Red	Below target
Amber	On track to deliver
Green	Delivered

Appendix C 275-2013

Ref.	Priority	Goals	Plans (Key Actions)	Outcome Measures	Lead	Links to…	Timescale	Progress (Brief update)	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)	Decrease in admission to formal care settings – homes and hospital REACH – service users are reabled and so not require an on-going service	Mandy Stott (Rutland County Council - RCC)	Reablement Service Integrated Care Project Dementia Strategy Carers Strategy Re-commissioning of services		Awaiting update (at January 2014 meeting)	
			2.First contact scheme – get information from preventative services to target those in need early Re-educate people about the referral routes available	Take up Referral onto other agencies Increased awareness	Sue Renton (Older Person's Forum)	Older Persons Form First Contact Bus	Report Quarterly	First Contact Mobile is on the road. 4 routes have been highlighted and these visit rural areas twice a month. In contact with RCC comms team re publicity.	
			3.Integrated Care Service – roll out to Rutland and develop multi- disciplinary team	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. KPIs being developed e.g. service user satisfaction	Yasmin Sidyot, East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG)	ELRCCG Integrated Plan 2012-2015	Roll out to the 4 Rutland practices begins late August, will be complete by end of September 2013.	Rutland practices care coordinator is in post. Patients that could benefit from the service are being identified. Full evaluation report expected at the end of November 2013.	

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			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	Increase in take up of supported housing options Keeping people safe	Mandy Stott (RCC)	James Faircliffe (Housing Strategy at RCC) Rutland County Council Older Person's Service Review		Older persons review underway	
			5. Utilise parish councils to raise awareness of the services available	Increased awareness of the offer available	Mandy Stott (RCC)			Not progressed yet	
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.	6. Develop and monitor delivery of joint health and social care action plan for Rutland as part of the dementia strategy	People are more educated about dementia Increased diagnosis rate for dementia Appropriate referrals to the Memory Assessment Clinics Improved accessibility to Memory Assessment	Mandy Stott (RCC) and Yasmin Sidyot (ELRCCG)	Dementia Strategy Carers Strategy Re-commissioning of services Older Person's Forum via Sue Renton		Awaiting update (at January 2014 meeting)	
			7. Monitor delivery of the Dementia Care and Support Compact action plan		Mandy Stott (RCC) and Yasmin Sidyot (ELRCCG)			Awaiting update (at January 2014 meeting)	
			8. 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		Yasmin Sidyot, (ELRCCG)		Dementia Service is a national Directed Enhanced Service (DES) issued by NHS England and will continue	Awaiting update (at January 2014 meeting)	

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			for Rutland Residents to access current provision c. Increase referrals into the pathway.	Clinics Increased referrals			until 31 March 2014.		
			9. Training with GPs to diagnose dementia more generally		Yasmin Sidyot, (ELRCCG)			Primary healthcare professionals have received appropriate education and training to provide the dementia service.	Amber
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.	10. Develop a plan to raise the profile of Mental Health conditions and support services using awareness and the production of easily accessible information	Increase in the number of people accessing advice and support on Mental Health issues.	Naomi Edwards (RCC) and Vicky Todd (RCC)	Staying Healthy Subgroup and the Mental Health Promotion Network		Awaiting update (at January 2014 meeting)	
			11. Education and Information – promotion of services, their location and pathways: Production of Mental Health services in Rutland booklet	Increased use of 'Books on prescription' scheme – GP's Increased prevalence of Mental Health events	Yasmin Sidyot, (ELRCCG) Naomi Edwards (RCC) and Vicky Todd (RCC)			Mental health awareness day took place and further events have been planned for 2014.	

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			12. Explore next steps in relation to the Improving access to psychological therapies service (I-APT): • Re-procurement of service • Engagement events	Use of IAPT – GPs: Support for people with long term conditions, depression and anxiety, and improving access for older people.	Yasmin Sidyot, (ELRCCG)		Current contract is due to end on 31st March 2014.	Provider will be known in December 2013.	
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	13. Monitor the delivery of the Carers Strategy Action Plan	More Carers will be identified; Increased no. of referrals into the service More carers will be signposted to services	Claire Nicholls (RCC) and Mandy Stott (RCC)	Carers Strategy Annual Social Care Survey Autism Strategy ELRCCG Integrated Plan 2012-2015 Re - commissioning of services IAG Services – CAB Local Offer – Children & Families Bill Spire Homes offer Healthwatch		Awaiting update (at January 2014 meeting)	
		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	14. Develop carers and service users forums including patient participation groups (PPGs)	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)			Awaiting update (at January 2014 meeting)	
			15. Further develop provider forum					Awaiting update (at January 2014 meeting)	
			16. Develop consultation strategy – carers and service users					Awaiting update (at January 2014 meeting)	
			17. Monitor the outcome of reviews (themes)					Awaiting update (at January 2014 meeting)	

