/16	77.6	72.2	70.3		
D06c - Population vaccination coverage: Shingles vaccination coverage (71 years)	P	71	2021/22	32.2	15/16	59.8	30.0	44.0		

Statistical Significance compared to England or Benchmark:
Better, Worse, Higher, Similar, Not compared, Lower

Direction of Travel:
Decreasing, Decreasing and getting better, Decreasing and getting worse, Increasing, Increasing and getting better, Increasing and getting worse, No significant change, Cannot be calculated

Data Source: Office for Health Improvement & Disparities
https://fingertips.phe.org.uk/

Produced by Business Intelligence Service
Updated September 2023

Priority 3: Healthy ageing and living well with long term conditions

Performance Summary

- Out of all the comparable indicators presented for the healthy ageing and living well with long term conditions priority, one is green and three are amber.

- Of all the indicators, Rutland ranks 1st (best performing) when compared to its similar neighbours for the following indicator:

    - **Percentage of cancers diagnosed at stages 1 and 2**

- There are currently no indicators where, when compared to similar areas, Rutland performs in the bottom three (worse performing).

Source:
*NHS Outcomes Framework
** Office for National Statistics (ONS)

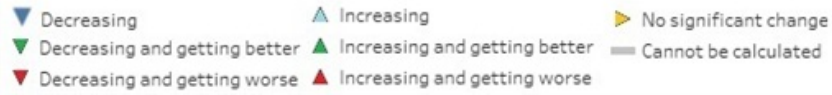
Rutland Joint Health and Wellbeing Strategy - Priority 3: Healthy ageing and living well with long term conditions

Ranking, Best and Worst columns are compared to the nearest neighbours only. Rank: 1 is calculated as the best (or lowest when no polarity is applied).

Indicator				Value	Rank	Best/Lowest	Worst/Highest	England	DoT	RAG
C23 - Percentage of cancers diagnosed at stages 1 and 2	P	All ages	2020	57.2	1/15	57.2	49.4	52.3		
C29 - Emergency hospital admissions due to falls in people aged 65 and over	P	65+ yrs	2021/22	1,565.3	3/16	1,486.9	2,524.7	2,099.9		
E13 - Hip fractures in people aged 65 and over	P	65+ yrs	2021/22	528.2	7/16	443.4	631.3	551.2		
E14 - Winter mortality index	P	All ages	Aug 2020 - Jul 2021	33.3	11/16	17.6	61.1	36.2		

Statistical Significance compared to England or Benchmark:

Direction of Travel:



Data Source: Office for Health Improvement & Disparities
https://fingertips.phe.org.uk/

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Priority 4: Ensuring equitable access to services for all Rutland residents

Performance Summary

- The one indicator presented below for the ensuring equitable access to services for all Rutland residents priority is the Access to NHS dental services – successfully obtained a dental appointment indicator.

- The percentage of people who successfully obtained an NHS dental appointment in the last two years has decreased from 94.6% in 2019/20 (where Rutland performed in the 2nd best quintile nationally) to 77.7% in 2020/21, where Rutland now performs in the middle quintile. Rutland is ranked 7th out of 16 when compared to its nearest neighbours.

Source:
*NHS Outcomes Framework
** Office for National Statistics (ONS)

Rutland Joint Health and Wellbeing Strategy - Priority 4: Equitable access to health and wellbeing services

Ranking, Best and Worst columns are compared to the nearest neighbours only. Rank: 1 is calculated as the best (or lowest when no polarity is applied).

Indicator				Value	Rank	Best/Lowest	Worst/Highest	England	DoT	RAG
Access to NHS dental services - successfully obtained a dental appointment	P	18+ yrs	2020/21	77.7	7/16	85.4	65.0	77.0	▶	

Statistical Significance compared to England or Benchmark:
- Better
- Worse
- Higher
- Similar
- Not compared
- Lower

Direction of Travel:
- ▼ Decreasing
- ▼ Decreasing and getting better
- ▼ Decreasing and getting worse
- ▲ Increasing
- ▲ Increasing and getting better
- ▲ Increasing and getting worse
- ▶ No significant change
- Cannot be calculated

Data Source: Office for Health Improvement & Disparities
https://fingertips.phe.org.uk/

Produced by Business Intelligence Service
Updated September 2023

Priority 5: Preparing for our growing and changing population

Performance Summary

- Out of all the comparable indicators presented for the preparing for our growing and changing population priority, one is green and four are amber. Three indicators were not suitable for comparison.

- Of all the indicators, Rutland ranks 1st (best/lowest performing) when compared to its similar neighbours for the following indicator:

    - **Violent crime - violence offences per 1,000 population**

- There are currently no indicators where, when compared to similar areas, Rutland performs in the bottom three (worse performing).

Source:
*NHS Outcomes Framework
** Office for National Statistics (ONS)

Rutland Joint Health and Wellbeing Strategy - Priority 5: Preparing for population growth and change

Ranking, Best and Worst columns are compared to the nearest neighbours only. Rank: 1 is calculated as the best (or lowest when no polarity is applied).

Indicator				Value	Rank	Best/Lowest	Worst/Highest	England	DoT	RAG
Air pollution: fine particulate matter (new method - concentrations of total PM2.5)	N/A	Not applicable	2021	6.9	8/16	5.7	7.7	7.4		
Average weekly earnings	P	16+ yrs	2021	551.3	4/16	575.3	402.7	496.0		
B12b - Violent crime - violence offences per 1,000 population	P	All ages	2021/22	17.3	1/16	17.3	38.9	34.9		
B17 - Fuel poverty (low income, low energy efficiency methodology)	N/A	Not applicable	2021	12.9	12/16	6.7	19.2	13.1		
Percentage of adults cycling for travel at least three days per week	P	16+ yrs	2019/20	1.1	11/16	3.1	0.6	2.3		
B18b - Social Isolation: percentage of adult carers who have as much social contact as they would like	P	18+ yrs	2021/22	27.0	8/16	38.4	16.0	28.0		
B08a - Gap in the employment rate between those with a physical or mental long term health condition (aged 16 to 64) and the overall employment rate	P	16-64 yrs	2021/22	6.8	3/16	6.3	14.4	9.9		
B15a - Homelessness: households owed a duty under the Homelessness Reduction Act	N/A	Not applicable	2021/22	6.1	3/15	4.4	13.5	11.7		

Statistical Significance compared to England or Benchmark:
Better, Worse, Higher, Similar, Not compared, Lower

Direction of Travel:
Decreasing, Decreasing and getting better, Decreasing and getting worse, Increasing, Increasing and getting better, Increasing and getting worse, No significant change, Cannot be calculated

Data Source: Office for Health Improvement & Disparities
https://fingertips.phe.org.uk/

Produced by Business Intelligence Service
Updated September 2023

Priority 6: Ensuring people are well supported in the last phase of their lives

Performance Summary

- Out of the four comparable indicators presented for the ensuring people are well supported in the last phase of their lives priority, one is amber, two are higher and one is lower.

- Rutland performed significantly higher than England/benchmark for the following indicators:

    - **Percentage of deaths that occur at home** - Rutland is ranked 16th out of 16 in 2021. The proportion of deaths that occur at home (all ages) has decreased from 33.9% in 2020 to 33.6% in 2021, which is significantly higher than the national average of 28.7%.

    - **Percentage of deaths that occur in care homes** - Rutland is ranked 14th out of 16 in 2021. The proportion of deaths that occur in care homes (all ages) has increased from 27.5% in 2020 (where it performed statistically similar to England) to 28.0% in 2021, which is significantly higher than the national average of 20.2%.

- Rutland performed significantly lower than England/benchmark for the following indicator:

    - **Percentage of deaths that occur in hospital** – Rutland is ranked 2nd out of 16 in 2021. The proportion of deaths that occur in hospital (all ages) has increased from 33.9% in 2020 to 35.5% in 2021. Rutland has performed significantly lower than England for this indicator since 2019.

Source:
*NHS Outcomes Framework
** Office for National Statistics (ONS)

Rutland Joint Health and Wellbeing Strategy - Priority 6: Ensuring people are well supported in the last phase of their lives

Ranking, Best and Worst columns are compared to the nearest neighbours only. Rank: 1 is calculated as the best (or lowest when no polarity is applied).

Indicator				Value	Rank	Best/Lowest	Worst/Highest	England	DoT	RAG
Percentage of deaths that occur at home	P	All ages	2021	33.6	16/16	23.0	33.6	28.7		
Percentage of deaths that occur in care homes	P	All ages	2021	28.0	14/16	15.1	30.3	20.2		
Percentage of deaths that occur in hospital	P	All ages	2021	35.5	2/16	34.9	48.5	44.0		
Temporary Resident Care Home Deaths, Persons, All Ages (%)	P	All ages	2021	39.8	10/16	30.7	50.8	39.6		

Statistical Significance compared to England or Benchmark:

- Better
- Worse
- Higher
- Similar
- Not compared
- Lower

Direction of Travel:

- Decreasing
- Decreasing and getting better
- Decreasing and getting worse
- Increasing
- Increasing and getting better
- Increasing and getting worse
- No significant change
- Cannot be calculated

Data Source: Office for Health Improvement & Disparities
https://fingertips.phe.org.uk/

Produced by Business Intelligence Service
Updated September 2023

Cross Cutting Themes:

Supporting Mental Health

Performance Summary

- Out of all the comparable indicators presented for supporting mental health, three are green, seven are amber and four are not comparable.

- Of all the indicators, Rutland ranks 1st (best/lowest performing) when compared to its similar neighbours for the following indicators:

    - **Emergency Hospital Admissions for Intentional Self-Harm (Males)**
    - **Admission episodes for alcohol-related conditions (Broad)**

- There is currently one indicator where, when compared to similar areas, Rutland performs in the bottom three (worse performing):

    - **Self reported wellbeing: people with a high anxiety score**

Source:
*NHS Outcomes Framework
** Office for National Statistics (ONS)

Rutland Joint Health and Wellbeing Strategy - Mental Health Indicators

Ranking, Best and Worst columns are compared to the nearest neighbours only. Rank: 1 is calculated as the best (or lowest when no polarity is applied).

Indicator				Value	Rank	Best/Lowest	Worst/Highest	England	DoT	RAG
90535 - Depression and anxiety among social care users: % of social care users	P	18+ yrs	2018/19	44.5	2/15	43.9	58.8	50.5		
B11 - Domestic abuse related incidents and crimes	P	16+ yrs	2021/22	24.1	4/16	23.0	40.6	30.8		
B18a - Social Isolation: percentage of adult social care users who have as much social contact as they would like	P	18+ yrs	2021/22	39.5	9/16	47.2	34.8	40.6		
		65+ yrs	2021/22	31.8	3/16	27.3	46.4	37.3		
B18b - Social Isolation: percentage of adult carers who have as much social contact as they would like	P	18+ yrs	2021/22	27.0	8/16	38.4	16.0	28.0		
		65+ yrs	2021/22	26.3	8/16	16.7	35.3	28.8		
C14b - Emergency Hospital Admissions for Intentional Self-Harm	P	All ages	2021/22	106.4	2/16	102.9	279.3	163.9		
	F	All ages	2021/22	150.1	2/16	136.4	408.1	220.1		
	M	All ages	2021/22	70.8	1/16	70.8	214.1	109.2		
C28d - Self reported wellbeing: people with a high anxiety score	P	16+ yrs	2021/22	29.2	16/16	18.2	29.2	22.6		
C17a - Percentage of physically active adults	P	19+ yrs	2021/22	70.2	10/16	77.3	64.8	67.3		
Depression: QOF prevalence (18+ yrs)	P	18+ yrs	2021/22	11.2	2/16	10.9	14.9	12.7		
Mental Health: QOF prevalence (all ages)	P	All ages	2021/22	0.7	3/16	0.7	1.2	1.0		
Admission episodes for alcohol-related conditions (Broad)	P	All ages	2021/22	1,068.2	1/15	1,068.2	1,869.1	1,734.5		

Statistical Significance compared to England or Benchmark: Better, Worse, Higher, Similar, Not compared, Lower

Direction of Travel: Decreasing, Decreasing and getting better, Decreasing and getting worse, Increasing, Increasing and getting better, Increasing and getting worse, No significant change, Cannot be calculated

Data Source: Office for Health Improvement & Disparities https://fingertips.phe.org.uk/

Note: RAG/Statistical Significance for indicator C14b in females should be similar. Rank for 'Admission episodes for alcohol-related conditions (Broad)' should be 1/16. There are concerns about the quality of the data for indicator 90535.

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Updated September 2023

Reducing Health Inequalities

Performance Summary

- Out of all the comparable indicators presented for reducing health inequalities, one is green, one is amber and two are not comparable.

- Of all the indicators, Rutland ranks 1st (best performing) when compared to its similar neighbours for the following indicators:

    - **Healthy life expectancy at birth (Males)**
    - **Life expectancy at birth (Males)**

- There are currently no indicators where, when compared to similar areas, Rutland performs in the bottom three (worse performing).

Source:
*NHS Outcomes Framework
** Office for National Statistics (ONS)

Rutland Joint Health and Wellbeing Strategy - Cross Cutting Theme: Reducing health inequalities

Ranking, Best and Worst columns are compared to the nearest neighbours only. Rank: 1 is calculated as the best (or lowest when no polarity is applied).

Indicator				Value	Rank	Best/Lowest	Worst/Highest	England	DoT	RAG
A01a - Healthy life expectancy at birth	F	All ages	2018 - 20	66.8	8/16	70.1	62.6	63.9		
	M	All ages	2018 - 20	74.7	1/16	74.7	61.8	63.1		
A01b - Life expectancy at birth	F	All ages	2018 - 20	85.0	3/16	85.2	83.4	83.1		
	M	All ages	2018 - 20	83.2	1/16	83.2	79.6	79.4		

Statistical Significance compared to England or Benchmark:
Better, Worse, Higher, Similar, Not compared, Lower

Direction of Travel:
Decreasing, Decreasing and getting better, Decreasing and getting worse, Increasing, Increasing and getting better, Increasing and getting worse, No significant change, Cannot be calculated

Data Source: Office for Health Improvement & Disparities
https://fingertips.phe.org.uk/

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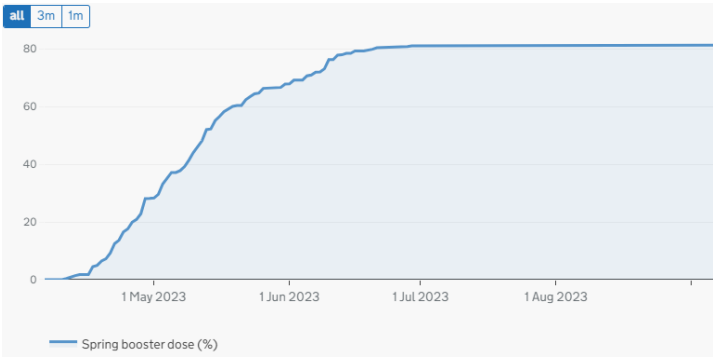
Updated September 2023

Covid Recovery

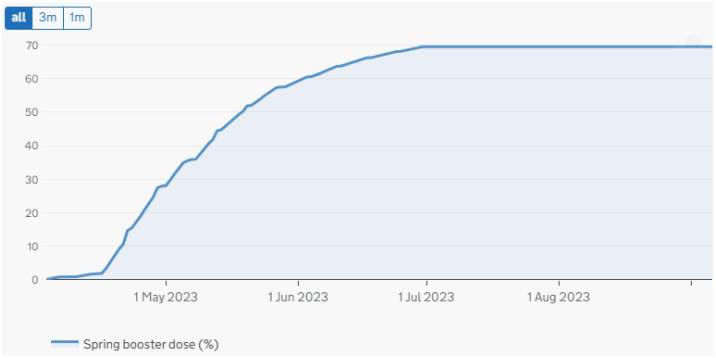
- **COVID-19 vaccinations (% Uptake)**

  The Covid-19 vaccination uptake in Rutland is higher than England for the spring 2023 booster dose (75+), as of 6th September 2023. 81.3% of over 75s in Rutland have had their 2023 spring booster compared to 69.5% nationally.

  Spring booster 2023 Uptake in Rutland (75+)



  Spring booster 2023 Uptake in England (75+)



Source: Coronavirus (COVID-19) in the UK dashboard (https://coronavirus.data.gov.uk/)

- **COVID-19 Deaths****

  As of week 35, in 2023, there have been a total of 118 Covid-19 deaths in Rutland. Of the total deaths involving Covid-19 in Rutland, 63 (53.4%) were in a hospital setting and 44 (37.3%) were in a care home setting.

  Since the beginning of the pandemic (week 12, 2020) there have been a total of 1,555 deaths (all causes) in Rutland.

  Based on the average mortality data for 2017-22 (excl 2020), we would expect 1,416 deaths in Rutland for this period. This reveals an excess of 139 deaths from any cause in Rutland during this period.

Source:
*NHS Outcomes Framework
** Office for National Statistics (ONS)

Appendix 1

Similar areas to Rutland

The Chartered Institute of Public Finance and Accountancy (CIPFA) Nearest Neighbours model seeks to measure similarity between Local Authorities. The nearest neighbours to Rutland are listed below.

Nearest CIPFA neighbours to Rutland available from fingertips include:

- Bath and North East Somerset
- Buckinghamshire UA
- Central Bedfordshire
- Cheshire East
- Cheshire West and Chester
- Cornwall
- Dorset
- East Riding of Yorkshire
- Herefordshire
- Isle of Wight
- North Somerset
- Shropshire
- Solihull
- West Berkshire
- Wiltshire

Source:
*NHS Outcomes Framework
** Office for National Statistics (ONS)

If you require information contained in this leaflet in another version e.g. large print, Braille, tape or alternative language please telephone: 0116 305 6803, Fax: 0116 305 7271 or Minicom: 0116 305 6160.

જો આપ આ માહિતી આપની ભાષામાં સમજવામાં થોડી મદદ ઇચ્છતાં હો તો 0116 305 6803 નંબર પર ફોન કરશો અને અમે આપને મદદ કરવા વ્યવસ્થા કરીશું.

ਜੇਕਰ ਤੁਹਾਨੂੰ ਇਸ ਜਾਣਕਾਰੀ ਨੂੰ ਸਮਝਣ ਵਿਚ ਕੁਝ ਮਦਦ ਚਾਹੀਦੀ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ 0116 305 6803 ਨੰਬਰ ਤੇ ਫ਼ੋਨ ਕਰੋ ਅਤੇ ਅਸੀਂ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਦਵਾਂਗੇ।

এই তথ্য নিজের ভাষায় বুঝার জন্য আপনার যদি কোন সাহায্যের প্রয়োজন হয়, তবে 0116 305 6803 এই নম্বরে ফোন করলে আমরা উপযুক্ত ব্যক্তির ব্যবস্থা করবো।

اگر آپ کو یہ معلومات سمجھنے میں کچھ مدد درکار ہے تو براہ مہربانی اس نمبر پر کال کریں 0116 305 6803 اور ہم آپ کی مدد کے لئے کسی کا انتظام کر دیں گے۔

假如閣下需要幫助，用你的語言去明白這些資訊，請致電 0116 305 6803，我們會安排有關人員為你提供幫助。

Jeżeli potrzebujesz pomocy w zrozumieniu tej informacji w Twoim języku, zadzwoń pod numer 0116 305 6803, a my Ci dopomożemy.

Business Intelligence Service
Chief Executive's Department
Leicestershire County Council
County Hall
Glenfield
Leicester
LE3 8RA
ri@leics.gov.uk
www.lsr-online.org

Joint Health and Wellbeing Strategy, Communication and Engagement

Strengths and Assets Report

Alexandra Chamberlain Co-Production and Engagement Lead

Introduction

The Joint Health and Wellbeing Communication and Engagement Working Group ("The Group") identified in April that to progress the Rutland Communications and Engagement Plan ("The Plan") - which supports the Joint Health and Wellbeing Strategy (JHWS) - that it would be beneficial to have an up-to-date picture of the strengths, assets, and communication channels of our partners' and stakeholders'.

The purpose of this audit, therefore, is to help plan coordinated approaches to communications, to share engagement tools and assets, so that The Group can support one another to tap into each other's assets to reach our communities. Such collaboration would also avoid duplication.

The audit was sent to eighteen partners on the 25th May 2023. Sixteen responses have been received. Two partners advised they are no longer able to participate in this work and two further partners have not submitted a response.

This report analyses the strengths and gaps, the challenges and successes in the communication and engagement channels obtained from the data received from these 16 responses. The report also contains recommendations and some proposed next steps for The Group.

It should be noted that the data is qualitative rather than quantitative. The report is written in the light of this. An appendix to the report contains the responses from the respondents in a spreadsheet format.

Brief overview of the Rutland Communications and Engagement Plan

The Plan sets out the following:

To support the role of the Rutland Health and Wellbeing Board and successful delivery of the Rutland Joint Health and Wellbeing Strategy 2022-27.

Health, care and wellbeing-related organisations in Rutland are working together, through the Joint Health and Wellbeing Strategy (JHWS), to make Rutland an even healthier place in which to live. This includes working to provide high quality services for all, to respond to inequalities which affect some health outcomes in our communities, and to ensure that people have access to the right information, advice and help at the right time. Another important dimension is to empower people to play a full role in looking after their own health across their lifetime, and to provide them with opportunities to get involved in shaping the local priorities and services they need.

The three core objectives of this plan are as follows:

1. To ensure that people have the information they need: to feel empowered to play a full role in maintaining their own health and wellbeing; to access health and wellbeing services to support them in living well; and, to take part in helping to shape services

2. To increase the public's understanding and awareness of the role of the Rutland Health and Wellbeing Board in shaping the conditions for local health and wellbeing.

3. To more fully involve the public and professional stakeholders in informing the design and delivery of strategies, plans and services to respond to individual and local needs.

Analysis of audit

The qualitative data from the audit highlighted the following common engagement themes:

- There are 41 people identified by The Group Leads as being either part of, or the lead for their communication and engagement.

- Their roles and responsibilities range from direct communication and engagement, marketing, public consultation, patient experience, project related engagement with focus groups and interviews, parent mail and parent volunteer team updates, as well as internal comms. It is evident that a large percentage of these roles prioritise communication and engagement principles and methodology to effectively engage with the public, service users, patients, parents, and children.

- 61% of respondents are linked to both National and Local campaigns, including National NHS/Government campaigns. These campaigns range in themes from the Armed Forces Community support around mental health, veterans' homelessness, housing, and employment to help veterans to live stable lives. Public Health protection campaigns range from Every Mind Matters, Better Health to promotion of vaccinations and immunisations programmes, especially in the winter months. Age UK, The Admiral Nurse Service, NHS Leicester, Leicestershire and Rutland (LLR) and Rutland Primary Care Network (PCN) link in and support campaigns based on Health and Social Care, to support mental wellbeing, dementia, loneliness, isolation and digital enablement and are often dually linked in with the voluntary, community and social enterprise sector across the area to include Dementia UK and Age UK National campaigns. Healthwatch Rutland is an active partner that sits on various boards and strategic forums within the Integrated Care Board (ICB) and Rutland Health and Wellbeing Board, as well as promoting their own National Healthwatch campaigns. They link in with Care Quality Commission (CQC) and National Health Service England (NHSE) regarding service quality. Citizens Advice Rutland are active within their own Citizens Advice national network and the National Council for Voluntary Organisations (NCVO) campaigns. The Safer Rutland Partnership/Community Safety at RCC participate and promote national safety campaigns as well as local campaigns on locations, demographics and crime patterns. Active Rutland link in with both national and local Active Together Campaigns. RCC's Children and Families departments collaborate with both National and Public Health campaigns, for example addressing improving adolescent health and behavioural change to support positive life choices for adolescents. RCC's Community Care

Services, to include Rutland Integrated Social Empowerment (RISE) Service rely on RCC's internal Communications Team to promote Social Prescribing, Reablement and Learning Disability and Autism Day Opportunities and Supported Living.

- Most of the respondents' intelligence to access the community includes social media via a combination of Face Book, X – previously known as Twitter, Instagram, LinkedIn, You Tube, Mail Chimp, What's App Groups, computer information boards in GP practices, Active Rutland website, The Joy Platform and RCC website and the Rutland Information Service (RIS).

