Priority 1: The Best Start for Life

Senior Responsible Officer (on HWB) Dawn Godfrey
Responsible Officer (on IDG) Bernadette Caffrey

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1.1	**Healthy child development in the 1,001 critical days (conception to 2 years old)**									
1.1.1		Clear 'Start for Life' offer for parents. The Family Hub programmes will be critical to bring activity together and ensuring an integrated offer across the 0 to 19 (25) years pathway. Information sharing agreements to be agreed. Watch - Family Hub programme receiving oversight from the Rutland CYP Partnership.	RCC/PH /Mina Bhavsar (ICB commissioning officer). Sham Mahmood. Public Health.	2022-24	Place and system	Family Hub operating 0 to 19, (25 yrs. SEND), clear, accessible , seamless and integrated services for families in place and achieving positve outcomes for children and young people. Quantative, qualitative feedback from parents on feeling supported through 1,001 critical days.NHS provider meeting KPis in 0 to 11 years Healthy Child contract and offer.	1001 Critical days launched across LLR with an agreed vision of 1001 Critical Days. Maternity Transformational Programme in place with key objectives. Family Hub Project plan and Steering Group established.	Engagement		
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 b) Targeted communication campaigns 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 2.2.3 Healthy conversations 7.1.1 Perinatal mental health support.	LPT/UHL	2022-23	Place and system	* Women healthier during pregnancy: reduction in overweight/obese or smoking. * Improved rates of immunisation for mothers (notably flu/Covid). * Women aware of the risk of Post Natal Depression and isolation. Better able to prevent and seek support where required. * Wherever women give birth, they have access to information about health in pregnancy and access to support.	LLR Strategic Healthy Baby Group led by Rob Howard. Focus to deliver health diet advice, healthy food boxes, reduce maternal obesity. Safer sleep campaign happening. ICON programme in place.Yes Stork campaign,to support parents with bonding and confidence in caring for their premature babies in neonatal unit and at home.	Lackof capacity and increased demand in key partner agencies		
1.1.3		Local implementation of the Maternity Transformation Programme considering: Improving quality and safety for mother and babies. Improving quality of pathway Implementing neonatal critical care review, improving access to perinatal health services. Link to above actions. LLR LMS Transformation Funding	LPT/UHL	2023-24	Place and System and Neighbourood. Working toward 6% perinatal access to increase access from 6% to to 10% by March 2023	Mothers in Rutland are happy with the services available to them. Positive change in longer term trends around low birth weights and infant Mortality. .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	Delivering all key requirements of the Transformation programme. Submitted a checkpoint equity assessment.			

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1.1.4		Implementation of 0-19 Healthy Child Programme, to support Rutland's Family Hub Programme. Including: 0-10year mandated child development checks (including 3-4month and 3.5year checks), a digital offer, evidence-based interventions for children (antenatal, 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 health services, including dental. Specific consideration for military population.11plus Public Health Teen Health contract and Offer for young people in Rutland	Public Health Rutland	From Sept 2022	Place and system	Positive development of children 1-10, in areas covered by the dashboard metrics .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 (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)	New contract in place from September2022			
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.	Rutland Public Health	2022-23	Place	Better understanding of the factors contributing to these patterns. Stronger evidence base for next steps to tackle these issues. Oral Health JSNA chapter · .Low birth weight for term babies · Infant mortality • Children with visibly obvious tooth decay at age 5years	Not yet underway			
1.2	**Confident families and young people**									
1.2.1		Implementation of 0-19 Healthy Child Programme, 11-19year element, which supports the Rutland Family Hub programme - including face to face offer for families, 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.) Integrated offer that include a whole family approach,(fathers/grandparents), and is supported by local and vountary groups and communities. 1.4 for vaccinations 2.1 communication campaigns 4.4.1 Digital inclusion 7.1.3 Children and Young People's mental health needs	Rutland County Council	From Sept 2022	Place and system	Happy and successful young people 11-19, receiving support and interventions early and when and where they need it. Provider meeting the KPIs. * 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	The 0-11 service commenced on 01/09/22 with LPT as the provider. Contract management has commenced. LPT has indicated that they have recruited to vacancies but it will be early next year before the benefits are realised. For the 11+ in house service the new staff have now started, links are being made and two mapping events are arranged for early December programme. Steering Group in place to drive the Rutland family Hub programme.	Capacity within key partner organisaitons to engage in and deliver programme.		

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1.2.2		Targeted, coordinated support for Rutland's most disadvantaged or vulnerable children, representative of Rutland's demograpic, to access their Early Years and Inclusion Offer and provision. Reduce the impact of Adverse Childhood Experiences on children and their families by embedding a 'trauma informed approach' to the workforce. Integrated Early Help, SEND, Health and Social Care offer	RCC,	2022-23	Place	Families who are disadvantaged or with additional needs have their needs identified early, and feel supported, and less likely to need specialist services.Adverse Childhood Experiences have less impact on children and families - through prevention and support to manage/recover. * 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	As above for Family Hub. Supporting Families Programme (formerly Troubled Families) in place and meeting targets. Reducing Parental Conflict programme secured and in place.			
1.3	**Access to health services**									
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. Funding RCC - DSG HNF. CHC CCG	ICB /LPT	2022-23	Place	Children with SEND are having their health checks in a timely fashion. This is helping those working with them to do this more successfully. * Immunisation uptake especially in SEND over 14s * Proportion of SEND Health check completed	Undertaken generally in Q3 and Q4.			
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.	ICB/ LPT	2022-23	Place and system	It is clear where immunisation take-up is lower than average (including among which demographics), and changes to delivery help to increase take-up to match or exceed comparator averages. * Review into immunisation uptake across Rutland * Immunisation uptake rates (Covid, HPV, school leavers' booster especially for those in care)	Uptake in Rutland is good,some dip during Covid. PCN Health and Wellbeing Coach developing advisory role for families around vaccinations.			

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1.3.3		Coordinated services for children and young people with long term conditions (LTCs) and SEND. 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. 3.2 Integrated care for LTCs 7.1 Integrated Neighbourhood Team development ND Pathway programnme, and Key Worker programme. To explore early planning for ASD/ADHD families	LPT	2022-24	Place and system	* Report with review of Leicester City Evaluation in context of Rutland needs	Iniital work complete. Further areas to develop.			

Priority 2: Staying Healthy and Independent: Prevention

Senior Responsible Officer (on HWB) **Mike Sandys**

Responsible Officer (on IDG) **Adrian Allen**

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2.1	**Supporting people to take an active part in their communities**									
2.1.1	Ensure residents are fully aware of the community and health and well-being offer in Rutland and understand how to access it.	Communication of Rutland's community and health and wellbeing offer including; a) 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. b) To include enhancing the reach and scope of the Rutland Information Service (RIS) via multiple channels (web, social media, print). c) Updating the RIS online platform to meet accessibility standards and be more usable on mobile devices as this is how most users access it. d) Enhancement of online functionality for clearer routes into preventative services.	RCC-Public Health (RIS)	Jun-23	Place	* Completed Health and Wellbeing Communication plan aligned with the HWB * Reach of communication campaigns including social media followers, posts and shares * RIS monthly visitor figures * Qualitative feedback on awareness of and access to service across Rutland				GREEN
2.1.2	Working in collaboration with the VCF sector to further strengthen relationships across the sector.	a) The VCF forum coordinated by Citizens Advice Rutland (CAR), also working with wider bodies and services e.g. Parish Councils, and statutory and commissioned services. Sharing intelligence, skills and resources; mutual aid; joint responses to community needs and funding opportunities. 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, with statutory and commissioned services, around sustainable improvement for households with multiple and/or complex needs impacting health and wellbeing.	CAR, RCC	Jun-23	Place	* VCF forum participants * Collaborations including events, shared resources, joint services, grants obtained * Mapping of Rutland voluntary and community sector				GREEN
2.1.3	Increase the level of volunteering across the county.	Working through the Citizens Advice Rutland (CAR) volunteering marketplace, making sure we are building on positive experiences in the pandemic.	CAR	Sep-23	Place	* Number of volunteers registered * Number of matches made * Number of hours of volunteering committed				GREEN
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 Camerados, an approach designed around people looking out for each other.	CAR	Mar-24	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				GREY
2.2	**Looking after yourself and staying well in mind and body**									

