Priority 1: The Best Start for Life

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

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

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1.1	**Healthy child development in the 1,001 critical days (conception to 2 years old)**										**GREEN**
1.1.1		Clear 'Start for Life' offer for parents. The Family Hub programmes will be critical to bring activity together and ensuring an integrated offer across the 0 to 19 (25) years pathway. Information sharing agreements to be agreed. Watch - Family Hub programme receiving oversight from the Rutland CYP Partnership.	RCC/PH /Mina Bhavsar (ICB commissioning officer). Sham Mahmood. Public Health.	2022-24	Place and system	Family Hub operating 0 to 19, (25 yrs. SEND), clear, accessible , seamless and integrated services for families in place and achieving positve outcomes for children and young people. Quantative, qualitative feedback from parents on feeling supported through 1,001 critical days.NHS provider meeting KPIs in 0 to 11 years Healthy Child contract and offer.		A performance dashboard is under development with a review of KPIs available. Work has now begun on a detailed feasibility study of the potential to develop additional face-to-face facilities beyond those available through the former children's centre in Oakham. Uppingham and in Ketton are being investigated and also to provide additional facilities in Oakham for the families of older children and young people. The feasibility study will entail the commissioning of architect's drawings and detailed costings for the proposed changes as well as consideration of any technical or planning issues related to what is proposed. A new microsite (a website provided through RCC arrangements) for family hub services and activities is being developed and has been funded through public health. It will go live in early 2024. The site will host information, training and real time group activities as well as the facility to self-refer for support. Alongside the microsite a new suite of information leaflets based on age groups, is being developed. Each will contain information about services and support as well as a timetable of group activity. For those aged 11+ there will be information aimed at young people which is separate to that provided for parents of this age group.	Engagement		**GREEN**
1.1.2		Healthy lifestyle information and advice for pregnant women or those planning to conceive, including: a) implementation of MECC+ healthy conversations across prevention services b) Targeted communication campaigns c) Increase awareness of postnatal depression and social isolation through midwifery and 0-10 children's public health service d) Immunisations in pregnancy (flu/covid) e) Ensuring women are also reached who have chosen to give birth out of area. Link to 2.1.1 Communications 2.2.3 Healthy conversations 7.1.1 Perinatal mental health support.	LPT/UHL	2022-23	Place and system	* Women healthier during pregnancy: reduction in overweight/obese or smoking. * Improved rates of immunisation for mothers (notably flu/Covid). * Women aware of the risk of Post Natal Depression and isolation. Better able to prevent and seek support where required. * Wherever women give birth, they have access to information about health in pregnancy and access to support.			Lackof capacity and increased demand in key partner agencies		**GREEN**
1.1.3		Local implementation of the Maternity Transformation Programme considering: Improving quality and safety for mother and babies. Improving quality of pathway Implementing neonatal critical care review, improving access to perinatal health services. Link to above actions. LLR LMS Transformation Funding	LPT/UHL	2023-24	Place and System and Neighbourood. Working toward 6% perinatal access to increase access from 6% to to 10% by March 2023	Mothers in Rutland are happy with the services available to them. Positive change in longer term trends around low birth weights and infant Mortality. .Maternity service patient satisfaction surveys · Qualitative feedback re maternity service access, including cross border · Location of Rutland births · Low birth weight for term babies · Infant mortality					**GREEN**

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1.1.4		Implementation of 0-19 Healthy Child Programme, to support Rutland's Family Hub Programme. Including: 0-10year mandated child development checks (including 3-4month and 3.5year checks), a digital offer, evidence-based interventions for children (antenatal, breastfeeding, dental care and peer support for developing active, resilient children, awareness around shaking and head trauma (ICON)), and safeguarding. Consideration of accessibility of related health health services, including dental. Specific consideration for military population.11plus Public Health Teen Health contract and Offer for young people in Rutland	Public Health Rutland	From Sept 2022	Place and system	Positive development of children 1-10, in areas covered by the dashboard metrics .New Born Visits within 14 days • Breast milk is baby's first feed • Breastfeeding initiation and continuation rates • 2.5 year development checks (fine, gross and motor skills) • Healthy Together 2.5 year development checks (communication, fine and gross motor skills) • Early Years Foundation Stage Progress Check between 2-3 years of age, including communication and language, physical development and personal, social and emotional development • Attainment of a Good Level of Development (GLD) at the end of reception year, taking into consideration children eligible for Free School Meals (FSM) • Immunisation rates in under 2years • School readiness at the end of foundation year (especially those receiving Free School Meals) • Children with visibly obvious tooth decay at age 5years • A&E attendance for children aged under 1years and aged under 4years. • Qualitative feedback from parents on feeling supported through 1,001 critical days		Both the 0-11 and the Teen Health services attended the Community Market afternoon at Kendrew barracks to promote the services on offer. The Teen health service in their first 6 months has reach 5% of the secondary school population offering both individual and group support. The Teen Health website in conjuction with Leicestershire Teen Health is under development. For the 0-11, LPT undertook a pilot of the Lime Survey that resulted in additional support given to families that were universal and would not have had another contact with the programme. The Lime survey has been used to address the backlog caused by covid and is also being scoped to be used for the 2 year year reviews to help settings to attend. There has been liaison with Kendrew backs to look at have an onsite presence.			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		Oral Health Promotion work well underway in Rutland now commissioned from LCC and beig delivered across settings in Rutland. Supervised Toothbrushing and support at an early stage are being undertaken.			Green
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.		Teen Health delivery of One-to-one Total number of YP referred to the THS 1:1 during Q2 x 11 (18% were for multiple areas). - 27% of referrals for Healthy Relationships (relationship challenges, family dynamics) - 91% Emotional Wellbeing (Anxiety and self-esteem, managing emotions, low mood, school related stress). - 100% of YP reporting improved health & wellbeing on leaving the service. Groupwork Total number of YP referred to the THS for groupwork during Q2 x 15 - 33% for Healthier Choices - 67% Emotional Wellbeing 'Best Start to Secondary' pilot project Total number of young people accessing pilot programme x26 54% of participants identified as being SEND	Capacity within key partner organisaitons to engage in and deliver programme.		GREEN
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

