Rutland Joint Health and Wellbeing Strategy

Appendix 1: Initial Place Based Delivery Plan 2022 – 2027

V1.0

February 2022

Contents

The Rutland Joint Health and Wellbeing Strategy Delivery Plan

This Delivery Plan sets out the programme of work through which the Rutland Joint Health and Wellbeing Strategy (JHWS) 2022-27 will be delivered. The plan should be viewed in conjunction with the JHWS. Please note the following:

- In keeping with the collaborative nature of this Strategy, further joint work is anticipated to finalise these plans, and the plans will therefore be subject to some further change, including to timescales. Governance structures are being adjusted to support delivery of the Strategy, including through thematic sub-groups which will work together to prioritise and schedule their actions to a confirmed timetable.
- In common with previous JHWS, this plan brings together and influences the spending plans of its constituent partners or programmes (including the Better Care Fund), and will enhance the ability to bid for national, regional or ICS funding to drive forward change. The JHWS, in setting out shared priorities across health and care partners, is intended to support and inform commissioning of local health and care services for 2022-27. It is not associated at this stage with new recurrent funding.
- While lead organisations are identified at a high level below, many of the plans will be implemented through the participation or collaboration of wider groups of partners.
- After July 2022, when the Leicester, Leicestershire and Rutland (LLR) Integrated Care System is fully operational, the LLR Clinical Commissioning Groups (CCGs) will transition to the LLR Integrated Care Board (LLR ICB). 'CCG' should then be read to mean 'ICB'.

Priority 1: The best start for life

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB role: Do Sponsor Watch
1.1	**Healthy child development in the 1,001 critical days from conception to 2 years old**						
1.1.1	**Clear 'Start for Life' offer for parents and carers**, showing families what support they can expect during the 1,001 critical days. Including development of family hubs. Feasibility study and project manager appointed.	RCC	RCC General Fund	TBC March 22	Place	• Healthy Together 2.5 year development checks (communication, fine and gross motor skills) • Early Years Foundation Stage Progress Check between 2-3 years of age, including communication and language, physical development and personal, social and emotional development • Attainment of a Good Level of Development (GLD) at the end of reception year, taking into consideration children eligible for Free School Meals (FSM) • Qualitative feedback from parents on feeling supported through 1,001 critical days	Do Do
1.1.2	**Healthy lifestyle information and advice for pregnant women or those planning to conceive,** Including: a) Implementation of MECC+ healthy conversations across prevention services including GP and integrated sexual health service. b) Targeted communication campaigns.	RCC/ CCG/ LPT/ PCN	RCC/ PH budget/ CCG	23/24	System and Place	• Smoking in pregnancy and at time of delivery • Proportion of pregnant women that are overweight/obese • Relevant immunisation rates • Mental health indicator re postnatal depression - number of MECC conversations with pregnant women highlighting possible causes of PND	Sponsor

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB role: Do Sponsor Watch
	c) Increase awareness of postnatal depression and social isolation through midwifery and 0-10 children's public health service. d) Immunisations in pregnancy (flu/Covid) e) Ensuring women are also reached who have chosen to give birth out of area. Link to 2.1.1 communications and 2.2.3 healthy conversations, 7.1.1 Perinatal mental health support.					and provision of information such as that provided by the Royal College of Psychiatrists. • Screening in pregnancy by healthcare professionals - using validated self-report questionnaires, such as the Edinburgh Postnatal Depression Scale [EPDS], Patient Health Questionnaire [PHQ-9] or the 7-item Generalized Anxiety Disorder scale [GAD-7]) as per NICE Guidelines.	Do Do Do Sponsor
1.1.3	**Local implementation of the Maternity Transformation Programme** considering: a) The implications of the UHL reconfiguration (including LGH obstetrics and St Mary's birthing unit) on maternity services for Rutland residents. b) Access to cross border maternity services and implications including relating to funding and the flow of clinical information.	CCGs	LLR LMS Transformation Funding	22/23	Place and system	• Maternity service patient satisfaction surveys • Qualitative feedback re maternity service access, including cross border • Location of Rutland births • Low birth weight for term babies • Infant mortality	Sponsor
1.1.4	**Implementation of 0-19 Healthy Child Programme – 0-10year Public Health service**, to support the Family Hub national Programme. Including: 0-10year mandated child development checks (including 3-4month and 3.5year checks), a digital offer, evidence-based interventions for children (antenatal,	RCC/ PH/ LPT	PH budget	0-10year service starts Sep 2022	Place	• New Born Visits within 14 days • Breast milk is baby's first feed • Breastfeeding initiation and continuation rates • 2.5 year development checks (fine, gross and motor skills) • Healthy Together 2.5 year development checks	Do

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB role: Do Sponsor Watch
	breastfeeding, dental care and peer support for developing active, resilient children, awareness around shaking and head trauma (ICON)), and safeguarding. Consideration of accessibility of related health services, including dental. Specific consideration for military population.					(communication, fine and gross motor skills) • Early Years Foundation Stage Progress Check between 2-3 years of age, including communication and language, physical development and personal, social and emotional development • Attainment of a Good Level of Development (GLD) at the end of reception year, taking into consideration children eligible for Free School Meals (FSM) • Immunisation rates in under 2years • School readiness at the end of foundation year (especially those receiving Free School Meals) • Children with visibly obvious tooth decay at age 5years • A&E attendance for children aged under 1years and aged under 4years. • Qualitative feedback from parents on feeling supported through 1,001 critical days	
1.1.5	**Further investigation into** • **High proportion of low birth weights** at term in Rutland. • **Children and Young People's dental care** in Rutland, including dental education and access to services**.**	RCC/ PH	PH Grant	22/23	Place	• Report into low birth weights in Rutland presented to HWB/ subgroups. • Report into dental education and care to HWB/subgroups.	Do

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB role: Do Sponsor Watch
1.2	**Confident families and young people**						
1.2.1	**Implementation of 0-19 Healthy Child Programme, 11-19year element,** reflecting the Family Hub national programme - including face to face element, a digital offer, health promotion campaigns including via schools, health behaviours survey, safeguarding, evidence-based interventions for healthy, active resilient children and young people who are able to transition effectively into adulthood. Specific work on transitions for children with LD (up to the age of 25years.) Link to 1.4 for vaccinations, 2.1 communication campaigns, 4.4.1 Digital inclusion, 7.1.3 Children and Young People's mental health need.	RCC/ PH	RCC General fund/ PH Budget	11+ service implemented for Sep 2022	Place and system	• Immunisation uptake (Covid, HPV, school leavers booster especially for those in care) • Proportion of children at a healthy weight (NCMP data at reception and year 6) • Under 18year conceptions • Health behaviour survey results indicating positive lifestyle choices and access to a trusted adult • A&E attendance for under 18years • Rate of hospital admissions caused by unintentional and deliberate injuries (Children aged 0-14yrs) • Educational attainment • Proportion of young people not in education, employment or training • Specific split of data from those with LD including qualitative feedback on transition from CYP service to Adult Services for those with additional needs.	Do
1.2.2	**Strengths-based approach to growing and supporting confident families** across Rutland. Including a) Peer support including for fathers, face to face wherever possible. b) Links to Rutland voluntary sector.	RCC, VCS	RCC General Fund/ PH budget	23/24	Place	• Qualitative feedback from parents on feeling supported through 1,001 critical days • Social prescribing referrals for families	Do