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2.2.1	Supporting residents to live more active lives	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.	Active Rutland, Active Together, PCN RISE	Mar-24	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				GREEN
2.2.2	Supporting residents in health awareness and ensuring they can self-care where appropriate.	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), Public Health, PCN, VCF sector	Mar-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				GREEN
2.2.3	Ensure our workforce are trained and empowered to have healthy conversations	a) 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. b) To include professionals working with housebound and digitally excluded people, and those who struggle to travel. c) Accessible signposting resources.	RCC, PH, LPT	Jun-23	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				GREEN
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.	a) Promote clear routes for wellbeing enquiries/ requests for support through Rise front door and RIS.Link to' prevention front door.' 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	Jun-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				GREEN
2.3	**Encourage and enable take up of preventative health services**									

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2.3.1	Increase uptake of immunisation and screening programmes.	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) c) Use the Health and Wellbeing Coach, healthy conversations (MECC+), Core20Plus5 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.	PH/ PCN/ NHS England	Mar-23	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), uptake of screening programmes closer to home.				**GREEN**
2.4	**Maintaining and developing the environmental, economic and social conditions to encourage healthy living for all**									
2.4.1	To have a focus on 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 travel; fuel poverty; air quality; and healthy housing.	RCC PH	Mar-24	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.				**GREEN**

Priority 3: Living Well with Long Term Conditions and Healthy Ageing

Senior Responsible Officer (on HWB) **John Morley**

Responsible Officer (on IDG) **Emma Jane Perkins**

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3.1	**Healthy ageing, including living well with long-term health conditions, and reducing frailty and over 65s falls**										
3.1.1	Empower people towards self care	1. Development of new digital front door	PH/rcc	22/23	p	Number of people accessing front door	initial scoping meeitng to be held 5/12/22		funds to progress this project buy in from across partners		
		2. Full use of the Joy social prescribing platform as the referal route to Rise	pcn/rise	22/23	p	number of rise referals against target for year of 507 from PCN	245 referals to rise from PCN to end Oct 2022 - a rise of nearly 50% seen from some surgeries following introduction of Joy	321 referals received to end of Dec 2022			
		3. Rutland prehab pilot	icb/pcn/active rutland/vol sector	22/23	p	number of residents engaging in prehab activites prior to below the waist operations	intial meeitng held 14th Sept - await numbers from UHL	onhold due to pressures in secondary care			
	also in health plan	4. Recruit dedicated Digital Inclusion and Communications resources to support development, access, and navigation of e.g., Patient Online System/NHS App services/remote consultations/ practice websites (22/23)	pcn	22/23	p	number of patients accessing ppintment online	Linking in with the work of the stakeholder and communications group to ascertain local needs and work with partner organisations so as not to create duplication. Consideration giving to local sessions on how to use the NHS app and patient online services. Linkages to the pilot model in the city.				
3.1.2	Anticipatory care	**1 Monitoring deterioration in a persons health using:-**									
	also in health plan	**1. Whzan – NEWS2/Restore Mini**	Pcn/rcc	22/23	p	number of people admitted to acute from a care home	care home admissions 20/21 = 162 21/22 = 149 22/223 = 32 9 care homes signed up to whzan pilot - pilot starting 1/11/22	pilot started in Rutland care homes			
	also in health plan	**2. Population health management anticipatory care project - pre dementia** **Embed operational and anticipatory care/ population health management approach through Multi-Disciplinary Teams to jointly manage frail, complex and high-risk patients (Jan 23)**	Pcn/rcc	22/23	p	number of MDTs from neighbourhood facilitator number of people engaged with pilot/project"PCN MDT meetings taking place at agreed intervals Increase in identification of patient cohorts identified by the Anticipatory Care regional team • Increase in care planning for above cohorts	new neighbourhood facilitator started 21/11/22" • Target cohort for anticipatory care agreed by end of November 2023 Rutland is one of 7 Anticipatory Care Early Adopter sites across LLR. The Rutland project will focus on holistic assessment and action planning for patients with memory/cognitive issues but no formal dementia diagnosis. Project planning underway, with expected go live in January 2023. Finalise project planning (December 2022), with delivery to commence in January 2023.	project plan agreed - intial stakeholder meeting planned for Jan 2023			
	also in health plan	3. Increase the number of Blood Pressure monitors available for Hypertensive patients to self-monitor (Blood Pressure @ Home) (22/23)	pcn	22/23	p	Rutland Health PCN to increase the number of BP monitors to support Hypertensive patients to self monitor at home. Monitor the use of the BP machines and average waiting times for patients Monitor the use of the BP machines and average waiting times for patients	The PCN now has a total of 180 BP monitors for use across the four practices.				
	also in health plan	4. Implement a proactive framework for identifying and managing frailty, using care coordinators to target support for Housebound and/or frail patients in collaboration with RISE team (22/23) action from strat health plan We aim to implement a proactive framework for identifying and managing frailty, using care coordinators to ensure that all patients are offered 1.Shingles vaccination 2.Screening for dementia 3.Structured Medication Review 4.Referral to integrated care coordinator 5.Falls prevention advice and referral 6.Proactive management of long term conditions and care planning	pcn	22/23	p	Review and evaluate based on: Reduced rate of hip fractures. Increase number of patients with frailty flag using the electronic frailty index. Increased uptake of shingles vaccination. Number of completed structured medication reviews. Number of completed care plans including RESPECT where appropriate. Number of patients referred to Steady Steps and falls prevention services.	PCN DES Inequalities plan targeted at Housebound patients and patients with frailty. Care coordinators are actively identifying selected cohort and proactively contacting patients, identifying those who are experiencing digital exclusion to offer interventions. Integrated care coordinators, working as part of Rutland's RISE social prescribing team provide a comprehensive social assessment, whilst the frailty coordinator ensures that all the health interventions are complete and long term conditions optimised. Plan underway in support for RISE team and WHZAN project.				
		5.. EHCH - Frailty assessment	pcn/ccs	22/23	p	number of care home residents with a frailty assessment/score					
	also in health plan	6.Implement Proactive Care at Home frameworks for managing Cardiovascular Disease Long Term Conditions, using risk stratification to prioritise patient condition reviews (22/23) To deliver the Network Contract DES including the requirements for the delivery of a cardiovascular disease (CVD) prevention and diagnosis service by primary care networks (PCNs).	pcn	22/23	p	Recruitment of 7 clinical pharmacists as a part of the ARRS 2022/23 programme who will help to improve access for CVS risk management.					