- Other sources of intelligence include access to national Age UK 'Loneliness Heat Maps', Carers groups and Men and Women in Sheds, as well as feedback from families, patients, service users and veterans. Ministry of Defence (MOD) distribution lists, the Office of Veterans Affairs, the Civil Military Partnership Board (CMPB) for LLR and the Forces in Mind Trust are some of the principal sources of intelligence for the Armed Forces Officer, as well The British Legion, RAF Association as well as direct media and direct contacts with charities. Other sources range from word of mouth, face to face meetings both in person and on-line, satisfaction surveys, Survey Monkey, Multi-Disciplinary Meetings (MDT's), public consultation, co-production groups, and pop-up stands in libraries, villages, parish halls. Access to patients records as the care provider as well as national NHS data, data and intelligence from voluntary groups, population health management data and Census 2021 data are other forms of intelligence. Population level intelligence communications are also received from a variety of sources including the Public Health Outcomes Framework.

- A third of partners have their own Uniform Resource Locator (URL) website to promote engagement activities, local and national campaigns and events. Those internal partners to RCC use the Rutland Information Service (RIS) website and internal communications for RISE and Community Care Services (CCS), Admiral Nurse Service, Children and families, Community Safety and The Armed Forces. Currently Children Young People's Services (CYP) are in the process of developing a Rutland and Leicestershire Teen Health website and The Admiral Nurse Service are exploring an independent website to use in addition to internal/external RCC comms/the RIS. Public Health link-in with the RIS rather than accessing a dedicated Public Health site. CAR also use Mailchimp for an urgent bulletin service reaching 240 VCSE organisations in Rutland if required.

- A report received from Children and Families Young People Services (CYP) identified that as they do not have their own social media platforms, this is a missed opportunity to engage with young people on the platforms that they utilise. During 2020 Young people said they preferred to access information via social media platforms with Instagram accounting for 80% followed by Snapchat (74%), Facebook (29%) and the least used is Twitter at 17%. 61% of young people told YPS that family were their source of information about what is happening in their area followed by friends (48%) and school (47%) compared to only 7% who access RCC website.

- There is less dependency on radio and TV media coverage, but local media outlets include the Rutland Information Service (RIS), Rutland Health PCN website, Rutland and Stamford Sound (RSS), there is only a small percentage of editorial material, included in The Stamford Mercury and The Rutland Times, as well as any leaflets printed by all voluntary and health

services. CAR, Healthwatch and RCC Communications Team share intelligence and complete interviews on radio – R7Ss and Greatest Hits radio, with occasional publications in hyper-local publications such as RSS, Stamford Mercury, Nub News and Radio Leicester. RCC Comms is the only partner who appears to utilise TV engagement, with ITV Central News and BBC East Midlands.

- Service updates, staff bulletins, staff e-magazines, volunteer newsletters, VCSE announcement bulletins, monthly newsletters, Councillor briefings, the Joy platform updates, GP newsletters and Citizen panel newsletters all contribute to the sharing of internal messaging on communication and engagement. The frequency of these Communications range from ad-hoc/as and when required, to weekly, monthly and quarterly. Listed circulation numbers range from 31 to 700 staff and volunteers.

- External publications, both printed or e-newsletters and magazines have a wider coverage of subscribers, with particular focus for Healthwatch Rutland, Age UK Leicestershire and Rutland, and Citizens Advice Rutland which can be targeted mailings rather than publications targeting the public. Most of these reach a target audience between 240-310 subscribers/public. It is worth noting that RCC Communications Team distribute an e-newsletter which is sent out monthly with a current distribution list of 4.5K. This is a significantly higher, wider and broader spectrum of people to share communication and engagement strategies, events and activities with. However, as a proportion of our 38K population, this figure is not as high as it initially appears at 12% and may benefit from further focus to look at how distribution can be strengthened.

- The Partners involvement for 'in person' Physical Events' range from either attending or organising ad-hoc events to local community events throughout the year. Citizens Advice appear to be the most active with an estimation of between 15-20 per year, as well as attending a series of events that are run across the county in conjunction with the Safer Rutland Partnership, as well as monthly VCSE events. Citizens Advice Rutland identify the importance of operating pop-up stalls, approximately 12 events per year across the county targeting small rural communities.

- RCC attend events based in schools, with a particular focus for Active Rutland on School games, adult G.P Active Referrals and National Programmes. Parents evening events and the delivery of groupwork sessions in schools and community form part of Children and Families event participation. The Disabled Youth Forum meets monthly and is led by people with a disability and attended by support workers from RCC. Rutland Youth is not managed by the CYP, so there is a delay in posts and there is no direct promotion, which is reflected by their small number of followers with 83 in total.

- The Admiral Nurse Service attend promotional events ad-hoc to include community events in Barrowden and Young Onset dementia event which took place at Leicester Football Club. Age UK are currently organising a consultation event regarding the LLR Dementia Strategy in August and organised by Leicestershire Dementia Support Service. Healthwatch usually join any local health or care themed events, resource permitting. Armed Forces Officer is engaged with National and Midlands Armed Forces Covenant Forums, the East Midlands Reserve and Cadet Units Association, Rutland Royal British Legion and RAF Association meetings, Citizens Advice Rutland VCSE meetings, CMPB and attendance at the veterans' fair

with the Welfare Teams on local military units. The Armed Forces Lead also chairs a Rutland Forces Family Forum on a quarterly basis and charities such as veterans Breakfast Clubs to signpost to events, initiatives, and national campaigns such as Op Courage. Public Health attend a limited number of physical events around engagement, but service users look at opportunities to link in when referrals are low. Public Health and RCC are working collaboratively focusing on asset-based community development around health inequalities in an identified specific area pf Rutland as a pilot project.

- Monthly voluntary sector meetings and Mental Health Neighbourhood meetings form a priority for CSS and RISE as well as using and entering events on the Voluntary Sector Community Engagement calendar. Rutland PCN utilise events arranged by individual surgeries and RCC to include Carers Week, as well as the Patient Participation Group Network (PPG). NHS LLR also host events with the VCSE Alliance and PPG network but tend to go out to established existing group events.

- It is also to be noted that Age UK's shops and resource centres provide an opportunity to share information and disseminate information and leaflets. The Rutland shop is located in Uppingham.

- Note that one respondent is no longer working within Rutland, and the other respondent advised that the information was not relevant to their role. As a result, there is no data from either of these respondents.

Challenges and Successes

Media/Editorial/TV/Radio coverage - There is a large dependency on e-literature, and digital communication methods from all partners. There is concern that for people who do not feel comfortable using digital, are not digitally enabled, do not have the financial capacity to invest in digital, they could be at risk of missing information and opportunities. Age UK is working with digital champions who provide sessions at Tesco's as well as a support worker who can access community to include those who are unable to access the community independently. However, the medium of radio does appear to have a good proportion of communication and engagement activity with some mainstream TV coverage.

Children and Young People – From a recent report (see link in audit spreadsheet in Appendices to Teen Health Service Briefing May 2023 SL, Half Term Unplugged survey summary and Family Hub Consultation Findings Report June 2023) that Instagram needs to share posts instantly in the moment of engagement activities for young people, but they must wait to share with the Local Authority Design Officer who manages the account. This limits their numbers to 83 in total. The recent June 2023 Family Hub consultation with families, children and young people highlighted that *'It is worth noting that information dissemination should extend beyond websites and social media platforms. It was found that 12% of families do not access any websites at all and instead rely on community channels for information.'*
…'it should be acknowledged that not everyone would have access to or utilise a virtual offering and data poverty should be considered whereby 'Data poverty in the UK excludes people from access to essential services and participating in UK society' (Digital Poverty Alliance 2022). *To gain a deeper understanding of the impact of a virtual offer, it is recommended that this is explored further with focus groups to determine the extent of its effectiveness and to identify appropriate channels for sharing information with those who do not access websites and social media.'*

The report goes on to say that there is a gap in promoting trusted reliable resources with 0 respondents accessing healthforkids.co.uk and only 5 accessing healthforteens.co.uk schools and services such as Health for Teens, who are well placed to share important messages to children, young people and families. The Family Hub report's conclusions and recommendations identify the importance of integrating face-to-face services alongside an accessible online presence. Families highly value the personalised and direct support received through in-person interactions, emphasising the need to incorporate face-to-face services within the Family Hub model. Effective communication strategies are crucial to bridge the information gap and improve awareness among residents about the existing services and support available. By addressing this knowledge gap, there is an opportunity to promote self-help behaviours that can effectively reduce the demand for services accessed through referral routes. Creating clear and recognisable branding will help increase awareness and understanding of the available support. An accessible online presence is essential, providing easily accessible information about local services, guidance, and links to relevant resources. Partners are well placed to share information for CYP but this cannot rely solely on these. For example, information about booking onto Rutland's Holiday Activity and Food Programme is shared via schools but CYP are not always confident that this has been disseminated to those who are eligible, and when they have spoken with young people, they are not aware of this opportunity.

Rural communities - Accessing rural communities especially farming communities with the increase in social isolation, and the perceived increase in suicide risk, there does not appear to be robust communication and engagement activities managing this risk throughout the audit. CAR does identify specific events operating pop-up stalls, with approximately 12 events per year across the county targeting small rural communities and Public Health Rutland is piloting a health inequalities project looking at Community Assets. Previously the Changing Connections Project, from the Rural Community Council and their coffee connect van as well as referrals from GP's through RISE to the Changing Connections Project were able to target some of these more rural communities. As funding has not been provided since June 2023, this opportunity no longer exists.

The interim period for recruitment at CAR for their Engagement Officer post, which has now been recruited to, will support the need to access those more rural communities and provide community social groups, digital enabling workshops and other opportunities and activities within rural parish halls and community venues.

CAR's success with their continuous pop-up venues throughout the year is to be celebrated, as is the identification that Youth Services would benefit from a communication and engagement tool specifically targeted and commonly used by their audience, that can relay and engage in real time.

Recommendations and Next Steps

The task and finish group of partners will review the overarching Joint Health and Wellbeing Strategy delivery plan, using the results and recommendations from this audit, to identify the key communications and engagement linkages and dependencies. This report will be used for agreeing scope to coordinate with systems/ICS level communications activity and mechanisms. The task and finish group will establish reporting timescales for the Integrated Delivery Group (IDG) and HWB communication and engagement activity and performance.

Recommendations to include:

1. Consider shared approaches in engagement with hard to reach/rural communities
2. Consider strategies to increase the engagement activity using the learning from the report
3. Increase promotion and usage of existing Team Upp calendar of engagement events across the year; a centralised point of access for Communication and Engagement Leads to share opportunities for engagement
4. Ensure that use of social media is linked where appropriate and that all communication and engagement leads are following each other on social media platforms.

A modest prioritised programme of engagement activity for year 1/2 of the JHWS will support delivery of the priorities. The engagement approach, including the proposed toolkit for partners to use and drawn from best practice within the report will include:

- Approach to compensation where/if required for co-production
- Existing groups who could be engaged
- How to reach less often heard groups and groups facing inequalities

An annual report will be complied by the Communication and Engagement Lead to take stock of overall performance and change and share the 'You Said, We Did' outcomes via the Health and Wellbeing Board and other communication and engagement channels throughout Rutland to the general public.

The ten Communication and Engagement Principles of The Plan (see Summary Infographic in Appendices) to centre decision making around the voices of the people and communities, involve people and communities at every stage and feedback on how it has influenced decisions, understand the community's needs, aspirations, experiences and ideas using engagement to assess if change is working, build relationships based on trust, especially groups affected by health inequalities, work with Healthwatch Rutland and the voluntary community, providing clear and accessible public information, using community approaches and making connections to what works already, use a variety of ways for people to take part in health and care services, tackle system priorities and service reconfigurations and lastly, but not least, build on the assets of all health and care partners, will enable the priorities and actions of the Plan to be achieved.

The purpose of both the audit and the subsequent annual report, as outlined above in the communication and engagement principals, is to ensure people of Rutland are accessing the correct information, are empowered to look after their own health and are involved in shaping local priorities. The Group are committed to raising the profile of the Rutland Health and Wellbeing Board. This can be achieved through the Communication and Engagement Plan and identified deliverables, by involving public and professional stakeholders to co-produce service design and change, and work together in an equal partnership.

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Rutland Health and Wellbeing Board
Joint Health and Wellbeing Strategy
12 Month Review August 2023
Katherine Willison – Health and Wellbeing Integration Lead

Contents

Introduction

The Joint Health and Wellbeing Strategy (JHWS) was launched in April 2022. This is a review of the first 12-16 months of the strategy delivery plan. While excerpts from the plan are included to indicate progress and challenges, it also focuses on the process and format of reporting.

The Health and Wellbeing Integration Lead (HWIL) met with all the Responsible Officers on the Integrated Delivery Group or Priority 'Leads.' This was an opportunity to talk through the plans for each Priority area, discuss challenges and ideas for improvements. It highlighted where pieces of work had been completed and where workstreams could be classed as business as usual. It also highlighted the many linkages across the Priority areas, particularly areas 4 and 5. People generally felt that a meeting was useful.

Extracts from the Delivery Plan

Priority 1 The Best Start for Life

The Family Hub opened in January 2023, offering accessible, seamless services for families to achieve positive outcomes for children and young people. The Family Hub steering group has now been amalgamated with the Children's Centre Governance group so that there is a joined-up approach, making the best use of time. Feasibility work being undertaken to develop further sites to service more rural areas.

The 11-19 Teen Health Service is now being provided by Rutland County Council, providing early intervention public health programmes. It incorporates a 'Whole School Approach' to improving the emotional wellbeing and health of students. The service includes one-to-one sessions and group work, drop-in sessions and involves networking and building relationships with schools and other partners.

Priority 2 Staying Healthy and Independent: Prevention

The Active Referral Programme delivered by Active Rutland commenced in April 2023. Oral Health promotion services commenced in February 2023. The Rutland Weight Management Service was mainstreamed funded from April 2023 providing more opportunities to promote the service, linking with Making Every Contact Count (MECC), Active Rutland and Health Checks. MECC training has been commissioned.

The VCSE survey has been completed and themes are being evaluated. Citizens Advice Rutland (CAR) are running a campaign using various communication channels to increase

numbers of volunteers. A new directory and information exchange forum will be launched in September. A monthly stakeholder Information Exchange session began in 2023 which is very well attended and a useful point for sharing updates and ideas on progress. Mapping of the Rutland Voluntary and Community Sector has been completed by CAR and this workstream is now business as usual.

Priority 3 Healthy Ageing and Living Well with Long Term Conditions

There is a wealth of schemes and initiatives where partners are working across Place and System for this Priority. There are strong links with the Voluntary and Community Sector partly facilitated by a monthly Integrated Neighbourhood Network meeting. Notable examples of progress in delivery include the Falls Prevention Programme across Rutland care homes with a recent focus on prevention of falls leading to hip fractures. The 'Whzan' tele-health digital kit has been in use in Rutland care homes since Autumn 2023, calculating an early warning score, enabling signs of deterioration or illness to be identified. This helps to prevent the need for GP visits and hospital admissions.

As part of the Anticipatory Care Project, Memory Clinics were re-established in July, run by the LPT Memory Service. Also present are the RCC RISE Team, Admiral Nurses and the PCN to offer information and advice.

Priority 4 Ensuring Equitable Access to Services for all Rutland Residents

A PCN Capacity Access and Improvement Plan (CAIP) is now being implemented. Strong relationships have been built with partners from Rutland's bordering authorities and trusts, including Lincolnshire and Northamptonshire, enabling more equitable access into services. See Priority 5 below. Working with Healthwatch on the results of their research and The Primary Care Access Survey was completed. Views and comments provided will be incorporated into plans over the next 18 months. Of note is that Covid recovery has been successful in availability of GP appointments.

The Rutland Memorial Hospital (RMH) business case and an Estates Review has been completed. Work is being done for an MRI machine and breast screening facility to be available in Oakham. A business case was submitted for an application for Community Infrastructure Levy (CIL) monies for renovation of a ward at Rutland Memorial Hospital, for the provision of a clean room/ day care procedures.

Priority 5 Preparing for Significant Population Growth and Change

The ICB and RCC have built excellent working relationships gaining a mutual picture of impact on the local plan position. The Levelling Up bid has been approved and discussions are now taking place regarding a Moby Hub and a Meditech Centre on Oakham.

The Primary Care Estates Strategy (PCES) has been agreed. Strong links have been made with the North Place Partnerships. Regular active meetings take place with North West Anglia Foundation Trust (NWAFT). There are also good working relationships with South Kesteven. Plans are shared across Stamford Minor Injuries Unit and Rutland Memorial Hospital regarding provision, including tangible plans for diagnostics provision. There is a good understanding of each other's challenges.

'Health and care workforce fit for the future': This action has been completed. PCN training courses have been delivered and career development opportunities are in place. This has enabled a more sustainable workforce for the locality.

Key areas of development for health and equity in policies are training for Leicestershire staff and then Rutland; ensuring reflection of health inequality issues and health and wellbeing is incorporated in recommendation and reports as routine; support for the next stages of the Rutland Local Plan from September 2023 to January 2024 following public consultation.

Priority 6 Ensuring People are Well Supported in the Last Days of their Life

There has been no Lead for priority 6 for several months, resulting in some delays in co-ordinating progress. There has also been a challenge in that the progress of the LLR End of Life Programme has been slow in recent months. A workshop took place in July where required actions were clarified and an agreement that much of the work would link with the LLR End of Life Task and Finish Group. We now have two people who have agreed to take on the role of Lead and Senior Reporting Officer respectively which should ensure progress of delivery going forwards.

Despite the above, there has been progress made, including an updated, streamlined ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) form, making the process more efficient and therefore more likely to be utilised. There is a palliative care suite at Rutland Memorial Hospital and the PCN recruited an End-of-Life Care co-ordinator via the Additional Roles Reimbursement Scheme.

Cross-Cutting Themes

Priority 7a Supporting Good Mental Health

The Rutland Mental Health Neighbourhood Group was formed in 2023, a subgroup of the Rutland Health and Wellbeing Board (HWB). The aim of the group is to lead on driving, co-ordinating and enabling mental health transformation within Rutland. A Mental Health Pathway has been produced which shows access points and referral routes to support. A Mental Health Neighbourhood Café has been established, with funding for transport, thereby addressing the rurality access issue.

Priority 7b Reducing Health Inequalities Across Rutland

The Rutland Staying Healthy Partnership Group formed in 2022, a subgroup of the HWB. A needs assessment to understand health inequalities in Rutland, considering hidden deprivation, geographical inequality, inclusion, and vulnerable populations has been completed. Findings from the assessment were taken forward to a Health Inequalities workshop in January 2023 and work is progressing.

Priority 7c Covid 19 Recovery

Recovery from Covid 19 has been progressing well in Rutland with partners generally stating that services are back to pre-Covid efficiency. There is, however, potential for learning to be taken forward to assist in dealing with potential similar crises in the future. In addition, where structures have been put into place for Covid and are being removed, there will be less resilience to respond. An annual report, Horizon Scan of Future Threats' is being developed which is due to be presented at the HWB meeting in October 2023.

Evaluation

There is a great amount of progress being made across the seven priorities which is having a significant impact on the health and wellbeing of Rutland residents and users of Primary Care. There are also plans in place for work to commence later – we still have nearly four years to

achieve the aims of the strategy. It is challenging for Leads to co-ordinate all the information required for regular updates because there are often several sources to liaise with. In addition, some partners do not respond, leaving gaps. There are challenges with the regularity of monthly reporting as many workstreams do not have progress or outputs which can be measured this frequently.

There has been little take up of the use of SMART (Specific Measurable Achievable Relevant Timebound) goals for setting and measuring outputs which makes demonstrating successes more challenging, albeit this type of measuring is not possible with some workstreams. It is not always explicit what the impact of the workstreams will have on people and communities; it relies on assumptions which could be missing the depth and gravity of the impact.

Recommendations

Leads to:

- Consider inclusion of SMART measures in plans
- Prioritise feedback from service users, patients and professionals and record in plans
- Include explicit detail on impact
- Continue to work collaboratively as the Leads for the 7 Priorities and ensure linkages are clearly referenced, avoiding duplication
- Raise with the HWIL any issues on progress due to lack of engagement from partners

HWIL to:

- Book regular quarterly meetings with Leads
- Identify, respond to, and escalate as appropriate, any concerns from Leads or issues with progress
- Monitor updates via Highlight Reports and the delivery plan in Sharepoint
- Review the reporting processes, structure, and layout of the delivery plan with Leads and the Chair of the IDG

Report No: 150/2023
PUBLIC REPORT

RUTLAND HEALTH AND WELLBEING BOARD

10 October 2023

COMMUNICATION AND ENGAGEMENT PLAN 2022-2027

Report of the Portfolio Holder for Adult Care and Health

Strategic Aim:	All	
Exempt Information	No	
Cabinet Member(s) Responsible:	Cllr D Ellison, Portfolio Holder for Adult Care and Health	
Contact Officer(s):	Kim Sorsky, Strategic Director of Adult Services and Health	01572 758352 ksorsky@rutland.gov.uk
	Katherine Willison, Health and Wellbeing Integration Lead	01572 758409 kwillison@rutland.gov.uk
Ward Councillors	Not applicable	

DECISION RECOMMENDATIONS
That the Committee: 1. Notes the content of the report. 2. Notes the finalisation of the Health and Wellbeing Communication and Engagement Plan following input from stakeholders, including representation from Children's Services.

1 PURPOSE OF THE REPORT

1.1 The purpose of this report is to brief the Health and Wellbeing Board (HWB) that the plan has been finalised, including input from Rutland County Council Children's Services.

2 BACKGROUND AND MAIN CONSIDERATIONS

2.1 The Communication and Engagement Plan (CEP) was developed to support the role of the HWB and successful delivery of the HWB Strategy. Organisations work together through the delivery of the strategy to ensure that people have the right information, advice and help at the right time. Another important element is to empower people to play a full role in looking after their own health and provide them with opportunities to get involved in shaping the local priorities and services they need.

2.2 The purpose of the CEP is to enhance the health and wellbeing of people in Rutland by facilitating effective health and wellbeing communications and engagement.

2.3 The plan was developed by a working group with a range of representation from HWB partner organisations. The plan is focussed on communication and engagement involving two key sets of stakeholders:

- Residents and patients of Rutland.
- Agencies and their workforces.

2.4 **A Delivery Plan** has been developed with the following elements:

- Readiness to deliver the plan.
- Ensuring people have access to the information they need to maintain their health and wellbeing and to navigate change successfully.
- Raising the profile of the Rutland Health and Wellbeing Board.
- Involving the public and professional stakeholders in service design and change.

3 CONSULTATION

3.1 A meeting of the working group took place in January 2023 where it was decided which stakeholders were required to be consulted with regard to the CEP and a timescale for comments. Further to this, it was agreed at the HWB in June 2023, that representation from Children's Services was required. Consultation has now taken place with a representative who has made some additions to the Delivery Plan element of the plan and will a member of the Communications and Engagement Plan Task and Finish Group.

3.2 Additions have been made to the Delivery Plan at points 1 and 3. See appendix A.

3.3 The proposal is to engage with the public and the workforce, including presenting key aspects to interested groups such as the Patient Participation Groups (PPG) and those 'Experts by Experience', to further enhance and inform the draft CEP.

4 ALTERNATIVE OPTIONS

4.1 Not applicable at this time.…

5 FINANCIAL IMPLICATIONS

5.1 The CEP has been developed using existing staffing resources. The delivery of the CEP will depend upon time being committed by partners.

5.2 The board is requested to note the input from many partners and that the delivery of the plan is being managed by the RCC Quality Assurance Team, led by the Co-Production and Engagement Lead.

6 LEGAL AND GOVERNANCE CONSIDERATIONS

6.1 The CEP has been produced with involvement from stakeholders and has been finalised after further consultation with stakeholders. The delivery plan updates of the CEP will be presented to the Integrated Delivery Group on a monthly basis for monitoring of progress.

7 DATA PROTECTION IMPLICATIONS

7.1 There are no new Data Protection implications. The CEP contains only anonymised information.

8 EQUALITY IMPACT ASSESSMENT

8.1 Not applicable to the CEP.

9 COMMUNITY SAFETY IMPLICATIONS

9.1 There are no identified community safety implications from this report.

10 HEALTH AND WELLBEING IMPLICATIONS

10.1 Co-production acknowledges that people with **'**lived experience' of a particular condition are often best placed to advise on what support and services will make a positive difference to their lives. Incorporating co-production principles into programmes for people with long-term conditions can help them to gain knowledge, learn skills and adopt behaviours that are thought to be important in achieving better health and wellbeing.

