NHS
Leicester, Leicestershire and Rutland
Integrated Care Board

# Rutland Healthcare Plan: October 2023 Refresh

## Rutland Health and Wellbeing Board 10th October 2023

A proud partner in the:

Leicester, Leicestershire and Rutland
Health and Wellbeing Partnership

# Strategic and Transformation Context

- Previous HWB Submission -  July 2022
- Key LLR developments since – LLR5YP,  Partnerships and LLR Primary Care Strategy (Inc. Fuller actions)
- 9 Transformation delivery themes of the refreshed plan - Clear alignment to LLR5YP for Rutland  (where applicable)
- Will support future ways of working for Healthcare transformation in Rutland HWB priorities context
- Includes actions that have been progressed during 2022/23
- Includes new actions to the local healthcare plan – Black Text
- Includes actions that build on previous plan achievements (Evolved Actions) – **Purple Bold Text**

# Place Delivery Challenges

- Rural area bordering a number of ICB areas – bordering plans developing at different rates with variation in priorities and timescales
- Local plan development – will provide a better idea of where housing growth will be in Rutland to aid planning once finalised in 2024
- Alignment to local plans for Levelling Up / Transport developments
- Primary Care workforce and infrastructure support in context of rurality – Explore primary care to better understand rural need
- No significant NHS Capital funding to fund local healthcare infrastructure plans
- Partnerships – unique position in LLR compared to national picture – Single acute and MH provider landscape
- Alignment of resources to Place across LLR from System level actions
- Sustainability of local Armed Forces OP Community pilot is currently reliant on national programme funding – ends in Sept 2024

1. Preventing Illness
2. Keeping People Well
3. Right Care, right time, right place
4. Integrated Community Health and Wellbeing Hubs
5. Optimal Pathways for Elective Care
6. Learning Disabilities and Autism
7. Mental Health
8. Women's Health, including Maternity
9. Childrens and Young People

# 1. Preventing Illness (1)

| Progress to date | Our Plans for 2023 – 2025 |
|---|---|
| ✓ Increased Blood Pressure monitors available for Hypertensive patients to self care in Rutland – full allocation has been issued locally and embedded as standard practice<br><br>✓ An LLR programme that supports eligible patients to lose weight, improve their diabetes control, reduce diabetes-related medication and in some cases, put their Type 2 diabetes into remission<br><br>✓ An LLR tier 3 weight management pilot programme has been commissioned<br><br>✓ An LLR programme in place that will monitor delivery against the NICE recommended nine care processes for those with Diabetes aged 12 and over | ➢ **Promote and increase NHS health checks with Rutland Practices and the PCN Inc. determining local targets and resolving technical issues**<br>➢ **22/23 data shows that** of invitations per eligible population, Rutland has significantly worse rates compared to England However The proportion of Health Checks delivered to those invited is significantly better than England<br><br>➢ Look at baseline referral numbers and increase channels for referrals for lifestyle services<br><br>➢ **Work with PCN and local pharmacists to help address detection targets for Hypertension and Arterial Fibrillation**<br>➢ 22/23 data shows that Rutland has a higher prevalence of both Hypertension and Atrial Fibrillation than the ICB and England average.<br><br>➢ Baseline local patients clinically coded with Familial Hypercholesterolemia (FH) and identify patients for referral to the LLR pathway for this. |

**Our Pledge:**

Spend more money on preventing people becoming ill in the first place

## 1. Preventing Illness (2)

| Progress to date | Our Plans for 2023 – 2025 |
|---|---|
| ✓ As per previous slide | ➢ **Working with Rutland GP practices to actively engage and promote the LLR Diabetes Prevention Programme to increase local referrals** |
| | ➢ Review referral patterns and overall local need (Type 1 and 2 Diabetes) ensuring delivery against NICE guidance for those aged 12 and over |
| | ➢ Work with Rutland GP practices to promote local referrals to tier 3 weight management pilot programme |
| | ➢ **Rutland will utilise social prescribers as a means to promote smoking cessation as well as referrals using the Joy platform** |
| | ➢ **Promote NHS Armed Forces support services (OpCommunity and referrals locally Inc. through Joy platform** |