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB role: Do Sponsor Watch
	c) Increased awareness and access to local children's services. Link to RIS development action 2.1. d) Family social prescribing referrals. Link to 1.1.1 Family hub and 1.1.4 0-10years public health service.					• ONS4 surveys showing improvements to wellbeing from social prescribing	
1.2.3	**Targeted, coordinated support for disadvantaged or vulnerable children** to access their 2-2.5 year and Early Years Foundation Stage Progress Check (including those in care, SEND, Free school meals (FSM), young carers and those with parents actively or recently serving in the Armed Forces). Option of family social prescribing referrals. Link to 1.1.1 Family hub and 1.1.4 0-10years public health service.	RCC/ PH	RCC General Fund/ PH budget	22/23	Place	• 0-5 year development indicators specifically for target groups • Healthy lifestyle indicators reviewed for specific groups including immunisation uptake for SEND in over 14years • Proportion of annual Looked After Child Reviews carried out by Looked after Children Nurses • Proportion of Strengths and Difficulties Questionnaires (SDQ) undertaken for Looked After Children • Proportion of Education and Health Care Plans completed	Do
1.2.4	**Reduce the impact of Adverse Childhood Experiences on children and their families** by embedding a 'trauma informed approach' to the workforce.	PH/ RCC/ CCG/	RCC/ CCG	TBC	System	• Workforce trained in trauma informed approach	Sponsor
1.3	**Access to health services**						

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB role: Do Sponsor Watch
1.3.1	**Increase health checks for SEND children aged 14years and over** ensuring that status is built into the education and health provision set in a Child's Education and Health Care Plan.	LA/GP/PH	CCG	22/23	Place	• Immunisation uptake especially in SEND over 14s • Proportion of SEND Health check completed	Do
1.3.2	**Increase immunisation take-up for children and young people** where this is low, including identifying sub-groups where take-up is lower and understanding why.	RCC PH/ PCN	CCG/ PH budget	23/24	Place and system	• Review into immunisation uptake across Rutland • Immunisation uptake rates (Covid, HPV, school leavers' booster especially for those in care)	Do
1.3.3	**Coordinated services for children and young people with long term conditions (LTCs).** Long term condition support for children and young people with asthma, diabetes and obesity including access to appropriate medication, care planning and information to self-manage their conditions, and to relevant support services. To include learning from the Leicester City CYP asthma review and take-up of Tier 3 weight management services. Link to 1.1.1 Family hub and 3.2 Integrated care for LTCs and 7.1 Integrated Neighbourhood Team development.	LPT/ UHL PCN	CCG	22/25	Place and System	• Report with review of Leicester City Evaluation in context of Rutland needs	Do (Place) Sponsor (System)

Priority 2: Staying healthy and independent: prevention

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB role: Do Sponsor Watch
2.1	**Supporting people to take an active part in their communities**						
2.1.1	**Communication of Rutland's community and health and wellbeing offe**r including; • Develop and implement a multi-channel communication plan to enhance information for signposters and for the public, including distinctive groups. This will also align with the work of the HWB and cater for those that are digitally excluded or use cross border services. • To include enhancing the reach and scope of the Rutland Information Service (RIS) via multiple channels (web, social media, print). • Enhancement of online functionality for clearer routes into preventative services.	RCC	RCC General Fund/ BCF/ further invest-ment required	22/23 22/24	Place	• Completed Health and Wellbeing Communication plan aligned with the HWB • RIS monthly visitor figures • Indicators to demonstrate the reach of the communication campaigns including social media followers, posts and shares • Qualitative feedback on the awareness and access to service across Rutland	Do
2.1.2	**VCF collaboration.** Further strengthening collaborative relationships across the voluntary, community and faith (VCF) sector via: a) The VCF forum coordinated by Citizens Advice Rutland (CAR), also working with wider bodies and services e.g. Parish Councils, statutory and commissioned services. Sharing intelligence, skills and resources; mutual aid; joint responses to community needs and funding opportunities.	CAR/ RCC	RCC General Fund/ VCS	22/23	Place	• VCF forum participants • Collaborations including events, shared resources, joint services, grants obtained • Number of new community groups formed or placed on a more robust/ sustainable footing • Mapping of Rutland voluntary and community sector	Do

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB role: Do Sponsor Watch
	b) VCF groupings with a shared focus e.g. deprivation, armed forces. c) Community development encouraging the formation and confident operation of new groups in Rutland for shared interests. d) Mapping of the Rutland voluntary and community sector to understand its strengths and areas for development. e) Collaboration, also with statutory and commissioned services, around sustainable improvement for households with multiple and/or complex needs impacting on health and wellbeing. Link to 7.2.1 mapping inequity, including deprivation.						
2.1.3	**Increase volunteering**, including through the Citizens Advice Rutland (CAR) volunteering marketplace, building on positive experiences in the pandemic.	CAR	RCC General Fund	22/23	Place	• Number of volunteers registered • Number of hours of volunteering committed to	Do
2.1.4	**Building Community Conversations.** Explore the potential application of innovative models to empower individuals and communities, including: the Healthier Fleetwood model in which facilitated conversation spaces enable communities/groups with a common interest to meet informally to discuss opportunities and issues and progress improvements; and	TBC	TBC	24/25	Place	• Feasibility study on implementation of potential community models in Rutland • Qualitative feedback that community conversations are taking place • Number of participants in the model .	Do

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB role: Do Sponsor Watch
	Camerados, an approach designed around people looking out for each other.						
2.2	**Looking after yourself and staying well in mind and body**						
2.2.1	**Living more active lives.** Including: a) Increasing exercise on referral and promotion of active opportunities – helping people to increase activity positively in ways that work for them - personalised approach building on strengths. Also targeting groups such as patients on waiting lists, with mental ill health or living with dementia or cancer, people isolated or unable to travel. b) Local progress of the LLR Active Together strategy, including engaging organisations including businesses, care homes and schools in facilitating active lives. c) Secure funding for the active referral scheme following leisure contract review. Consider feasibility of subsidised participation for people on lower incomes. d) Secure funding via PCN to develop a wider offer e.g. hip, knee and back school. Link to 2.1 Active Communities, 2.4.1 Health in all policies.	Active Rutland/ Active Together/ PCN	Multiple incl PH Budget, CCG, RCC	22/25	Place	• Exercise referrals made • Exercise referral service user numbers • Reduction in the proportion of adults overweight or obese • Increased proportion of physically active adults • Increased proportion of adults engaging in active travel (cycling or walking) at least 3 days a week • Proportion of health checks completed	Do Sponsor Do