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	also in health plan	7. PCN to Increase frailty identification and assessment on collaboration with RISE team by 25% (Oct 22)	pcn								
	also in health plan	8. Increase uptake of community eye scheme provided by local optometrists (22/23) Completion of a business case for consideration by the Strategic Estates Team that demonstrates the utilisation of ringfenced S106 funds that complies with criteria outlined by Rutland County Council. Agreement of S106 funding for re-purposing of a waiting room at Oakham Medical Practice in to additional clinical rooms.	icb?	22/23	p	numbers accessing	??				
	also in health plan	9. All vulnerable patients (including end of life) have quality care plans in place by Oct 22 (22/23)	pcn	22/23	p	number with a quality care plan					
3.1.3	prevention of falls	1. Exercise referral and promotion of active opportunities makes it easier for people to increase their activity levels in a way that works for them.	Active rutland /pcn/dhu/rcc therapy	22/23	p	Living with ill health	paper on future of exercise referal programme to be presented to PH board - Mitch Harper	agreed funding secured for new coordinator poat in Active Rutland Team	funding request not supported by PH		
		2. DHU urgent falls response car		22/23	p	Number of responses by DHU car	Rutland area. Of these 6 were referred into hospital services either via ED or admission pathways and the utilization of urgent transport rather than 999. project extended to march 2023				
		3. Personalised falls prevention programme - Therapy project for support to care homes to prevent falls	LHis	22/23	p	Period No of reported Hip Fractures in Care/Residential Homes July – October 2021 12 July – October 2022 1 Number of care homes engaged in falls project and resulting reduction in number of falls	Four care homes have now enrolled onto the personalised falls prevention programme. Our Falls OT is working collaboratively with the Clinical Care Home Coordinator to ensure accurate reporting of falls from all care and residential homes in Rutland, not just those enrolled onto the programme. Data analysis has started to look at the impact of the programme, initial figures are positive. Falling amongst our most vulnerable cannot be fully eradicated, however this programme is demonstrating a reduction in the impact/severity of falls.	RCC Therapy and Quality Assurance are continuing to work with the 5 Care Homes enrolled onto the personalised falls prevention programme. An integrated approach between Therapy and the Primary Care Network is addressing the inclusion of Chater Lodge. As a cross border surgery this enables streamlined work, avoiding duplication and benefiting from regional best practice. Falling can never be fully eradicated, however this programme is continuing to be demonstrate significant benefit to minimising the impact of a fall. There has been 1 hip fracture reported in the last two months (Oct/Nov) in the care homes enrolled.	Staff Capacity: Currently 1 Full time OT dedicated to falls prevention, as the programme expands capacity would need to be considered. Demand – the programme has created a huge demand on therapy services increasing the falls reporting to unmanageable levels. The programme is constantly evolving, and process is being revised in line with the demand that has been created. This will be seen in the 2023 rollout for the next homes and changes for those enrolled.	
		4. Care homes digital falls monitoring		23/24	p	Reduction in admissions to acute from care homes due to falls	project being led by Lhis - intiial scoping being undertaken of digital access of falls equipment from care homes	Phil Eagle from Lhis assessing number of care homes with digital care records			
	also in health plan	5. Pilot of Falls Crisis Response Service in Rutland (22/23)	Charlie Summers/ Kerry Kaur								
3.2	**Integrating services to support people living with long-term health conditions**										
3.2.1	MDT/collaborative neighbourhood working	1. Weekly care home MDTs EHCH	Rise/pcn/vol/lpt	22/23	p	Number of care home weekly board round. Strutured medication review (SMR) residents with a care plan	mdt = 49 for sept 100% rutland homes have a weekly MDT/ward round 100% residents have a SMR tbc care plans in place	MDT = 41 for Nov			
		2. Monthly Rise /asc/pcn in each of the 4 Gp practices			p	Number of cases discussed at weekly MDT					
		3. Full use of the Joy social prescribing platform			p	number of partners using Joy Outcomes of individuals – ONS4 + qualitative		321 referals up to Dec 2023			
		4. Weekly DN board rounds			p						
	also in health plan	5. Neighbourhood monthly meetings			n	Professional experience of MDT working	51 partners/professionals on monthly	meeting held			
		6. expansion of housing MOT to support people with digital access	longhurst/rcc	22/23	p	number accessing servcies digitally	In addition to the launch of the Digital Mot pilot				
		7. fire servce home safety checks	rutland and	22/23	p	target of 650 oakham 50 upingham home	24 warm packs availble for people identified				
3.2.2	MDT access to resident records/information	1. Case management taking place on Joy platform and informing asc LL & PCN S1	Rise	22/23	p	Number of cases on joy platform		rise fully case managing on the joy platform			

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	also in health plan	2. Use of LLR electronic shared care record when available	lhis	22/23	p	number of professionals using the LLR shared care record " • Ensuring all pilot users can access the LLRCR and any issues are investigated, resolved and documented. • Analysis and report of feedback gained throughout pilot • Pilot users are able to successfully navigate the LLRCR and use it routinely. • Information visible aids efficiency and works towards realising benefits. • Successful connectivity • Evaluation of data set provided, Inc. feedback on any additional fields needed for efficiency • Feedback from pilots team on implementation process, incl training and support. •Staff satisfaction of interface and usability "	The Rutland discharge team will imminently be going live as the first team in LLR to pilot the LLR Electronic Care Record to enable key information relating to an individual's care to be shared between all LLR health care settings and Rutland County Council staff (Q1 22/23) " • LPT and Rutland pilot teams ready to go live • Progress on extended UHL data which should be available in the LLRCR towards the end of July • Public engagement and comms continuation - positive feedback so far and good interest • In response to feedback GP connect information tab has been created in the interim of having structured data. This is now more visible in our new top-level tab structure."		too few professionals engaged with this project reduces the gain of using the system		
3.2.3	prompt safe hospital; discharge	1. Minimise hospital stay	Rcc hospital team	22/23	p	Length of stay 14+ days length of stay 21+ days	We currently don't have anyone that is 14 days plus.	Length of Stay isn't a good metric for this, swe have tried to look at the time taken from receiving the Home First form to the point of discharge. Ideally, we'd want this to be happening within 48hrs. However, we've got problems with these figures too – in that PCH sometimes send the form days or weeks before discharge is ready – so we can only really measure the UHL discharges – and looking at these for October (8 in total), only two were within 2 days – the others were all longer, but most of those delays were down to internal UHL processes rather than then RCC delay. Going to continue to explore this to find something we can measure to evidence we're doing what we can to minimise the delay.	measurement to show the outcomes delays are not attributable to RCC but the acute process	continue to discuss at LLR discharge meeitngs	
		2. Discharge to home first	Micare and therapy reablement	22/23	p	Discharge to usual place of residence	micare holding 16/17 cases daily in sept 2022 17 new starts and 15 cases ended of support	micare holding 14 cases a day with 38 D2A cases in Dec 20 new cases and 18 ended durign December	MiCare ability to recruit carers and therefore there might be insufficient capacity to support timely discharge.	full recruitment in place including a new video	
		3. assessment on discharge to right size support	Rcc hospital team	22/23	p	numbers on D2A	30 service users on D2A during September 2022	38 D2A in Dec			
		4. Increased reablement following hospital discharge			p	Reablement – effectiveness 91 days still at home	ave length of stay on reablement = 13 days for sept 22 Effectiveness – 100% in September Still at home 91 days after Reablement commenced – 100% in September	ave length of stay on reablement = 14 days effectiveness 100% dec 2022 100% still at home 91 days after reablement	Staffing: Ageing Well monies have been used to employ Therapists to cover weekend working, but unlikely to get repeat funding next year. No weekend OTs may impact on timely flow through		
	also in health plan	5. Implement Ageing Well Urgent Crisis Response 7-day therapy new ways of working in Rutland (22/23)	Rcc hospital team	22/23	p						
	also in health plan	Enhancing the end-of-life discharge pathway through testing an integrated EOL social care bridging and co-ordination offer (22/23)	Rcc hospital team	22/23	p		Currently a pilot being offered by ICRS to specific county resident post codes. Referrals continue to increase for County patients into the ICRS EoL service for patients in last weeks and month of life, supporting step up and discharge. Reducing reliance on CHC.				
3.3	**Support, advice, and community involvement for carers**										
3.3.1	support for carers	1. Identifying carers Identification of carers to be improved through distribution of information, improved online content and face to face engagement activities across the county to raise awareness and recognition of carers, their rights, needs and support available. This will include raising awareness with carers themselves, professionals and the wider public.	Rcc	22/23	p	Increase number known to RCC/PCN					
		2. Providing support Support to be provided for adult carers of adults directly through RCC's Carers Team and additional support available for carers of those living with dementia through the Admiral Nursing service. Support includes information, advice and signposting to other agencies, eg local voluntary partner agencies. Carers Passports to be available to carers of all ages to support with accessing services and valuing carers. RCC to explore signing up with Carefree to offer free short breaks to adult carers of carers.	rcc		p	Satisfaction and carers ability to care	The draft LLR Carer Strategy will go to cabinet on Dec 13th for sign off. Following further consultation by RCC, carers feedback has informed both the strategy and our local delivery plan.				

