Rutland Joint Health and Wellbeing Strategy: The Rutland Place based Plan 2022 – 2027

Foreword

Rutland is a very special community in which to live, work and study. The Rutland Joint Health and Wellbeing Strategy sets out our vision to create a place where we all work together in partnership to improve health outcomes and opportunities for all our residents.

The past two years have tested our community like no others; we have lost friends and family and our frontline staff have been tested to their limit. And yet, the community spirit of Rutland has risen to the challenge. Many ways of partnership working we thought impossible have been achieved. These are the seedlings through which our integrated care strategy can grow.

As we emerge from the pandemic and with the reorganisation of Health and Social Care, we have the opportunity to develop a system for us all.

This strategy sets out our vision and commitment, and is a living document that will grow as we need it with the voice of our community at its heart.

I would like to thank the Health and Wellbeing Board and all of our colleagues and partners for their time and commitment developing this strategy, especially as it was produced during the peak of the pandemic. Special thanks also go to all our community who took the opportunity to feed in their own experiences and views, and develop its heart.

Together we can build an ever healthier community for Rutland.

Councillor Samantha Harvey
Rutland County Council Portfolio Holder for Health, Wellbeing and Adult Care,
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 five 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) (January 2019)**: The LTP created Integrated Care Systems (ICS), giving a platform for partnership working and integration. Across the Leicester, Leicestershire and Rutland (LLR) system, we are now approved as an 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 (January 2021):** 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. At the Place level, i.e. for the Leicester, Leicestershire and Rutland local authority areas respectively, local partnerships are responsible for developing 'place led plans' to meet the population's health, public health, and social care needs. This Joint Health and Wellbeing Strategy (JHWS) is the 'place led plan' for Rutland, and 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** – This programme represents a significant and ambitious capital investment **change** programme for the University Hospitals Leicester (UHL), which 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 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 use of Rutland community assets are imperative to 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 an 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 five 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 through surveys, focus groups and interviews, including analysis of levels of happiness and satisfaction with life (e.g. for users of social prescribing services).
- National datasets 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, prevalence of specific diseases and uptake of screening programmes and immunisations.

[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

- 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 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.[2] The total GP registered population of Rutland was 40,710 as at July 2021.[3] 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*".[4] This recognises the social model of health (as defined by Dahlgren and Whitehead (1991)[5]) 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 that all factors except for age, sex and hereditary factors are modifiable to change, and therefore lie 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[6].

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).[6] Specific groups in Rutland are also known to have poorer outcomes than the wider population, including people living on low incomes, SEND children, the Armed Forces community, the prison population, carers, people living with learning disabilities and some farming communities.

[2] Source: https://www.ons.gov.uk/releases/nationalpopulationprojections2018based
[3] Source: https://digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice
[4] Health Psychology: Theory, research and practice (5th Edition), London: SAGE, (2018), Marks, D et al.
[5] 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.
[6] Source: https://fingertips.phe.org.uk/profile/public-health-outcomes-framework

2.4 Overview of Health - Children

Overall, health outcomes for children in Rutland 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%.[7]

However, there are a number of areas where Rutland performs significantly less well than the England or benchmark averages, including low birth weight babies at term, visible tooth decay in 5 year olds, and school readiness in females receiving free school meals.**Error! Bookmark not defined.** The percentage of children in care who are up to date with their vaccinations in Rutland has also decreased since 2017 and has remained significantly worse in comparison to England since 2019.

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.[7]

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[7]. 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.[8] 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 residents' needs, we have reviewed insights and intelligence collected through ongoing engagement, involvement and consultation over recent years. We have examined existing local reports, produced by NHS bodies, Rutland County Council and other local organisations, which represent feedback from local people - including staff, patients and carers. In addition, recent LLR consultation and engagement findings were taken into account:

- Building Better Hospitals consultation (Leicester Hospitals Reconfiguration published in May 2021)
- Step Up to Great Mental Health consultation (published late Autumn 2021)
- Primary care engagement (published September 2021)