**Our Pledge:**

Spend more money on preventing people becoming ill in the first place

## 2. Keeping People Well (1)

| Progress to date | Our Plans for 2023 – 2025 |
|---|---|
| ✓ Local PCN Royal College of General Practitioners - Veterans re-accreditation in Rutland<br><br>✓ Proactive identification of Frail / Housebound patients<br><br>✓ Net Increase in vulnerable patients in Care Homes that have quality care plans<br><br>✓ Pilot of Whzan Tele-Health Technology in local Care Homes<br><br>✓ Emergency Admissions from Rutland Care Homes have reduced by 50% (110 down to 50 financial year April – July 22-23) | ➢ **Drive up primary care identification of people with diseases (and their carers) to expected prevalence levels Inc Veterans**<br>➢ Diabetes Prevalence in Rutland is below the national average, 5.2% in comparison to 6.5%.<br><br>➢ **Further increase in referrals to the local Community Pharmacy Consultation Service**<br>➢ 6 pharmacies signed up to provide the service with limited uptake in 2022/23.<br><br>➢ **Develop Population Health Management and Multi Disciplinary Team working approach within Rutland INT**<br><br>➢ **Proactive Care at Home frameworks for managing Cardiovascular Disease Long Term Conditions**<br>➢ Between Feb 2022 and Feb 2023, 634 patients have been optimised for Asthma, 177 for COPD, 431 for Diabetes and 943 for Hypertension. |

**Our Pledge:**

Identify the frailest in our communities and wrap care and support around them

## 2. Keeping People Well (2)

| Progress to date | Our Plans for 2023 – 2025 |
|---|---|
| ✓ As per previous slide | ➢ **Continuation and evaluation of the anticipatory care project that focuses on Dementia** (Contributing to the increase of our lower than expected diagnosed rates of Dementia) |
| | ➢ **Develop Population Health Management and Risk Stratification capability around Veterans to support local Integrated Neighbourhood Team** |
| | ➢ **Proactive identification of Frail / Housebound patients with a dedicated care co-ordinator being identified for care plan creation.** |
| | ➢ Rutland practices detection of frailty is slightly higher than the LLR average – at 5% of capitation . Levels of care planning for vulnerable people across LLR have dropped. In Rutland , the rate of care planning remains comparatively high |

**Our Pledge:**

Identify the frailest in our communities and wrap care and support around them

# 3. Equitably access the right care at the right time (1)

| Progress to date | Our Plans for 2023 – 2026 |
|---|---|
| ✓ PCN expanded through Additional staff roles and training for these including Clinical Pharmacists. Digital Lead also recruited to support digital access | ➢ **Review and scope operating model for local same day access including minor injury unit, minor illness and urgent care** |
| ✓ Implemented Cloud Telephony across local GP practices | ➢ **Develop links to the Community Pharmacy Consultation Service to enable inter service referrals** |
| ✓ Implemented Ageing Well Urgent Crisis Response 7-day therapy | ➢ **Link Urgent Care Coordination Hub to local Care Homes (Whzan Enabled)** |
| ✓ Imaging Services reviewed for plain film and ultrasound provision re opening times at RMH | ➢ **Understand plans for UTC development in Lincolnshire ICB to enable local impact to be considered in LLR UTC developments** |
| ✓ New Enhanced Access service resulting in more appointments available a minimum of two weeks in advance | ➢ Refresh the LLR ICB Oral Needs Assessment inclusive of a view of Rutland |
| ✓ Completed reviews of Minor Injury Service and Urgent Treatment Centre provision | ➢ Develop and agree commissioning options for routine Dental Access provision to meet need in Rutland |
| ✓ Developed understanding of highest utilised ED's out of county including reasons and reviewing those pathways | ➢ Develop and agree commissioning options for urgent Dental Access provision to meet need in Rutland |
| ✓ Rutland Primary Care Network estate strategy complete | ➢ **Explore Rutland's individual practice Estate requirements to understand proposals for estate development Inc. Digitisation of paper records** |
| ✓ Oakham S106 Business Case | ➢ **Implement additional clinical treatment rooms in Oakham Medical Practice (S106)** |
| ✓ Secured NHSE funding for OPCOMMUNITY Pilot in LLR | ➢ **Replace PRISM (LLRs Local pathway referral system) to a system that will include offering better support for Out of Area Referrals** |
| | ➢ **Monitor delivery and evaluate the LLR Armed Forces OP COMMUNITY (SPOC) pilot to inform future plans for local sustainability** |
| | ➢ **Improve access to end-of-life care pathways through considering links to Same Access Provision model for Rutland** |

