Rutland County Council

Catmose, Oakham, Rutland, LE15 6HP
Telephone 01572 722577 Email: governance@rutland.gov.uk

Ladies and Gentlemen,

A meeting of the **RUTLAND HEALTH AND WELLBEING BOARD** will be held Via Zoom - https://us06web.zoom.us/j/86409035180 on **Tuesday, 5th October, 2021** commencing at 2.00 pm when it is hoped you will be able to attend.

Yours faithfully

Mark Andrews
Chief Executive

Recording of Council Meetings: Any member of the public may film, audio-record, take photographs and use social media to report the proceedings of any meeting that is open to the public. A protocol on this facility is available at www.rutland.gov.uk/my-council/have-your-say/

A G E N D A

1) WELCOME AND APOLOGIES RECEIVED

2) RECORD OF MEETING

To confirm the record of the meeting of the Rutland Health and Wellbeing Board held on 22 June 2021.
(Pages 5 - 8)

3) DECLARATIONS OF INTEREST

In accordance with the Regulations, Members are invited to declare any personal or prejudicial interests they may have and the nature of those interests in respect of items on this Agenda and/or indicate if Section 106 of the Local Government Finance Act 1992 applies to them.

4) PETITIONS, DEPUTATIONS AND QUESTIONS

To receive any petitions, deputations and questions received from Members of the Public in accordance with the provisions of Procedure Rule 93.

The total time allowed for this item shall be 30 minutes. Petitions, declarations and questions shall be dealt with in the order in which they are received. Questions may also be submitted at short notice by giving a written copy to the

Committee Administrator 15 minutes before the start of the meeting.

The total time allowed for questions at short notice is 15 minutes out of the total time of 30 minutes. Any petitions, deputations and questions that have been submitted with prior formal notice will take precedence over questions submitted at short notice. Any questions that are not considered within the time limit shall receive a written response after the meeting and be the subject of a report to the next meeting.

5) LEICESTER, LEICESTERSHIRE AND RUTLAND (LLR): LEARNING DISABILITY AND AUTISM (LDA) 3 YEAR PLAN

To receive Report No. 132/2021 from David Williams, Director of Strategy and Business Development Leicestershire Partnership NHS Trust
(Pages 9 - 20)

6) INTEGRATED CARE SYSTEM (ICS): PURPOSE, PRINCIPLES AND PRIORITIES

To receive Report No. 129/2021 from Sarah Prema, Executive Director of Strategy and Planning, Leicester, Leicestershire and Rutland City Clinical Commissioning Group
(Pages 21 - 30)

7) HEALTH INEQUALITIES FRAMEWORK

To receive Report No. 128/2021 from Sarah Prema, Executive Director of Strategy and Planning, Leicester, Leicestershire and Rutland City Clinical Commissioning Group
(Pages 31 - 52)

8) PLACE LED PLAN: DRAFT

To receive Report No. 130/2021 from Emma Jane Perkins (Rutland County Council), Charlie Summers (LLR Clinical Commissioning Groups), Viv Robbins / Kajal Lad (Public Health), Tracey Allan-Jones (Rutland Healthwatch), Sandra Taylor (Rutland County Council) and Adhvait Sheth (LLR Clinical Commissioning Groups)
(Pages 53 - 78)

9) REVIEW OF FORWARD PLAN AND ANNUAL WORK PLAN

To consider the current Forward Plan and identify any relevant items for inclusion in the Rutland Health and Wellbeing Board Annual Work Plan, or to request further information.

The Forward Plan is available on the website at:

https://rutlandcounty.moderngov.co.uk/mgListPlans.aspx?RPId=133&RD=0
(Pages 79 - 80)

10) ANY URGENT BUSINESS

11) DATE OF NEXT MEETING

The next meeting of the Rutland Health and Wellbeing Board will be on Tuesday, 11 January 2022 at 2.00 p.m.

Proposed Agenda Items:

a) Place Led Plan: Update
b) Social Care White Paper: Update
c) Better Care Fund: Update
d) Pharmaceutical Needs Assessment: TBC

---oOo---

DISTRIBUTION
MEMBERS OF THE RUTLAND HEALTH AND WELLBEING BOARD:

Name		**Title**
1.	Councillor A Walters (Chair)	Portfolio Holder for Health, Wellbeing and Adult Care
2.	Ms Fay Bayliss	Deputy Director of Integration and Transformation LLR CCG
3.	Insp. Audrey Danvers	NPA Commander Melton & Rutland, Leicestershire Police
4.	Ms Rachel Dewar	Head of Community Health Services, Leicestershire NHS Partnership
5.	Mr Simon Down	Acting Chief Executive/Monitoring Officer, Office of Police and Crime Commissioner
6.	Ms Sheila Fletcher	Chief Operating Officer, Citizens Advice Rutland
7.	Dr Hilary Fox	Clinical Director, Rutland Health Primary Care Network
8.	Ms Fiona Myers	Director of Community Health Services, Leicestershire Partnership NHS Trust
9.	Ms Louise Platt	Executive Director of Care and Business Partnerships, Longhurst Group
10.	Mr Mark Powell	Deputy Chief Executive, Leicestershire Partnership NHS Trust
11.	Ms Dawn Richards	Senior Services Manager, The Longhurst Group
12.	Mr Mike Sandys	Director of Public Health for Leicestershire & Rutland, LCC

13.	Ms Mel Thwaites	Associate Director: Children and Families, LLR CCG
14.	Dr Janet Underwood	Chair of Healthwatch Rutland

PORTFOLIO HOLDER:

Name		**Title**
15.	Councillor D Wilby	Portfolio Holder for Children, Young People and Families

OFFICERS:

Name		**Title**
16.	John Morley	Strategic Director for Adults and Health (DASS)
17.	Dawn Godfrey	Strategic Director of Children and Families (DCS)
18.	Karen Kibblewhite	Head of Commissioning

Rutland County Council

Catmose Oakham Rutland LE15 6HP
Telephone 01572 722577 Email: goverance@rutland.gov.uk

Minutes of the **MEETING of the RUTLAND HEALTH AND WELLBEING BOARD** held as a virtual meeting via Zoom on Tuesday, 22nd June, 2021 at 2.00 pm.

PRESENT:

Cllr Alan Walters (Chair)	Portfolio Holder for Health, Wellbeing and Adult Care
Cllr David Wilby	Portfolio Holder for Education and Children's Services
Ms Fay Bayliss	Deputy Director of Integration and Transformation LLR CCGs
Dr Hilary Fox	Clinical Director, Rutland Health Primary Care Network
Dr Janet Underwood	Chair of Healthwatch Rutland
Mike Sandys	Director of Public Health
Rachel Dewar	Head of Community Health Services, Leicestershire Partnership Trust

IN ATTENDANCE:

Sarah Prema	Executive Director for Strategy and Planning at LLR CCGs

OFFICERS PRESENT:

John Morley	Director – Adult Services and Health (Interim)
Joanna Morley	Governance Manager (Interim)

1 APOLOGIES

Apologies were received from Insp. Audrey Danvers, Sheila Fletcher, Louise Platt and Mel Thwaites. Mina Bhavsar attended for Mel Thwaites.

2 RECORD OF MEETING

The minutes of the meeting of the Rutland Health and Wellbeing Board held on 12 January 2021 were confirmed as a correct record.

3 DECLARATIONS OF INTEREST

No declarations of interest were received.

4 PETITIONS, DEPUTATIONS AND QUESTIONS

No petitions, deputations or questions had been received.

5 MATTERS ARISING

John Morley, Director for Adult Services and Health, updated the Board on the Joint Health and Wellbeing Strategy which would now become the Place Plan and would be one document. The Plan was currently being worked on by the Integrated Delivery Group (IDG) and subgroups, and a detailed outline would be submitted to the Adults and Health Scrutiny Committee for consideration before coming back to the next Health and Wellbeing Board in a draft format.

An update on the engagement strategy was provided by Healthwatch. Data collection began in April which comprised of interviews with individuals and groups, both face to face where possible, and by telephone. The information gained from these interviews would be shared as a draft report with the Portfolio Holder, once agreed with Healthwatch officials. Issues identified include primary care access, cross boundary services, lack of public visibility in the development of plans, learning disability services, transport difficulties and the need for a more local hemodialysis service.

Dr Underwood also confirmed that a representative from Healthwatch had been appointed to the IDG.

---o0o---

Agenda items 6 and 7 were amalgamated into one agenda item.

---o0o---

6 OUR APPROACH TO INTEGRATING CARE AND THE INTEGRATED CARE SYSTEM

A joint presentation (appended to the minutes) was received from Sarah Prema, Fay Bayliss and John Morley.

During discussion the following points were noted:

- Issues had been identified with those living on or around the county borders accessing the healthcare offering within Rutland due to being registered with GPs out of county. This was also true in reverse with patients registered with Rutland GPs not matching criteria within their county of residence to access services provided by their local healthcare providers. An example of this was access to Admiral Nurses for dementia patients; Rutland criteria was based on residency in the county but across the Northamptonshire border it was based on GP registration, this meant that if a Northamptonshire resident was registered with a Rutland GP they did not qualify for Admiral support in either provision.
- Rutland would be happy to engage with other Integrated Care System (ICS) groups to try and put into place some mutual arrangements for healthcare, in order to prioritise people rather than borders.
- The CCG needed to work on publicising the extent of its healthcare provision as it was noted that residents previously interviewed were not generally aware of the range of services offered. It was noted that 90% of the healthcare provided in Rutland was done so locally.

7 THE INTEGRATED CARE SYSTEM JOURNEY

This item has been included in the previous minute text.

8 WORKING INSIDE OUT

A presentation (appended to the minutes) was received from Emma-Jane Perkins, Head of Service – Community Care Services. The presentation covered supporting people's independence and helping them stay at home, or at the least allow them to return home from acute care settings more quickly by utilizing informal and formal networks, as well as an element of self-management with regard to healthcare and integrated community health and social care networks available.

During discussion the following points were noted:

- Communication would be the key to community encouragement to get behind the initiative and the HWB should work on this.
- Following their success, RISE and MiCare could be expanded to offer more services to aid the initiative.
- Focus should be on encouraging people to work as a strength base approach working on things that are good in the community and that people can access and support. This could prevent more expensive longer term and crisis response.
- The engagement interviews conducted by Healthwatch also indicted that a greater sense of community was felt in Rutland villages.
- The initiative was a great way forward but there was still work to be done to make it viable in practice.

9 BETTER CARE FUND UPDATE

Report No. 81/2021 was received from the Director of Adult Services and Health.

During discussion the following points were noted:

- There was an opportunity for the Health and Wellbeing Board to develop a strategy for obesity given that weight management was now a priority for Primary Care Networks. It was suggested that this should form part of the grand plan for Rutland and should be considered by the IDG as partners who could facilitate services across the Tiered system were already around the table.
- Community wellbeing should be about promoting activity and healthy lifestyles.
- There was a need to approach surrounding counties in regard to the BCF provision they had in order to ensure no-one living around borders was disadvantaged.

10 ANY URGENT BUSINESS

There was no urgent business.

11 DATE OF NEXT MEETING

The next meeting of the Rutland Health and Wellbeing Board would be on Tuesday, 5 October at 2.00pm.

---o0o---

The Chairman closed the meeting at 3.49pm.

---o0o---

Report No. 132/2021

Rutland Health and Wellbeing Board

Date: 5 October 2021

Title of report:	The Learning Disability and Autism 3-year plan for LLR
Author:	David Williams
Presenter:	David Williams, Director of Strategy & Business Development at Leicestershire Partnership NHS Trust and joint SRO for the Transforming Care Programme in LLR

Purpose of report:

To update the Rutland Health and Wellbeing Board on the progress, priorities and opportunities to improve provision for our population with a Learning Disability and or Autism

Key points to note:

- There is a window of opportunity to make significant difference to the lives of our population with a learning disability or autism
- We have significantly improved our joint working between health, local authorities and providers in the last 12 months
- We are close to becoming regional and national exemplars for our work

Actions required by Rutland Health and Wellbeing Board members:

- Understand and support the 3-year programme
- Recognise that change will be delivered through individuals including members of the Health and Wellbeing Board
- Champion joined up working between system partners to deliver improvements
- Recognise their role and opportunities to improve and enhance pathways to provide great care, support and lives
- Contribute to our system goal of making LLR FIT, focused, integrated and targeted on need.

This page is intentionally left blank

Leicestershire Partnership NHS Trust

Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

Transforming Care in Leicester, Leicestershire and Rutland

3 Year Road Map 2021 to 2024

Leicester City Council

Leicestershire County Council

Rutland County Council

Leicestershire Partnership NHS Trust

Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

LLR Vision

"All people with a learning disability and/or autism will have the fundamental right to live good fulfilling lives, within their communities with access to the right support from the right people at the right time".

Leicester City Council

Leicestershire County Council

Rutland County Council

A Unique Opportunity

- LLR performance has improved
- National funding in addition to local funding. NHS England has invested a dedicated three year funding to transform services. This will enable long term planning for the first time
- National policy shifts Integration and innovation: working together to improve health and social care for all (white paper 2021)
- Team LLR, we are all working together so much more than we were before, now a regional and national leader of joint working

Aims and Objectives

Improve the wellbeing of people living with learning disabilities or autism or both across LLR
Person-centred, proactive and preventative approach
Reduce health inequalities
Improve quality
Increase the focus on autism especially 14+
Improve specific needs and pathways e.g. forensic, autism and transitions
Reduced admissions
Early intervention
Crisis avoidance

Engagement & feedback

- Service users, carers and families
- Clinical and operational teams and partners across LLR:
  - Virtual focus groups between 6th and 16th April 2021

As a founding member of Leicestershire support for families caring for Special Needs Young Adults on Facebook, I just wanted to give you a big thank you for organising the special vaccination sessions. My daughter would have been unable to cope with going to the same centre I went to. All very well organised and everyone we encountered was really helpful and friendly.