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1.3.1		Increase health checks for SEND children aged 14years and over ensuring that status is built into the education and health provision set in a Child's Education and Health Care Plan. Funding RCC - DSG HNF. CHC CCG	ICB /LPT	2022-23	Place	Children with SEND are having their health checks in a timely fashion. This is helping those working with them to do this more successfully. * Immunisation uptake especially in SEND over 14s * Proportion of SEND Health check completed					**GREEN**
1.3.2		Increase immunisation take-up for children and young people where this is low, including identifying sub-groups where take-up is lower and understanding why.	ICB/ LPT	2022-23	Place and system	It is clear where immunisation take-up is lower than average (including among which demographics), and changes to delivery help to increase take-up to match or exceed comparator averages. * Review into immunisation uptake across Rutland * Immunisation uptake rates (Covid, HPV, school leavers' booster especially for those in care)					**GREEN**
1.3.3		Coordinated services for children and young people with long term conditions (LTCs) and SEND. Long term condition support for children and young people with asthma, diabetes and obesity including access to appropriate medication, care planning and information to self-manage their conditions, and to relevant support services. To include learning from the Leicester City CYP asthma review and take-up of Tier 3 weight management services. 3.2 Integrated care for LTCs 7.1 Integrated Neighbourhood Team development ND Pathway programnme, and Key Worker programme. To explore early planning for ASD/ADHD families between GP and schools.	LPT	2022-24	Place and system	* Report with review of Leicester City Evaluation in context of Rutland needs					**GREEN**

Priority 2: Staying Healthy and Independent: Prevention

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

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

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2.1	**Supporting people to take an active part in their communities**											
2.1.1	Ensure residents are fully aware of the community and health and well-being offer in Rutland and understand how to access it.	See tab 8 - Communication and Engagement Plan										**BLUE**
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**
2.2	**Looking after yourself and staying well in mind and body**											
2.2.1	Supporting residents to live more active lives	a) Increasing exercise on referral and promotion of active opportunities – helping people to increase activity positively in ways that work for them - personalised approach building on strengths. Also targeting groups such as patients on waiting lists, with mental ill health or living with dementia or cancer, people isolated or unable to travel.	Active Rutland, Active Together, PCN RISE	Mar-24	Place	* Exercise referrals made * Exercise referral service user numbers * Reduction in the proportion of adults overweight or obese * Increased proportion of physically active adults * Increased proportion of adults engaging in active travel (cycling or walking) at least 3 days a week * Proportion of health checks completed						**GREEN**
	Supporting residents to live more active lives	b) Local progress of the LLR Active Together strategy, including engaging organisations including businesses, care homes and schools in facilitating active lives.										
	Supporting residents to live more active lives	c) Development of Active Referral programme delivered by Active Rutland, utilising the Joy platform for referrals.										
	Supporting residents to live more active lives	d) Secure funding via PCN to develop a wider offer e.g. hip, knee and back school.										
	Supporting residents to live more active lives	e) Access to Holiday Activities and Food programme delivered by Active Rutland.										

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2.2.2	Supporting residents in health awareness and ensuring they can self-care where appropriate.	a) Providing information to increase awareness of changing health needs, and confidence to self-care. b) Clear prevention 'front doors' for additional support (See 2.2.4 Social Prescribing). c) Increase uptake of Weight Management Rutland service for adults, and family-focused support programmes, including Holiday Activities and Food Programme. Encourage take-up of NHS health checks and ongoing blood pressure monitoring for early diagnosis of cardio vascular risk. d) Review Chlamydia screening across Rutland to identify reasons for low level of Chlamydia detection and screening.	RCC (incl RIS, RISE, libraries), Public Health, PCN, VCF sector	Mar-24	Place	* Communication measures on Health awareness campaigns and RIS webpages (reach, shares, posts etc.) * Uptake of prevention services * Uptake of NHS health checks and numbers of referrals to prevention services * No. of blood pressure checks in the community * Improvement in Chlamydia screening rate and understanding of detection rate						**GREEN**
2.2.3	Ensure our workforce are trained and empowered to have healthy conversations	a) Implement Healthy Conversations training (Making Every Contact Count Plus – MECC+) to empower Rutland's diverse front line staff to discuss health and wellbeing with service users and signpost them. b) To include professionals working with housebound and digitally excluded people, and those who struggle to travel. c) Accessible signposting resources.	RCC, PH, LPT	Jun-23	Place and System	* Numbers trained in MECC+, train the trainers and super trainers in Rutland * Data on source of referrals to prevention services * Reach of RIS website * Qualitative feedback and evaluation of MECC+ training package						**GREEN**
2.3	**Encourage and enable take up of preventative health services**											**GREEN**
2.3.1	Increase uptake of immunisation and screening programmes.	a) Completion of a health equity audits on immunisation and screening programme uptake across Rutland. (Including childhood immunisations.) See 1.1 and 1.2. b) Targeted communications campaigns using behavioural science to support increasing uptake. (See 2.1) c) Use the Health and Wellbeing Coach, healthy conversations (MECC+), Core20Plus5 and other routes to increase cancer screening uptake including mammograms, bowel scope screening and cervical screening [see 2.2] d) Considering how services could be delivered closer to home (for example breast and bowel scope screening) See 4.2.	PH/ PCN/ NHS England	Mar-23	Place and System	* Health Equity audits completed on areas of concern. Results/ recommendations reported to HWB and LLR Health Protection Board. * Uptake of specific immunisation and screening programmes. Specifically reviewing vulnerable or under-served groups. * Including offer/ uptake of health checks (including those for LD), uptake of screening programmes (including breast and bowel scope screening), uptake of screening programmes closer to home.						**GREEN**
2.4	**Maintaining and developing the environmental, economic and social conditions to encourage healthy living for all**											**GREEN**
2.4.1	To have a focus on health and equity in all policies.	Focus will include the economic, social and environmental contributions to health (wider determinants of health). a) Aiming for an overall commitment of relevant organisations in Rutland to building in consideration of health and equity in all that they do. b) Health Impact Assessments (HIA) or Integrated Assessments for decision making and policy development. Health Impact Assessment (HIA) of individual policies/investments, considering social value. c) Support decision makers with training and development on Health in all Policies and the wider determinants of health.	RCC PH	Mar-24	Place	* Organisations committed to a Health and Equity in all Policies approach. * Evidence that organisations have embedded a process to systematically consider health, wellbeing and equity in everything they do. * Evidence of enhanced designs/decisions from HIAs * Colleagues trained in HiAP		Training opportunities for HiAP are being considered for roll out in 2024. An e-learning package on wider determinants of health will be available for all staff and face to face sessions aimed at senior leaders and decision makers.				**GREEN**

