Rutland Joint Health and Wellbeing Strategy Delivey Plan 2022 - 2027

1. Purpose of this Document

This Delivery Plan document shares the Joint Health and Wellbeing Strategy delivery plan and corresponding actions that will be collectively focussed on for 2022 - 2027. This plan has been informed by the views of Rutland people, local staff, partnership groups and health and care commissioners.

This document aims to give stakeholder visibility around the key priority actions identified during the development of the Rutland Joint Health & Wellbeing Strategy. It provides a single focused strategic partnership overview with detail of the local actions we will deliver to make or influence Place level improvement. It also includes key measures to enable us to check if we are seeing improvement through our collective efforts and includes information to help us to keep track of progress in one place. The document will also help with keeping track of key issues and points for influence at a Place level that will make improvement in Rutland.

2. Guiding Principles for Delivery

- Improve health equity/support reduction of health inequalties inc, the needs of the veteran community, issues caused by rurality, mental health needs.
- Strengthen self care and prevention services.
- Consider the wider determinants of health.
- Improve local access to, and integration of, health and care services
- Support collboration at a local level where this is potential for greater impact/improvement
- Make the Rutland population aware of the services offered locally - ensuring an adaptable set of communication approaches for different groups

3. Partnership Delivery Governance

It is anticipated that groups such as the Health & Wellbeing Board will be a key recipient user of the detailed information contained within this document. This action plan will be a key partnership tool to enable all partners to see which activities are the highest priorities for the Health and Wellbeing Board and the Integrated Delivert Group, how these are progressing and support local discussions for implementation. The tool will also provide ongoing opportunity for stakeholders/partners to reflect, using the guiding principles, on where their contributions can help deliver the aims of the group.

It is important to note that some of the actions within this tool have direct links to longer term major NHS strategic priorities for Leicester, Leicestershire and Rutland (LLR) Integrated Care System (ICS). It has dependencies on other complex organisational partners and/or national programmes requiring closer working with local and national partners at all levels and our communities to ensure we successfully deliver this plan for the people of Rutland.

4. Key Focus Priorities

1. Better Start in Life
2. Prevention
3. Living with Ill Health
4. Equitable Access
5. Growth and Change
6. Dying Well

7a. Mental Health
7b. Inequalities

8. Comms & Engagement

5. Guidance on Delivery Stage for Melton Partnership Delivery Leads:

Not Started - The work described in the plan is yet to commence
Feasibility - The work to support decisions/approvals around delivery are taking place
Delivery - The work described in the plan is being delivered
Evaluation - The work described in the plan is being evaluated against improvement aims
Completion - The work described in the plan has been completed

6. Guidance on RAG Status for Rutland Priority Leads:

Overall	What is overall status of Action / Project to deliver as per plan?
	Progressing as Planned nothing to escalate
	Progressing as planned but some challenges with risks or issues/Timeline / Finance that can or are being resolved
	Challenges / risks or issues that cant be resolved and require escalation as will not deliver as planned

7. Workbook Guidance

Leads please follow the below process for updating the workbook:
- Click on the JHWS Delivery Plan tab.
- In the "Priority" column (col. B) filter by priority you which to update.
- If you need to add or close activities, please discuss with Katherine Willison

8. Lead Names and Contact details

Priority	Lead	Contact Details
Better Start in Life	Bernadette Caffrey	bcaffrey@rutland.gov.uk
Prevention	Adrian Allen	adrian.allen@leics.gov.uk
Living with Ill Health	Emmajane Hollands	ehollands@rutland.gov.uk
Equitable Access	Charlie Summers	charlotte.summers7@nhs.net
Growth and Change	Adhvait Sheth	adhvait.sheth1@nhs.net
Dying Well	Sammi Le Corre	sammi.le-corre1@nhs.net
Mental Health	Mark Young	myoung@rutland.gov.uk
Inequalities	Mitch Harper	mitchell.harper@leics.gov.uk
Comms & Engagement	Alexandra Chamberlain	achamberlain@rutland.gov.uk

Count of Project Stage	Column Labels				
Row Labels	**(blank)**	**Delivery**	**Not started**	**Feasibility**	**Grand Total**
Best Start in Life					
Dying Well		5	2	7	14
Equitable Access					
Growth & Change					
Living with Ill Health					
Prevention					
Comms & Engagement		7	1		8
Mental Health		6			6
Inequalties					
Grand Total		**18**	**3**	**7**	**28**

Count of Montly RAG	Column Labels			
Row Labels	**(blank)**	**Green**	**Grey**	**Grand Total**
Best Start in Life				
Dying Well		7	8	15
Equitable Access				
Growth & Change		1		1
Living with Ill Health				
Prevention				
Comms & Engagement		8	2	10
Mental Health		6		6
Inequalties				
Grand Total		**22**	**10**	**32**

Row Labels	**Count of High Level Actions**
Best Start in Life	3
Dying Well	11
Equitable Access	
Growth & Change	1
Living with Ill Health	9
Prevention	8
Comms & Engagement	9
Mental Health	6
Inequalties	1
Grand Total	**48**