"I just wanted to share the good news that the new cul de sac has its sign; in my books you guys deserve to have had the honour to cut the ribbon and to unveil the name of the court because you, Julie and the whole team had done superb job under very difficult circumstances to assist young people with disabilities to have homes. On behalf of all these young people I can only thank you because I will never ever be able to repay you all. God Bless You All"

Comment from carer following the move to a new specially adapted home for his son post discharge from hospital.

LLR Learning Disabilities and Autism 3 Year Road Map

Current State

(identified from Mapping exercise)

Community services for both adults and children & young people with LD and ASD and are not fully joined up.

Some services have received previous investment and are well developed, some are in development and some services and resources are not currently available at all.

Some services are in place but without sufficient capacity and are currently managing long waiting lists. Individuals may not be receiving the most appropriate support whilst they are waiting for the appropriate diagnosis and signposting.

Urgent unplanned care is not always available and this may lead to a admission to a hospital bed that may have been avoided had a rapid response home support service been in place. Unplanned respite facilities are not sufficient.

Specialist hospital care and treatment is reliant upon out of area providers and patients are admitted far from friends and family.
Discharge is often more difficult to facilitate resulting in increased LOS.

Health, social care and education are all committed to delivering the right care but effective joint working processes are not always in place. This leads to inconsistent approaches and outcomes.

The quality and timeliness of communication and information flows between teams is inconsistent and this results in some duplication of work, some missed actions which then result in missed deadlines and unnecessary use of capacity.

It is believed that the development of more efficient processes and removal of duplication and waste in the system will create capacity which can be reallocated to patient facing activities.

CYP
Implementation of Key Worker Model

CAMHS Collaborative
CYP Respite Services

Every Voice Counts
Role of Autism Officer
Autism Website
Patient/Carer Engagement/ Involvement and Co-production

Care Co-ordination
LD Complex Care Coordinators working with primary care, LAs, Secondary care, families and care providers to coordinate the health care of people with LD and complex needs

Pathway Development
Further increase in capacity in community services to deliver PBS training and coaching.
Focus on PBS as minimum standard

Admission Avoidance
Design and set up of a Dynamic Support Pathway (DSP)
All Age

Joint Commissioning
Rapid Response
Wraparound
Home Support
Adult Respite
Accommodation
CYP Respite

Year 1	Year 2	Year 3

Integrated Working
Development of an integrated LLR health and social care TCP Hub

STOMP/STAMP
Rationalisation of medication prescribing for individuals with LD, Autism or both.
Lead: RG/CB

Workforce Development
Establish PBS as the minimum and essential quality standard

Pathway Development
Outreach
Expansion
SAT
LDA Forensic Service
ASD Forensic Service
CHAT Health

Health Inequalities
LeDeR Clinical Oversight
LeDeR Support & Co-ordination
LD AHC
Autism Registers
Autism Health Checks

LDA QIP Projects
Optimising Utilisation of IT
Staff Health and Well-being
Suitable Environments for Care.
Achievement of National Quality Standards

Pathway Development
Community service for CYP who do not meet the CAMHS threshold but are struggling to cope in the community

Pathway Development
Increase capacity of the adult ASD diagnostic service.

Pathway Development
Increase capacity of ASD 14+ service to enable more robust care and support post diagnosis i.e. Psycho-education, Family workshops, Behavioural workshops, anxiety management,

Pathway Development
Improved transition of CYP from children's into adult services.
Provision of a planned Respite Services for CYP who are moving up into adult services to support with a smooth transition into more appropriate services

Future State

LLR will have in place an inclusive, person-centred, proactive and preventative approach that supports the individual's needs and preferences. All services will be of high quality and meet required standards.

Adults, children and young people with a learning disability, autism or both are able to thrive in the community in their own homes and are able to integrate into society, maintain family and friend relationships, take part in hobbies and activities and lead a life of 'beautiful ordinariness'.

All individuals have the opportunity to live in the least restrictive environment as possible, to develop their own optimum level of independence and create a lifestyle that fulfils their own wishes, goals and choices.

Family units remain together in the community. A reduced number of young people a placed in residential schools.

Individuals are able to contribute to society through vocational activities and paid employment. An individuals emotional and mental well-being is maintained.

Individuals physical health is maintained and individuals are better able to manage physical health long term conditions.

When support is required all individuals will have access to the right support at the right time, in the right place and be delivered by the right person.
This will be delivered right first time.

Key Priorities & pathways for Year 1

- Increased focus on co-production with people with LD and Autism
- Admission avoidance for CYP and adults
- Integrated team working – development of TCP Hub – joint working across LLR
- Continue to improve Annual Health Checks (AHC) completion rates – look to developing ASD AHCs
- Provide community and inpatient support for people with Autism without LD
- Learn from LeDeR – make service changes
- Provide better support for our forensic cohort

Pathway Development

Specialist Autism Team (14+ community Service)

- Consultation & advice
- Positive Behaviour Support & early intervention
- Admission avoidance & support
- Inpatient discharge planning
- Post discharge support

LD & A Community Forensic service

- Able to demonstrate effectiveness in reducing serious reoffending in individuals discharged from secure inpatient services.
- Dual emphasis on promoting and enabling individual recovery and independence, while also ensuring the protection of the public.

How things will look….

In year 1	Integrated working , New processes and protocols embedded, Learning from LedeR Dedicated support to the Dynamic Support Pathway, Reduced number of admissions New teams and new models of care for individuals with ASD and for those people with LD/ASD forensic needs
In year 2	Timely discharges. No delays in Transfer of Care, Reduced reliance on in-patient care Alternatives to admission available for all CYP and adults, Increased delivery of AHC Early intervention to support well-being, Post diagnostic support in place for all age ASD Highly capable workforce
In year 3	Person-centred, proactive and preventative approach, LLR targets for reduced reliance upon in-patient care achieved. 75% of people with LD will be having annual health checks. All CYP will have a designated key worker Health inequalities reduced, lessons from LedeR learnt and outcomes embedded. Co-ordinated healthcare across the system. Long Term Plan objectives achieved

Make LLR FIT (focussed on the needs of our people, integrated team delivery and targeted on where we can make the greatest difference)

This page is intentionally left blank

Report No: 129/2021
PUBLIC REPORT

RUTLAND HEALTH AND WELLBEING COMMITTEE

5 October 2021

LEICESTER, LEICESTERSHIRE AND RUTLAND INTEGRATED CARE SYSTEM

Report of the Strategic Director for Adult Services and Health

Strategic Aim:	All	
Exempt Information	No	
Cabinet Member(s) Responsible:	Mr A Walters, Portfolio Holder for Health, Wellbeing and Adult Care	
Contact Officer(s):	Sarah Prema, Executive Director, Strategy and Planning, LLR CCGs	Telephone 0116 2951570 Email: sarah.prema@LeicesterCityCCG.nhs.uk
	Rachna Vyas, Executive Director of Integration & Transformation, LLR CCGs	Telephone: 0116 295 1478 Email: rachna.vyas@leicestercityccg.nhs.uk
Ward Councillors		

DECISION RECOMMENDATIONS
That the Committee: 1. Endorses the Leicester, Leicestershire and Rutland Integrated Care System Purpose, Principles and Priorities.

1 PURPOSE OF THE REPORT

1.1 This report seeks endorsement from the Rutland Health and Wellbeing Board to the Leicester, Leicestershire and Rutland Integrated Care System's Purpose, Principles and Priorities.

2 BACKGROUND AND MAIN CONSIDERATIONS

2.1 The Leicester, Leicestershire and Rutland Integrated Care System (LLR ICS) is a partnership of health and local authorities and wider partners working together to improve outcomes for our populations.

2.2 To guide its work, it has developed a purpose; a number of principles and priorities and these are set out in Appendix One of this report.

2.3 These were developed through the Health and Care Partnership Group for LLR which includes representatives (members/non-executives and officers) from all partners. They were developed through a series of workshops and focus groups.

3 CONSULTATION

3.1 The LLR ICS Purpose, Principles and Priorities has been produced by the partnership this included representation from Healthwatch Rutland.

4 ALTERNATIVE OPTIONS

4.1 N/A

5 FINANCIAL IMPLICATIONS

5.1 N/A.

6 LEGAL AND GOVERNANCE CONSIDERATIONS

6.1 N/A

7 HEALTH AND WELLBEING IMPLICATIONS

7.1 The purpose, principles and priorities will guide the work of the LLR ICS to improve outcomes for its populations

8 BACKGROUND PAPERS

8.1 There are no additional background papers to the report.

9 APPENDICES

9.1 Appendix A – Leicester, Leicestershire and Rutland Integrated Care System Purpose, Principles and Priorities, Health and Care Partnership Group: Final Proposals – Purpose, Principles and Priorities

A Large Print or Braille Version of this Report is available upon request – Contact 01572 722577.

Appendix A. **Leicester, Leicestershire and Rutland Integrated Care System, Health and Care Partnership Group: Final Proposals – Purpose, Principles and Priorities**

This page is intentionally left blank

Leicester, Leicestershire and Rutland Integrated Care System

Health and Care Partnership Group

Final Proposals – Purpose, Principles and Priorities

Updated 28th June 2021

Background

- The Leicester, Leicestershire and Rutland Integrated Care System Health and Care Partnership has developed its Purpose, Principles and Priorities through a series of workshops.
- Each workshop has built on the previous discussion to finalise proposals.
- Support has been provided through a Task and Finish Group between workshops to refine the proposals.
- At the final workshop on 17th May 2021 members were asked to provide final comments and feedback to form the final proposals before the Group today.
- Therefore the Health and Care Partnership is asked to **APPROVE** the Purpose, Principles and Priorities set out in this document.
- Once this is done design work will be undertaken to turn this into a graphic.

Purpose

Working together for everyone in Leicester, Leicestershire and Rutland to have healthy, fulfilling lives

Principles

Principles Everything we do is centred on the people and communities of LLR and we will work together with respect, trust, openness and common purpose to		
Ensure that everyone has equitable access to health and care services and high quality outcomes	Make decisions that enable great care for our residents	Deliver services that are convenient for our residents to access
Develop integrated services through co-production and in partnership with our residents	Make LLR health and care a great place to work and volunteer	Use our combined resources to deliver the very best value for money and to support the local economy and environment

Transformational Priorities

Transformational Priorities
we will transform the following areas ensuring we take steps to improve the equity of access and outcomes

Best Start in Life We will focus on the first 1001 days of life to enable more equity in outcomes as we know this is critical to a child's life chances	**Staying Healthy and Well** We will support our residents to live a healthy life and make healthy choices to maintain wellbeing and independence within their communities
Living and Supported Well We will focus on supporting those with multiple conditions and who are frail to manage their health and care needs and live independently	**Dying Well** We will ensure people have a personalised, comfortable, and supported end of life with personalised support for carers and families

Operational Priorities

Operational Priorities – We will:	
Work together across health and local authorities to deliver the COVID vaccination programme and winter Flu programme ensuring maximum uptake	Recover services across all sectors of our partnership that have been affected during the pandemic improving our communication with our residents as we do this
Deliver changes to UHL hospitals and transform our mental health services ensuring appropriate local delivery	Work together across health and care to transform access to the health and care services we provide, with a focus on primary care, urgent care, chronic conditions and mental health services

Note: these priorities will be the focus of the LLR ICS NHS Board to deliver working with partners as necessary

Report No: 128/2021
PUBLIC REPORT

RUTLAND HEALTH AND WELLBEING BOARD

05 October 2021

LEICESTER, LEICESTERSHIRE & RUTLAND HEALTH INEQUALITIES FRAMEWORK

REPORT OF THE STRATEGIC DIRECTOR OF ADULTS AND HEALTH

Strategic Aim:	Reducing inequalities	
Exempt Information	No	
Cabinet Member(s) Responsible:	Councillor Alan Walters - Portfolio Holder for Health, Wellbeing and Adult Care	
Contact Officer(s):	Sarah Prema, Executive Director Strategy & Planning, LLR CCGs Mike Sandys, Director of Public Health	0116 2953413 sarah.prema@nhs.net mike.sandys@leics.gov.uk
	Mark Pierce, Head of Population Health, LLR CCGS Steve McCue, Senior Strategic Development Manager, LLR CCGs	07545 761012 mark.pierce2@nhs.net 07825 657990 steve.mccue@nhs.net
Ward Councillors		

DECISION RECOMMENDATIONS
That the Committee: Notes the LLR Health Inequalities Framework and the intended implementation of the Framework across partner organisations

1 PURPOSE OF THE REPORT

1.1 The purpose of this report is to present the final version of the Leicester, Leicestershire and Rutland (LLR) Health Inequalities Framework to the Rutland Health and Wellbeing Board

2 BACKGROUND AND MAIN CONSIDERATIONS

2.1 NHS England define health inequalities as the preventable, unfair and unjust differences in health status between groups, populations or individuals that arise

from the unequal distribution of social, environmental and economic conditions within societies. Reducing or removing health inequalities is a core purpose of the NHS and other partners in the LLR Integrated Care System (ICS). The LLR Health Inequalities Framework is a system framework, guiding principles and a set of initial actions.

2.2 In November 2020, a Task and Finish Group was established to lead the development of an LLR System Health Inequalities Framework. The Group included a range of GPs from all the CCG Boards, Lay members from all CCG Boards, Equality and Inclusion Specialists and senior managers from UHL and LPT, Public Health Consultants from all three "places" - Leicestershire, Leicester and Rutland, CCG Executive Team members, CCG management staff and Health Watch Representatives.