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

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

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

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All aspects of 3	Receipt of information on services including villages and rural areas. Identify and connect to those vulnerable and carers increase number of volunteers	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	place	Oakham Market / Empingham/Ashwell	Armed Forces Engagement event at Kendrew Barracks 27th September. Attended by RISE, CAR, RCC Carers	31.10.23. RISE team in attendance at Mobile vaccination unit in Cottesmore, Exton and Market Overton to raise awareness of RISE.	01.11.23 - 03.11.23 - RISE team attended alongside mobile vaccination unit at 13 village locations in Rutland to raise awareness of the RISE team					green
	recruitment of 4 vols for Rutland - outcomes??	digital volunteers	Jane Kibble/ S-J Sharman?	?	place	Currently on hold due to Age UK gaining funding to run weekly sessions from Tesco	Tesco sessions ongoing through Age UK	this is rcc work not age uk?? - ask Jane K aboutthe longhurst project	individuals are offered a digital MOT as part of their housing MOT. If a need is identified, they have been referred to Age UK. There has been very little uptake on digital skills support identified by Longhurst					green
	care home can see DSCR and are able to communictae via NHS email securely	LLR pathfinders project - all care homes to complete DSPT and have NHS email and access to DSCR	Lhis	ongoing	system	number in rutland with DSPT/NHE email and accessing DSCR		see im&T papers						blue
	secure access to records across the system - patient only telling story once and acurate up to date assessment can be made	all providers to have digital care records to allow secure and access to peoples care records across the system	LHIs	Mar-24	system	Phil Eagle update to add here		see im&T papers						amber
	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.	VAR Christmas Appeal	VAR	Dec-23	place	Funding has been applied for to help facilitate this project		The Christmas appeal is going well. VAR have been distributing leaflets, Tesco has a collection trolley in the store and they are collaborating with Oakham Fire Station.	Tom from VAR and Matt from Oakham Fire station did an interview with Rob Persani from Rutland & Stamford Sound in Mid-November to help raise awareness of the Christmas appeal	Fire Station is collecting gifts to give to people in need of all ages/genders. Lands End have pledged to donate money for more gifts. Partners have been made aware that they can nominate people to receive a gift.	need to know the outcomes please - how mnay people have been supported and what diference has it made			green
	Carry out 600 per year	Home safety checks by the Fire Service	Fire Service	Ongoing	place	68 home safety checks completed in May	112 home safety checks carried out in September	70 Home Safety Checks carried out in October	65 Home Safety Checks carried out in November	As at 19th December 2023, 729 home safety checks have been carried out in Rutland this year by the Fire Stations and the community safety team				green
	25 vulnerable adults issued with a warm safety pack	Warm Pack	Fire Service	Winter 2022	place	progress on how to obtain winter 24 warm packs?	Lisa meeting with Matt Basey in October to discuss further. Plans are underway for provision of warm packs again this winter.	Lisa met with Matt Basey. LFRS will be providing up to 50 warm packs this winter from 1st December onwards. Lisa to provide RISE leaflets and MIABs to go into the warm packs and help to raise awareness of the warm packs	Warm and Wise leaflets from Age UK delivered to Oakham Fire Station, as well as 50 RISE leaflets. Matt Basey to secure 50 MIABs from Rutland Lions	There are currently 25 Warm packs at Oakham Fire Station. Partners have been asked to nominate people directly to the Fire station if required. They can provide up to another 25 warm packs if needed.				green
	reduce demand on duty and direct people to right therapy offer	Empower people towards self care - through the development of a digital front door for ASC	Mat Wise	autumn 2023	place	is this live? - if so how many accessing it?	42 referrals through ASC portal in September	78 referrals through ASC portal in October	82 referrals through ASC portal in November.					green
	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	Below Waist Pilot Rutland pre-hab pilot	Pre-hab pilot project group	Jun-23	system	EJH- chased Helen Mather for list of names of those on consultant or hospital waiting lists for below the waist consultation or operation. Also progress of LLR business proposal to roll out the city pilot currently taking place. Rise continue to receive referrals from GPs for people at early stage consultations with Gps about pain in joints below the waist Helen M also to update on plans for MSK clinic in Rutland								blue
	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	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	place	Eilidh has held meeting with care homes and organised set months for each home to complete PCSP. 39 MDTs held in May	40 MDTs held in September / Personalised Care Plans = 22	40 MDTs held in October / 33 PCSP's completed	39 MDTs held in November / 0 PCSP's in November					green

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3.1 Healthy ageing including living well with long-term conditions, reducing frailty and falls prevention	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 (Not able to deliver this) 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	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 (Not able to deliver this) 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	place		16 Housebound patients visited in September	17 Housebound patients visited in October	13 Housebound patients visited in November					green
	prevention of a repeat fall reduction in the number of people haiving a hip fracture in Rutland	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	place	We are continuing to collect data on Rutland residents with a hip fracture to ascertain the local pictures and ensure services are meeting need. RCC Principal Occupational Therapist continues to represent Rutland at the RCC Falls Steering Group and are working on mapping services, standards of assessment and parity across the region	jane kibble advising	Recent audit examining the local picture for Rutland showed 16 hip fractures in all areas for a 7 month period. 12 of theses were anticipated falls - people who have health issues, became unwell, mutiple conditions most over 85. Only 4 were environmental hazards causin trips / slips. All 4 met 100% of reablemet goals. Use of DHU car in Rutland continues to pose questions with little to no activity. Paper submitted to Director ASC to consider place led option.		i need an update for this please - LH - Jane Kibble advised that this is ongoing, but there is currently nothing significant to report 13.12.23.				green
	using NEWS residents are able to avoid hospital admission as deterioration is identified early and treatments received	Monitoring deterioration in a persons health using:-Whzan – NEWS2/Restore Mini	RCC - Karen Payter	ongoing	system	Whzan equipment issued to 7 care homes across the Rutland PCN (10 care homes in the Rutland PCN). Waterside (supported living, not a care home) were issued with their equipment in May – they are awaiting their training before going live. Crown House now wish to have Whzan – equipment to be delivered and training to be arranged.		October 2023 update Pilot has been externally evaluated by Tara Marshall. Fortnightly meetings with pilot leads (LLR) and Tara Marshall Monthly meetings including the above plus providers in the pilot (across LLR) Current participation is 08/10 eligible care homes in the Rutland PCN, and one supported living (Waterside). Of the 08/10 the most recent addition is Crown House who now have their Whzan box, and are awaiting their final training session before going live.		can you ask for the evidence of the effectiveness of this - i believe Sammi suggesgted a 50% reduction in a&e attendances for rutland care home residents? LH 14.12.23 - Kelly M will speak with Sammi Le Corre regarding this.				green
	preventing falls via use of tech	sensory based falls tech in care homes	LLR falls group - jane kibble (Sarah Humphries)		place	number of Rutland care home with sensory tech		jane kibble to advise	Personalised Falls prevention strategy live in all care settings in Rutland. 53% reduction in safeguarding for falls. Significant reduction in hip fracture numbers for all areas including care homes with only 3 in 7 month period from April to Oct 2023.					green
	Digital switchover rollout for those using monitoring services - Rurality and network/signal coverage may raise an issue?	digital transformation - utilising the digital switchover as a catalyst to transform care technology in Rutland.	Jane Kibble and Longhurst (Sarah Humphries)	Jun-23	place	We are taking time to visit care tech providers to demonstrate systems approach to environmental control and health monitoring with a view to pilot schemes for the future		jane kibble to advise	Recommisssiomed care tech service continuing to support our vulnerable residents throughout the process with customer engagement events and regular communication, support and advice in various formats.					green
	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	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	ongoing	place	47 D2A cases May 23. Avg stay on reablement is 14 days. Percentage of Discharges at home 91 days later 87.5% EDT calls 4	50 D2A cases September 2023. Average days for reablement is 21 days. Percentage of discharges at home 91 days later = 88%. EDT calls = 4	40 D2A cases October 2023. Average days for reablement is 19 days. Percentage of discharges at home 91 days later = 80%. EDT calls = 5	47 D2A cases November 2023. Average days for enablement is 15 days. Percentage of discharges at home 91 days later = 87%. EDT calls - 4					green
	increased use of joy will supprt self referral/access to services and be able to track outcomes for people	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	place	number of tiles of support listed on Joy	RISE team making people aware of JOY and its benefits. Lisa continues to discuss with various people when meeting with them.	RISE team continue to take referrals and manage case load through the use of JOY. Services being added where applicable	RISE team continue to take referrals and manage case load through the use of JOY. Services being added where applicable					blue
	increased referrals to community and professionals to access preventative services and support those supported by rise have increased outcomes demonstrated via ONS4	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 referals to Rise integrated neighbourhood team via the joy platform	rise	ongoing	place	Number of referrals to Joy in May = 63. GP referrals - 36 / 27 from other professionals or self-referrals.	Number of referrals to Joy in September = 77. GP referrals = 33 / Referrals from other professionals or self-referrals = 44	Number of referrals to RISE through JOY in October = 55 / GP referrals = 32 / Referrals from other professionals or self-referrals = 22 can you add the detail of the satisfaction or ons4 score here please from jy dashboard	Number of referrals through Joy in November = 81 / GP Referrals = 38 / Referrals by other professinals or self-referrals = 43. CLIENT SATISFACTION = 94% (Joy Benchmark 74%)					green