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		3. Launch of new carers support group – Oakham 'together we care'	carers centre	22/23	p	numbers attending group	launching on wed 9th Nov at St Josephs church hall 1 - 2.30pm				
3.4	**Healthy, fulfilled lives for people living with learning or cognitive disabilities and dementia**										
3.4.1	supporting people with LD and autism	1. Annual health checks	Rcc	22/23		% Number of LD health checks completed					
		2. Sharing Leder findings	rcc	23/24	s		The Autism Strategy Working Group will be meeting in November. This will begin the foundation of the delivery plan, identifying task and finish groups to work on the areas where there are gaps and mapping good practice. This is across all ages.	Dec's Leder steering group attended by RCC Manager. 2 leder governance summaries shared with current Learning into Actions identified These will be added to RCC's Leder CPD prsenatation. Aspiration Pneumonia Thematic analysis has been completed, health and clinicians are meeting to see how best to proceed with the learning from report.			
		3. Providing specialist care close to home		22/23	p	Qualitative feedback from this cohort number being carered for out of county					
		4. Supporting people with LD/autism to access vol/work/education opportunities		22/23	p	% Number in employment	RCC's employment officer has unfortunately been sick for the last few months, impacting on the delivery of this service	RCC's employment Officer is now back from sick leave. Currently working with 10 indiviuals who are wanting to either gain paid employment or voluntary positions. All 10 have outcomes and action plans to work towards.			
3.4.2	supporting people with dementia/cognitive impairment	1. Increase in identification of people likely to develop dementia through anticipatory care project – using Aristotle PHM tools	PCN	22/23	p	Number of people identified at risk of developing dementia	meeting to plan project 9/11/22				
		2. Increase diagnosis rate for Rutland population	icb memory clinic	23/24	s	Number of people with a diagnosis of dementia					
		3. Equity in access to admiral nurse	Admiral Nurses		p	Admiral Nurse service availability % number of people supported by admiral nurses	Referrals have increased to our dementia service following the targeted work on pre/peri diagnosis to support those waiting for a diagnosis and as part of the further complexities resulting from Covid. Due to cost savings required by the LA, we are not able to recruit to a dementia support worker for another 12 months, which will result in a waiting list for this service to manage risk and demand.				
		4 increase support opportunties for familes/carers/people with dementia	vol sector	22/23	s	number attending sailing club sessions	As part of the Living Well with Dementia Grant Fund, the Dementia Programme Board of Leicester, Leicestershire, and Rutland (LLR) have secured funding to support voluntary and community sector organisations (VCS), to enable them to continue to develop their work with people living with dementia, their family or informal carers. We are part of the VCS Dementia Grant Phase 1& 2 evaluation panel. In Phase 1 Rutland Community Ventures (RCV) were awarded funds to support carers of those awaiting or coping with a new diagnosis within Rutland. The aim is to run 4 workshop sessions, which will be craft based, offering an opportunity for conversation, and sharing at the end of the session . These will be run in a dementia-friendly environment at the Rutland Sailing Club.				

Priority 4: Ensuring Equitable Access to Services for all Rutland Residents and Patients

Senior Responsible Officer (on HWB) **Debra Mitchell**

Responsible Officer (on IDG) **Charlotte Summers**

GREEN = On Track

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4.1	**Understanding the access issues**									
4.1.1	Indentify services that are commissioned locally in Rutland via the LLR and ICB and map equivalent services available across the neighbouring borders. To include both Primary and secondary care. Identify the cohort of patients who are registered with a Rutland GP but outside of Rutland. Finding to inform future pathway design.	Identification of the number of patients who are registered with a Rutland GP but live outside of the Rutland CC boundary. Identification of patients who live inside the Rutland boundary but access GP services outside the Rutland CC boundary. Identify issues of health and social care provision across borders to inform targeted work looking at certain cohorts of patients. Check services available in Leicestershire and indentify pathways in neighbouring counties and vice versa. Indentify top ten secondary care referral specialities for Rutland patients. Identify top ten reasons for attendnace at A&E for Rutland patients. Identify top ten reasons for admission in to secondary care for Rutland patients. Identify RMH community hospital inpatient bed utilisation and occupancy rates, including Rutland patients who are admitted to a community hospital bed outside of Rutland. Operational Service mapping of key OOA pathways where there are inequalities	ICB	Apr-23	Place	Report on border issues Documented mapping of key OOA service pathways and reference to specific issues Agreement on areas of focus of inequalities as part of delivery of PCN Network DES Agreed data sets and reports available for Rutland on Aristotle.	Baseline of data available from the initial population health management work that idenitifies both patients who are registered with a Rutland GP but live outside the Rutland CC boundary and patients who live inside the Rutland CC boundary but are registered with a GP outside of Rutland. Additional deliverables have been included from November which will include further work in the coming months but key meaurement metrics have been indetified.	Variability in the availability of certain data from different providers. Some data may not already be routinely collected.	Work closely with Midlands and Lancs CSU and providers to ascertain whether it is feasible to establish regular data collection to inform measurement of the metrics.	**Amber**
4.1.2	Develop strategic relationships with cross border commisisoners and providers to ensure equitable services are developed and available ensuring Rutland's residents and those registered at a Rutland GP have greater choice across boundaries and inform future strategy development of partner ICB's. Build equitable access into pathway design.	Greater understanding of services that patients access or should be able to access across borders in Peterborough, Lincolnshire, Northamptonshire and Cambridge. Check services available in Leicestershire and indentify pathways in neighbouring counties and vice versa. Established links with associate commissioners and other partner agencies to inform future commissioning arrangements. Patients will feel more informed with regards to the services that they can access, where they can access and the different services available other than an appointment with a GP. Highlighting different roles such as first contact physio, clinical pharmacist, mental health practitioners.	ICB	Apr-23	Place	Improved patient feedback from people reporting health and care inequity Established regular meetings with associate commissioners and regular two way dialect.	Regular meetings have been established with assocate commissioners to better undertstand the devlopment of their place led plans. They have also been invited to attend the Rutland Strategic Health Developments Board. We have shared our local plans with both providers and commissioners so that our plans can be considered when developing theirs. Working collaboratively with Lincolnshire on the planning for a new housing devlopment and on the borders between Stamford North and South Kesteven. Anticipating the impact on local health care provision and how this can be mitigated.			**Amber**
4.1.3	Work with local Rutland population to understand the key issues that they identify as a patient living in a rural location such as Rutland. Publicise the wide range of services and extended roles available through primary care. Patient and public engagement to inform long term plans.	Engage with the local population with regards to the design of the enhanced access service. Address the key recommendations from the RCC Primary Care Access Survey. Engage with PPG's and Rutland HealthWatch	ICB	Apr-23	Place	Number of survey responses Patient feedback Progress against the individual recommendations outlined in the Primary Care Accesss Survey.	Comms and enagement working group established.			**Amber**
4.2	**Increase the availability of diagnostic and elective health services closer to home**									**Amber**
4.2.1	Improving public information about locally available diagnostic and planned care services as part of increasing access including urgent care and when mobile facilities such as the mobile breast screening unit are in the area, and accessible out of area provision.	GP, PCN and Rutland Information Service having dedicated areas on their websites/directories with information that is kept up to date and active signposting to out of county equivalent services. Map all local services available.	ICB	Apr-23	Place	Local communication plan and RIS development including specific campaign on out of hours access				**Amber**
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.	A completed estates review that identifies all areas that are curently being used, idenitfy areas for consideration not just from a health pespective but local authority and other local businesses such as leisure centres and vountary sector organisations.	ICB	Apr-23	Place	Quantified understanding of available space and existing medical facilities' appropriateness for clinical activity	LPT strategic estates review currently underway which should be complete by January. MIU engagement to start in January. Preliminary engagement event held with Rutland HealthWatch RCC are also undertaking a strategic estates review. Stakeholder mapping currently underway.			**Amber**