JHWB Strategy Ref:	Priority	Aim	High Level Actions	Lead Organisation	Lead	Project Stage	Health Inequalities Considered	Start Date	Expected End Date	Actual End Date	Milesones for 24/25	Measures of Success	Progress Updates March 2024	Progress Updates April 2024	Progress Updates May 2024	Key Risks	Mitigations	Montly RAG
1.1	Best Start in Life	**Healthy Child Development in the 1001 critical days (conception to 2 years old)**			**Bernadette Caffrey**													
1.1.1	Best Start in Life	Expand Family Hub locations	Increase the number of Family Hub venues	RCC	**Bernadette Caffrey**			Jan-24										
1.1.2	Best Start in Life	Local implementation of the Maternity Transformation Programme		LPT	**Bernadette Caffrey**				Mar-23			•Reduction in low birth weight term babies. •Reduction in infant mortality						
1.2	Best Start in Life	**Confident Families and Young People**			**Bernadette Caffrey**													
1.2.1	Best Start in Life	Transitions improvement project for our LD community (0-25yrs)		RCC	**Bernadette Caffrey**		Y	Sep-22										
1.2.2	Best Start in Life	Improve school readiness in pupils receiving free school meals		RCC	**Bernadette Caffrey**		Y					Improve the percentage of pupils who are receiving free school meals who have a good school readiness score						
1.3	Best Start in Life	**Acess to Health Services**			**Bernadette Caffrey**													
1.3.1	Best Start in Life	Increase health checks for children with SEND aged 14+	Ensure that children with SEND are receiving their health check and that this health check is holistic, considering the wider determinants of health.	LPT	**Bernadette Caffrey**		Y		Mar-23			•Increase the number of health checks being completed for children 14+ with SEND.						
1.3.2	Best Start in Life	Improve the quality of EHCPs for children with SEND		RCC	**Bernadette Caffrey**		Y	Jan-24										
1.3.3	Best Start in Life	Increase immunisation take-up for children and young people where this is low	Identify sub-groups where take up is low and understand why.	LPT	**Bernadette Caffrey**				Mar-23			•Increase in the number of children receiving immunisations						
2.1	Prevention	**Supporting People to Take an Active Part in Their Communities**			**Adrian Allen**													
2.1.1	Prevention	Increase the levels of volunteering across the county	Use the Citizens Advice Rutland (CAR) volunteering marketplace to improve the availability of volunteers.	CAR	**Adrian Allen**				Sep-23			Number of volunteers in Rutland						
2.1.2	Prevention	Feasibility study of potential community models in Rutland	Explore the potential application of innovative models to empower individuals and communities.	CAR	**Adrian Allen**				Mar-24									
2.2	Prevention	**Looking after Yourself and Staying Well in Mind and Body**			**Adrian Allen**													
2.2.1	Prevention	Support our residents to increase their activity levels	Increase referrals into excersise and activity programmes	Active Rutland	**Adrian Allen**				Mar-24		•Implement Healthy Conversations Training (Making every							
2.2.2	Prevention	Improve residents health education/awareness and increase confidence to self-care			**Adrian Allen**				Mar-24									
2.2.3	Prevention	Ensure our workforce are trained and empowered to have healthy conversations	Implement Health Conversations training (Make Every Contact Count MECC+). Include professionals working with housebound individuals		**Adrian Allen**				Jun-23									
2.2.4	Prevention	Promote and support residents to achieve or maintain a healthy weight.	• Develop a whole systems approach to healthy weight, factoring in actions across different strands including the food environment, school setting, workplaces and physical activity. • Map gaps and opportunities across the strands to inform priorities and specific actions to be delivered.		**Adrian Allen**		Y		Mar-26									
2.2.5	Prevention	Support the wellbeing of the armed forces community through the wider Rutland service offer.	• Review and support all parts of the armed forces community to improve their health and wellbeing outside of MoD support, with specific actions delivered within the Staying Healthy Partnership • Align with healthcare actions already progressing within the Rutland Health Plan.		**Adrian Allen**		Y		Mar-25									
2.3	Prevention	**Encourage and Enable up take of Preventative Health Services**			**Adrian Allen**													
2.3.1	Prevention	Increase uptake of immunisation and screening programmes	Completion of health equity audits on uptake of immunisation and screening programmes across Rutland.		**Adrian Allen**		Y		Mar-23									
