Priority 1: The Best Start for Life

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

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

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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**

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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 Meals) • Children with visibly obvious tooth decay at age 5years • A&E attendance for children aged under 1years and aged under 4years. • Qualitative feedback from parents on feeling supported through 1,001 critical days					**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**

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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**
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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2.1	**Supporting people to take an active part in their communities**											**GREEN**
2.1.1	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	Working Group re-established with good reach of stakeholders. Group aware that finalisation of plan is required. Quality Improvement Officers have been assigned actions including engaging with community groups, digital imporvements.					**GREEN**
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	VCF forum ongoing and CAR providing support to the VCF sector. Research underway into the development needs of the VCF sector to support commissioning of this service from 2022-23. Recent proposal put together by VCS partners to better support individuals calling on many services and reduce ongoing need - however only partially funded as yet. Attendees at neighbourhood monthly meeting increasing.	• Monthly VCF meeting held, NHS VCS alliance website promoted and voluntary sector groups encouraged to sign up. • Cooperation mechanisms established with Primary Health Care, Rise Team, Safer Rutland partnership agreed and signed off (shared calendar created (https://teamup.com/ksjakxfkk2bhunra2a) in series of pop up stalls in markets and community events where multiple agencies working together to promote events in the community. • Community Development Officer visited a number of hyper local events and promote services and signposted in small rural community spaces. • Rutland Health and Inequalities report using 2021 census data shared with 180+ voluntary sector partners across County.	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	Volunteering site is in place and actively promoted, range of opportunities increasing. Celebrated volunteers week at the end of May. Main current challenge is numbers of volunteers coming forward.	• Volunteer Plus Website continues to have traffic with 60 vacancies posted. • Collaboration with Local radio station Rutland and Stamford Sounds to promote the site ongoing. • Site will be promoted at 5 pop up events in the year. • A welfare and Benefits Focus Group will be convened in March to improve coordination and links between portioners RCC and Primary Health care. • Event held at Langham Village Hall Coffee Morning, Rutland Safety Partnership, Neighbourhood Policing, RISE Team, AGE UK. Promoted Farming Community Network and Bereavement Help Points literature. Attended by 27 residents aged 64+	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	Community conversations work to to be planned in. Neighbourhood lead in post and attendance at new neighbourhood meetings increasing.	Survey on VCF sector across Rutland has now passed Beta Testing. Database of 800 VCS organisations has been compiled and Survey will live in mid-March, results published in May 2023. Leading to VCSE strategy development phase, draft strategy ready by August 2023.				**GREY**
2.2	**Looking after yourself and staying well in mind and body**											**GREEN**
2.2.1	Supporting residents to live more active lives	a) Increasing exercise on referral and promotion of active opportunities – helping people to increase activity positively in ways that work for them - personalised approach building on strengths. Also targeting groups such as patients on waiting lists, with mental ill health or living with dementia or cancer, people isolated or unable to travel. b) Local progress of the LLR Active Together strategy, including engaging organisations including businesses, care homes and schools in facilitating active lives. c) Secure funding for the active referral scheme following leisure contract review. Consider feasibility of subsidised participation for people on lower incomes. d) Secure funding via PCN to develop a wider offer e.g. hip, knee and back school.	Active Rutland, Active Together, PCN RISE	Mar-24	Place	* Exercise referrals made * Exercise referral service user numbers * Reduction in the proportion of adults overweight or obese * Increased proportion of physically active adults * Increased proportion of adults engaging in active travel (cycling or walking) at least 3 days a week * Proportion of health checks completed	New funding and a service model has been agreed for the continuation of Active Referral from April 23. The programme will be coordinated by the Active Rutland team based at Rutland County Council.					**GREEN**