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4.2.3	Review and identify potential solutions for Elective and Community services feasible for closer local delivery, to macimise the use of local existing estates Infrastructure whilst supporting restoration and recovery post covid including considering e.g. cancer 2 week wait, cardio respiratory services and orthopaedics and the delivery methods for such services i.e. virtual or face or face, satelite clincs. Consider longer term options for children's services (incl phlebotomy), end of life, chemotherapy and diagnostics. Consider both new and existing infrastructure sites including Rutland Memorial Hospital (RMH).	Clarity of what services are delivered by GP practices, PCN, PCL, Acute and Community Services both locally and out of county. Review waiting lists for key priority areas. Explore potential areas for consideration to support reduction in waiting times and post covid back log for elective and community services.	ICB	Apr-24		Review of current and potential services delivered at RMH Evaluation of AI Tele - dermatology service Increase in availability and access to services locally	Talks have been continuing with regards to the potential for a local MRI scanner, funding through a local charity has been sourced but housing of the unit is still to be resolved. The unit has special requirements and restrictions for power supply and also access to facilities for patients attending.	The unit has special requirements and restrictions for power supply and also access to facilities for patients attending.	Additional sites for housing the unit are being considered.	Amber
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.	Establish current usage of pulmonary rehab, anticipated future requirements and commissioning a service to be provided locally if required.	ICB	Jun-23	Place	Evaluation of local pulmonary rehabilitation take-up Increased take-up of pulmonary rehabilitation by relevant patients	No update on progress to date			RED
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.	Establishment of Integrated Neighbourhood Teams by: Adopting a Population Health Management approach including risk stratification Delivering co-ordinated care at a local level Multi-disciplinary teams (MDT) working to deliver better outcomes Delivering a preventative approach to care, with access to a local prevention offer including social prescribing				Partnership agreement on way forward and dedicated plan on next steps	Integrated neighbourhood network established and meeting on a monthly basis. Monthly MDT's taking place			Amber
										Amber
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 such as dementia assessment, community paediatrics and mental health.	Increase the understanding locally of the extended primary care team and the many ways in which an appointments can be booked . Implmented enhanced access locally More appointments in total in comparison to 2019 but acknowledgement of the wide range of appointment types available. Increase in the number of patients accessing the community eye scheme in comparison to baseline. Increase referrals to the community pharmacy referral scheme. A review of key services and waiting lists/times and put appropriate and deliverable plans in place to address whilst maximising the use of out of county providers and provision of more local services where possible.				•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 •Identified waiting lists/wait times reduced	Enhanced access was implmented from October 2023. Services are now available from 6.30 - 8.00pm Monday to Friday and 9.00 - 5.00pm on a Saturday. The most recent GPAD data demonstrates that all four practices are delivering more appointments than in comparison to pre-pandemic levels.	Phlebotomy blood collections	The ICB has been in negotation with UHL for addirional weekend blood collections. A paper has gone to SCG in December and it is hoped that PCN's can start to delivery a full saturday phlebotony service from Janaury.	Amber
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.	Standardised format for all 4 PCN practices making navigation easier. Recruitment of a digital inclusion officer (subject to funding) to work with patients to educate on the use of NHS app and websites. How to book appointments online, online consultations. Direct work carried our with the patients and public of Rutland to communicate the many services/clinics available and the varied roles. The role of care navigators and reception staff. Informing patients when appointments are released.	PCN	Apr-23		•Evaluation of PCN and practice websites and future developments.	PCN to look at reviewing each of the practices websites for usability and easy navigation. PCN is currently considering the the recruitment of a digital transformation lead as a result of additional in years scope with ARRS. This will also feed in to the work of the Comms and Engagement group.			GREEN
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.	Reduction in the number of patients waiting for joint injections. Increase in the number of patients being referred to community pharmacy and reduction in appointments in primary care that relate to conditions within the remit of CPCS.	ICB	Mar-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	**Update from Helen Mather Required**			Amber
4.3.4	Maximisation of clinical space utilisation within primary care including existing primary care premises.	Undetake a clinical estates strategy. Seek to increase clinical consultantation rooms at Oakham Medical Practice via S106 investment. Explore potential Increase in designated clinical space at Uppingham Surgery.	PCN	Jun-23	Place	•Practices with increased consulting spaces •Increased appointment capacity	There has been a slight delay in the production of the clinical estates strategy for Rutland and this is now antipated by end of January/early February. Amendments are currently being made to the Oakham S106 business case and will be submitted for consideration by RCC in Janaury 2023.			Amber
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).	Establish links with primary care providers for military personnel. Identiication of seldom heard or under-served groups and increase in uptake of services via targeted comms and engagement.	ICB	Mar-24	Place	•Health equity audit on GP registrations	Comms and enagement working group established.			GREEN
4.3.6	Ensuring full use of specialist primary care roles tailored to needs (e.g. practice pharmacist, muscular-skeletal first contact, health coach).	Increase in number of ARRS roles year on year Increase in the number of patients being seen by these roles. Maximisation of ARRS allocation Increase in staff undertaking training and further development.	PCN	Mar-23	Place	•Employment and delivery of specialist primary care roles in Rutland •Impact on primary care capacity of specialist roles	All clinical pharmacists posts recruited to. Maximisation of ARRS allocation in year. Exploration of a digital and transformation lead as a part of the changing guidance in October.			GREEN

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4.3.7	Engage with local Armed Forces Defence Medical Services (DMS) to better understand to improve local health and social care interactions with regards to local service offers and and pathways. facilities to inform changes in local Health and Care services including referral processes/documentation e.g. RMH provision.	Establish links with primary care providers for military personnel. Identiication of seldom heard or under-served groups and increase in uptake of services via targeted comms and engagement. Reduction in barriers to referral to secondary care services.	Put in inequalities section links to service movements			•Qualitative feedback that local services better reflect the needs of the military population				
4.3.7	Develop a single point of contact for the Armed Forces community, offering support and guidance to navigate the (local) NHS systems and prevent disadvantage	Develop and outline LLR wide model to act a as a single point of contact embedding key elements of the due regard framework. Due regard for the armed forces in health referral e.g. duty to consider this population in pathway navigation and communicating appropriate health offers locally.	ICB	Sep-24	System	National and local pilot evaluation. Metrics to be agreed.	Task and finish group being established to work a model up by the end of January.			**GREEN**
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. Community Transport pilot in Uppingham.	****Identify lead for this****	RCC			•Pilot evaluation report of findings and recommendations •Options appraisal of community transport models including collaborative financial strategy with Parish Councils				
	4.4 Improving access to services and opportunities for people less able to travel, including through technology									
4.4.1	Decrease digital exclusion and Increase digital inclusion by 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. Identify reasons for digital exclusion e.g, affordability, skills, confidence, connectivity, choice. Support to take up digital services e.g. access to medical record, booking appointments, virtual appointments, prescription ordering. b. Fit for purpose local internet infrastructure and access across Rutland including access to high speed broadband within community setting such as libraries. Advice to support household choices.	Increased number of people booking on line and using the practice websites. Increase in number of patients being seen virtually. Increase number of patients with digital access to their health care record. Provision of digital enablement sessions - training on how to use the NHS app and practice websites. Promotion of onine access at local events Consideration of a digital transformation lead within the PCN. Increase in number of location public access points for high speed broadband. Standardisation of the practice websites so they all have the same navigation for ease of use. Consideration of services that may be able to be offered virtually. Monitoring of website usage and collection of patient feedback.				•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 against the baseline comparator. Practice website usage data and feedback Number of people attedning NHS App training sessions	Standardisation of practice websites being looked at, at a PCN level. PCN currently scoping the potential of a digital transformation lead. Work underway to see what baseline data we can capture for a number of the metrics.	Originally a business case was going to be written for consideration against BCF underspend for the digital enablement element of this work but this is no longer available.	Instead this will be taken forward through the work of the comms and engagement group, linking in with key stakeholders, local volunteers and linking with the PCN Digital Transformation Lead.	**AMBER**
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 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).	****Confirm Reporting Lead for this element****				•Review of current transport routes and health inequalities needs assessment •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.	Review which third party services are provided and consister whether they are able to be delivered locally in Rutland. Increase in number of venues identified that can be used for health and social care service delivery. Identification of services that can be offered locally that were originally accessed external to Rutland.	ICB	Apr-24	Place	•More services delivered within Rutland wherever possible				
	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	Identify key contracts that are used by Rutland out of area.				•Review of cross boundary working across health and care				
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. Explore potential for future digital referral routes from out of area.	** Update from Sharon Rose Required**				Electronic shared records implemented across a range of health and care providers				