**Our Pledges:**

1.Improve and maintain access to routine general practice appointments

2. Reduce Category 2 (emergency calls such as stroke patients) ambulance response times

3. Reduce and maintain waiting times in the Accident & Emergency department

# 3. Equitably access the right care at the right time (2)

| Create a modern GP and an integrated Primary Care | Our Plans for 2023 – 2026 Continued |
|---|---|
| Implementation of the **Capacity Access and Improvement Plan**. Supporting PCN's to focus on making improvements to help manage demand and improve patient experience of access. Allowing patients to access care more equitably and safely and prioritised by clinical need. Addressing the 8am morning rush, long telephone waits and on the day appointments. | ➢ **Local PCN telephony to allow the prioritisation of high-risk groups through priority phone lines for our most vulnerable patients such as Palliative care patients, carers and housebound patients**<br>➢ **Improve design and functionality of practice websites to support patient navigation, reporting on website traffic data, patient survey results, and number of patients who submit online forms via the website**<br>➢ **All practices to have telephony that includes call back capability**<br>➢ **Demonstrate increased use of local online consultation systems as a digital access route and triage support to mitigation to 8am morning rush**<br>➢ **PCN to map all appointment categories in line with national guidance and have a mechanism for monitoring**<br>➢ **Local Care homes to be have NHS.net connections to support integrated working.**<br>➢ **As a part of the targeting inequalities work, undertake holistic annual reviews of housebound patients**<br>➢ **Identify a lead in Rutland PCN for Prevention and tackling Frailty within Rutland**<br>➢ **Undertake local consultation on future Minor Injuries and Urgent Treatment Centre model of provision and model of delivery** |

## Our Pledges:

1.Improve and maintain access to routine general practice appointments

2. Reduce Category 2 (emergency calls such as stroke patients) ambulance response times

3. Reduce and maintain waiting times in the Accident & Emergency department

# 4. Health and Wellbeing Hubs

| Progress to date | Our Plans for 2023 – 2026 |
|---|---|
| ✓ Undertook strategic review of unused Theatre space at RMH including development of a Business Case to inform future potential for this area | ➢ **Develop a more comprehensive understanding of the full RMH estate in Rutland (Including future plans for Levelling Up) through a wider estate feasibility review** |
| ✓ Facilitated RCC programme team in the development of options for a local Health Campus /Medi-tech trials facility in support of a levelling up funding opportunity which has since been successful. Health support at Exec level in place. | ➢ Undertake a baseline assessment of current health and care staff capacity and skills, based on locally agreed services sequencing including MH Staff, geographically linked community nursing staff that are currently based elsewhere |
| ✓ The Rutland discharge team implemented LLR Electronic Care Record to enable key information relating to an individual's care to be shared between all health care settings and Rutland County Council staff | ➢ Define an outline a specification and/or blueprint for what a local Health and Wellbeing hub in Rutland should look like |
| ✓ Developed SystmOne Community Module in support of new ways of Integrated working | ➢ **Agree implementation plan for local Health and Wellbeing hub model** |
| ✓ Working relationships developed with neighbouring ICSs to share information consistently across local infrastructure delivery plans to maximise potential for CIL/S106 contributions – resulted in BAU joint planning meetings, due process around CIL / S106 is understood and there is cross border representation at ICB Rutland Strategic Group | |
| ✓ Working relationships developed with out of county providers and commissioners to routinely discuss neighbouring area plans | |