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB role: Do Sponsor Watch
2.2.2	**Health awareness and self-care.** Including: a) Providing information to increase awareness of changing health needs, and confidence to self-care. b) Clear prevention 'front doors' for additional support (See 2.2.4 Social Prescribing). c) Increase uptake of Weight Management Rutland service for adults, and family-focused support programmes, including Holiday Activities and Food Programme. Encourage take-up of NHS health checks and ongoing blood pressure monitoring for early diagnosis of cardio vascular risk. d) Review Chlamydia screening across Rutland to identify reasons for low level of Chlamydia detection and screening.	RCC (incl RIS, RISE, libraries), PCN, VCF sector	Yes	23/24	Place	• Communication measures on Health awareness campaigns and RIS webpages (reach, shares, posts etc.) • Uptake of prevention services • Uptake of NHS health checks and numbers of referrals to prevention services • No. of blood pressure checks in the community • Improvement in Chlamydia screening rate and understanding of detection rate	Do
2.2.3	**Healthy conversations.** Implement Healthy Conversations training (Making Every Contact Count Plus – MECC+) to empower Rutland's diverse front line staff to discuss health and wellbeing with service users and signpost them To include professionals working with housebound and digitally excluded people, and those who struggle to travel. Accessible signposting resources. See development of the RIS in 2.1.1.	RCC/ PH/ LPT	PH Budget/ LLR Cancer funding	23/24	Place and System	• Numbers trained in MECC+, train the trainers and super trainers in Rutland • Data on source of referrals to prevention services • Reach of RIS website • Qualitative feedback and evaluation of MECC+ training package	Do and sponsor for wider system roll out

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB role: Do Sponsor Watch
2.2.4	**Increase and enhance social prescribing for wellbeing,** focussing on personalised, strengths based care assessment and planning via the joint RCC and PCN 'RISE team' and other local providers. Including; a) Promote clear routes for wellbeing enquiries/ requests for support through Rise front door and RIS. b) Enhance social prescribing tools by developing: • Consistent assessment frameworks for use across agencies. • Social prescribing signposting network. • Service maps for consistent referral. • Social prescribing platform managed by RISE, aiding referral between agencies and monitoring of pathways and outcomes.	RCC (RISE)/PCN	BCF and PCN	22/23	Place	• Increased social prescribing referrals • Social prescribing platform users and activity • Development of signposting network • Number of groups/activities referred to by RISE team • Patient changes to ONS4 scores (a 4 element self-assessed measure of wellbeing) • Evaluation of the impact on social prescribing including understanding the impact on GP practices by service users	Do
2.3	**Encourage and enable take up of preventative health services**						
2.3.1	**Increase uptake of immunisation and screening programmes**. Including; a) Completion of a health equity audits on immunisation and screening programme uptake across Rutland**.** (Including childhood immunisations.) See 1.1 and 1.2. b) Targeted communications campaigns using behavioural science to support increasing uptake. (See 2.1)	PH/ NHS England	PH Budget/ NHS EI	24/25 as required	Place and System	• Health Equity audits completed on areas of concern. Results/ recommendations reported to HWB and LLR Health Protection Board. • Uptake of specific immunisation and screening programmes. Specifically reviewing vulnerable or under-served groups. • Including offer/ uptake of health checks (including those for LD), uptake of screening programmes (including breast and bowel scope screening),	Do (Place) Sponsor (System)

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB role: Do Sponsor Watch
	c) Use the Health and Wellbeing Coach, healthy conversations (MECC+) and other routes to increase cancer screening uptake including mammograms, bowel scope screening and cervical screening [see 2.2] d) Considering how services could be delivered closer to home (for example breast and bowel scope screening) See 4.2.					uptake of screening programmes closer to home.	
2.4	**Maintaining and developing the environmental, economic and social conditions to encourage healthy living for all**						
2.4.1	**Health and equity in all policies**. Focus will include the economic, social and environmental contributions to health (wider determinants of health). a. Aiming for an overall commitment of relevant organisations in Rutland to building in consideration of health and equity in all that they do. b. Health Impact Assessments (HIA) or Integrated Assessments for decision making and policy development. Health Impact Assessment (HIA) of individual policies/investments, considering social value. c. Produce a wider determinants review with partners for Rutland. The review will explore existing work across Rutland, identifying any gaps to consider additional action across partners. Focus will include the built environment; open and green spaces; active	RCC PH	RCC General Fund/ PH budget	24/25 22/23	Place	• Organisations committed to a Health and Equity in all Policies approach. • Evidence that organisations have embedded a process to systematically consider health, wellbeing and equity in everything they do. • Evidence of enhanced designs/decisions from HIAs • Development of wider determinants review.	Do

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB role: Do Sponsor Watch
	travel; fuel poverty; air quality; and healthy housing.						

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

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB role: Do Sponsor Watch
3.1	**Healthy ageing, including living well with long-term health conditions, and reducing frailty and over 65s falls**						
3.1.1	**Accessible information and advice supporting people to adapt their self-care** as they age for optimum health, tailored to populations with worse outcomes. (Links to 2.1)	RCC/ CCG	Yes	24/25	Place	• See 2.1.	Do
3.1.2	**Tailored support to help individuals live well with changing health circumstances, including through the Proactive Care @home programme. Including;** d. Personalised information, advice and support to help people and their families to adapt as they become more vulnerable to illness or are diagnosed with long term conditions, to play a full role in their care and to manage the wider impact of ill health on their lives. e. Building patient and family skills in managing illnesses at home, including using monitoring equipment/ telehealth such as SystmOne Airmid, Whzapp and over the counter monitoring equipment. f. Wider involvement in recognising and assessing signs of deterioration including using NEWS. g. Extended local rehabilitation offer.	RCC RISE. PCN, comm unity pharm acy	Partial	24/25	Place & System	• Numbers taking up these 1:1 services • Positive changes to service users' ONS4 self-assessed wellbeing scores. • Telehealth and monitoring: TBC based on target conditions and PCN metrics. • Numbers assessed at key levels of frailty • No. of individuals with active care plans. • Rate of ambulatory admissions in categories considered as preventable (BCF)	Do (Place) Sponsor (System)

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB role: Do Sponsor Watch
	Link to 3.1.3 Falls, 3.3 Carers, 3.4 Learning disabilities and cognitive impairment, 4.4.1 Digital inclusion.						
3.1.3	**Falls prevention, including promoting strength and balance and faller response. Including;** a) Awareness raising re strength and balance preventing falls and availability of preventative exercise referral, plus what to do in the case of a fall (See 2.1) b) Exercise for strength and balance offered to patients who have fallen or are at risk of falling, including Steady Steps courses and enabling virtual as well as in person delivery. Putting Steady Steps on a sustainable financial footing. c) Embedding the DHU quick response pilot for fallers not seriously injured. d) Personalised falls prevention plans for Rutland care homes, tailored to individual residents. Frailty champions and training. Initial priority to reduce the impact of lockdown deconditioning through reablement/ social prescribing/ self-help. e) e) Patients with frailty flag referred for assessment by integrated care	RCC incl Active Rutland, LPT Therapy/OTs/ PCN	Partial	22/25	Place & System	• No. of Steady Steps participants • Rate of hip fractures in people aged 65-79 and 80+ • Rate of emergency admissions due to falls injuries in people aged over 65yrs • Number and proportion of people rated at different levels of frailty (defined by ACG tool) • Integrated care coordinator referrals relating to falls/frailty • Structured Medication Reviews relating to falls/frailty	Do (Place) Sponsor (System)