2.3 The Group has met fortnightly since late November 2020 to develop a system framework with agreement from all ICS partners to a set of high-level system principles and actions to effectively reduce health inequalities.

2.4 The Framework clearly states that place-led plans to reduce health inequalities must be developed based on a local understanding of the circumstances of each place and on engagement with local communities. Across LLR, this will mean a place led plan being developed for each of our 'places', Leicester City, Leicestershire, and Rutland, focussing on a collaborative approach to health and well-being, bringing together a range of partners and people to plan together. It is at place level and beneath that most of the actual work to reduce health inequalities will need to take place.

2.5 This final version is the product of feedback not only from the Task and Finish Group Members but also from the LLR Clinical Executive, The CCG Governing Bodies-in-Common, the LLR NHS Executive and Health and Wellbeing Boards in City and County.

2.6 The Framework has been quality checked by the CCG Communications Team for plain English and final editing and is currently being designed to become a public facing document. It is expected that the final designed version will be completed by the end of September 2021

2.7 The Framework was approved by the LLR ICS Health and Care Partnership Board at its meeting on 19 August 2021, subject to the Framework being received and noted by the Rutland Health and Wellbeing Board

3 IMPLEMENTATION

3.1 In some cases, actions will be primarily in the hands of one partner. In other cases, reducing inequity will require close collaboration between several organisations across the system. The ICS partners are committed to acting at all levels of the system:

- System level – across the whole LLR area
- Place level – across the area covered by our Upper Tier Local Authorities (Leicester City Council, Leicestershire County Council, Rutland County Council) and led by Health and Wellbeing Boards

- Neighbourhood or locality level – smaller (though locally meaningful) populations within the wider Upper Tier boundaries

3.2 At each of these levels the partners within the ICS – not just the NHS and the Local Authority, but the voluntary and community sectors too – will come together to plan in even finer detail the actions they are going to take, individually and collectively, to reduce health inequity.

3.3 Detailed plans on action to reduce health inequity will be agreed at place level. The development, delivery and evaluation of place led plans will be led by Directors of Public Health and Health and Wellbeing Boards. The plans will be based on local data and intelligence – qualitative and quantitative – derived from Public Health, local authority services, the NHS, other public sector partners, and communities themselves.

3.4 This framework sets out how partners plan to act, both collectively and through specific organisations to positively impact not just the direct causes, but the "causes of the causes" of these differences. Some work, therefore, will fall to the NHS to do, some mainly to other partners such as local authorities or other public sector bodies, and some to joint working at system, place or neighbourhood. Often this is not something one organisation can do on their own – it requires the system to work together to act as anchor institutions – using their collective resources and working with the voluntary and community sector to make a difference

4 CONSULTATION

4.1 Health Watch representatives have been a member of the Task and Finish Group for drafting the framework

4.2 Report history and prior review includes.

- LLR NHS System Executive – 19 January 2021
- LLR CCGs Governing Body meetings in common – 9 March 2021
- LLR ICS NHS Board – 16 March 2021
- Leicester City Health and Wellbeing Board – 25 March 2021
- Leicestershire Health and Wellbeing Board - 25 March 2021
- UHL Trust Board – 6 May 2021
- LLR ICS Health and Care Partnership Board – 17 June 2021
- LLR ICS Health and Care Partnership Board - 19 August 2021

5 ALTERNATIVE OPTIONS

5.1 N/A.

6 FINANCIAL IMPLICATIONS

6.1 No financial implications

7 LEGAL AND GOVERNANCE CONSIDERATIONS

7.1 Governance will be via the LLR Prevention and Health Inequalities Reduction Board, chaired by the Director of Public Health.

8 DATA PROTECTION IMPLICATIONS

8.1 N/A

9 EQUALITY IMPACT ASSESSMENT

9.1 A stage 1 Equality, Health Inequality, and Impact Risk Assessment (EHIIRA) has been completed, quality assured and approved by the Midlands and Lancashire Clinical Support Unit Equality and Inclusion Business Partner.

9.2 A copy of the stage 1 EHIIRA is appended to the report as 'Appendix B'.

10 COMMUNITY SAFETY IMPLICATIONS

10.1 N/A

11 HEALTH AND WELLBEING IMPLICATIONS

11.1 Reducing health inequalities is likely to remain a priority of the Rutland Health and Wellbeing Strategy. The Framework sets out a set of principles to guide action at system, place and neighbourhood

12 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

12.1 Some groups in our communities have poorer health or are more likely to have poor health outcomes in the longer term. This includes children living in poverty; routine and manual workers; people with disabilities; and military families.

12.2 Reducing or removing health inequalities is a core purpose of the NHS and other partners in the LLR Integrated Care System (ICS), including Health and Wellbeing Boards in each 'place'.

13 BACKGROUND PAPERS

13.1 Health Equity in England: The Marmot Review 10 Years On

https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on

14 APPENDICES

14.1 Appendix A - LLR Health Inequalities Framework

14.2 Appendix B – Stage 1 EHIIRA

A Large Print or Braille Version of this Report is available upon request – Contact 01572 722577.

Better health for all

A framework to reduce health inequalities in Leicester, Leicestershire and Rutland

What are health inequalities?

Health inequalities are avoidable and unfair differences in health between different groups of people. Health inequalities concern not only people's health but the differences in care they receive and the opportunities they have to lead healthy lives.

Those living in the most disadvantaged areas often have poorer health, as do some ethnic minority groups and vulnerable/socially excluded people. These inequalities are due to many factors, such as income, education and the general conditions in which people are living. In addition, the most disadvantaged are not only more likely to get ill, but less likely to access services when they are ill.

Health inequalities have been made worse by the Covid-19 pandemic, which has hit hardest the groups who already do not have the best health. The rate of people dying from the virus has been higher in more deprived areas and among some ethnic minority communities and people with disabilities. People in crowded housing, on low wages, unstable or frontline work have experienced a greater impact from Covid-19.

There are always going to be differences in health, some are unavoidable, due to people's age or genetics, but many differences in health are avoidable, unjust and unfair – it is these that we are concerned about and that this framework seeks to address.

What does it mean for local people?

Health inequalities across Leicester, Leicestershire and Rutland (LLR) are stark*. A boy born today in our most deprived area could be expected to die up to nearly nine years earlier than a boy born in the least deprived area*. Furthermore, people from less affluent areas will be spending a greater proportion of their (often shorter) lives in poor health compared to people from more affluent parts of our area.

What will this framework seek to achieve?

We want local people to be healthier, with everyone having a fair chance to live a long life in good health. This is why we will aim to 'level up' services and funding, rather than take anything away from areas where outcomes are already good.

This framework sets out how local organisations will plan to take action to not only affect the causes of these health inequalities but the 'causes of these causes'.

Health and wellbeing is not just the concern of the NHS. The health and wellbeing of people is an asset to individuals, to communities, and to wider society. Good mental and physical health is a basic precondition for people to take an active role in family, community and work life. The NHS, local authorities and other public bodies all have a part to play. Often, it will involve a number of different organisations working together to improve all the things that can affect someone's health. Locally, we have set up an integrated care system (ICS) which brings organisations together to ensure better partnership working, and improvements in people's health and care. By listening and responding to local people, we will achieve a fairer and healthier future for us all.

What does equity look like?

'Health inequalities' is the commonly used term, however we are actually referring to 'health equity and inequities'. 'Equality' means treating everyone the same or providing everyone with the same resource, whereas 'equity' means providing services relative to need. We can show what this looks like in the illustration below. Figure one shows, on the top line, four people of different sizes all trying to cycle the same size of bicycle. One person in a wheelchair cannot use the bicycle at all. The second line shows each person happily using a bicycle correctly sized or adapted for their needs.

Figure one: Representation of equality and equity using adapted bicycle example. Source: Reproduced with authorisation from Robert Wood Johnson Foundation (Better Bike Share, 2017)

Inequalities can be seen as being present from birth, through someone's early years and into later life. At each stage this can result in relatively poorer mental and physical health. This can be shown in a tale of two babies in figure two below. While we must recognise that no outcome is set in stone, the story aims to illustrate the different opportunities and difficulties that two babies might encounter throughout their life. This graphic shows two parallel curving lines – the top line showing outcomes for those from the most deprived areas in LLR. The bottom line shows the outcomes for those born in the most affluent areas.

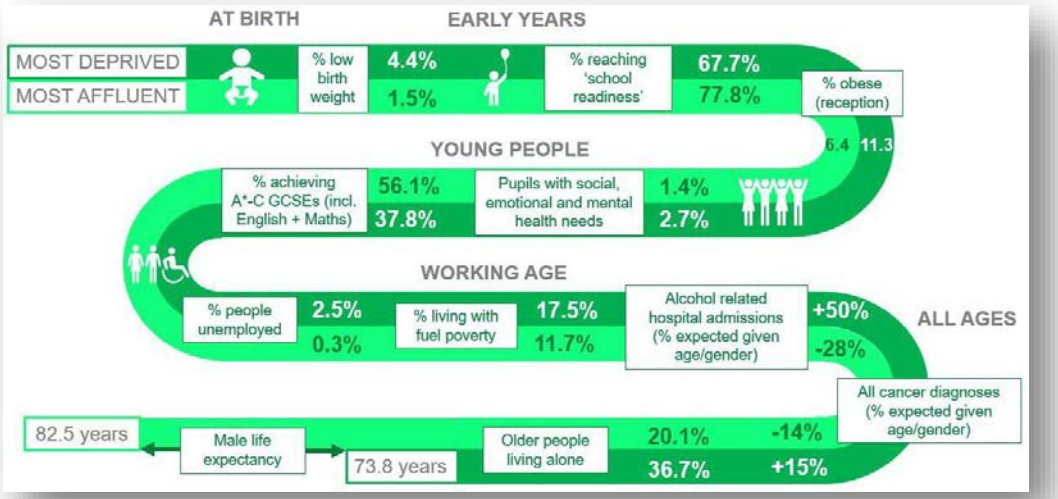


Figure two: Difference in health indicators between the most and least deprived local areas of LLR. Source: PHE Fingertips

What is 'health'?

Health has been defined as: "a state of wellbeing with physical, cultural, psychosocial, economic and spiritual attributes, not simply the absence of illness." We are using this definition of health in assessing health inequalities. Our work is also based on a 'social model' of the factors that can influence someone's health. This is shown in figure three below. It shows that everything but age, sex and hereditary factors can be modified in terms of factors that can influence an individual's health.

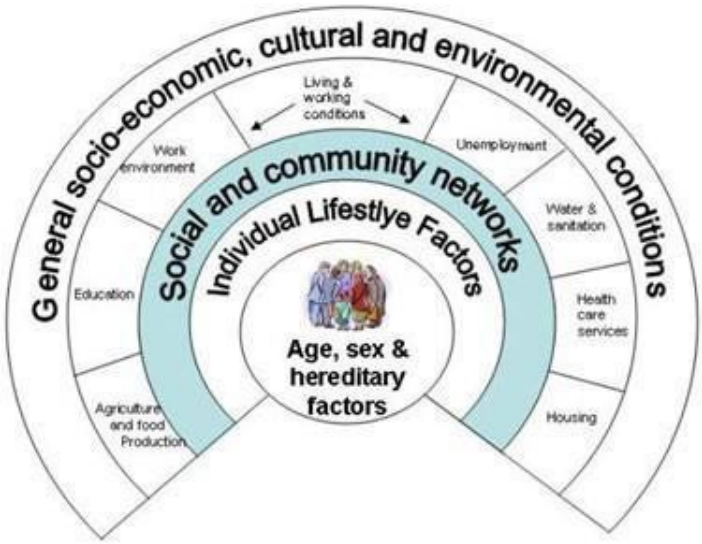


Figure three: A social model of health. Source: The World Health Organisation

Things like education, housing, transport and clean air are often known as ‘wider determinants of health’. They can also be seen as the ‘causes of causes’ which we mentioned earlier. It shows the importance of the NHS working with local authorities and other organisations who can influence these factors.

Our principles for reducing health inequalities

Our work in this area will be guided by the following principles:

Principle 1

Reducing health inequalities is a key factor in all work caried out within the ICS – it is everyone’s business. Reducing health inequalities and improving health equity should run through all our work, at all levels, as a ‘golden thread’. Appropriate training and support will be given to enable people to think and act in ways that reduce health inequity.

Principle 2

We will use data and insight to better understand local health inequalities and how they affect people. We will draw upon the best evidence to take action to reduce inequalities and to evaluate the impact of our services. This is known as ‘population health management’. Where services are failing to reduce inequity, or (by accident) are increasing it, the services will be adjusted or changed completely.

Principle 3

We will prioritise prevention, helping prevent or lessen the impact of illness. This is important in improving health equity as the burden of disease is borne unfairly by those who are more deprived, marginalised or in a minority. Primary prevention includes a focus on and increased investment in reducing inequalities in lifestyle risk factors (such as smoking, diet, exercise or alcohol consumption), mental wellbeing, housing, income, education, working conditions and the wider environment. In these areas, it is critical that the NHS works effectively with local authority partners.

Principle 4

A focus on gaining a fair balance between mental and physical health - reducing inequalities in mental health will be prioritised to the same extent as reducing inequalities in physical health.

Principle 5

Local public sector organisations will seek to reduce health inequalities through offering ‘social value’. This approach includes efforts to make the workforce more representative of the local population. We will use mentoring, reverse mentoring and apprenticeships to improve opportunities for under-represented groups, support people from less affluent backgrounds to establish a career in the public sector, and seek to tackle racism and prejudice in society. In

addition, we will seek to maximise the value of our collective spending on the local economy.