10.2 Principles of 'Think Local, Act Personal's (TLAP)' 'Making It Real' is central to communication and engagement practice. 'Making It Real' is a framework to support good, personalised care and support for providers, commissioners and people who access services. This is in line with the 'Thriving Places Guidance' which is within the plan, which asks place-based partnerships to 'systematically involve professionals, people and communities in their programmes of work and decision-making processes'.

10.3 The RCC Improvement Officers support the delivery of the Rutland Communication and Engagement Plan. They have led on developing the digital and self - assessment portal which promotes self-directed care and access and are supporting with the Greetham Project amongst many other workstreams. They work to ensure the voice of more marginalised and deprived groups are represented and heard and ultimately utilised in the co-design of services and support.

11 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

11.1 The Committee is recommended to note the contents of the report and the finalisation of the Health and Wellbeing Communication and Engagement Plan following input from stakeholders, including representation from Children's Services.

12 BACKGROUND PAPERS

12.1 There are no additional background papers to the report.

13 APPENDICES

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

Health and Wellbeing Communication and Engagement Plan for Rutland 2022-27

Supporting the role of the Rutland Health and Wellbeing Board and
successful delivery of the Rutland Joint Health and Wellbeing Strategy 2022-27

Status	Draft
Version	0.6
Lead author	Sandra Taylor / Katherine Willison
Date	March 2023

Contents

Purpose

Health, care and wellbeing-related organisations in Rutland are working together, through the Joint Health and Wellbeing Strategy (JHWS), to make Rutland an even healthier place in which to live. This includes working to provide high quality services for all, to respond to inequalities which affect some health outcomes in our communities, and to ensure that people have access to the right information, advice and help at the right time. Another important dimension is to empower people to play a full role in looking after their own health throughout their lifetime, and to provide them with opportunities to get involved in shaping the local priorities and services they need.

This communication and engagement plan aims to enhance the health and wellbeing of people in Rutland by facilitating effective health and wellbeing communications and engagement.

The plan is focused on communication and engagement involving two key sets of stakeholders:

- residents and patients of Rutland; and
- stakeholder agencies and their workforce.

It has been developed by a working group of Rutland Health and Wellbeing Board partner organisations and informed by what the public have told us about their needs and wishes from communications and engagement.

Different partners have different requirements on them for communication and engagement, and different resources, drivers, working practices and aims from this activity. Therefore, delivery of this plan will be a journey in which they will be evolving shared ways of working, along with the public, including the development of a common language around communications and engagement.

We propose to engage with the public and the workforce on this draft plan between March and June 2023 HWB meetings, including by presenting key aspects to interested groups such as the Patient Participation Groups, to further enhance and inform the plan before it is finalised.

The plan is part of the wider integrated health and care system.

In line with the NHS Long Term Plan, health and care services are designed and delivered collaboratively at three levels, with services managed as close as possible to the communities they serve while allowing for an efficient, effective and safe operating scale:

- The Integrated Care System level equates to the area of Leicester, Leicestershire and Rutland (LLR) and provisions strategic services such as acute hospitals.
- LLR has three 'Places' – equating to individual Local Authorities, with Rutland being a Place in its own right. Places have a key role in maintaining health, integrated care services closer to home and reducing inequalities.
- The third level is Neighbourhoods – the scale at which primary care services are planned. Rutland is both a Place and a Neighbourhood.

In parallel with their health and wellbeing strategies, systems and places are each developing complementary communications and engagement plans. This document is the

communications and engagement plan for Rutland as a Place and Neighbourhood, and complements the ICS communications plan, its 'People and Communities Strategy' (LLR Integrated Care Board, 2022).

In designing this plan, we have been guided by ten practical national communication and engagement principles[1] which have been published as part of 2021 LGA and NHS guidance on building a strong Integrated Care System (ICS). The principles aim to set out how each level of the ICS (system, place and neighbourhood) should aim to work closely with people and communities for the best outcomes:

1. Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS.	6. Provide clear and accessible public information about vision, plans and progress, to build understanding and trust.
2. Start engagement early when developing plans and feed back to people and communities how their engagement has influenced activities and decisions.	7. Use community development approaches that empower people and communities, making connections to social action.
3. Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect.	8. Use co-production, insight and engagement to achieve accountable health and care services.
4. Build relationships with excluded groups, especially those affected by inequalities.	9. Co-produce and redesign services and tackle system priorities in partnership with people and communities.
5. Work with Healthwatch and the voluntary, community and social enterprise (VCSE) sector as key partners.	10. Learn from what works and build on the assets of all ICS partners - networks, relationships, activity in local places.

The plan also responds to the 'Thriving Places Guidance' (LGA and NHS, 2021, pp21) which asks that place-based partnerships "systematically involve professionals, people and communities in their programmes of work and decision-making processes", and that these arrangements should:

- "be a source of genuine co-production and a key tool for supporting accountability and transparency of the system;"
- "establish a shared understanding of the community's needs;"
- "build relationships with all communities, including excluded groups and those affected by inequalities" (also to meet Equality Act 2010 obligations); and
- "use continued engagement to measure if partners are improving experiences of care and support."

We also used two further important elements to inform this draft plan:

- a review of what the public told us about their needs and wishes from health and wellbeing-related communications and engagement in the course of recent JHWS consultation and engagement (see Appendix 2); and

[1] LGA and NHS (2021) Building strong ICSs everywhere – working with people and communities

- an analysis of current communications-related strengths, weaknesses, opportunities and threats as viewed by colleagues in the Rutland health and care system involved in this activity (summarised in Appendix 3).

Key aspects of the public's feedback have been as follows.

- **Communications**
  - difficulties in finding out what services and opportunities are available to them to support their health and wellbeing;
  - a wish to have access to the information they need to care for themselves and make timely and informed choices; and,
  - not wanting to see an over-reliance on digital channels which excludes those who are not online.
- **Engagement**
  - a willingness among many to share their experiences and views of care to help to inform and shape service improvements.

The Rutland Health and Wellbeing Board (HWB) as an enabler for health and wellbeing

The Rutland Health and Wellbeing Board is pivotal to health and care change in Rutland. It is a statutory committee of health and care partners who work together to understand Rutland's health and wellbeing needs and to facilitate these needs being met. This includes by directing their respective resources towards mutually agreed, evidence-based change, as set out in the Joint Health and Wellbeing Strategy 2022-27. The HWB meets quarterly in public session, its papers are published online and key items of business are regularly reported in the local press.

This plan aims to increase the visibility and public profile of the Board so that it can play a fuller role in making the public aware of how proposed health and care changes will benefit them and can encourage more feedback and involvement from members of the public with first-hand experience of key services.

The key responsibilities of the HWB are as follows:

- To guide and deliver the **Joint Strategic Needs Assessment (JSNA)** for health and wellbeing which brings together a wide range of data and insight to inform policy and commissioning decisions affecting the local population.
- To prepare and deliver the **Joint Health and Wellbeing Strategy (JHWS)**, informed by the JSNA, to respond to the specific health and wellbeing needs of the local community.
- Supporting suitable and sufficient provision of health services, including through the **Pharmaceutical Needs Assessment (PNA)**.

Scope of communications and engagement in this plan

To deliver its objectives, this plan covers several types of interaction, as set out in the 'ladder of engagement' below. There is not yet consistent terminology across different frameworks used to describe types and levels of interaction, particularly for the most substantive types of involvement, so it is important to define the anticipated scope of interactions within this plan. The definitions we have

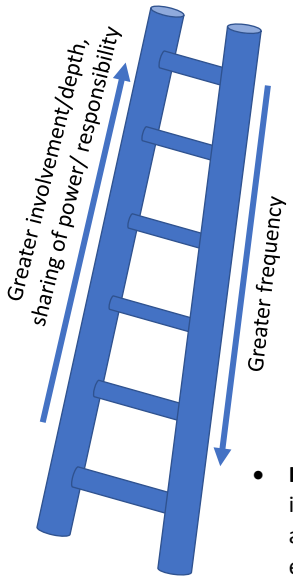
adopted aim to align with those used by Think Local, Act Personal, which has extensive experience in this domain and promotes the meaningful participation of people in shaping services.

The lowest rungs of the ladder adopted here are **educating** around maintaining health and **informing** the public about services and opportunities. Informing and educating are fundamental communications activities and will account for a lot of what this plan delivers.

In line with the Thriving Places Guidance', a key ambition of this plan is to build on this foundation by more routinely enabling service users and the workforce to use their experience in richer ways to help to shape and enhance services. Higher up the ladder, therefore, are progressively richer forms of dialogue aiming to harness the experiences and creativity of the public and the workforce in the design and delivery of successful services. There are not clear-cut lines between these higher rungs on the ladder of involvement. Instead, the ladder offers a representation of a sliding scale that aims to help the participants in any given dialogue to be clear on the scope for influence and balance of responsibilities that is entailed.

Consultation is a structured and formal dialogue which usually takes place well into the design of a plan, policy or service and is constrained in its scope. **Engagement**, in turn, entails richer and more free flowing dialogue, the learning from which can be used more flexibly to inform and shape outputs. **Co-design** involves people with lived and professional experience having a greater influence in shaping approaches and services, but still at this stage without responsibility for strategic decision-making or delivery. At the top of the hierarchy, **co-production** involves a more equal relationship between those using and providing services, in which the public as experts by experience have an even greater role and responsibility across more of the lifecycle of a service.

A ladder of public and professional involvement



- **Co-producing** – a more equal relationship between the people who use services and the people responsible for them. Experts by experience work with experts by profession from design to delivery, sharing strategic decision-making about services. They may also share in delivery. This can be with different levels of focus, for example designing how a whole service works, or as stakeholders in how shared accommodation is run.
- **Co-designing** – People who use services take a significant and more equal role in helping to design or improve them, based on their experiences and ideas. They have genuine influence, but are not responsible for strategic decision-making or delivery.
- **Engaging** - two-way, richer, more exploratory and open-ended dialogue, for example: understanding user experiences and points of view to inform proposals or an early version of a plan or project. Informs the work done by 'experts by profession'.
- **Consulting** - formal and structured two-way communication, often using questionnaires to confirm what ideas or approaches have the greatest public support. Consultation often seeks views and inputs to plans or proposals that are at a fairly advanced stage of development.
- **Informing and educating** – sharing accessible information with people for a variety of purposes, including: sharing knowledge about maintaining health; raising awareness of services and how to access them; motivating people to take positive action. Information may be universal or tailored, e.g. to groups facing greater health challenges or who are less likely to take up preventative services.

Informed by the Think Personal, Act Local 'Ladder of Participation'

In this journey, engagement and co-design opportunities are likely to be the key forms of rich dialogue initially enabled by this plan, while together building up collective understanding of using these

approaches effectively, and of the potential of co-production. Co-production, at the top of the hierarchy, requires sustained commitment and continuity also from participating service users, and is likely to lend itself particularly well, for example, to decision-making in the social care arena (where indeed it is already used) where people may be directly shaping their own lives.

The ambition and extent of what can be achieved in engagement has a number of dependencies including: working cultures, funding, staffing capacity, skills, and public appetite. This is addressed further below.

The objectives of this plan

The three core objectives of this plan are as follows:

1. To ensure that people have the information they need: to feel empowered to play a full role in maintaining their own health and wellbeing; to access health and wellbeing services to support them in living well; and, to take part in helping to shape services.

2. To increase the public's understanding and awareness of the role of the Rutland Health and Wellbeing Board in shaping the conditions for local health and wellbeing.

3. To more fully involve the public and professional stakeholders in informing the design and delivery of strategies, plans and services to respond to individual and local needs.

The rationale for these objectives, how they will be progressed and how they relate to the ladder of participation is set out below.

1. Ensuring people can access the information they need to maintain their health and wellbeing and navigate change.

The issue

People have told us that they want to play a full role in looking after their own health and wellbeing, and that they need the right information and advice to enable them to do this. This includes information that supports healthy lifestyles, e.g. relating to community life, getting active, looking after your mental health and more.

In parallel with public feedback about challenges in accessing health services, a consistent message from the public is that many people currently find it difficult to find out about health and wellbeing services and other opportunities available to them in Rutland. At the same time, not all of the services commissioned to promote health and wellbeing are always used to full capacity, even though the need for them can be demonstrated using local data. Lack of information about sources of support could affect people negatively, for example during times of change. They might miss out on accessing advice or services that could help them to manage change, leading in some cases to avoidable deterioration in their circumstances or even to crisis.

When they are facing concerns such as parenting challenges, anxiety, a new diagnosis, money worries or caring responsibilities, people need information which is relevant, clear and timely. They might access this directly, or approach organisations such as the Council, Family Hub - Best Start For Life, GP practices

or Citizens Advice, all of whom need to be aware not only of their own services but also what is available from others.

Another important purpose for communications is to keep the public up to date with how services are changing. Current health and care services are often quite different than services were a few years ago, but these changes have not always been clearly communicated to the public (e.g. a shift to day surgery rather than overnight hospital stays for planned care, potential for self-monitoring of e.g. blood pressure rather than GP visits for this, more people going straight home after hospital with 'reablement' at home while they recover rather than rehabilitation in a local hospital ward.

How we will use different types of communication to ensure people have access to the information they need

By working together on effective communications, we can help to make it easier for people to find out about the support and opportunities that are available to them wherever they live in Rutland and whatever their circumstances:

Educating and informing
• Health and care stakeholders will work collaboratively to publicise and promote services and opportunities to the public in an accessible, coordinated and inclusive way, innovating to reach key audiences, including those facing inequalities leading to worse health outcomes. • We will use different communications channels to maximise our reach, develop self-care skills and promote services and opportunities, including websites such as the Rutland Information Service, social media, print media and face to face opportunities, complementing and amplifying each other's campaigns. Wherever possible, we will enhance existing communications routes rather than creating new ones. • As a key shared platform, we will seek to make the Rutland Information Service better known, more accessible and easier to access on a mobile phone as this is how a growing proportion of people now access local information, including relating to their health and wellbeing. This has a dependency on funding. • We will develop tools including a visual brand and hashtags for Rutland partners' collective health and wellbeing messages to make communications more memorable and deliver greater impact. • We will equip a wide range of front-line workers across Rutland to signpost people to appropriate health and wellbeing services through a project called 'Making every contact count,' including self-service guides to services for professionals. • We will use communications to evolve people's 'mental maps' around health and social care services so that they feel better informed and more able to make choices, should they come to need these services.
Engaging, co-designing and co-producing
• We will involve the public and colleagues in the design of information platforms and campaigns to ensure that they meet the needs of different groups in Rutland. • We will work with the public and professionals and use the principles of behaviour change to shape what information and advice is delivered and how, so that this is more likely to inspire people to follow up or make a change.

2. Raising the profile of the Rutland Health and Wellbeing Board

The issue

Rutland's Health and Wellbeing Board (HWB) brings together local leaders from health, social care and the voluntary and community sector, who work together on behalf of the public to improve the prospects for local people to live long and healthy lives. Although they already meet in public and invite questions from them, and their meetings are often reported in the local press, they are still relatively little known. They would like the work of the HWB to be more visible to the public so that more people feel better informed about how services are shaped, what is likely to change over the next 5 years, and how they can get involved in this.

How we will use the different types of communication to raise the profile of the HWB

Educating and informing
• We will enrich the information available about the Health and Wellbeing Board and its role through dedicated web pages and print media. • We will use a range of pre-existing channels and newsletters to promote awareness of the Board, its members, its strategy and the progress being made on behalf of Rutland people. • At minimal cost, we will develop tools including a visual brand and hashtags for the Health and Wellbeing Board to give it a stronger public identity. • We will make it easier for people to find out about the Joint Health and Wellbeing Strategy and what it means for people. • We will produce accessible communications materials to disseminate the main business of the HWB. • Working with wider partners, we will look to align our communications about the HWB and Strategy with the other LLR 'Places' and the LLR system level so that it is easier for the public to be clear on how the different elements of the health and care system now fit together.
Consulting
• We will consult the public and professionals so that their views are taken into account in key HWB decisions, including for the Joint Strategic Needs Assessment, the Joint Health and Wellbeing Strategy and the Pharmaceutical Needs Assessment. • The HWB will promote wider health and wellbeing consultations so that the public are aware of the opportunities available to them to have their say and influence how policy and services are shaped.
Engaging, co-designing and co-producing
• The HWB will champion richer engagement with the public and workforce as integral tools in the design of policies and services. • They will provide challenge to the local health and care system around the depth and nature of involvement of the public and workforce in new proposals.

3. Involving the public and professional stakeholders in service design and change

The issue

There are areas of good practice in Rutland in designing services hand in hand with service users and rich engagement to understand what works, but engagement approaches that involve patients, service users and the workforce more deeply are not yet routine across all services.

At the same time, the public have told us that many of them actively want to be involved in the design and improvement of services, so that their lived experience can help to inform service design. It follows that there is more scope for the workforce and members of the public with lived experience to work together to problem solve and design service improvements together.

Increasing public involvement is an additional ask on individuals and teams and will need some level of resources to be allocated to building capability and capacity, and also to ensuring that members of the public participating in substantive engagement processes do not find themselves out of pocket as a result. This is addressed further below.

How we will increase the involvement of the public and professional stakeholders in service design and delivery

Educating and informing
• We will make it easier for people to find out about opportunities for them to have their say or to get involved in the design of local health and wellbeing services (whether through consultation, engagement, co-design or co-production). • We will make it clear which levels/types of engagement are being undertaken so that the expectations of all participants are clear. • We will communicate about the impact that the involvement of the public and workforce has had on plans and services, validating everyone's investment in this work ('You said, we did' – and, where the public and workforce are involved in shaping and delivering solutions together, 'We said, we did.')
Consulting
• Alongside richer, more interactive forms of engagement, formal consultation still has its place, particularly to invite views at the latter stages on more fully formed strategies or proposals. • Where we use consultation, we will work to ensure this is meaningful by consulting on proposals in line with government best practice and the four Gunning Principles. These are: that consultation is only legitimate if it takes place when proposals can still be influenced; enough information is provided for intelligent consideration; there is adequate time to consider and respond; and conscientious consideration is given to the responses before a decision.
Engaging, co-designing and co-producing
• We will put together a business case for developments strengthening the local capability and capacity around deeper forms of engagement in health and wellbeing and shape plans in this area based on available resources. • We will bring together a shared toolkit for good quality engagement that is realistic in its approach, building on established and recognised good practice in this domain. • Resources permitting, we will incrementally increase the amount and depth of joint working with the public and workforce to solve service challenges, working creatively within the constraints presented by time and resources, prioritising openness, active listening and creative problem solving. • We will build skills and confidence incrementally in engagement, starting on a small scale, with the workforce and members of the public learning together. • We will progressively instill an operating culture in which engagement, co-design and co-production as appropriate become routine parts of service design and change. We will use

different types of engagement to develop a shared understanding of the needs and potential of our communities and workforce, prioritising the voices of those with lived experience, whether as service users or professionals, and work together across different stakeholders to shape and improve services.

- We will use engagement to reduce health inequalities, targeting, involving and better understanding key populations who may be less often heard and who face specific disadvantages.
- We will apply principles which respect the time and contribution of those feeding in – for example, we must keep in mind previously gathered intelligence, and work to ensure that opportunities are accessible to all and that individuals are not out of pocket as a result of their participation. Where relevant, as an accelerator, we will seek to engage with pre-existing groups of individuals with lived experience in a given area rather than generating sets of participants from scratch each time (e.g. via carers support groups, disability forums, etc.).
- We will work to achieve continuous improvement in this area, learning both from what has gone well and what has not been so successful.

Overall principles and approach

A collaborative approach

We will take a **collaborative approach** to communications and engagement, and aim for **continuous improvement**, learning from local experiences and looking outwards to wider good practice and learning. In doing this, we will aim to make best use of the different communications resources and assets across different partners.

We will also work mindful of the fact that each organisation has its own requirements, norms, cultures and expectations around communications and engagement.

In our joint work, not everything will go perfectly, and the resulting opportunities to learn will help to inform future practice.

Communication and engagement are integral parts of service design and delivery.

This plan aims to embed an approach across the health and wellbeing community in which it is everyone's job to communicate and engage as an integral part of what they do. In particular, communications and engagement will be seen as integral to the planning of change, and promotion of services, not an add-on. The working group will work to support the development of this culture by establishing or identifying suitable guidance, toolkits and training opportunities. At the same time, projects or services will be responsible for organising their associated communications and engagement activities, and linking these into the wider network's activities, rather than this being the responsibility of the communication and engagement working group or communications leads.

The following principles will inform <u>communications</u> activities:

- **Clarity.** Brief plain English. Avoiding jargon. Acronyms avoided and explained if required.
- **Communicate in varied and appropriate formats and channels, chosen based on who needs to be reached.** Variety of communications channels to reach intended audiences, not disadvantaging those who are not online. Using different communication styles and channels for different age groups. Employing Easy Read and other visual approaches such as animated presentations and video

recordings where beneficial. Also considering who conveys messages as well as how they are conveyed, as that can increase credibility and impact.

- **Coordinate our communications activities to avoid audience fatigue.** Being selective about what are the high priority campaigns relative to Rutland's needs, and coordinating activity across partners so that messages are amplified not duplicated. A shared communications forward plan for key campaigns will facilitate this.
- **Informed by the need to reduce inequalities.** Tailoring communications approaches to reach more people who are disadvantaged, including in terms of their health, their income or their ability to access services.
- **Use and build on national and regional campaign resources.** We will align with wider communications campaigns, actively using Public Health and NHS campaign resources, and tailoring these campaigns to local circumstances.
- **Understand the audience, and what interests and inspires them.** Engage with audiences to understand how best to inform and empower them to maintain their health and wellbeing.
- **Use behavioural insights to shape effective messages.** Communication activities will be informed by better understanding what encourages people to act on information or make a change.
- **Evidence-based.** Using data and user insights, including from engagement, consultation, co-design and co-production, to inform communications.

The below principles, in turn, will inform richer <u>engagement</u> activities.

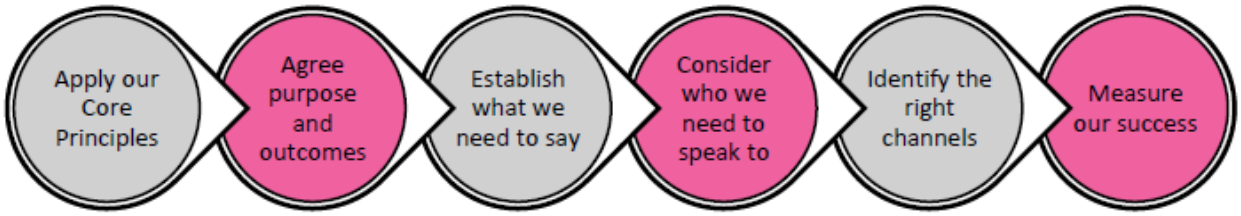
- **Timely.** Engagement is appropriately timed for meaningful input to change processes and helps to inform decisions.
- **Clear.** Again, plain English will help everyone to feel equal in contributing. Avoiding jargon and acronyms and explaining them if they are required.
- **Transparency about the scope to change.** Being clear up front about what type of engagement is proposed, how decisions will be made, any limiting constraints and what is and is not negotiable.
- **Two-way.** Placing the emphasis on listening. Mutual opportunities for everyone to gain a more rounded perspective.
- **Responsive.** Public feedback also guides what issues are prioritised for engagement.
- **Building on wider experience and expertise.** Including using toolkits from projects/areas with well-established and leading engagement practice.
- **Prioritising lived experience.** Those with first-hand experience of situations or services have the most to contribute to understanding them.
- **Engaging with existing groups of interested people where appropriate.** If there are existing groups with relevant experience (e.g. Patient Participation Groups, peer support groups for specific long-term conditions), they should be included in engagement. These approaches need to be validated to ensure that relevant first-hand experience is prioritised.
- **Being inclusive and accessible.** Working to reach people who are less often heard, at times and in places that are accessible by target groups. Using methods that make it easier for people to contribute and to feel comfortable doing this.
- **Engaging using different methods.** Employing a variety of engagement approaches to capture different inputs from different groups. Some may prefer workshops, others a one-to-one discussion.

Consider approaches that engage people's creativity, e.g. drawing 'rich pictures' to capture aspects of a situation figuratively, considering a letter or poem conveying lived experience.

- **Respecting people's time and resources, and their privacy.** Valuing pre-existing intelligence rather than repeating research. Sustaining trust by respecting the Data Protection rights of those feeding in and being clear about anonymity, how long data from engagements will be kept and how it will be used.
- **Squaring the circle. R**eporting back in a timely and systematic way on the difference that people's inputs made**.**
- **Over time, changing the culture around the balance of influence.** More equally valuing both the expertise of professionals and those with relevant lived experience.