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2.2.2	Supporting residents in health awareness and ensuring they can self-care where appropriate.	a) Providing information to increase awareness of changing health needs, and confidence to self-care. b) Clear prevention 'front doors' for additional support (See 2.2.4 Social Prescribing). c) Increase uptake of Weight Management Rutland service for adults, and family-focused support programmes, including Holiday Activities and Food Programme. Encourage take-up of NHS health checks and ongoing blood pressure monitoring for early diagnosis of cardio vascular risk. d) Review Chlamydia screening across Rutland to identify reasons for low level of Chlamydia detection and screening.	RCC (incl RIS, RISE, libraries), Public Health, PCN, VCF sector	Mar-24	Place	* Communication measures on Health awareness campaigns and RIS webpages (reach, shares, posts etc.) * Uptake of prevention services * Uptake of NHS health checks and numbers of referrals to prevention services * No. of blood pressure checks in the community * Improvement in Chlamydia screening rate and understanding of detection rate	The Rutland weight management service will be mainstreamed funded from April 1st this will provide more opportunities to promote the service and increase take up of the offer to Rutland residents. Linking into the MECC, Active Rutland, and the newly commissioned Health checks. Alterations made to the health checks service are designed to improve the invite and take up process. Sexual health services are currently out to consultation and the results of which will inform the					GREEN
2.2.3	Ensure our workforce are trained and empowered to have healthy conversations	a) Implement Healthy Conversations training (Making Every Contact Count Plus – MECC+) to empower Rutland's diverse front line staff to discuss health and wellbeing with service users and signpost them. b) To include professionals working with housebound and digitally excluded people, and those who struggle to travel. c) Accessible signposting resources.	RCC, PH, LPT	Jun-23	Place and System	* Numbers trained in MECC+, train the trainers and super trainers in Rutland * Data on source of referrals to prevention services * Reach of RIS website * Qualitative feedback and evaluation of MECC+ training package	Paper going to the Health & Wellbeing Board in March on MECC+ rollout in Rutland. Train the Trainer dates agreed for March 23.					GREEN
2.2.4	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.	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.	RCC (RISE), PCN	Jun-23	Place	* 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						GREEN
2.3	**Encourage and enable take up of preventative health services**											GREEN
2.3.1	Increase uptake of immunisation and screening programmes.	a) Completion of a health equity audits on immunisation and screening programme uptake across Rutland. (Including childhood immunisations.) See 1.1 and 1.2. b) Targeted communications campaigns using behavioural science to support increasing uptake. (See 2.1) c) Use the Health and Wellbeing Coach, healthy conversations (MECC+), Core20Plus5 and other routes to increase cancer screening uptake including mammograms, bowel scope screening and cervical screening [see 2.2] d) Considering how services could be delivered closer to home (for example breast and bowel scope screening) See 4.2.	PH/ PCN/ NHS England	Mar-23	Place and System	* Health Equity audits completed on areas of concern. Results/ recommendations reported to HWB and LLR Health Protection Board. * Uptake of specific immunisation and screening programmes. Specifically reviewing vulnerable or under-served groups. * Including offer/ uptake of health checks (including those for LD), uptake of screening programmes (including breast and bowel scope screening), uptake of screening programmes closer to home.	Health Check programme procured from 1st April for Health Checks, new payment schedule will support increased activity. Monitoring will happen through existing governance structures.					GREEN
2.4	**Maintaining and developing the environmental, economic and social conditions to encourage healthy living for all**											GREEN
2.4.1	To have a focus on health and equity in all policies.	Focus will include the economic, social and environmental contributions to health (wider determinants of health). a) Aiming for an overall commitment of relevant organisations in Rutland to building in consideration of health and equity in all that they do. b) Health Impact Assessments (HIA) or Integrated Assessments for decision making and policy development. Health Impact Assessment (HIA) of individual policies/investments, considering social value. c) Produce a wider determinants review with partners for Rutland. The review will explore existing work across Rutland, identifying any gaps to consider additional action across partners. Focus will include the built environment; open and green spaces; active travel; fuel poverty; air quality; and healthy housing.	RCC PH	Mar-24	Place	* Organisations committed to a Health and Equity in all Policies approach. * Evidence that organisations have embedded a process to systematically consider health, wellbeing and equity in everything they do. * Evidence of enhanced designs/decisions from HIAs * Development of wider determinants review.	Some initial Health in all Policies work has started, including focus on a training package covered in action 5.3.1. This will lead onto a more formalised approach once learning from pilots is complete.					GREEN