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB role: Do Sponsor Watch
	coordinator and for structured medication reviews (SMR).						
3.1.4	**Peer support.** Encouraging and enabling peer support for people living with related challenges (both physical and mental health). Build expertise and materials supporting high quality peer support. Develop via support groups and via shared interests or experiences e.g. art and exercise classes, veterans. Link to building strong communities 2.1	RCC incl RISE/ VCS	RCC/ VCS	TBC	Place	• Peer support groups established • No. of service users participating • Qualitative feedback on impact of peer support groups.	
3.2	**Integrating services to support people living with long-term health conditions**						
3.2.1	**Collaborative coordinated care.** Including; a) Planning for greater structural integration across and between health and care services through a population health management approach. b) Working together to shape integrated neighbourhood teams, multidisciplinary working and services to better serve the needs of the Rutland population living with ill health. (Including relationships between nursing and therapy.)	RCC, PCN, LPT	RCC/ CCG	TBC	Place	• Pooled budgets • Qualitative feedback from patients that services are more integrated. Including families and friends test. • Reduced delays in hospital discharges, length of stay etc. • Increased scope and use of trusted assessments as appropriate. • Proportion of complex patients that have an active, up to date care plan	Do

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB role: Do Sponsor Watch
	c) All staff working to the top of their capabilities. Using trusted assessment and delegated tasking to expand capacity. d) Enhancing coordinated care planning, including with specialist support for the most complex patients. e) Clear and coordinated communication with patients.						
3.2.2	**Building a resilient care sector** Working with the care sector in all its forms to support a clear and sufficient offer providing choice in high quality services to service users and reducing pressure on acute hospitals through collaborative care and prompt hospital discharge. a) Further progress implementation of the Enhanced Health in Care Homes (EHCH) model, led by the Rutland Clinical Care Home Coordinator, including multi-disciplinary team working, use of technology to support collaborative care, and frameworks to identify and manage health deterioration. b) Supporting a resilient care sector, including workforce development to make the care sector in Rutland an attractive place to work.	RCC Clinical Care Home Coordinator and Broker Commissioning team	RCC/ Care sector	TBC	Place and System	• Participation in the provider forum • Covid related compliance (e.g. vaccination take-up) • Care sector capacity • Number of homes participating in MDT working for residents • Breadth of MDT working in place • Care home hospital admissions	Do (place) Sponsor (System)

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB role: Do Sponsor Watch
	Link to 3.2.4 Hospital discharge.						
3.2.3	**Sharing information for better informed direct care.** Embedding use of the LLR electronic Shared Care Record across the Rutland health and care workforce and pathways to support coordinated, fully informed patient care, initially within LLR. Link to 4.5.2 which addresses future cross-boundary sharing, building on 3.2.3.	LHIS	DHSC	TBC	System and place	• Number of organisations connected to the LLR care record • Number of accesses made to the LLR CR for direct care.	Watch
3.2.4	**Prompt, safe hospital discharge.** Working together including out of area to minimise long hospital stays and to get people home promptly to their usual place of residence and reabled whenever possible.	RCC discharge team, Micare		24/25	System and place	• Rate of patients staying in hospital 14+ and 21+ days (BCF) • Rate of discharge to usual place of residence (BCF)	Sponsor (System) Do (Place)
3.3	**Support, advice, and community involvement for carers**						
3.3.1	**Understanding carer needs.** Understand carers' support needs to ensure interventions are well tailored, including transitions to adulthood for child carers and appropriate respite opportunities.	RCC carers team	RCC	24/25	Place	• Qualitative feedback on carers needs.	Do
3.3.2	**Carer recognition and wellbeing.** Identifying more carers of all ages and offering support. a) Increasing take-up of carer health checks and eligible benefits.	RCC carers team	Existing budgets	24/25	Place	• Proportion of estimated carers identified (including young carers)	Do

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB role: Do Sponsor Watch
	b) Addressing barriers to social contact for carers, including via peer support opportunities, social prescribing and digital channels. c) Support for carer mental health. d) Contingency planning for carers. e) Build the role of the VCF sector, including armed forces groups, in enhancing carer wellbeing. Link to 2.1 Active communities, 2.2.2 Health awareness and self-care, 2.2.3 Healthy conversations, 2.2.4 Social prescribing, 2.3.1 Preventative health services, 3.1.4 Peer support, 4.4.1 Digital inclusion, 7.2 Good mental health.					• Proportion of carers who have as much social contact as they would like • Proportion of carers taking up health checks	
3.3.3	**Supporting households during hospitalisation of the cared for person or carer.** Multi-disciplinary working across involved teams when a carer or an individual with a carer is hospitalised. Inclusion of the carer in home first planning for discharge - confirming realistically what the carer is able to undertake and what additional support may be needed. Enabling honest dialogue for safe, sustainable discharge.	RCC carers, discharge, hospital teams, PCH carer liaison	Existing budgets	24/25	Place	• Carer feedback on hospital episodes	Do

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB role: Do Sponsor Watch
	Link to 3.2.4 Prompt, safe hospital discharge.						
3.4	**Healthy, fulfilled lives for people living with learning or cognitive disabilities or impairments, or dementia**						
3.4.1	**Timely annual health checks** for people with learning disabilities to identify health issues early, supporting good quality care.	PCN	CCG	22/23	Place	• Increased % people registered with learning disabilities who have had an annual health check	Do
3.4.2	**Active learning to enhance care for people with learning disabilities.** Sharing LeDER findings widely and acting on them to enhance care for people with learning disabilities. Ensuring safe discharge for people with learning disabilities.	LLR LD group	CCG/ RCC	24/25	System	• LeDER recommendations actioned • Qualitative feedback on quality of life from people with LD	Sponsor
3.4.3	**Meeting care needs in Rutland for people with significant disabilities.** Wherever possible, pursuing creative solutions enabling people with significant disabilities to be cared for in Rutland rather than having to go out of area See Bring care closer to home 4.2.	RCC (ASC, CSS)	Allocated personal budgets	24/25	Place	• Service users brought fully or partially in-county • If care is returned to Rutland, cost differential • Proportion of people with LD in their own homes	Do
3.4.4	**Community involvement.** Further strengthening opportunities in Rutland for people with learning disabilities to have	RCC/ VCS	RCC General	24/25	Place	• Proportion of those with learning disabilities in work and volunteering	Do