A six-step approach to planning communications and engagement

To provide a consistent approach across communications and engagement for health and wellbeing, we will encourage partners to apply RCC's six step approach to communications planning as set out in the RCC Communications Strategy:



Key outcomes of the plan

Successful delivery of this plan aims to deliver the following key outputs and outcomes/impacts. At this stage, it is more straightforward to identify outputs than outcomes or impacts as we do not yet know in detail what will be supported through communications and engagement.

Objectives
1. Ensuring people have access the information they need to maintain their health and wellbeing and to navigate change successfully.
Outputs • Shared communications calendar with prioritised campaigns. • Joint and coordinated communications campaigns. Campaigns informed by behavioural insights and/or public engagement. • Trends in numbers of followers of key Rutland health and wellbeing social media accounts. • Visits/visitors to relevant websites including the Rutland Information Service and Rutland Health PCN website. • Number of front-line staff briefed under 'Making Every Contact Count' to use key information sources to make health and wellbeing recommendations to people. **Outcomes/Impacts**

- More positive qualitative feedback about people's awareness of how to find the services they need in Rutland.
- Improved take-up of target services contributing to JHWS aims e.g. shingles vaccination, weight management services, exercise referral.

2. Raising the profile of the Rutland Health and Wellbeing Board

Outputs

- Number of visitors to HWB web pages, followers of HWB related social media.
- Number of HWB health and wellbeing related posts
- Public attendance at HWB meetings
- Questions received at HWB meetings.
- Media coverage of HWB meetings

Outcomes/impacts

- Qualitative feedback on new approaches (complaints/compliments, social media responses, etc.) indicating whether the activity is responding to community needs.
- Wider outcomes/impacts are a contribution to the effective delivery of the JHWS and other HWB responsibilities, reported elsewhere.

3. Involving the public and professional stakeholders in service design and change

Outputs

- Locally defined/selected engagement/co-design/co-production toolkit
- Number of co-production and co-design exercises undertaken
- Number of people with lived experience involved in different forms of engagement.

Outcomes/Impacts

- 'You said, we did' changes – impacts of engagement.
- Qualitative feedback from engagement projects on the quality of engagement.
- Project-specific insight into whether/how engagement enhanced solutions.

Outline delivery plan 2023-24

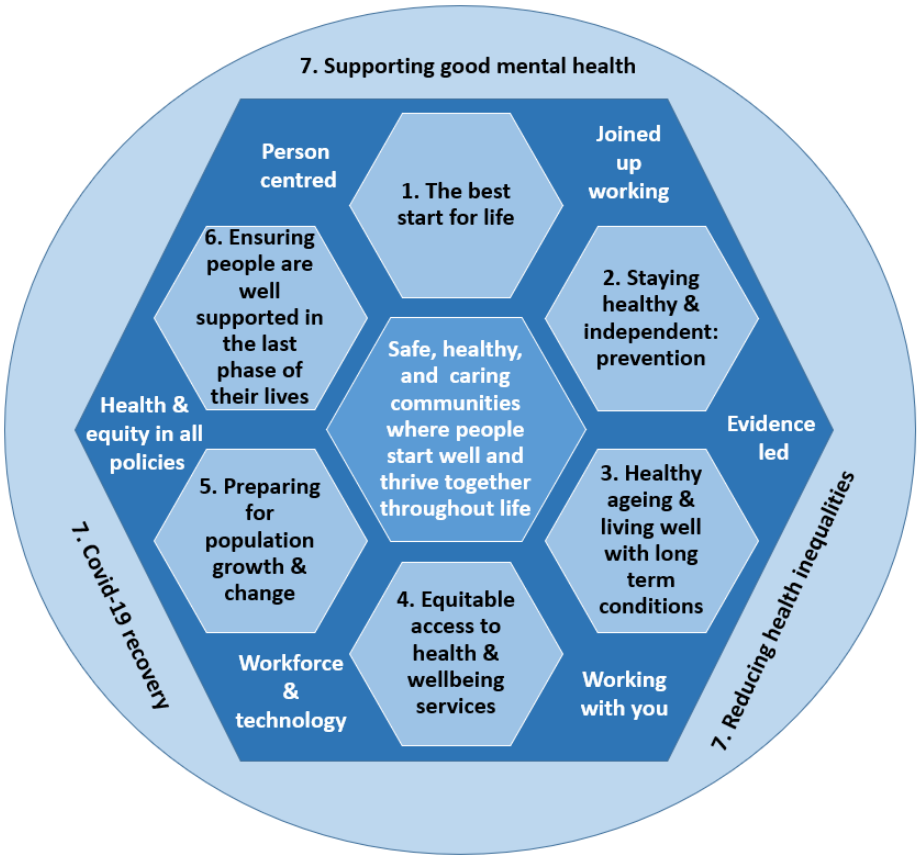
Action	Lead	Timetable
0. Readiness to deliver the plan		
Sustain communications working group through year 1 of the plan to support establishment of new ways of working.	Working group	Jan 2023 ongoing
Strengthening this plan through engagement with the public and professionals	Working group	Re-launch of working group Jan 2023
High-level audit of communications and engagement assets across involved partners (skills, resources, channels and tools) to help to plan coordinated approaches to communications (assets and gaps/opportunities).	Working group	Re-launch of working group Jan 2023
Agree scope to coordinate with system/ICS level communications activity and mechanisms – e.g. access to citizen panels.	LLR leads working together.	June 2023
Identify and deliver some 'quick wins' for local communications	Working group	June 2023
Reporting to IDG and HWB on communications and engagement activity and performance.	Working group	Ongoing
Annual report taking stock of overall performance and change.	Working group	2023-24 Q4
1. Ensuring people have access the information they need to maintain their health and wellbeing and to navigate change successfully		
Coordinate with ICB and places on a visual brand for health and wellbeing in Rutland	Working group	June 2023
Agreed approach for collaborative communications across health and care in Rutland. Including investigating mechanisms to engage Rutland's villages in improved communications. Focus to be given to communication and engagement with children and young people using social media platforms which they utilise. Also to include communications management	Working group	June 2023
Shared, rolling communications campaign calendar with selected campaigns prioritised and/or in common across the year – design, maintain, deliver.	RIS lead	2023 Q1-Q3
Training: Progress training opportunities including behavioural insights, social media.	Working group	2023-24
Link to local actions building digital confidence.	RCC Quality Assurance team (QA)	2023-2024
Enhance the Rutland Information Service (RIS) as a key shared source of information about local services and opportunities. • Develop RIS social media presence – bringing content to the online places people visit.	RCC Public Health	2023-2024

• Website technical code refresh for accessibility and ease of use via a mobile phone. • Using website usability testing to increase the effectiveness of RIS content.		
2. Raising the profile of the Rutland Health and Wellbeing Board		
Web content conveying the role and purpose of the HWB and inviting public involvement.	QA team	2023-24 Q2
Visual identity for the HWB – papers, web page, social media.	TBC	2023-24 Q2
Social media account for HWB health and wellbeing news/messages with shared hashtags.	RCC comms	2023-24 Q2
Ongoing promotion of HWB activity including public engagement opportunities in health and wellbeing change.	Working group	Ongoing
3. Involving the public and professional stakeholders in service design and change		
Business case setting out options for engagement activity depending on level of resourcing. *This activity has been taken on by Adult Social Care Improvement Officers in the RCC QA Team therefore business case no longer required as of March 23*	Working group *Now Improvement Officers*	March 2023
Potential LGA support to develop approach to increasing engagement. *As above – March 23*	Better Care Fund lead *As above*	TBC *As above*
Modest prioritised programme of engagement activity for year 1 of the JHWS supporting delivery of JHWS priorities.	Working group with priority and action leads	April – October 2023
Establish an engagement approach, including a toolkit for partners to use, drawn from wider best practice, including children and young people. To include: • Approach to compensation where required. • Existing groups who could be engaged. • How to reach less often heard groups and groups facing inequalities.	Working group to identify	Q2 2023
Engagement training. Improve representation of children and young people in health participation groups.	TBC	Dependency on resourcing.
Sharing of 'you said, we did' outcomes via the HWB and/or Rutland Information Service.	RCC QA team and working group	As required

Appendix 1: Summary of the Rutland Joint Health and Wellbeing Strategy 2022-27

Overall aim

The central aim of the JHWS is **'people living well in active communities'**. The strategy aims to nurture **safe, healthy and caring communities in which people start well and thrive together throughout their lives**. To deliver this aim, the five-year strategy has seven inter-related priority areas for action, supported by seven guiding principles or enablers.



Seven priorities for action

The seven priorities for action are set out in the above diagram:

1. Best start for life.
2. Staying healthy and independent: prevention.
3. Living well with long term conditions and healthy ageing.
4. Equitable access to health and wellbeing services.
5. Preparing for population growth and change.
6. Ensuring people are well supported in the last phase of their lives.
7. Cross-cutting themes.

Seven Guiding Principles and Enablers

- **Person-centred.** People told us they want a strategy that treats them as individuals and supports them to live independently with good health and wellbeing, building on their abilities and potential.
- **Joined up working.** We will build on Rutland's track record of integration and partnership to deliver the best value for Rutland, working together inclusively across sectors and communities to improve outcomes.
- **Evidence-led.** We will use a wide range of data to understand the health and wellbeing challenges of Rutland. We will learn what works by evaluating services and talking to service users. We will renew the Rutland Joint Strategic Needs Assessment (JSNA), using new Census data available from April 2022, to inform targeting and funding decisions.
- **Working with you.** We will develop a communications and engagement plan to ensure that changes are informed by listening to what local people, including those from seldom heard groups, need from health and wellbeing services. Professionals and service users will work alongside each other to inform service design and improvement.
- **Workforce development.** Our workforce is vital to driving change and improving health and wellbeing in Rutland, but it is under pressure due to growing needs. We will continue to develop our integrated workforce, making Rutland an attractive place to work and thrive.
- **Information sharing, supported by technology.** We are committed to using technology and appropriate information sharing to guide, inform and improve patient care.
- **Health and equity in all policies and plans.** The Health and Wellbeing Board will ask all partners to consider the potential impact of all their plans on health, wellbeing and equity, so that more opportunities are taken to make Rutland a healthy place for all.

Building on previous joint working, this strategy provides a new opportunity for a wider range of partners to work together on key priorities to improve health and wellbeing across Rutland as part of the evolving LLR Integrated Care System.

Some actions will be delivered at system level (LLR), and these will be carefully reviewed through the newly developed LLR Integrated Care Partnership and translated to Rutland by the HWB. The HWB will also evolve its approach to ensure effective support, monitoring, engagement and co-design during implementation of the strategy.

Inevitably, needs and priorities may change over time. For this reason, the HWB will review action plans on an annual basis to ensure these priorities are still the right ones. The overall action plan will be supplemented by a specific implementation plan for each financial year with clear commitments and timescales from the various participating partners.

Appendix 2: Public feedback relating to communications and engagement

The **What matters to you?** report commissioned by the Council from Healthwatch Rutland in 2021 brought forward a range of feedback about communications, while the public consultation on the draft Joint Health and Wellbeing Strategy received feedback about increasing public involvement in designing plans and services. Key themes are highlighted below, with examples of what people said.

Communications-related feedback

Difficulties in finding out what services and opportunities are available to them to support their health and wellbeing;

- Information is always a problem; some people know about some things and not about others. We really must get that sorted.
- I think there are things to do and join but they are not advertised. People don't know [about them] (young person)
- What we need is a central person or point of contact for signposting. Someone who knows both about health services and social services who has all the info [...] Like a liaison officer that we could go to (parent).

A wish to have access to the information they need to care for themselves and make timely and informed choices.

- The Rutland County Council COVID support letter was brilliant – it gave loads of support.
- During one of my annual check-ups about 3 years ago they said I was borderline with diabetes and offered me a course. I learned so much. It was a whole year, meeting monthly at Empingham community centre and it was fantastic. There were 25-30 people there, all singing their praises, saying how much they had learned. It was run by someone from the NHS in Leicester and should definitely carry on being offered locally.
- We want to learn about preventative things to stop things happening (parent).

Not wanting to see an over-reliance on digital channels which could exclude those who are not online.

- We have a community centre in Greetham and the village shop is excellent for keeping people informed. We also have a village newsletter.
- [Rutland Radio] used to be very good. If you got into somebody's car nearly everybody would have Rutland Radio switched on. Now it's gone 'internet only', so people can't listen to it in their cars.
- Libraries can be an important local hub for information to keep people involved but they are closed, of course, as well [due to COVID-19].
- Informed Parish Councils could disseminate this information in their parish newsletters but they would need briefing.
- I should like to take this opportunity to say that we must not expect or rely on patients using emails, texts and websites. I should also like to stress the need for clearly laid out text, with vocabulary that is in everyday use, when any information is provided in a written form.

Engagement-related feedback

A willingness among many to share their experiences and views of care to help to inform and shape service improvements.

In the Joint Health and Wellbeing Strategy consultation, people were asked what role they could play in helping to deliver the strategy. In addition to looking after their own health and that of those around them, the most frequent answers related to an appetite for greater engagement:

- Willing to provide comments and support.
- Continue to give customer feedback with a background in dealing with the disadvantaged.
- To be proactive in communicating what is working or not working in our local community.
- I don't know - what are the options for me to get involved?
- By providing effective feedback on any problems to our GP practices, hospitals and other health services, and to the Board.
- Being aware of all the changes being made and responding; following Healthwatch; belonging to PPG.
- Keep everyone in the loop, invite the public to meetings to ensure we can all support the six priorities.
- Provide a patient-oriented perspective and work as a volunteer with commercial and healthcare experience to help strengthen the Rutland HealthPlan. Appoint a patient advisory panel to work with RCC HWB and LLR ICB on the county's plan.
- Via actual experiences.
- I encourage RCC to continue to interact with your constituents as these strategies are developed into specific plans.
- I would be willing to support by providing feedback and by volunteering.
- Critical comment only.

Appendix 3: Rutland's Communications and Engagement Strengths, Weaknesses, Opportunities and Threats (SWOT)

Strengths	**Opportunities**
• Health and care a theme the public cares about • Future Rutland Conversation – the public have already fed in views. • 'What matters to you?' – surfacing consistent findings across engagements. Helps guide confident next steps. • Long tradition of positive health and care integration - close working across teams already, good mutual understanding across services • Successful joint Covid vaccination campaigns • Existing links into seldom heard groups – e.g. travellers, armed forces. • Boosting each other's comms already, albeit reactively • Rutland Information Service – c1000 diverse local opportunities advertised. • Skills, knowledge and resources of partners including comms channels	• New census data due out – Rutland insights • The collaborative process of building a joint comms/engagement plan. • Progress to build on e.g. digital progress during Covid. • Feedback indicates the public want to be more involved in shaping services. • Healthwatch Rutland's expertise and links • Multi-channel communications to reach more groups, including non-digital. • Routes into less heard groups • Appetite of HWB and partners to engage and involve. • Nudge techniques, behavioural science – potential to have more impact. • National guidance on Place includes co-design – encouragement to embed. • Potential sources of future funding • LCC Public Health campaigns – potential to adapt for Rutland
Weaknesses	**Threats**
• Insufficient communication to date about available services and progress – people don't know what is there or how/why it is changing. • No shared brand for health and wellbeing in Rutland – impression of many apparently unconnected services/changes • Some public information is out of date. • Are the people with the most lived experience being heard? • Limited co-production so far – not the norm • Over-reliance on digital channels? • Don't always reach everyone or approach them in the best way e.g. seldom heard groups, digitally excluded, young, learning disabilities. • Limited coordination between stakeholders with shared aims • No existing pool of citizen volunteers to call on	• Have done a lot of engagement recently – need to follow up on this or could lose trust/willingness. • Inequalities can be hidden in Rutland and may not get the attention needed – need to understand and involve all. • Public wants to be involved at a policy level – we also need to engage around a more practical level. • Potential reluctance for change among parts of the public • Lot of potential 'asks' of the public –the 'fight for people's attention' – will need to be creative and prioritise well. • No additional resources confirmed. • Not straightforward to change human behaviours through communications. • Reaching everyone – not everyone has access to digital information

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Report No: 151/2023
PUBLIC REPORT

RUTLAND HEALTH AND WELLBEING BOARD

10 October 2023

AREA SEND INSPECTION REPORT

Report of the Strategic Director of Children and Families

Strategic Aim:	Healthy and well	
Exempt Information	No	
Cabinet Member(s) Responsible:	Cllr T Smith, Portfolio Holder for Children's Services	
Contact Officer(s):	Dawn Godfrey, Strategic Director of Children and Families	01572 758358 dgodfrey@rutland.gov.uk
	Bernadette Caffrey, Head of Early Intervention, SEND and Inclusion	01572 720943 bcaffrey@rutland.gov.uk
Ward Councillors	NA	

DECISION RECOMMENDATIONS
That the Board: 1. Notes the Area SEND inspection outcome and the Delivering Better Value (DBV) Programme progress.

1. PURPOSE OF THE REPORT

1.1. To inform the Board of the outcome and present the findings of the Area SEND inspection and recommendations for future development.

2. BACKGROUND AND MAIN CONSIDERATIONS

2.1. Rutland County Council and Leicester, Leicestershire, and Rutland Integrated Care Board (ICB) are jointly responsible for the planning and commissioning of services for children and young people with SEND. This Local Area Partnership was inspected by Ofsted and the Care Quality Commission (CQC) in May 2023. The purpose of the inspection was to evaluate the effectiveness of arrangements for children and young people with SEND and recommend where any improvements could be made across all education, social care and health services working in the Rutland area.

2.2. The inspection looked closely at what it is like to be a child or young person with SEND in Rutland. Inspectors spoke directly to children and families, as well as professionals who are responsible for leading and delivering local services, including Rutland County Council, schools, and providers of health services, such as Leicestershire Partnership

NHS Trust. The inspectors determined that: “The local area partnership’s arrangements typically lead to positive experiences and outcomes for children and young people with special educational needs and/or disabilities (SEND)” (Appendix A).

2.3. The inspection highlighted the following areas for improvement:

- ICB leaders should ensure that they set measurable targets to reduce waiting times and provide effective support for children and young people awaiting neurodevelopmental and mental health assessments.

- ICB leaders should ensure that specialist health needs for ‘service children’ and those who access a general practice outside of Rutland are assessed and met.

- Leaders across the partnership must ensure that they work together to further improve their joint planning and oversight arrangements using robust data.

2.4. The DBV Programme is commissioned by the DfE and supports 55 Local Authorities (LA), and their local systems to identify the highest impact changes that each system involved can make to better support their local children with SEND and make plans to implement those changes. The programme places children and young people with SEND at the centre of the approach and decision making. The implementation plans will build on existing initiatives and address the underlying challenges in each LA’s high needs systems.

2.5. The Programme involves local partners, parent and carers and our front-line staff and ensures the programme is underpinned by a comprehensive data-driven and evidence-led diagnostic. Rutland has completed the diagnostic phase and has submitted its application for an implementation grant offered by DfE. (Ref: DBV presentation).

3. ALTERNATIVE OPTIONS

3.1. Not applicable.

4. FINANCIAL IMPLICATIONS

4.1. There are no direct implications from the decisions request in the report. The financial information below gives financial context to SEND within Rutland

4.2. The position as at the end of financial year 2022/23 on the Dedicated Schools Grant is as per the table below.

Dedicated Schools Grant (DSG)	**Schools**	**High Needs**	**Early Years**	**Central Schools**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**
(Surplus) / Deficit from 2021/22	**(1)**	**1,257**	**(107)**	**(69)**	**1,081**
DSG Allocations prior to recoupment	(28,367)	(5,272)	(1,718)	(184)	(35,540)
Transfer between blocks	142	(142)	-	-	-
Academy Recoupment	26,348	310	-	-	26,658
Total Funding	**(1,877)**	**(5,104)**	**(1,718)**	**(184)**	**(8,882)**
Expenditure in Year					
Schools’ allocations	1,882	-	-	-	1,882
Nationally Agreed School Licences	-	-	-	41	41
Admissions Service- staffing costs	-	-	-	61	61
Statutory & Retained Duties	-	-	-	65	65

Education for under 5's	-	-	83	-	83
3 & 4 Year Old Funding	-	-	1,519	-	1,519
2 Year Old Funding	-	-	115	-	115
SEN Funding Maintained Schools and Academies	-	3,033	-	-	3,033
SEN Funding Post 16	-	159	-	-	159
SEN Recovery Plan Expenditure	-	246	-	-	246
SEN Funding - Independent Special Schools	-	1,113	-	-	1,113
SEN Funding EOTAS & Tuition	-	569	-	-	569
SEN Staff Recharge	-	197	-	-	197
Early Years Inclusion (SENIF)	-	45	-	-	45
Total Expenditure	**1,882**	**5,362**	**1,717**	**167**	**9,128**
(Under) / Overspends in 2022/23	**5**	**258**	**(1)**	**(17)**	**245**
(Surplus) / Deficit to 2023/24	**4**	**1,515**	**(108)**	**(86)**	**1,325**
SEN = Special Educational Needs					

4.3. The DBV implementation plan sets out key priority actions specific to Rutland, including addressing recommendations set out in the CQC and Ofsted report, for example, improved and robust data to inform effective commissioning and strategic planning, which will be underpinned by £1m grant from DfE.

4.4. The SEND Recovery Plan initiatives currently mandated and funded via School's Forum will be continued. Sustainable positive SEND system change and development will be a key measure of success of the DBV programme.

5. LEGAL AND GOVERNANCE CONSIDERATIONS

5.1. The Rutland Area SEND Strategic Partnership Board provides leadership in delivering a Programme in support of SEND strategic partnership planning, the Delivering Better Value Programme and utilising the DfE SEND Capital funding in support of outcomes for children and young people in Rutland (Appendix B).

5.2. The Partnership Board, through co-production with the SEND community, will revise the current Rutland SEND and Inclusion Strategy informed by the findings of the CQC and Ofsted inspection process, and the priorities identified in the DBV Implementation Plan, and will reflect the direction set by the national SEND and Alternative Education Plan.

6. DATA PROTECTION IMPLICATIONS

6.1. None

7. EQUALITY IMPACT ASSESSMENT

7.1. Not required as report is for information only.

8. CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

8.1. The Board should note the excellent inspection outcome and the high level of service children and young people with SEND experience in Rutland.

9. BACKGROUND PAPERS

9.1. None

10. APPENDICES

10.1. Appendix A - Area SEND Inspection Report.

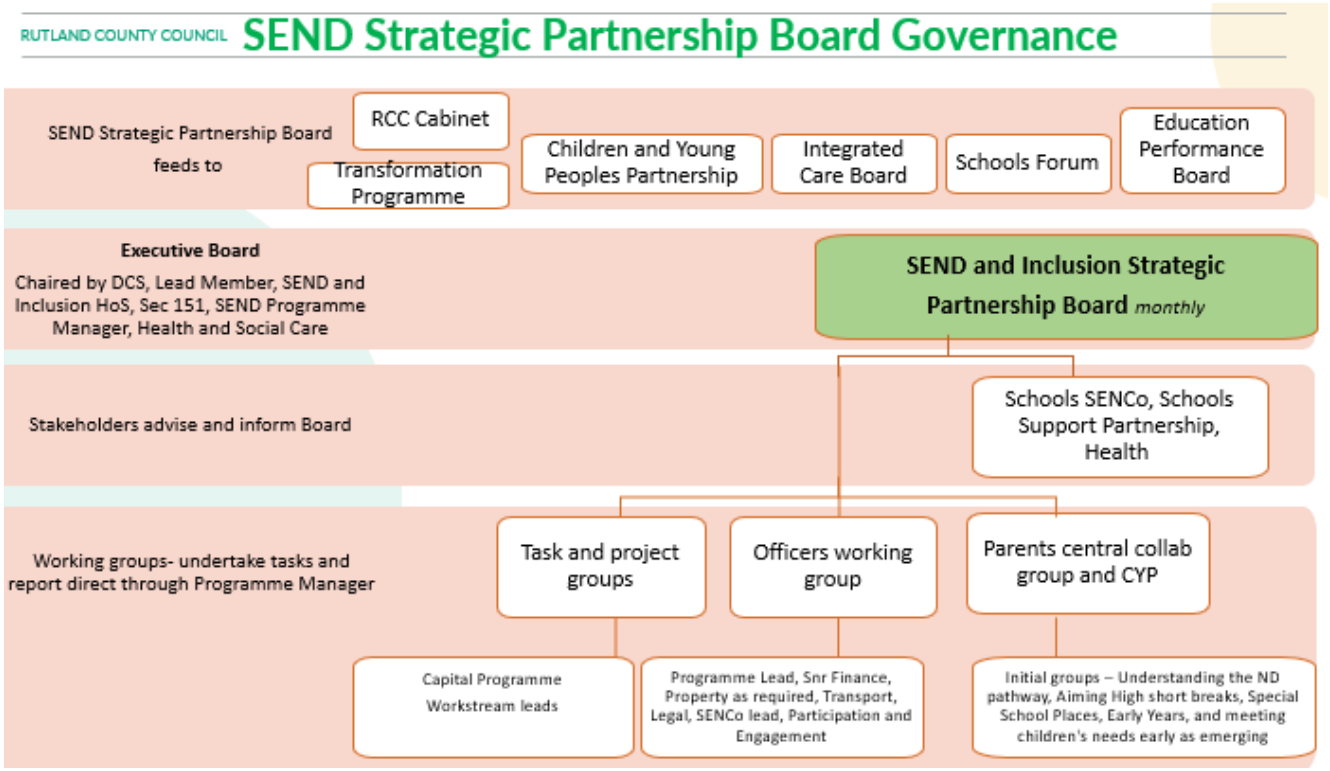
10.2. Appendix B - SEND Governance Structure.