Principle 6

Investment in services will be proportionate to the needs of people using those services. This means that although there will be a universal offer of services to all, we will vary the provision of services in response to differences in need within, and between, groups of people. In this way we will look to 'level up' the way that services are offered and outcomes achieved.

Principle 7

We will draw on the strengths of communities and individuals to reduce health inequality and inequity. Our services will aim to focus on 'what matters to people' rather than focusing on 'what is the matter' with them. We will listen to local people with lived experience to shape local priorities and redesign services. As part of strengthening resilience in communities we will work to improve health literacy – the skills, knowledge and understanding that people have to make use of available information and access local services.

Principle 8

We will ensure that all plans and policies put forward by the ICS partners take into account issues of health equity. This is particularly important in relation to the wider factors that can affect people's health such as housing, education or employment.

Principle 9

We will take effective action during the key points of a person's life to help reduce health inequality and inequity. This means a specific focus on giving children the best start in life, prevention of ill health and the promotion of wellbeing and resilience.

Principle 10

The ICS is accountable for delivering on health inequalities across the local health and care system. We acknowledge that organisations within the ICS also have a statutory duty to reduce health inequalities. The work required to reduce health inequalities will tend to take place at a 'place' (or local neighbourhood) level. These places will need to be responsive to the particular needs of local people.

Principle 11

Actions will be undertaken at the most appropriate level of the ICS where they can be most effectively owned and delivered. This will tend to be determined by the relevant statutory responsibilities of the partner organisations. Housing, education, and licensing rest with local authorities, for example, while commissioning responsibility for most health services sits with the local NHS clinical commissioning groups and their successors.

Principle 12

There is significant potential to improve people's health through better and more widespread use of digital technologies. Digital technologies are integral to many of the changes envisaged in the NHS Long Term Plan. However, it will also be important to take steps to prevent digital technologies entrenching or widening health inequalities. This means understanding and addressing the issue of digital exclusion and ensuring that people can still receive face-to-face services where required.

Taking steps to reduce health inequalities

Actions to address health inequalities will need to take place at different levels:

- System level - across the whole LLR area
- Place level - across the area covered by the upper tier local authorities (Leicester City Council, Leicestershire County Council, Rutland County Council) and led by Health and Wellbeing Boards
- Neighbourhood or locality level – smaller (though locally meaningful) populations within the wider upper tier boundaries.

Medium to long term priorities will be determined at place level and are likely to include:

1. A focus on the first 1,001 days of life. Events and people's health during this period often determine outcomes across the whole of someone's life
2. Improving healthy life expectancy through early intervention and prevention. This will include actions relating to the other factors that can affect someone's health such as education or job opportunities
3. Using the lived experiences of people to inform our plans and actions
4. Each organisation having their own executive lead for health inequalities who will be responsible for driving this agenda forward
5. An approach which is smart, measurable, achievable, realistic and timed (SMART).

Shorter term goals are to:

1. Restore NHS services inclusively (following the impact of Covid-19)
2. Mitigate against digital exclusion
3. Ensure that our data is accurate and providing the necessary insights
4. Accelerate preventative programmes that engage those at greatest risk of poor health (management of long-term conditions, annual health checks for people with learning disabilities/serious mental illness, continuity of maternity care for BME women and those from deprived neighbourhoods)
5. Strengthen leadership and accountability.

Strategic actions to reduce health inequalities at the ICS level

Action 1

Places will be expected to apply the principles, outlined in this framework, to their specific populations, in the most appropriate way, that meets their local needs. This is likely to embrace the various factors that can affect people's health (as shown in figure three).

Action 2

The ICS will make investment decisions for people across LLR that reflect the various needs of different communities. In this way, actions can be universal, but adjusted and made proportionate to the level of disadvantage. The aim of reducing health inequalities will be a high priority. Specifically, we will develop a new strategic long-term model of primary care (GP practice) funding, distribution and investment. This will 'level up' funding based on population need rather than historical allocation.

Action 3

We will establish a defined resource to review health inequalities at this strategic level. This will be a virtual partnership between the NHS, local authorities and local universities. An enhanced ability to process and analyse data will support a better understanding of inequity across the area. We will gather and share best practice in effective interventions and provide teaching and training to all levels of staff in undertaking health equity audits. We will facilitate local research. Public health teams will deliver, with partners, the health inequalities support function at a place and neighbourhood level. Specifically, a proposal for the establishment of an LLR health inequality resource will be presented to the system executive by the end of September 2021.

Action 4

All decision makers within the ICS will have expertise, skills, insight and understanding of health inequity and how to reduce it. Specifically, health inequity and inequality training will be mandatory for all executive decision makers in each organisation by the end of November 2021. We will work with local and regional partners to develop appropriate and robust training packages relevant to roles.

Action 5

Partner organisations will work together to understand the impact of Covid-19 on health inequalities across LLR, to allow effective and equitable recovery after the pandemic. We will be looking to:

- Identify groups and communities, across all ages and across protected characteristics, which have been most affected by the pandemic as a result of pre-existing vulnerabilities and disadvantages
- Undertake proportionate additional work to ensure vaccine uptake is equitable
- Include consideration of the role of the wider determinants of health, such as

education, employment, housing and poverty
- Promote equal support for mental and physical health to those groups worst affected by the pandemic and the consequences of lockdown.

Action 6

All partners will work to improve the completeness and consistency of their data to enable a better understanding of health inequity. This mainly relates to data collection on people with 'protected characteristics' under the Equality Act. Specifically, partner organisations will develop an action plan for having ethnicity, accessibility and communication needs of their population appropriately coded in records by the end of July 2021. In addition, we will make better use of our data sets in order to identify vulnerable groups and individuals to offer proactive, holistic care through Integrated Neighbourhood Teams.

Action 7

At the ICS level, we will obtain and use data to help us better understand where we can do more work to reduce health inequity. Specifically, by the end of October 2021, each organisation will have adopted a standard health equity audit tool and put training plans in place to use this tool, so that each 'place' area can compare their performance against other areas.

Action 8

We will undertake health equity audits to identify health inequalities between different population groups. These will be carried out at the planning stage when we commission, redesign or evaluate services. Action to reduce health inequity will be taken based on audit findings (at a minimum considering the protected characteristics of the Equality Act 2010).

Action 9

The NHS and public sector partner organisations within the ICS will seek to reduce health inequalities through seeing what we can do together, especially in the areas of work opportunities, use of buildings and purchasing.

How will we know if this work is succeeding?

If this framework is successful in driving effective action, we expect to see the following outcomes:

- A reduction in health inequities
- An increase in healthy life expectancy
- A reduction in premature mortality
- A workforce that is representative of the local population
- Better use of data.

Health inequalities case study: Introduction of new technology to improve care in diabetes

Case study by Professor Azhar Farooqi

Diabetes is one of the most common chronic disorders affecting nearly five million people in the UK. It is a significantly more common condition in people of low socio-economic status and in BME groups. Diabetes is a costly condition, not only in financial terms (more than 10% of the NHS budget), but also in terms of mortality and morbidity. Sufferers lose several years of life and the condition is the biggest cause of acquired blindness, renal failure and amputations.

The evidence that good control of blood glucose improves outcomes for patients and reduces NHS costs is overwhelming. Freestyle Libre (FSL) is a new technology, known as flash glucose monitoring, which allows patients to monitor in real time their blood glucose using a skin patch and a small handheld sensor. It avoids multiple lancet jabs and time-consuming use of glucose strips and machines.

The technology is approved by NICE for patients with type 1 diabetes who normally would test multiple times a day and is likely soon to be extended to patients with type 2 diabetes on insulin and other groups deemed at high risk of hypoglycaemia.
It costs about £500 per patient per year. The real-world impact of this technology has shown significant improvements in blood glucose levels, reduced hospital admissions and paramedic call-outs, less severe hypoglycaemia and improved overall blood glucose control.

How was this technology rolled out?

The prescribing of FSL has been via secondary (hospital) care to eligible patients who have an education session on how to use it. As with all new technologies and treatments, patients learn about the availability of this via media and friends and those most empowered tend to know about it first. The patient benefit is not only in improved diabetes control but also the avoidance of painful finger pricks. It was entirely predictable that the most articulate, informed and persuasive patients would be in a position to demand this technology and persuade their health care professional they are eligible and would benefit. The criteria of existing multiple testing and the education package also favours English speakers, literate patients and those already empowered in looking after their condition - all of which make it less likely that people form deprived backgrounds would either push for this technology or be prioritised for it.

What has been the health inequality?

Type 1 patients in the most deprived area of Leicester, Leicestershire and Rutland had a 29% chance of receiving this technology, compared to 39% in the least deprived area. Only 14% of type 1 patients received FSL in GP practices with the most BME people in their population, whereas this figure was 38% for the practices with fewest BME people.

Why has this happened?

This data was produced by the pharma company Abbot, who in effect, 'whistle blew' the problem. The local NHS service provider had no idea of this health inequality and in fact denied it was occurring. There was no consideration of health inequalities in the introduction of this technology, nor monitoring of uptake by deprivation or socio-economic status. Despite the data, little has changed on the provision of this technology to date.

Lessons to be learnt

It is important that a full equity impact assessment is carried out when all new technology (or therapies) are introduced. It is important that monitoring of uptake by socio-economic status and BME status, as well as other characteristics, is undertaken, and data reported and shared. It is important to consider if specialist-only provision will worsen health inequalities. Most type 1 patients (60%) and the vast majority of type 2 diabetics (95%) receive care only in general practice. It is likely that appropriate primary care provision will improve wider access to this intervention. Language is likely to be a significant barrier in addressing health inequalities, in particular, when a mandatory education package is only available in English. Specific thought, investment and planning needs to take place to reverse this inequality of provision of FSL.

Where can I find out more?

Public health experts routinely put together assessments of health and health inequalities for local areas. These are known as Joint Strategic Needs Assessments and are available for:

- Leicester City
- Leicestershire
- Rutland

Midlands and Lancashire
Commissioning Support Unit

Stage 1 Equality, Health Inequality Impact and Risk Assessment

- **Title of Assessment:**
  Leicester, Leicestershire & Rutland (LLR) Health Inequalities Framework 2021 - 2024

- **Person Responsible:**
  Steve McCue, Senior Strategic Development Manager, LLR CCGs
  Mark Pierce, Head of Population Health Management, LLR CCGs

- **Service Area:**
  Strategy & Planning Directorate, LLR CCGs

- **Overview of proposal, policy, service etc:**

Health inequalities across Leicester, Leicestershire, and Rutland (LLR) are stark. A boy born today in the most deprived area of LLR could be expected to die up to 8.7 years earlier than a boy born in the least deprived area. The difference in the proportion of a person's life lived in good health is even more marked – again, with those from less affluent areas spending a greater proportion of their (often shorter) lives in poor health compared to people from more affluent parts of our area. In acknowledging this, we also must accept that the above facts refer only to the extreme poles of what is a distribution of effects throughout the whole population. This is not an issue affecting only the least affluent in our community. Health inequalities affect almost everyone living in LLR to some degree and therefore it will be the business of everyone in our system to take action to reduce these unfair and avoidable differences in health outcomes.

We have known about health inequalities for a long time now and individual partners have been making efforts to reduce them. The COVID-19 pandemic has laid out in stark focus the depth of the inequalities that exist and the devastating impacts they can have on our families and communities. As we come together in LLR as an Integrated Care System, one of our central roles and duties is to implement the evidence-based actions needed to increase health equity in our society and reduce or eliminate health inequality. We want the people of LLR to be healthier with everyone having a fair chance to live a long life in good health. Therefore, we will aim to "level up" services and funding, rather than take anything away from areas where outcomes are already good.

The Leicester, Leicestershire and Rutland (LLR) Health Inequalities Framework sets out how we plan to take action, both collectively and through specific organisations to positively impact not just the direct causes, but the "causes of the causes" of these differences. Some work, therefore, will fall to the NHS to do, some mainly to other partners such as local authorities or other public sector bodies, and some to joint working at system, place or neighbourhood. Often this is not something one organisation can do on their own – it requires the system to work together to act as anchor institutions – using

their collective resources and working with the voluntary and community sector to make a difference.

The aim of the LLR Health Inequalities Framework is to improve healthy life expectancy across LLR, by reducing health inequalities across the system. The purpose of this Framework is therefore to:

- Provide a system mandate for action to address health inequalities across LLR
- Establish a collective understanding of the terms ‘Inequality’, ‘Inequity’ and ‘Prevention’ in relation to population health, across all parts of the LLR Integrated Care System (ICS)
- Strengthen a whole system collaborative approach to reduce (and remove entirely where possible) avoidable unfairness in people’s health and wellbeing in LLR
- Establish the high-level principles of how LLR ICS partners will approach the work of reducing health inequity at system level
- Recognise the framework will be implemented and agreed at system level, with much operational, political and community action taking place at ‘place’ and ‘neighbourhood’ level. It is the systems’ minimum ask of Place in relation to reducing health inequalities.
- Set out some key actions that can be delivered at system level with support through the Integrated Care System (ICS), with recognition that some actions will be primarily for individual organisations e.g. the NHS or the Local Authority however many requiring partners to work together.

Equality, Health Inequality Impact and Risk Assessment

Section one: equality impact

For each question, please answer **Yes** or **No**, and provide a brief rationale for your answer.

1. Will this (decision / proposal / change) affect / impact on people in any way? (e.g. population, patients, carers, staff)?
   Yes - The aim of the LLR Health Inequalities Framework is to improve healthy life expectancy for people across LLR, by reducing health inequalities across the system. The health and wellbeing of people is an asset to individuals, to communities, and to wider society. Good mental and physical health is a basic precondition for people to take an active role in family, community, and work life. Although there is growing concern about stalling life expectancy, the existing wide inequalities in health outcomes tend to be overlooked. Improving healthy life expectancy enables people to live in better health for longer. A workforce that remains fit, healthy, and working for longer can contribute to a productive economy and decrease the costs of supporting an ageing society. However, health inequalities undermine these benefits.