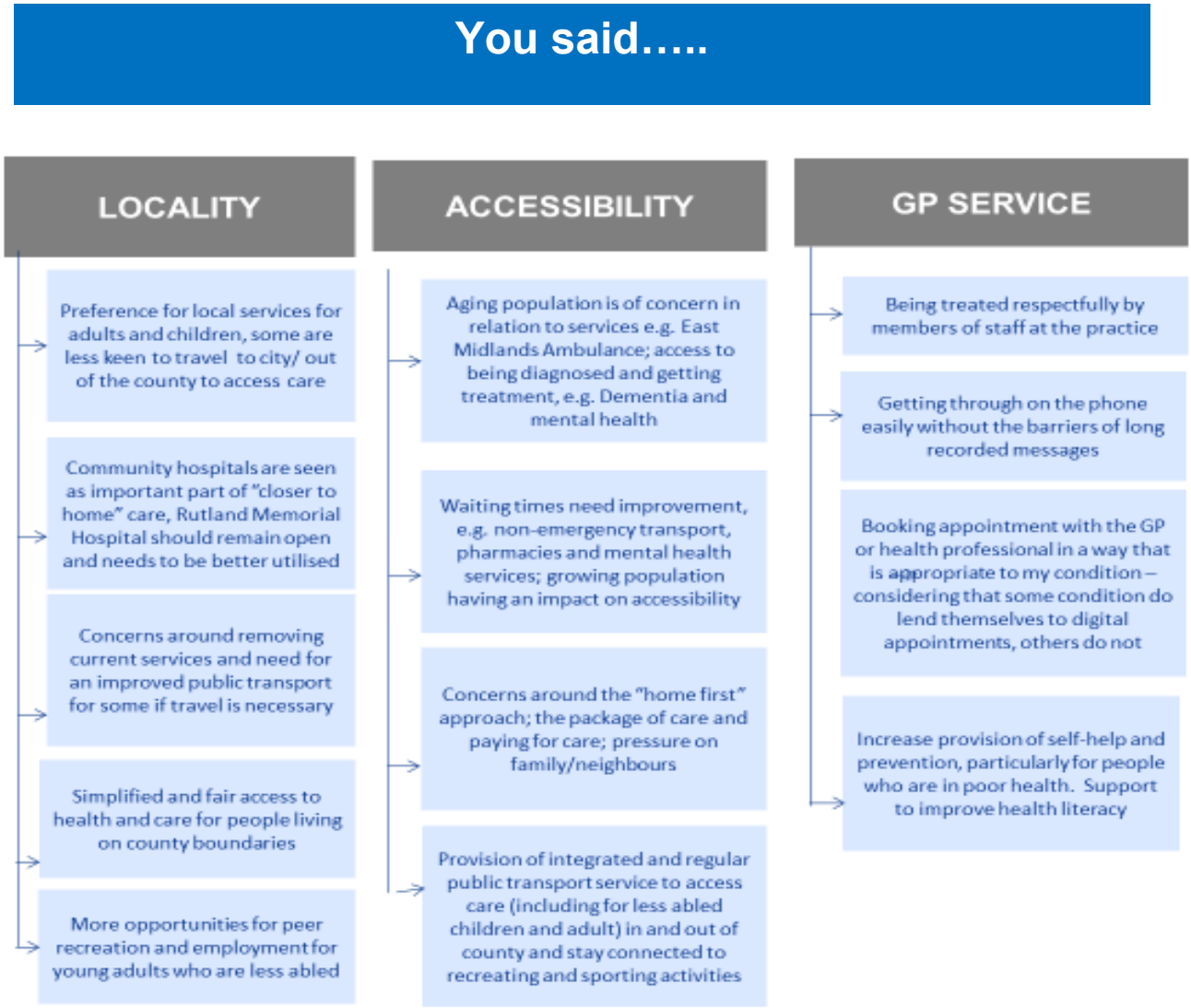
[7] Source: https://fingertips.phe.org.uk/
[8] Source: https://fingertips.phe.org.uk/profile/nhs-health-check-detailed/data#page/1/gid/1938132768/pat/6/par/E12000004/ati/102/are/E06000017/yrr/1/cid/4/tbm/1

- 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 in the **Future Rutland Conversation**[9] undertaken by Rutland County Council and ***What Matters to you?***[10] research conducted by Healthwatch Rutland. In November 2021-January 2022, the public were also consulted on the draft of this strategy.

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.