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

APPENDIX A: AREA SEND INSPECTION OF RUTLAND LOCAL AREA PARTNERSHIP

https://files.ofsted.gov.uk/v1/file/50225252

APPENDIX B – SEND Governance Structure



Area SEND inspection of Rutland Local Area Partnership

Inspection dates: 15 to 19 May 2023

Date of previous inspection: 10 to 14 July 2017

Inspection outcome

The local area partnership's arrangements typically lead to positive experiences and outcomes for children and young people with special educational needs and/or disabilities (SEND). The local area partnership is taking action where improvements are needed.

The next full Area SEND inspection will be within approximately 5 years.

Ofsted and CQC ask that the local area partnership updates and publishes its strategic plan based on the recommendations set out in this report.

Information about the local area partnership

Rutland County Council and Leicester, Leicestershire and Rutland Integrated Care Board (ICB) are jointly responsible for the planning and commissioning of services for children and young people with SEND in Rutland. This is a small local authority, and many of the acute health services and further education providers are located outside of Rutland.

There have been changes to the local area SEND leadership since the last inspection. A new director of children's services has been appointed. The commissioning of health services changed across England in 2022. On 1 July 2022, Leicester, Leicestershire and Rutland ICB became responsible for the commissioning of health services in Rutland.

The local authority commissions full-time alternative provision for children and young people through its inclusion team. The provision includes a combination of one-to-one tuition and part-time placements in unregistered alternative provision. The local authority maintains suitable oversight of these placements. This offer provides support for some pupils whose health needs have led to extensive periods of non-attendance at mainstream secondary schools. Additionally resourced provision in mainstream primary and secondary schools provides support for pupils with social, emotional and mental health needs as well as those with communication and interaction needs.

What is it like to be a child or young person with SEND in this area?

Children's and young people's voices are heard and acted on. Groups such as the Rutland disabled youth forum have contributed significantly to the review of the 'local offer'. The local authority's pledge to parents and carers to improve communication has led to more parents feeling that their voice is heard. The voice of the child and young person as well as their parents comes across strongly in most education, health and care (EHC) plans.

Most children and young people in Rutland benefit from an early and effective identification of their additional needs. Health visitors consistently deliver the five mandated developmental checks as part of the healthy child programme. This provides for the effective identification of any unmet needs. High-quality inclusion support for practitioners in the early years provides them with the confidence to identify and assess children's needs. Those families who require support through early help are typically identified in a timely way. Social workers provide welcome support and information for parents about how to manage and provide for the emerging needs of their children.

Children and young people benefit from an effective school support programme. There has been a significant improvement in the identification and assessment of the needs of children and young people in mainstream schools. For example, pupils who require it benefit from access to speech and language therapy within a few weeks. The anxiety related non-attendance project has led to the accurate identification and coherent support of children's and young people's mental health needs.

Children and young people are well supported by targeted coaching through the local area's 'thriving through change' approach. This is helping children and young people with SEND understand and prepare for changes in their education, including when moving to alternative provision or post-16 settings. This helps to provide a settled start to their new education provision.

Effective and timely preparation for adult life equips children and young people with the skills and knowledge they need for their next steps in education or employment. Where young people with SEND need support from adult social care, teams work closely together to ensure that they experience a smooth transition to their next social worker. This was highlighted by parents expressing views that their children are 'thriving' and 'living their best possible life' due to the support they receive.

Children and young people with SEND achieve typically positive outcomes across education, health and care. Many achieve excellent educational results. Their placements are ambitious and meet their needs. The number of those who progress into further education or employment is high.

Many more children and young people now access their education close to where they live. This allows them to participate in community activities. 'Aiming higher' programmes and personal assistants enable young people to enjoy activities with their friends.

However, due to long waiting times, there is limited access to overnight short break activities, which leads to some children, young people and families' needs not being met.

Some children and young people with SEND are waiting too long for some specialist health assessments, according to national guidance, including those waiting on the neurodevelopmental pathway and child and adolescent mental health services.

What is the area partnership doing that is effective?

- Leaders are ambitious for children and young people with SEND. They have a vision to remove barriers to opportunity, to improve equality of access and to enable children and young people to achieve their maximum potential. The introduction of the targeted school support programme is an example of how leaders are realising this vision.
- All partners are committed to improving local services to meet individual needs. They listen to key stakeholders and make changes based on their input, such as redesigning the local offer website to make it more accessible. School leaders have a shared ambition for an inclusive approach to SEND provision across schools in Rutland, which allows more pupils to access education locally.
- Education and social care leaders know the families they support well and understand the issues they face. They are able to respond quickly to the changing needs of families. Leaders have improved their response to parents' requests for EHC plan assessments. All assessments are completed within statutory timescales. Leaders have ensured that additional training for staff on the SEND panel has led to more accurate assessments and to less parents having to challenge the decisions they make.
- Leaders from across the partnership have high aspirations for looked after children who have SEND. Their knowledge of these children and their commitment to them help to ensure that the needs of this vulnerable group remain a high priority. Relationships between social workers and families are strong. Children and young people known to social care benefit from regular multi-agency meetings, in which their plans are reviewed and amended where required.
- Leaders have provided training to practitioners to ensure that EHC plans more accurately represent children's and young people's needs and aspirations. The quality of these plans has improved as a result. Social workers and health professionals work closely with children and young people, including those who do not use words to communicate, to ensure that plans reflect their needs and wishes. Practitioners make sure that most plans are regularly updated with accurate information and their current targets.
- Leaders have introduced the school support programme across all primary and secondary schools. This programme has transformed the provision for pupils at the SEND support level. Pupils now have timely assessments and early interventions from health professionals, which means they can continue to access and benefit from their school placement.

- The dynamic support register (DSR) has been mapped against the minimum standards. The team's responsiveness in arranging care, education and treatment reviews is a strength. Leaders have ensured that the DSR is underpinned by an effective risk management process. The risk ratings give clear indications of needs and suggested actions for practitioners working with the children and young people. This support means that more of the needs of children and young people can be met without admission to hospital.
- The members of the teen health team carry out effective, bespoke packages of care and support during their one-to-one sessions with young people. The sessions follow evidenced-based practice to ensure that young people's individual needs are met, for example advice and support for healthy eating, exercise, relationships, drugs and alcohol, emotional well-being and happiness. Young people receiving this support comment positively about the progress they are making as a result of these sessions.
- Leaders have successfully commissioned effective alternative provision as well as additionally resourced provision in mainstream schools. Pupils accessing these provisions speak positively about the tailored support they receive and how it leads to the achievement of their targets and successful preparation for their next steps. Leaders regularly check the quality of the alternative provision they commission to ensure that it continues to meet the needs of all young people. Leaders have developed strong working relationships with key providers, which ensures effective sharing of information.
- Partnership leaders are starting to work more closely together to evaluate provision. Their recent joint review, with the parent carer forum, of a large number of EHC plans led to some of the more recent improvements in the quality of these documents.

What does the area partnership need to do better?

- Due to neuro-developmental and mental health assessments not taking place in a timely manner, some children and young people are not getting the right support at the right time. Although families do have access to a range of neuro-developmental workshops and resources while they wait, this provision is not mirrored for mental health support.
- ICB leaders' oversight and strategic planning for 'service children' with SEND living on military bases, and children and young people supported by a general practitioner outside of Rutland, are not fully implemented. This has led to a gap in support for these families. The plans leaders have in place to address this have not yet had an impact for children and young people and their families.
- ICB leaders' use of health information and data to establish, advance and monitor priorities and outcomes is underdeveloped. Leaders are aware of these issues and have started to refine their data for the local area.

- Historically, the local area partnership's strategic approach has not always included all partners equally. This is reinforced by the partnership's self-evaluation, which has a strong education focus. While planning is effective at a local level, strategic plans do not always demonstrate how partners are effectively working together to commission services. More recently, there is evidence that joint strategic working has strengthened and is starting to have a positive impact on the outcomes of children and young people with SEND.
- Outcomes for children and young people are typically positive across education, health and care. However, complex oversight and accountability systems mean leaders cannot easily assure themselves of this.

Areas for improvement

ICB leaders should ensure that they set measurable targets to reduce waiting times and provide effective support for children and young people awaiting neuro-developmental and mental health assessments.
ICB leaders should ensure that specialist health needs for 'service children' and those who access a general practice outside of Rutland are assessed and met.
Leaders across the partnership must ensure that they work together to further improve their joint planning and oversight arrangements using robust data.

Local area partnership details

Local Authority	Integrated Care Board
Rutland County Council	Leicester, Leicestershire, and Rutland Integrated Care Board
Dawn Godfrey, Strategic Director Children and Families	Caroline Trevithick, Chief Nursing Officer and Deputy Chief Executive.
www.rutland.gov.uk	www.leicesterleicestershireandrutland.icb.nhs.uk
Catmose House Catmose Street Oakham Rutland LE15 6HP	Room G30, Pen Lloyd Building County Hall Glenfield Leicester LE3 8TB

Information about this inspection

This inspection was carried out at the request of the Secretary of State for Education under section 20(1)(a) of the Children Act 2004.

The inspection was led by one of His Majesty's Inspectors (HMI) from Ofsted, with a team of inspectors, including two HM'I/Ofsted Inspectors from education and social care, a lead Children's Services Inspector from Care Quality Commission (CQC), and another Children's Services Inspector from the CQC.

Inspection team

Ofsted

Dave Gilkerson, Ofsted HMI lead inspector

Maire Atherton, Ofsted HMI

Matthew Rooney, Ofsted Inspector

Care Quality Commission

Lyndsey McGeary, CQC lead inspector

Kaye Goodfellow, CQC inspector

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Report No: 149/2023
PUBLIC REPORT

RUTLAND HEALTH AND WELLBEING BOARD

10 October 2023

RUTLAND MENTAL HEALTH NEIGHBOURHOOD STRATEGY AND ACTION PLAN

Report of the Portfolio Holder for Adult Care and Health

Strategic Aim:	Neighbourhood approach to Mental Health support	
Exempt Information	No	
Cabinet Member(s) Responsible:	Councillor Dianne Ellison, Portfolio Holder for Adult Care and Health	
Contact Officer(s):	Mark Young, Senior Mental Health Neighbourhood Lead	myoung@rutland.gov.uk
	Emmajane Hollands, Head of Service Community Care Services	ehollands@rutland.gov.uk
Ward Councillors	N/A	

DECISION RECOMMENDATIONS
That the Committee: 1. Approve the Rutland Neighbourhood Mental Health Strategy 2023-2027 and Rutland Neighbourhood Mental Health Action Plan 2023-2027 for the Rutland Mental Health Neighbourhood Group, which are attached as Appendix A and B to this report.

1 PURPOSE OF THE REPORT

The purpose of this report is to seek the Health and Wellbeing Board's approval for the Rutland Neighbourhood Mental Health Strategy 2023-2027 and Rutland Neighbourhood Mental Health Action Plan 2023-2027 for the Rutland Mental Health Neighbourhood Group, which is a subgroup of the Rutland Health and Wellbeing Board.

2 BACKGROUND AND MAIN CONSIDERATIONS

2.1 Mental health is an important area reflected in the recognition and commitment to parity of esteem in national strategies by which mental health and physical health must be given equal priority, an approach which is enshrined in law by the Health and Social Care Act 2012 and the recent Health and Care Bill 2022, which became

law in April 2022.

2.2 The Rutland Mental Health Neighbourhood Group brings partners together in Rutland to lead on driving, coordinating and enabling mental health transformation within Rutland. The Rutland Mental Health Neighbourhood Group will work with the Rutland Health and Wellbeing Board, local authority, local VCS partners and local health organisations to set local priorities and take informed local decisions on implementation.

2.3 There is recognition within the Rutland Joint Health and Wellbeing Strategy: The Rutland Place based plan 2022 – 2027 for the need to address and improve mental health which is recognised as a cross-cutting priority. In this plan, this group will aim to deliver specific actions:

- 7.1.1 - Increase access to perinatal mental health support services.
- 7.1.2 - Understand the gaps in service reported by service users where children and young people need help with their mental health.
- 7.1.3 - Increase local resource to respond to children and young people's mental health.
- 7.1.4 - Creating a local plan to better coordinate care for mental health across neighbourhood service areas.
- 7.1.5 - Increased response for low level mental health issues.
- 7.1.6 - Long-term objectives to deliver an integrated neighbourhood approach to mental health needs in Rutland are met.

3 CONSULTATION

3.1 A collaborative approach including members from the local authority, local VCS partners and local health organisations have discussed the strategy and action plan. The Rutland Mental Health Neighbourhood Group will discuss each action and seek to reach conclusions by consensus, which will be evidence-based or underpinned by the most relevant information we have at that point in time.

4 ALTERNATIVE OPTIONS

4.1 Not applicable

5 FINANCIAL IMPLICATIONS

5.1 Where it is deemed relevant, the group will assess any funding opportunities. By using local data and evidence-based insights to support neighbourhoods with information and themes, we can better enable them to design initiatives to meet local needs.

6 LEGAL AND GOVERNANCE CONSIDERATIONS

6.1 The Rutland Mental Health Neighbourhood Group is a sub-group of the Rutland Health and Wellbeing Board.

6.2 The group is also part of the LLR Mental Health collaborative governance. Collectively, this brings together three Place-based Mental Health groups from Rutland, Leicester City and Leicestershire alongside the LLR Mental Health Collaborative Group. The collaborative governance feeds directly into the Integrated Care Board. The Place-based groups are not subordinates to the collaborative group but will work together to form the Mental Health Collaborative for the Leicester, Leicestershire and Rutland system.

7 DATA PROTECTION IMPLICATIONS

7.1 Data Protection Impact Assessments (DPIA) will be undertaken for individual projects as and when required to ensure that any risks to the rights and freedoms of natural persons through proposed changes to the processing of personal data are appropriately managed and mitigated.

8 EQUALITY IMPACT ASSESSMENT

8.1 An Equality Impact Assessment (EqIA) will be completed for each project by the group. For the strategy, work in this area will provide positive impact to all Rutland residents.

9 COMMUNITY SAFETY IMPLICATIONS

9.1 Having a safe and resilient environment has a positive impact of health and wellbeing and people's mental health. There are no specific community safety implications, and we will continue to work closely with our neighbourhood partners to build strong and resilient relationships across Rutland.

10 HEALTH AND WELLBEING IMPLICATIONS

10.1 The Rutland Mental Health Neighbourhood strategy and action plan will bring local partners to work together effectively with the aim to enable positive mental health transformation within Rutland, which will look to enhance the health and wellbeing of the local population.

11 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

11.1 We want the people in Rutland to live long and healthy lives. By ensuring that support for their mental health needs is met using the data already researched that shows any current need and gaps, as well as working closely with the local population, will be key to seeing this vision realised. To achieve this, the collaborative group will discuss each action and agree on how we will deliver this, as well as how we can measure the effectiveness and success of the work. The strategy and action plan will identify the needs of people living within Rutland, being locally informed and responsive to local populations. We are therefore looking to have the Rutland Neighbourhood Mental Health Strategy 2023-2027 and Action Plan approved for the Rutland Mental Health Neighbourhood Group.

12 BACKGROUND PAPERS

12.1 There are no additional background papers to the report.

13 APPENDICES

13.1 Appendix A – Rutland Mental Health Neighbourhood Strategy 2023-2027

13.2 Appendix B – Rutland Mental Health Neighbourhood Action Plan 2023-2027

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

Rutland Neighbourhood

Mental Health Strategy

2023-2027

Contents

Introduction

Wellbeing starts with people: our connections with family, friends and colleagues; the behaviour, care and compassion we show one another; the environment we create to live in together.

Mental health is integral to overall health, and recognised as being fundamental to growth, development, learning and resilience. Accordingly, the social, physical and economic environments in which people are born, grow, live, work and age have important implications for mental health. The support needs of people experiencing mental health difficulties therefore extend beyond health service provision and into wider public services.

This strategy aims to take a preventative approach by addressing the wider factors that influence mental wellbeing as well as ensuring that we have responsive high-quality services and support available. It covers all ages from birth to death, not only linking to the 7 Priorities within the Health and Wellbeing Board strategy, but also the Maternity transformation programme, enabling young people to grow into independent adults and positive citizens.

Wellbeing encompasses social, emotional, and mental wellbeing. It can be best summarised as feeling good and functioning well. Poor mental health is both a cause and consequence of overall health inequalities due to its associations with physical health, employment, housing, and lifestyle factors. People with severe and prolonged mental illness die 15-20 years earlier on average than others. At all ages traumatic experiences, poor housing, or homelessness, being part of a marginalised group, or having multiple needs such as a learning disability or autism are all associated with increased risk of mental health problems and may also limit access to support.

Physical and mental health are inextricably linked. Mental wellbeing and resilience are protective factors for physical health as they reduce the prevalence of risky behaviours such as smoking, substance misuse and unhealthy eating, which are often used as coping mechanisms in the absence of other support. Conversely, people with cancer, diabetes, asthma, and high blood pressure are at greater risk of a range of mental health problems such as depression, anxiety, and PTSD.

This strategy details how we aim to improve mental health and wellbeing in the community in Rutland for the next 4 years to 2027, through strong integration between health and social care, and the voluntary and community sector (VCSE). This is about supporting recovery, but also preventative measures including staying well and reducing further deterioration. Pooling knowledge and resources through collaborative working between health and social care is paramount, with a focus on local needs and a strength-based community approach.

The Rutland Mental Health Neighbourhood Group will bring partners together in Rutland to lead on driving, coordinating, and enabling mental health transformation within Rutland. The group will be responsible to deliver the new Rutland Mental Health Neighbourhood strategy by working towards an integrated neighbourhood-based approach to meeting mental health needs in Rutland.

We want the people in Rutland to live long and healthy lives. By ensuring that support for their mental health needs is met using the data already researched that shows any current need and gaps, as well as working closely with the local population, will be key to seeing this vision realised.

What do we mean by mental health and wellbeing?

Mental wellbeing includes both our feelings, such as contentment and enjoyment, and our ability to function well in our lives and to engage with the world. It could be summarised as living in a way that is good for us and for others.

Many factors can have a positive influence on mental wellbeing, these are considered protective factors and include things such as:

- Enhancing control
- Individual resilience, self-esteem, and confidence
- Being part of a safe and supportive community
- Involvement in meaningful activity, i.e., employment, volunteering
- Being socially included and supported
- Good physical health
- Economic security
- Equality of access to services
- Having supportive family and friends

No Health Without Mental Health defines mental wellbeing as "a positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment." Positive mental health is more than the absence of mental illness. 'Mental wellbeing' and 'mental health' are often used interchangeably, though mental health is more often used in a context where mental illness is being discussed, for example, to describe treatment services.
Other factors can have a negative impact:

- Long-term health problems or disability
- Adults with low education
- Poor English language skills
- Misuse of alcohol
- Use of opiates and/or crack cocaine
- Lone parent households
- Relationship breakdown
- People living alone
- Children leaving care
- Socio-economic deprivation

Stigma is a major issue for those with a mental health condition. This can lead to social isolation or exclusion which can impact on things such as relationships and employment. This adds to the barriers that those with mental ill health already experience. There are some groups which evidence suggests are more likely to experience poor mental health. These groups may benefit from targeted approaches to promote mental health and wellbeing.

Mental health and wellbeing can also be influenced by 'wider' factors such as employment, good housing, accessing green space, access to transport, good physical health and security and taking part in leisure activities. Caring responsibilities can also have an impact. In the 'State of Caring Survey', Carers UK 2018, 72% of carers have experienced mental ill health because of caring. Often, services, activities or interventions can support positive mental health outcomes without being identified as mental health interventions.

Mental illnesses include common conditions such as depression and anxiety as well as schizophrenia and bipolar disorder (which may also sometimes be referred to as severe mental illnesses).

Strategic context and governance

This strategy is focused on mental health and wellbeing and complements and expands on improving mental health and wellbeing which has been identified as a key priority for the Rutland Health and Wellbeing Board Strategy. This Strategy brings out key strategic and delivery themes across Rutland Health and Wellbeing workstreams to articulate a cohesive, population-based approach to promote wellbeing and improve mental health In Rutland

Delivery of this strategy will be through the Rutland Mental Health Neighbourhood group who are responsible for monitoring detailed action plans to ensure that the strategy is delivered and makes a difference to people's lives. The Rutland Mental Health Neighbourhood group is accountable to the Rutland Health & Wellbeing Board, being a formal sub group of the Board.

The Rutland Mental Health Neighbourhood Group is also part of the Leicester, Leicestershire and Rutland Mental Health collaborative governance. Collectively, this brings together three Place-based Mental Health groups from Rutland, Leicester City and Leicestershire alongside the LLR Mental Health Collaborative Group. The collaborative governance feeds directly into the Integrated Care Board. The Place-based groups are not subordinates to the collaborative group but will work together to form the Mental Health Collaborative for the Leicester, Leicestershire and Rutland system.

LLR Mental Health Collaborative Governance

The NHS Long Term Plan (LTP) created Integrated Care Systems (ICS), giving a platform for partnership working and integration. Across the Leicester, Leicestershire and Rutland (LLR) system, we are approved as an ICS, consisting of the NHS bodies of the Integrated Care Boards (ICBs), the three local authorities: Leicester City Council, Leicestershire County Council, and Rutland County Council, and wider partners such as the voluntary and community sector and key provider agencies.

Our vision and identifying priority groups.

Mental health problems have very high rates of prevalence, estimated to affect around 1 in 4 people every year[1]. They are often of long duration, even lifelong in some cases and have adverse effects on many aspects of people's lives. Our vision is for every resident in Rutland to have the best mental health that they can at every stage of their life. We will promote an approach that prevents and treats mental health problems with the same drive, passion, and commitment as for physical health problems, embedding mental health and wellbeing across the health, care and wider system. This approach recognises the importance of enabling everyone to feel good and function well throughout their everyday lives.

The aim is to not only meet the specific needs of different age groups, but also to reduce cumulative disadvantage associated with poor mental health and wellbeing and related risk factors. These strategies can be built into community initiatives and broader health promoting programmes, as well as into support and treatment services.

Like the HWB strategy, our vision is for safe, healthy, and caring communities where people start well and thrive together through their life. There are many areas we will adopt a adopt a Do, Sponsor and Watch approach. There will be specific areas we will lead on, whereas other areas we may sponsor or oversee a project or work or keep an oversight of what other groups are doing, even if no direct involvement is required.

Over the next 4 years, we will use a variety of data sources and demographics to identify cohorts of people to work with. This will include but not exclusively, the following sources: relevant data provided from public health, VCSE partners and specific identified health needs provided by ICB partners (for example, data obtained from the Neighbourhood Mental Health Café). We are also able to access LPT's secondary care data set, which we can refine to Middle Layer Super Output Area (MSOA) levels. We will look at data Rutland County Council have collected, which includes work set across the priorities within the Health and Wellbeing Strategy. There may be further specific LLR joint ventures or initiatives, as well as any identified data from commissioned services highlighting mental health needs that can be used.