2.4	Prevention	**Maintaining and Developing the Enrivonmental, Economic and Social Conditions to Encourage Healthy Living for All**			**Adrian Allen**													
2.4.1	Prevention	Ensure there is a health and equity focus in all policies	Obtain commitment of relevant organisations in Rutland to building in consideration of health and equity in their day to day.		**Adrian Allen**		Y		Mar-24									
			Health Impact Assessments (HIAs) or Integrated Assessments for decision making and policy development		**Adrian Allen**													
			Support decision makers with trainng and development on Health in all Policies and the wider determinants of health.		**Adrian Allen**													
3.1	Living with Ill Health	**Healthy Ageing - Living Well with Long-Term Conditions, Reducing Frailty and Falls Prevention**			**Emmajane Hollands**													
3.1.1	Living with Ill Health	Ensure patients are at optimum pre-operative fitness, including an holistic assessment of needs and enviroment requirements.	Initiate Below the Waist Pre-Hab pilot in Rutland		**Emmajane Hollands**					Jun-23	•Requires evaluation							
3.1.2	Living with Ill Health	Monitor deterioration of residents' health.	Use NEWS2/Restore Mini and Whzan to monitor the health and possible deterioration of a cohort of residents, to identify deterioration early, initiate appropriate treatment and reduce avoidable hospital admissions	RCC	**Emmajane Hollands**						•Requires evaluation							
3.1.2	Living with Ill Health	Ensuring people in rural communities have access to peer support	Initiate a befriending service for isolated individuals, delivered by Age UK	Age UK	**Emmajane Hollands**													
3.2	Living with Ill Health	**Support, Advice and Community Involvement for Carers**			**Emmajane Hollands**													
3.2.1	Living with Ill Health	Improve the identification of unpaid carers within our communities.	Increase the number of unpaid carers identified.	RCC	**Emmajane Hollands**		Y					•Numbers of carers registered in practice systems.						
			RCC and PCN staff to use the LLR Care Record to integrate carer		**Emmajane Hollands**													
3.2.2	Living with Ill Health	Integrate information processes and pathways with local partners, ensuring carers have access to the right information	Creation of a leaflet that can be given to carers on patient discharge.	RCC	**Emmajane Hollands**													
3.3	Living with Ill Health	**Healthy, fulfilled lives for people living with Learning or Cognitive Disabilities and Dementia**			**Emmajane Hollands**													
3.3.1	Living with Ill Health	Ensure that residents with LD are regularly monitored and support is provided early to enable them to live healthy lives.	Increase the number of LD health checks being completed		**Emmajane Hollands**		Y					•Number of LD health checks completed						
3.3.2	Living with Ill Health	Provide care and supprot for people with LD closer to home. Enabling them to stay in Rutland with access to friends and family.	Scope what is needed and potential resource requried.	RCC	**Emmajane Hollands**		Y					•Number of out of area placements for Rutland residents with LD.						
3.3.3	Living with Ill Health	Support people with LD and/or Autism to access volunteering, work and/or education oppurtunities	Scope current position and if there is a target to meet. This will inform next steps.	RCC	**Emmajane Hollands**		Y					Increase the % of our LD and Autistc community in employment						
3.3.4	Living with Ill Health	Increase Dementia diagnosis rates in Rutland and improve the dementia pathway experience for patients and their family/carers.	Pilot a Proactive Care Dementia Project to support diagnosis closer to home.	ICB	**Emmajane Hollands**		Y					•Increase in dementia diagnosis rates in Rutland •Increase in patients and carers offered follow-up support.						
		Increase Dementia diagnosis rates in Rutland and improve the dementia pathway experience for patients and their family/carers.	Reinstigate the Memory Clinic at Rutland Memorial Hospital	RCC	**Emmajane Hollands**		Y											
		Increase Dementia diagnosis rates in Rutland and improve the dementia pathway experience for patients and their family/carers.	As part of the pilot, trial a wrap-around clinic for Rutland patients attending the Memory Clinic.	RISE	**Emmajane Hollands**		Y											
4.1	Equitable Access	**Increase the Availabilty of Diagnostic and Elective Health Services Closer to Home**			**Charlie Summers**													
5.1	Growth & Change	**Planning and Developing "Fit for the Future" Health and Care Infrastructure**			**Adhvait Sheth**													