**Our Pledge:**

Provide more joined up, holistic and person-centred care, delivered closer to home

# 5. Elective Care

| Progress to date | Our Plans for 2023 – 2025 |
|---|---|
| ✓ Developed a Business Case for moving appropriately selected high demand out of area activity to inform RMH Business Case | ➢ **Continue the expanded community diagnostics locally (to range already in place) and introduce GP direct access to diagnostics** |
| ✓ Analysis of all historical Secondary Care Rutland Outpatient activity to understand where Rutland patients are travelling to for their care to inform future plans | ➢ Explore tech enabled OP delivery at Rutland Memorial Hospital including improving access to Dermatology locally (Teledermatology) |
| ✓ Exploration of the possibility of local provision of Magnetic resonance imaging (MRI) with local NHS and private providers | ➢ **Develop a new Enhanced Procedure Suite / Clean Room facility** |
| | ➢ **Review AMD delivery to bring more closer to home** |
| | ➢ **Review further clinic activity across key Specialities Inc. Renal Medicine and Cardiology for more local access.** |
| | ➢ Establish local Pre-Assessment and Rehabilitation service to support elective outpatients for Cardiac, Respiratory and Cancer Surgery |
| | ➢ Following LLR review work with High Street Optometrists to consider local Glaucoma Outpatient follow up provision in Rutland |
| | ➢ Deliver elective priorities including a reduction in 62+ day cancer and 65+ week wait RTT |

**Our Pledge:**

Reduce waiting times for consultant-led hospital treatment

# 6. Mental Health (1)

| Progress to date | Our Plans for 2023 – 2025 |
|---|---|
| ✓ Recruitment of local MH Neighbourhood Lead | ➢ Understand service offer and Support local promotion and raise awareness of the Perinatal Mental Health Service to increase numbers accessing it |
| ✓ Creation of the Rutland Mental Health Neighbourhood Group | ➢ **Use recent surveys, such as the Family Hub consultation, as well as specific priorities set within the Rutland Children and Young People's Strategy 2022-2025 to understand local gaps and look to increase resource.** |
| ✓ Developed partnership working in Rutland to lead on driving, coordinating and enabling mental health transformation within Rutland. | ➢ **Launch of MySelfReferral service to allow local CYP to self-refer themselves or seek support for their mental health** |
| ✓ Developed and approved Rutland Mental Health Strategy 2023 - 2027 | ➢ A clear co-designed approach to supporting local MH services via funding bids and promotion of available grants and funding opportunities with all partners |
| ✓ A mental health pathway has now been completed for Rutland | ➢ **Promote access to the Rutland Neighbourhood Mental Health Café working closely with Rutland Health PCN and Peppers including increase uptake of free transport offer** |
| ✓ Continued engagement with local partners and the creation of a shared calendar to promote events, awareness and services | ➢ We are looking to create a clear co-designed approach to support farmers' and other individuals' needs linked to rurality. |
| ✓ Rutland has become an innovator site adopting the 3 conversations approach and have a dedicated mental health reablement worker | ➢ Develop local model with capacity for Lived experience / Peer Support |
| ✓ Established the Rutland Neighbourhood Mental Health Café delivered by Peppers | ➢ **Help local people build connections through Rural Coffee Connect van provision delivered at local community sites.** |
| | ➢ **Continue support for community engagement events organised by Citizens Advice and RCC.** |

## Our Pledge:

Reduce inequity in access to mental health services across each of our neighbourhoods

# 6. Mental Health (2)

| Progress to date | Our Plans for 2023 – 2025 |
|---|---|
| ✓ As per previous slide | ➢ Creation of local MH Pathway, which can be used in Rutland GP surgeries. |
| | ➢ Support to increase the capacity in local low level mental health services and closer working between involved local agencies and services. |
| | ➢ **Introduce new MDT specifically for community based Mental Health support.** |
| | ➢ **LPT Mental Health Facilitator role to support 60% of people within Rutland diagnosed with an SMI Including an annual physical health check.** |
| | ➢ **LPT Employment Support Service Individual Placement and Support Lead, to support people with SMI into employment.** |
| | ➢ Working closer with NHS LLR Talking Therapies to ensure our local population are accessing their services Inc. AF Community. |
| | ➢ Create a clear co-designed approach to better meet veterans' and armed forces families' mental health needs. |
| | ➢ Promote recognised self-service self-help tools and frameworks, such as Five Ways to Wellbeing. |
| | ➢ Explore opportunities to support people with developing resilience skills, e.g. through the Recovery College. |