2. Is this decision or change part of a transformation programme or commissioning / decommissioning review?
   Yes. The development of the LLR Health Inequalities Framework is part of the transformation work to create the LLR Integrated Care System (LLR ICS). This involves bringing a range of system partners together to collaborate on implementing a wide programme of interconnected transformation in the commissioning and provision of a range of public and voluntary services to improve the lives of the residents of LLR. The framework principles and its proposed system-wide actions will ensure that the development of an ICS is underpinned by a commitment that future changes to services will be undertaken with a central aim of reducing health inequalities and increasing health equity.

3. Is this a decision that may change or potentially change the delivery of a service / activity or introduce a charge?
   Yes – Under the principles of this framework, future Investment in services will be proportionate to the needs (the ability to benefit) of the people using those services (the principle of "proportionate universalism"). This means that although there will be a universal offer of services to all, there will be justifiable variation in services in response to differences in need within and between groups of people using these services. Where we find variation in services that appears not to be justified by the variation in need, we will act to "level up" the way the services are offered, and outcomes achieved.

4. Will this (decision / proposal / change) potentially reduce the availability of a service or activity or product (e.g. prescriptions)?
No - While levelling up is generally a good thing, levelling down is not. So, applying focus and resources in one area and targeting those resources to make them most effective will be appropriate, however, diverting those resources from somewhere they were also needed in order to improve health outcomes will not be. Proposals or decisions about specific services are not within the remit of this framework and will be made by identified responsible bodies within a specialist sphere. The framework proposes principles which are intended to support decision-making bodies reach conclusions about proposed changes to any services that keep the needs of traditionally underserved groups at the centre of these processes. We can see that health inequalities are the result of a complex range of interrelated causes – and "the causes of those causes". In some cases, actions will be primarily in the hands of one partner. In other cases, reducing inequity will require close collaboration between several organisations across the system. The ICS partners are committed to taking action at all levels:

- ***System level – across the whole LLR area***
- ***Place level – across the area covered by our Upper Tier Local Authorities (Leicester City Council, Leicestershire County Council, Rutland County Council) and led by Health and Wellbeing Boards***
- ***Neighbourhood or locality level – smaller (though locally meaningful) populations within the wider Upper Tier boundaries.***

At each of these levels the partners within the ICS – not just the NHS and the Local Authority, but the voluntary and community sectors too – will come together to plan in even finer detail the actions they are going to take, individually and collectively, to reduce health inequity

5. Is this a review of a policy, procedure, protocol or strategy?
No – The LLR Health Inequalities Framework is a first strategic approach to guide reducing health inequalities across LLR. Places will be expected to translate the system level principles to their specific populations in the most appropriate way that meets their local needs. This is likely to take an approach encompassing the wider determinants of health, acknowledging that much of this work happens at this level.

6. Is this (decision / proposal / change) about improving access or delivery of a service?

Yes - The most detailed implementation plans, and actions will be developed by partners working together at a very local level (Neighbourhood or locality level). Multi- Disciplinary Team working, the sharing of information and engagement of individuals and communities around their assets and strengths will ensure that action is direct, person-centred, and sensitive to feedback from the integrated teams and the people those teams serve.

7. Will this (decision / proposal / change) potentially negatively impact groups covered by the Equality Act and other vulnerable groups?
   No

8. Will this (decision / proposal / change) affect Employees or levels of training for those who will be delivering the service?
   Yes – All decision makers within the ICS will have training and development to gain expertise, skills, insight and understanding of health inequity and how to reduce it, specifically;

   - ***Health Inequity and Inequality training will be mandatory for all executive decision makers in each organisation***
   - ***We will work with local and regional partners to develop appropriate and robust training packages relevant to roles***

9. Will this (decision / proposal / change) have any **positive** effect / impact in reducing health inequalities?
   Yes - The aim of the LLR Health Inequalities Framework is to improve healthy life expectancy for people across LLR, by driving action on evidence-based approaches to reducing health inequalities across the system

10. Will this (decision / proposal / change) have any **negative** effect / impact on health inequalities?
    No

Section two: equality risk

For each question, please answer **Yes** or **No**, and provide a brief rationale for your answer.

11. To reach your (decision / proposal / change) have you considered any information / supporting documents?
    Yes – A detailed analysis of local demographic and health data demonstrating the extent of inequality is available through local JSNA (Joint Strategic Needs Assessment) reports produced by each Public Health Team. Local JSNA's are available via the following organisational links:

    Leicester City: https://www.leicester.gov.uk/your-council/policies-plans-and-strategies/public-health/data-reports-information/jsna/

    Leicestershire: https://www.lsr-online.org/leicestershire-2018-2021-jsna.html

    Rutland: https://www.rutland.gov.uk/my-services/health-and-family/health-and-nhs/joint-strategic-needs-assessment/

12. Have you engaged or consulted with people or stakeholders / staff that may be affected by the (decision / proposal / change)?
Yes – Multiple partners have been involved in the production of the LLR Health Inequalities Framework to include LLR CCGs,(including Independent Lay members) Public Health, Clinicians, and Leicester/Leicestershire and Rutland Healthwatch.

13. Have you taken specialist advice in regard to impacts of the (decision / proposal / change)?
Yes – the production of the LLR Health Inequalities Framework has been clinically led with managerial support. Equality, Diversity and Inclusion Leads from University Hospitals of Leicester and Leicestershire Partnership Trust have been part of the document drafting group advising on issues of equity and equality. Public Health Consultants from city, county and Public Health England have reviewed and drafted the framework's health equity position.

14. Have you considered how this can address and eliminate discrimination, harassment and victimisation?
Yes - Reducing Health inequalities for everybody, including those with protected characteristics, is identified in the framework as a key component in all the work undertaken within the ICS – it is everyone's business. Reducing health inequalities and improving health equity should run through all work programmes at all levels as a "golden thread" from system to place to neighbourhood. The framework identifies Appropriate training and support to enable people to think and act in ways that lead to reductions in health inequity as one of the key system actions.

15. Have you considered how this can help to address inequality issues to enable all groups to access services?
Yes – as above and the framework identifies that undertaking health Equity Audits and using the LLR Inclusive Decision Making Framework will be required at the outset of service redesign work by Design Groups.

16. Have you considered how this can help foster good relations and community cohesion within communities?
Yes – The LLR Health Inequality Framework explicitly states "We will draw on the assets and strengths of communities and individuals to reduce health inequality and inequity. Our services will always try to listen to what really matters to people rather than focusing solely on "what is the matter" with them. We will listen to the voices of local people with lived experience to shape local priorities and redesign services." It refers to our intention to draw upon the positive community engagement arising during the COVID pandemic as a template of how to create inclusive and positive involvement of all communities in pursuing common goals.

17. Can you address or minimise any negative impacts that may represent an equality risk?
Yes - Where specific actions / projects will be undertaken by the LLR Health Inequalities Support Unit or Task and Finish Group, an EHIIRA will be undertaken to identify potential unintended adverse consequences and mitigate those risks.

Most of the actions proposed in the framework will be delivered by either LLR Design Groups or by individual organisations who will undertake Health Equity Audits or EIIHRs to identify risk and mitigations of any negative impacts related to those individual pieces of work. The framework sets out the expectation that the LLR Inclusive Decision-Making Framework and health Equity audits are the process to be used to capture any potential or actual negative impacts and our responses.

18. Will your decision reports be available to the public?
    Yes - The Health Equity Audits and EIIHRs for individual projects or service redesigns will all be in the public domain

Section three: human rights impact

For each question, please answer **Yes** or **No**, and provide a brief rationale for your answer.

19. Is there any concern that Article 2: Right to life may be breached?
    No

20. Is there any concern that Article 3: Right not to be treated in an inhuman or degrading way may be breached?
    No

21. Is there any concern that Article 5: Right to liberty may be breached?
    No

22. Is there any concern that Article 6: Right to a fair trial or hearing (this includes right to fair assessment, interview or investigation) may be breached?
    No

23. Is there any concern that Article 8: Right to respect for private and family life may be breached?
    No

24. Is there any concern that Article 9: Right to freedom of thought, conscience and religion may be breached? E.g. right to participate (individually or as a group) religion / belief
    No
25. Is there any concern that Article 10: Right to freedom of expression may be breached? E.g. concern that people won't be able to have opinions and express their views on their own or in a group
    No

26. Is there any concern that Article 14: Right not to be discriminated against in relation to any human rights, may be breached?
    No

27. Is there any concern the obligation to protect human rights may be breached? E.g. concern that systems, processes and monitoring will not identify human rights breaches.
    No

Section four: Assessment Comments

28. Further comments from individual / team drafting this assessment:
    More detailed plans on action to reduce health inequity will be agreed at place level. The development, delivery and evaluation of place-led plans will be led by Directors of Public Health and Health and Wellbeing Boards. The plans will be based on local data and intelligence – qualitative and quantitative – derived from Public health, Local authority services, the NHS, other public sector partners, and communities themselves – and will reference the principles and high-level facilitative actions identified in this framework.

- Stage 1 Assessment / Approval comments from MLCSU Equality and Inclusion Business Partner:

The policy has been quality assured, and I am happy that this provides a rigorous assessment of the LLR Health Inequalities Framework.

Shaun Cropper E&I Business Partner MLCSU 28/05/21

Report No: 130/2021
PUBLIC REPORT

RUTLAND HEALTH AND WELLBEING BOARD

5 October 2021

DRAFT HEALTH AND WELLBEING STRATEGY: A PLAN FOR PLACE 2022-25

Report of the Strategic Director for Adult Services and Health

Strategic Aim:	All	
Exempt Information	No	
Cabinet Member(s) Responsible:	Mr A Walters, Portfolio Holder for Health, Wellbeing and Adult Care	
Contact Officer(s):	John Morley, Strategic Director for Adult Services and Health	01572 758442 jmorley@rutland.gov.uk
	Mike Sandys , Director Public Health RCC	0116 3054259 Mike.Sandys@leics.gov.uk
	Fay Bayliss, Deputy Director of Integration and Transformation, LLR CCGs	07717 346584 Fay.Bayliss@LeicesterCityCCG.nhs.uk
Ward Councillors		

DECISION RECOMMENDATIONS

That the Board:

1. Notes the context for and progress towards the development of the *Rutland Health and Wellbeing Strategy: A Plan for Place 2022-25* (*the HWS*).

2. Discusses, agrees and endorses the overall vision, principles, priorities and action areas set out in the draft strategy and plan.

3. Confirms proposals for a public consultation and authorises the Integrated Delivery Group to run a public consultation on the draft strategy.

4. Agrees the frequency of reporting of the performance of the action plan to the Health and Wellbeing Board

5. Approves the timetable for finalisation of the strategy.

1 PURPOSE OF THE REPORT

1.1 The purpose of this report is to update the Health and Wellbeing Board (HWB) on the development of the new **Health and Wellbeing Board Strategy: A Plan for Place 2022-25 (the HWS)**. This strategy is a statutory responsibility of the HWB and falls under its governance.

1.2 To set out the timetable for finalisation of the Health and Wellbeing Strategy (the HWS).

1.3 To propose a frequency of reporting of the plan to be agreed by the HWB.

2 BACKGROUND AND MAIN CONSIDERATIONS

2.1 Rutland HWB has a statutory function to have a partnership-based joint Health and Wellbeing Strategy (the HWS), informed by a Joint Strategic Needs Assessment (JSNA), which provides an area-specific framework for health and care partners to work together to improve the health and wellbeing of their population.

2.2 The HWB was part-way through updating its HWS when the pandemic started in March 2020. This work was necessarily put on hold, and resumed in March 2021, as soon as emergency measures started to ease. Since then, the sub-group of the HWB, the Integrated Delivery Group (IDG), has been working to refresh and renew the strategy on behalf of the HWB.

2.3 In February 2021 the Department of Health and Social Care (DHSC) published proposals through the White paper: *Integration and Innovation: Working together to improve health and social care for all*, to replace the former Sustainability and Transformation Partnership (STP) arrangements for health and care system footprints with statutory Integrated Care Systems (ICS) from April 2022. The ICS for Leicester, Leicestershire and Rutland (LLR) was approved in April 2021. Development of the Rutland HWS is in line with the ICS requirement for 'place led planning'.

2.4 The Rutland HWS includes the ICS requirement for a Rutland 'place led plan'. This will reflect varying local needs, define local health and care priorities and feed up to help inform the wider Leicester, Leicestershire and Rutland ICS vision.

2.5 The national ambition for place planning sets the aim of creating a tailored offer for the local population of each place, which ensures that everyone is able to access:

- clear advice on staying well;
- a range of preventative services;
- simple, joined-up care and treatment when they need it;
- proactive support to keep as well as possible, where they are vulnerable or at high risk; and
- digital services that put the citizen at the heart of their own care (with non-digital alternatives when required).

2.6 Also, that the principle of the NHS, alongside other key partners, through its employment, training, procurement and volunteering activities, and as a major estate owner, will play a full part in both the social and economic development and environmental sustainability of places.

2.7 Members of the IDG directly engaged a wider range of partners to seek the latest Rutland local needs & population data, recognising the JSNA had lapsed during the pandemic. This work will also help to inform and accelerate the subsequent formal renewal of the JSNA.

2.8 A **public engagement** exercise was commissioned from Healthwatch Rutland in addition to considering insights from a wider range of engagements such as the **Future Rutland Conversation** and Clinical Commissioning Group exercises to ensure that the views of the public were fully factored in.