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3.2 Integrating services to support people living with long-term health conditions	a) Promote clear routes for wellbeing enquiries/ requests for support 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				place									green
	Easier referral from the GP to the admiral nurse service rather than the current Prism referral.	Admiral nurses using JOY as a direct referral from GPs	Jane Lee	May-23	place	We have had referrals via Joy all from ASC and RISE team no referrals from GP'S	8 referrals in September via Joy platform.	3 referrals in October via Joy platform						blue
	those requiring an MDT approach to support are discussed at each MDT as appropriate	monthly MDTs taking part in all 4 GP practices - following the LLR MDT framwork	RISE team	Aug-23	place	Lisa has messaged James Burden to offer assistance with MDT set-up now that Megan has left - awaiting response.	MDTs taking place in Oakham and Empingham attended by the RISE team	MDTs taking place in Oakham and Empingham attended by the RISE team	MDTs taking place in Oakham and Empingham attended by the RISE team					amber
	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	Prompt safe hospital discharges	RCC hospital team	ongoing	place	Discharged 36 people, 15 of whom left on the same day as becoming medically fit. Of the 36 discharged in May we supported 27 discharges within 48 hours. For May our average discharge delay per person was 2 days.	Discharged 35 people, 14 of whom left on the same day as becoming medically fit. Of the 35 discharged in September, we supported 23 discharges within 48 hours. For September our average delay per person was 2 days.	Discharged 45 people, 15 of whom left on the same day as becoming medically fit. Of the 45 discharged in October, we supported 24 discharges within 48 hours. For October our average discharge delay per person was 3.9 days	Discharged 37 people, 12 of whom left on the same day as becoming medically fit. Of the 37 discharged in November, we supported 20 discharges within 48 hours. For November our average discharge delay per person was 3 days.					green
	more support availble to vulnerable people in Rutland	VAR - expansion of support beyond the community transport services - now based at OEP	VAR	ongoing	place	10,243 miles driven with around 531 journeys in May. over 100 cancellations (most commonly at the moment due to NHS strikes, backlogs forcing appointment postponement).	9,419 miles driven with 482 trips in September	8,245 miles driven with 441 trips in October	11,686 miles driven with 624 trips in November.	VAR carried out the Christmas appeal alongside the Fire Service. They also organised the Lands End Christmas lunch for 40 people. Currently trying to seek funding to run a monthly lunch at Lands End. They are also providing SEN school transport for RCC				amber
	Tackling loneliness and increasing social engagement amongst older people with a view to combating social isolation and improving health.	Men and Women in Sheds Project	Age UK	Ongiong	place	Funding applied for in order to support the ongoing work provided by Men and Women in Sheds project. Currently awaiting outcome of a funding bid that was submitted to the LLR Community Foundation. The project will continue to generate income through a combination of funding bids and the sale of items produced by the shed	No updates for September	Sadly the funding bid for the dementia friendly session at the shed was unsucessful. If another avenue becomes available to try to get this off the ground in the future, Age UK will try again. 128 people attended 3.5hr sessions during October	178 people attended 3.5 hr sessions in November					green
	Offering people support to use digital devices such as smart phones and tablets	Digital Champions	Age UK	Ongoing	place	Planning to move from 3 drop in sessions per month to weekly sessions.	Weekly digital drop in sessions continue at Tesco store in Oakham. 15 people supported in September. Digital Cahmpions Project Co-ordinator promoted the weekly Tesco Drop in sessions.	Sadly the digital champions project will come to and end at the end of 2023. Age UK hope to still be able to offer some reduced provision but will update in due course. 6 people attended 10 sessions in October	3 people attended 3 sessions in November. There was only one drop-in session in November.					green
	people in rural community have access to peeer support through the befriending project	befriendng support for isolated and vulnerable	Age UK	ongoing	place	The befriending project is currently supporting 49 older people across Rutland.	New befriending Co-ordiantor has been recruited. Commences in past 2.10.2023. Induction is currently being planned.	The new befriending co-ordinator unfortunately pulled out so the job has gone out to advert again.	New befriending coordinator post filled from January 2024					amber
	Promotion of programme to people living with long-term health conditions. Number of bottles given out.	Lions Message in a Bottle programme (MIAB)	Lisa Hamilton / Admiral nurses (JOY)	Aug-23	place	Collection 100 MIABS from Lions in May. Awaiting promotional materials. Lisa took MIABs to Ashwell community event where she discussed the programme with Hollie at Age UK and put her in touch with a contact at Rutland Lions to enable Age UK to also order and distribute MIABs	Lisa provided Georgina from the Rutland PCN with more MIABs for her visits to housebound patients.	More MIABs were distributed at Oakham Market by RISE alongside the mobile vaccination unit on 4th October. They continue to be topped up for our partners to help spread the word. Another 20 MIABs given to PCN for distritubution to housebound patients.	Around 75 MIABs distributed by RISE alongside the mobile vaccination unit at 13 villages throughout Rutland in the first 3 days of November. Lisa has spoken with the Lions to order more MIABs and is awaiting confirmation of when she can collect more.	Lisa collected 200 additional MIABS and has given 50 to the Fire Station for the winter warm packs and 50 to the proactive care coordinator at the Rutland Health PCN as she had run out and distributes regularly to the housebound patients she visits.	please could we have the outcomes of distributing these bottles - have emas been using the messages?			green
	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.	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	place	14 attending in May	12 people supported in September.	11 people supported in October	13 people supported in November	can we have the numbers update please and also the outcomes of people attending				green
	increase in information and knowledge through regular speakers attending the group - peer support ave number attending is between 3 - 6	Carers' Centre LLR 1. Weekly get- together with carers - skills based learning & peer support.	Carers Centre LLR	Nov-22	place	•Total carer attendances for May was 17 •Attendance at each TWC session was 4, 5, 4, 1, 3 •4 speakers joining via zoom and in person.	This pilot has come to an end and is sadly not going to be extended.	This pilot has come to an end and is sadly not going to be extended.						blue