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		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	18. 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)			Awaiting update (at January 2014 meeting)	
5.	<u>Hospital Discharges:</u> People may stay in hospital longer than is medically required Avoidance of hospital admissions	a. Maximising the opportunities for people to receive care and treatment within the community rather than in hospital or other residential setting.	19. Develop a plan for localised services:- • Physio • Chiropody • Dietetics • Community Clinics	People travel less Reduced admissions Local providers Permanent admissions to residential care (quarterly stats) The no. of over 65's to be admitted to permanent care settings (expected to be a new KPI)	Yasmin Sidyot, (ELRCCG), Jill Haigh (RCC) Mandy Stott (RCC)	Better Care Together programme Integrated Care Project Discharge Transfer of Care (DTOC) Steering Group		Awaiting update (at January 2014 meeting)	
			20. 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)	Patients receive treatment & support in the most appropriate setting for their needs	Yasmin Sidyot, (ELRCCG)			Data sharing agreement with GPs is being signed off shortly	

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			especially looking to pull patients out of UHL that no longer need acute care by accessing services that are currently available.						
		b. Ensuring that people do not stay in hospital beyond the point where they have been deemed no longer requiring acute care	21. 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		Awaiting update (at January 2014 meeting)	
			22. More intensive community nursing - *Aspirational*	Increased expertise and specialists in the community Community hospital length of stay target	Rachel Dewar (Leicestershire Partnership Trust)	Anna Grainger (Rutland County Council)		Not commenced	
			23. Monitor delivery of Hospital Discharge Project to improve the discharge process through working with the hospitals.	Patients get discharged from hospital when appropriate. • Delayed transfers of Care data • Peterborough activity analysis e.g. elective care spells – broken down to Rutland Level • CCG minimum dataset tool	Susan Mcintosh (Peterborough & Stamford Hospital)			This will be an agenda item for January 2014 where more information will be shared.	

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			24. Develop home from hospital schemes; scope out similar existing projects - *Aspirational*		Sue Renton (Older Persons Forum)			Not commenced	
			25. Set up an operational group for frontline staff to keep them up to date with pathways i.e. what is available and what is capacity like	Improved communication and increased use of community services Acute transfer information	Mandy Stott (RCC) Susan McIntosh	Local Hospitals LPT ELRCCG RCC Adult Social Care Team Voluntary Sector providers		Awaiting update (at January 2014 meeting)	
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.	26. Agree a joint approach between health provision and social care services for end of life care and the dying.	Patients have more choice about where they wish to die The no. of carers registered with GPs surgeries, and the no. of carers registered with Local Authority (for comparison) The no. of carers who have received carers assessments	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	Awaiting update (at January 2014 meeting)	
			27. 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		Yasmin Sidyot (ELRCCG)			Awaiting update (at January 2014 meeting)	

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			28. a) Establish interfaces with advanced care plan and social care support plan to ensure joint approach to this priority in the future. b) Embed the above through developing a training programme.		Yasmin Sidyot (ELRCCG) and Mandy Stott (RCC)			Awaiting update (at January 2014 meeting)	

Other statutory areas that the Complex Needs Sub Group will monitor								
Ref.	**Area**	**Action Plan in place?**	**Key Actions**	**Lead**	**Links to**	**Timescale**	**Progress (Brief Update)**	**RAG rating**
7.	Winterbourne View	To be developed	29. Develop an action plan, monitor assessment and review outcomes	Vicky Todd (RCC) Emmajane Perkins (RCC)	LD Partnership Board/Better Health Group		Assessment complete and feedback received	
8.	Six Lives Action Plan		30.	Vicky Todd (RCC) Emmajane Perkins (RCC)				
9.	Health and Social Care Self-Assessment		31.	Vicky Todd (RCC) Emmajane Perkins (RCC)		30th November 2014		
10.	Employment Strategy for disabled people		32.	Vicky Todd (RCC) Emmajane Perkins (RCC)				
11.	Autism Strategy	Agenda item for January 2014	33. Develop and monitor the delivery of the Rutland Action Plan	Vicky Todd (RCC) Emmajane Perkins (RCC)	LLR Autism Planning Group			