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB role: Do Sponsor Watch
	healthy, fulfilled lives and be a full part of Rutland's communities, including engagement in education, work and volunteering.		fund/ CCG				
3.4.5	**Dementia friendly communities in Rutland.** Explore the potential to progress accreditation as dementia friendly villages, high streets, facilities and tourist attractions in Rutland.	TBC	TBC	24/25	Place	• No. of dementia friends trained • No. of venues advertising themselves as dementia friendly • Improved dementia diagnosis rate	Do
3.4.6	**Increase the diagnosis rate for dementia** including: a) Giving people confidence to come forward when they are experiencing memory issues. b) Addressing the backlog in diagnosis of memory issues.	PCN, RCC	CCG	23/24	Place & System	• Improved Dementia diagnosis rate • Reduced waiting list for memory services diagnosis	Sponsor
3.4.7	**Equity in access to Admiral Nurse support provided by RCC.** Confirm approach enabling everyone registered with a Rutland GP practice to benefit from Rutland Admiral Nurse support or its equivalent. Ensure Rutland residents with a GP outside Rutland are aware they are able to use the RCC service.	RCC, PCN, Alzheimer's UK	BCF. funding required	22/23	Place	• Confirmation that all Rutland residents and Rutland GP practice patients have access to a service	Do

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

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB role: Do Sponsor Watch
4.1	**Understanding the access issues**						
4.1.1	**Map inequities and patient experience feedback in health and care services across boundaries** between Rutland residents and those registered with a Rutland GP and living outside Rutland. Findings to inform future pathway design. To also include the challenges for patients using non-GP services out of area.	RCC, CCG, PH	CCG/ PH/BCF Budget	22/23	Place	• Report on border issues • Agreement on areas of focus of inequalities as part of delivery of PCN Network DES	Do
4.1.2	**Ensure equitable services are developed and available** ensuring Rutland's residents and those registered at a Rutland GP have greater choice, enabled through cross boundary service contractual agreements and other solutions. Build equitable access into pathway design. See 4.5.3 cross border collaboration.	**RCC, CCG**				• Improved patient feedback from people reporting health and care inequity	Do
4.2	**Increase the availability of diagnostic and elective health services closer to the population of Rutland**						
4.2.1	**Improving public information about local diagnostic and planned care services** as part of increasing access (e.g. including urgent care and when mobile facilities such as the mobile	RCC	RCC, LPT, CCG	22/23	Place	• See 2.1. Local communication plan and RIS development including specific campaign on out of hours access	Do

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB role: Do Sponsor Watch
	breast screening unit are in the area, and accessible out of area provision). See 2.1. Improving communication.						
4.2.2	**Develop understanding of used and vacant space at Rutland Memorial Hospital to inform scope for potential solutions.** Followed by strategic review of other vacant space that could enable health services closer to the population.	CCG / LPT	TBC	22/23	Place	• Quantified understanding of available space and existing medical facilities' appropriateness for clinical activity	Do
4.2.3	**Review and identify immediate potential solutions for Elective and Community services feasible for closer local delivery**, through optimising existing Estate Infrastructure whilst facilitating restoration and recovery including considering e.g. cancer 2 week wait, cardio respiratory service and orthopaedics and the delivery methods for such services i.e. virtual or face or face. Consider longer term options for children's services (incl phlebotomy), end of life, chemotherapy and diagnostics. Consider existing infrastructure sites including Rutland Memorial Hospital (RMH).	CCG	CCG	22/23	Place	• Review of current and potential services delivered at RMH • Evaluation of AI Tele - dermatology service	Do

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB role: Do Sponsor Watch
4.2.4	**Explore the possibility** for a localised Pulmonary Rehabilitation Service through the evaluation of the pilot project in train to inform local feasibility models/review in Rutland.	PCN/CCG LPT/Inspire2 Tri	CCG	22/23	Place	• Evaluation of local pulmonary rehabilitation take-up • Increased take-up of pulmonary rehabilitation by relevant patients	Do
4.2.5	**Develop a longer term locally based integrated primary and community offer and supporting infrastructure for the residents of Rutland**, driven forward by a dedicated partnership Strategic Health Development Group.	CCG	CCG / National/ RCC	23/24	Place	• Partnership agreement on way forward and dedicated plan on next steps	Do
4.3	**Improving access to primary and community health and care services**						
4.3.1	**Improve access to primary and community health care:** In primary care, take steps to increase the overall number of appointments in comparison to a baseline of 2019 and to ensure an appropriate balance between virtual and face to face appointments. (NB dependency on premises constraints). Increase uptake of community eye scheme provided by local optometrists and monitor usage. In community health, understand and work to reduce waiting lists/wait times for key services	CCG, GP practices, optometrists LPT	CCG	23/24	Place	• Increased access to GP practice appointment in comparison to 2019 • Appropriate proportion of appointments delivered face to face in comparison to Aug 21 baseline • Qualitative feedback on GP practice access across Rutland	Do

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB role: Do Sponsor Watch
	such as dementia assessment, community paediatrics and mental health. See also 4.3.3 b Community Pharmacy Consultation Service.					• Identified waiting lists/wait times reduced	
4.3.2	**Informing patients.** Review PCN and practice website developments and online tools including review of usage data analysis to inform further website enhancements and engagement with registered population. Link to 4.4.1 Digital inclusion.	PCN	CCG	22/23	Place	• Evaluation of PCN and practice websites and future developments.	Do
4.3.3	**Review local pathways**, with focus on: a) Satellite clinics nearer to Rutland – e.g. Joint injections at RMH being explored to manage local backlog b) Community Pharmacy Consultation Service (CPCS) pilot to support increase in referrals in key areas and reduce pressures in Primary care. This will be supported by the Rutland Pharmaceutical Needs Assessment.	CCG	CCG	23/24	Place	• Review of joint injections pathway • Reduced joint injection backlog • Reduced pressure on primary care • Review of community pharmacy services • PNA complete for October 22	Do
4.3.4	**Investigation and follow up to increase primary care consulting space capacity,** including within existing primary care premises.	PCN CCG	TBC	23/26	Place	• Practices with increased consulting spaces • Increased appointment capacity	Do

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB role: Do Sponsor Watch
4.3.5	**Review of GP registrations in the context of seldom heard or under-served groups to increase coverage where required** for communities such as the travelling community, veterans and armed forces families (i.e. health equity audit learning from Leicester City Approach). Link to health inequalities needs assessment 7.2.1.	CCG/ PH	CCG/ PH budget	23/24	Place	• Health equity audit on GP registrations	Do
4.3.6	**Ensuring full use of specialist primary care roles tailored to needs** (e.g. practice pharmacist, muscular-skeletal first contact, health coach). Link to 4.3.4 Primary care infrastructure capacity.	PCN	CCG	TBC	Place	• Employment and delivery of specialist primary care roles in Rutland • Impact on primary care capacity of specialist roles	Do
4.3.7	**Engage with local Armed Forces Defence Medical Services (DMS) facilities** to inform changes in local Health and Care services including referral processes/documentation e.g. RMH provision. Due regard for the armed forces in health referral (e.g. duty to consider this population in pathway design and communicate health pathways to military primary care).	CCGs/ PCNs	CCG	TBC	Place	• Qualitative feedback that local services better reflect the needs of the military population	Do