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5.1.1	Growth & Change	Work with local/neighbouring Integrated Care Systems (ICSs) partners to share information to ensure in border and cross border population impacts are consistantly 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	ICB	**Adhwait Sheth**			Sep-22	Apr-24			• 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 Meeting in September 2023 meaning that plans to bring care closed 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 fo scale/alternative funding sources.	Green
6.1	Dying Well	**We want people to feel comfortable and confident in talking about, and planning for, the end of life.**			**Sammi Le Corre**													
6.1.1	Dying Well	To scope historic comms and engagement activities and develop next steps for a local approach.	•Gain access to the insight hub and share findings with Comms and Engagement lead. •Interrogate what is available and plan local approach.	RCC	**Sammi Le Corre**	Feasibility		Jan-24	Apr-24		Develop a comms and engagement programme centred around a shift in culture when it comes to talk about end of life.	A rolling rota of communications out to the Rutland public and service providers. A possible impact on end of life conversations occuring in services.						Green
6.1.2	Dying Well	Develop comms plan linking into LLR PEoLC Task Force schedule for the LLR End of Life Strategy		RCC	**Sammi Le Corre**	Feasibility		Jan-24	Jul-24		Aligning the comms and engagement work being completed by the LLR PEoLC Task Force with the programme in Rutland. Including the LLR PEoLC strategy engagement.							Green
6.2	Dying Well	**We want to make it possible for people to die in their place of choice**			**Sammi Le Corre**													
6.2.1	Dying Well	Develop a local data set to support our understanding of end of life in Rutland.	Monitor place of death data.	ICB	**Sammi Le Corre**	Not started		Apr-24			Align metrics with the LLR Task Force data work stream. Where we have metrics already, look to begin monitoring these through the IDG.							Grey
6.2.2	Dying Well	Scope if conducting an "After Death" audit is feasible considering clinicians availability and the needs of patients.	Discuss with Dying Well and LLR Task Force clinical leads to ascertain what is necessary and would this excersise add value.	ICB	**Sammi Le Corre**	Not started		Apr-24										Grey
6.3	Dying Well	**We want to ensure people are support throughout their journey**			**Sammi Le Corre**													
6.3.1	Dying Well	Develop our understanding of what the end of life/palliative care pathway looks like for Rutland patients	Hold a pathway mapping workshop	ICB	**Sammi Le Corre**	Delivery		Apr-24										Green
6.3.2	Dying Well	Increase the completion of ReSPECT planning for appropriate patients	Base line end of life care planning in Primary Care	ICB	**Sammi Le Corre**	Feasibility		Jan-24										Green
6.3.3	Dying Well	Improve identification of residents who would benefit from a conversation about end of life planning	Develop a risk stratification approach for end of life care and support for our population	ICB	**Sammi Le Corre**	Feasibility		Apr-24										Grey
6.3.4	Dying Well	Improve identification of residents who would benefit from a conversation about end of life planning	Identifty Rutland's "2%".	ICB	**Sammi Le Corre**	Feasibility		Jan-24										Grey
6.4	Dying Well	**We want to ensure that carers are fully supported in their role**			**Sammi Le Corre**													Grey
6.4.1	Dying Well	Develop our understanding of what services are available for carers of people who are towards the end of their life.	Review the service carers have access to, with a focus on carers of people who are near the end of their lives.	RCC	**Sammi Le Corre**	Feasibility												
6.5	Dying Well	**We want to make it possible for all those bereaved to have access to bereavement support, if they want it.**			**Sammi Le Corre**													Grey
6.5.1	Dying Well	Develop our understanding of bereavemement services	Review bereavement support services. Ensuring to consider the Veteran Communities.	RCC	**Sammi Le Corre**	Feasibility												Green
6.6	Dying Well	**We want to implement the Marie Curie (2022) recommendations**		ICB	**Sammi Le Corre**	Delivery	Y	Dec-23	Jan-27									Green
6.7	Dying Well	**We want to implement the End of Life JSNA (2022) recommendations**		ICB	**Sammi Le Corre**	Delivery	Y	Dec-23	Jan-27									Green
6.8.1	Dying Well	**We will work to the Palliative and End of Life Care Ambitions Framework**	Review our maturity against the ambitions maturity matrix	ICB	**Sammi Le Corre**	Delivery	Y	Dec-24	Jan-25									Grey
6.8.2	Dying Well	**We will work to the Palliative and End of Life Care Ambitions Framework**	Continue to add necessary actions to the detailed action plan	ICB	**Sammi Le Corre**	Delivery	Y	Jan-25	Mar-25									Grey
7a.1	Mental Health	**Supporting Good Mental Health**			**Mark Young**													
7a.1.1	Mental Health	Increase access to perinatal Mental health support services, wherever Rutland women have chosen to give birth.	•increase our understanding of the Perinatal Mental Health Service. •Develop an action plan to increase the number of people accessing this service.	LPT	**Mark Young**	Delivery						An increase in the number of people accessing perinatatl services						Green
7a.1.2	Mental Health	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.	•Align priorities and actions with the Rutland Children and Young People's Strategy 2022/25 •Analyse recent surveys, such as the Family Hub consultation to inform next steps.	LPT/PH	**Mark Young**	Delivery	Y	Mar-23	Apr-25			Gaps identified and solutions put in place.						Green
7a.1.3	Mental Health	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.	•Improve our understanding of the gaps and what children and young people are telling us about what support they need. •Launch of MySelfReferral service to allow CYP to self-refer or seek support for their mental health	RCC,VCS, ICB	**Mark Young**	Delivery	Y	Mar-23	Apr-25			Increased resource available for children and young people.						Green
7a.1.4	Mental Health	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 oppurtunities with all parthers and support where necessary. •Creation of MH pathway, which can be used in GP surgeries. •Engagement with the veterans and farmers communities. Exploring what we can do to support those who have access issues due to rurality.	LPT/ICB/RCC	**Mark Young**	Delivery	Y					•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. •The farming and veteran communities are working more closely with us to better understand their needs.						Green