2.9 The resulting draft strategy is presented at Appendix 1 for the consideration of the HWB.

3 THE PROPOSED STRATEGY

3.1 The proposed overall aim of the Rutland HWS is to develop **safe, healthy, happy and caring communities in which people start well and thrive together throughout their lives**. The essence of the Plan's goal is that 'people will be able to live well in active communities.' With a strong emphasis on prevention, supporting independence and building inclusive and resilient communities.

3.2 The HWS has been built around a number of principles:

- **Person-centred:** the HWS is built around and for individuals, whatever their circumstances, listening to lived experience and tailoring responses to specific needs. This also recognises that individuals want an active role in their own health and wellbeing, alongside health and care services.

- **Levelling up:** the HWS would embrace an approach of 'proportionate universalism' in which interventions are targeted to enable a 'levelling up' of the gradient in health outcomes. This means that although there will be a universal offer of services to all, there will be justifiable variation in services in response to differences in need within and between groups of people, that will aim to bring those experiencing poorer outcomes the opportunity to 'level up' to those achieving the best outcomes.

- **Evidence-led:** the HWS is evidence-based, calling on a wide range of sources of data and intelligence to cast light on the health and wellbeing situation and challenges in Rutland. This has included stakeholder and resident engagement, notably through Healthwatch Rutland's What matters to you? report and the Council's Future Rutland Conversation.

- **Building on strengths:** building on Rutland's strong track record of partners working together to shape and deliver effective and efficient services.

- **Using our combined resources to deliver the best value for money in Rutland:** considering relevant funding sources and shared resources and more collaborative delivery actions.

- **Health in all policies:** asking partners to consider making an ongoing commitment to systematically consider the impact on health and inequalities, including consideration of the impact on climate change as a key factor in future population health.

3.3 The proposed strategic approach would be progressed through five inter-related priorities:

- **1. The best start in life**, supporting healthy child development, in particular the first 1001 critical days and the development of confident, resilient young adults.

- **2. Staying healthy and independent for as long as possible**, adopting a prevention approach and resilient communities, and more targeted services where people are already living with ill health, plus coordinated care that also involves patients themselves as key players in their own health management.

- **3. Reducing health inequalities across Rutland**, intervening to 'level up' the gradient of health outcomes for defined groups facing particular disadvantage.

- **4. Ensuring equitable access to health and wellbeing services**, ensuring fair access to services, including bringing more services closer to the population of rural Rutland and considering digital technologies where appropriate to increase access.

- **5. Preparing for population growth and change**, by evolving local infrastructure and the health and care workforce to meet future needs of a growing and older population.

3.4 The priorities are inter-related and mutually supportive so, for example, children and young people will benefit not only from actions under Priority 1, but also a number of other actions such as access to services (Priority 4), more equitable outcomes (Priority 3) and the sufficiency of future services (Priority 5).

3.5 When finalised, the HWS would be implemented through a detailed action plan, with specific commitments from partners.

4 TIMELINE

4.1 The below table sets out the timetable for HWS development. We are currently completing Phase 2 and moving into phase 3, which includes proposals for a public consultation (see Section 5).

4.2

Phase	Activity	Scope
Phase 1 Mar-Jul 2021	Engagement, analysis and exploration	• Engagement via Future Rutland Conversation and Healthwatch **Rutland *What matters to you?*** • Collation of up-to-date data and intelligence relevant to the HWS. • Review of key data by partners and development

		of priorities.
Phase 2 Aug-Sep 2021	Development of outline HWS	• Development of draft HWS with involved stakeholders • Governance: review of draft plan – Council's Scrutiny Panel, Health and Wellbeing Board • Update draft HWS based on feedback to date
Phase 3 Oct- Dec 2022	Refinement of HWS	• Draft HWS presented at HWB • **Public and stakeholder consultation on the plan** (Oct-Nov 2021) • Enriching and updating the plan based on feedback • Development of first year action plan implementation • Development of indicator set and monitoring dashboard
Phase 4 Jan-Mar 2022	Publish and operationalise HWS	• Sign off Rutland HWS by Health and Wellbeing Board (Jan 2022) • Publication of plan
Phase 5 Mar 2022-23	Plan delivery – Year 1	• Delivery of the first year of the plan • Regular monitoring and reporting of progress, impacts, risks and issues • Review plan for year two (2023-24) deliverables

5 CONSULTATION

5.1 As set out above, the Rutland HWS has been informed by a number of public engagement and consultation exercises, including system level health consultations, the Council's Future Rutland Conversation https://future.rutland.gov.uk and a dedicated engagement exercise commissioned from Healthwatch Rutland in spring 2021 to feed directly into this work, and whose findings were published in the report What matters to you?

5.2 HWB are now asked to consider initiating a public consultation on the draft HWS. A six-week consultation is proposed across October/November 2021, with responses informing a further version of the strategy to be presented to the HWB in January 2022 for approval.

5.3 This consultation would invite responses from residents, stakeholder organisations, councillors and the workforce via an online survey, by phone or a postal questionnaire. The survey would be designed to generate both a quantitative response and qualitative feedback. The HWS will also be presented at key partner meetings for comment and support.

6 ALTERNATIVE OPTIONS

6.1 The draft strategy presented has built on the earlier visioning work undertaken by and with the HWB before the start of the pandemic, when the Board used local evidence to identify key priorities and considered a range of different approaches to structuring priorities. This work fed directly into the development of this draft HWS.

7 FINANCIAL IMPLICATIONS

7.1 In common with previous HWS, the strategy brings together and influences the spending plans of its constituent partners or programmes (including the Better Care Fund).

7.2 The HWS, in setting out shared priorities across health and care partners, is intended to support and inform the commissioning of local health and care services for Rutland for 2022-25.

8 LEGAL AND GOVERNANCE CONSIDERATIONS

8.1 This plan answers the statutory duty of the HWB to produce a joint HWS and Place Led Plan for the local population.

8.1 The strategy will need to be endorsed by the HWB The HWS actions will be delivered on behalf of the HWB via the IDG, which will monitor progress using a dashboard, to be defined and report regularly on progress to the HWB.

9 DATA PROTECTION IMPLICATIONS (MANDATORY)

9.1 A Data Protection Impact Assessment (DPIA) has not been completed because the Plan itself does not entail or propose uses of personal data which pose risks or issues to the rights and freedoms of natural persons.

9.2 Should DPIAs be required for specific projects being delivered as part of the Plan, then these will be undertaken in the context of those specific pieces of work, at the relevant time.

10 EQUALITY IMPACT ASSESSMENT

10.1 Equality and human rights are key themes in embedding an equitable approach to the development and implementation of the Plan. An Equality Impact Assessment (EqIA) will be completed as part of the next phase of work on the Plan and submitted with the final strategy.

10.2 It is anticipated that the plan has the potential to have a positive impact on equality, through its equity-related priorities. In terms of protected characteristics, populations specifically targeted include: females, whose healthy life expectancy has declined; people living with disabilities, including those with learning disabilities who, nationally, have been found to live shorter lives on average than the wider population in part due to the quality of healthcare they may receive; people of different ages who may be disadvantaged, here, children and young people facing challenges which may impact on their future development, and older people with complex care needs who may struggle to access services.

11 COMMUNITY SAFETY IMPLICATIONS

11.1 The Plan has no significant community safety implications but will work to build strong resilient communities across Rutland. National evidence has also shown that more equal societies experience less crime and higher levels of feeing safe than unequal communities.

12 HEALTH AND WELLBEING IMPLICATIONS

12.1 The Plan will be a central tool in supporting local partners to work together

effectively with the Rutland population to enhance and maintain health and wellbeing.

13 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

13.1 The draft HWS for Rutland as a place will provide a clear, single vision for health and care that will drive change and improve health and wellbeing outcomes for Rutland residents. This will meet the statutory duty of the HWB and need to develop a Place led Plan as part of the emerging ICS. The draft strategy presents five key priorities with associated actions and principles that will be further consulted on by the public, stakeholders and partners. A final strategy and proposed implementation plan will be presented at the HWB in January for implementation from April 2022. …

14 BACKGROUND PAPERS

14.1 Additional background papers are as follows:

- Department of Health and Social Care (February 2021) White paper: Integration and Innovation: Working together to improve health and social care for all, https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all

- Healthwatch Rutland (2021) What matters to you? https://www.healthwatchrutland.co.uk/report/2021-08-19/what-matters-you-report

15 APPENDICES

15.1 Appendices are as follows:

- Appendix 1: DRAFT Health and Wellbeing Strategy: A Plan for Place 2022-25

A Large Print or Braille Version of this Report is available upon request – Contact 01572 722577.

Appendix A. DRAFT Health and Wellbeing Strategy: A Plan for Place 2022-25

Rutland Health and Wellbeing Strategy: The Rutland Place based Plan 2022 – 2025

DRAFT

Contents

Foreword

Rutland is a healthy place to live and I am pleased to say that people in Rutland enjoy some of the best health in England. However, whilst we are proud of this, Rutland is not without challenges and we are keen to continue to work to sustain this positive picture, including by evolving infrastructure and services in response to our growing and changing population, and improving outcomes where these could be better, especially for people facing disadvantages which can contribute to health inequalities. Our aim is for safe, happy and caring communities that remain some of the healthiest and happiest places to live.

Our new strategy focusses on working in partnership across organisations and communities to improve health and wellbeing, targeting where there are inequalities in health outcomes, and fully involving people as stakeholders in their own care. We will use a whole life approach – supporting all age groups and communities in Rutland to have the best health and wellbeing they can, whilst recognising that some people need more support than others.

We have made great strides in the last six years to integrate health and social care support in Rutland, bringing improvements that have been of benefit to the public and to service providers. We have also found new ways to live, work and deliver services through the unprecedented COVID-19 pandemic. As we start to return to normal, we remember and acknowledge what we have lost, whilst building on the innovation and community resilience we have developed.

We will work as partners across Rutland, with our colleagues in the Leicester, Leicestershire and Rutland health system, and with our equivalents in the neighbouring areas of Lincolnshire, Peterborough, Cambridgeshire and Northamptonshire, to ensure the best outcomes for the residents and service users of Rutland.

I commend this strategy to you and welcome your feedback, and the opportunity to work together towards 'active communities, living well'.

Councillor Alan Walters
Rutland County Council Portfolio Holder for Adult Social Care,
Public Health, Health and Leisure,
on behalf of the Rutland Health and Wellbeing Board

1. Introduction

1.1 Rutland Health and Wellbeing Context

People in Rutland on the whole live long and healthy lives, enjoying better than average mental and physical health when compared with many parts of the country. The county's health and care partners have a strong track record of working together effectively to support health and wellbeing, developing integrated approaches which prioritise prevention and place the individual front and centre, and supporting change for people of all ages facing a range of disadvantages which can lead to poorer outcomes. There are always new challenges, however, and we cannot stand still. The population is growing and changing, and patterns of inequality are evolving. We are also facing new demands recovering from the COVID-19 pandemic. This document aims to share our collaborative journey in how we will set a clear single vision for Rutland over the next 3 years that responds to meet the health and wellbeing needs of our population, building on the excellent foundations in place already.

1.2 Wider System Context

NHS Long Term Plan (LTP) - Jan 2019 - created ICS's, giving a platform for partnership working and integration. Across the Leicester, Leicestershire and Rutland (LLR) system, we are now approved as an Integrated Care System (ICS), consisting of the NHS bodies of the LLR Clinical Commissioning Groups (CCG's), the three local authorities: Leicester City Council, Leicestershire County Council, and Rutland County Council, and wider partners such as the voluntary and community sector and key provider agencies.

- **Integration and innovation: working together to improve health and social care for all (Jan 21)** - This white paper put ICS's on a statutory footing and created an ICS Health and Social Care partnership, bringing together local authorities, the voluntary and community sector, NHS bodies and others to look collectively at the needs of the population at the various partnership levels i.e. System, Place and Neighbourhood. This partnership is responsible for developing a plan to meet the population's health, public health, and social care needs. This place led plan will provide the place and neighbourhood level priorities reflecting the differences in need and the services required across Rutland and its neighbouring areas.

- **'Building Better Hospitals'** – Represents a significant and ambitious capital investment change programme for the University Hospitals Leicester (UHL). This will inform key changes in hospital provision across LLR.

1.3 Leadership and Governance for the Plan – the Health and Wellbeing Board

This Plan will be delivered under the governance and leadership of Rutland's Health and Wellbeing Board (HWB)[1]. The Board's purpose is to achieve better health, wellbeing and social care outcomes for Rutland's population. The HWB is a statutory committee of the

[1] For further details and Terms of Reference, see: https://www.rutland.gov.uk/my-services/health-and-family/health-and-nhs/health-and-well-being-board

County Council, chaired by the Council's Portfolio Holder for Adult Social Care, Public Health, Health and Leisure. It has senior representation from partner organisations responsible for shaping and delivering local health and social care services.

1.4 Collaborative and Evidence-Based Strategic Commissioning

Going forward we recognise that a wide range of partnership resources and utilising of the Rutland community assets are imperative to notably address the priorities in this strategy. We will seek to bring funding/resource streams together along with future Place Based funding allocations as and when they become available to Rutland. This will allow shared strategic investment decisions based on evidence driven approach.

1.5 Implementing the plan and measuring progress

This is a high-level document setting out broad health and wellbeing priorities and principles to be progressed in and for Rutland over the coming three years.

Whilst we have been careful to select priorities for the plan that reflect the future need as well as the present, inevitably these may change over time. For this reason, our partnership action planning will be reviewed on an annual basis, with HWB approval to ensure these priorities are still the right ones.

