Priority 1: The Best Start for Life

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

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

GREEN = On Track

AMBER = Off track but mitigations in place top recover

RED = Off track and at risk

GREY = Not Started

BLUE = Complete

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

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

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

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

Priority 2: Staying Healthy and Independent: Prevention

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

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

GREEN = On Track

AMBER = Off track but mitigations in place top recover

RED = Off track and at risk

GREY = Not Started

BLUE = Complete

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

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

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

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

GREEN = On Track

AMBER = Off track but mitigations in place top recover

RED = Off track and at risk

GREY = Not Started

BLUE = Complete

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

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

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

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

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

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

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

GREEN = On Track

AMBER = Off track but mitigations in place top recover

RED = Off track and at risk

GREY = Not Started

BLUE = Complete

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

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

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

Ref	What Do We Want To Achieve?	How Are We Going To Do It?	Lead Organisation	Timeframe for Delivery (Month/Year)	Level (System, Place or Neighbourhood)	How Will Success Be Measured?	Progress for August 2023	Progress for Sept 2023	Key Identified Risks	Mitigations	Sept 2023 Project RAG Status
		New Enhanced Access service resulting in more appointments available a minimum of two weeks in advance, and a mixture of in person face to face and remote (22/23) Consider a local Enhanced Access service (part of review of access to primary and urgent and emergency care) encompassing same day access for Primary Care, Urgent Care, including (Minor Injuries), and Frailty Care Recruit dedicated Digital Inclusion and Communications resources to support development, access, and navigation of e.g., Patient Online System/NHS App services/remote consultations/ practice websites (22/23) Review GP registrations in the context of unique or under-served groups to increase registration for Health Services e.g., Armed Forces Families and Traveller Community (23/24) Develop an enhanced access model that supports access to same day appointments. (22/23) Review Minor Injury Service provision and Urgent Treatment Centre provision to ensure that it meets the needs of the local population and reduces the need for presentation at ED. (22/23) Identify the highest utilised ED's out of county and across borders in relation to Rutland residents looking at reasons for presentation and reviewing associated pathways (22/23) Expand the number of Clinical Pharmacists working locally who can treat Minor Illness such as coughs, UTI's and Cellulitis and Long-Term Conditions. (22/23)									