**Our Pledge:**

Reduce inequity in access to mental health services across each of our neighbourhoods

# 7. Learning Disabilities & Autism

| Progress to date | Our Plans for 2023 – 2025 |
|---|---|
| ✓ The LLR Learning Disability and Autism Collaborative includes representation from both health and social care in Rutland – this collaborative has made good progress since 2022.<br><br>✓ Rutland has made outstanding progress in its roll-out of the mandatory Oliver McGowan Tier 2 training.<br><br>✓ In-patient numbers good; below target maximum, managed through weekly discharge planning meetings.<br><br>✓ Refreshed Dynamic Support Pathway successful in minimising need for hospital admissions<br><br>✓ Successful venepuncture pilot to take bloods from patients who have exhausted all other support available. | ➢ **To work with Primary Care to ensure delivery of annual health checks and completion of health action plans for the 149 people that are eligible**<br><br>➢ Explore the use of digital apps to support access to annual health checks and improved health action plans<br><br>➢ Evaluate current work plan against commissioned specification/core responsibilities and priorities review service specification and make adjustments to working practices as required<br><br>➢ **Extend the current successful pilot in Annual Healthchecks, which targets those who have not had a check in the previous 2 years.**<br><br>➢ **Ongoing monthly monitoring of individual practice performance against AHC delivery.**<br><br>➢ New data triangulation process in place to ensure accuracy of performance. Practices needing support to work with AHC Delivery Group |

**Our Pledge:**

Increase the percentage of people on GP learning disability registers who receive an annual health check and health action plan

## 8. Women's Health and Maternity

| Progress to date | Our Plans for 2023 – 2025 |
|---|---|
| N/A - New LLR ICB Strategic Programme | ➢ Develop a proposal to assess feasibility for a Women's Health Hub that operationally covers the Rutland and Melton geographies ensuring links to wider Integrated Health and Wellbeing Hubs rollout |
| | ➢ Agree a local Women's Hub model for implementation that aligns to the local Community Health and Wellbeing hub model for Rutland |
| | ➢ Identify further local Women's Health priorities that need addressing. |
| | |

**Our Pledge:**

We will engage with, listen to, empower and co-produce services with women and girls

# 9. Childrens and Young People (CYP)

| Progress to date | Our Plans for 2023 – 2025 |
|---|---|
| ✓ The LLR CYP Partnership includes representation from both health and social care in Rutland<br>✓ Work has commenced to identify the areas of concern and inequity for the Children and Young People in Rutland which will identify core areas of work.<br>✓ Neurodevelopmental system working group commenced in September, to bring together all professionals to ensure service improvement plans are focused on improving access to services and a reduction in waiting times.<br>✓ Send language and living project currently in cohort 2, ensuring early intervention of SALT and OT at a universal level is available in schools.<br>✓ Overall positive outcome from Rutland Ofsted SEND inspection<br>✓ LLR Asthma group has commenced work on improving the management of Asthma for CYP in Primary Care across LLR<br>✓ Rutland has completed the Delivering Better Value in SEND (DBV) programme, diagnostic phase and has submitted its application for an implementation grant offered by DfE | ➢ **Strengthen the CYP Partnership to allow for shared learning and joint commissioning of services.** Planning day on 3rd November. This will enable this work to shape our delivery of CYP services by working together to **further improve joint planning and oversight arrangements using robust data.**<br>➢ Obesity Plan in development following a positive 12 month pilot<br>➢ **Develop a plan to address the inequities identified for CYP in Rutland to include**<br>➢ **Smoking cessation**<br>➢ **Mental Health**<br>➢ **Oral Health**<br>➢ Influence the neurodevelopmental partnership opportunities across the system. Progress transformation plans Including working in partnership with VCS.<br>➢ **Develop the current pilot into the ELSEC programme with larger scale delivery. (National initiative , 1 of 9 early adopters)**<br>➢ LLR identified as region to be involved in DfE Change Pilot. Enable this pilot to bring support, education and resource for SEND workforce throughout LLR ICS.<br>➢ **Set measurable targets to reduce waiting times and provide effective support for children and young people awaiting neurodevelopmental and mental health assessments**<br>➢ **Strengthen joint strategic working across borders to enable specialist health needs for 'service children' and those who access a general practice outside of Rutland to be assessed and met** |