There are existing reports where we will use relevant information, which include the Rutland Health Inequalities & Hidden Need report, Rutland County Council's Family Hub Consultation, Healthwatch Rutland's 'What Matters to You' report[2] 19th Aug 2021 and 'The Future Rutland Conversation'[3] 2022, as well as identified priorities from the Joint Strategic Needs Assessment (JSNA). By using this data, we will be able to map what is already available in the community and identify the priority groups who we will work with.

[1] https://www.mind.org.uk/information-support/types-of-mental-health-problems/statistics-and-facts-about-mental-health/how-common-are-mental-health-problems/#References:~:text=McManus%2C%20S.%2C%20Meltzer%2C%20H.%2C%20Brugha%2C%20T.%20S.%2C%20Bebbington%2C%20P.%20E.%2C%20%26%20Jenkins%2C%20R.%20(2009).%C2%A0Adult%20psychiatric%20morbidity%20in%20England%2C%202007%3A%20results%20of%20a%20household%20survey.

[2] https://www.healthwatchrutland.co.uk/report/2021-08-19/what-matters-you-report

[3] https://www.rutland.gov.uk/yoursay/future-rutland

Strategic priorities

There are specific actions within the Rutland Joint Health and Wellbeing Strategy (JHWS) that the group will focus on when creating the Rutland Mental Health Neighbourhood strategy and Place-led plan.

Supporting good mental health is part of three cross-cutting themes, which interlink multiple priorities across the strategy, for example the priority 1 – the best start in Life. All seven priorities from the (JHWS) will be looked at when making decisions, although there has been a specific ask within the strategy for the neighbourhood mental health group to focus on the following actions:

- **Action 7.1.1** - Increase access to perinatal mental health support services.
- **Action 7.1.2** - Understand the gaps in service reported by service users where children and young people need help with their mental health.
- **Action 7.1.3** - Increasing local resource to respond to children and young people's mental health need.
- **Action 7.1.4** - Creating a local plan to better coordinate care for mental health across neighbourhood service areas.
- **Action 7.1.5** - Increased response for low level mental health issues.
- **Action 7.1.6** - Long-term objectives to deliver an integrated neighbourhood approach to mental health needs in Rutland are met.

Each of these actions include specific areas that we have been identified to focus on, which will be mapped out within a separate action plan to accompany this strategy. We will report on each action and the elements that are included within each point. The action plan will explain what we are looking to achieve, our measures to recognise how we know this has been successful, as well as any risks and mitigations that are in place.

This will be achieved through the following key objectives, drawing upon the wealth of skills and expertise across the Council, NHS, and partner organisations:

- Focus on mental health promotion including information, advice and guidance, mental illness prevention and recovery throughout the life course
- Promote resilience in individuals, families and communities through asset-based working and the wider social determinants of health
- Deliver timely, person-centred, effective services that align health and social care outcomes to provide integrated, responsive services and care
- Improve people's experiences of mental health and social care services
- Reduce inequalities in mental health and wellbeing and in access to care and support
- Challenge stigma and discrimination related to mental health problems.

Measurable outcomes

Outcome indicators will be compiled which will help to monitor progress to achieve our vision. To complement the impact of the strategy, periodic qualitative surveys of service users, carers, staff groups, voluntary sector organisations and other interested parties will be undertaken on behalf of the Rutland Mental Health Neighbourhood group.

We are looking to achieve measurable outcomes that demonstrates an understanding of local health inequalities and their impact on service delivery and transformation.

Outcomes

1. People will live longer and have healthier lives.
2. People will live full, active, and independent lives, including access to employment and education.
3. People's quality of life will be improved by access to quality services.
4. People will be actively involved in their health and their care.
5. People will live in healthy, safe, and sustainable communities.
6. People have timely access to support they need

Financial

The Rutland Neighbourhood Mental Health group will explore any funding opportunities where there are identified needs and look to agree decisions by consensus, which will be evidence-based or underpinned by the most relevant information we have at that point in time.

Review

The review of the strategy will take place annually to check the current scope, conduct, composition and effectiveness unless circumstances require a review more frequently.

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Rutland Mental Health Neighbourhood Action Plan

What Do We Want To Achieve?	How Are We Going To Do It?	Responsible	Timeframe for Delivery (Month/Year)	How Will Success Be Measured?
7.1.1 - Perinatal support				
Increase access to perinatal Mental health support services, wherever Rutland women have chosen to give birth.	Understand more about the Perinatal Mental Health Service and what we can do to increase the numbers of people accessing this. Support promotion and raise awareness of this service.	LPT	Ongoing	Increased number of people accesssing perinatal services.
7.1.2 - Undestand gaps in CYP mental health support needs				
Understand the gaps in service	Use recent surveys, such as the Family Hub consultation, as well as specific priorities set within the Rutland Children and Young People's Strategy 2022-2025.	LPT, PH / RCC Early Help Services	2022/24	Gaps identified and solutions/services put in place.
7.1.3 - Increase local resource for CYP for families and carers.				
Increasing local resource to respond to children and young people's mental health need	This will link to action 7.1.2, as we need to understand the gaps and what children and young people are asking for support with.Launch of MySelfReferral service to allow CYP to self-refer themselves or seek support for their mental health.	LA, VCS, ICB	Sep 23 - Sep 25	Increased resource available for children and young people
7.1.4 - Transformation project for Rutland - Ensure Mental Health services are delivered in Rutland				
A clear co-designed approach to supporting services via funding bid slinked to the needs of the Rutland population	Promote available grants and funding opportunities with all partners and support where necessary.	LPT/ ICB / RCC		Ensure that funding bids are best suited to the current needs of our population and are able to demonstrate effective results.
A clear local plan to better coordinate care across Rutland and neighbouring service areas	Creation of MH Pathway, which can be used in GP surgeries.	MY / PCN	Aug-23	The MH pathway is used within the GP surgeries and is recognised as the pathway to follow when there is a mental health support need.

Rutland Mental Health Neighbourhood Action Plan

What Do We Want To Achieve?	How Are We Going To Do It?	Responsible	Timeframe for Delivery (Month/Year)	How Will Success Be Measured?
7.1.5 - Increased response for low level mental health issues				
Promotion of recognised self-service self-help tools and frameworks and increase the capacity in local low level mental health services and peer support, so more people access help sooner in their journey.	Support to increase the capacity in local low level mental health services and closer working between involved local agencies and services, including in the voluntary and community sector and peer support, so more people access help sooner in their journey.	LPT / RCC / ICB		
7.1.6 - Deliver on the long-term plan objectives for mental health for the people of Rutland				
Move towards an integrated neighbourhood based approach to meeting mental health needs in Rutland.	Establish a neighbourhood mental health group .Introduce new MDT specifically for community based Mental Health support	LPT, PCN, RCC, Community	Ongoing	Closer and integrated working in our neighbourhood approach.
Annually assessing the physical health needs of people with Serious Mental Illness (SMI) in Rutland	LPT Mental Health Facilitator role supports people within Rutland diagnosed with an SMI. Including an annual physical health check.	ICB / LPT / Mental Health Facilitator		There is a national target of 60% of people living with SMI to have aphysical health check.
Aiding people with serious mental illness into employment	LPT Employment Support Service Invidividual Placement and Support Lead, supports people with SMI into employment.	LPT		Increase numbers of people with SMI into employment.
Delivering psychological therapies - NHS LLR Talking Therapies (previously known as IAPT) run by VitaMinds,for individuals as locally as possible to Rutland	Working closer with NHS LLR Talking Therapies to ensure our local population are accessing their services.			Increased number of people within Rutland are accessing the NHS LLR Talking Therapies service.

Report No: 146/2023
PUBLIC REPORT

RUTLAND HEALTH AND WELLBEING BOARD

10 October 2023

BETTER CARE FUND – 2023-2025 PLAN SUBMISSION

Report of the Strategic Director of Adult Services and Health

Strategic Aim:	All	
Exempt Information	N/A	
Cabinet Member(s) Responsible:	Councillor D Ellison, Portfolio Holder for Adult Care and Health	
Contact Officer(s):	Kim Sorsky, Director of Adult Services and Health	Telephone 01572 758352 ksorsky@rutland.gov.uk
	Katherine Willison, Health and Wellbeing Integration Lead	Telephone 01572 758409 kwillison@rutland.gov.uk
Ward Councillors	NA	

DECISION RECOMMENDATIONS
That the Committee: 1. Notes the content of the report. 2. Notes the Rutland 2023-25 Better Care Fund plan, submission of which to the BCF national team on 28 June 2023 was signed off by the Chair of the Health and Wellbeing Board.

1 PURPOSE OF THE REPORT

1.1 Brief the Health and Wellbeing Board (HWB) on the 2023-25 Better Care Fund (BCF) Programme Plan.

1.2 Update the HWB on the progress of the Rutland BCF Partnership Board

2 BACKGROUND AND MAIN CONSIDERATIONS

2.1 The **end of year report for the Rutland BCF programme for 2022-23** was signed off by the HWB chair and was submitted to the national BCF team on 22 May 2023

2.2 The Programme Plan for 2023-25 was submitted to the national BCF team on 28 June 2023. It includes:

- A **Narrative Plan** providing a summary of how the budget has been spent over the previous year and how it is planned to be spent over 2023-25, which meets mandatory Planning Requirements and fulfils the 4 National Conditions – see below.

- A **Planning Template** detailing

    - Planned expenditure including the new Additional Discharge Fund
    - Confirmation that the national conditions of the BCF have been met
    - Ambitions and plans for performance against BCF national metrics
    - Intermediate care capacity and demand proposals for reablement for community and hospital discharge

2.3 The 4 BCF **national conditions** are as follows:

- Plans to be jointly agreed by the ICB and the local government chief executive prior to being signed off by the HWB.

- Implementing policy objective 1

- Implementing policy objective 2

- Maintaining NHS contribution to adult social care and investment NHS commissioned out of hospital services.

2.4 The **vision** for BCF for 2023025 is to support people to live healthy, independent, and dignified lives through joining up health, social care and housing services seamlessly around the person. The **priorities** are improving discharges; reducing pressure on Emergency and Acute care and social care; supporting intermediate care, unpaid carers and housing adaptations.

The vision is underpinned by the 2 core BCF **objectives**:

- enable people to stay well, safe and independent at home for longer.

- people have the right care at the right place at the right time.

In meeting these objectives, commissioners should agree how services will continue to promote independence and address the needs of people who are at risk of losing independence including admission to residential care or hospital. They should continue to focus on ensuring people are discharged in a way that maximises independence and leads to the best possible outcomes.

2.5 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. Services include the Community Wellbeing Service which provides advice and support and includes Citizens' Advice; Social Prescribing including joint GP and RCC RISE Team. Integrated care services support people with long term conditions and frailty which includes physiotherapy; Disabled Facilities Grants help to finance adaptations and equipment to enable people to live in their homes for longer. The plan includes Carers support workers including Admiral Nurses who provide support and advice for the carers of people living with dementia. Regarding hospital flows, the plan assists to fund staffing to support Reablement and timely

discharge from hospital, plus crisis management to avoid hospital admissions.

2.6 **High Impact Change Model for Transfers of Care**

These are approaches identified as having a high impact on supporting timely and effective discharges through joint working across the social care and health system. This is a significant area for the BCF, with 31% of the budget being allotted to this area. It includes approaches such as improved discharge to care homes and multi-disciplinary teams supporting discharge. A summary of a self-assessment in this area was included in the plan. See appendix A for the Narrative document for full details.

2.7 **Income:**

Funding for 2023-24 and 2024-25 is set out in Table 1. Showing the minimum NHS funding contributions to the Better Care Fund, channelled via the integrated care boards. A uniform 5.66% increment has been awarded to all Health and Wellbeing Board areas. The Disabled Facilities Grant had no uplift from the previous year. See appendix B for full breakdown

Table 1: BCF budget for 2023-25

Funds	**2023-24 (£)**	**2024-25 (£)**
NHS Minimum contribution	2,783,104	2,940,628
Improved BCF	218,818	218,818
Disabled Facilities Grant	270,255	270,255
LA Discharge Funding	30,678	50,295
ICB Discharge Funding	29,300	53,874
Total	**3,332,155**	**3,534,500**

2.8 **Expenditure:**

Spend on the programme for 2022-23 including the Improved BCF, and Disabled Facilities Grant allocations and previous underspend built into the programme totalled £3,122,922. The 2022-23 funds did not include an Additional Discharge Fund.

2.9 **Metrics:**

There are currently 5 metrics to report against for 2023-24 with an additional metric ‘hospital discharge to be added ahead of winter 2023. The plan sets out the ambitions and performance plans for these metrics. See Appendix C.

- **Avoidable admissions**
  Unplanned admissions for Chronic Care Sensitive Ambulatory Conditions. Indirectly standardised rate of admissions per 100,000 population.

- **Falls**
  Emergency hospital admissions due to falls in people aged 65 and over. Directly aged standardised rate per 100,000.

- **Discharge to usual place of residence**

The Percentage of people, discharged from acute hospital to their normal place of residence.

- **Residential admissions**
  Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population.

- **Reablement**
  Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into Reablement/ rehabilitation services.

2.10 Kim Sorsky, Strategic Director of Adult Services and Health approved Rutland's 2023-25 Plan on behalf of the Council. All three LLR returns went to the LLR ICB Executive Management Team on 26/5/23 for IBC approval. The HWB Chair approved the Rutland return on behalf of the Rutland Health and Wellbeing Board prior to its submission on 28/5/23.

2.11 **Rutland BCF Partnership Board**

The first meeting (since 2020) of the Partnership Board took place on 8/9/23 with senior officers from RCC and ICB in attendance. It was agreed that the Portfolio Holder for Adults and Health/ Chair of the HWB will chair the meetings which will take place on a quarterly basis. The Terms of Reference have been reviewed.

The aim of the Board is to ensure that the Better Care Fund Plan achieves its aims and outcomes within the Financial Contributions agreed by the Partners. It provides governance to ensure the rules and processes of the Rutland BCF are embedded as standard. Financial data and outputs on activity of the schemes within the plan will be reported for evaluation and scrutiny. Requests for BCF monies will need to be referred to the Board for consideration. A template for this is currently in draft.

3 CONSULTATION

3.1 Not applicable at this time.

4 ALTERNATIVE OPTIONS

4.1 Not applicable at this time.

5 FINANCIAL IMPLICATIONS

5.1 As in previous years, local partners have proceeded to deliver the current year's BCF programme 'on trust', based on consensus across the Council and IBC, pending national publication of guidance.

6 LEGAL AND GOVERNANCE CONSIDERATIONS

6.1 The plans have been produced with involvement and input from ICB. The plans received sign off by the Executive Team at the ICB.

7 DATA PROTECTION IMPLICATIONS

7.1 There are no new Data Protection implications. The annual report contains only anonymised data.

8 EQUALITY IMPACT ASSESSMENT

8.1 Not applicable to the annual report.

9 COMMUNITY SAFETY IMPLICATIONS

9.1 There are no identified community safety implications from this report.

10 HEALTH AND WELLBEING IMPLICATIONS

10.1 The Better Care Fund programme is an important element of Rutland's response to enhancing the health and wellbeing of its population, representing more than £3m of ICB and LA funding to be used for integrated health and care interventions. This report sets out that Rutland continues to be committed to improving the outcomes of the population.

11 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

11.1 The Committee is recommended to note the Rutland 2023-25 Better Care Fund plan, submission of which to the BCF national team on 28 June 2023 was signed off by the Chair.

12 BACKGROUND PAPERS

12.1 There are no additional background papers to the report.

13 APPENDICES

13.1 Appendix A: Rutland 2023-25 BCF Programme Narrative Plan

13.2 Appendix B: Rutland 2023-25 BCF Plan Return: Income

13.3 Appendix C: Rutland 2023-25 BCF Plan Return: Metrics

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

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Rutland Better Care Fund Programme

2023-25

Programme of the Rutland Health and Wellbeing Board

Contents:

1 Context and Governance

This document, combined with the Excel workbook 'Rutland HWB BCF Planning Template 2023-25', sets out the Rutland Better Care Fund (BCF) Programme for 2023-25.

The area covered coincides with the unitary Local Authority boundary of Rutland County Council, which is a 'place' as defined in the NHS Long Term Plan. Rutland falls within the wider health and care footprint of the Leicester, Leicestershire and Rutland (LLR) Integrated Care System (ICS)

Bodies involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils).

Programme development has been led by the Integrated Delivery Group (IDG), involving all its members (RCC, LLR ICB, LPT, the Rutland PCN and Healthwatch Rutland).

VCS organisations including Citizens Advice, Mind, Age UK have been consulted and accepted the plan.

How have you gone about involving these stakeholders?

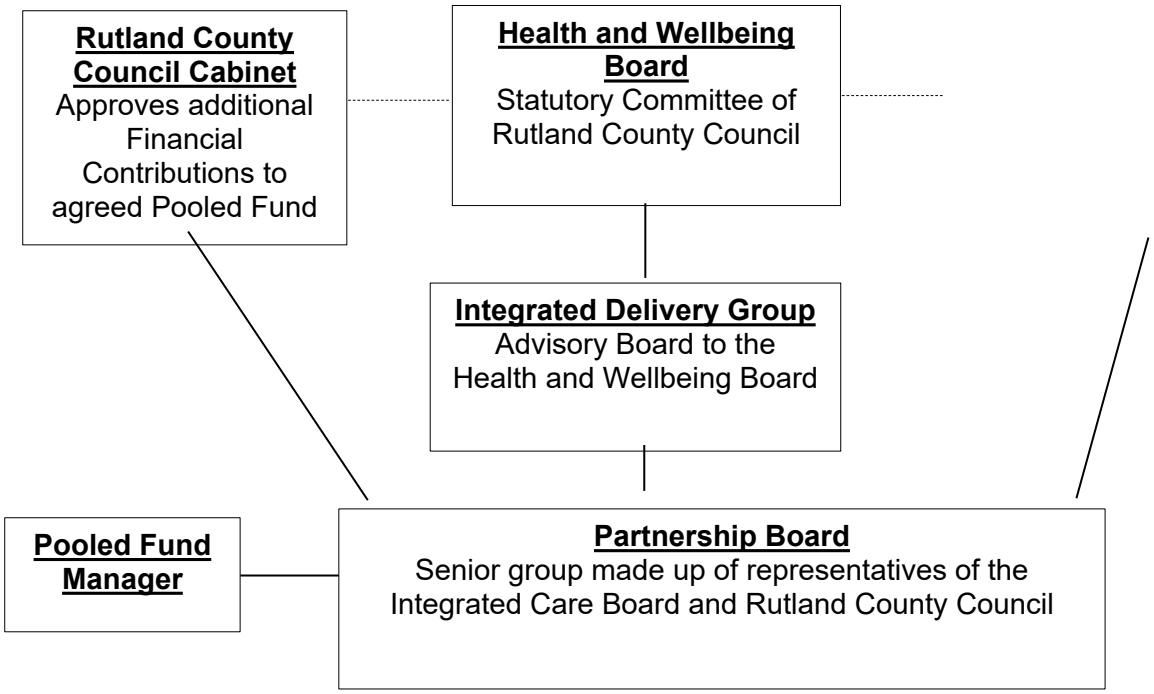
The IDG meets on a monthly basis. BCF reporting is provided at each meeting and consultation and planning with partners takes place.

Separate meetings have taken place with the ICB Deputy Chief Operating Officer for Rutland and Head of Commissioning.

The BCF Lead for RCC attended the Rutland Voluntary and Community Sector Networking Meeting. A presentation was given, and the group were consulted on the plan which was ultimately accepted. The involvement will continue to be facilitated through quarterly meetings with representatives from RCC and the VCS organisations. Consultation will take place on BCF planning and, in addition, on how RCC should be meeting the required standards of the Care Quality Commission.

There have been sessions held with colleagues from Leicester and Leicestershire at system level for consistency and to clarify interventions at this level.

Overall governance arrangements diagram:



The BCF programme is governed by, and has been developed under the leadership of, the Rutland Health and Wellbeing Board (HWB) which meets on a quarterly basis and brings together the following:

Rutland County Council (RCC) (members and officers, including People services and Public Health)
NHS Leicester, Leicestershire, and Rutland (LLR) – the LLR Integrated care board (ICB)
The Rutland Primary Care Network (PCN) on behalf of its constituent practices
Leicestershire Partnership Trust (LPT)
Healthwatch Rutland
Citizens Advice Rutland, on behalf of the wider Voluntary and Community Sector (VCS)
NHS England
Longhurst Housing Association, on behalf of the social housing sector
Leicestershire Constabulary
Plus other such persons as are appropriate to the Board's agenda

Quarterly reports on the progress of the BCF plan are provided to the HWB and are presented and discussed. To further improved governance, RCC will re-establish the BCF Partnership Board. The board will meet on a quarterly basis to with the purpose of ensuring that the Better Care Fund Plan achieves its aims and outcomes within the financial

contributions agreed by the partners. The BCF manager will provide financial and activity information regarding the performance of the individual schemes and will take decisions on the delivery of the schemes and the BCF plan based on that information. Attendees will include representatives from ICB, RCC including the Council's Leader or another appropriate Councillor.

2 **Executive summary**

Priorities are aligned with:

'People at the Heart of Care: Adult Social Care Reform' which focuses on areas such as access to the right quality care, at the right place and the right time; recognition and support for unpaid carers.

'Delivery plan for recovering urgent and emergency care services' with the aim of patients being seen more quickly in emergency departments and improved ambulance response time – through improvements across the health and social care system.

As in previous years, the BCF plan for Rutland for 23-25 reflects delivery against the established framework already in place for delivery of this across the Leicester, Leicestershire and Rutland (LLR) system. The Rutland plan and pooled budget continues to be utilised to progress current successful and enable new models of care.

The Rutland BCF plan and pooled budget continues to be utilised to expedite models of care through embedding already successful schemes and supporting new approaches. Priorities continue to be aligned to delivery of the Rutland Joint Health and Wellbeing Strategy (JHWS). The strategy focuses on the life course approach, with specific integration focus on Living Well with Ill Health and Inequalities. There are two new subgroups, the Mental Health Neighbourhood Group giving much needed focus to improvements in mental health and the Staying Healthy Partnership which is focussed on inequalities.

Priorities:
Prevention at all stages so preventing the need for primary or secondary care and preventing, reducing or delaying the need for social care provision through Home First, reablement, social prescribing, community health.

LLR are committed to implementing a cohesive model or intermediate care aligned to the NICE guidelines (2017). This will ensure a robust step-up and step-down offer of reablement, rehabilitation and recovery to support people to live as independently as possible at home. This is to improve whole system flow regarding hospital admission, stays and discharge. Discharge funding for reablement, staff retention, and at ICS level for expansion of the discharge hub and home first training.
Carers recognition, support and breaks including carers of people living with dementia

Expansion of technology, equipment and adaptations in the home

Capacity in the market for meeting need through personalised, quality services whilst promoting independence and asset based approaches

Falls prevention has had increased focus mobilisation of increased falls prevention strategy in Rutland and Falls Steering Group across System – already increased level of activity in these area which is aligned with the requirement for a new metric on falls leading to hospital admission.

National Condition 1: Overall BCF plan and approach to integration

With regard to joint commissioning, RCC are in the progress of setting up a Health and Care Collaborative with partners including ICB, Public Health and the PCN. This is looking to expand on section 75 arrangements, and will focus on prevention, access and expenditure around complex care as initial priorities.

Other joint commissioning arrangements include:

- A s256 agreement with the ICB for a contribution to VCS infrastructure support.
- A Service Level Agreement with Leicestershire Public Health who provide Public Health in Rutland, which includes a shared Director of Public Health. This provides economies of scale and shared knowledge and planning related to primary prevention services.
- Mental Health Wellbeing and Recovery Service, provide by P3, is jointly commissioned with the ICB, which supports people with less severe mental health issues.
- The advocacy services provided by POhWER are jointly commissioned with Leicestershire County Council

The BCF programme remains structured into four high level priorities as these continue to reflect national and local demand.

1. Unified Prevention: improving individual health and wellbeing, and the vitality of communities
2. Holistic health management in the community: services for people living with ill health, particularly those whose needs are complex, providing a range of 'home first' co-ordinated support tailored to the care needs of individuals, helping them to live well and, where possible, to sustain their independence
3. Hospital flows: reducing avoidable hospital admissions and ensuring prompt, safe and sustainable discharge
4. Enablers: support to the programme itself, alongside analytics, technology and communications and engagement

Access to primary care is a LLR priority as it is nationally. Communication around raising awareness of the Additional Roles Reimbursement Scheme (ARRS) and use of the NHS App is in place across the system.