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB role: Do Sponsor Watch
4.3.8	**Development of a Rutland wide partnership community transport project** to look at demand and response bus service models with outline of enabling financial models. This will include current pilots e.g. CPRE Community Transport pilot in Uppingham.	RCC with CPRE and Parish Councils	RCC	TBC	Place	• CPRE Pilot evaluation report of findings and recommendations • Options appraisal of community transport models including collaborative financial strategy with Parish Councils	Do
4.4	**Improving access to services and opportunities for people less able to travel, including through technology**						
4.4.1	**Increase digital inclusion** targeting people who want to use technology to improve access to services and/or reduce social isolation. a. Collaborative approach across involved agencies and services. Tailor responses to reasons for digital exclusion (affordability, skills, confidence, connectivity). Include supporting to take up digital services e.g. access to medical record, prescription ordering (POMI) b. Fit for purpose access to the internet across Rutland including access to high speed broadband within community setting such as libraries. Advice to support household choices.	TBC RCC	TBC RCC/ individual budgets	22/25	Place	• Number of people digitally enabled. • Residents in Rutland have the option to subscribe to high speed broadband • No. of public access points for high speed broadband • Number of people with access to their GP record • Numbers of people using the NHS app to order repeat prescriptions and make GP appointments	Do
4.4.2	**Identify existing issues and routes /modes to improve physical access to services from rural areas** by working with RCC Transport Plan team (including through further travel time	RCC	RCC	22/23	Place	• Review of current transport routes and health inequalities needs assessment	Do

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB role: Do Sponsor Watch
	mapping for different modes of transport and times of day, to support wider planning, also considering out of area access to services and ambulance response times). Link to access and health inequalities needs assessment 7.2.1.					• Rutland travel time and bus route napping including costs	
4.4.3	**Delivering commissioned services within Rutland.** Encouraging LLR services commissioned from third party providers to be offered directly in Rutland including through venue support. See 7.1.6.d VitaMinds local delivery.	RCC	RCC/ VCS	22/25	Place	• More services delivered within Rutland wherever possible	Do
4.5	**Enhance cross boundary working across health and care with key neighbouring areas**						
4.5.1	**Undertake an Out of Area contract review of LLR CCG commissioned services**	CCG	CCG	23/24	System	• Review of cross boundary working across health and care	Watch
4.5.2	**Phase 2 of electronic shared care records** including sharing with organisations not on the LLR Care Record system, notably out of area providers and other specialist providers including Defence Medical Services. Dependency on national shared care record programme.	CCG	National funding	26/27	System	• Electronic shared records implemented across a range of health and care providers	Watch Do for specific links to Rutland services

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB role: Do Sponsor Watch
	Explore potential for future digital referral routes from out of area. See 3.2.3 LLR Care Record.						
4.5.3	**Maintain close operational working with neighbouring CCGs, Councils and associate commissioners** in Lincolnshire, Northamptonshire, Peterborough and Cambridgeshire with an initial focus on Primary Care impact on local provision, and implications of UHL restructure on demand for out of area services. Consider representation on respective governance groups.	CCG/ RCC	CCG/ RCC	22/23	Place	• Clear links with local CCGs and LAs re cross boundary working	Do

Priority 5: Preparing for our growing and changing population

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB role: Do Sponsor Watch
5.1	**Planning and developing 'fit for the future' health and care infrastructure**						
5.1.1	**Work with neighbouring areas around cross border development impact and opportunities through Strategic Infrastructure Development Planning** (notably currently South Kesteven CCG and Lincolnshire CCGs) to support future cross border funding allocation commensurate to local impact of out of area growth.	CCGs	CCG	22/23	Place	• Aligned fit for the future plans with neighbouring ICS's	Do
5.1.2	**Reviewing the implications of the UHL reconfiguration and redistribution of planned and diagnostic care for Rutland patients**, feeding Rutland population needs into wider system planning, including consideration of key needs such as children and young people's services closer to home. To include out of area use patterns and impact on budgets.	CCG, UHL, RCC, PH for HWB	CCG, RCC	26/27	System and Place	• Rutland feedback and insight supplied into system level reconfiguration	Do
5.1.3	**Undertake a Community Infrastructure Levy (CIL) policy review** with due consideration of enabling greater support for local healthcare infrastructure to ensure this is a key priority area of support going forward	RCC	RCC	22/23	Place	• Health Strategic Partners Involvement in CIL review process and receipt of report on new policy implications	Do

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB role: Do Sponsor Watch
5.1.4	**Develop and agree a Rutland population model to inform future Health funding decisions and CIL application** to enable Strategic Health Infrastructure Investment commensurate to future population healthcare needs. Including; a) Ensuring health partners have visibility of Rutland's latest non-local plan trajectory of speculative and planned developments to enable development of joint strategic planning for future growth. b) Ensuring the Board has access to CCG estates information relating to the Rutland PCN area. c) Consideration of anticipated growth in care home population and impact on local health services. d) Consideration of the impact of rurality and distance from acute services on demand for primary and community care.	CCG/RCC	RCC/ CCG	As required	Place	• Monitoring of the number of speculative and planned applications • Reviewed CIL policy • Clear plan for future health infrastructure	Do
5.2	**Health and care workforce fit for the future**						
5.2.1	**Adapt PCN roles to changing needs.** Plan for and undertake recruitment of the Rutland Health PCN Additional Roles reimbursement scheme and align with RISE team.	PCN	CCG	23/24	Place	• PCN additional roles recruited and services delivered. • Roles meeting their objectives	Do
5.2.2	**Workforce sufficiency.** Develop links with Health Education England (HEE) around	CCG	CCG	24/25	System	• Sustainable health and social care workforce	Watch

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB role: Do Sponsor Watch
	sustainable long-term recruitment and succession planning for clinicians.						
5.2.3	**Career development structures.** 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	CCG	CCG	TBC	System	• Carer development and increased potential for workforce • Proportion of health and care staff remaining in work after 55	Watch
5.2.4	**Promoting career opportunities.** Increase engagement with local young people around careers in health and care, including through collaboration with schools and opportunities for work experience	CCG	CCG	TBC	System	• Sustainable health and social care workforce • Increase in proportion of staff in health and care sector locally	Watch
5.2.5	**Meet training needs.** Identify training needs for the PCN in relation to the Enhanced Basket of services where agreed for local delivery in Rutland. Also consider training needs of associated teams/professionals working with PCN roles.	PCN	CCG	22/23	Place	• Completion of PCN training courses and evaluation of training and impact on patient outcomes	Do
5.3	**Health and equity in all policies, in particular developing a healthy built environment aligned to projected growth in Rutland**						
5.3.1	Embed Health and Equity in all strategies and policies across Rutland County Council and then partner organisations, considering their impact on mental and physical health, health	RCC/CCG/ PH	RCC/ PH budget	24/25	Place	• Completion of a Local Plan Health Impact Assessment with clear and achievable recommendations	Do