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

[10] 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

3. Vision and Approach

3.1 Strategic vision and goal

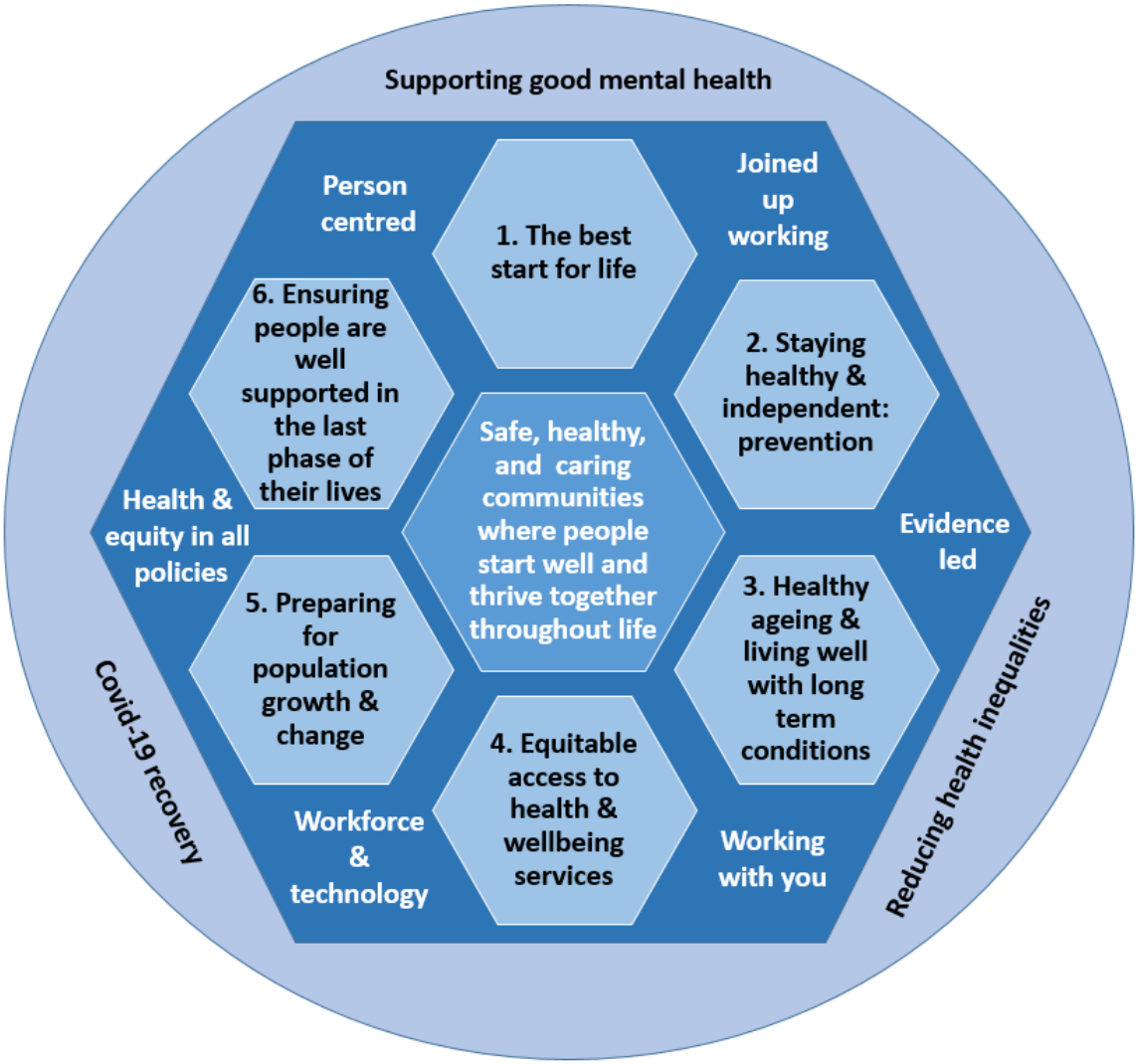
Good health is the result of much more than clinical healthcare. It is also the product of our circumstances, our lifestyles and choices, our environment, and our engagement with the communities in which we live. Our overall vision is to nurture **safe, healthy and caring communities in which people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

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

3.2 Strategic Approach

Our strategic approach for the next five years has seven 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: The strategy, illustrating its vision, priorities, principles and enablers, and cross-cutting themes



This strategy has also been built around a number of guiding principles and key enablers that will support its delivery.

