Ref.	Priority	Goals	Plans (Key Actions)	Outcome Measures	Targets	Responsible person	Links to…	Timescale	Progress (RAG rating)
	Key priorities outlined in the Joint Health and Wellbeing Strategy 2013-16								
1.	<u>Frail Elderly Population:</u> Our elderly population is above the national average in number and rising, have increasingly complex health and social needs.	To have an integrated Health and Social care service that is able to identify and assess those with complex needs who are at risk of losing their ability of independent living, and thus put in place short and long term support	1. Embed the final stage of the REACH restructure (Reablement Service) 2.First contact scheme – get information from preventative services to target those in need early 3.Integrated Care Service – roll out to Rutland and develop multi- disciplinary team 4. Develop plans for: • More community options / capacity to support people to remain living at home • Extra Care Housing • Good Neighbour scheme • Step up / down accommodation and services Utilise parish councils to raise awareness of the services available	Decrease in admission to formal care settings – homes and hospital REACH – service users are reabled and so not require an on-going service Take up Referral onto other agencies Service model uses an integrated health and social care coordinator role, who via use of risk stratification and multidisciplinary meetings carries out a holistic integrated assessment on patients who opt into the service. Increase in take up of supported housing options Keeping people safe Increased awareness of the offer available	Quarterly reporting	Mandy Stott (Rutland County Council - RCC) Sue Renton (Older Person's Forum) Yasmin Sidyot, East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG) Mandy Stott (RCC)	Reablement Service Integrated Care Project Dementia Strategy Carers Strategy Re-commissioning of services ELRCCG Integrated Plan 2012-2015 James Faircliffe (Housing Strategy at RCC) Rutland County Council Older Person's Service Review	Roll out to the 4 Rutland practices begins late August, will be complete by end of September 2013.	

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2.	<u>Dementia:</u> People with dementia, are currently often unrecognised, and will require increasing health and social care in future.	To have Health and Social services that both encourage and enable those who are worried about or at risk of, developing dementia (and their carers), to receive appropriate assessment , treatment and support.	1. Develop and monitor delivery of joint health and social care action plan for Rutland as part of the dementia strategy 2. Monitor delivery of the Dementia Care and Support Compact action plan 3. Dementia Service – Primary Medical Care: a. Practices assess patients that may have dementia in a structured way, referrals made to the Memory Assessment Clinics within Leicestershire Partnership Trust. b. Investigate how easy it is for Rutland Residents to access current provision c. Increase referrals into the pathway. Training with GPs to diagnose dementia more generally	People are more educated about dementia Increased diagnosis rate for dementia Appropriate referrals to the Memory Assessment Clinics Improved accessibility to Memory Assessment Clinics Increased referrals	Increased diagnosis	Mandy Stott (RCC) and Yasmin Sidyot (ELRCCG) Mandy Stott (RCC) and Yasmin Sidyot (ELRCCG) Yasmin Sidyot, (ELRCCG) Yasmin Sidyot, (ELRCCG)	Dementia Strategy Carers Strategy Re-commissioning of services Older Person's Forum via Sue Renton	Dementia Service is a national Directed Enhanced Service (DES) issued by NHS England and will continue until 31 March 2014.	Primary healthcare professionals have received appropriate education and training to provide the dementia service.
3.	<u>Depression and Anxiety:</u> This is a common problem, especially in the elderly and isolated. There is a recognised social stigma that prevents people looking for help.	To increase awareness and use of current and future services within primary care, social care and voluntary sector that support and help those with stress related problems, depression and / or anxiety.	1. Develop a plan to raise the profile of Mental Health conditions and support services using awareness and the production of easily accessible information 2. Education and Information – promotion of services, their location and pathways: Production of Mental Health services in Rutland booklet 3. Explore next steps in relation to the Improving	Increase in the number of people accessing advice and support on Mental Health issues. Increased use of 'Books on prescription' scheme – GP's Increased prevalence of Mental Health events Use of IAPT – GPs: Support for people with		Naomi Edwards (RCC) and Vicky Todd (RCC) Yasmin Sidyot, (ELRCCG) Naomi Edwards (RCC) and Vicky Todd (RCC) Yasmin Sidyot, (ELRCCG)	Staying Healthy Subgroup and the Mental Health Promotion Network	Current contract is due to end on 31st	