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB role: Do Sponsor Watch
	inequalities and climate change. This will include Health and Equity Impact assessment development and training. See 2.4. Public Health and Health Strategic partners to support the Planning Authority on the RCC Local Plan development to maximise the opportunity for a healthy built environment aligned to projected growth in Rutland. Work will utilise the national evidence base combined with locally developed resource, for example the 'Active Together – Healthy Place Making' toolkit. Completion of a Health Impact Assessment of the Local Plan at the appropriate point of development with clear recommendations for mitigation and/or enhancement.					• Progress against identified recommendations in the Local Plan development • Health and Equity in all policies embedded across Rutland	

Priority 6: Dying well

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB role: Do Sponsor Watch
6.1	**Each person is seen as an individual**						
6.1.1	**Ensure there is choice at the end of life**, in terms of place and type of care, to include continuity of care.	CGG/ RCC / LPT/ LOROS	CCG/ RCC	TBC	Place and system	• Qualitative feedback on end of life experience and quality of services including from family and carers	Do (Place) Sponsor (System)
6.1.2	**Support individuals in achieving their wishes around end of life care**, including through awareness raising about support already available for them and their carers, and how to access it, including the Integrated Community Specialist Palliative Care Service, specialist nursing, virtual day therapy, befriending support and training	CCG/ RCC/ LPT/ LOROS	CCG/ RCC existing budgets	TBC	Place and System	• Qualitative feedback on the quality of support received • Proportion of people dying in usual place of residence (DiAPR)	Do (Place) Sponsor (System)
6.2	**Each person has fair access to care**						
6.2.1	**Explore the possibility of delivering more end of life care services closer to home,** with consideration for the use of the Rutland Memorial Hospital. Also consider out of hours palliative care access. See 4.2 Care closer to home.						

6.2.2	**Improve access to hospice care**, including transport issues, and facilitating commissioning where the provider is not within LLR. See 4.4	CCG/ RCC	CCG/ RCC existing budgets	TBC	Place and System	• Qualitative feedback on the quality of support received	Do (Place) Sponsor (System)
6.2.3	**Support early identification of those likely to be in the last year of their life**, through the use of assessment tools (e.g. Aristotle Population Health Management system validated tools) to support further ReSPECT planning.	CCG/ PCN	CCG/ PCN	23/24	Place and System	• Defined list of patients nearing the end of their lives • Increased proportion of those at the end of life with a ReSPECT plan in place	Do (Place) Sponsor (System)
6.3	**Maximising comfort and wellbeing**						
6.3.1	**Review bereavement support services for families and carers**, including for armed forces, and children and young people.	CCG/ RCC	CCG/ RCC existing budgets	TBC	Place and System	• No. of people accessing bereavement support • Qualitative feedback on the quality of support received	Do (Place) Sponsor (System)
6.3.2	**Understand access to hospice and other services for End of Life care**, and requirements for these commissioned services.	RCC/ PH/ VSC	RCC/ PH budget/ VCS	22/23	Place	• JSNA chapter recommendations	Do
6.3.3	**Timely management of medical equipment and small aids for palliative/terminal care at home** - provision and removal	RCC	RCC	22/23	Place	• Qualitative feedback on support around equipment to remain at home	Sponsor
6.4	**Care is coordinated**						

6.4.1	**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.	CCG/ PCN	CCG	TBC	Place and system	• Proportion of people at end of life that have ReSPECT plans in place	Do (Place) Sponsor (System)
6.4.2	Utilise **responsive and flexible pathway**s to allow for rapid discharge from hospital where needed.	CCG/ RCC	CCG/ RCC existing budgets	TBC	Place and System	• Qualitative feedback on the quality of support received	Do (Place) Sponsor (System)
6.4.3	**Review of end of life care coordination**. To include cross border coordination and hospital discharge facilitating next steps of palliative support. Link to needs assessment (see 6.6.4)	RCC/ PH/ VCS	PH budget	22/23	Place and System	• Review of end of life coordination as part of JSNA chapter	Do (Place) Sponsor (System)
6.5	**All staff are prepared to care**						
6.5.1	**Provide training for carers (formal and informal) in end of life care**, so that individuals can receive appropriate care irrespective of place, with awareness raising around advance care planning and Power of Attorney.	CCG/ PCN/ LOROS/ Carers Matter Stake-holder Group	CCG	TBC	Place and system	• Proportion of people at end of life that have ReSPECT plans in place	Do (Place) Sponsor (System)
6.5.2	**Provide training to support the care of those identified** through a population health management approach **as approaching the end of their lives**. Training can help identify major life events that serve as trigger points	CCG/ PCN	CCG/ PCN	23/24	Place and System	• Defined list of patients nearing the end of their lives • No. of people trained in palliative and End of Life support • No, dying in usual place of residence (DiAPR)	Do (Place) Sponsor (System)

	for conversations. Support transition to palliative care phase.						
6.6	**Each community is prepared to help**						
6.6.1	**Further develop the Dying Matters website** to support coordination and choice of End of Life services.	Dying Matters	TBC	23/24	Place	More accessible website and links to RIS	Do
6.6.2	**Support a Compassionate Community approach** across Rutland, developing volunteer networks skilled to work with people facing terminal illness or at end of life.	Dying Matters / RCC / LOROS	TBC	TBC	Place	• Volunteers trained • Rutland achieving Compassionate County status.	Do
6.6.3	**Behavioural change campaign** to work towards changing social norms, to promote greater acceptance of discussions relating to end of life. This may include the use of alternative terminology and promote conversations about getting affairs in order. Use of behaviour change wheel methodology.	RCC/ PH/ Dying Matters	RCC/ PH Budget	24/25	Place	• Behavioural change campaign. • Communication indicators re reach and shares etc. • Qualitative feedback that people feel more comfortable to discuss end of life	Do
6.6.4	**Joint Strategic Needs Assessment** (JSNA) to be undertaken to understand the needs of the local population (including those nearing the end of their lives, their carers and the bereaved), the services available, and the quality of care provided. A focus will be given to capturing the views of those who use and provide services.	PH/ RCC	PH Budget	22/23	Place	• End of Life JSNA chapter with clear recommendations to the HWB. Including self-assessment against national ambitions	Do

	To include a comparison of progress against the National Ambitions for Palliative and End of Life Care, using the self-assessment tool.						