3.2.1. Guiding Principles

- **Person centred.** People told us they want a plan that is built around them as individuals, whatever their circumstances, that supports them to live independently with good health and wellbeing. This will mean that significant engagement will be needed with local residents, listening to and learning from those with relevant lived experience.

- **Joined up working.** We will build on Rutland's strong track record of integration and partnership to shape and deliver effective joined-up services, including to achieve value for money. This includes building on our strong community led, strength-based approach to improving outcomes for and with local residents. We will use our combined resources to deliver the best value and outcomes in Rutland and will consider relevant

funding sources and shared resources where this can enable us to improve outcomes through targeted and more collaborative delivery action whilst enhancing partnership working. We will also continue to work closely with voluntary sector partners, business and specific communities (including the armed forces, travelling families and rural farming communities) to understand and effectively respond to their strengths and needs.

3.2.2. Enablers underpinning Plan Delivery

- **Evidence-led.** We will be evidence-led, calling on a wide range of sources of data to cast light on the health and wellbeing situation and challenges in Rutland. We will also generate evidence around what works by monitoring and evaluating services and interventions. This will help to ensure we target actions in the right way and to those who need them most. We will renew the core Rutland Joint Strategic Needs Assessment (JSNA), using new Census data available from April 2022. This will offer a baseline for the Strategy and will be supplemented with periodic thematic chapters, guided by the Rutland Health and Wellbeing Board, supporting the design and targeting of health and wellbeing interventions and informing funding decisions across Rutland bodies.

- **Working with you through ongoing engagement, consultation and co-production.** We will develop an engagement plan to run alongside this delivery plan addressing ongoing engagement (sharing of information), consultation (eliciting of views) and co-production (co-creation of solutions). The engagement plan will seek to ensure that the delivery plan is informed by an ongoing process of listening to what residents need from their local services when they are ill and to live well. This will include an equalities dimension to better understand seldom heard groups with lower uptake or worse outcomes so that the design and promotion of interventions can be tailored to be more inclusive. Users of services will also be involved in the co-design of interventions to tackle needs, working alongside other stakeholders. We will work together to strengthen co-production as an approach to design and problem solving, working with organisations like HealthWatch Rutland.

- **Workforce development.** Our workforce is a valuable asset to drive change and improve health and wellbeing outcomes across Rutland. However, we know it is under additional pressures due to growing needs and the COVID-19 pandemic. We will therefore continue to build and develop our integrated workforce, making Rutland an attractive place to work and thrive.

- **Information sharing, supported by technology.** Patients and service users often complain about having to tell their story multiple times. In parallel, health and care professionals involved in a person's direct care can find it difficult to access the information they need to support that person effectively. We are committed to using technology and appropriate information sharing effectively to guide and inform patient care, so that people can be better served.

- **Health and equity in all policies and plans.** The Health and Wellbeing Board will be asking all partners to consider making an ongoing commitment to systematically consider the impact of their plans and interventions on health, wellbeing and equity, so that more opportunities are taken to make Rutland a healthy place to live for everyone.

3.2.3. Cross-cutting Themes

A number of cross-cutting themes have also been identified which interlink with multiple priorities across the strategy. These themes - addressing mental health, reducing inequalities and COVID-19 recovery - have been collected together as a seventh priority (see Section 4).

4. Priority Themes

Priority 1: The best start for life

The best start for 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."[11] 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. Children and young people must have the emotional and physical well-being to navigate and prosper in society.

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

Rutland performs similarly to the national average for several indicators related to early years, children and young people. 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%.**Error! Bookmark not defined.** Therefore, although most children and young people start out well in Rutland, some face challenges which could impede their healthy development and affect their future potential. There are a number of other areas where Rutland performs significantly less well than the England or benchmark averages, including low birth weight babies at term, school readiness in females receiving free school meals and visible tooth decay in 5 year olds.**Error! Bookmark not defined.** The public also highlighted a number of further opportunities for improvement, including a wish for enhanced information about children's and young people's services, the practical challenges of accessing distant appointments with children, and a need for quicker and

[11] 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/

easier access to dental and mental health services. Families also indicated they wanted to be at the centre of any decision-making relating to them.