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3.3 Support, Advice and community involvement for Carers	Understand the impact of the carer's role and what help is available to them target 20 people	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	place	•3 attended the launch •2 carers attended the 1-2-1 sessions	4 carers supported through 1:2:1 sessions during September	8 carers supported through 1:2:1 support during October	10 carers supported through 1:2:1 support sessions during November. 5 carers received 1 session each and 5 received 2 sessions each.					green
	carers only tell their story once - all professioanls are aware that a person is a carer - MDT support given All care support options are on joy platform to ease referals and signposting	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	place	sync of lists achieved?? Tiles for all carers support on joy platform - PCN has list of current known carers and is making contact to offer support. Was paused to finish Covid campaign.	PCN continue to make contact with known carers to offer support and where appropriate, to refer to RCC for a carers's assessment	PCN continue to make contact with known carers to offer support and where appropriate, to refer to RCC for a carers's assessment	PCN continue to make contact with known carers to offer support and where appropriate, to refer to RCC for a carers's assessment	can you asceertain how many carers are known to pcn and Rcc - how is the linking of these 2 lists happening? Whenever the PCN coordinator codes someone as a carer on systmone, they automatically refer to RCC for a carers assessment if consent is given.				green
	carers have information available on discharge of cared for	Information via a leaflet on discharge from hospital for carers	carers matters group - RCC carers team	Jun-23	place	check if this is now available	Libby will try to make contact with Cheryl Clegg and will update regarding progress for hospital discharge leaflet for carers			A lot of the time, our reablement people, the short term carers are generally not offered carer support at this time due to the likelihood of them not needing anything after 2-6 weeks. The longer term carers get verbal information at point of discharge or on arranging longer term support and get offered a carers assessment or given information to self refer if they want one at a later time. They do not hand out printed information unless required as they are budget conscious and try not to print unless needed (to save paper) as things get lost in hospital also don't often know if they will have carers until someone has left hospital and Micare/Therapy are often more able to recognise this				amber
	* 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	LLR carers group actions - identifying unpaid carers as they are less likely to reach breaking point and require emergency assistance	rcc carers team	?	system	CDG are working on developing training across LLR to provide a consistent approach. ICB have re-written carer GP registration forms - these can now be distributed to our carers. Awaiting May figures for carer passport. Mobilise is up and running but because they're commissioned by ICB for LLR there is no way of breaking down into Rutland-specific figures. We have requested this information but Mobilise are saying this isn't possible. Hayley is still attempting to resolve this.				CDG are working on developing training across LLR to provide a consistent approach. ICB have re-written carer GP registration forms - these can now be distributed to our carers. Awaiting figures for carer passport. Mobilise is up and running but because they're commissioned by ICB for LLR there is no way of breaking down into Rutland-specific figures. We have requested this information but Mobilise are saying this isn't possible. Hayley is still attempting to resolve this. I have been invited to the mobilise meeting and will carry this action on.				amber
	more carers are aware of carers assessment and support on offer	raise the profile of support via rcc carers team	RCC carers team	Jun-23	place	leaflet produced and comms done in order to raise awareness of carers week and event at Catmose on 7th June	Carers Community Liaison Worker attended Armed Forces Community Event at Kendrew Barracks in September to help raise awareness of support available.			Leaflet to be produced comms done in order to raise awareness of carers rights day				green
	Improving means of communication with carers across Rutland	Carers having access to the right information at the right time	RCC carers team	Ongoing	place	A request has been made for a mailchimp account to enable regular communication with carers through Information Governance. Awaiting response.	Still awaiting decision from governance. Work is ongoing regarding digital information and solutions for carers. Further work is being undertaken on the portal to make this more acessible for carers to complete self-referrals and contingency plans.			A request has been made for a Mailchimp account to enable regular communication with carers through Information Governance declined and raised with Hayley Morris and Tracey Webb to escalate				grey
	reduce carer strain	RCC to explore signing up with Carefree to offer free short breaks to adult carers of carers.	RCC carers team	?	place	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.	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.	Carefree became a chargeable service to RCC so Rutland, Leicester and Leicestershire no longer offer this service.	Carefree has been removed as changed to a chargeable service. Leicester city have also with drawn this service.				grey

