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

DRAFT

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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

20th November 2017 to 16th November 2021

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

[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

social care outcomes for Rutland's population. The HWB is a statutory committee of the 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.

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[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

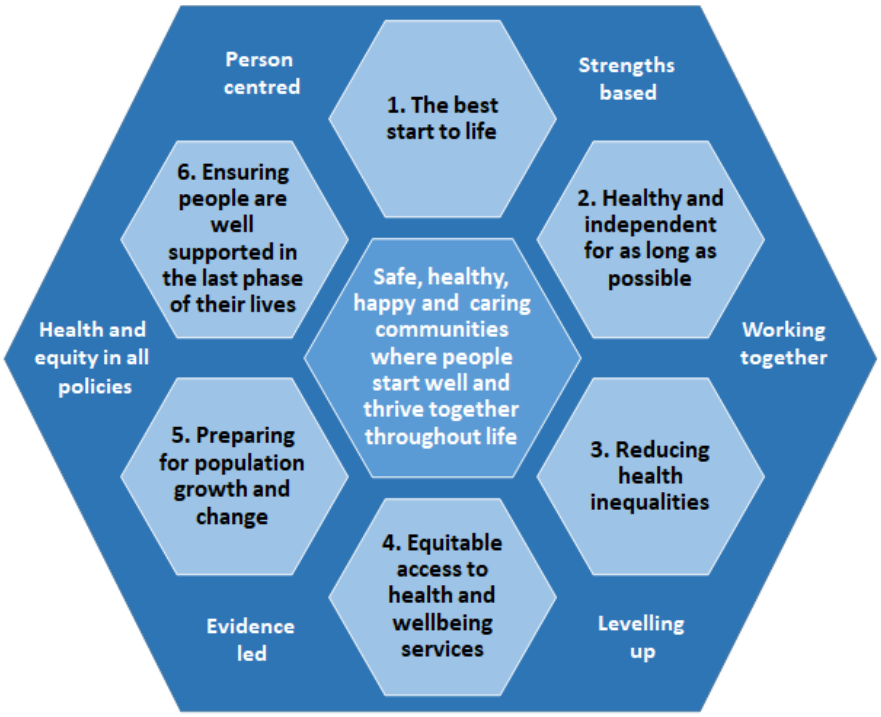
Good health is the result of much more than clinical healthcare. It is also the product of our circumstances, our lifestyles and choices, our environment, and our engagement with the communities in which we live. Our overall vision is to nurture **safe, healthy, happy & caring communities in which people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

Priority 6: Ensuring people are well supported in the last phase of their lives

The aim of this priority is to support and care for people to live well during the last period of their life, and to ensure those important to them are given the support during this phase and after the death of a loved one. This support is needed whether that is a sudden or an

expected death following a life limiting diagnosis. The aim is to support people to comfortably, proactively plan ahead for the end of their life by working in partnership with the person, family, services and the local community. This priority aims to normalise end of life as an important part of the life course and extends the support to their carers and families throughout this period and into bereavement.

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

Rutland currently performs significantly higher than England for the percentage of deaths that occur in care homes and significantly lower than England for the percentage of deaths occurring in hospital and in a hospice. In terms of premature mortality,
the highest percentage of deaths from the indicators presented on the underlying causes for the under 65 age group were Cancer (50.0%), followed by Circulatory disease (22.2%).

We want to ensure that people are supported to be care for and where possible die in the place of choice with the people around them whom they are familiar with. We want to support people in Rutland to have as good a quality as life for as long as possible irrespective of the life limiting conditions. We want people to feel comfortable to have conversations about end of life care planning when they are well and that their wishes are clearly documented to ensure they get the right for care and support at the end of their lives. We want to support the carers and families when they are caring for a loved one who is nearing the end of their life, and after their bereavement to enable them to regain their independence and lives after caring for someone who has died.

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.
Priority 6: Ensuring people are well supported in the last phase of their lives		
6.1	TBC	