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7a.1.5	Mental Health	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.	•Increase capacity in local low-level mental health services. •Establish closer working between involved agences/services, including the voluntary and community sector and peer support.	PCN/LPT/RCC/VCS	Mark Young	Delivery						Closer working relationships bettwen agencies/services. Resulting in people receiving the correct time at first contact. Reducing their need to repeat their stories.				Increase in referals to the RISE team for MH support. Concerns over capacity and staff burn-out.	There are ongoing talks to look at allocation of the BCF funding to recruit a new social prescriber/low level mental health support worker to help support those experiencing low-level mental health support needs.	Green
7a.1.6	Mental Health	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 a new MDT specifically for community based MH support. •LPT MH Facilitator role to support people within Rutland diagnosied with an SMI (includes an annual health check). •LPT Employment Support Service Individiaul Placement and Support Lead, to support people with SMI into employment. •Work more closely with NHS LLR Talking Therapies to ensure our local population are accessing their services.	LPT/PCN/RCC/VitaMinds	Mark Young	Delivery	Y					•Improved relationships and integrated wokring within Rutland's neighbourhood approach. •Increase in numbers of people diagnosied with an SMI receiving physical health checks. - National Target - 60% •Increase the numbers of people with SMI into employment. •Improved understanding of Rutland residents accessing NHS LLR Talking Therapies services.						Green
7b.1	Inequalties	Ensure addressing health inequalities is considered across planning and delivery of actions within the core priorities.	•Priority leads consider opportunities to address health inequalities within all action areas. •Insight from the health inequalities needs assessment is used to ensure population groups experiencing inequalities are supported. The needs assessment will inform new projects across the core priorities.		Mitch Harper	Delivery	Y											
8.1	Comms & Engagement	**Readiness to Deliver the Plan**			Alexandra Chamberlain													
8.1.1	Comms & Engagement	Ensure coordination of communications activity and mechanisms across partners	•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	Alexandra Chamberlain	Delivery		Mar-23				•Clarity regarding remit for the communications work programme. •Regular, productive, communication meetings.						Green
8.1.2	Comms & Engagement	Identify SMART goals and objectives for specific pieces of work	•Appoint leads to ensure delivery, measurement and review.		Alexandra Chamberlain	Delivery											Pending high level audit.	Green
8.2	Comms & Engagement	**Ensuring People have Access to the Information they need to Maintain their Health & Wellbeing and to Navigate Change Successfully**			Alexandra Chamberlain													
8.2.1	Comms & Engagement	Create a visual health and wellbeing brand for Rutland	•Coordinate with the ICB and places on what this brand is to be.		Alexandra Chamberlain	Delivery						Agreement on the brand.						Green
8.2.2	Comms & Engagement	Ensure residents are fully aware of the community and health and well-being offer in Rutland and understand how to access it.	•Develop and implement a multi-channel communication plan to enhance information for signposters and the public. Including distinct groups. Aligning with the work of the HWB and cater for those that are digitally exlucded or use cross-boarder services.	RCC/RIS	Alexandra Chamberlain	Delivery	Y		Jun-23			•Completed Health and Wellbeing Communication plan aligned with the HWB. •Expanded reach of communication campaigns, including social media followers, posts and shares. •RIS montly visitor figures. •Qualitative feedback on awareness of and access to services across Rutland.						Green
8.2.3	Comms & Engagement	Coordinate engagement mechanisms for Rutland's population.	•Improve Learning Disability Partnership Board •Rolling engagement events - Carers Week •Launch of self-referral portal. •Analysis of the Adult Social Care annual feedback survey •Update personalisation survey.	RCC	Alexandra Chamberlain	Delivery	Y		May-23			Agree to a coordinated approach at place.						Green
8.2.4	Comms & Engagement	Improve training oppurtunties, including behavioural insights and social media.	•Promote the digital inclusion network via the Rutland libraries. •Promote digital champions training, their resources (Learn my way) and the national data bank - https://www.onlinecentresnetwork.org/resources/health	RCC	Alexandra Chamberlain	Delivery	Y		Mar-24			Number of digital champions (waiting training to be rolled out.)						Green
8.2.5	Comms & Engagement	Build digital confidence in Rutland	•Coordinate with digital champions in the community to design and promote the self service portal. •Link to local actions and consult with leads	RCC	Alexandra Chamberlain	Delivery												Green
8.2.6	Comms & Engagement	Enhance the Rutland Information Service (RIS)	•Develop RIS social media presence - bringing content to the online places people visit. •Website technical code refresh for accessibility and ease of use via mobile phone. •Initiate website usability testing to increase the effectiveness of RIS content. •Enhance the reach and scope of the Rutland Information Service (RIS) via multiple channels (web, social media, print). •Update RIS online plaftorm to meet accessibility standards and improve mobile device operability (most users access RIS via mobile device). •Enhance online functionality of RIS for clearer routes into preventative services. -Map digital confidence, to consult.		Alexandra Chamberlain	Not started	Y										Grey
8.3	Comms & Engagement	**Involving the Public and Professional Stakeholders in Service Design and Change**			Alexandra Chamberlain													
8.3.1	Comms & Engagement	Develop a local engagement approach	•Create an enagement 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.		Alexandra Chamberlain		Y											Green
8.3.2	Comms & Engagement	Engagement Training			Alexandra Chamberlain													Grey
8.3.3	Comms & Engagement	Promote commitement to the Think Local Act Personal, Making it Real framework			Alexandra Chamberlain													Green
8.4	Comms & Engagement	**Communication Activities to Support Access and Navigation of Local Services**			Alexandra Chamberlain													
8.4.1	Comms & Engagement	Training and education for the general public on the use of the NHS app for booking appointment and ordering medication			Alexandra Chamberlain													
8.4.2	Comms & Engagement	Create a how to guide/video for practice websites to show patients how to download and use the NHS app			Alexandra Chamberlain													
8.4.3	Comms & Engagement	Promotion of the changing structure of local primary care and the new roles available through the additional roles reimbursement scheme.			Alexandra Chamberlain													
8.4.4	Comms & Engagement	Link in with LLR ICB comms to inform and influence planned LLR campaigns in 2023/24			Alexandra Chamberlain													
8.4.5	Comms & Engagement	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)			Alexandra Chamberlain													
8.4.6	Comms & Engagement	Creation of an infographic to demonstrate the anticipated inpact of the Rutland Health and Wellbeing Strategy and what that will mean to patients.			Alexandra Chamberlain													