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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.	Establish links with neighbouring commissioners and providers and establish regular dialect.	ICB	Mar-23	Place	Clear links with local CCGs and LAs re cross boundary working	Regular meetings have been established with assocate commissioners to better understand the devlopment of their place led plans. They have also been invited to attend the Rutland Strategic Health Developments Board. We have shared our local plans with both providers and commissioners so that our plans can be considered when developing theirs. Working collaboratively with Lincolnshire on the planning for a new housing devlopment and on the borders between Stamford North and South Kesteven. Anticipating the impact on local health care provision and how this can be mitigated.			**GREEN**

New Enhanced Access service resulting in more appointments available a minimum of two weeks in advance, and a mixture of in person face to face and remote (22/23)
Consider a local Enhanced Access service (part of review of access to primary and urgent and emergency care) encompassing same day access for Primary Care, Urgent Care, including (Minor Injuries), and Frailty Care

Recruit dedicated Digital Inclusion and Communications resources to support development, access, and navigation of e.g., Patient Online System/NHS App services/remote consultations/ practice websites (22/23)

Review GP registrations in the context of unique or under-served groups to increase registration for Health Services e.g., Armed Forces Families and Traveller Community (23/24)
Develop an enhanced access model that supports access to same day appointments. (22/23)
Review Minor Injury Service provision and Urgent Treatment Centre provision to ensure that it meets the needs of the local population and reduces the need for presentation at ED. (22/23)
Identify the highest utilised ED's out of county and across borders in relation to Rutland residents looking at reasons for presentation and reviewing associated pathways (22/23)
Expand the number of Clinical Pharmacists working locally who can treat Minor Illness such as coughs, UTI's and Cellulitis and Long-Term Conditions. (22/23)

Priority 5: Preparing for our Growing and Changing Population

Senior Responsible Officer (on HWB) **Sarah Prema**

Responsible Officer (on IDG) **Jo Clinton**

GREEN = On Track
AMBER = Off track but

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5.1	**Planning and developing 'fit for the future' health and care infrastructure**									
5.1.1	Work with local/ neighbouring Integrated Care Systems (ICSs) partners to share information to ensure in border and cross border population health impacts are consistently understood	•LLR CCGs PCES Population Model that shows impact on health infrastructure as a result of growth in the Rutland border • Documented population health impact of Stamford North Housing Developments outside of the border shared with partners • Routine joint dialogue between partners •Initial baseline of Non Local plan impact by Rutland LSOA • Ongoing 6 monthly reviews and updates of latest LSOA level impact vs initial baseline position •RCC and Neighbouring LPA approach to prioritisation and CIL allocation plans is in place and visible to partners •Agreed population model with robust methodology that can be used to support dynamic impact modelling by LSOA •Work with Rutland County Council to facilitate development of a set of options for a Health Campus /Medi-tech trials facility	RCC/ICB	Apr-24	Place	•Aligned fit for the future plans with neighbouring ICS's • Healthcare is confirmed as priority for infrastructure funding and recieved adequate support in line with growth and impact • Understanding of current CIL funding including trajectory of allocations and any unallocated funding • Understand where Healthcare sits in wider prioritisation of infrastructure support • Agreed updated Information requirements and timely sharing with health partners to inform dynamic modelling •RCC to 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 •Health Strategic Partners Involvement in CIL review process and receipt of report on new policy implications	• ICB has provided comments on the Rutland Local Plan Issues and Options • CIL Cabinet paper has been developed by RCC which indicates priorities for CIL funding inc Healthcare • Awiating site list with relevant information from RCC to enable baseline model			Amber
5.1.2	Work with in county and out of county providers and commissioners to cross share plans for Healthcare to inform future local service provision	• Routine joint dialogue between partners on latest plans and possibilities for joint solutions •Aligned fit for the future plans with neighborhing Places to inform local commissioning in and out of county provision in the future • Agreed LLR representation on North Place Alliance • Ongoing Engagement with OOA senior transformation leads for Primary Care and Planned Care Transformation • Cross sharing of latest LLR and OOA CDC plans with understanding of timelines and key service offers to plans impacting Rutland residents	ICB	Apr-24	Place	•Aligned fit for the future plans with neighborhing Places to inform local commissioning in and out of county provision in the future • Documented population health impact of Stamford North Housing Developments outside of the border shared with partners • Understanding of emerging options for joint solutions on the Stamford and Rutland border • Joint messaging around direction of travel for cross border developments in place and evolving over time	• Established partnership links with our Local Planning Authority (LPA) and commissioning partners not only in Rutland but over the border with Lincolnshire ICB and South Kesteven Local Authority. Extended to include Allison Homes for developments in Rutland and Gummer Leathes in Stamford, with regular meetings now in place • Meeting with Andrew Pike has taken place to see whether there are any learnings from other areas in how to take fwd locally • Regular meetings with ICB lincs are taking place to ensure allignment of Primary Care Clinical and Estates Strategy • Stage 1 Outline Proposal submitted to National LUF Team	Local Primary Care Project Provider for LLR Wave 1 programme has been de commissioned and a new provider to take fwd is being identified. This will result in delay to development of Rutland PCN Clinical and Estate Strategy		Amber
5.1.3	Enable a fit for the future local healthcare	• Documented PCN Clinical and Estates Strategy to inform how future clinical strategy can be supported to deliver going fwd. • Business Cases development and approvals for future Estate solutions •Undertake strategic site feasibility review of local Health Estates including Rutland Memorial Hospital	ICB	Apr-23	System and Place	• Identified PCN clinical priorities and reccomendations for future sustainable solutions that are documented and that can inform the delivery of the Healthcare Plan • Quantified understanding of available space on site at Rutland Memorial Hospital within existing medical facilities' appropriateness for clinical activity against criteria • Develop a Business Case for RMH based on feasibility findings	• Rutland Health PCN are being engaged as part of phase 1 of LLR programme to develop Clinical/Estates Strategy. • Feasibility work has been commissioned by the ICB and is in development for findings to be shared by end Feb • Oakham Business case is still being finalised and is currently sitting with the Strategic Estates Team. Once finalised it will be submitted to the Strategic Estates Group for consideration.	Local Primary Care Project Provider for LLR Wave 1 programme has been de commissioned and a new provider to take fwd is being identified. This will result in delay to development of Rutland PCN Clinical and Estate Strategy		Red
5.2	**Health and care workforce fit for the future**									
5.2.1	Develop training for new ways of working	Ensure appropriate local development opportunities are being accessed by all roles where available i.e. Community Pharmacy Academy development programme - for Occupational Therapy, Clinical Pharmacist, Paramedic connected to Network, muscular-skeletal first contact staff and health coach	PCN/RCC	Apr-23	Place	•Completion of PCN training courses and evaluation of training and impact on patient outcomes	James / Emma Jane to Advise			
5.2.2	PCN continue to expand on its Additional Roles Reimbursement Scheme	• Recruitment of all ARRS roles outlined in the 2022/23 workforce plan for Rutland Health PCN • Looking at care co-ordination and clinical pharmacists' capacity	PCN/RCC	Apr-23	Place		The PCN has ran a very successful Clinical pharmacist recruitment campaign which will equate to 7 new clinical pharmacists joining the PCN. They also have in train 1 wte first contact physio, 4 care coordinators which will support a lot of the care planning and proactive care work.			
5.2.3	Develop Career Development Structures	• Mat to advise whether to remain, be changed or removed • Consider projects to increase career development and satisfaction for retention e.g. via delegation of health tasks	RCC			•Carer development and increased potential for workforce •Proportion of health and care staff remaining in work after 55	Mat to advise whether to remain, be changed or removed			
5.2.4	Promote local Career Opportunities	• Mat to advise whether to remain, be changed or removed • Increase engagement with local young people around careers in health and care, including through collaboration with schools and opportunities for work experience	RCC			•Sustainable health and social care workforce •Increase in proportion of staff in health and care sector locally	Mat to advise whether to remain, be changed or removed			
5.3	**Health and equity in all policies, in particular developing a healthy built environment aligned for projected growth**									