We will work together to further strengthen our approaches in 2022-27 to ensure that all children and young people get the best start in life that they can. This will include prioritising the first 1,001 critical days (from conception to aged 2 years), supporting confident families and young people, and having access to the health services. 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: Prevention

Good health and social wellbeing is an asset to individuals, communities and the wider population. Maintaining good health and social wellbeing throughout our lives will allow Rutland the opportunity to have active communities that live well. To achieve this, we must look wider than health and wellbeing focussed services to acknowledge and consider a wide range of social, economic and environmental factors which impact on people's health. We must also recognise 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 are we now and what do we want to achieve?

The Rutland population enjoys better than average health and a lengthy life expectancy[12]. However, we also face some challenges. The percentage of those offered an NHS health check in 2016/17-2020/2021 in Rutland was significantly worse than the national average[13]; this could represent a missed opportunity for early diagnosis and treatment. Take-up rates for vaccinations and screening offers are also not uniformly good, meaning that some people are missing out on opportunities to prevent sometimes serious illness or to be diagnosed sooner, when conditions such as cancer are more easily treated. At a more fundamental level, three very effective actions people can take for their health are to move more, maintain a healthy weight and avoid loneliness. Although Rutland performs relatively well here, there is scope to improve in all of these areas, with potentially significant impacts for health and wellbeing.

We want people in Rutland to live long and healthy lives. This broad area of work aims to embed prevention in everything we do, create active and inclusive communities, and increase the opportunities to maintain good mental and physical health. It will support increasing access to preventative interventions, including information and advice, vaccination, screening and social prescribing which reconnects people with the goals that motivate them and empowers them towards self-care

[12] Source: https://fingertips.phe.org.uk/profile/public-health-outcomes-framework
[13] Source: https://fingertips.phe.org.uk/profile/nhs-health-check-detailed/data#page/0/gid/1938132726/pat/6/par/E12000004/ati/102/are/E06000015

Priority 3: Healthy ageing and living well with long term conditions

Evidence suggests that as the number of long-term conditions (rather than age) of an individual increases, so does the level of health and social care support needed and the impact on their health outcomes. When people develop ill health, timely and well-coordinated support is needed to ensure this does not dominate their lives and to allow them to stay independent for as long as possible. People also have a key role to play in their own care, monitoring and managing their conditions to help them to have more good days. Family and friends can also play a critical role as carers and may themselves need support to maintain their own wellbeing alongside their caring role.

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

People of all ages may be living with long term health conditions. Rutland also has an older population, which is predicted to grow over the coming years. While ensuring good care services for people of all ages with impaired health, we also want to support healthy ageing, in particular for those with several long term conditions, complex care or frailty (a state which makes people more vulnerable to serious consequences from fairly minor health events such as an infection or fall). This includes encouraging and enabling earlier diagnosis of conditions. The dementia diagnosis rate, for example, (the proportion of people with a formal diagnosis relative to the number predicted to be living with the condition) in 2020 for Rutland was significantly lower than the target of 66.7%.**Error! Bookmark not defined.**

We also want to work together to ensure coordinated, joined up services that respond to people in the round, not just in terms of their health conditions, and which involve individuals and support and empower them to live well. This priority also addresses the important role of carers and support for those with learning or cognitive disabilities and dementia.

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. Related to this, 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 are we 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 by car and even longer times by public transport.

The challenge of accessing services in Rutland is one of the public's most frequently raised health and care issues, with experiences varying depending on individual factors such as the extent of health need, any access needs, the remoteness of the home address, modes of transport, and time and money available. 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 GP practices outside the county. This can lead to inequities between the health and care support available to different residents and patients. We will work with cross border partners to understand and reduce some of these barriers.

To reduce the overall distances that need to be travelled, we also intend to bring a wider range of planned and diagnostic health services closer to Rutland residents. We will also be working to improve access to primary and community health and care services in Rutland, including community pharmacy. We will also consider the implications of the UHL reconfiguration on Rutland residents specifically.

We will work to improve access to services and wider opportunities for people who are less able to travel, including through access to public transport and increased use of technology where appropriate, while recognising that suitable options need to be in place for those who are vulnerable or isolated or who do not have access to suitable technology.

Priority 5: Preparing for significant population growth and change

For Rutland to remain a great place to live, work and grow we need to ensure the appropriate infrastructure and services are in place to support its current and increasing population.