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

Senior Responsible Officer (on HWB) **John Morley**

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

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3.1	**Healthy ageing, including living well with long-term health conditions, and reducing frailty and over 65s falls**										
3.1.1	Empower people towards self care	1. Development of new digital front door	PH/rcc	Dec-24	p	Number of people accessing front door	await new meeting to discuss - Kevin Quin	Development of a self-assessment portal for Therapy Services is in final stage development. The portal will be accessed via the Rutland County Council website and will direct members of the public and professionals to complete an on-line self-assessment for therapy services. The portal aims to seamlessly direct referrals to the right therapy offer including those accessed via our social prescribing platform Joy. This ensures the right professionals are involved in the persons care and support from the start, preventing duplication and telling your story twice. Access to an efficient self-directed referral could also reduce the demand on our therapy duty offer and enable our therapy resource to be focused where most needed. This focus of resource will also assist in futureproofing against the ever increasing demand on services	funds to progress this project buy in from across partners		**amber**
		2. Full use of the Joy social prescribing platform as the referal route to Rise	pcn/rise	Mar-23	p	number of rise referals against target for year of 507 from PCN	joy being used for all GP referals - further onboarding of the market place taking place this month	referals from GP still high Gp recroded 46 referals for Feb 2023 - total 414/507 of the pcn target for the year to date. Rise referals of 72 for jan - 10 being self referals			**GREEN**
		3. Rutland prehab pilot	icb/pcn/active rutland/vol sector	Jul-23	p	number of residents engaging in prehab activites prior to below the waist operations	meeting with health to discuss bringing the pilot being undertaken in the county to Rutland - small numbers going to Leicester - 11 waiting Knees replacement and 6 waiting for hips. Group have sdiscussed other sources to obtain the cohort	UHL Fit4Surgery team have a business case currently being considered by the ICB to provide a consistent service across LLR for orthopaedic surgery and that should this be approved, we would discuss how we could work together to implement this.			**GREEN**
	also in health plan	4. 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	22/23	p	Number of patients accessing ppintment online	update needed from comms group - charlie S	Rutland Health PCN have now recruited to a diigital transformation lead in conjunctiuon with the Additional Roles Reimbursement Scheme. I have held a premliminary meeting with Dave Rowson who is the ICB comms and marketing lead to discuss the possibility of maximising use of of patient online services and guides to downloading the NHS app that can be made available to the Rutland practice websites and other information portals.			**GREEN**
3.1.2	Proactive care pilot (formally anticipatory care)	1 Monitoring deterioration in a persons health using:-Collaboration between Rutland PCN, Rutland County Council, Leicestershire Partnership NHS Foundation Trust and local VCSE organisations Project is co-ordinated by MDT Facilitator (fixed-term, 10 month post until September 2023) Focuses on patients with identified memory loss/issues with cognitive functioning – but no formal diagnosis of dementia – approximately 200 patients identified Patients will be invited to MDT Clinic, where they can access a range of health specialisms and wider services – location will depend on where patients are clustered Carers will be invited to a follow-up event, tailored to needs of carers Carers will bring in photos of the patients home, so environmental issues can be identified An 'proactive care action plan' will be developed for each patient Clinics will take place in March 2023	pcn	Apr-24	p	number attending clinics		memory clinic in contact with a venue to bring the memory assessment clinic into Rutland - poss from begining of April 2023. PCN clensing list of 200 patinets identified in this cohort. Planning for events will take place once we know where and how many patients	recruitment of MDT facilitator	further funding to emable inital advert for a 12 month rather than 8 month contract - seek to make this longer using BCF funding	**GREEN**
	also in health plan	1. Whzan – NEWS2/Restore Mini	Pcn/rcc	Mar-23	p	Number of people admitted to acute from a care home	9 rutland homes all on board and starting to use the Whzan boxes - intial evaluation is hihglighting the long waiting times for homes to	peer support group established with those homes taking part in the rutland whzan pilot - will extend the monitoring inot the falls app linked to the blue box	homes not using the box	peer support group established ad taking place monthly	**GREEN**
	also in health plan	2. Population health management Embed operational population health management approach through Multi-Disciplinary Teams to jointly manage frail, complex and high-risk patients	Pcn/rcc	Jun-23	p	Number of MDTs from neighbourhood facilitator MDT meetings taking place at agreed intervals Increase in identification of patient cohorts	recruiting to MDT facilitator	Rutland neighbourhood meeting to be held in March to reestablish group and formalise the MDT framework approach to working in Rutlanad	recruitment to MDT facilitator	seek more and longer term funding for this role - as above	**GREEN**
	also in health plan	3. Increase the number of Blood Pressure monitors available for Hypertensive patients to self-monitor (Blood Pressure @ Home) (22/23)	pcn	Dec-22	p	Rutland Health PCN to increase the number of BP monitors to support Hypertensive patients to self monitor at home. Monitor the use of the BP machines and		Rutland have secured the maximum amount of BP machines avaialble within 2022/23 and they are being well utilised. Additional equipment is being made available through the role out of the community diagnostics work.			**GREEN**
	also in health plan	4. 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	Apr-23	p	Review and evaluate based on: Reduced rate of hip fractures. Increase number of patients with frailty flag using the electronic frailty index. Increased uptake of shingles vaccination. Number of completed structured medication reviews. Number of completed care plans including RESPECT where appropriate. Number of patients referred to Steady Steps and falls prevention services.	nicola - pcn to update	meeting with Eilidh to update progress 2.Health Inequalities a.Long Term conditions review b.Shingles Vaccination c.Falls Assessment d.Memory Assessment			**GREEN**