Ref	What Do We Want To Achieve?	How Are We Going To Achieve It?	Lead Organisation	Timeframe for Delivery (Month/Year)	Level (System, Place or Neighbourhood)	How Will Success be Measured?	Progress for November 2022	Key Identified Risks	Mitigations	November 2022 Project RAG Status
5.3.1	Embed Health and Equity in all strategies and policies across Rutland County Council and then partner organisations	• Core partnership working group estavblished to take this forward in an agreed timeline • To consider their impact on mental and physical health, health 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.	PH	TBC	Place	•Completion of a Local Plan Health Impact Assessment with clear and achievable recommendations •Progress against identified recommendations in the Local Plan development •Health and Equity in all policies embedded across Rutland Completion of a Health Impact Assessment of the Local Plan at the appropriate point of development with clear recommendations for mitigation and/or enhancement.	Paper for RCC being developed in New Year. Leicestershire are looking at a HiAP training package, which we will be utilising in Rutland if it's agreed. We're waiting for this offer to be finalised and then we have more of a 'sell' for the broader HiAP paper and recommendations as this one will be more tangible. The Whole Systems Approach to obesity work the Staying Healthy Group will be working on will be an example of HiAP			GREEN

Priority 6: Ensuring People are Well Supported in the Last Phase of Their Lives

Senior Responsible Officer (on HWB) James Burden

Responsible Officer (on IDG) Charlie Summers

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GREY = Not Started
BLUE = Complete

Ref	What Do We Want To Achieve?	How Are We Going To Do It?	Lead Organisation	Timeframe for Delivery (Month/Year)	Level (System, Place or Neighbourhood)	How Will Success Be Measured?	Progress for November 2022	Key Identified Risks	Mitigations	November 2022 Project RAG Status
6.1	Each person is seen as an individual									
6.1.1										
6.1.2										
6.2	Each person has fair access to care									
6.2.1		Refresh our JSNA and LLR all age end of life strategy (22/23)					LLR strategy to be in draft form by March 2023 - meetings being arranged to review both the EOL Ambitions Framework and JSNAs to ensure where strategy needs to focus - other work will form part of EOL task force workplan			
6.2.2										
6.2.3										
6.3	Maximising comfort and wellbeing									
6.3.1		Strengthen our community palliative and end of life care offer (22/23)					This is included within the revised Statutory Guidance for ICBs and will form part of LLR EOL task force workplan			
6.2.2		Support more people to die in their place of choice through Increased identification of people in their last year of life via increased use of RESPECT planning (22/23					System-wide launch of ReSPECT V3 planned for 2023 - this will include training and comms to system partners.			
6.2.3										
6.3	Care is coordinated									
6.3.1		Improve access to end-of-life care provision through design and mobilisation of a 24/7 advice line for patients, carers, and professionals (23/24)					Proposals to be considered as part of EOL task force workplan.			
6.3.2		Enhancing the end-of-life discharge pathway through testing an integrated EOL social care bridging and co-ordination offer (22/23)					Currently a pilot being offered by ICRS to specifica county resident post codes. Referrals continue to increase for County patients into the ICRS EoL service for patients in last weeks and month of life, supporting step up and discharge. Reducing reliance on CHC.			
6.3.3		Increase advance End of Life Care Planning by using risk data tools to identify people reaching last years of their life (22/23)					part of the national core metrics data for 'improving access' will be to identify their last year of life and percentage of individuals in the last year of life who have been offered personalised care planning - quarterly reporting from start of Q2			
6.4	All staff are prepared to care									
6.4.1		Quality and co-production review of patient and carer experiences at end of life. Ensure end of life remains everyone's business through appropriate training and support (22/23)					•Commissioned a co-production piece of work, which resulted in the identification of an approach for co-production. However, this needs support to mobilise and will be picked up via home first agenda			
6.4.2										
6.5	Communities are prepared to help									

Ref	What Do We Want To Achieve?	How Are We Going To Do It?	Lead Organisation	Timeframe for Delivery (Month/Year)	Level (System, Place or Neighbourhood)	How Will Success Be Measured?	Progress for November 2022	Key Identified Risks	Mitigations	November 2022 Project RAG Status
6.5.1		Raise local awareness to Integrated Community Specialist Palliative Care Service, specialist nursing, virtual day therapy, befriending support (22/23)					There are plans to have a communications campaign that pulls together the golden thread of 'Home First', which will include key messages for EOL support			
6.5.2										
6.5.3										
6.5.4										

Priority 7a: Cross Cutting Themes - Mental Health

Senior Responsible Officer (on HWB) - 7a Mental Health **Mark Powell**

Responsible Officer (on IDG) - 7a Mental Health **Justin Hammond**

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Ref	What Do We Want To Achieve?	How Are We Going To Do It?	Lead Organisation	Timeframe for Delivery (Month/Year)	Level (System, Place or Neighbourhood)	How Will Success Be Measured?	Progress for December 2022	Key Identified Risks	Mitigations	November 2022 Project RAG Status
7.1	**Supporting good mental health**									
7.1.1	Increase access to perinatal Mental health support services, wherever Rutland women have chosen to give birth.	1.2.2 Healthy lifestyle information for women pregnant or planning to conceive (c) mental health.	LPT	2022/23	System		Not yet underway.			Grey
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	2022/24	Place and System		Not yet underway.			Grey
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, VCS, CCG	2022/23	Place		Not yet underway.			Grey
7.1.4	Transformation project for Rutland- Ensuring Mental Health services are delivered in Rutland including; a) Supporting services via funding bids: (Mental Health VCS grant scheme – crisis café - second round June 2022, Small grants - £3k - £50k - second round to open June 2022, OPCC commissioner safety fund – up to £10k) b) A clear co-designed approach to supporting farmers' and other individuals' needs linked to rurality c) A clear co-designed approach to better meeting veterans' and armed forces families' mental health needs d) A clear local plan to better coordinate care across neighbouring service areas		LPT/ CCG/ RCC	2022/23	Place and System		Early actions underway: * Publicising open calls for funding bids to local agencies. * LLR workshops underway developing system and place MH plans. * Third round of senior mental health lead recruitment underway for Rutland.			Green
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	TBC	Place		* LLR workshops underway developing system and place MH plans. * Third round of senior mental health lead recruitment underway for Rutland.			Green
7.1.6	Deliver on the Long-term plan objectives for mental health for the people of Rutland: 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		LPT, PCN, RCC, VitaMinds	2022/23	System and Place		* New neighbourhood facilitator in post to organise MDT holistic approach of support. * LLR workshops underway developing system and place MH plans. * Agreement of physical space for Vita Minds to deliver support from within Rutland. * Resources agreed and transferred to Rutland Council by CCG to support development of prevention and resilience schemes.			Green