Priority 5: Preparing for our Growing and Changing Population

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

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

GREEN = On Track

AMBER = Off track but mitigations in place top recover

RED = Off track and at risk

GREY = Not Started

BLUE = Complete

Ref	What Do We Want To Achieve?	How Are We Going To Achieve It?	Lead Organisation	Timeframe for Delivery (Month/Year)	Level (System, Place or Neighbourhood)	How Will Success be Measured?	Progress for August 2023	Progress for Sept 2023	Key Identified Risks	Mitigations	Sept 2023 Project RAG Status
5.1	**Planning and developing 'fit for the future' health and care infrastructure**										**GREEN**
5.1.1	Work with local/ neighbouring Integrated Care Systems (ICSs) partners to share information to ensure in border and cross border population health impacts are consistently understood	•LLR CCGs PCES Population Model that shows impact on health infrastructure as a result of growth in the Rutland border • Documented population health impact of Stamford North Housing Developments outside of the border shared with partners • Routine joint dialogue between partners •Initial baseline of Non Local plan impact by Rutland LSOA • Ongoing 6 monthly reviews and updates of latest LSOA level impact vs initial baseline position •RCC and Neighbouring LPA approach to prioritisation and CIL allocation plans is in place and visible to partners •Agreed population model with robust methodology that can be used to support dynamic impact modelling by LSOA •Work with Rutland County Council to facilitate development of a set of options for a Health Campus /Medi-tech trials facility	RCC/ICB	Apr-24	Place	•Aligned fit for the future plans with neighbouring ICS's • Healthcare is confirmed as priority for infrastructure funding and recieved adequate support in line with growth and impact • Understanding of current CIL funding including trajectory of allocations and any unallocated funding • Understand where Healthcare sits in wider prioritisation of infrastructure support • Agreed updated Information requirements and timely sharing with health partners to inform dynamic modelling •RCC to undertake a Community Infrastructure Levy (CIL) policy review with due consideration of enabling greater support for local healthcare infrastructure to ensure this is a key priority area of support going forward •Health Strategic Partners Involvement in CIL review process and receipt of report on new policy implications			Risk that RCC does not approve the RMH Enhanced Procedure Suite Business Case at Full Council in Sept meaning that plans to bring care closer to residents may not be delivered. Prioritisation of CIL due to limited funding against number of schemes may result in some not being supported	None identified with no NHS Capital available Continue strategic dialogue around priorities for CIL / look at economies of scale / alternative funding sources	**GREEN**
5.1.2	Work with in county and out of county providers and commissioners to cross share plans for Healthcare to inform future local service provision	• Routine joint dialogue between partners on latest plans and possibilities for joint solutions •Aligned fit for the future plans with neighborhing Places to inform local commissioning in and out of county provision in the future • Agreed LLR representation on North Place Alliance • Ongoing Engagement with OOA senior transformation leads for Primary Care and Planned Care Transformation • Cross sharing of latest LLR and OOA CDC plans with understanding of timelines and key service offers to plans impacting Rutland residents	ICB	Apr-24	Place	•Aligned fit for the future plans with neighborhing Places to inform local commissioning in and out of county provision in the future • Documented population health impact of Stamford North Housing Developments outside of the border shared with partners • Understanding of emerging options for joint solutions on the Stamford and Rutland border • Joint messaging around direction of travel for cross border developments in place and evolving over time					**GREEN**