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		5.. EHCH - Frailty assessment 1. Person Centred Support plan - All people living in a care home a. What would you like to achieve? b. Are there any barriers stopping you from achieving this?	pcn/ccs	Jul-23	p	number of care home residents with a frailty assessment/score		all but one survey returned from care homes. PCN Pro-active Care Co-ordinator and clinical care home lead are wrking together to look at how care homes can share their experiences with what went well with PCSPs and future changes that would work for them. They could also just know that they have a contact if they would like advice on a particular issue.We do hold quarterly Provider Forums at Rutland County Council, open to care homes and dom care providers. These are hybrid meetings, so providers can attend in person or virtually. We held one yesterday and two care homes attended (1 in person and 1 virtually) so maybe a less formal meeting might be more appealing to care homes Oakham Grange are keen on this and would be happy to have it at their care home as they have the space			GREEN
	also in health plan	6.Implement Proactive Care at Home frameworks for managing Cardiovascular Disease Long Term Conditions, using risk stratification to prioritise patient condition reviews (22/23) To deliver the Network Contract DES including the requirements for the delivery of a cardiovascular disease (CVD) prevention and diagnosis service by primary care networks (PCNs).	pcn	22/23	p	Recruitment of 7 clinical pharmacists as a part of the ARRS 2022/23 programme who will help to improve access for CVS risk management.		All clinical pharamcists recruited and now in post. Proactive care also being offered as a part of the enhanced access appointmments. All practices meeting the target for Percentage of patients aged 18 or over with an elevated blood pressure reading (=140/90mmHg) and not on the QOF Hypertension Register, for whom there is evidence of clinically appropriate follow-up to confirm or exclude a diagnosis of hypertension at the ned of January 2023.			GREEN
	also in health plan	7. PCN to Increase frailty identification and assessment on collaboration with RISE team by 25% (Oct 22)	pcn	Dec-23				Need an update from the PCN.			GREY
	also in health plan	8. Increase uptake of community eye scheme provided by local optometrists (22/23) Completion of a business case for consideration by the Strategic Estates Team that demonstrates the utilisation of ringfenced S106 funds that complies with criteria outlined by Rutland County Council. Agreement of S106 funding for re-purposing of a waiting room at Oakham Medical Practice in to additional clinical rooms.	icb?	22/23	p	numbers accessing		Update required from Helen Mather's team			GREEN
	also in health plan	9. All vulnerable patients (including end of life) have quality care plans in place by Oct 22 (22/23)	pcn	22/23	p	number with a quality care plan	charlie??	Palliative patient care planning including ReSPECT, overall Rutland position has improved over the last 12 months and further improvement in 3 out of the 4 practices between Dec 22 and January 23. Oakham and meeting the 80% target as of Dec with 83.47%			AMBER
3.1.3	management of falls	1. Exercise referral and promotion of active opportunities makes it easier for people to increase their activity levels in a way that works for them.	Active rutland /pcn/dhu/rcc therapy	Apr-23	p	Living with ill health	active rutland onboarding case management onto the joy platform	Active Referral update - Active Referral interim coordinator in place. Active Referral offer is as strong as its ever been. 2 new community venues established for Active Referal supported activity. Joy platform being used, aspiration to move all referals to joy. Two new steady steps classes being delivered in the community, these classes will be for 24 wks, starting FEb 23. SS data to be included in April. Data collection submission due April 13th. Quarterly reporting. numbers update and data update will be April 23.	funding request not supported by PH		GREEN
		2. DHU urgent falls response car		22/23	p	Number of responses by DHU car	pots??	renewal of this is being considered by the Home First collaboration	further continuation is not supported		GREEN