Priority 7b: Cross Cutting Themes - Inequalities

Senior Responsible Officer (on HWB) - 7b Inequalities **Mike Sandys**

Responsible Officer (on IDG) - 7b Inequalities **Adrian Allen**

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Ref	What Do We Want To Achieve?	How Are We Going To Do It?	Lead Organisation	Timeframe for Delivery (Month/Year)	Level (System, Place or Neighbourhood)	How Will Success Be Measured?	Progress for December 2022	Key Identified Risks	Mitigations	November 2022 Project RAG Status
7.2	**Reducing Health Inequalities**									
7.2.1	Complete a needs assessment to understand the current health inequalities in Rutland. The assessment will apply a rural lens, considering hidden deprivation and the resultant needs, calling on wider sources of intelligence across the community, voluntary and faith sector. The assessment will also focus on geographical inequality, inclusion health and vulnerable populations.		PH	2022/23	Place		Health inequalities study well underway, engaging partners to maximise local insight. The report is on the HWB forward plan for Autumn 22.			BLUE
7.2.2	Embedding a proportionate universalism approach to service delivery including principles of the CORE 20 PLUS 5 and HEAT tool. 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	2024/25	Place and System		Not yet underway.			Grey
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		ICB, PH, LLR Academy	2023/24	System		Not yet underway. Will be informed by 7.2.1 Inequalities report.			Grey
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, ICB, Providers	2022/23	Place and System		Armed Forces lead newly in post at RCC.			Green
7.2.5	Complete military and veteran health needs assessment to understand the inequalities facing this group	Refresh Inisghts data to reflect Rutland. Qualitative piece for current personnel and people coming back from Cyprus.	ICB, PH	2022/23	Place and System		System level analysis underway.			Green
7.2.6	Mapping Rutland community assets, including its voluntary and community sector.		RCC	2022/24	Place		Initial mapping of the voluntary and community sector across Rutland is underway, also drawing on data from the Rutland Information Service directory.			Green
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 and RCC	2024/25	System		Not yet underway.			Grey
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	2024/25	System		Neighbourhood facilitator in post to progress Population Health Management approaches via Aristotle.			Grey

Priority 7c: Cross Cutting Themes - Covid Recovery

Senior Responsible Officer (on HWB) - 7c Covid Recovery **Mike Sandys / James Burden**

Responsible Officer (on IDG) - 7c Covid Recovery **Adrian Allen**

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Ref	What Do We Want To Achieve?	How Are We Going To Do It?	Lead Organisation	Timeframe for Delivery (Month/Year)	Level (System, Place or Neighbourhood)	How Will Success Be Measured?	Progress for December 2022	Key Identified Risks	Mitigations	November 2022 Project RAG Status
7.3	**Covid recovery and readiness**									
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, PH	2022/23	Place		Not yet underway			Grey
7.2.2	Consider the service offer for patients with long Covid, including accessibility.		LPT	TBC	Place		Not yet underway			Grey
7.2.3	Pandemic readiness. Maintaining a collaborative health protection approach and response ready for future Covid-19 surges or other future pandemics.		PH	Ongoing	Place and System		Ongoing readiness via the UK Health Security Agency and relevant local Public Health teams, for infectious diseases that could be a significant threat to health, including Covid-19 variants and monkeypox. Rutland specific Health protection and infection control resource now in place.			Green

8. Communications and Engagement

Senior Responsible Officer (on HWB) John Morley
Responsible Officer (on IDG) Katherine Willison/Charlie Summers

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Ref	What Do We Want To Achieve?	How Are We Going To Do It?	Lead Organisation	Timeframe for Delivery (Month/Year)	Level (System, Place or Neighbourhood)	How Will Success Be Measured?	Progress for November 2022	Key Identified Risks	Mitigations	November 2022 Project RAG Status
8.1	**Readiness to deliver the plan**									
8.1.1	Sustain communications working group through year 1 of the plan to support establishment of new ways of working.									
8.1.2	Strengthening this plan through engagement with the public and professionals									
8.1.3	High-level audit of communications and engagement assets across involved partners (skills, resources, channels and tools) to help to plan coordinated approaches to communications (assets and gaps/opportunities).									
8.1.4	Review of the overarching JHW strategy delivery plan to identify key comms and engagement linkages and dependencies									
8.1.5	Agree scope to coordinate with system/ICS level communications activity and mechanisms – e.g. access to citizen panels.									
8.1.6	Establish working group and outline reporting timescales for IDG and HWB on communications and engagement activity and performance.									
8.2	**Ensuring people have access the information they need to maintain their health and wellbeing and to navigate change successfully**									
8.2.1	Coordinate with ICB and places on a visual brand for health and wellbeing in Rutland – consult to see if this is a want across the Place (inc Sue Venables) Agreed approach for collaborative communications across health and care in Rutland.									
8.2.2	Investigating mechanisms to engage Rutland's population in improved communications and communications management (digital impact)									
8.2.3	Shared, rolling communications campaign calendar with selected campaigns prioritised and/or in common across the year – design, maintain, deliver.									
8.2.4	Training: Progress training opportunities including behavioural insights, social media.									
8.2.5	Link to local actions building digital confidence – to consult with the proposed leads. (Join up with initiatives across LLR)									
8.2.6	Enhance the Rutland Information Service (RIS) as a key shared source of information about local services and opportunities. • Develop RIS social media presence – bringing content to the online places people visit. • Website technical code refresh for accessibility and ease of use via a mobile phone. • Using website usability testing to increase the effectiveness of RIS content. Map digital confidence To consult									
8.3	**Raising the profile of the Rutland Health and Wellbeing Board**									

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8.3.1	Web content conveying the role and purpose of the HWB and inviting public involvement. The role of the HWB is already on the RCC site. Query inviting public involvement in the role and purpose of the Board. What is this trying to achieve?									
8.3.2	Visual identity for the HWB – papers, web page, social media. Minutes and papers are available on the RCC site for the public. Do we want a separate page for HWB? Do we want a Twitter account?									
8.3.3	Social media account for HWB health and wellbeing news/messages with shared hashtags. As above?									
8.3.4	Ongoing promotion of HWB activity including public engagement opportunities in health and wellbeing change. Yes - We can cover this in delivering actions 1 and 2 – ensure this weaves within all comms and engagement where appropriate									
8.4	**Involving the public and professional stakeholders in service design and change**									
8.4.1	Identify key stakeholders for delivery									
8.4.2	Business case setting out options for engagement activity depending on level of resourcing.									
8.4.3	Mapping events held over the year to contribute/offer advice and information/gain views Programme of engagement activity - supporting delivery of JHWS priorities. (RCC Comms +)									
8.4.4	Establish an engagement approach, including a toolkit for partners to use, drawn from wider best practice. To include: • Approach to compensation where required. • Existing groups who could be engaged. • How to reach less often heard groups and groups facing inequalities.									
8.4.5	Sharing of 'you said, we did' outcomes via the HWB and/or Rutland Information Service.									

Strategic Priority Area	Strategic Priority Worksream	Workstream/Project Lead	Email
Best Start in Life	1.1 Healthy child development in the 1,001 critical days (conception to 2 years old)		
	1.2 Confident Families and Young People		bcaffrey@rutland.gov.uk
	1.3 Access to Health Services		jdowling@rutland.gov.uk
Prevention	2.1 Supporting people to take an active part in their communities		
	2.2 Looking after yourself and staying well in mind and body		
	2.3 Encourage and enable take up of preventative health services		
	2.4 Maintaining and developing the environmental, economic and social conditions to encourage healthy living for all		
Living With Ill Health	3.1 Healthy ageing, including living well with long-term health conditions, and reducing frailty and over 65s falls		
	3.2 Integrating services to support people living 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		
Equitable Access	4.1 Understanding the access issues		jamesburden@nhs.net
	4.2 Increase the availability of diagnostic and elective health services closer to home		debra.mitchell3@nhs.net
	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, including through technology		
	4.5 Improving access to services and opportunities for people less able to travel, including through technology		
	4.6 Enhance cross boundary working across health and care with key neighbouring areas		
Growth and Change	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, in particular developing a healthy built environment aligned for projected growth		
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 Communities are prepared to help		
Cross Cutting Themes	7.1 Mental Health		
	7.2 Inequalities		
	7.3 Covid Recovery		

Acronyms and 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