Support for unpaid carers is also a joint priority. The **LLR Joint Carers Strategy 2018–2021 'Recognising, Valuing and Supporting Carers'** sets out eight key strategic priorities relating

to unpaid carers of all ages, and was developed jointly by the LLR local authorities and the (then) CCGs. It is currently being refreshed. The **LLR Carers Strategy Delivery Group** is in place to ensure awareness and support for carers continues to develop. Carefree, Mobilise and carer awareness training for PCN staff. Professionals across the system work together on Carers Week planning and facilitating events.

Joint commissioning has led to the establishment of a new MDT Facilitator, who acts a central point of information for health, care and the voluntary sector. See page 7 for further details of these roles.

Certain BCF funded services are continuing from previous years as they are successfully supporting progress with priorities of collaborative commissioning, a viable care market and further improving outcomes of those who require support with care. For this reason, the BCF will contribute towards funding of the senior commissioning, compliance and improvement officers.

The RCC Commissioning Team supports budget holders to commission high quality and value for money services and supports the County's care market. The team ensures the provision of services, facilities, and resources to help prevent, delay, or reduce the development of care needs. There must be easy access to information and advice so people can make good decisions about the potential care and support needed. The following activity is planned to ensure a wide range of high quality, appropriate services is commissioned.

- Collaborate with budget holders to understand where there are issues/challenges/weaknesses in care delivery and work to resolve these.
- Commission services efficiently and work with providers so we are aligned with our vision for care and that they are complaint in their delivery.
- Support the care market so it can meet local needs including proactive measures to detect emerging risks.

RCC will run a quarterly provider forum for homecare and care home providers to promote engagement, integration and:

- Give guidance and advice.
- Offer training opportunities.
- Communicate council priorities and local trends/needs.
- Facilitate peer support.
- Obtain feedback/views.

Work is being planned in line with DHSC to ensure we can receive Market Sustainability and Improvement Fund to further support the market.

There will be a newly developed RCC Compliance Lead, who will work as part of the Quality Assurance Team within Adult Social Care to take a lead role in managing the quality of the external care provider sector. They will lead on a programme of work which focuses on

compliance, improvements to quality of health, care and development of the provider sector. The role will also focus on providing assurance of effective local commissioned care services by driving service improvement, quality assurance and contract compliance. Alongside this they will work in partnership with local health partners and the voluntary sector on improvements to service provision. Ultimately working to ensure local market sustainability, advice and support to promote CQC regulatory compliance within the sector and to support positive outcomes for adults with care and support needs.

The Improvement Officers are new posts which support the leadership and implementation of key projects which improve compliance with statutory functions. They will take on activities such as facilitating co-production of services and support in areas such as learning disability, where people with lived experience are co-chairing the Learning Disability Partnership Board. They will lead on digital accessibility including the implementation of a social care referral portal. They are leading on the communication and engagement for a local project, in an area identified in the Joint Strategic Needs Assessment based on socio-economic deprivation and rurality/access to the community. This supports delivery of the Joint Health and Wellbeing Strategy, ensuring any projects incorporate priorities for both health and social care including integration.

Working with the Voluntary and Community Sector as partners is vital to support the health and wellbeing needs of the Rutland community. The BCF will fund the Vista contract which assists people with sensory impairment to continue to live as independently as possible. BCF also contributes to the funding of Citizens Advice in Rutland which gives vital information, advice, and support on many matters relating to welfare and wellbeing and is also making a large contribution to funds to develop the Voluntary and Community Sector Strategy, with the aim of amending and improving services in line with the needs and wishes of the population.

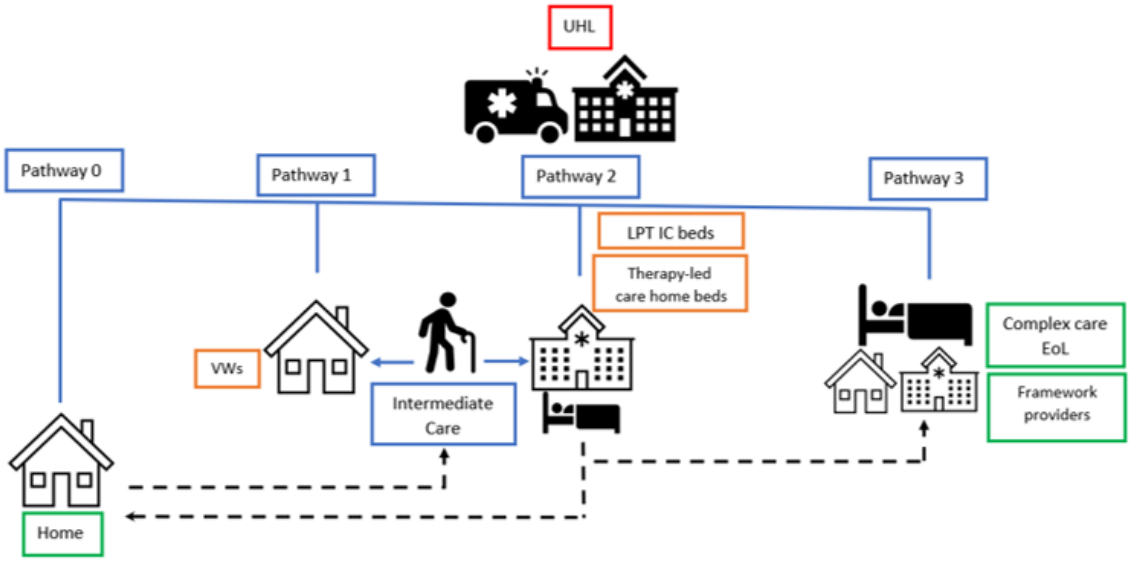
National Condition 2

BCF objective 1: Enabling people to stay well, safe and independent at home for longer.

The LLR vision is to adopt a consistent Home First approach, underpinned by intermediate care, that ensures people are supported to remain independent, in their usual place of residence, for as long as possible. The vision will be achieved through the establishment of a refreshed ‘transfer of care’ hub with four distinct functions:

1. Ward-based MDT: patient facing clinical decision-making; implement criteria-led discharge
2. Integrated Discharge team: focus on complex discharges – through face to face reviews
3. Improve Intermediate Care and discharge pathways: ensure right care, right place, right time.
4. Establish a Transfer Control Centre: Building on the existing data hub to provide discharge, intelligence and operational coordination across the LLR system.

LLR Vision for Intermediate Care (University Hospitals Leicester – UHL)



*EoL = End of Life

Our home first offer helps deliver access a range of preventative and proactive services, deliver more care outside of hospital and closer to home and provide integrated, personalised, and holistic services. The table below is a summary of our Home First priorities and the developments that aim to meet the above priorities in addition to existing services described in previous years' plans, including outputs and outcomes. During the course of 23/25 we plan for our Unscheduled care hub, UCR, and our falls offer to become business as usual.

LLR Home first Priorities 23/24

No	Priority	Priority Description
1	Virtual Wards	Min 276 VW beds by March 24 80% occupancy by Sept 23.
2	Care Homes	Reduce conveyance rates from top 10 CHs by 25% by the end of March 24.
3	Urgent Community Response	80% for 2 hours and 2 days response by end of March 2024
4	Falls Management Tier 1 and Tier 2 falls response across LLR	Consistent falls offer across LLR by the end of March 2024 10% reduction in admissions from falls by the end of March 2024
5	UCCH	Reduce EMAS activity by 15% (from the stack)
		Increase referrals from 111, self referrals, PC and EMAS by 25%
6	Intermediate Care	Roll out step-up/step-down intake model by March 25.
		Increase P1 discharges and decrease P2 discharges by 20% by the end of March 24
7	INTs/ Community Health and Wellbeing Teams at Place	Formation and delivery of 9 (7) in the County CHWTs (INTs) across LLR by the end of March 2024
8	Carers	35,000 identified informal carers across LLR by the end of March 2024

A cohesive approach to BCF planning and delivery allows us, as a system, to continue to deliver our mature LLR out of hospital model based on a wrap-around care concept. The aim is to develop community teams aligned to the recommendations from the Fuller stocktake to ensure care is planned and delivered locally underpinned by a population health management approach.

The BCF contributes to roles within the Rutland Integrated Social Empowerment (RISE) Service focussing on social prescribing. This takes an Integrated Neighbourhood Team approach, enriching collaboration, and coordination across local partners; a personalised, asset- based approach, helping people to engage with what motivates them, and use this to drive changes that improve their physical and mental health and wellbeing. The aim of the service is to support people to maintain their independence, thereby helping to drive preventative practice and benefit those who may otherwise frequently attend primary or secondary health care services.

RISE receive referrals from a range of sources. They work with the local community and a wide range of health, social care, and voluntary sector professionals to ensure the optimum support is progressed. RISE holds between 40-60 active cases, receiving 80+ referrals each month.

RISE Core Principles

- Aim to 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.

Rutland also has a new social prescribing website 'Joy', which has improved access to health and wellbeing services. The online system can be used by health and social care

professionals, the voluntary sector, and members of the public. This is a close collaboration between RCC, the four GP practices of the Rutland PCN, and the ICB through LPT.

There are other new initiatives which contribute to the vision of BCF. There is a Multi-Disciplinary Team (MDT) Facilitator who leads on multi-disciplinary neighbourhood facilitation and coordination, acting as a central point of information for health, social care and voluntary sector services and as a hub for coordinated collaborative working between partners. The facilitator has introduced a population health management approach to case finding, using algorithms to interrogate GP data to identify cohorts sharing characteristics that mean they are likely to benefit from the prevention and wellbeing services provided by the social prescriber link workers, PCN pharmacists, case coordinators, health coaches. The facilitator is also leading on the Anticipatory Care Project, supporting people with cognition issues and/or a new diagnosis of dementia.

BCF also funds the RCC Clinical Care Home Lead. She supports care home residents through co-ordinating MDT meetings with managers and staff, to identify issues early in order to reduce the need for social care and health contacts. She is leading on the implementation of WHZAN, a telehealth case which completes assessments and measures to detect signs of deterioration or illness which is shared with health. Also funded by BCF is the Brokerage Lead who works with social care staff and providers, to broker care on the service user's behalf in a person-centred way, to enable hospital discharge and following reablement.

There is a new Neighbourhood Mental Health Sub-Group of the HWB. The plan is for this to be established with a formal Terms of Reference. This recognises the significant need to more support for people with enduring mental health needs in Rutland. It is also an area of priority for JSNA work for 2023.

Seven- day therapy offer

In April 2021 RCC were successful in securing Ageing Well monies via a bid to provide a seven-day therapy offer supporting the D2A model. The resource identified as being required to deliver the improvement was 1.6 Occupational Therapists who were then recruited.

Data analysis of role performance - 2022.

Total Number of Referrals Received JAN 2022-DEC 2022	Total Number of Referrals requiring weekend intervention	Total Number of D2D cases	Total Number of Admission Avoidance
78	**23**	**60**	**18**

Without weekend therapy, delay to reablement commencing would have totalled 46 days for 2022. The impact for the person of a two-day delay to start reablement is a likely

decrease in their reablement effectiveness and possible increase in care need. The impact for staff is an increased workload pressure during Monday to Friday.

The current effectiveness of the reablement service is demonstrated by 75 of the 78 reablement cases had no ongoing care and support needs at the end of their reablement.

The 7-day working model is also a key driver in the work we do with the LLR Integrated Therapy Board and aligns social care with health. It positively impacts the resource available to health and a continued commitment to integration. We have created the roadmap for our neighbouring authorities to follow. Because this service is so effective, it is planned to continue for 2023-24.

At the request of the Allied Health Professions (AHP) and Clinical Director at LPT, RCC showcased the successful therapy integration roadmap to date as part of the National AHP week celebration. The presentation has since been shared at the ICS LLR leadership event.

Falls Prevention -The Rutland Offer

Personalised Falls Prevention Strategy for Care Homes

Premise for change

There are 10 times more hip fractures among older people living in care homes compared with older people living in other environments.
Whilst there is a significant amount of generic training and advice available it doesn't feel relevant to staff or residents and any impact quickly diminishes.
We should treat everyone as an individual regardless of where they live.

Aims

- Change the culture of practice to make falls prevention personal and embed in practice.
- Reduce preventable falls.
- Minimise the risk of serious harm for falls that cannot be prevented.
- Identify patterns of falls risk and create a personalised strategy for each care home

.

Interventions

- Identify the key roles to make change happen.
  Each care home now has an assigned falls champion to liaise directly with dedicated falls prevention therapist.

- Collaboration at operation and managerial levels.
  Buy in to the vision is required at all levels across the organisations involved and communication, change management and promoting individualised care are key.

- Improve accuracy and incidence of reporting through guidance and joint working.
- Empower staff to feel they could help prevent falls.

Outcomes

- Care homes are requesting a falls prevention forum to network and share good practice.
- 53% reduction in safeguarding for falls.

Jan - April	Safeguarding for falls
2021	19
2022	21
2023	9

- Reduction in falls with injury

Period	No of reported Hip Fractures in Care/Residential Homes
July – December 2021	17 (6 Months)
January – December 2022	8 (12 months)

Community Offer Hip fracture data is now being collected more widely to ascertain the hip fractures rates across Rutland and not simply the most at high risk in care settings. This is to demonstrate the efficacy of our current therapy offer and identify any gaps.

Falls Recovery Service From consultation we have successfully established a direct referral route from the Falls Recovery Service into Adult Social Care Therapy. This will enable:

- Monitoring of the number of falls
- Early identification of those falling in the Community
- An offer of wrap around therapy services from our current offer which includes the Raizer Chair loan and a falls recovery training and equipment offer for formal and informal carers in the person's own home.

This will begin to address equity of service to those in the community, reducing preventable falls and minimising the risk of serious harm if falls do occur. This will reduce the need for a crisis response and hospital conveyance.

The LLR Falls Steering Group is an initiative at System level in response to the priority of falls prevention which is attended by a range of health and social care staff. The Ambition Statement is as follows:

We aim to work in partnership across health, social and voluntary care to improve the health and wellbeing of people at risk of or affected by falls living in the place they call home. We will develop a plan for and take action to ensure the system is equipped to deliver an

effective, accessible and equitable falls prevention and management offer across LLR which includes:

1. *Identification of falls risk and assessment*
2. *Addressing falls risk factors to reduce the risk falling.*
3. *Ensuring that specific falls incidents are effectively managed*
4. *Reducing impact of falls injury to reduce the associated distress, pain, injury, loss of confidence and loss of independence caused by a fall.*
5. *Reducing further falls after specific events*
6. *Recognise value in difference in service provision model across LLR where appropriate but ensure parity of access to services at each stage of the pathway across LLR*

National Condition 2 (continued)

Estimates of demand and capacity for intermediate care to support people in the community.

Metric targets have been jointly produced across LLR, with each area using the same methodology for target setting. This has been through a collaboration of representation from Mids and Lancs Commissioning Support Unit, LA's and ICB with targets and metrics agreed with all partners prior to formal governance sign-off. These have been added to the performance framework across LLR for joint delivery of outcomes related to activity to support timely discharge.

Estimates of demand and capacity have largely been made based on last year's usage. There was no unmet demand where people had to be offered support in a less beneficial service, due to there being insufficient capacity. There was low utilisation of community step-up beds last year. With greater usage of this provision in 2023-24, there is confidence that there should be no over utilisation of inappropriate bedded provision. Assumptions have been made that this will continue as there has been no reduction in provision of services such as MiCare and therapy led reablement. The Home First model continues to be further embedded which will serve to promote the efficient utilisation of support in people's own homes.

National Condition 3

BCF objective 2: Provide the right care in the right place at the right time.

Services which will impact on the following metrics:

- **Discharge to usual place of residence**

It is recognised that enabling people to return home after a hospital stay is a national challenge and there are issues such as an over-reliance on bedded pathways and transition to long-term residential care.

The approaches described below are in line with People at the Heart of Care: Adult Social Care Reform. MiCare is based on an innovative model of care which recognises the importance of planning for changing needs and focuses on prevention and health promotion.

The Home First approach is firmly embedded throughout LLR and working well in Rutland to promote discharge home as the primary and preferred discharge destination (see also page 8). The effectiveness of the Home First Model in Rutland and ensuring sufficient capacity through investing in community based provision, is reflected in data which includes an average of 96% of people who received reablement were still at home 91 days later (2022-23)

Working in conjunction with the wider LLR Discharge Hub, Rutland's MDT triages all requests for support with discharge.

The Integrated Hospital Team combines health and social care colleagues. It successfully supports transfers of care in an empowered and flexible way. Taking shared responsibility for discharges across health and social care colleagues continues to offer a more efficient and effective way to work. For example, having nurses working within the team makes transfer of care considerably smoother, ensuring that the medical needs of services users are supported appropriately on discharge. Working as a Multi- Disciplinary Team provides proactive case management of all P1, P2 and P3 discharges, therefore both the immediate and long-term care needs are supported in a timely fashion.

The Nurses complete Decision Support Tools for Continuing Health Care, arrange the support of those who have short term health conditions (non-weightbearing or delirium patients) and support the transition of those people who require long term health intervention. In accordance with D2A principles the Nurses complete Fast Track applications in the community, expediting discharges from the hospitals, meaning that people with short prognosis get to be in their preferred place for death. Discharge planning starts before the Home First form are received in many cases, as the Rutland Hospital Team are aware of Rutland patients in hospital before they are Medically fit for discharge, having access to Etrack in Peterborough City Hospital allows for proactive triage and anticipates the support needs of pre-discharge patients, streamlining the associated workload. This is something that the Discharge Team will look to emulate with University Hospitals of Leicester over the coming months.

Alignment with D2A facilitation as part of the Adult Social Care Discharge Fund.

The Adult Social Care Discharge Fund was used to fund additional block booked reablement beds in a residential nursing home to facilitate timely discharges. The reablement was delivered by RCC therapists who were available at point of discharge and throughout the patient journey. Additional community capacity was secured through additional funding to retain staff in the MiCare service – see below for service description.

The plan for the Discharge Fund for 2023-24 includes two D2A beds in a residential home in Rutland. These will be used flexibly for any type of D2A need including assessment and reablement. This is based on learning from the previous discharge fund where wrap around and night- time domiciliary care was not utilised, and beds specifically commissioned for reablement although used effectively when there was need, were not fully always utilised. Beds have also been jointly commissioned across LLR. These will utilise the RRR model (Rehabilitate, Reable, and Recover) D2A services, supporting Pathway 2 discharges. At ICS level, the fund is also to be used for training purposes.

It has been recognised that there has been low usage of Step- Up beds throughout 2022. Rutland Memorial Hospital was closed for some months during this period due to structural repair work being required. Therefore, beds were not accessible for Step Up. In addition, there was low usage across LLR and whilst the location of these beds is not optimal for Rutland residents, there could still be potential. This has been considered within the demand and capacity section of the plan. Work is required across LLR regarding utilisation of these beds. These beds can also support with Pathway 2 discharges. However, there is no significant capacity issue affecting Pathway 2 hospital discharges for Rutland. Data shows a very good rate for the proportion of older people who were still at home 91 days after discharge from hospital into reablement. This has hit 96% which demonstrates effective planning and utilisation of Pathway 1 discharges and no over reliance on Pathway 2.

The Rutland Integrated Hospital team historically has strong retention of staff and is currently fully staffed with experienced practitioners and managers including In Reach nurses. Recruitment is therefore not an issue and there is no impact on discharge planning. There are occasional complex discharge cases which require and multi-disciplinary approach with a wide range of professionals' input. Due to excellent localised collaborative working, we can quickly respond and identify appropriate care plans. Whilst placements in Rutland can have their challenges due to home closures and Local Authority fee rates not being accepted, we have remained able to place within Rutland, albeit some have chosen homes outside of the Rutland boundary.

It is recognised that therapists are best placed to manage the functional and environmental risks of returning home. A 7-day service enables RCC to have a therapist triage daily and appropriately designate to P1 or P2 pathway. Rutland Joint Strategic Needs assessment 2018 reported a high and rising level of frail and ageing population. To manage domiciliary care capacity effective routes in to reablement remains our best defence. The above D2A context and motivations for delivery, validated by positive data supports continued investment in the 7-day therapy model for RCC.

MiCare

A creative approach to outcome focused care that tailors support to service users' goals and wishes rather than time and task orientated care in the person's own home. It was developed based on the principles of the Buurtzorg model with small neighbourhood teams integrated health and care provision. The service aims to help people in Rutland to remain

independent and living at home for as long as possible and supports the system flow, providing the right care in the right place at the right time.

The service provides support 7 days a week on a 24 hour basis. On average Micare hold 15 cases per day (7 cases of reablement, 2 safety net, 1 crisis response, 3 complex care, 1 end of life) Micare supports hospital discharges and has on average 40 – 45 cases per month.

Values:

- enable and promote independence
- people are involved in any decisions relating to the service
- people have a service which adapts and changes to meet their needs, preferences and wishes.
- listen, work flexibly and respond to how people want to be supported.
- integrate care and support across health and social care, linking to other specialist and voluntary sector services and the local community

Types of support:

- Reablement—Time limited, therapy led assessment Programme and goal setting with a mixture of health, therapeutic care interventions. **Reablement**, starting within 2 days of referral, is also primarily delivered by Micare, which follows the NICE guidance on intermediate care as "a multidisciplinary service that helps people to be as independent as possible. It provides support and rehabilitation to people at risk of hospital admission or who have been in hospital. It aims to ensure people transfer from hospital to the community in a timely way and to prevent unnecessary admissions to hospitals and residential care".

  Average length of stay on reablement is 22-25 days while maintaining 80 – 100% effectiveness (acscof)

- SafetyNet—Short Term Care. Support whilst longer term care is sourced

  Average stay on safety net is 10 – 21 days

- Crisis response—2 hour response to Rutland residents experiencing a social care crisis, preventing unnecessary residential care or hospital admission. They also provide a **step- up crisis response service** offering short-term care and support following a referral via health or social care emergency routes to reduce the risk of unwarranted hospital admission e.g due to a health crisis, a temporary inability to transfer, risks following a fall or a carer crisis
- D2A—support out of hospital whilst long term needs are assessed. The Micare integrated health and social care offer is delivered by community-based nursing, therapy and Micare carers to support people and their carers when there is a change in need.
- Complex Care—people who may require a gradual/flexible introduction to support, who may benefit from longer term support from Micare before a long term package can be considered..
- End of life—people who may require support to support them to stay/return home inline with their advance care plan / end of life wishes.

Following the CQC inspectors visit on 12th January 2023,

Micare has been awarded a rating of outstanding overall, with good being awarded in the key lines of enquiry of safe, effective and caring service and outstanding awarded in the areas of responsive and well led.

In the summary - the inspector highlighted that People's experience of using this service and what we found was that People were at the heart of the service and received exceptionally responsive, person-centred care which enabled them to live a life of their choosing. In light of this, the service is planned to continue for 2023-24.

In line with this approach and promoting this further, there is work planned on analysing the 'Wider Determinants of Health' from a Health Inequalities perspective. This is linked with the JHWS Prevention priority. Staying healthy and independent, as per the mission of MiCare, further work is planned for 2023-24 to prevent and reduce health inequalities.

The Rutland JSNA identified work was needed regarding End of Life care. This work is supported by MiCare and joint working with community nursing to enable people to remain at home or receive treatment in the first choice of location. This continues to be a priority in Rutland and will be delivered by this collaborative approach.

In addition, a new project is planned based on learning from the JSNA and Health Inequalities. A specific area within Rutland has been identified as a priority area based on socio-economic deprivation and rurality and access to the community. The project will involve active working with small communities to identify and build on the strengths of assets withing villages and surrounding areas, with the purpose of improving access to health and wellbeing resources.

National Condition 3 (continued)

Estimates of demand and capacity for intermediate care to support discharge from hospital.

Estimates of demand and capacity have largely been made based on last year's usage. There was no unmet demand where people had to be offered support in a less beneficial service, due to there being sufficient capacity. There is ample capacity to provide support for people in their own homes on discharge from hospital meaning there is no over utilisation of bedded provision. Assumptions have been made that this will continue as there has been no reduction in provision of services such as MiCare and therapy led reablement. The Home First model continues to be further embedded which will serve to promote the efficient utilisation of support in people's own homes. We are confident in the use of 2022-23 data due to the above.

National Condition 3 (continued)

High Impact Change Model

LLR HICM Assessment June 202.