5.1.3	Enable a fit for the future local healthcare	• Documented PCN Clinical and Estates Strategy to inform how future clinical strategy can be supported to deliver going fwd. • Business Cases development and approvals for future Estate solutions •Undertake strategic site feasibility review of local Health Estates including Rutland Memorial Hospital •Identify venues for colocation of key services e.g., MH Staff, consideration for Rutland community nursing staff to be based in Rutland that are currently based in Melton (23/24) - Links to community hub considerations	ICB/RCC	Apr-25	System and Place	• Identified PCN clinical priorities and reccomendations for future sustainable solutions that are documented and that can inform the delivery of the Healthcare Plan • Quantified understanding of available space on site at Rutland Memorial Hospital within existing medical facilities' appropriateness for clinical activity against criteria • Develop a Business Case for RMH based on feasibility findings • Approved Business Case for RMH Enhanced Procedure Suite that enables the associated service transformation to bring care closer to home • Maximised utlisation of local estates space to meet growing health needs in the future •Documented PCN Estates Strategy to inform how future clinical strategy can be supported to deliver going fwd.			Risk that RCC does not approve the RMH Enhanced Procedure Suite Business Case at Full Council in Sept meaning that plans to bring care closer to residents may not be delivered.	None identified with no NHS Capital available	**GREEN**
5.2	**Health and care workforce fit for the future**										**GREEN**
5.2.1	Develop training for new ways of working	Ensure appropriate local development opportunities are being accessed by all roles where available i.e. Community Pharmacy Academy development programme - for Occupational Therapy, Clinical Pharmacist, Paramedic connected to Network, muscular-skeletal first contact staff and health coach	PCN/RCC	Apr-23	Place	•Completion of PCN training courses and evaluation of training and impact on patient outcomes					**Blue**
5.2.2	PCN continue to expand on its Additional Roles Reimbursement Scheme	• Recruitment of all ARRS roles outlined in the 2022/23 workforce plan for Rutland Health PCN • Looking at care co-ordination and clinical pharmacists' capacity	PCN/RCC	Apr-23	Place	Key roles being acessed and utilised by local residents					**Blue**
5.2.3	Develop Career Development Structures	• Mat to advise whether to remain, be changed or removed • Consider projects to increase career development and satisfaction for retention e.g. via delegation of health tasks	RCC			•Carer development and increased potential for workforce •Proportion of health and care staff remaining in work after 55					**Blue**
5.2.4	Promote local Career Opportunities	• Mat to advise whether to remain, be changed or removed • Increase engagement with local young people around careers in health and care, including through collaboration with schools and opportunities for work experience	RCC			•Sustainable health and social care workforce •Increase in proportion of staff in health and care sector locally					**Blue**
5.3	**Health and equity in all policies, in particular developing a healthy built environment aligned for projected growth**										**GREEN**
5.3.1	Embed Health and Equity in all strategies and policies across Rutland County Council and then partner organisations	• Core partnership working group estavblished to take this forward in an agreed timeline • To consider their impact on mental and physical health, health inequalities and climate change. This will include Health and Equity Impact assessment development and training. See 2.4. • Public Health and Health Strategic partners to support the Planning Authority on the RCC Local Plan development to maximise the opportunity for a healthy built environment aligned to projected growth in Rutland. Work will utilise the national evidence base combined with locally developed resource, for example the 'Active Together – Healthy Place Making' toolkit. • Completion of a Health Impact Assessment of the Local Plan at the appropriate point of development with clear recommendations for mitigation and/or enhancement.	PH (Mitch Harper)	Apr-24	Place	•Completion of a Local Plan Health Impact Assessment with clear and achievable recommendations •Progress against identified recommendations in the Local Plan development •Health and Equity in all policies embedded across Rutland Completion of a Health Impact Assessment of the Local Plan at the appropriate point of development with clear recommendations for mitigation and/or enhancement.					**GREEN**