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3. Right Care, right time, right place	Older Peoples Health	Link Urgent Care Coordination Hub and Rutland Care Homes that are enabled to monitor health digitally (Whzan Enabled)	With the linking of care homes that were involved in the Whazan pilot it is hoped that there can be a reduction in convaynces to A&E by intervention of the Urgent Care Co-ordination hub and this can lead to more referrals to alternative pathways.	Charlie Summers/MC/JM	Apr-24	Mar-25	• Agreement from System Exec for the expansion of the urgent care co-ordination hub pathway. • Agreement from Oakham Medical Practice to participate in the pilot. • Baseline of conveyance rate from care home to emergency admission for particpating care homes. • Agreement of pathway to be followed • Commencement of pilot	• Currently awaiting proposal to go to System Exec for additional funding for the expansion of the Urgent Care Co-ordination Hub pathway. Initial scoping work with Oakham Medical Practice has been put on hold until this has been agreed	• Paper to go to System Exec at the end of January for discussion.	• Expansion of pilot is not agreed at System Exec and additional funding not identifed.	Not Started
2. Keeping People Well	Older Peoples Health	Proactive Care @ Home Frameworks for managing Cardiovascular Disease Long Term Conditions	Embedding of the proactive care @ home frameworks in primary care.	Sammi Le Corre / Jess Lucas	Jan-24	Mar-25	•Scoping the project •Working with Rutland practices to understand current use of the frameworks. •Increasing use of the frameworks	•Work not yet started	•Meet with Jess Lucas - previous lead for embedding the framsworks and identify next steps	•No risks currently	Not Started
2. Keeping People Well	Older Peoples Health	Proactive identification of Frail / Housebound patients with dedicated Care Co-ordination Support	By identiifying frail and housebound patients through the use of population health management, those that may be at increased risk of hospital admission and managing that risk by effective care planning and dedicated care co-ordination, therefore hopefully reducing risk of deterioration and /or risk of admission.	Charlie Summers	Apr-23	Mar-24	• Identification of a group of frail and housebound patients in Rutland who are at increased risk of a hospital admission through the use of population health management and risk stratication. • Baseline of number of patients without a care plan • Identification of patients within the cohort group that have a care plan in place.	• This project has been in place within Rutland Health PCN since April 2023 as a part of their inequalities plan. An update on number of patient identified and who have a care plan has been requested.	• Data to be collected at the end of 2023/24 and a decision made with to continue approach.	• Implemented as a part of the PCN DES in 2023/24.	Green
3. Right Care, right time, right place	Older Peoples Health	Priority phone lines for vulnerable patients such as Palliative care patients, carers and housebound patients in Rutland	As a part of the capacity access and improvement plan, creation of a dedicated phone line for patients identified as vulnerable ensuring they can quickly get through to the practice if required. therefore reducing potential for escalation and reduce the risk of emergency admission and improved outcomes.	James Burden / Charlie Summers	Jul-24	Jun-25	• As a part of the capacity access and improvement plan this was indetified as an area of need as well as a part of the integrated community services workshop in November 2023.	• Update with regards to progress requested from Rutland Health PCN.	• Seek clarity as to whether this element of the Capacity Access and Improvement Plan has been implemented.	The PCN has not had a PCN Manager in post since November 2023. The new PCN manager is due to commence in February 2024.	Amber
2. Keeping People Well	Older Peoples Health	Develop Population Health Management and Multi Disciplinary Team working approach within Rutland INT	Idenitfying a cohort of patients that are most of risk for a deterioration in their condition by using population health management. Case managing these patients on a regular basis via discussion at a multi-disciplinary team approach.	Emma Jayne Perkins / James Burden / Sammi Le Corre	Aug-24	Jul-25	•Developing a PHM approach. •Obtaining approval of approach from Rutland's Health and Care Collaborative. •Approval of project management resource •Project scoping and initiation	•PHM approach proposal taken to Health and Care Collaborative in December 2023 - approved and RCC want to invest in a project management role to drive the work forward.	•Waiting on recruitment of the project management resource	•Delay in recruitment	Not Started
2. Keeping People Well	Older Peoples Health	Continuation and evaluation of proactive care project that focuses on Dementia (Contributing to the increase of our lower than expected diagnosed rates of Dementia)	Rutland's was idenitfied as an outlier for the dementia diagnosis rates. As a part of the anticipatory care project, Rutland has re-established the Memory Clinic at RMH and also combines this with a wrap around service provision provided by the Admiral Nurse, PCN Care Co-ordinator and consultant.	Sammi Le Corre	Jul-23	On-going	•Write up Proactive Care Dementia Pilot evaluation with recommendations. •Agree next steps and service offer development •Gain approval for BCF monies to be used for a Social Prescriber within the RISE team to embed the programme as BAU.	•The dementia diagnosis rate in Rutland has been increasing steadily since the commencement of the project. •The Health and Wellbeing noted the progress made by the project in January 2024	•Write up complete pilot evaluation.	•BCF funding will not be approved for the Social Prescriber role	Green