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	Increasing number of carers identified and supported	PCN Carer project	PCN	Jun-23	place	PCN has list of current known carers and is making contact to offer support. PCN will launch comms campaign to identify new carers. 21 carers contacted so far (paused to complete Covid programme) - Recommenced 12/06/23	14 peple referred to Libby by Proactive Care Coordinator at the PCN for carers assessment	18 people referred to Libby by Proactive Care Coordinator at the PCN for Carers Assessment	7 people referred to Libby for Carers' assessment by Proactive Care Coordinator at the PCN					grren
	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	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	system	check with carers team on progress - I think Rutland homes have engaged in this research?								grey
	Young carers supported in their caring role	Identification of young carers	RCC Children & Adults / Family Hub	Aug-23	place	18 young carers supported during May	13 young carers supported during September	18 young carers supported during October	21 young carers supported during November					green
	* Co-produced. * Service tailored to need. * Improve dementia care. * Raise awareness. * New WOW including digital. * Collaborative work - Health & Social care.	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	system	LLR document continuing to meet with LLR Colleagues. Taking to CLT 22nd June. Due to go to Public Consultation beginning of July for 8 weeks.	Lisa and Admiral nurses continued to raise awareness of the survey by distributing posters in local GPs / pharmacies / events. Consultation closed on 22nd September	Consultation closed 22nd September - Action closed	Action Closed					blue
	* 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	Rutland LD Partnership Board	Alexandra Chamberlain	March 23 & quarterly	place	Agenda for 21st June Meeting: Co-chair opens meeting Minutes review LDPB reporting and govenance Presentation from Rutland Information Service Presentation from Co-Chair and introducing Day Opportunities Adult Learning – what the board would like to have offered to them. Presentation by Rutland PCN LD Annual health Checks. Co-chair discusses Money Management. Safety around summer weather. Questions .	Next LDPB to be held on 20th November	Next LDPB to be held on 20th November	LDPB was held on 20th November. Topics covered included a talk by Albert Marazi (Social Worker) about what happens at a Social Care Review. Catrina O'Regan, LD Nurse gave a talk about Healthy Relationships. Rory gave a talk about the Brightways pop up lunch shop on a Thursday.	could i have numbers and outcomes please added here - how many people attended and what did they say/do. Cannot obtain numbers currently due to staff absense.				green
	people with LD are regulalry monitored and support given early to ensure they are living healthy and well	Increase the % number of LD health checks completed	? (Speak to Sam Screaton)?		system	Achieved PCN target for 22/23 (achieved 84% of LD health checks). These are completed in Q4. Main difficulty is patients declining	LPT offer support around Annual Health Checks, providing training updates and advice around reasonable adjustments. They have also got involved in health promotion events to promote the annual health checks. Sue Mullinger is going to promote AHCs amongst the parent carer groups	The Pilot is to support Primary Care to enable people with learning disabilities who have complex needs who require additional reasonable adjustments and patients who have not been seen in 2 years + for their LD annual health check, to access their health check. GP surgeries must refer into the pilot, but surgeries in Rutland are aware of this and are referring as needed.		To date on 19th December, 25 LD annual health checks have been completed. All GP's are aware of the pilot and are referring as needed. The pilot runs until March 2024 with hopes that it will be extended				green
	people are supported to stay in Rutland rather than access support a long way from family and friends	providing care and support for people with LD closer to home	RCC ASC (Mat Wise)	ongoing	place			mat and social worker to advise what the strategy is for this						amber
	% Number in employment	Supporting people with LD/autism to access vol/work/education opportunities	rcc employment officer		place		Unable to obtain this information due to staff absence.	Linda Wylie to advise these numbers	10% of people with LD in Rutland are in employment					amber
	fundraiser for admiral nurses	dementia awareness week 15 - 21st May 2023	admiral nurses rcc	17/05/23	place	Funds raised from the *Time for a cuppa* was £273 for dementia UK 28 guests attending the Musical memory café	Action completed	Action completed						blue
3.4 Healthy, fulfilled lives for people living with learning or cognitive disabilities and dementia	* Earlier diganosis. * Quicker support including meds, treatment etc. increase number of those diagnosed with dementia	Anticipatory Care Project - To improve educaction regarding dementia including in care homes	EJH & PCN / Admiral nurse	Sep-23	system	Room secured at RMH to run weekly memory clinic from June. Lists of patients ready and plan in place to provide care coordinator one day a week.	First dementia outreach event was held at Barrowden Village Hall on 19th September. Representatives included RISE, Rutland Healthcare PCN, Admiral Nurses, Age UK, VAR, Active Rutland, Citizens Advice, Leicestershire Fire & Rescue Service and the Longhurst Group. It was a well-attended event and several attendees expressed that they thought it was wonderful that we had put on an event in their community.	Discussions beginning around some smaller dementia outreach events to coincide with mobile vaccination bus in November.	Dementia outreach event planned for 11th December at Greetham Community Centre. Flyers sent out to all invitees, along with flyers given out to community centre and Church at Greetham and the Wheatsheaf pub. Also requested for it to go on the village facebook page. Attended a village coffee morning to speak to people to help raise awareness. Comms will also help to spread awareness					green
	support for carers - evaluation of the difference attending has made	Carer support on zoom - For those caring for someone with dementia or memory loss	Rutland community Ventures	May - July 2023	place	5 people supported in May	5 people attended both of the zoom support sessions in September	The final zoom support session was held on 3rd October and was attended by 5 people	Project finished due to end of funding					blue
	Jane - please add here the outcomes of these 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	place	Funding applied for to help support the craft sessions and work carried out by RCV to support people and carers living with dementia.	13 people attended each of the craft sessions (2 sessions) in September	Project ended on 2nd October. It is hoped that it can be reinstated if more funding becomes available.						blue

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	Finding different ways to communicate, such as sensory, music, memory boxes etc.	Dementia support - Creative communication for dementia carers - Finding different ways to communicate - sensory, music, memory boxes etc.	Carers Centre LLR	May-23	system	2 attended in May	No funding for this currently from Carers Centre	No funding for this currently from Carers Centre						blue
	Strengthening and maintaining cognition for people living with mild to moderate dementia in a fun and friendly setting.	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	place		MCST 6 sessoins held (no sessions 19th September due to the dementia outreach event at Barrowden). 17 individuals supported.	8 MCST sessions held with 19 individuals supported during the weekly sessions.	8 sessions held with 72 attendances by 18 regular attendees					green
		Dementia support - various groups to support people living with dementia and their carers	Age UK	Ongoing	place		Time in Nature: 2 sessions (17 guests) Memory Cafe: 1 session (17 guests) Coffee & chat: 2 sessions (18 guests) Hopper coffee: 11 people supported	Time in Nature: paused for winter until April 2024 Memory Cafe: 1 session (16 guests) Coffee & Chat: 2 sessions (23 guests) Hopper coffee: 8 people supported	Memory cafe: 19 guests supported Coffee & Chat: 2 sessions - 23 people supported Hopper coffee: 11 people supported Leicester memory music box special - 22 guests supported					green