		3. Personalised falls prevention programme - Therapy project for support to care homes to prevent falls	LHis	22/23	p	Number of care homes engaged in falls project and resulting reduction in number of falls Period No of reported Hip Fractures in Care/Residential Homes July – October 2021 12 July – October 2022 1	The programme is continuing to be rolled out with the aim of enrolling all homes this calendar year. Its effectiveness continues to be demonstrated with **no reported hip fractures** in December 2022 within the care home population of Rutland.	Five care homes have now enrolled onto the personalised falls prevention programme and progressed in their programme development to stage two. Our dedicated Falls Occupational Therapist is working collaboratively with the Clinical Care Home Coordinator to ensure accurate reporting of falls from all care and residential homes in Rutland, not just those enrolled onto the programme. Data has been collected since July 21. Analysis has started to look at the impact of the programme and initial figures are positive: Period No of reported Hip Fractures in Care/Residential Homes July – December 2021 17 January – December 2022 8 We are continuing to collect data and we have one recorded hip fracture for 2023 to date. Falling amongst our most vulnerable cannot be fully eradicated, however this programme is demonstrating a reduction in the impact/severity of falls.	Staff Capacity: Currently 1 Full time OT dedicated to falls prevention, as the programme expands capacity would need to be considered. Demand – the programme has created a huge demand on therapy services increasing the falls reporting to unmanageable levels. The programme is constantly evolving, and process is being revised in line with the demand that has been created. This will be seen in the 2023 rollout for the next homes and changes for those enrolled.	**Staff Capacity**- We have secured a locum role for 2 months to assist with the current demand and give opportunity for the inhouse therapist to revise the process and streamline to a manageable level. Demand – as stated the programme has created a huge demand, increasing the falls reporting to unmanageable levels. The recruitment of temporary cover will give opportunity for the programme to be revised in line with the demand that has been created.	GREEN
		digital transformation	rcc	Mar-23	p	all switched over to digital care tech	Longhurst Group have been successful in securing the contract and we will be commencing mobilisation in the coming weeks. The new specification and business plan for this contract gives a clear direction for the service. We are looking forward to working with them and moving at pace utilising the digital switchover as a catalyst to transform care technology in Rutland.	Longhurst Group have been successful in securing the Assistive Technology contract and we will be commencing mobilisation in the coming weeks. The new specification and business plan for this contract gives a clear direction for the service. We are looking forward to working with them and moving at pace utilising the digital switchover as a catalyst to transform care technology in Rutland. Our commissioned partners are continuing to lead on the research concerning the digital switch over, working closely with the TSA and exploring concern such as rurality and network coverage	**Digital switchover rollout for those using monitoring services** - Rurality and network/signal coverage.		
		4. Care homes digital falls monitoring		23/24	p	Reduction in admissions to acute from care homes due to falls		app as part of the whzan box is being rolled out - will form part of the whzan evaluation	Our commissioned providers are ae continuing to lead on the research for this, working closely with the TSA.		GREEN
	also in health plan	5. Pilot of Falls Crisis Response Service in Rutland (22/23)	Charlie Summers/ Kerry Kaur					charlie??	LPT advised they are not going to release any therapy resource to attend weekly care home MDTs		GREY
3.2	**Integrating services to support people living with long-term health conditions**										
3.2.1	MDT/collaborative neighbourhood working	1. Weekly care home MDTs EHCH	Rise/pcn/vol/lpt	22/23	**p**	Number of care home weekly board round. Strutured medication review (SMR) residents with a care plan		43 MDTs held in Dec 2022 - 11 care home MDTs every week. The care home MDTs are part of the Enhanced Health in Care Homes Framework, and as such they will continue. When the MDTs first started we had three therapists covering all 11 meetings. The therapists were an integral part of the meeting, and proved to be a valuable source of support and advice for the care home managers. Over time this has changed, and the current therapy cover is one therapist once a month for Oakham Medical Practice care homes (5 care homes). This leaves 6 care homes with no MDT therapy cover at all. I have been given the hotline number so that enquiries can be made, but this does not replace the familiar face at MDT, that people build relationships with and feel able to ask questions of.	**LPT have advised that they are not going to release any therapy resource to attend weekly care home MDTs in Rutland - LPT therapists rather than RCC therapists need to attend the MDTs because the MDTs are about Health and activities of daily living, rather than the aids and adaptations side of things (that RCC therapists tend to focus on)**	**Nurse attendance is very hit and miss too, although recently Jules Hollingsworth (band 6) has started joining in some of the MDTs, so it's not all on Lorraine's shoulders, and there has been some improvement in attendance. we are going to discuss this with Dee at the nursing catch up this week**	GREEN