Teams and services continue to keep their practice under review, including relative to the High Impact Change Model (HICM). LLR has undertaken a self-assessment against the HICM of care for 2023/24. Attached is the summary of the assessment conducted and the work to progress through the levels of maturity. This interweaves with this content of this narrative.

National Condition 3 (continued)

Duties under the Care Act

Care Act 2014 duties include promoting wellbeing, preventing need for care and support, promoting integration, promoting diversity and quality in provision of services.

Commissioning and carers support are covered elsewhere in the plan.

BCF funding supports functions such as a reviewing officer, required to ensure that an adult's needs are being met in line with choice and using and asset- based approach. A Rapid Response worker is also funded whose remit is to react to potential crises, to prevent deterioration and the need for admission to hospital or residential care. Social care, therapists and nurses are funded from BCF who work together to facilitate safe, timely and effective discharges following the D2A pathway and utilising an integrated approach.

Supporting unpaid carers

It is recognised that informal carers have a vital role, often without recognition of the commitments they make, and the substantial impact that their commitment to providing care can have on their own wellbeing. The RCC Carers Team provides support to informal carers to prevent carer breakdown and enable the cared for to remain in their own home, reducing the need for admission to residential and nursing care and the impact on health services.

The aims of the team are below:

- Ensure carers have access to support that promotes their physical and emotional well being
- Early identification of carers to ensure that the right support is accessible in the right places and at the right time for all carers
- Promote supporting carers and the cared for the live at home for as long as possible
- To provide support to carers and the cared for to prevent hospital admission
- To provide carers with a holistic support service

The team remit includes the identification of resources, planning events and undertaking networking activities to communicate relevant and helpful information to carers to help meet their needs. It is an integrated service to which therapists and health professionals are able to refer for carers' assessments.

There is an ASC Rapid Response function, the roles for this also being funded through BCF. This, in the case of carer breakdown, enables prevention of admission to hospital by visiting the carer and cared for quickly, and co-ordinating any necessary response or actions to keep the person safe, well and sustain levels of independence in their own home setting.

The LLR Joint Carers Strategy 2018–2021 'Recognising, Valuing and Supporting Carers' sets out eight key strategic priorities relating to unpaid carers of all ages, and was developed jointly by the LLR local authorities and the (then) CCGs. It is currently being refreshed.

The strategy aims to ensure that carers have access to support that promotes their physical and emotional wellbeing. An important element is identifying carers early and ensuring that the right support is accessible in the right places and at the right time. The priorities were built upon feedback from carers. There is a LLR Carers Delivery Group in place to ensure the outcomes of the strategy are actioned.

The BCF contributes to the funding of the RCC Admiral Nurse Service and Age UK Leicestershire and Rutland dementia contract.

The Admiral Nurse service is a key part of dementia support in Rutland and continues to grow and develop. Referrals have increased by 36% over the last two years. The nurses support the carers of those living with dementia and work with health colleagues on programmes such as refining the dementia assessment pathway to promote people being diagnosed in a timely manner. They work to improve access to the Dementia Support Service which through its interventions helps to delay admissions to residential care or hospital.

There is a three-year contract in place for a support worker to cover pre and peri diagnosis support. This offers practical and emotional support to people living with dementia and their carers through activities and home visits. Information and advice and help to access group events which support for those on waiting lists for memory services.

Disabled Facilities Grant (DFG) and wider services

The strategic approach centres on prevention, enabling people to stay at home for as long as possible using creative and innovative approaches.

Housing services are managed in Rutland as part of Adult Social Care through the Housing Options Team, with Private Sector Housing, Environmental and Enforcement being commissioned out to Peterborough City Council. The team is part of the Prevention and Assurance Service within adult social care, working to prevent and relieve homelessness in line with duties set out in the Homelessness and Reduction Act 2017. This extended entitlements to help, placed a renewed focus on the prevention of homelessness and local joint working. The Team working alongside local housing providers in line with these duties, only occasionally having to support people in emergency temporary accommodation. Rutland is a non- stock holding authority.

RCC is a unitary authority and therefore does not have formal agreements with districts around the use of the DFG, so RCC staff work with providers to facilitate adaptations and provision of equipment.

As in previous years, the DFG continues to be used to fund standard DFG projects and smaller Health and Prevention Grants for a range of adaptations including home access improvements, stair lifts and level access showers. There are no delays in provision of adaptations, again supporting the prevention agenda, enabling people to remain at home for longer, optimising the wellbeing of service users and their carers.

The Housing MOT scheme, funded by BCF, continues to be a successful service providing holistic assessments of the home environment, including elements such as falls prevention, equipment, adaptations and general housing conditions. This is a home check service providing information, advice and support to promote people's independence and living safely in their own homes. The Digital MOT continues to assess the extent a person can be digitally enabled. Age UK partner with the local Housing Improvement Agency to provide options to upskill people, and a technology loan service.

The AT service has successfully been recommissioned, the new contract focussing on new technologies and smart home technologies. The AT OT will continue to work closely with the AT Development and Quality Manager to research this and look at how these can be incorporated into DFG schemes of work where appropriate.

Additional information

Regulatory Reform

Further to the traditional DFG process delivery RCC fully utilised the wider purpose of Regulatory Reform Order to deliver all adaptation creatively and effectively without delay. The latest data showed RCC are completing adaptation from initial inspection/ assessment to full completion of work within an average of 56 working days.

RCC plans to use this element of the Grant flexibly and according to the needs of the demographic. This will flow between DFG, RRO and HaP. This is in line with the Government's narrative regarding flexible use of the Grant in line with need. The DFG is individual to Rutland at place level, having distinct needs and demand. The tight boundaries of the DFG do not align with the needs of many Rutland residents. Therefore, the therapy service utilises the RRO to cover situations, for example, supporting a house move, where adaptions would be extremely costly and take time to complete.

Equality and health inequalities

Reducing health inequalities and disparities for the local population

In 2021-22, a health inequalities plan was developed by LLR ICS partners to consolidate LLR's approach to reducing health inequality. To develop a Place level understanding of health inequalities, Public Health developed a Rutland Health Inequalities Needs Assessment in 2022-23. The assessment, developed with partners, has been well received by the Health and Wellbeing Board and subgroups.

The assessment covered the four overlapping dimensions of health inequality:

- socioeconomic groups and deprivation;
- inclusion health and vulnerable groups;
- protected characteristics in the Equality Duty; and
- geography.

Recommendations from the assessment included the need for a Health and Wellbeing Board development session on health inequalities to identify actions and an approach to take forward. The session was delivered in January 2023. From the session, additional engagement was identified as a need to supplement the quantitative understanding we gained from the assessment.

The assessment identified variation in economic and health indicators across small areas of Rutland. Partners are therefore progressing developments on an asset-based approach, working with small areas of Rutland showing additional need. Pilots will commence throughout 2023-24 and learning taken forward for sharing across the wider county.

BCF delivery this year and BCF planning and delivery going forward will be aligned to the findings and recommendations of the needs assessment, ensuring allocations are supporting those experiencing the poorest health outcomes, or with worse access to services.

Strategically, at Place level reducing health inequalities remains a cross cutting priority within the Rutland Health and Wellbeing Strategy. The priority has its own workplan, with oversight from a Health and Wellbeing Board subgroup – Staying Healthy Partnership. As it is a cross cutting priority, reducing health inequalities is also engrained within other priorities and workplans. In parallel, health inequalities have become a strategic focus of the Integrated Delivery Group, the subgroup of the Health and Wellbeing Board which operationally drives the BCF programme. This will help ensure partners work collaboratively on reducing the inequalities presented in the needs assessment, including through the delivery of BCF actions.

A more considered and governed approach to addressing health inequalities will enable more structured mechanisms to monitor progress on reducing inequalities, allowing BCF projects to align and demonstrate their impact in a more coherent way.

Core20Plus5 is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at national and system (LLR) level. Rutland is a relatively affluent area so does not have populations among the 20% most deprived nationally according to the Index of Multiple Deprivation. The ‘Plus’ element, however, allows local places to determine priority disadvantaged groups sitting outside of the core 20% most deprived. The Rutland Health and Wellbeing Board are currently confirming their local ‘plus’ groups based on local intelligence. Once identified, these groups will also be considered in respect of BCF implementation and future planning.

We also recognise that disadvantage is often multi-faceted. Considering equality factors in this way helps to see circumstances in the round to ensure appropriate responses. This underlines the need to tailor services to individuals and their circumstances in order to bring

about positive change and reduce avoidable need for health services, also building on available strengths. The County's social prescribing, health and care services all aim to work within this holistic framework.

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Rutland

Local Authority Contribution		
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2
Rutland	£270,255	£270,255
DFG breakdown for two-tier areas only (where applicable)		
Total Minimum LA Contribution (exc iBCF)	**£270,255**	**£270,255**

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2
Rutland	£30,678	£50,925

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2
NHS Leicester, Leicestershire and Rutland ICB	£29,300	£53,874
Total ICB Discharge Fund Contribution	£29,300	£53,874

iBCF Contribution	Contribution Yr 1	Contribution Yr 2
Rutland	£218,818	£218,818
Total iBCF Contribution	**£218,818**	**£218,818**

Are any additional LA Contributions being made in 2023-25? If yes, please detail below	No

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding
	£0	£0	No comments
Total Additional Local Authority Contribution	**£0**	**£0**	

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS Leicester, Leicestershire and Rutland ICB	£2,783,104	£2,940,628
Total NHS Minimum Contribution	**£2,783,104**	**£2,940,628**

Are any additional ICB Contributions being made in 2023-25? If yes, please detail below	No

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional NHS Contribution	**£0**	**£0**	
Total NHS Contribution	**£2,783,104**	**£2,940,628**	

	2023-24	2024-25
Total BCF Pooled Budget	**£3,332,155**	**£3,534,500**

Funding Contributions Comments
Optional for any useful detail e.g. Carry over

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Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Rutland

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	127.1	123.4	123.4	103.0	This is an area which needs to and can improve with a more focussed approach on prevention across LLR	Promotion of ARRS and the NHS app etc. Better utilisation of Community Health Beds for Step Up. Roling out of Public Health inequalties work with communities.
	Number of Admissions	70	68	68	-		
	Population	40,476	40,476	40,476	40,476		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Indicator value	105	117	112	103		

>> link to NHS Digital webpage (for more detailed guidance)

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,565.3	1,217.1	1,155.4	Trialling falls prevention programme in care homes, which has seen a reduction in falls leading to admissions	Embedding of falls prevention programme, increasing capacity of AT from DFG
	Count	170	133	120		
	Population	10,386	10,386	10,386		

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	89.6%	90.7%	90.5%	90.4%	With fewer avoidable admissions the number of discharges should ultimately decrease. P2 likey to continue at 9-10% of discharges. A Lowe target is unrealistic given unavoidable discharge pathways such as Non Weight Bearing	Better utilisation of Community Health Beds; good care market sustainablity;
	Numerator	637	679	601	650		
	Denominator	711	749	664	719		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Quarter (%)	90.7%	90.9%	91.2%	91.2%		
	Numerator	650	680	620	620		
	Denominator	717	748	680	680		

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	705.7	280.9	196.7	193.2	The target has remained same as 2022-23 as there are challenges to make improvements. The numerator plan was 30 and the estimated actual is considerably lower at 21. The figure of 73 actual for 2021-22 is not accurate.	Utilisation of Home First, Reablement, Rapid Response, Community Health
	Numerator	73	30	21	21		
	Denominator	10,345	10,679	10,679	10,869		

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	96.4%	90.0%	97.0%	95.7%	RCC is performing at a very high level and we plan to continue offering the same good quality service	Continuation of MiCare and therapy reablement offer.
	Numerator	27	45	32	44		
	Denominator	28	50	33	46		

Please note that due to the demerging of Cumbria information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- Actuals and plans for Cumberland and Westmorland and Furness are using the Cumbria combined figure for all metrics since a split was not available; Please use comments box to advise.
- 2022-23 and 2023-24 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2021-22 estimates.

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Revised October 2023

Rutland Health and Wellbeing Board
Terms of Reference

The Health and Wellbeing Board (HWB) has been appointed by Rutland County Council as a statutory committee of the Local Authority. It will discharge directly the functions conferred on Rutland County Council by Section 196 of the Health and Social Care Act 2012 and any other such legislation as may be in force for the time being.

1. Aim

To achieve better health, wellbeing and social care outcomes for Rutland's whole population, reducing health inequalities and delivering a better quality of care for people using services through the provision of:

1) collaborative leadership that influences, shapes and drives a wide range of services and interventions spanning health care, social care and public health.

2) strategic oversight of, and challenge to, the planning, strategy, commissioning and delivery of services across health, social care, public health, children's and young people's services and other services that the Board agrees impact on the wider determinants of health.

2. Statutory Functions

Under the Health and Social Care Act 2012, the HWB has the following duties and functions:

1) To encourage integrated working between health and social care commissioners, including arrangements under Section 75 of the National Health Service Act 2006 in connection with the provision of health and social care services.

2) To prepare and publish successive Joint Strategic Needs Assessments (JSNA) and Joint Health and Wellbeing Strategies (JHWS) that are evidence based and supported by all stakeholders to set out Rutland's objectives, trajectory for achievement and how members of the Board will be jointly held accountable for delivery.

3) To encourage close working between commissioners of health-related services and the Board itself.

4) To encourage close working between commissioners of health-related services (such as housing and many other local government services) and commissioners of health and social care services.

5) Any other functions that may be delegated by the council under section 196(2) of the Health and Social Care Act 2012.

The HWB has an additional responsibility derived from the amended NHS Act 2006, under which NHS England has powers to attach conditions to the payment of the Better Care Fund (BCF):

1) The HWB is required to jointly agree plans for how BCF pooled funds will be spent to progress health and care integration in Rutland, with plans signed off by the relevant Local Authority and Clinical Commissioning Group or its successor body.

3. Additional Responsibilities

The Board has also agreed additional responsibilities which complement its statutory functions:

1) To constructively challenge and hold to account partners (including local partners, those delivering services, projects and programmes across LLR, and those delivering services outside the ICS area that have significant Rutland implications), to ensure that their strategies, plans and services are aligned to Rutland's JHWS priorities, and to consider what is best for Rutland within their plans and actions.

2) To have oversight of the use of relevant public sector resources across a wide range of services and interventions, with greater focus and integration across outcomes spanning health care, social care and public health.

3) To task relevant groups, whether standing or time-limited, including the sub-groups of the HWB, to develop solutions to challenges outlined in the JSNA and JHWS.

4) To inform the development and assure the delivery of the Rutland BCF programme.

5) To facilitate partnership working across health and social care to ensure that services are joined up around the needs of service users.

6) To focus resources on the agreed set of priorities for health, wellbeing and social care (as outlined in the JSNA and JHWS).

7) To ensure alignment, where appropriate, between ICS commissioning plans and the Rutland JHWS and BCF programme.

8) To ensure that the work of the Board is aligned with policy developments both locally and nationally.

9) To communicate with the public about Rutland's health, care and wellbeing needs, services and developments and to use their experiences and views to inform the work of the HWB.

4. Principles

The Board agree to work to the following principles:

1) Shared ownership of the Board by all its members (with commitment from their nominating organisations) and accountability to the communities it serves for delivering the Board's priorities.

2) Commit to driving real action and change to integrate services and to improve services and outcomes, also by making investment decisions that support shared aims.

3) To adapt a proportionate universalism approach that targets resources to prioritise the most vulnerable and reduce health inequalities and improve wellbeing opportunities and outcomes.

4) Support people to maintain their independence and play a full role in looking after themselves, encouraging and enabling people to make informed healthy choices.

5) Share success and learning to make improvements cross-organisationally for the wider benefit of Rutland.

6) Be evidence led, open and transparent in the way that the Board carries out its work, using local data and intelligence, and listening to service users/patients and the public, and acting on what this tells us.

7) Represent Rutland at LLR, regional and national platforms to ensure Rutland's voice is heard.

5. Position within wider governance

The Board will coordinate its work with that of the system-level LLR Integrated Care Partnership (the Health and Wellbeing Partnership), the former fulfilling the responsibilities of 'place' (Rutland) and the latter of 'system' (Leicester, Leicestershire and Rutland).

There will be two permanent sub-groups of the Board:

a. **Children and Young People's Partnership (CYPP)**:
Responsible for the development and improvement of services for children and young people 0-19 years, (and to the age of 25 years for some vulnerable young people), overseeing the delivery of the agreed vision and priorities of the Children, Young People and Families Plan.

b. **Rutland Integrated Delivery Group (IDG)**:
Responsible for health and care needs in Rutland, managing the resources available to do this and working in partnership to provide leadership, direction and assurance to the integration and enhancement of health and care services in Rutland, with a particular focus on key local change programmes contributing to this aim, notably the JHWS and BCF programme.

The Terms of Reference for each of these sub-groups is attached.

Additional sub-groups may be formed on a time-limited basis at the request of the Board to address specific issues or undertake specific pieces of work. Where additional sub-groups are formed, the Chair of the Board will appoint a Chair for the sub-groups and agree reporting requirements and timescales.

Other temporary or permanent groups taking forward relevant work may also be asked to provide updates to the HWB.

6. Safeguarding

The Board will work in line with the agreed protocol in place between the Leicestershire & Rutland Children's Safeguarding Partnership (LRCSP), the Leicestershire & Rutland Safeguarding Adults Board (LRSAB) and the HWB. The protocol outlines the relationship between the Boards, how safeguarding shall be taken into account within the business of the HWB, and how health & wellbeing shall be taken into account within the business of the LRSCP and the LRSAB.

The protocol shall be approved by both the Board and by the LRSCP and the LRSAB and reviewed at least three yearly.

7. Membership

The minimum membership of the Board shall consist of the following voting members:

- Two representatives from the Leicester, Leicestershire and Rutland Clinical Commissioning Groups or their successor body. (2)
- Two local elected representatives (2) at least one to be the Portfolio Holder for Health.
- The Director of Adult Services and Health for Rutland County Council. (1)
- The Director for Children and Families for Rutland County Council. (1)
- The Director of Public Health for Rutland County Council. (1)
- One representative of Rutland Healthwatch. (1)
- One representative of NHS England. (1)
- The Clinical Director of the Rutland Health Primary Care Network. (1) (Non statutory member)
- One senior representative of the Leicestershire Partnership Trust. (1) (Non statutory member)
- One representative from the Voluntary and Community Sector (1) on behalf of this sector. (Non-statutory member)
- One representative from a Registered Social Landlord on behalf of social landlords. (1) (Non statutory member)
- One representative from Leicestershire Constabulary. (1) (Non statutory member)
- One representative of current and veteran Armed Forces. (1) (Non statutory member)

and such other members as the Board thinks appropriate, including, but not limited to: - additional system and place representatives from neighbouring areas, voluntary sector representatives; clinicians; and provider representatives, to be added to the Terms of Reference at the next review point.

Meetings may also be attended by non-members, bringing agenda items or supporting with particular skills and knowledge. They are non-voting.

Members are kindly asked to attend all HWB meetings. All members can appoint a maximum of one deputy to attend meetings by exception in their absence.

Members (and their deputies where required) will act with the necessary delegated responsibility from their organisation and take decisions on behalf of that organisation in relation to the work of the Board. It is acknowledged that resource allocation and formal approval will need to be sought from the members' respective governing bodies.

8. Voting

All members of the Health and Wellbeing Board are allowed to vote (unless the County Council directs otherwise).

Rutland County Council's Meeting Procedure Rules in relation to voting apply; however, it is hoped that decisions of the Board can be reached by consensus without the need for formal voting.

Decisions can be taken by the Chair where necessary for reasons of urgency outside of formal meetings. Any decisions taken outside of formal meetings shall be recorded at the following meeting along with the reasons for the urgency and the basis for the decision.

Under current legislation, decisions may only be formally taken in meetings held face to face. Decisions in principle can be taken during virtual meetings and carried forward to the next in-person HWB meeting for ratification.

9. Standing Orders and Meetings

The Access to Information Procedure Rules and Meeting Procedure Rules (Standing Orders) laid down by Rutland County Council will apply with any necessary modifications including the following:

a. The Chairperson will be Rutland County Council's Portfolio Holder for Health; the vice-chair will be elected from one of the other statutory members of the Board.

b. The quorum for a meeting shall be a quarter of the membership including at least one elected member from the County Council and one representative of the East Leicestershire and Rutland Clinical Commissioning Group/LLR Integrated Care Board.

The business of the Board will be supported by Officers of the Board, the Rutland Consultant for Public Health and the Health and Wellbeing Integration Lead at Rutland County Council. Administration support will be provided by Rutland County Council.

There will be standing items on each agenda to include:

1. Declarations of interest

2. Minutes of the previous meeting
3. Matters arising
4. LLR ICS, JHWS, JSNA and BCF update

Meetings will be held online and in public at least quarterly (4 times a year), unless members agree otherwise, or as guided by decision-making requirements or any pandemic-related guidelines in force. In particular, significant decisions must currently be taken in person.

Public meetings will be up to three hours in duration.

The Board may also meet for workshops or seminar sessions and for Board learning and development. These meetings, to include an annual review of the JSNA and JHWS, will be informal and not held in public, although outcomes will be made public (e.g., as relates to the JSNA and JHWS) as part of subsequent main Board meetings.

10. Review

These Terms of Reference will be reviewed at least annually, and more frequently where circumstances dictate.

Rutland Health and Wellbeing Board
Work Plan 2023-24 v12

STANDING AGENDA ITEMS	AUTHOR
Apologies Record of Previous Meeting Actions arising Declaration of interest Petitions, deputations, and questions Questions with notice from members Notices of motions from members	Statutory Agenda Items
LLR Integrated Care System: update	Sarah Prema, Chief Strategy Officer, LLR Integrated Care Service
JSNA: Update & Timeline	Adrian Allen, Assistant Director - Delivery, Public Health
Joint Health and Wellbeing Strategy	Katherine Willison, Health and Integration Lead, RCC.
Better Care Fund: 2023-2025	Katherine Willison, Health and Integration Lead, RCC.

MEETING DATE	PROPOSED ITEM	AUTHOR	PURPOSE
27/06/23	Election of Vice-Chair	Chair	Statutory Decision
	HPV Vaccinations To receive an update from NHS England		Discussion
	JSNA: Update & Timeline: Armed Forces: Personnel and Families Survey Report Update and information from the meeting held with NHS England. Chapters to be reviewed: A) Preparing for Population Growth	 Adrian Allen / Mitch Harper Mitch Harper Richard Wilding	 Discussion Discussion Decision
	LLR Integrated Care System: update 5 Year Joint Forward Plan Health and Wellbeing Partnership Strategy	 Sarah Prema Sarah Prema	 TBC TBC
	JHWB Strategy Falls Data Update following clarification of the data Communication and Engagement Strategy and Plan	 Katherine Willison Katherine Willison	 Discussion Decision

	Health and Wellbeing Board Annual Report 2022/23	Katherine Willison	Decision
	Primary Care Strategy	Debra Mitchell	Discussion

MEETING DATE	PROPOSED ITEM	AUTHOR	PURPOSE
10/10/23	Rutland Health & Wellbeing Board: Terms of Reference		Review/ Decision
	JSNA: Update & Timeline: ~~Chapters to be reviewed:~~ A) ~~Substance Misuse~~ B) ~~Alcohol Misuse~~	~~Mitch Harper~~	~~Decision~~
	LLR Integrated Care System: update Health and Wellbeing Partnership Strategy: Implementation Plan – update Rutland Health Plan: Update	Sarah Prema	Discussion Discussion
	JHWB Strategy Communication and Engagement Plan 2022-2027	Katherine Willison	Decision
	Area SEND Inspection Report	Dawn Godfrey	Information
	Sub-Group Update c) Rutland Mental Health Neighbourhood Strategy and Action Plan	Emma Jane Hollands / Mark Young	Approval
	~~**Winter Preparedness**~~		~~Information~~

MEETING DATE	PROPOSED ITEM	AUTHOR	PURPOSE
16/01/24	**JHWB Strategy** Falls Data: 6 Month Study Results	Katherine Willison	Discussion
	JSNA: Update & Timeline: Armed Forces Covenant Duty and Health Inequalities Chapters to be reviewed: A) Substance Misuse B) Alcohol Misuse	Karen Kibblewhite Mitch Harper	Discussion Decision

	Rutland Proactive Care Dementia Pilot	Emma Jane Hollands	Discussion

MEETING DATE	PROPOSED ITEM	AUTHOR	PURPOSE
30/04/24			

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