Priority 7: Cross cutting themes

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB interest Do, Sponsor, Watch
7.1	**Mental health**						
7.1.1	**Increase access to perinatal Mental health support services**, wherever Rutland women have chosen to give birth. Link to 1.2.2 Healthy lifestyle information for women pregnant or planning to conceive (c) mental health.	LPT	LLR LMS Transformation Budget	**22/23**	System	• No. of people accessing perinatal support • Qualitative feedback on the support provided	Sponsor
7.1.2	**Understand the gaps in service reported by service users where children and young people need help with their mental health** but have not reached the thresholds for mainstream mental health services, or have reached thresholds but are on waiting lists for CAMHS services, and ways to address these, including via new local services and low level/interim support offers delivered through library and wider commissioned and community services. Factor in anticipated future changes e.g. end of Resilient Rutland funding for children and young people's counselling in 2023.	LPT/ PH	LLR LMS Transformation Budget	TBC	Place and system	• Gap analysis on service provision for children and young people and recommendations for the HWB	Do (Place) Sponsor (System)

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB interest Do, Sponsor, Watch
7.1.3	**Increasing local resource to respond to children and young people's mental health need** through implementation of Key Worker role, Mental Health support workers support in Schools, contribution of Resilient Rutland programme (funding ending Jan 23). Support to families on waiting lists and for those requiring support but not reaching CAMHS thresholds. Parallel support for parents and carers of children and young people with mental health needs.	LA/ Vol sector /CCG	TBC	22/23	Place	• Reduced presentation of children and young people at urgent care settings in crisis	
7.1.4	**Support system implementation of 'Step up to Great' LLR Mental Health Transformation Programme**, following results of the consultation. Transformation project for Rutland- Ensuring MH services are delivered in Rutland including; a) Mental Health VCS grant scheme – crisis café - £30k - open from 14/1 - 4/2 2022 b) Small grants - £3k - £50k - open until 31/1/22 c) OPCC commissioner safety fund – up to £10k	LPT/ CCG/ RCC	LLR MH transform ation budget VAL coordinati ng	22/23	System Place Place	• Waiting times reduced for VitaMinds service users • Mental Health neighbourhood lead in post • Crisis café in Rutland • Rutland voluntary sector access to grant funding	Sponsor Do

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB interest Do, Sponsor, Watch
	d) Covid permitting, face to face provision in Rutland of relevant commissioned services e.g. VitaMinds e) A clear co-designed approach to supporting farmers' and other individuals' needs linked to rurality f) A clear co-designed approach to better meeting veterans' and armed forces families' mental health needs g) A clear local plan to better coordinate care across neighbouring service areas					• Commissioned services accessible face to face in Rutland	
7.1.5	**Increased response for low level mental health issues.** Promotion of recognised self-service self-help tools and frameworks notably *Five ways to wellbeing.* Expansion of capacity in local low level mental health services and closer working between involved local agencies and services, including in the voluntary and community sector and peer support, so more people access help sooner in their journey. Opportunities to develop resilience skills, e.g. through the Recovery College.	PCN, LPT, RCC, VCS	CCG	TBC	Place	• Increased support for low level mental health conditions for all ages • Self-help tools promoted	Do
7.1.6	**Deliver on the Long-term plan objectives for mental health for the people of Rutland**:	LPT, PCN, RCC, Vita	CCG - LLR LMS Transfor	22/23	System and place	• 60% physical health checks for individuals with Serious Mental Illness (SMI)	Sponsor

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB interest Do, Sponsor, Watch
	a) Move towards an integrated neighbourhood based approach to meeting mental health needs in Rutland b) Annually assessing the physical health needs of people with Serious Mental Illness (SMI) in Rutland c) Aiding people with serious mental illness into employment d) Delivering psychological therapies (IAPT - VitaMinds) for individuals as locally as possible to Rutland		mation Budget			• Evidence of integrated working (e.g. 3 conversation innovation site) • Increase in people with SMI being supported into employment • Increase in people accessing IAPT treatment	Do Watch Watch
7.2	**Reducing Health Inequalities**						
7.2.1	**Complete a needs assessment to understand the current health inequalities in Rutland.** Including understanding specific factors contributing to the decline of Rutland Female Life Expectancy. This will include understanding impact of isolation, lifestyle factors, carer status and local end of life patterns for females. To also consider deprivation, including hidden, and the resultant needs, calling on wider sources of intelligence across the community, voluntary and faith sector.	PH	PH Budget	22/23	Place	• Completed needs assessment and recommendations to HWB	Do

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB interest Do, Sponsor, Watch
7.2.2	**Embedding a proportionate universalism approach to service delivery including principles of the CORE 20 PLUS 5.** Targeted support based on need including for families and communities who experience the worst health outcomes across Rutland e.g. military, rurally isolated, carers, SEND, LD children in care etc.	All	Existing budgets	24/25	Place and System	• Tailoring of service delivery to meet the needs of specific vulnerable groups. • Reduction in social gradient of health. (Index slope of inequality.) • Improved healthy life expectancy in females.	Do (Place) Sponsor (System)
7.2.3	**Strengthen leadership and accountability for health inequalities** including health inequalities training with senior leaders and use of the Inclusive Decision Making framework	CCG/ PH/ LLR Academy	CCG	23/24	System	• Take-up of senior Rutland leaders on training course.	Sponsor
7.2.4	**Embed Military Covenant duties** across all key organisations across the system but specifically in Rutland (due regard for armed forces in health, housing, and education).	RCC/ CCG/ Providers		22/23	Place / System	• Update report on how organisations have embedded this legislation • Armed forces health needs assessment	Do
7.2.5	**Complete military and veteran health needs assessment** to understand the inequalities facing this group	CCG/PH	CCG/ PH budget	22/23	Place and System	• Completed needs assessment on military and veteran population. Recommendations taken to HWB to progress	Do (System)
7.2.6	**Mapping Rutland community assets, including its voluntary and community sector.**	RCC	RCC	TBC	Place	• Single register of local community assets to support development of	Do

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB interest Do, Sponsor, Watch
						RIS, community development and inclusive design of interventions	
7.2.7	**Role of anchor institutions in reducing health inequalities** Working with key Rutland organisations considering how they can support reducing health inequalities through employees, resources and estate.	System plus RCC	RCC/ CCG/ ICS	24/25	System	• Organisational plans and commitments to reduce health inequalities. Regular uptakes on progress • Slope index of inequality • Rate of improvement on life and healthy life expectancy between the most and least deprived groups in Rutland	Sponsor (Do for Rutland specific organisations)
7.2.8	**Ensuring complete and timely datasets**. Collecting data on protected characteristics (including ethnicity and disabilities) to support future service needs and development	All providers	RCC/ CCG/ ICS	24/25	System	• Accurate recording of protected characteristic including ethnicity and disabilities	Sponsor
7.3	**Covid recovery**						
7.3.1	**Review the impact of the Covid-19 pandemic period on emerging demand for prevention services** including sexual health and provide recommendations for service adjustments or future commissioning of services to respond to these changing needs. This will take place in response to intelligence about patterns of need, and/or as each service is recommissioned.	RCC/ Public Health	Various Covid funds/ RCC/ PH budget	22/23	Place	• Services adjusted/ increased/introduced in response to post-pandemic needs • Outcomes in those services	Do

Ref	Key Activities	Lead	Funding	Indicative Timescale	Place or System Led	Metrics	HWB interest Do, Sponsor, Watch
7.3.2	**Consider the service offer for patients with long Covid**, including accessibility.	LPT	CCG/ Covid funding	TBC	Place	• Clear pathway and accessible service offer for long Covid patients	Do (Rutland)
7.3.3	**Pandemic readiness.** Maintaining a collaborative health protection approach and response ready for future Covid-19 surges or other future pandemics.	PH	PH budget	Ongoing	Place and System		Do (Rutland) Sponsor (System)

Glossary

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 five, 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
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