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		2. Monthly Rise /asc/pcn in each of the 4 Gp practices			**p**	Number of cases discussed at weekly MDT		this is continuing to take place - linking this to a more formalised MDT neighbourhood meeting will be discussed at the next neighbourhood meeting- lin to new LLR draft MDT framework			**GREEN**
		3. Full use of the Joy social prescribing platform			**p**	number of partners using Joy Outcomes of individuals – ONS4 + qualitative		increased activity to put all activities onto the market place is takign pleace			**GREEN**
		4. Weekly DN board rounds			**p**						**GREEN**
	also in health plan	5. Neighbourhood monthly meetings			p	Professional experience of MDT working		coninuing			**GREEN**
		6. expansion of housing MOT to support people with digital access	longhurst/rcc	22/23	p	number accessing servcies digitally		The Housing MOT service continues to successfully deliver against our Heath and Wellbeing priorities and the contract has been extended to September 2024.			**GREEN**
		7. fire servce home safety checks	rutland and melton fire	22/23	p	target of 650 oakham 50 upingham home safety checks completed each year safer					**GREEN**
3.2.2	MDT access to resident records/information	1. Case management taking place on Joy platform and informing asc LL & PCN S1	Rise	22/23	p	Number of cases on joy platform					**GREEN**
	also in health plan	2. Use of LLR electronic shared care record when available	lhis	22/23	p	number of professionals using the LLR shared care record " • Ensuring all pilot users can access the LLRCR and any issues are investigated, resolved and			too few professionals engaged with this project reduces the gain of using the system		**GREY**
3.2.3	prompt safe hospital; discharge	1. Minimise hospital stay	Rcc hospital team	22/23	p	Length of stay 14+ days length of stay 21+ days	Numbers for Dec are: We discharged 34 people, 10 of whom left on the same day as becoming medically fit. Of the 34 discharged in Dec we supported 21 discharges within 48 hours. For Dec our average discharge delay per person was 2.3 days.	Numbers for Jan are: We discharged 34 people, 12 of whom left on the same day as becoming medically fit. Of the 34 discharged in Jan we supported 25 discharges within 48 hours. For Jan our average discharge delay per person was 2.1 days.	measurement to show the outcomes delays are not attributable to RCC but the acute process	continue to discuss at LLR discharge meeitngs	**GREEN**
		2. Discharge to home first	Micare and therapy reablement	22/23	p	Discharge to usual place of residence	micare holding 18 cases	As demands upon health and social care services continue to rise, delivering the right services at the right time and supporting people to go home and stay home after a hospital stay is a National Challenge. Rutland's Hospital and Reablement Team plays a vital role facilitating discharges home from hospital, preventing crisis admission and is an essential tool in managing the demand on care capacity. The team focuses on a home first approach, with individuals returning home to receive assessment, care and support and achievement of individualised goals. As a measure to address winter pressures, from January to April 2023 four beds will open at Rutland Care Village, to support individuals who are leaving hospital but are not quite ready to return home and require additional support first.	MiCare ability to recruit carers and therefore there might be insufficient capacity to support timely discharge.	full recruitment in place including a new video	**green**
		3. assessment on discharge to right size support	Rcc hospital team	22/23	p	numbers on D2A	all cases on D2A receive a first visit to rightsize package of care and provide the correct support from Micare	38 D2A cases on micare in Dec 2022			**BLUE**
		4. Increased reablement following hospital discharge			p	Reablement – effectiveness 91 days still at home	ave length of stay is 15 days	dec ave stay on reablement is 15 days	Staffing: Ageing Well monies have been used to employ Therapists to cover weekend working, but unlikely to get repeat funding next year. No weekend OTs may impact on timely flow through Reablement.		**GREEN**
	also in health plan	5. Implement Ageing Well Urgent Crisis Response 7-day therapy new ways of working in Rutland (22/23)	Rcc hospital team	22/23	p			Delivered at the right time, reablement can reduce, delay, or remove the need for ongoing care and support. For the last 2 years a 7-day reablement services has been operational with a qualified therapist available to ensure the right decisions are made and the right services are accessed. An individual receives an assessment within 48 hours of returning home from hospital. The effectiveness of Rutland reablement service can be seen by the following data: April to November 2022, 78 individuals received home based reablement. Of those 78, 75 individuals left the service with no ongoing support needs. The success in our home first approach of go home and stay home can be seen by the following data: 63 out of 68 individuals who accessed this service remained at home 91 days after discharge from hospital. The national average is 79.1%. Rutland have exceeded this from April – November 2022, attaining over 90% for 4 of the 8 months.			**GREY**
	also in health plan	Enhancing the end-of-life discharge pathway through testing an integrated EOL social care bridging and co-ordination offer (22/23)	Rcc hospital team	22/23	p			Phase One of a new Virtual Ward for Specialist Palliative Care was launched on Monday 27th February 2023. The first phase of the new service will be for referrals made by a University Hospitals of Leicester (UHL) Palliative Care nurse or medic only, to support early discharge from UHL acute inpatient settings. The new virtual ward service will provide enhanced medical & nursing monitoring, assessment, and intervention. This includes remote monitoring, holistic support and follow-up for patients admitted to hospital with a clinical specialist palliative diagnosis or exacerbation of their palliative condition, who could be at risk of deterioration after discharge.	Concern raised with regards to end of life patients who may not be admitted to UHL in the first instance.	Greater clarity has been sought with regards to additional phases of the virtual ward scheme to establish when this will be available to other out of county acute providers.	**GREEN**
3.3	**Support, advice, and community involvement for carers**										
3.3.1	support for carers	1. Identifying carers Identification of carers to be improved through distribution of information, improved online content and face to face engagement activities across the county to raise awareness and recognition of carers, their rights, needs and support available. This will include raising awareness with carers themselves, professionals and the wider public.	Rcc	22/23	p	Increase number known to RCC/PCN	ASC Carers Team, Young Carers, Admiral Nurses and Co-production are already working together to plan this year's Carers Week events (in June) which will promote carer awareness, carer friendly communities and provide recognition of carers.	Month by month increase numbers of carers supported			**GREY**