We will develop a dashboard to monitor progress and provide regular progress updates to the HWB. We will also share our progress with you and celebrate our successes by publishing an annual report each year and promoting its findings through the partnership and community events.

2. Insights into the Current Health and Wellbeing Picture of Rutland

To provide the foundation to our evidence based approach in developing this strategy we have recognised that real world intelligence is key to texturing the data picture for Rutland. Below are examples of sources of intelligence:

- **Engagement with the local population including surveys, focus groups and interviews, including analysis of levels of happiness and satisfaction with life (e.g. for users of social prescribing services)**
- National data sets on health and care outcomes including the Public Health Outcomes Framework, the Social Care Outcomes Framework and NHS metrics including overall levels of healthy life expectancy but also prevalence of specific diseases and uptake of screening programmes and immunisations.
- Local and national performance and uptake data on health and care services including use of prevention, routine and crisis services.
- Geographical mapping of Health and Care Strategic Assets to understand the pockets of deprivation and provide a deeper population profile of people on Rutland borders and in receipt of local health and care services

2.1 Rutland's Population

The total resident population of Rutland in 2019 was 39,927, an increase of 0.6% since 2018. The total GP registered population of Rutland was 40,710 as at July 2021. Compared to nationally, Rutland has a significantly higher proportion of the population aged 65 years and over. Using the 2020 estimated population as a baseline, the population of Rutland is projected to grow by 5% to 42,277 by 2025 (an increase of 1,890 residents)

2.2 The Wider Determinants of Health

Health is can be defined as: "*a state of wellbeing with physical, cultural, psychosocial, economic and spiritual attributes, not simply the absence of illness*"[2] This recognises the social model of health (as defined by Dahlgren and Whitehead (1991)[3]) and highlights the significant impact of the wider determinants of health (including social, economic and environmental factors) on people's mental and physical health. It also identifies all but age, sex and hereditary factors are modifiable to change and therefore lying within the scope of this plan, particularly in relation to primary prevention.

2.3 Life Expectancy and Health Inequalities

Life expectancy at birth for males and females living in Rutland is generally better than the national average.

Inequalities in health outcomes exist between areas within Rutland. Oakham North West ward has significantly worse values compared to England for hospital admissions for hip fractures, life expectancy at birth (females), deaths from all causes and circulatory diseases. Cottesmore and Greetham, respectively, have significantly worse values for emergency hospital admissions in under 5 year olds and for Chronic Obstructive Pulmonary Disease (COPD). Specific groups in Rutland are also known to have poorer outcomes than the wider population including SEND children, the Armed Forces community, the prison population, carers, people living with learning disabilities and some farming communities.

2.4 Overview of Health - Children

In terms of health outcomes for children in Rutland they are statistically similar to the national averages.

In terms of education, the average attainment 8 score for pupils in Rutland has remained significantly better than the national average since 2016/17. The percentage of school pupils with special education needs for Rutland in secondary school age children in 2018 is 14.0%, this is significantly worse in comparison to the England average of 12.3%.

The percentage of children in care who are up to date with their vaccinations in Rutland has decreased since 2017 and has remained significantly worse in comparison to England since 2019.

[2] Health Psychology: Theory, research and practice (5th Edition), London: SAGE, 2018., Marks, D et al.
[3] European strategies for tackling social inequities in health – levelling up part 2 (WHO report, PDF), 1991, Dahlgren and Whitehead, https://www.euro.who.int/__data/assets/pdf_file/0018/103824/E89384.pdf.

2.5 Overview of Health - Adults

A number of other health outcomes for residents in Rutland are significantly worse in comparison to the England average or benchmark goal. Key examples are dementia diagnosis rates in those aged 65 years and over, the rate of hip fractures and shingles vaccination coverage.

Health indicators relating to wider determinants and behaviours for adults in Rutland are generally similar to or better than the national average for most indicators. While Rutland compares favourably in relative terms, the figures still indicate that two out of three people are overweight, one in three is inactive and one in ten is a smoker. These factors diminish the potential for future good health. There is room for Rutland to further improve on these patterns to ensure we have the most active communities, living well.

2.6 Key outcomes from engagement

To gain an understanding of our resident's needs we have reviewed insights and business intelligence collected through ongoing engagement, involvement and consultation over the course of recent years. We have examined existing local reports, produced by NHS bodies, Rutland County Council and other local organisations, which represents feedback from local people - including staff, patients and carers. In addition, recent findings from the Building Better Hospitals (Leicester Hospitals Reconfiguration published in May 2021) and the Step Up to Great Mental Health consultations (to be published late Autumn 2021) and primary care engagement (published September 2021) and Covid-19 hesitancy engagement (published in April 2021).

In addition, insight of Rutland people's views was sought in Spring 2021 using a focused lens of *wellbeing* and what people need in Rutland to help them when they are ill and to live healthy lives;

- The **Future Rutland Conversation**[4] undertaken by Rutland County Council and
- ***What Matters to you?***[5] research conducted by Healthwatch Rutland.

2.6.1 Key themes

The following table shows what people have told us. What you have said has greatly influenced this Strategy and shaped the priority themes in section 4:

4 Future Rutland Conversation, 2021, Rutland County Council, https://future.rutland.gov.uk

5 What Matters to You? Our report on what people in the county want from Place-based Health and Care , 2021, Healthwatch Rutland, https://www.healthwatchrutland.co.uk/report/2021-08-19/what-matters-you-report

You said…..

LOCALITY

- Preference for local services for adults and children, some are less keen to travel to city/ out of the county to access care
- Community hospitals are seen as important part of "closer to home" care, Rutland Memorial Hospital should remain open and needs to be better utilised
- Concerns around removing current services and need for an improved public transport for some if travel is necessary
- Simplified and fair access to health and care for people living on county boundaries
- More opportunities for peer recreation and employment for young adults who are less abled

ACCESSIBILITY

- Aging population is of concern in relation to services e.g. East Midlands Ambulance; access to being diagnosed and getting treatment, e.g. Dementia and mental health
- Waiting times need improvement, e.g. non-emergency transport, pharmacies and mental health services; growing population having an impact on accessibility
- Concerns around the "home first" approach; the package of care and paying for care; pressure on family/neighbours
- Provision of integrated and regular public transport service to access care (including for less abled children and adult) in and out of county and stay connected to recreating and sporting activities

GP SERVICE

- Being treated respectfully by members of staff at the practice
- Getting through on the phone easily without the barriers of long recorded messages
- Booking appointment with the GP or health professional in a way that is appropriate to my condition – considering that some condition do lend themselves to digital appointments, others do not
- Increase provision of self-help and prevention, particularly for people who are in poor health. Support to improve health literacy

DELIVERING CARE

- Time required to build relationships, building confidence in new healthcare solutions; some are feeling lonely and isolated
- "Joined-up way of working" between services and across borders to deliver care. Also integration of mental and physical health services
- Care at home is preferred but no confidence, some feeling there is no clear "end of life" path
- High quality of care, provided by appropriate, well trained staff
- Mental health and provision of high quality local services including self help and guidance which is easy to access. Provision of high quality information on managing conditions. Improved promotion of mental health support , with quicker response times, services provided by appropriate staff with consideration of the needs of family members and the vulnerable. Delivery of services in appropriate way with careful balance of digital and non-digital to ensue loneliness and isolation are not exacerbated if people don't have social community connections

COMMUNICATIONS AND BUILDING RELATIONSHIPS AND COMMUNITIES

- People and families at centre of decision making
- Education and support for people who are unable to engage digitally
- Build and empower communities to support services and enhance care
- Empowering people through improved communications with people at all stages of the care journey including prior to illness through to discharge.
- Ensure messages are delivered by a trusted and respected source, known to people, delivered in a way that is seen as personal and relevant
- Enhanced relationship between staff across services to support a seamless journey
- Improved awareness of services available locally

3. Vision and Approach

3.1 Strategic vision and goal

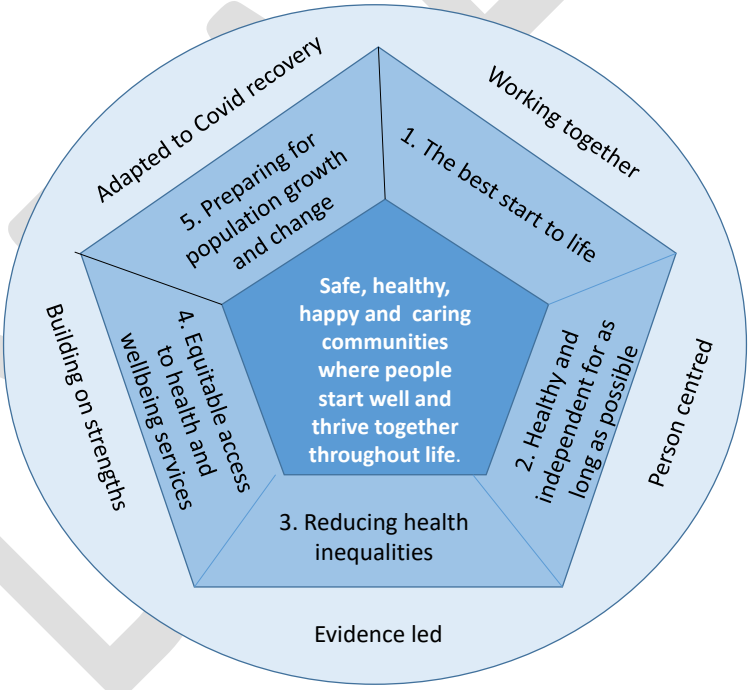
Good health is the result of much more than clinical healthcare. It is also the product of our circumstances, our lifestyles and choices, our environment, and our engagement with the communities in which we live. Our overall vision is to nurture **safe, healthy, happy & caring communities in which people start well and thrive together throughout their lives**.

The essence of the strategy's goal is **'people living well in active communities'**.

3.2 Our Strategic Approach

Our strategic approach for the next three years has five priority areas for action. These priorities are not standalone; they are mutually supported and may have interrelated actions where relevant to ensure the greatest overall impact on health and wellbeing outcomes.

Figure 2 Summary of priorities and principles



4. Priority Themes

Priority 1: The best start in life

Priority 1: The best start in life recognises that a stable and supportive childhood sets the foundation for future physical and mental health. "Positive early experiences provide a foundation for sturdy brain architecture and a broad range of skills and learning capacities. Health in the earliest years—beginning with the future mother's well-being before she becomes pregnant—strengthens developing biological systems that enable children to

thrive and grow up to be healthy adults."[6] Disruptions to early healthy development can have the opposite effect, leading to lifelong impacts on learning, health and wellbeing.

Creating a positive environment starts at home, and extends into many aspects of our communities and services. Young people must have the emotional and physical well-being to navigate and prosper in a challenging modern life.

Where we are now and what do we want to achieve?

Rutland performs similarly to the national average for several indicators related to the early years. However, there is a significantly higher proportion of secondary school pupils with special educational needs in Rutland with 14.0% in 2018 compared to the England value of 12.3%.Therefore, although most children and young people start out well in Rutland, some face challenges which can impede their healthy development and affect their future potential.

We will work together to further strengthen our approaches in 2022-25 to ensure that all children and young people get the best start in life that they can. Future plans to work together are being brought together into a renewed Children's and Young People's Partnership Plan for Rutland which will run alongside and inform this Plan.

Priority 2: Staying healthy and independent for as long as possible

Good health and social wellbeing is an asset to individuals, communities and the wider population. Maintaining good health and social wellbeing throughout our life will allow Rutland the opportunity to have active communities that live well. Hence we must acknowledge and consider the wider determinants of health and that Rutland has an aging population, so ensuring older people live with good health and social wellbeing for as long as possible will benefit the whole population.

Where we are now and what do we want to achieve?

The Rutland population enjoys better than average health and a lengthy life expectancy. However, we also face some challenges. The percentage of those offered a NHS health check in 2016/17-2020/2021 in Rutland was significantly worse than the national average; this could represent a missed opportunity for early diagnosis and treatment. The dementia diagnosis rate in 2020 for Rutland was significantly worse than the target of 66.7%.

We want people in Rutland to live long and healthy lives. This is a broad area of work, aiming to embed prevention in everything we do, increase the opportunities for people to maintain good health and create lively and inclusive communities where people live healthy lives, supported when needed by preventative interventions including social prescribing which reconnects people with the goals that motivate them and empowering people towards self care.

[6] In brief: the foundations of lifelong health, Harvard University, 2021, Center on the Developing Child https://developingchild.harvard.edu/resources/inbrief-the-foundations-of-lifelong-health/

Should people develop ill health, timely support is there to ensure this does not dominate their lives and to allow them to stay independent for as long as possible. Coordinated care involves them and supports them to live well. At the end of life, people can be confident that high quality services are there for them.

Priority 3: Reducing health inequalities across Rutland

"Health inequalities are the **preventable, unfair and unjust differences** in health status between groups, populations or individuals that **arise from the unequal distribution of social, environmental and economic** conditions within societies" (NHS England) [5]

In large part, Rutland is a healthy place to live. However, not everyone enjoys the same prospects for health and wellbeing. Health inequalities are underpinned by social determinants of health, which are determined by the broad social and economic circumstances into which people are born, live, work and grow old. Hence those living in the most deprived areas often have poorer health outcomes, as do some ethnic minority groups and vulnerable/socially excluded people. In addition, the most disadvantaged are not only more likely to get ill, but less likely to access services when they are unwell. This is known as the inverse care law.

Where we are now and what do we want to achieve?