## Our Pledge:

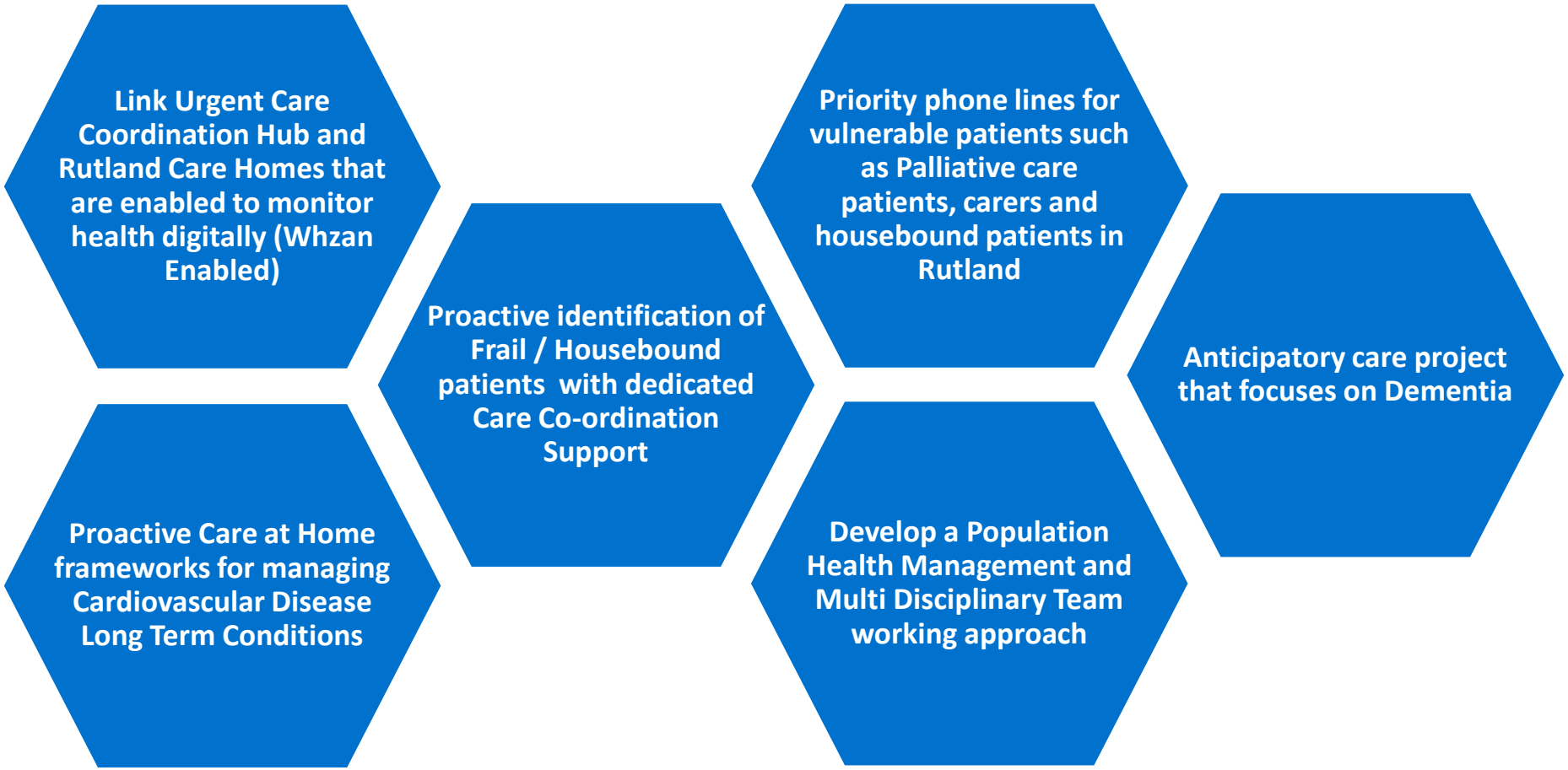
Improve access to, experience of, and outcomes for children and young people - with a special focus on driving up health equity