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		2. Providing support Support to be provided for adult carers of adults directly through RCC's Carers Team and additional support available for carers of those living with dementia through the Admiral Nursing service. Support includes information, advice and signposting to other agencies, eg local voluntary partner agencies. Contingenncy planning with carers, to ensure alternative plans are in place to provide care, if there carer is unable to continue. This provides peace of mind and a sense of security for carers.	rcc		p	Satisfaction and carers ability to care	Rutland ASC's Improvement Officer is reviewing Personalisation surveys to support with ensuring feedback gathered is meaningful. Contingency planning is completed by the Carers Team, with all carers who have any level of intervention from the team and who consent.	ASC pilot started in January 2023. Carers worker part of the new contact and response team. Supports first part of carer's assessment and specialist support with information and guidance - more timely discussions for carers needing support.			GREY
		3. Carers Passports to be available to carers of all ages to support with accessing services and valuing carers.					RCC's Business Intelligence are now reporting on the number of Carers Passports issued to adult carers which will support with monitoring progress of carer identification. (Young Carers Passports are separate to this.) Carers Delivery Group CDG partners are working to develop the carer passport scheme across hospital settings. Total 253 Carers' passports issued as of January				
		4. RCC to explore signing up with Carefree to offer free short breaks to adult carers of carers.					Memorandum of Understanding with Carefree is being worked on by ASC and Data Protection	Still in progress			
		5. Launch of new carers support group – Oakham 'together we care'	carers centre	22/23	p	numbers attending group	Carers Team contacting carers' groups to guage usage levels	Still in progress			blue
3.4	**Healthy, fulfilled lives for people living with learning or cognitive disabilities and dementia**										
3.4.1	supporting people with LD and autism	1. Annual health checks (rationale for this to be added)	Rcc	22/23		% Number of LD health checks completed			Need to develop link for reporting this data across Health and ASC Partners		AMBER
		2. Sharing Leder findings (rationale for this to be added)	rcc	23/24	s	Learning Into Action	Preparing CPD to share learning from Aspirational Pneumonia Thmatic Analysis as identified at the Leder Steering Group				GREEN
		3. Providing specialist care close to home		22/23	p	Qualitative feedback from this cohort number being carered for out of county			Needs discussion and planning		GREY
		4. Supporting people with LD/autism to access vol/work/education opportunities		22/23	p	% Number in employment			Needs discussion and planning		GREY
3.4.2	supporting people with dementia/cognitive impairment	1. Increase in identification of people likely to develop dementia through anticipatory care project – using Aristotle PHM tools	PCN	22/23	p	Number of people identified at risk of developing dementia					GREY
		2. Increase diagnosis rate for Rutland population	icb memory clinic	23/24	s	Number of people with a diagnosis of dementia		LLR Dementia Programme Board meets bi-monthly to ensure best practice across all areas of dementia care. Memory assessment services workshops in place, looking at improving waiting times diagnosis assessment.			GREY
		3. Equity in access to admiral nurse	Admiral Nurses		p	Admiral Nurse service availability % number of people supported by admiral nurses					AMBER
		4 increase support opportunties for familes/carers/people with dementia	vol sector	22/23	s	number attending sailing club sessions					GREY