8. Women's Health, including Maternity	Access to Health Services	Assess feasibility for a Women's Health Hub that covers Rutland *(Women's Health Hub - WHH)*	To meet national requirements in having a women's health hub in each ICB (nationally) as set-out in the Women's Health Strategy 2022 and NHSE deliverable.	Katie Connor/ James Burden	Mar-24	Mar-26	• Mobilsation of Rutland's Women's Health Hub • Implementation of Rutland's Women's Health Hub • Reporting schedule (including reporting into the Women's Partnership bi-monthly) • Evaluation(?) - Depends on timescale • Links into the Women's Engagement Strategy	• Rutland's Health Hub modelled and agreed through ICB sign-off routes (covering Melton) • Rutland Health Hub clinical and operational leads engaged in Women's Hubs Delivery Group with wider LLR WHHs • • •	• Await further information on timelines due to challenge sighted in column N • Opportunities for existing integration and engagement with women around hubs • Opportunities for wider workforce and public upskilling on women's health • Scope wider Women's National deliverables for Rutland •	• WHH timelines delayed by ICB. Further work ongoing to determine benefits realisation and funding models to re-present at SCG. KC and MT to meet with EMT colleagues to discuss 11/01/24. Challenge sighted in Women's risk/issue register which is flagged to ICB board and subsequent partner boards. ICB Women's Team working hard to engage and provide progress updates to partners and WHH leads to ensure expctations are managed as well as good working relationships.	Amber
4. Integrated Community Health and Wellbeing Hubs	Access to Health Services	Specify requirements for a local Health and Wellbeing Hub	A priority of the Rutland Joint Strategic Health and Wellbeing Strategy is to expand and improve the experience of receiving care locally within Rutland so that the growing population can be better cared for nearer home, minimising the length of time spent in acute hospital settings, and where possible, avoiding acute hospital admissions in the first instance. This can be achieved through collaborative opportunities to work with partners across health and care to develop a more holistic offer in Rutland with the right mix of services through the development of a local Health and Wellbeing Hub inclusive of same day access provision at Rutland Memorial Hospital.	Debra Mitchell / Kim Sorsky /	Jan-24	Sep-25	• Develop a clear partnership understanding of local Assets / Services in scope of hub developments • Identify key service dependencies across the healthcare plan • ? • ? • ?	• Workshop took place to start documentation of all key assets and services that are in scope • ? • ? • ? • ?	• Firmer summary of the model of care and associated infrastructure requirmements • ? • ? • ? • ?	•Only certain amount of Capital is available therefore everything will not be possible, prioritisation and sequencing will be key •Political support will be key to approval for any proposals / business cases	Amber
3. Right Care, right time, right place	Access to Health Services	Primary Care Capacity and Access Plans	The Capacity Access and Improvement Plan aim is to provide the space, funding, and licence for PCNs to focus on making improvements to help manage demand and improve patient experience 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 work can be data-led. PCN's will be assessed against three key areas, these are patient experience, ease of access and demand management, and accuracy of recording in appointments. The PCN has implmented a number of initaitives throughout 2023/24 that have been baselined and improvements will be measured as a part of the evaluation in 2024/25.	Charlie Summers	Apr-23	Mar-24	• Design and produce a Capacity Access and Improvement plan that supports improvement to demand and capacity and patients experience of care. • Submission of plan to the ICB for approval. • Approval of submitted plan. • Baseline measures taken for all indicators in the plan. • Mid year review of plan implementation.	• Baseline measures taken for all key indicators submitted as a part of the plan. • Redesign of all four individual practices websites to support ease of use and stanardisation in line with NHSE guidance. • LLR patients survey launched on behalf of all LLR practices to ascertain patients views on accessibility and satisfaction. • Mid year review of Capaccity Access and Improvement Plan undertaken. • Final report submitted with performance indicated against all of the areas identified.	• Update from the PCN requested on progress to date with the Capacity and Access Improvement Plan • Websites updated, standardised across all four practices and re-launched. • Mid year review undertaken and assurance given with regards to progress to date.	• Rutland PCN manager left post at the end of October and the new PCN Manager will not be in post until February 2024. Concern that momentum may be lost with regards to implementation of the Capacity Access and Improvement Plan in the short term.	Green
3. Right Care, right time, right place	Access to Health Services	Expand local Elective Care / Diagnostics Provision		Jo Clinton / Deb Mitchell			• ? • ? • ? • ?	• ? • ? • ? • ?	• ? • ? • ? • ?	• ? • ? • ? • ?	Not Started
7. Mental Health	Access to Health Services	Help local people build connections through Rural Coffee Connect mobile provision delivered at local community sites		Mark Young			• ? • ? • ? • ?	• ? • ? • ? • ?	• ? • ? • ? • ?	• ? • ? • ? • ?	Not Started