Ref	What Do We Want To Achieve?	How Are We Going To Achieve It?	Lead Organisation	Timeframe for Delivery (Month/Year)	Level (System, Place or Neighbourhood)	How Will Success be Measured?	Progress for August 2023	Progress for Sept 2023	Key Identified Risks	Mitigations	Sept 2023 Project RAG Status
5.3.2	Explore digitisation of paper records by exploring digital record storage for practices using SystmOne to optimise space for PCN activity (23/24)	• Digitisation routes established in line with national programme requirements • Potential to embrace new national programme when that comes on stream, expected to be a scan on demand offer • Ensure that LLR act in accordance with national programmes and plans • Ability to free up space on practice site • Robust scan / digitisation facility which adheres to legal requirements	PCN	TBC	System and Place	TBC - AS to pick up discussion with ICB Digital Team around national picture and also PCN about local view on this, amber as not been able to prioritse reporting this period rather progress issue.			**TBC**	**TBC**	**Amber**

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

Senior Responsible Officer (on HWB) Lynette Friere-Patino

Responsible Officer (on IDG) Sammi Le-Corre

GREEN = On Track

AMBER = Off track but mitigations in place top recover

RED = Off track and at risk

GREY = Not Started

BLUE = Complete

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

Ref	What Do We Want To Achieve?	How Are We Going To Do It?	Lead Organisation	Timeframe for Delivery (Month/Year)	Level (System, Place or Neighbourhood)	How Will Success Be Measured?	Next steps - Key actions following our meeting and next steps	Progress for August 2023	Progress for Sept 2023	Key Identified Risks	Mitigations	Sept 2023 Project RAG Status
6.4.3	How information is shared and exploration of how the LLR care record links with those who are at EoL.	Look at what might want to be shared. Evidence and Information	Laura Godtschalk	Nov-23	System		Link in with Ali Brooks to undertsand the progress with the RESPECT forms and also link in with Sharon Rose with regards to the LLR Shared Care Record.					
6.5	**All staff and carers are prepared to care**											
6.5.1	Provide training for informal carers in end of life care, so that individuals can receive appropriate care irrespective of place, with awareness raising around advance care planning and Power of Attorney.	Ensure that there is appropppriate training available, that is accessible and that they are aware of.	EOL T&F Group	Mar-24	Place		Establish what training is available and where from Undertake a training needs analysis of all staff that have involvement in the provision of EoL services.					
6.5.2	Provide training for formal care workers to support the care of those identified . Training can help identify major life events that serve as trigger points for conversations. Support transition to palliative care phase.	Training that can be accessed through Loros. Ensure there is appropporiate training that is accessible, collect feedback on training	EOL T&F Group	Mar-24	Place	Number of poeple attending EoL training courses in comparison to baseline.	Establish a list of training courses that are available and how they are accessed					
6.5.3	Staff having 24/7 access to medication, equipment and support.	Establishment or a 24/7 EoL service.	EOL T&F Group	Mar-24	System		Link in with the EoL Task and Finish Group to see how the work has progressed with regards to the extension on the Integrated Community Specialist Palliative Care Service to include 24/7 provision.					
6.6	**Communities are prepared to help**											
6.6.1	Support a Compassionate Community approach across Rutland, developing volunteer networks skilled to work with people facing terminal illness or at end of life.	Explore the possibility of adopting a compassionate communities					Review the original proposal as I believe it had three potential models of delivery based on varying degrees of funding. Link in to the work of the Place Based Collaborative.					
6.6.2	Behavioural change campaign to work towards changing social norms, to promote greater acceptance of discussions relating to end of life. This may include the use of alternative terminology and promote conversations about getting affairs in order. Use of behaviour change wheel methodology. Moments of reflection when wider planning is possible, also around organ donation and preparation of ReSPECT forms - e.g. when will writing.	Raising awareness and reducing the taboo around the conversations around EoL. Need to identify a lead to inform the work of the Task and Finish Group.	Public Health Susan Louise Hope	Mar-24	Place		Understand what is being done via the EoL task and Finish Group. Also link in with the Comms and Engagement team to see if they have any EoL specific campaigns scheduled in. Get an update on progress with the roll out of the new RESPECT forms. Identify lead for EoL Priority Six in Rutland.					
6.6.3	Joint Strategic Needs Assessment (JSNA) to be undertaken to understand the needs of the local population (including those nearing the end of their lives, their carers and the bereaved), the services available, and the quality of care provided. A focus will be given to capturing the views of those who use and provide services. To include a comparison of progress against the National Ambitions for Palliative and End of Life Care, using the self-assessment tool. Also considering learning from the Medical Examiner if this becomes available in time.	JSNA chapter - review where we are up to with this and see how this can inform this priority.	EOL T&F Group	Mar-24	Place		Link in with Rutland Public Health to understand the progress of the JSNA. Link in with the EoL T&F Group to understand the refresh of the LLR EoL Strategy and the Ambitions Framework. Established whether a gap analysis has been undertaken on an LLR basis and consider for Rutland once the Rutland pathway mapping is completed.					

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

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

Priority 7a: Cross Cutting Themes - Mental Health

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

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

GREEN = On Track

AMBER = Off track but mitigations in place top

RED = Off track and at risk

GREY = Not Started

BLUE = Complete

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

Priority 7b: Cross Cutting Themes - Inequalities

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

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

GREEN = On Track

AMBER = Off track but mitigations in place top recover

RED = Off track and at risk

GREY = Not Started

BLUE = Complete

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

Priority 7c: Cross Cutting Themes - Covid Recovery

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

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

GREEN = On Track

AMBER = Off track but mitigations in place top recover

RED = Off track and at risk

GREY = Not Started

BLUE = Complete

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

8. Communications and Engagement

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

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

GREEN = On Track

AMBER = Off track but mitigations in place top recover

RED = Off track and at risk

GREY = Not Started

BLUE = Complete

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

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

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

Ref	What Do We Want To Achieve?	How Are We Going To Do It?	Lead Organisation	Timeframe for Delivery (Month/Year)	Level (System, Place or Neighbourho	How Will Success Be Measured?	Progress for August 2023	Progress for Sept 2023	Key Identified Risks	Mitigations	Sept 2023 Project RAG Status
8.5.5		Recruit dedicated Digital Inclusion and Communications resources to support development, access, and navigation of e.g., Patient Online System/NHS App services/remote consultations/ practice websites (22/23)	PCN								
8.5.6		Creation of an infographic to demonstrate the anticipated inpact of the Rutland Health and Wellbeing Strategy and what that will mean to patients.	ICB								

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

Acronyms and glossary

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