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

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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	Apr-23	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 commisisoners 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 identify 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.					AMBER
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.					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, idenitfy 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					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		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
4.2.5	Develop a longer term locally based integrated primary and community offer 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				Partnership agreement on way forward and dedicated plan on next steps					AMBER
											AMBER
4.3	**Improving access to primary and community health and care services**										AMBER

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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.				•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			Phlebotomy blood collections	The ICB has been in negotation with UHL for addirional weekend blood collections. A paper has gone to SCG in December and it is hoped that PCN's can start to delivery a full saturday phlebotony service from Janaury.	**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 Rutland 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					**AMBER**
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					**AMBER**
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					**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					**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					**AMBER**
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.					**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.				•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**

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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****				•Review of current transport routes and health inequalities needs assessment •Rutland travel time and bus route napping including costs					**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**
											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.				•Review of cross boundary working across health and care					**AMBER**
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					**GREEN**

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)

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Priority 5: Preparing for our Growing and Changing Population

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

Responsible Officer (on IDG) — **Jo CLinton / Adhvait Sheth**

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5.1	**Planning and developing 'fit for the future' health and care infrastructure**										AMBER
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					AMBER
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			Local Primary Care Project Provider for LLR Wave 1 programme has been de commissioned and a new provider to take fwd is being identified. This will result in delay to development of Rutland PCN Clinical and Estate Strategy		AMBER
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	ICB	Apr-23	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			Local Primary Care Project Provider for LLR Wave 1 programme has been de commissioned and a new provider to take fwd is being identified. This will result in delay to development of Rutland PCN Clinical and Estate Strategy		RED
5.2	**Health and care workforce fit for the future**										RED
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					RED
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						RED
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					RED
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					RED
5.3	**Health and equity in all policies, in particular developing a healthy built environment aligned for projected growth**										RED
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)	TBC	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.	Training on Health in all Policies via an e-learning package is being piloted throughout February in other areas. Outcomes and learning will be assessed to determine an approach for Rutland to take forward. Engagement with the Planning team at RCC continued throughout the Issues and Options stage. A Health Impact Assessment policy has been included for developers meeting set thresholds. Further work is needed on this in further Local Plan development stages.				GREEN

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

Senior Responsible Officer (on HWB) **James Burden**

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

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6.1	**Each person is seen as an individual**										
6.1.1											
6.1.2											
6.2	**Each person has fair access to care**										
6.2.1		Refresh our JSNA and LLR all age end of life strategy (22/23)									
6.2.2											
6.2.3											
6.3	**Maximising comfort and wellbeing**										
6.3.1		Strengthen our community palliative and end of life care offer (22/23)									
6.2.2		Support more people to die in their place of choice through Increased identification of people in their last year of life via increased use of RESPECT planning (22/23									
6.2.3											
6.3	**Care is coordinated**										
6.3.1		Improve access to end-of-life care provision through design and mobilisation of a 24/7 advice line for patients, carers, and professionals (23/24)									
6.3.2		Enhancing the end-of-life discharge pathway through testing an integrated EOL social care bridging and co-ordination offer (22/23)									
6.3.3		Increase advance End of Life Care Planning by using risk data tools to identify people reaching last years of their life (22/23)									
6.4	**All staff are prepared to care**										
6.4.1		Quality and co-production review of patient and carer experiences at end of life. Ensure end of life remains everyone's business through appropriate training and support (22/23)									
6.4.2											
6.5	**Communities are prepared to help**										
6.5.1		Raise local awareness to Integrated Community Specialist Palliative Care Service, specialist nursing, virtual day therapy, befriending support (22/23)									
6.5.2											
6.5.3											
6.5.4											

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						**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						**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						**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						**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						**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						**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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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		This is now complete	This is now complete			**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		Not yet underway.	Not yet underway.			**GRAY**
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		ICB, PH, LLR Academy	2023/24	System		Not yet underway.	Not yet underway.			**GRAY**
7.2.4	Embed Military Covenant duties across all key organisations across the system but specifically in Rutland (due regard for armed forces in health, housing, and education).		RCC, ICB, Providers	2022/23	Place and System		Ongoing	Mapping has been completed to identify partner progress on due regard for armed forces.			**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	2022/23	Place and System		Work is underway to plan for a survey to be undertaken of the next rotation of personnel coming in from Cyprus with a refresh of the data also.	Work is underway to plan for a survey to be undertaken of the next rotation of personnel coming in from Cyprus with a refresh of the data also.			**GREEN**
7.2.6	Mapping Rutland community assets, including its voluntary and community sector.		RCC	2022/24	Place		CAR are mapping Voluntary Sector currently with results being shared once available	CAR are mapping Voluntary Sector currently with results being shared once available			**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.		System and RCC	2024/25	System		Not yet underway.	Not yet underway.			**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		Not yet underway.	Not yet underway.			**GRAY**

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**

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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