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3. Right Care, right time, right place	Access to Health Services	Develop the clinical model for local same day access at Rutland Memorial Hospital	Local development of a model for same day access that best meets the needs of the population of Rutland. This includes a review of minor illness and minor injury needs. Once a model has been formulated this will go out to consultation in preparation for procurement and mobilisation in April 2025.	Jeremy Bennett / Charlie Summers	Apr-23	Mar-25	• Undertake a review of all current same day service provision for Rutland including GP appts, NHS 111, CPCS, urgent care and MIU including data for out of county providers. • Formulate a same day access working group and meet to go through the data. • Complete a case for change document for Rutland and get it signed off. • Request to extend current urgent care contracts to to go to SCG. • Write an options appriasal paper that outlines the key future model/s for future consideration. • Individual follow up meetings were held wiht providers (inlcuding DHU) to inform potential model development. • Current work is ongoing to produce an options appraisal document for same day access from 25/26, to be submitted for discussion at a second workshop Go out to formal consultation on future model of care for Rutland's same day access.	• A data collation and reiew has been undertaken that brings together all the services that either support or deliver same day access to Rutland patients. • A Case for Change process was followed to identify current and future patient needs for Primary Care in rutland was developed and submitted to the ICB in September 2023. • A workshop was held with key Rutland stakeholders to assess provision and identify the need for same day services in Rutland.	• Await outcome of request to extend urgent care contracts for 24/25 to enable consultation and pathway redesign to be undertaken. • Await confirmation of the consultation timescales to be advised by communications and engagement team. • Continue to further develop the various options to be included in the options appraisal. • •	• Anticpated that the liklihood of an election may bring additional delay due to purdah rules and regulations. • The timescale of the extension of the current hub provision is unknown at present • ? • ?	Amber
N/A	Armed Forces Community	Engagement with Kendrew Barracks to develop relationships with Defence Medical Services leads and to develop understanding of key areas of need		Debra Mitchell / Adhvait Sheth	Jan-24	Mar-25	• ? • ? • ? • ?	• ? • ? • ? • ?	• ? • ? • ? • ?	• ? • ? • ? • ?	Green
1. Preventing Illness	Armed Forces Community	Promote NHS Armed Forces support services (OPTIMAL Model) and referrals locally Inc. through Joy platform and local GP accredited practices	To increase identification of Veterans / AFC in local Primary Care services to improve local recording and access to services. To ensure that the full range of Optimal services including OpCommunity are available on the Joy system. Monitor referrals and their sources that are available through the Insigts available on the Joy Platform to ensure there is some activity from Rutland services. Raise awareness within the AFC of the need to self identify as a Veteran when accessing services in Rutland	Emma Jayne Perkins / Adhvait Sheth / Ian Reynolds	Jan-24	Mar-25	• To add full range of Optimal model of services as service tiles onto the Joy platform ensuring that these are visible to services in Rutland. • To review referrals and sources on a quarterly basis to inform any targeted engagement or communicatiom to drive up appropriate use • Work with local AF covenant lead and local welfare team Vterans channels to raise awareness of the benefits for Veterans to self identify upon accessing services • To share AFC e-learning guides with local INT / operational teams so that there is an awarensss of this community	• All Optimal Model services are live tiles on Joy platform • ? • ? • ? •	• Run a first quarter report to understand levels of usage and whether any patterns of access • ? • ? • • ?	• ? • ? • ? • ? • ?	Green
3. Right Care, right time, right place	Armed Forces Community	Implement LLR Armed Forces OpCOMMUNITY (SPOC) pilot for Armed Forces Families and Veterans and Communicate this across Rutland and neighboring areas.	Delivery of an ICB commissioned single point of contact for the AFC starting by Q3 2023/24, that can be accessed via email and telephone. Development of specific communication material to raise awareness of the service across LLR. Undertake a Local and regional evaluation of service during 2024/2025 to inform future ICB sustainability options for 2025/2026.	Adhvait Sheth	Sep-23	Mar-25	• Agreed funding in place and carry over of finances is accomodated by finance teams to ensure delivery upto Dec 2024 in current form. • Communication material is produced and shared across LLR stakeholders. • Local evaluation process commences and report of findings is produced (commence July 2024) • LLR ICB EMT agree by Q3 2024/25 a sustainabe route for enabling access to services for AFC, beyond national pilot funding	• OpCommunity went live in Sept 2023 • Communication material shared in Nov 2023 with local Welfare Teams, IDG stakeholders inc HW Rutland for wider dissemination aross Rutland • Finance transfers have been clarified to ensure delivery unto Dec 2024. LPT are clear that they need to ensure carry over into the 24/25 raher than the ICB.	• Local evaluation to commence not earlier than July 2024 with a view to an LLR ICB EMT paper in Sept 2024 with options and reccomendations	• Future options sustainability of local ways of working beyond NHSE funding will be important to sustained improvement for this community. Risk to continuity of care improvement and local discharge of due regard for health for this population. Mitigation for this includes local evaluation to inform benfits picture and also further increase GP accreditation and encourage as a route into Optimal service.	Green
2. Keeping People Well	Armed Forces Community	Develop Population Health Management and Risk Stratification capability around Veterans to support local Integrated Neighbourhood Teams	To enable the capability to have a distinct view of Veterans across LLR PHM and Risk Stratification Tool.	Mark Pierce / Adhvait Sheth	Jan-25	Jun-26	TBC	TBC	TBC	If Veterans status is not being recorded in Primary Care and other care settings then we will not see the benefits of this capability. Dependency on identification of Veterans in Primary Care and ensure is as close to prevelance as possible	Not Started
9.Children and Young People	Armed Forces Community	Strengthen joint working across borders to enable specialist health needs for 'service children' and those who access a general practice outside of Rutland to be assessed and met		TBC??			• ? • ? • ? • ? • ?	• ? • ? • ? • ? • ?	• ? • ? • ? • ? • ?	• ? • ? • ? • ? • ?	Not Started