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 November 2023	Key Identified Risks	Mitigations	Nov 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.	Work is ongoing to establish regular monthly datasets and data provided by Aristotle is suppporting the planning and development of a number of different initiatives such as Same Day Access and implementation of the Women's hub.	Variability in the availability of certain data from different providers. Some data may not already be routinely collected.	Work closely with Midlands and Lancs CSU and providers to ascertain whether it is feasible to establish regular data collection to inform measurement of the metrics.	AMBER
4.1.2	Develop strategic relationships with cross border commisisoners and providers to ensure equitable services are developed and available ensuring Rutland's residents and those registered at a Rutland GP have greater choice across boundaries and inform future strategy development of partner ICB's. Build equitable access into pathway design.	Greater understanding of services that patients access or should be able to access across borders in Peterborough, Lincolnshire, Northamptonshire and Cambridge. Check services available in Leicestershire and 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.	Established link with cross border commissioners and providers. Inclusion in discussions such as the North Cambridgeshire and Peterborough Care Partnership Board, representation from out of county colleagues on the Rutland Strategic Health Partnership Board and North place development collaboration.	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 borders.	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 and PCN development.	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-24	Place	Number of survey responses Patient feedback Progress against the individual recommendations outlined in the Primary Care Accesss Survey.	An ICB GP Practice Communications and Engagement Open Forum was established in September and there is representation from Rutland. AS a part of the delivery of the Capacity Access and Improvement Plan a PCN newsletter is being developed that will be distributed to all patients and one of the articles planned is an overview of the primary care team which included details on the ARRS roles that the practices have and the services they provide as a a result. The PCN is also developing a strategy that demonstrates how it will take on board patient feedback. Also as a part of the CAIP regular patient surveys are being planned to inform service development and improvement.	N/A	N/A	AMBER
4.1.4	Implementation of the capacity access and improvement plan for primary care that: Considers patient experience of contact Ease of access and demand management Accuracy of recording in appointment books	Each PCN as a part the Network Contract DES has to implment a capacity access and improvement plan that aims to focus on making improvements to help manage demand and improve patients experiences of access, so patients can access care more equitably and safely prioritised on clinical need. It also supports the accurate recording of general practice activity so that improvement can be data-led. The plans will include the review of patient survey data and improvements to be implemented that address areas highlighted, implmentation of cloud based telephony to support access along with a review of online resources.	PCN	Apr-24	Place	As a part of the implmentation of the CAIP a number of baseline metrics have been taken to ensure that the effectiveness of the plan and its outlined actions can be measured.	A mid year was undertaken with the PCN and the demonstrated that considerable progress had been made against the plan. All four practices websites have now been reviewed and standardised across the PCN so irrespective of which practice your are registered at you recieve the same information. Changes made in line with NHSE guidance for accessibility and useability.	The PCN manager has left and although recruitment has been undertaken the successful applicant will not be in post until February 2024	This has been mitigated by the key tasks of the PCN manager being distributed to the 4 practice managers across the constituent practices and is the PCN CAIP Plan delivery is being overseen by the PCN Clinical Director.	GREEN
4.2	**Increase the availability of diagnostic and elective health services closer to home**									AMBER

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4.2.1	Improving public information about locally available diagnostic and planned care services as part of increasing access including urgent care and when mobile facilities such as the mobile breast screening unit are in the area, and accessible out of area provision.	GP, PCN and Rutland Information Service having dedicated areas on their websites/directories with information that is kept up to date and active signposting to out of county equivalent services. Map all local services available.	ICB	Apr-23	Place	Local communication plan and RIS development including specific campaign on out of hours access				**AMBER**
4.2.2	Develop understanding of used and vacant space at Rutland Memorial Hospital to inform scope for potential solutions. Followed by strategic review of other vacant space that could enable health services closer to the population.	A completed estates review that identifies all areas that are curently being used, idenitfy areas for consideration not just from a health pespective but local authority and other local businesses such as leisure centres and vountary sector organisations.	ICB	Apr-23	Place	Quantified understanding of available space and existing medical facilities' appropriateness for clinical activity		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**
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**

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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
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

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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

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
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RED = Off track and at risk
GREY = Not Started
BLUE = Complete

Ref	What Do We Want To Achieve?	How Are We Going To Achieve It?	Lead Organisation	Timeframe for Delivery (Month/Year)	Level (System, Place or Neighbourhood)	How Will Success be Measured?	Progress for October 2023	Progress for November 2023	Key Identified Risks	Mitigations	Nov 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**

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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**
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**

Overall Priority RAG

First Dying Well Steering Group held on Monday 6th of November. Key outcomes:
1. Full Steering Group members agreed
2. Next key actions agreed, one being to review the below delivery plan to the Marie Curie recommendations and the suggestions in the EoL JSNA.
3. Full Steering Group to be held in December with reviewed action plan and ToRs

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 November 2023			Key Identified Risks	Mitigations	Current Month 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 Eol 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 thrugh 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.	

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 November 2023			Key Identified Risks	Mitigations	Current Month Project RAG Status
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, incorporating 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						
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 approppriate 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 approporiate 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.						

Priority 7a: Cross Cutting Themes - Mental Health

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

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

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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 October 2023	Progress for November 2023	Key Identified Risks	Mitigations	Nov 2023 Project RAG Status
7.1	**Supporting good mental health**										**GREEN**
7.1.1	Increase access to perinatal Mental health support services, wherever Rutland women have chosen to give birth.	Understand more about the Perinatal Mental Health Service and what we can do to increase the numbers of people accessing this. Support promotion and raise awareness of this service.. There are links with priority 1.2.2 - Healthy lifestyle information for women pregnant or planning to conceive (c) mental health.	LPT	Ongoing	System	The number of people accesssing perinatal services increases.					**GREEN**
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.	Use recent surveys, such as the Family Hub consultation, as well as specific priorities set within the Rutland Children and Young People's Strategy 2022-2025.	LPT, PH	2023/2025	Place and System	Gaps identified and solutions/services put in place.	Working with the Mental Health GP Lead for the Rutland PCN, a SEN Operations Officer and Inclusion and Early Help Officer, we are forming a new MDT that will start in November to look at Section 19 and the support we can offer for those both on or not reaching CAMHS eligbility				**GREEN**
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.	This will link to action 7.1.2, as we need to understand the gaps and what children and young people are asking for support with.Launch of MySelfReferral service to allow CYP to self-refer themselves or seek support for their mental health.	LA, VCS, CCG	2023/2025	Place	Increased resource available for children and young people	Working with the Mental Health GP Lead for the Rutland PCN, a SEN Operations Officer and Inclusion and Early Help Officer, we are forming a new MDT that will start in November to look at Section 19 and the support we can offer for those both on or not reaching CAMHS eligbility				**GREEN**
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	Promote available grants and funding opportunities with all partners and support where necessary. Creation of MH Pathway, which can be used in GP surgeries. Engagement with armed forces, farmers and exploring what we can do with regards to support those who have barriers around rurality	LPT/ CCG/ RCC	Ongoing	Place and System	Funding bids are best suited to the current needs of our population and are able to demonstrate effective results. The MH pathway is used within the GP surgeries and is recognised as the pathway to follow when there is a mental health support need. Farming community and armed forces are working closer with us to better suit their needs.	We hve been working alongside the vaccination van to raise awareness of the RISE team and our support offer. We made connections with 97 people in October, which only started on the 31st of October, with further dates planned over the winter months.				**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.	Support to increase the capacity in local low level mental health services and closer working between involved local agencies and services, including in the voluntary and community sector and peer support, so more people access help sooner in their journey.	PCN, LPT, RCC, VCS	Ongoing	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 story.	Our new 3 Conversations MH Reablement Worker started mid-October. They are working closely with the RISE team and are currently exploring options for a drop-in venue. The review of the Mental Health Neighbourhood Cafe took place at the start of the month and they were assessed on 5 criteria; Café Model and Good Practice, Comms and Marketing, Engagement & Integration, Staffing Model and Monitoring & Reporting. Pepper's scored 4 in each of these (out of a top score of 5) and acheived an overall rating of 4, which equates to Good. They are one of the higher rated Mental Health Neighbourhood cafes across all of LLR as all were reviewed in September and October. I have spoken with the Principal Clinical Lead for the PCN, who has agreed that all GP surgeries in Rutland will update their websites to include information about the Mental Health Neighbourhood Cafe.				**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	Establish a neighbourhood mental health group .Introduce new MDT specifically for community based Mental Health support LPT Mental Health Facilitator role supports people within Rutland diagnosed with an SMI. Including an annual physical health check. LPT Employment Support Service Invividual Placement and Support Lead, supports people with SMI into employment. Working closer with NHS LLR Talking Therapies to ensure our local population are accessing their services.	LPT, PCN, RCC, VitaMinds	Ongoing	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 employment. Working closer with NHS LLR Talking Therapies to ensure our local population are accessing their services.	The 2023-2027 Neighbourhood strategy and action plan were presented to the Health and Wellbeing Board in October, which were both approved. The Community Mental Health and Wellbeing Team MDT meetings continue to take place weekly and we are getting additional attendees joining these to bring people to discuss for an MDT approach. Out new MH Reablement Worker started working with mid-October and we have now merged meetings so they join these MDT's. The World Mental Health Day event took place and we received lots of engagement from our community, as well as local radio and BBC Radio Leicester in attendance. Vita Health Group launched their 'Get on Board with Your Mental Health' bus campaign and I worked closely with them to organise them to visit Kendrew Barracks as well as going to Uppingham market.				**GREEN**