Where are we 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 local capacity to be increased.[14]

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 in development, with joint work underway with local GP practices, Strategic Health partners 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 Strategy, we will take opportunities to

[14] ONS Subnational Population Projections 2018
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

review the trajectory of developments alongside the Local Authority and Voluntary Sector Asset Reviews to ensure we have a health and care infrastructure that is fit for the future.

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

We will also embed a 'Health and Equity in all Policies' approach across Rutland to ensure that future housing planning and wider infrastructure decisions have due regard to their potential impact on improving health and reducing health inequalities.

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 the loss of someone is sudden or takes place 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 (including young 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 at home, 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%).**Error! Bookmark not defined.**

We want to ensure that people are supported to be cared for and, where possible, to die in the place of their 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 as they can for as long as possible, irrespective of their life limiting conditions. We want people to feel comfortable to have conversations about end of life care planning when they are well and their wishes to be clearly documented to ensure they get the right for care and integrated support at the end of their lives. We want to support carers and families when they are caring for a loved one who is nearing the end of their life, and after their bereavement.

Priority 7: Cross-cutting themes

This priority brings together three cross-cutting themes that interlink with multiple priorities across the strategy as follows:

Supporting good mental health.

Mental health issues will affect at least one in four people at some point in their life. Good mental health is an important part of our overall health and wellbeing, and the impacts of

poor mental health are wide-reaching including lower employment, reduced social contributions and reduced life expectancy.

The NHS Long-term plan and NHS 5 year forward view for mental health have highlighted that mental health has been proportionally under-funded and had insufficient focus through statutory services. The national strategies set out a commitment to achieve parity of funding, esteem and outcomes between mental and physical health needs. A sizeable investment programme is being put in place to enhance and increase support targeting mental health needs including:

- Accessible mental health self-management, guidance and support.
- Joining up mental health, physical health, wider care and voluntary sector support in local geographical areas.
- Increasing access and strengthening offers for children and young people, and for women and families before, during and after pregnancy.
- Earlier intervention for people presenting with early signs of psychosis.
- Psychological offers for the full range of defined mental health conditions.
- Increasing retention and attainment of employment for people with mental health illness.

The LLR vision for mental health of both children and adults across the system is 'We will deliver the right care to meet the needs of individual patients at the right time. We will integrate with health and social care partners to care for people when they feel they have mental health needs'. This strategy will progress the Rutland place specific elements of this work to champion Rutland's needs and support delivery of mental health prevention, care and treatment services that improve local patient experience and outcomes.

Reducing health inequalities across Rutland.

In large part, Rutland is a healthy place to live. However, not everyone enjoys the same prospects for health and wellbeing. "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]. They are determined by the broad social and economic circumstances into which people are born, live, work and grow old and exist between different geographical areas and vulnerable/ socially excluded groups within Rutland.

To ensure all people in Rutland have the help and support they need, we will focus on those living in the most deprived areas and households of Rutland and some specific groups (for example the military, carers and learning disability population and those experiencing significant rural isolation) as a priority over the time of this strategy.

We will embed a 'proportionate universalism' approach to the overall strategy and services, meaning there will be a universal offer 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.

COVID-19 recovery

The Covid-19 pandemic has and continues to be a long and difficult period for everyone in Rutland and will continue to impact on our mental and physical health and wellbeing for some time. This strategy will acknowledge what the local population has been through, and the losses it has felt, and support the population and services to live with Covid-19 in the longer term. This will include harnessing the community spirit and innovation that has emerged throughout the pandemic and maintaining a strong health protection response.

5. Rutland Health and Wellbeing Delivery Action Plan

Building on previous joint working, this strategy provides a new opportunity for a wider range of partners to work together to improve health and wellbeing across Rutland as part of the evolving LLR Integrated Care System. This is a high level strategy that complements and is supported by a wide range of more detailed strategies and plans including: the NHS Long term plan; the national Enhanced Health in Care Homes framework; the LLR Health Inequalities Framework; LLR ICS programmes including 'Step up to great mental health' and Home First; UHL's Building Better Hospitals; the LLR and Rutland dementia and carers strategies; the Rutland Corporate Plan; the Rutland Local Plan; the Rutland Transport Plan; the Rutland Children, Young People and Families Plan, and the Rutland Better Care Fund programme.