# How the Rutland Place Healthcare plan supports the local Demographics and Growth in Rutland

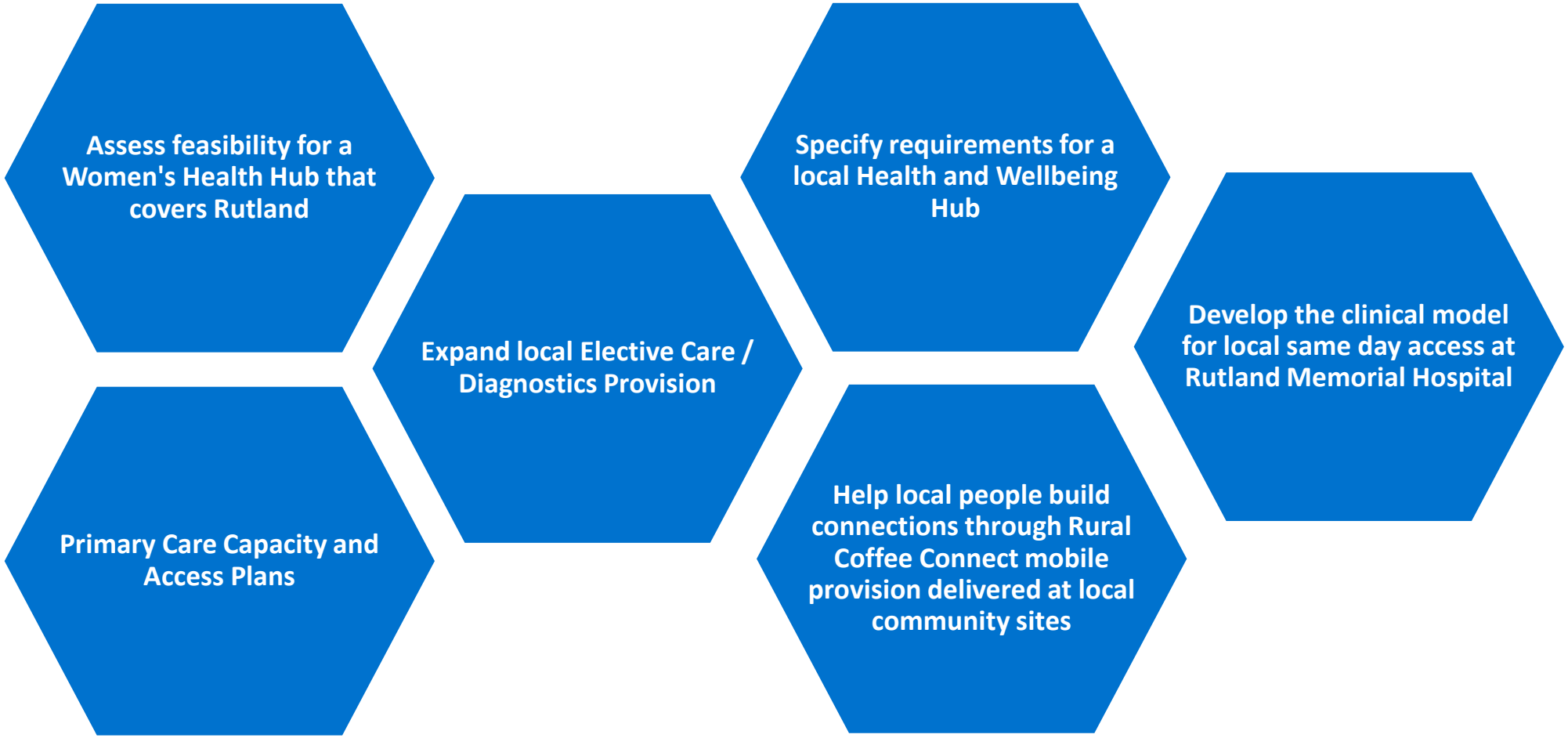
Across the delivery themes of the Rutland Healthcare Plan, the following areas have been identified as the key focus for Rutland Place:

1. Older Peoples Health
2. Access to Health Services
3. The Armed Forces Community

# 1. Older Peoples Health



# 2. Access to Health Services



# 3. Armed Forces Community – Circa 20% (approx. 1 out of 5)

Promote NHS Armed Forces support services (OPTIMAL Model) and referrals locally Inc. through Joy platform and local GP accredited practices

LLR Armed Forces

OpCOMMUNITY (SPOC) pilot for Armed Forces Families and Veterans

Develop Population Health Management and Risk Stratification capability around Veterans

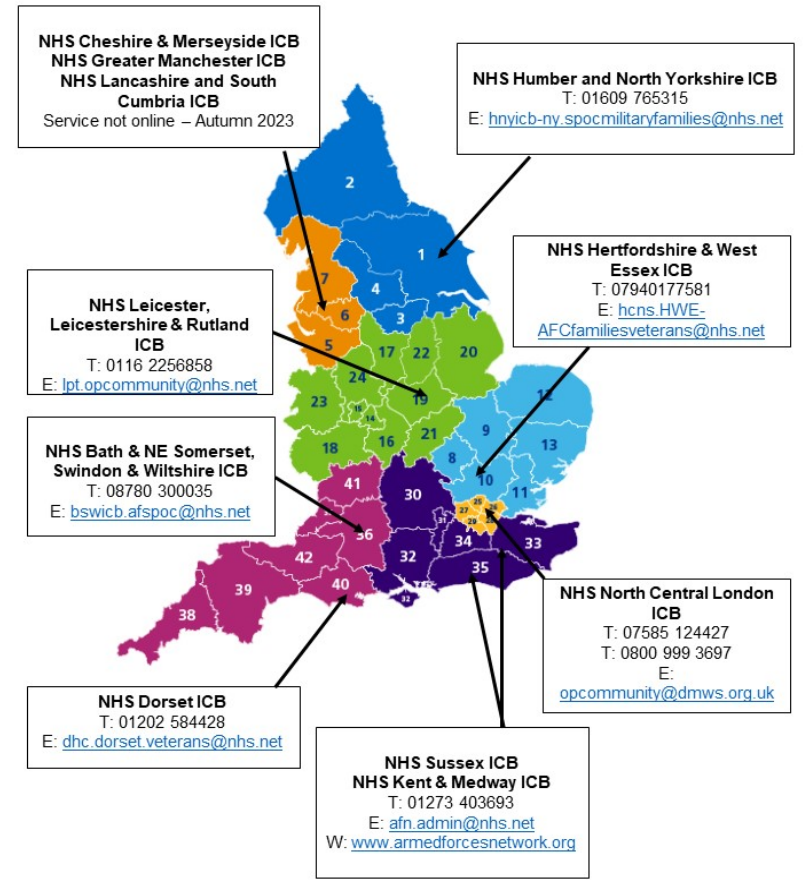
Engagement with Kendrew Barracks to raise awareness of LLR OpCOMMUNITY

Strengthen joint working across borders to enable specialist health needs for 'service children' and those who access a general practice outside of Rutland to be assessed and met

OpCOMMUNITY

NHS Armed Forces Community Support

**OpCommunity Pilot Sites**



# Next Steps

- Develop a public facing version of the plan – focusing on the key deliverables pertinent to Rutland Place.
- Continue to translate plans into measurable actions with baseline
- Link to HWB strategy and delivery plan
- Further focussed work in a few key areas

# THANK YOU