Priority 7b: Cross Cutting Themes - Inequalities

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

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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?	Mitigations	Nov 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			**GREEN**
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			**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			**BLUE**
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			**BLUE**
7.2.6	Mapping Rutland community assets, including its voluntary and community sector. *To be removed from this section of the plan.*		RCC	2022/24	Place			**BLUE**
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			**GREEN**
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.		**GREEN**
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.		**GREEN**

Priority 7c: Cross Cutting Themes - Covid Recovery

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

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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 October 2023	Progress for November 2023	Key Identified Risks	Mitigations	Nov 2023 Project RAG Status
7.3	**Covid recovery and readiness**										
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) **Alexandra Chamberlain**

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Ref	What Do We Want To Achieve?	How Are We Going To Do It?	Lead Organisation	Timeframe for Delivery (Month/Year)	Level (System, Place or Neighbourhood)	How Will Success Be Measured?	Progress for October 2023	Progress for November 2023	Key Identified Risks	Mitigations	Nov 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.	ASC Carer's Bi-Annual survey deadline closed and collating data. 1st Lived Experience Participation group met on 30/10/23. Agreed to TOR and to co-produce Charter. Requested Health to be part of group as well as those in receipt of services and not just carers. Charging for Care and Support policy consultation live from 1st Nov 23 to 24th Jan 24. AC arranging engagement and promotion of this consultation throughout the period. https://www.rutland.gov.uk/chargingpolicy The Improvement Project – Social Care Waiting Lists in the East Midlands. Contact made to all people on ASC & Therapy Waiting lists. Uptake for attending virtual meeting was very low but people happy to complete survey – period of engagement extended https://forms.office.com/e/qGi7FadKP3				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		Task and Finish Group met on 30/10/21 to agree scope and actions/deliverables form C & E Plan. Agreed each Priority Lead to identify one core C & E campaign to move forward with for next 18 months. To bring back to IDG in Dec.				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.	Task and Finish Group met on 30/10/21 to agree scope and actions/deliverables form C & E Plan. Agreed each Priority Lead to identify one core C & E campaign to move forward with for next 18 months. To bring back to IDG in Dec.				GREEN
8.1.5		Identify SMART goals and objectives, appoint leads on these are to be delivered, measured & reviewed.					Task and Finish Group met on 30/10/21 to agree scope and actions/deliverables form C & E Plan. Agreed each Priority Lead to identify one core C & E campaign to move forward with for next 18 months. To bring back to IDG in Dec.			Pending completion of high-level audit	GREY
8.1.6		Identify and deliver some 'quick wins' for local communications					Task and Finish Group met on 30/10/21 to agree scope and actions/deliverables form C & E Plan. Agreed each Priority Lead to identify one core C & E campaign to move forward with for next 18 months. To bring back to IDG in Dec.				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 October 2023	Progress for November 2023	Key Identified Risks	Mitigations	Nov 2023 Project RAG Status
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,	AC Coordinate with ICB and Places on a visual brand for health and wellbeing in Rutland				**GREEN**
8.2.1		Agree approach for collaborative communications across health and care in Rutland.	RCC	Sep-23	System		"Task and Finish Group met on 30/10/21 to agree scope and actions/deliverables form C & E Plan. Agreed each Priority Lead to identify one core C & E campaign to move forward with for next 18 months. To bring back to IDG in Dec. "				GREY
		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.	Self-referral platform Pilot – Needs Assessment referral page active and in process of compiling users and professional's feedback. Identification of some issues with users bypassing areas on Portal which has been rectified. LM working on Carers, O/T's, Safeguarding pages to include JOY and specific comms to PCN/GPs . Better Care Funding Page live on RCC website, under Health and Wellbeing page to include 7 Priority Areas https://www.rutland.gov.uk/health-wellbeing/better-care-fund				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					BLUE

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 October 2023	Progress for November 2023	Key Identified Risks	Mitigations	Nov 2023 Project RAG Status
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)	Behavioural Insights training first session commencing Manager Training 12th October 23. 3 sessions in total with Manager cohort to be completed by end of November 23. View will be to share this training with partners in community.				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				Behavioural Insights training first session commencing Manager Training 12th October 23. 3 sessions in total with Manager cohort to be completed by end of November 23. View will be to share this training with partners in community.				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
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.					2nd Edition ASC 'Quality Assurance Today' newsletter. To be produced on a 6 weekly timeframe and disseminated to all ASC staff. Newsletter provides updates of all workstreams and comms and engagement projects for ASC and CQC. Articles to include: Co-Production Key Events, Portal comms to include digital resource for public - Age UK and Rutland Adult Learning (RALS), CHC reminder to complete Recharge Form for all those in receipt of CHC funding.				BLUE
8.3.3		Social media account for HWB health and wellbeing news/messages with shared hashtags. As above?									BLUE

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 October 2023	Progress for November 2023	Key Identified Risks	Mitigations	Nov 2023 Project RAG Status
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 and Finish Group met on 30/10/21 to agree scope and actions/deliverables form C & E Plan. Agreed each Priority Lead to identify one core C & E campaign to move forward with for next 18 months. To bring back to IDG in Dec. """				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.									GREEN
		Engagement Training									GREY
8.4.5		Verifying commitment to the Think Local Act Personal, Making It Real framework and set of statements					Identified Training Need: Easy Read Training to be arranged for ASC Admin and QA				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						
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
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	
	1.3 Access to Health Services	
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
	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	
	4.2 Increase the availability of diagnostic and elective health services closer to home	
	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
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
	7.3 Covid Recovery	Adrian Allen

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