It is acknowledged that some actions will be delivered at system as well as place and these will be carefully reviewed through the newly developed LLR Integrated Care Partnership and translated to Rutland by the HWB. The HWB will also evolve its approach to ensure effective support, monitoring, engagement and co-production during implementation of the strategy.

Whilst we have been careful to select priorities for the plan that reflect the future need as well as the present, inevitably needs 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. The overall action plan will be supplemented by a specific implementation plan for each financial year with clear commitments and timescales from the various participating partners.

A dashboard will be employed to monitor progress against this plan with SMART performance measures (Specific, Measurable, Achievable, Realistic, and anchored in a Time frame) and we will provide regular performance reports and 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.

Plan priorities and action areas: Summary

The overall structure of the plan, set out in full in Appendix 1, is as follows.

Priority 1: Best start for life

1.1 Healthy child development in the first 1001 days
1.2 Confident families and young people
1.3 Access to health services

Priority 2: Staying healthy and independent: prevention

2.1 Taking an active part in your community
2.2 Looking after yourself and staying well in mind and body
2.3 Encouraging and enabling take-up of preventative health services

Priority 3: Healthy ageing and living well with ill health

3.1 Healthy ageing, including living well with long term conditions and frailty, and falls prevention
3.2 Integrating services to support people with long term health conditions
3.3 Support, advice and community involvement for carers
3.4 Healthy fulfilled lives for people living with learning or cognitive disabilities and dementia

Priority 4: Equitable access to services

4.1 Understanding the access issues
4.2 Increasing the availability of diagnostic and elective health services closer to home
4.3 Improving access to primary and community health and care services
4.4 Improving access to services and opportunities for people less able to travel
4.5 Enhancing cross boundary working across health and care

Priority 5: Preparing for our growing and changing population

5.1 Planning and developing fit for the future health and care infrastructure
5.2 Health and care workforce fit for the future
5.3 Health and equity in all policies, including developing a healthy built environment for projected growth

Priority 6: Dying well

6.1 Each person is seen as an individual
6.2 Each person has fair access to care
6.3 Maximising comfort and wellbeing
6.4 Care is coordinated
6.5 All staff are prepared to care
6.6 Each community is prepared to help

Priority 7: Cross-cutting themes

7.1 Supporting good Mental health
7.2 Reducing health inequalities
7.3 COVID-19 recovery

Glossary and Acronyms

A&E	Accident and Emergency
ACG	Adjusted Clinical Groups (tool for health risk assessment)
BCF	Better Care Fund
CAR	Citizens Advice Rutland
CIL	Community Infrastructure Levy
CCG	Clinical Commissioning Group(s)
Core20PLUS5	NHS England and Improvement approach to reducing health inequalities
CPCS	Community Pharmacy Consulting Service
CVD	Cardio Vascular Disease
CYP	Children and Young People
EHCP	Education and Health Care Plan
FSM	Free School Meals
HEE	Health Education England
HIA	Health Impact Assessment
HWB	Health and Wellbeing Board
ICON	Framework to prevent shaking of crying babies (Infant crying is normal, Comfort methods can work, Ok to take 5, Never shake a baby)
ICB	Integrated Care Board
ICS	Integrated Care System
JHWS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
LAC	Looked After Child
LD	Learning Disability
LeDER	Learning from deaths of people with a learning disability programme
LLR	Leicester, Leicestershire and Rutland
LPT	Leicestershire Partnership Trust
LTC	Long Term Condition
MDT	Multi-Disciplinary Team
MECC+	Making Every Contact Count
MH	Mental Health
NCMP	National Child Measurement Programme
NEWS	National Early Warning Score
NHS LTP	NHS Long Term Plan
ONS4	A 4-factor measurement of personal wellbeing
OOA	Out of Area
OOH	Out of Hospital
OPCC	Office of the Police and Crime Commissioner
PCH	Peterborough City Hospital
PCN	Primary Care Network
PH	Public Health
RCC	Rutland County Council
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
RIS	Rutland Information System
RISE	Rutland Integrated Social Empowerment
RMH	Rutland Memorial Hospital
RR	Resilient Rutland

SEND	Special Educational Needs and Disability
SMI	Serious Mental Illness
TBC	To be confirmed
UHL	University Hospitals of Leicester
VAR	Voluntary Action Rutland
VCF	Voluntary Community and Faith
VCS	Voluntary and Community Sector

Appendix 1: Delivery Plan