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			access to psychological therapies service (I-APT): • Re-procurement of service • Engagement events	long term conditions, depression and anxiety, and improving access for older people.				March 2014.	
4.	<u>Living Independently:</u> Some people experience difficulty in accessing the health and social care support that they need to live as independently as possible in the community of their choice.	To enable people to remain living in the community of their choice for as long as possible through: a. Supporting carers to care for family and friends within the community	Monitor the delivery of the Carers Strategy Action Plan	More Carers will be identified More carers will be signposted to services	Increased no. of referrals into the service Increased no. of identified carers	Claire Nicholls (RCC) and Mandy Stott (RCC)	Carers Strategy Annual Social Care Survey Autism Strategy ELRCCG Integrated Plan 2012-2015 Re - commissioning of services		
		b. Listening to service users, carers and providers of services in order to improve the experience that people have of health and social care services	Develop carers and service users forums including patient participation groups (PPGs) Further develop provider forum Develop consultation strategy – carers and service users Monitor the outcome of reviews (themes)	Future commissioning is shaped by users' views Improved patient and carer experience	Limit the no. of patient experience issues	Mandy Stott (RCC), Yasmin Sidyot (ELRCCG) and Gemma Hammond (Healthwatch)	IAG Services – CAB Local Offer – Children & Families Bill Spire Homes offer Healthwatch		
		c. Providing the right information to service users and their carers at the right time to help them to make informed choices about their care and support	Look at the potential to commission a joint approach to identifying and publishing what services are available across the county: develop a "Service directory" proposal for the Executive & Integrated Commissioning Group.	Carers, service users and providers will have an increased awareness of services available		Mandy Stott (RCC) and Yasmin Sidyot (ELRCCG)			

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5.	<u>Hospital Discharges:</u> People may stay in hospital longer than is medically required Avoidance of hospital admissions	Maximising the opportunities for people to receive care and treatment within the community rather than in hospital or other residential setting.	Develop a plan for localised services:- • Physio • Chiropody • Dietetics Community clinics Virtual wards -Step Down Care: Develop a programme to look at how we move patients that no longer need acute care to the right location in a more timely way than currently occurs. In the short term Leicestershire Partnership Trust's Community Health Services (LPT CHS) are providing in-reach to the Leicester Royal Infirmary (LRI) especially looking to pull patients out of UHL that no longer need acute care by accessing services that are currently available.	People travel less Reduced admissions Local providers Patients receive treatment & support in the most appropriate setting for their needs		Yasmin Sidyot, (ELRCCG), Jill Haigh (RCC) Yasmin Sidyot, (ELRCCG)	Better Care Together programme Integrated Care Project Discharge Transfer of Care (DTOC) Steering Group		
			Commission services for people with behaviour that challenges services as close to their local community as possible where appropriate	More people receive services closer to home. Reduced number of 'out of county' placements for people with complex care needs.		Vicky Todd (RCC)	Winterbourne View/Six Lives action plan/SAF		
		Ensuring that people do not stay in hospital beyond the point where they have been deemed medically fit for discharge	More intensive community nursing - *Aspirational* Monitor delivery of Hospital Discharge Project to improve the discharge process through working with the hospitals. Develop home from hospital schemes; scope out similar existing projects - *Aspirational*	Increased expertise and specialists in the community Patients get discharged from hospital when appropriate.		Rachel Dewar (Leicestershire Partnership Trust) Susan Mcintosh (Peterborough & Stamford Hospital) Sue Renton (Older Persons Forum)	Anna Grainger (Rutland County Council)		

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6.	<u>End of Life Care:</u> Most people would prefer to die at home given a choice	Continue to provide the current level of service available to support patients and their carers and families during the process of agreeing care pathways with their GP and other providers.	Agree a joint approach between health provision and social care services for end of life care and the dying. Palliative Care/End of Life services: continue to provide structured end of life care. The service requires practices to: • Add patient's onto the palliative care register • Undertake a face-to-face consultation with patients and develop an Advanced Care Plan (ACP) • Communicate with the OOHs service within 2 weeks of developing the ACP • Conduct an after death audit Establish interfaces with advanced care plan and social care support plan to ensure joint approach to this priority in the future. Embed the above through developing a training programme.	Patients have more choice about where they wish to die.		Yasmin Sidyot (ELRCCG) and Mandy Stott (RCC) Yasmin Sidyot (ELRCCG) Yasmin Sidyot (ELRCCG) and Mandy Stott (RCC)	ELRCCG Integrated Plan 2012-2015	The service is currently on-going within ELR CCG general medical practices until 31 March 2014	
	Other areas that the Complex Needs Sub Group will monitor								
	Area	**Action Plan in place?**	**Key Actions**	**Progress**		**Lead**	**Links to**	**Timescale**	**RAG rating**
	Winterbourne View/Six Lives/H&SC SAF					Vicky Todd (RCC) Emmajane Perkins (RCC)	LD Partnership Board/Better Health Group		
	Employment Strategy for disabled people					Vicky Todd (RCC) Emmajane Perkins (RCC)			
	Autism Strategy		Develop and monitor the delivery of the Rutland Action Plan			Vicky Todd (RCC) Emmajane Perkins (RCC)	LLR Autism Planning Group		