Although Rutland is an affluent County, there are health inequalities that exist between different geographical areas and groups within Rutland. To ensure all people in Rutland have the help and support they need, we will focus on some groups as a priority over the time of this strategy, for example the military and prison populations or the farming communities. We will embed a 'proportionate universalism' approach to services, meaning there will be a universal offer of services to all, but with equitable variation in service provision in response to differences in need within and between groups of people, that will aim to 'level up' the gradient in health outcomes to those achieving the best outcomes across Rutland.

Priority 4: Ensuring equitable access to services for all Rutland residents

The aim of this priority is to understand and take steps to ameliorate some of the inequities that are faced in Rutland in the ability to access services. This has a number of aspects which are set out below.

NB: The sufficiency of GP services is also addressed in Priority 5, which looks at evolving services in response to a growing and changing population.

Where we are now and what do we want to achieve?

Rutland is a rural county that borders a number of other local authorities and healthcare systems, and has no acute healthcare facilities within its boundaries. This creates challenges for many in accessing services which can often be distant, requiring long travel times.

The challenge of accessing services in Rutland is one of the public's most frequently raised health and care issues. While we cannot entirely remove the challenges around access to

services, we will work to improve access to health and wellbeing services and opportunities, by working on a number of dimensions of this problem:

Equity of access to services across borders is a challenge for Rutland. The Council can only provide statutory services to people defined as living in Rutland, but some people registered with the Rutland GP practices live outside the area, and require other solutions if a Council service is needed. Likewise, some people living in Rutland are served by GPs outside the county. This can lead to inequities between the health and care support available to different residents and patients.

The aim of is to bring a wider range of planned and diagnostic health services closer to Rutland residents to reduce the distances that need to be travelled. We will also be working to improve access to primary and community health and care services in Rutland, including community pharmacy.

Improving access to services and wider opportunities for people less able to travel, including through increased use of technology where appropriate but recognising suitable options need to be in place for those who are vulnerable or isolated or do not have access to suitable technology will struggle.

Priority 5: Preparing for significant population growth and change

Where we are now and what do we want to achieve?

The overall population of Rutland is projected to grow by 5% to 42,277 by 2025 (an increase of 1,890 residents) additional demand for health and care services is expected particularly in Oakham and Empingham, requiring capacity to be increased.

The population is also ageing, requiring expansion of some services more than others, and posing the need for the health and care workforce to keep pace. Our young people are an important asset in that regard.

A **Primary care Estates Strategy** is already in development, with joint work underway with local GP practices and the Council to understand local issues and solutions, including consideration of the cross-border impact of changes to GP services in Stamford. Planning takes place against population change predictions and housing growth plans which are currently in flux. During the duration of this Plan, we will take opportunities to review the trajectory of developments alongside the Local Authority and Vol sector Asset reviews.

Readiness in terms of infrastructure only goes so far if we do not work actively to develop a health and care **workforce of the future** that keeps pace in terms of size and skills to deliver future models of care.

6. Rutland Health and Wellbeing Delivery Action Plan

Whilst we have been careful to select priorities for the plan that reflect the future need as well as the present, inevitably these may change over time. For this reason, our partnership action planning will be reviewed on an annual basis, with HWB approval to ensure these priorities are still the right ones. This action plan will be supplemented by a specific implementation plan for 2022-23 with clear commitments and timescales from the various participating partners.

We will develop a dashboard to monitor progress against this plan with SMART performance measures and we will provide regular performance reports and regular progress updates to the HWB.

We will also share our progress with you and celebrate our successes by publishing an annual report each year and promoting its findings through the partnership and community events.

Ref	Action Areas	High level actions
Priority 1: Enabling the best start in life		
1.1	Healthy child development in the 'First 1001 Critical Days', including support for parents and key groups such as military and low income families	* Develop a plan for Rutland, tailoring the First 1001 Critical Days approach to Rutland's needs, supporting healthy child development. * Awareness building around the critical 1001 days. * Clear Start for Life offer for parents and carers, showing families what support they can expect to receive during the 1,001 critical days from conception to age two.
1.2	Supporting confident parenting to enhance children's and young people's health	* Effective implementation of 0-19 Healthy Child Programme. * Helping families to instil positive lifestyle habits and make best use of health services. * Supporting informed take-up of preventative services by families - immunisation for mothers, children and young people (e.g. HPV, flu, Covid-19 a appropriate), dental check-ups - evolving based on take-up data and current guidance. Awareness raising about the best clinical services to call on for different circumstances. * Factoring learning about the impact of the pandemic into the design and delivery of services for families.
1.3	Building emotional and mental resilience in children, young people and parents	* Coordinated changes with the wider LLR ICS service design work on mental health services, following the wide public consultation which finished at the end of August 2021. * Build on positive recent work on mental resilience for children and young people in Rutland, and learning about the impact of the pandemic, in the delivery of mental health support and services for children and young people. * Increasing local resource to respond to children and young people's mental health needs.

Ref	Action Areas	High level actions
Priority 2: Staying healthy and independent for as long as possible		
2.1	Making it easier for people to take an active part in their communities	* Further development and visibility of the Rutland Information Service as a reliable and accessible source of information about opportunities in communities across Rutland - for the public and sign posters. * Further strengthening of collaborative relationships across the voluntary, community and faith sector, also working with wider services ensuring people can easily access the most relevant support for them. * Increase active volunteering, including through a volunteering marketplace, building on experiences in the pandemic. * Community development encouraging the formation and confident operation of new groups across Rutland for shared interests (local or thematic). * Empower people towards self care
2.2	Encourage greater take up of preventative health services (immunisation and screening)	* Promotion of immunisation in accordance with evolving policy (Covid-19, flu, shingles, etc.) * Promoting health screening, including for earlier diagnosis of cancers and coronary and pulmonary disease (CPD). To include wider opportunities for blood pressure checking as an early indicator of CPD in collaboration with primary care.
2.3	Preventative interventions enabling people to maintain their physical and mental health through active lifestyles, weight management and mental wellbeing	* Social prescribing e.g. via the RISE team, helping people to refocus on what matters to them to improve wellbeing. Particular focus on people with multiple long term conditions and/or facing mental health challenges. * Improved signposting and 'healthy conversations' skills across more of the health and care workforce. * Exercise referral and promotion of active opportunities makes it easier for people to increase their activity levels in a way that works for them. * Post-pandemic, increased availability of weight management support, delivered in ways that people find motivating. * Expansion of capacity in local low level mental health services and closer working between involved local agencies and services, including in the VCF sector and peer support, so more people access help sooner in their journey. * Opportunities to develop resilience skills, e.g. through the Recovery College.
2.4	Supporting healthy ageing, including reducing frailty and falls in the over 65s	* Information and advice supporting people to adapt their self-care as they age for optimum health. Including awareness raising about strength and balance preventing falls, and equipping people for what to do in case of a fall to minimise avoidable consequences. * Increasing relevant self-care opportunities including exercise for strength and balance and peer support. * Working together to develop and strengthen interventions reducing the likelihood of falls injuries.

Ref	Action Areas	High level actions
2.5	Living well with ill health or multimorbidities – across all ages, and including people who are housebound or live in care homes	* Further embedding multi-disciplinary working across teams involved in the care of people living with multimorbidities, whether at home or in care homes, including across the GP practice, pharmacy, community health, and social care. * Building up closer working and collaboration across organisational boundaries in nursing and therapy. * Holistic approaches enabling quicker access to the right services for new presentations. * Embedding use of the forthcoming electronic Shared Care Record to support coordinated, fully informed patient care. * Enhancing coordinated care planning, including with specialist support for the most complex patients. * Holistic proactive care for high-risk patients to include social prescribing referrals, helping people to live better with ill health. Empowering individuals as active participants in shaping their care. Using feedback to understand what works.
2.6	Access to high quality palliative care at the end of life	* Working together to support people and their families at the end of their lives, including continuity of care and increased likelihood of dying in the place of their choosing. * Full and confident embedding of the ReSPECT process to capture and share wishes for care, and increasing coverage of advance care plans for those likely to be in the last year of life.
Priority 3: Reducing health inequalities		
3.1	Improve support, advice and community involvement for carers	* The County's Carers Strategy is being reviewed currently and actions will follow through on the outcomes of this exercise, but could include: * Identifying more carers so that that they can be offered the advice and support they need to sustain their caring role and increase peace of mind, including accessing relevant benefits and putting in place contingency planning in case they are incapacitated. * Promoting take-up of health checks for carers. * Opportunities for carers to increase their social contact, including through technology where appropriate.
3.2	Improve diagnosis rates, especially for early diagnosis, targeting those less likely to come forward	* Use the Health and Wellbeing Coach and other routes to increase cancer screening uptake including mammograms, bowel screening and cervical screening. * Better understand why some groups don't respond to preventative offers, to enable specific targeting of non-responders and increase take-up and positive outcomes. Key groups could include people on low incomes and those less able to travel.
3.3	Healthy, fulfilled lives for people of all ages living with learning or cognitive disabilities or impairments, or dementia	* Further strengthening of opportunities in Rutland for people with learning disabilities to have healthy, fulfilled lives and be a full part of Rutland's communities. * Wherever possible, pursuing creative solutions enabling people with significant disabilities to be cared for in Rutland rather than having to go out of area. * All relevant agencies acting on the lessons of the national LeDeR

Ref	Action Areas	High level actions
		programme about priorities for improved care for people with learning disabilities. * Continuing Admiral Dementia Nurse support for people with dementia and their carers, including ensuring they are not disadvantaged in their access to health services for their wider health.
3.4	Improve access to services for people facing inequalities and tailor services to better fit their needs	* Consideration of equality champions to ensure equity is considered across key services. * Work to ensure appropriate access to health services for military personnel and their families who face distinctive circumstances and may be using pathways into planned care which are less well established than for the civilian population. * Responsiveness to the needs of further groups which may be small in number but whose situation or outcomes may be worse than the general population e.g. Mental health in the farming community and those bereaved or otherwise impacted during the pandemic, people living with significant mental illness and/or homelessness.
Priority 4: Ensuring equitable access to services for all Rutland residents		
4.1	Increase equity and inclusion of access to key services across Rutland's borders	* Where areas of inequity are identified due to cross border issues, agencies will identify low-overhead solutions that mean that people can be referred to the right service for them and not be unfairly disadvantaged. * This includes strengthening relationships with neighbouring Council areas and health systems to ensure swift onward referral to equivalent services, and exploring preferred provider arrangements to enable the Council in some cases to provide non-statutory services to non-residents with a Rutland GP. * Engagement with neighbouring health and care systems whose services are actively used by Rutland residents, directly or via ICS engagement, to ensure visibility of Rutland needs.
4.2	Increase the availability of diagnostic and elective health services closer to the population of Rutland for patients of all ages	* Improving public information about available services as part of increasing access (e.g. including when mobile facilities such as the mobile breast screening unit are in the area). * An LLR review of diagnostic services is underway whose aim is to bring more services closer to the population, reducing the need to travel to acute hospital sites.
4.3	Improving access to primary and community health and care services	* Creation of a PCN Patient Participation Group with representation from all four practices to support two way conversation and active listening to patients and the public. * Improved website and social media presence to share relevant information, with parallel communication improvements for the non-digital audience. * Ensuring full use of a range of specialist primary care roles tailored to needs (e.g. practice pharmacist, muscular-skeletal first contact, health coach). * Encouraging LLR services commissioned from third party providers to be offered directly in Rutland including through venue support.

Ref	Action Areas	High level actions
4.4	Improving access to services and opportunities for people less able to travel, including through technology	* Targeted work to increase digital inclusion for people who would benefit from using technology to access services.
Priority 5: Preparing for our growing and changing population		
5.1	Developing 'fit for the future' health and care infrastructure	* We will work together to plan services relative to our growing and changing population. * A primary care estates strategy is in development, planning relative to anticipated population change.
5.2	Health and care workforce fit for the future	* Analysis to understand workforce trends including trajectory of attrition by retirement. * Measures to retain skilled people in key professions and to increase entrants. * Consider projects to increase career development and satisfaction for retention e.g. via delegation of health tasks to care workers, transition from carers to nursing associates. * Increase engagement with local young people around careers in health and care, including through collaboration with schools and opportunities for work experience.
5.3	Health and equity in all policies: consideration in all strategies and policies of their impact on mental and physical health, health inequalities and climate change. In particular the built environment.	* All partners to consider an approach in which health and care impacts are considered in all policies, not just those directly related to health and wellbeing, as areas such as transport, housing, planning, economic development, human resource management, nature conservation, etc can contribute significantly to creating an environment in which people can thrive.

This page is intentionally left blank

Rutland Health and Wellbeing Board Work Plan 2021/22			
Meeting Date	**Publication Date**	**Proposed Item**	**Author**
22/06/21	14/06/21	Our Approach to Integrating Care	Fay Bayliss
		The Integrated Care System Journey	Amit Sammi
		Working Inside Out	Emma Jane Perkins
		BCF: Update	Sandra Taylor
05/10/21	27/09/21	LLR LDA 3 Year Plan **(TO BE FIRST ON AGENDA)**	K Sorsky
		~~Pharmaceutical Needs Assessment Report (tbc)~~	~~S L Hope~~
		Place Led Plan: Draft	JNM/Sarah Prema
		ICS Purpose, Principles and Priorities	JNM/Sarah Prema
		LLR Health Inequalities Framework	Mark Pierce, LLR CCGs
11/01/22	31/12/21	Final Rutland Health and Wellbeing Strategy (Place Led Plan) inc. draft delivery plan	JNM/Sarah Prema
		Social Care White Paper: Update	
		Better Care Fund: Update	Sandra Taylor
		Pharmaceutical Needs Assessment Report (tbc)	S-L Hope
05/04/22	28/03/22		

Possible Items:

- Pharmaceutical Needs Assessment Report (tbc) (SL Hope) – postponed to either January or April meeting.

This page is intentionally left blank